FINAL BILL REPORT
E2SHB 2319

PARTIAL VETO
C 87 L 12
Synopsis as Enacted

Brief Description: Implementing the federal patient protection and affordable care act.

Sponsors: House Committee on Ways & Means (originally sponsored by Representatives Cody, Jinkins and Ormsby; by request of Governor Gregoire and Insurance Commissioner).

House Committee on Health Care & Wellness
House Committee on Ways & Means
Senate Committee on Health & Long-Term Care

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 two Health Benefit Exchanges, one for small businesses and one for individuals. The exchanges may be administratively operated as one entity (Exchange). 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 (Board). The powers and duties of the Exchange and the Board are limited to those necessary to apply for and administer grants, establish information

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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.

IX. Wellness Program Demonstration Projects.

Under the ACA, the federal Department of Health and Human Services must establish a 10-state wellness program demonstration project. Under the program, states will apply employer wellness program criteria to programs of health promotion offered by individual market insurers. A state that participates in the program may permit premium discounts, premium rebates, or cost-sharing modifications based on participation in a health promotion program and must:

- ensure that consumer protection requirements are met;
- require verification that premium discounts do not create undue burdens for enrollees, do not lead to cost shifting, and are not a subterfuge for discrimination;
- ensure that consumer data are protected; and
- ensure that the discounts or other rewards reflect the expected level of participation in the program and the anticipated effect the program will have on utilization or claim costs.

Summary:

I. Health Benefit Exchanges.

The provisions limiting the authority of the Exchange are eliminated. The Exchange is authorized to serve as a premium aggregator and to complete other duties necessary to begin open enrollment beginning October 2, 2013. The Board must establish rules or policies permitting entities to pay premiums on behalf of qualified individuals. The Exchange must report its activities to the Governor and the Legislature as requested, but no less often than annually.

The Exchange is required to be self-sustaining, which is defined as capable of operating without direct state tax subsidy. If at any time the Exchange is no longer self-sustaining, its operations must be suspended. Self-sustaining sources include, but are not limited to, federal grants, federal premium tax subsidies and credits, charges to health carriers, and premiums paid by enrollees. The Board must develop funding mechanisms that fairly and equitably apportion among carriers the administrative costs and expenses of the Exchange and must

develop a methodology to ensure that the Exchange is self-sustaining. The Board must report its recommendations to the Legislature by December 1, 2012, and may implement the recommendations if the Legislature does not enact legislation during the 2013 regular legislative session that modifies or rejects the recommendations.

A qualified employer may access coverage for its employees through the Exchange. The Exchange must allow any qualified employer to select a level of coverage so that any of its employees may enroll in any qualified health plan offered through the Exchange at the specified level of coverage.

Exchange employees are authorized to participate in state health benefit and retirement programs.

A designee of the Exchange, in addition to the Exchange itself, may authorize expenditures from the Health Benefit Exchange Account. The Health Benefit Exchange Account is terminated on January 1, 2014.

A person functioning as a navigator under the ACA, is not considered to be soliciting or negotiating insurance for purpose of the statute regulating insurance producers (agents/ brokers).

II. Market Rules.

The following market rules are created:

- For plan or policy years beginning January 1, 2014, if a carrier offers a Bronze plan outside the Exchange, it must also offer Gold and Silver plans outside the Exchange.
- Catastrophic plans (as defined in the ACA) may only be sold inside the Exchange.

By December 1, 2016, the Board, in consultation the Insurance Commissioner, must review the impact of the market rules on the health and viability of the markets inside and outside of the Exchange and submit recommendations to the Legislature on whether to maintain the market rules or let them expire.

The Insurance Commissioner must evaluate Platinum, Gold, Silver, and Bronze plans and determine whether variation in prescription drug benefit cost-sharing results in adverse selection. If so, the Insurance Commissioner may adopt rules to assure substantial equivalence of prescription drug benefits.

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 consistent with federal law. An integrated delivery system may be exempt from the essential community provider requirement if consistent with federal law.

A decision by the Board denying a request to certify or recertify a plan as a qualified health plan may be appealed according to procedures adopted by the Board.

The Board must allow stand-alone dental plans to be offered in the Exchange, consistent with the ACA. Dental benefits offered in the Exchange must be priced separately to assure transparency for consumers.

The Board may permit direct primary care medical home plans, consistent with the ACA, to be offered in the Exchange beginning January 1, 2014.

A state agency must provide information to the Board for its use in determining whether to certify a plan as a qualified health plan. The information must be provided within 60 days, unless the Board and the agency agree to a later date. The Exchange must reimburse the agency for the cost of providing the information within 180 days of its receipt.

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;
- enrollee satisfaction;
- provider reimbursement methods that incentivize health homes or chronic care management or care coordination for enrollees with complex, high-cost, or multiple chronic conditions;
- 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;
- high standards for covered services, including languages spoken or transportation assistance; and
- coverage of benefits for tax-deductible spiritual care services.

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 the largest small group plan in the state by enrollment as the benchmark plan for determining the essential health benefits.

The Insurance Commissioner must, in consultation with the Board and the Health Care Authority (HCA), supplement the benchmark plan as needed 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 not 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; and
- may consider whether the plan has a plan benefits design that would create a risk of biased selection based on health status and whether it contains meaningful scope and level of benefits in each of the 10 essential health benefits categories.

