HOUSE BILL REPORT
HB 2319

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to furthering state implementation of the health benefit exchange and related provisions of the affordable care act.

Brief Description: Implementing the affordable care act.

Sponsors: Representatives Cody, Jinkins and Ormsby; by request of Governor Gregoire and Insurance Commissioner.

Brief History:
Committee Activity:
Health Care & Wellness: 1/18/12, 1/26/12, 1/30/12 [DPS].

Brief Summary of Substitute Bill

- Removes the limitations on the Health Exchange Board's authority regarding operating the Washington Health Benefit Exchange (Exchange).
- Imposes market rules on carriers once certain conditions are met.
- Creates a process for certifying qualified health plans authorized to be offered in the Exchange.
- Establishes a rating system for qualified health plans.
- Creates a process for determining the "essential health benefits" that must be offered both inside and outside of the Exchange.
- Requires the state to adopt the federal "Basic Health Program Option" if the Governor makes certain findings.
- Establishes a reinsurance program for plans offered both inside and outside of the Exchange.
- Limits the Washington State Health Insurance Pool (WSHIP) to persons enrolled prior to December 31, 2013, who do not disenroll after December 31, 2013.
- Removes the ability of WSHIP plans to impose pre-existing condition waiting periods beyond December 31, 2013.
- Requires the WSHIP to offer premium subsidies.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Cody, Chair; Jinkins, Vice Chair; Schmick, Ranking Minority Member; Hinkle, Assistant Ranking Minority Member; Clibborn, Green, Kelley, Moeller and Van De Wege.

Minority Report: Do not pass. Signed by 2 members: Representatives Bailey and Harris.

Staff: Jim Morishima (786-7191).

Background:

I. Health Benefit Exchanges.

The federal Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (ACA) requires every state to establish a Health Benefit Exchange (Exchange). The ACA requires two Exchanges, one for small businesses and one for individuals, which may be administratively operated as one entity. If a state elects not to establish an Exchange, the federal government will operate one either directly or through an agreement with a nonprofit entity. The Exchange's functions must include:

- facilitating the purchase of qualified health plans by individuals and small groups;
- certifying health plans as qualified health plans based on federal guidelines;
- providing information to individuals about their eligibility for public programs like Medicaid and the Children's Health Insurance Program and enrolling eligible individuals in those programs;
- operating a telephone hotline and website to assist consumers in the Exchange; and
- establishing navigator programs to help inform consumers and facilitate their enrollment in qualified health plans in the Exchange.

In 2011 the Legislature established its Exchange as a public-private partnership separate from the state. The Exchange is to begin operations by January 1, 2014, consistent with federal law and statutory authorization. The Exchange is governed by a nine-member board appointed by the Governor from a list submitted by all four caucuses of the House of Representatives and the Senate. The powers and duties of the Exchange and the board are limited to those necessary to apply for and administer grants, establish information technology infrastructure, and other administrative functions. Any actions relating to substantive policy decisions must be made consistent with statutory direction.

II. Market Rules.

The ACA specifies four categories of plans to be offered through the Exchange and in the individual and small group markets. The categories are based on the actuarial value of the plans; i.e., the percentage of the costs the plan is expected to pay:

- Platinum: 90 percent actuarial value;
- Gold: 80 percent actuarial value;
- Silver: 70 percent actuarial value; and
- Bronze: 60 percent actuarial value.

III. Qualified Health Plans.

Only qualified health plans may sell insurance in the Exchange. In order to be a qualified health plan, a carrier must, at a minimum:

- be certified as a qualified health plan based on federal guidelines;
- provide coverage for the essential health benefits;
- offer at least one Silver and one Gold plan in the Exchange; and
- charge the same premium, both inside and outside the Exchange.

IV. Essential Health Benefits.

Health plans that offer plans in the Exchange and non-grandfathered health plans in the small group and individual markets outside of the Exchange must offer a federally defined package of benefits called "essential health benefits." The essential health benefits must include, at a minimum, benefits within the following 10 categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance abuse services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

On December 16, 2011, the United States Department of Health and Human Services issued a bulletin to solicit input from stakeholders on a regulatory approach that would allow states to choose a "benchmark" plan from the following:

- the three largest small group plans in the state by enrollment;
- the three largest state employee health plans by enrollment;
- the three largest federal employee health plan options by enrollment; and
- the largest Health Maintenance Organization (HMO) plan offered in the state's commercial market by enrollment.

