HOUSE BILL REPORT
E2SHB 2319

As Passed Legislature

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 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).

Brief History:

Committee Activity:

Health Care & Wellness: 1/18/12, 1/26/12, 1/30/12 [DPS];
Ways & Means: 2/4/12, 2/7/12 [DP2S(w/o sub HCW)].

Floor Activity:

Passed House: 2/11/12, 52-43.
Senate Amended.
Passed Senate: 3/1/12, 27-22.
Passed House: 3/3/12, 55-41.
Passed Legislature.

Brief Summary of Engrossed Second Substitute Bill

- Removes restrictions on the authority of, and adds new duties for, the Washington Health Benefit Exchange (Exchange).
- Authorizes Exchange employees to participate in state health benefit and retirement programs.
- Establishes new market rules for plans sold inside and outside of the Exchange.
- Creates a process for certifying qualified health plans authorized to offer coverage in the Exchange.
- Establishes a rating system for qualified health plans.
- Establishes a process for designating the "essential health benefits" that must be offered both inside and outside of the Exchange.
- Creates a process for identifying state-mandated benefits that would result in federally imposed costs to the state if enforced.

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.

- Requires the Health Care Authority to report to the Legislature on the federal Basic Health Option and specifies operational parameters should the Legislature determine to proceed with the option.
- Establishes federal reinsurance and risk adjustment programs and allows the Washington State Health Insurance Pool (WSHIP) to administer the programs by contract.
- Requires the WSHIP to make findings regarding continued operation after January 1, 2014.
- Requires the state to apply for a wellness program demonstration project.

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).

HOUSE COMMITTEE ON WAYS & MEANS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 16 members: Representatives Hunter, Chair; Darneille, Vice Chair; Hasegawa, Vice Chair; Carlyle, Cody, Dickerson, Haigh, Hudgins, Hunt, Kagi, Kenney, Ormsby, Pettigrew, Seaquist, Springer and Sullivan.

Minority Report: Do not pass. Signed by 11 members: Representatives Alexander, Ranking Minority Member; Bailey, Assistant Ranking Minority Member; Dammeier, Assistant Ranking Minority Member; Orcutt, Assistant Ranking Minority Member; Chandler, Haler, Hinkle, Parker, Ross, Schmick and Wilcox.

Staff: Erik Cornellier (786-7116).

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.

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 of Engrossed Second Substitute Bill:

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;
- protection of the privacy of patients' personal health information;
- high standards for covered services, including language 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.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 4, relating to the powers of the Exchange, sections 16 and 18, relating to risk management, and sections 19 through 23, relating to the participation of Exchange employees in public health benefit and retirement programs, which contain an emergency clause and take effect immediately.

Staff Summary of Public Testimony (Health Care & Wellness):

(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.

Staff Summary of Public Testimony (Ways & Means):

(In support) This bill is a work in progress and there are a lot of moving pieces. There are a lot of different ways to address the problems it deals with. The bill tries to balance flexibility for the board to be able to make the decisions it needs to make while retaining legislative oversight.

There is very little in federal health reform that directly addresses costs, but there are tools that allow states to drive down costs. This bill selectively utilizes those tools to address costs. It addresses consumer needs in the marketplace to ensure that enough plans offer products inside and outside the Exchange while addressing adverse selection. The state is going through a budget crisis and it is struggling to develop a sustainable budget. There is no more important area to address than health care.

Costs will only go down if people are able to afford and purchase coverage, otherwise they will go to the emergency room (ER) and receive expensive care. This bill helps avoid paying for ER services for the uninsured, which are paid by taxpayers and others with insurance.

There is no reason that citizens of Washington should pay 30 percent more than other countries, and 33 of 34 other industrialized countries pay 30 percent less for health care than Washington citizens do.

Insurance can save lives and money for cancer patients because it helps patients receive earlier diagnoses instead of expensive treatment at later stages. Insurance helps people with asthma purchase their medications, which keeps them out of the ER.

This bill represents the possibility of bringing federal funding into the state. This includes Exchange development grants. It also includes subsidies for populations with incomes up to 400 percent of the federal poverty level to make health care affordable for people in the state. The Medicaid expansion is not directly linked to the bill, but there is an impact and it is largely funded with federal dollars.