Beginning December 15, 2012, and every year thereafter, the Insurance Commissioner must submit to the Legislature a list of state-mandated health benefits, the enforcement of which would result in federally imposed costs to the state. The list must include the anticipated costs to the state of each benefit on the list. The Insurance Commissioner may enforce a benefit on the list only if funds are appropriated by the Legislature for that purpose.

It is clarified that nothing in the act prohibits the offering of benefits for tax-deductible spiritual care services in plans inside and outside of the Exchange.

V. The Basic Health Option.

By December 1, 2012, the Director of the HCA must submit a report to the Legislature on whether to proceed with a federal BHP option. The report must address whether:

- sufficient funding is available to support the design and development work necessary for the program to provide health coverage to enrollees beginning January 1, 2014;
- anticipated federal funding will be sufficient, absent any additional state funding, to cover the essential health benefits and administrative costs (enrollee premium levels will be below the levels that would apply to persons with income between 134 and 200 percent of the federal poverty level through the Exchange); and
- health plan payment rates will be sufficient to ensure enrollee access to a robust provider network and health homes.

Prior to making the finding, the Director of 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 the Legislature determines to proceed with implementation of a federal BHP, the director of the HCA must provide the necessary certifications to the federal government. To the extent funding is available, the HCA must assume the federal BHP will be implemented in Washington and initiate the necessary design and development work. If the Legislature determines not to proceed, the HCA may cease activities related to BHP implementation.

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

- meeting minimum state certification standards specified in the ACA;
- twelve-month continuous eligibility or enrollment or financing 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 incentivizing improvements and quality and enrollee health outcomes; and
- health plan payment rates and provider payment rates that are sufficient to ensure enrollee access to a robust provider network and health homes; and

- transparency in program administration.

VI. Risk Leveling.

The Insurance Commissioner, in consultation with the Board, must adopt rules establishing the reinsurance and risk adjustment programs required by the ACA.

The Insurance Commissioner's deliberations related to reinsurance rulemaking must include an analysis of an invisible high risk pool option, in which the full premium and risk associated with certain high-risk or high-cost enrollees would be ceded to the reinsurance program. The analysis must include a determination as to:

- whether the invisible high risk pool is authorized under federal law;
- whether the option would provide sufficiently comprehensive coverage for current non-Medicare high risk pool enrollees; and
- how an invisible high risk pool could be designed to ensure that carriers ceding risk provide effective care management to high-risk or high-cost enrollees.

The rules for the reinsurance program must establish:

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

The rules must also identify, and may require, submission of the data needed to support operation of the reinsurance program. The rules must identify the sources of the data, and other requirements related to their collection, validation, interpretation, and retention. The Insurance Commissioner may adjust the rules to preserve a healthy market both inside and outside of the Exchange.

The Insurance Commissioner must contract with one or more nonprofit entities to administer the risk adjustment and reinsurance programs. Contribution amounts for the reinsurance program may be increased to include amounts sufficient to cover administrative costs, including reasonable costs incurred for pre-operational and planning activities.

VII. The Washington State Health Insurance Pool.

The WSHIP Board must review the populations that may need ongoing access to pool coverage, including persons with end-stage renal disease or HIV/AIDS or persons not eligible for Exchange coverage. If the review indicates the need for continued coverage, the WSHIP Board must submit recommendations regarding modifications to pool eligibility that would allow new enrollees in the WSHIP on or after January 1, 2014, including any needed modifications to the standard health questionnaire or other eligibility screening tool that could be used to determine pool enrollment.

The WSHIP Board must also analyze pool assessments in relation to the assessments for the federal reinsurance program and recommendations for changes in the assessment or any credits that may be considered for the reinsurance program. The analysis must recommend whether the categories of members paying assessments should be adjusted to make the assessment fair and equitable among all payers.

The WSHIP Board must report its recommendations to the Governor and the Legislature by December 1, 2012.

The WSHIP is authorized to contract with the Insurance Commissioner to administer risk management functions if necessary, consistent with the ACA. Prior to entering into a contract, the WSHIP may conduct pre-operational and planning activities, including defining and implementing appropriate legal structures to administer the programs. The reasonable costs incurred by the WSHIP may be reimbursed from federal funds or from the additional contributions from plan members. If the WSHIP contracts to administer and coordinate the reinsurance or risk adjustment programs, the WSHIP Board must submit recommendations to the Legislature with suggestions for additional consumer representatives or other members of the WSHIP Board. The WSHIP must report on these activities to 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 meets or exceeds the adjustment required by the ACA.

IX. Wellness Program Demonstration Project.

The HCA must pursue an application to participate in a wellness program demonstration project as authorized in the ACA. The HCA must pursue activities that will prepare the state to apply for the demonstration projection once it is announced by the federal government.

Votes on Final Passage:

House	52	43	
Senate	27	22	(Senate amended)
House	55	41	(House concurred)

Effective: March 23, 2013
June 7, 2012 (Sections 1-3, 5-15, 17, and 24-27)

Partial Veto Summary: The section of the bill requiring the operations of the Exchange to be suspended in the event that it is no longer self-sustaining was vetoed.