Under this approach, the state would have to supplement the benchmark plan if the plan did not cover the 10 categories of essential health benefits. Health plans would have the option to adjust benefits as long as all 10 categories were still covered and the value of the plan is substantially equal.

V. The Basic Health Option.

Under the ACA, a state may contract with private insurers to provide coverage for low-income individuals between 133 and 200 percent federal poverty level, similar to Washington's existing Basic Health Plan. Individuals in the Basic Health Program (BHP) will not participate in the Exchange, but the state will receive federal funding for the BHP

equal to 95 percent of the tax credits and cost-sharing reductions the individuals would have received in the Exchange.

VI. Risk Leveling.

The ACA contains a variety of mechanisms to address adverse selection both inside and outside of the Exchange, including:

- the individual mandate;
- authorizing open enrollment periods; and
- requiring health carriers to pool risk both inside and outside of the Exchange.

In addition, the ACA creates two temporary and one permanent risk leveling mechanisms:

- Reinsurance: a temporary program administered by the state nonprofit entity, the Reinsurance mechanism requires most health plans (both inside and outside the Exchange) to make payments to the nonprofit entity that will then disburse those funds to plans with higher-risk enrollees.
- Risk Corridors: a temporary program administered by the federal government, the Risk Corridor mechanism is designed to compensate for the difficulty of establishing initial rates in the Exchange. Plans that have lower than expected costs will make payments to the federal government. The federal government will then disburse those funds to plans with higher than expected costs.
- Risk Adjustment: a permanent plan administered by the states, the Risk Adjustment mechanism assesses plans with lower-cost enrollees and makes disbursements to plans with higher-cost enrollees.

VII. The Washington State Health Insurance Pool.

Before purchasing insurance on the individual market, Washington residents must complete the Standard Health Questionnaire. Based on the results, an individual may be turned down for coverage. The Washington State Health Insurance Pool (WSHIP) provides health insurance to individuals who have been rejected from the individual market for medical reasons. A WSHIP insurance plan may impose a six-month waiting period for preexisting conditions. Premiums for the WSHIP plans must be between 110 percent and 150 percent of what the largest carriers charge for individual plans with similar benefits.

VIII. Catastrophic Plans.

Under the ACA, health plans may offer catastrophic plans to individuals inside and outside of the Exchange. Catastrophic plans are subject to an annual deductible of $5,950 for individuals and $11,900 for families (the deductible does not apply to preventive benefits and up to three primary care visits). The plans are only available to individuals who are both under the age of 31 and exempt from the individual mandate.

Under state law, a catastrophic health plan is defined as:

- a health plan requiring a calendar year deductible of at least $1,880 for individuals ($3,760 for multiple persons) and an annual out-of-pocket expense required for covered benefits of $3,760 for individuals ($6,450 for multiple persons); or

- a health plan that provides benefits for hospital inpatient and outpatient services, provides benefits for professional and prescription drugs provided in conjunction with the hospital services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

Summary of Substitute Bill:

I. Health Benefit Exchanges.

The provisions limiting the authority of the Exchange Board (Board) are eliminated. The Exchange is required to report its activities to the Governor and the Legislature as requested, but no less often than annually. The Chair of the Board serves at the pleasure of the Governor.

A designee of the Exchange, in addition to the Exchange itself, may authorize expenditures from the Health Benefit Exchange Account.

II. Market Rules.

The Insurance Commissioner may adopt a rule that prohibits a carrier from offering a Bronze plan outside the Exchange unless it offers the same plan inside the Exchange. The Insurance Commissioner may only adopt the rule if he or she finds, in consultation with the Board, that (1) the Exchange is experiencing (or is likely to experience) significant adverse selection; or (2) consumers do not have adequate choice of health plans inside the Exchange. The rules may not go into effect until one full regular session of the Legislature has passed.

All health plans outside of the Exchange, other than catastrophic plans, must offer plans that conform to the Platinum, Gold, Silver, and Bronze value tiers specified in the ACA.