The BHP is a key provision of the bill. It is an essential program to get people covered and make coverage affordable by bending the cost curve. The BHP will reduce the number of uninsured individuals and promote continuity of coverage. Estimates show that it could increase enrollment for eligible populations by as much as 50,000 people. It could also be more affordable than the products available in the Exchange.

This legislation goes a long way for provider rates. The language requires payment rates sufficient to provide access to care. Providers should be reimbursed at rates that reflect reasonable costs for services provided while incentivizing quality and outcomes. Rates determine the sizes of networks and without networks there is no access to care.

A continued and expanded role for the WSHIP will be critical to stabilize the Exchange risk pool. Plunging the WSHIP enrollees into the Exchange right away would immediately overload the Exchange with a high cost population. The HIV and AIDS groups have concerns about closing the WSHIP because it provides a robust pharmacy benefit.

The bill allows Washington to make choices instead of letting the federal government make decisions for Washington.

(With concerns) Establishing the Exchange should be the highest priority in the bill. As it relates to market rules and requirements on plans, the bill should focus on the ACA standards and state laws without applying additional requirements. The language in the bill goes a long way to support this. The Office of the Insurance Commissioner should be required to use objective actuarial analyses when implementing rules.

The BHP could generate costs to the state. Development of information technology systems for eligibility determination and oversight would be a state responsibility and there is no federal match. The state will receive less federal funding if this option is exercised. The BHP could also jeopardize the viability of the Exchange by reducing the number of people buying insurance in the Exchange. Providers are paid less than cost in Medicaid, and vague language in the bill could allow that to happen in the BHP. Access would be a fiction unless rates are substantially above Medicaid levels. With over 300,000 new Medicaid enrollees, providers are thinking of leaving Medicaid and the BHP. The language on rates and innovative payments is vague and should be defined. There is no time limit on implementing

the BHP so the priority should be on getting the Exchange running. The HCA should not establish the BHP unless findings are made affirmatively.

(Opposed) This bill should focus on simple compliance with the requirements of the ACA, which is not a de minimis standard. The bill should have clear instructions that the Exchange entity will only pursue the activities necessary to qualify for Level Two funding under the ACA.

The Legislature should also retain policy making authority instead of giving the power to the Office of the Insurance Commissioner and the Exchange Board.

The bill should encourage a diversity of plans inside and outside the Exchange.

The ACA will impose requirements that will inevitably increase premiums such as the "metallic" benefit values. This is a math question. The state cannot substantially increase the amount an insurer will pay relative to enrollees without increasing premiums.

Small businesses have huge concerns. The state needs to know more about the fiscal impacts before acting. Small businesses do not understand health care reform at all. They have no idea what they can buy or what it costs. Many have unfortunately decided that they will probably just drop out and discontinue benefits for employees. Insurance is hard to afford now and businesses are concerned about whether they will be able to afford it later. It will cause a great deal of dislocation if people currently insured by employers become uninsured. Many of the businesses with less than 50 employees will not participate.

It is unclear whether the funding for the BHP will be sufficient to provide the Essential Health Benefits in plans with affordable premiums and provider reimbursement rates that are robust enough to encourage provider participation. The Governor should have to answer questions about the availability of funding, but the obligation should be flipped. The Governor should be required to answer these questions before the HCA files the necessary papers for adoption of the BHP with the federal government.

There is litigation at the federal level to undo the ACA. If the lawsuit is successful at a minimum the individual mandate will be removed. The entire act could be rendered unconstitutional so the bill should include a null and void clause to prevent the state from being on the hook for additional costs.

Persons Testifying (Health Care & Wellness): (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 Testifying (Ways & Means): (In support) Representative Cody, prime sponsor; Teresa Mosqueda, Washington State Labor Council; Erin Dziedzic, American Cancer Society; Seth Armstrong; Misha Werskul, Service Employees International Union 775 Northwest; Jonathan Seib, Office of the Governor; and Pam Crone, Community Health Plans, Community Health Network, and Association of Community and Mirgrant Health Centers.

(With concerns) Dave Knutson, United Health Care; and Katie Kolan, Washington State Medical Association.

(Opposed) Mel Soresen, Washington Association of Health Underwriters, America's Health Insurance Plans, and National Association of Insurance and Financial Advisors; Len Sorrin, Premera Blue Cross; Chris Bandoli, Regence Blue Shield; Gary Smith, Independent Business Association; Lisa Thatcher, Washington State Hospital Association; and Patrick Connor, National Federation of Independent Business.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Ways & Means): None.