III. Qualified Health Plans.

The Board must certify a health plan as a qualified health plan if the plan:
- is determined by the Insurance Commissioner as meeting state insurance laws and regulations;
- is determined by the Board to meet the requirements of the ACA; and
- is determined by the Board to include tribal clinics and urban Indian clinics as essential community providers in the plan's provider network.

The Board must establish a rating system for qualified health plans to assist consumers in evaluating plan choices in the Exchange. Rating factors must, at a minimum, include:
- affordability with respect to premiums, deductibles, and point-of-service cost-sharing;
- provider reimbursement methods that incentivize chronic care management and care coordination for enrollees with complex, high-cost, or multiple chronic conditions;
- provider reimbursement methods that reward health homes that reduce emergency department and inpatient care;
- promotion of appropriate primary care and preventive services utilization;

- high standards for provider network adequacy, including consumer choice of providers and service locations and robust provider participation intended to improve access to underserved populations through participation of essential community providers, family planning providers, and pediatric providers; and
- protection of the privacy of patients' personal health information.

The Office of the Insurance Commissioner retains regulatory authority over qualified health plans sold in the Exchange.

IV. Essential Health Benefits.

The Insurance Commissioner must, by rule, select a benchmark plan for purposes of determining the essential health benefits from one of the following options:
- the three largest small group plans in the state by enrollment; or
- the largest health maintenance organization in the state's commercial market by enrollment.

The Insurance Commissioner must, in consultation with the Board and the Health Care Authority (HCA), supplement the benchmark plan to ensure that it covers all 10 categories of essential health benefits specified in the ACA. A health plan required to offer the essential health benefits by federal law may be offered in the state, unless the Insurance Commissioner finds that it is substantially equal to the benchmark plan. When making the determination, the Insurance Commissioner must ensure that the plan:
- covers the 10 essential health benefits categories required by the ACA;
- does not create a significant risk of biased selection based on health status; and
- contains meaningful benefits in each of the 10 essential health benefits categories.

V. The Basic Health Option.

The HCA must provide the necessary certifications to the federal government to establish the Basic Health Program (BHP), unless, by July 1, 2012, the Governor finds:
- anticipated federal funding will be insufficient to cover the essential health benefits through 2019:
    - at enrollee premium levels equivalent to the Exchange;
    - using payment rates sufficient to ensure access to care for enrollees and incentivize an adequate provider network, in conjunction with innovative payment methodologies and standard health plan performance measures that will create incentives for the use of effective cost containment and health care quality strategies; and
    - assuming reasonable BHP administrative costs and the potential impact of funding reconciliation; and
- sufficient funds are available to support the design and development work necessary for the program to begin providing coverage beginning January 1, 2014.

Prior to making the finding, the HCA must:
- consult with the Board, the Office of the Insurance Commissioner, consumer advocates, provider organizations, carriers, and other interested organizations; and

- consider any available objective analysis specific to Washington by an independent, nationally recognized consultant that has been actively engaged in analysis and economic modeling of the BHP for multiple states.

If adopted, the BHP must be guided by the following principles:

- meeting minimum state certification standards specified in the ACA;
- twelve month continuous eligibility and enrollment or financing methods mechanisms that enable enrollees to remain with a plan for the entire plan year;
- achieving appropriate balance with:
    - premiums and cost-sharing minimized to increase affordability;
    - standard health plan contracting requirements that minimize plan and provider administrative cost, while holding standard health plans accountable for performance and enrollee health outcomes, and ensuring adequate enrollee notice and appeal rights; and
    - health plan payment rates that are sufficient to ensure access to care and incentivize adequate provider networks, in conjunction with innovative payment methodologies and standard health plan performance measures that will create incentives for the use of effective cost-containment and health care quality; and
- transparency in program administration.

VI. Risk Leveling.

The Insurance Commissioner, in consultation with the Board, must adopt rules establishing the reinsurance program required by the ACA. The rules must establish:

- a mechanism for collecting reinsurance funds;
- a reinsurance payment formula; and
- a mechanism to disburse reinsurance payments.

To compensate carriers offering plans in the Exchange for the possibility of increased risk in the Exchange and to incentivize carrier participation in the Exchange, the rules must make any or all of the following modifications to the payment formula:

- a lower attachment point inside the Exchange;
- a higher cap inside the Exchange (or no cap at all inside the Exchange); or
- a higher coinsurance rate inside the Exchange.

The Insurance Commissioner may adjust the rules to preserve a healthy market both inside and outside of the Exchange.

VII. The Washington State Health Insurance Pool.

Beginning on January 1, 2014, a person is eligible for coverage in the WSHIP only if he or she is enrolled in pool coverage on December 31, 2013, and does not disenroll after December 31, 2013. For policies renewed on or after January 1, 2014, rates for pool coverage may be no more than the average individual standard rate charged for comparable coverage by the five largest carriers, measured in terms of individual market enrollment, in the state. If five carriers do not offer comparable coverage, the rates may be no greater than the standard risk rate established using reasonable actuarial techniques and must reflect

anticipated experience and expenses for such coverage in the individual market. A WSHIP plan may not impose a pre-existing condition waiting period that extends beyond December 31, 2013.

The WSHIP must reduce an enrollee's premium obligation as needed to provide him or her with premium subsidies equivalent to what he or she would have received in the Exchange. An enrollee is eligible for this reduction if he or she:

- has a modified adjusted gross income below 400 percent of federal poverty level;
- is not enrolled in Medicare; and
- does not have an offer of minimum essential coverage.

The WSHIP is authorized to perform all or part of the risk leveling functions in the ACA if authorized by statute. To further timely implementation, the WSHIP is authorized to conduct pre-operational and planning activities, including defining and implementing the appropriate legal structure to administer and coordinate the programs. Assessments for the reinsurance program may be increased to cover the pre-operation activities of the WSHIP. The WSHIP must report its activities to the appropriate committees of the Legislature by December 15, 2012, and December 15, 2013.

VIII. Catastrophic Plans.

Part of the current definition of "catastrophic health plan" is made applicable only to grandfathered health plans issued before January 1, 2014, and renewed thereafter. A grandfathered plan is a catastrophic health plan if it requires a calendar year deductible of at least $1,880 for individuals ($3,760 for multiple persons) and an annual out-of-pocket expense required for covered benefits of $3,760 for individuals ($6,450 for multiple persons). The part of the definition dealing with a health plan that (1) provides benefits for hospital inpatient and outpatient services, (2) provides benefits for professional and prescription drugs provided in conjunction with the hospital services, and (3) excludes or substantially limits outpatient physician services and those services usually provided in an office setting, is eliminated.

For non-grandfathered health plans issued on or after January 1, 2014, a "catastrophic health plan" is defined as:

- a health plan that meets the definition in the ACA; or
- a health benefit plan offered outside the Exchange that requires a calendar year deductible or out-of-pocket expenses for covered benefits that requires a calendar year deductible of at least $1,880 for individuals ($3,760 for multiple persons) and an annual out-of-pocket expense required for covered benefits of $3,760 for individuals ($6,450 for multiple persons).

Substitute Bill Compared to Original Bill:

The substitute bill:

- clarifies that the Chair of the Board serves at the pleasure of the Governor;
- removes the market rules in the underlying legislation. Instead, the Insurance Commissioner may require that carriers offering a Bronze plan outside the Exchange also offer a Bronze plan inside the Exchange, but only if:

        - the Insurance Commissioner finds that there is adverse selection or lack of choice; and
        - at least one legislative session has passed; and
    - requires carriers selling outside of the Exchange to offer coverage in the "metal" actuarial levels in the ACA;
    - removes the authority of the Insurance Commissioner to impose additional requirements on qualified health plans;
    - requires qualified health plans to include tribal clinics and urban Indian clinics in their provider networks;
    - authorizes carriers to sell stand-alone dental plans inside the Exchange;
    - requires the Board to establish a rating system for qualified health plans;
    - creates a process for determining the essential health benefits package and for determining whether a plan's benefits are substantially equivalent to the essential health benefits;
    - requires the state to establish a BHP, unless the Governor makes certain findings;
    - requires the Insurance Commissioner to establish a reinsurance program, as required by federal law, in which modifications are made in the payment formula to compensate for the possibility of higher risk in the Exchange and to incentivize carrier participation in the Exchange;
    - requires the WSHIP to reduce an enrollee's premium obligations to provide the enrollee with subsidies equivalent to subsidies inside the Exchange; and
    - allows the WSHIP to make preparations to administer the risk management functions in the ACA.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 3 and 4 relating to the powers of the Exchange Board and the Health Benefit Exchange Account, which contain an emergency clause and take effect immediately; and sections 15, 17, and 19 relating to WSHIP eligibility, which take effect on January 1, 2014.

Staff Summary of Public Testimony:

(In support) The Exchange is at the heart of the ACA. This bill will keep the state in line with key deadlines and will allow providers and carriers to start making decisions. This bill builds on the success of last year's process, including the selection of a board. The bill does not overreach; it does not add qualified health plan criteria or adopt the Basic Health Option. The bill also addresses adverse selection, which was not adequately addressed in the ACA. The issue of what to do with the WSHIP is also addressed. The establishment of an Exchange will drastically increase access to insurance and foster competition based on price, quality, and service. The current system is too complex. Individuals and businesses need a simple way to compare plans. The additional market rules will ensure a level playing field inside and outside of the Exchange; we should not wait to see if the ACA's risk leveling

mechanisms fail before the state does something. The definition of small group should be increased to 100 to ensure a larger risk pool. The state should pursue the Basic Health Option, which will increase affordability, lead to greater enrollment, result in fewer care disruptions, and will foster integrated delivery models. Lower income individuals are price sensitive. The Board and the Insurance Commissioner should be able to foster an optimal combination of choice, quality, and value. The Exchange should not become the new high risk pool; there should be more plans inside and outside of the Exchange to spread risk. Plans should be required to offer inside the Exchange if they offer outside the Exchange. The process for selecting the essential health benefits should be transparent. Plans should not be allowed to shift risk onto sick people. Tribes should be allowed to sponsor the premiums of tribal members and tribal providers should be essential community providers. The WSHIP funding is inadequate; the funding is not spread across the entire market. The Board should be responsive to the needs of providers. The state should consider leaving the WSHIP open.

(Information only) The WSHIP needs statutory changes to prepare to administer the reinsurance program required by the ACA.

(In support with concerns) The Legislature should maintain substantive control over Exchange policy. Giving authority to the Insurance Commissioner and the Board to impose more requirements on qualified health plans will limit competition and could fundamentally re-make the market. The WSHIP should have a broader role; it could even become an issuer in the Exchange. The tools in the ACA are sufficient to manage risk; they should be allowed to function on their own.

(With concerns) The ACA already recognizes the potential for adverse selection. The risk leveling mechanisms in the ACA should be allowed to work before the state imposes additional market rules. This bill gives too much authority to the Board.

(Opposed) There is no need for additional market rules. Bronze plans will have to be significantly cheaper outside the Exchange to compete with the subsidized premiums inside the Exchange. Even if the plans could be offered cheaply outside the Exchange, the ACA's risk leveling mechanisms will come into play. The state should examine additional market rules only after there has been more experience with what is in the ACA. Uncertainty and the perception that the ACA will make coverage more expensive is leading to many small businesses dropping coverage. The market rules in this bill will limit the number of available plans inside and outside of the Exchange and will increase costs. This bill deviates from the ACA. The bill also removes legislative oversight.

Persons Testifying: (In support) Jonathan Seib, Office of the Governor; Molly Voris, Health Care Authority; Drew Bouton, Office of the Insurance Commissioner; Teresa Mosqueda, Washington State Labor Council; Jen Estroff, Children's Alliance and Health Care Law Advocates; Misha Werschkul, Service Employees International Union Healthcare 775NW; Sofia Aragon, Washington State Nurses Association; Erin Dziedzic, American Cancer Society Cancer Action Network; Joe King, Group Health Cooperative; and Katie Kolan, Washington State Medical Association.

(Information only) Karen Larson, Washington State Health Insurance Pool.

(In support with concerns) Len Sorrin, Premera.

(With concerns) Dave Knutson, United Healthcare; and Lonnie Johns-Brown, American Indian Health Commission.

(Opposed) Chris Bandoli, Regence BlueShield; and Gary Smith, Independent Business Association.

Persons Signed In To Testify But Not Testifying: None.