Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

SSB 5445

Brief Description: Establishing a health benefit exchange.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Keiser, Pflug, White, Conway and Kline; by request of Governor Gregoire).

Brief Summary of Substitute Bill

- Requires the state to establish a health benefit exchange by statute.
- Establishes a Health Benefit Exchange Board, to be appointed September 1, 2011.
- Requires the Health Care Authority and the Health Benefit Exchange Board, in collaboration with the Joint Select Committee on Health Care Reform, to apply for and implement federal grants and to provide options to the Legislature for establishing an exchange.

Hearing Date: 3/17/11

Staff: Jim Morishima (786-7191).

Background:

Health Benefit Exchanges.

The federal Patient Protection and Affordable Care Act (PPACA) requires every state to establish an "American Health Benefit Exchange" (Exchange) no later than January 1, 2014. The Exchange must serve both small groups (in a so-called SHOP Exchange) and individuals and must be self-sustaining by January 1, 2015. If a state chooses not to establish an Exchange, the federal government will operate an Exchange either directly or through an agreement with a nonprofit entity.

Under the PPACA, an Exchange's functions include:

- facilitating the purchase of qualified health plans by individuals and small groups;
- certifying health plans as qualified health plans based on federal guidelines;

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- 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.

Health plans in the Exchange will be available in four different levels based on the percentage of costs the plan will pay: Bronze (60 percent), Silver (70 percent), Gold (80 percent), and Platinum (90 percent).

In order to be qualified to sell insurance in an Exchange, a carrier must:
- be certified as a qualified health plan based on federal guidelines;
- provide coverage for essential health benefits, as defined by the federal government;
- offer at least one Silver and one Gold plan in the Exchange; and
- charge the same premium, both inside and outside the Exchange.

Premium subsidies on a sliding scale will be available in the Exchange for persons between 133 percent and 400 percent of the federal poverty level (FPL) in the form of advanceable, refundable tax credits. Depending on a person's income level, the subsidies will ensure that the premiums the person pays will be no greater than a certain percentage of the person's income: under 133 percent FPL = 2 percent of income; 133-149 percent FPL = 3-4 percent of income; 150-199 percent FPL = 4-6.3 percent of income; 200-249 percent FPL = 6.3-8.05 percent of income; 250-299 percent FPL = 8.05-9.5 percent of income; and 300-399 percent FPL = 9.5 percent of income.

The PPACA provides states with some flexibility when implementing the Exchanges. For example:
- <u>Administration:</u> the Exchange may be administered by the state itself or a nonprofit entity.
- <u>Basic Health Option (BHO):</u> the state may contract with private insurers to provide coverage for low-income individuals between 133 and 200 percent FPL, similar to Washington's existing Basic Health Plan. Individuals in the BHO will not participate in the Exchange, but the state will receive federal funding for the BHO equal to 95 percent of the tax credits and cost-sharing reductions the individuals would have received in the Exchange.
- <u>Regional or Interstate Exchanges:</u> an Exchange may operate in more than one state. A state may also establish subsidiary Exchanges to serve geographically distinct areas within the state.
- <u>One Exchange or Two:</u> the state may operate separate Exchanges for the individual and small group markets, or may operate one Exchange that serves both (this is a separate issue from combining risk pools).
- <u>Combining Risk Pools:</u> the state may merge the individual and small group markets.
- <u>Essential Health Benefits:</u> the state may require insurers to offer benefits beyond what is required by federal law, but must pay for the increased costs of such benefits.

<u>State Planning Activities</u>.

In 2010 there was a variety of planning activities relating to Exchanges. For example, the Legislature established the Joint Select Committee on Health Reform Implementation, which established an advisory group to consider issues relating to establishing an Exchange. The Office of the Insurance Commissioner established a Realization Committee, which also made recommendations relating to an Exchange. Finally, the Health Care Authority received a planning grant, which it used, in part, to develop several issue briefs relating to Exchanges.

Summary of Bill:

Establishing an Exchange.

The state must establish, by statute, an Exchange no later than January 1, 2014. The Exchange is intended to:

- increase access to quality, affordable health care coverage and reduce the number of uninsured people in Washington;
- recognize the need for a private health care market outside of the Exchange and the need for a regulatory framework both inside and outside the Exchange, to be performed by the Insurance Commissioner;
- create an organized, transparent, and accountable health insurance marketplace for people to purchase affordable, quality health care coverage; claim available premium tax credits and cost-sharing subsidies; and meet the federal personal responsibility requirements for minimum essential coverage;
- strengthen the state health care delivery system and maximize existing efficiencies within the system;
- promote quality improvement, cost containment, and innovative payment structures;
- increase the availability of health care coverage through the private health insurance market;
- encourage carrier competition based on price and quality, not on risk selection, to ensure a sustainable system of health care coverage;
- promote consumer literacy and empower consumers to compare plans and make informed decisions about coverage;
- effectively and efficiently administer health care subsidies and determination of eligibility for publicly-subsidized health care programs;
- seamlessly direct consumers to information about, and enrollment in, other programs that are available to low-income individuals;
- enhance portability of insurance coverage and ensure seamless coverage options for enrollees with income and eligibility changes; and
- create opportunities and flexibility to address possible future changes in federal law and funding challenges.

The Health Benefit Exchange Board.

The Health Benefit Exchange Board (Board) is established as a nonprofit, public-private partnership the membership of which will be appointed by the Governor by September 1, 2011. The membership of the Board must be as follows:

- two employee benefits specialists;
- a health economist or actuary;
- small businesses;

- health care consumer advocates;
- the administrator of the Health Care Authority;
- the Insurance Commissioner (as an ex-officio member); and
- two members from a list of four recommendations submitted by the Legislature. Each chamber of the Legislature must submit two names, which must be mutually agreed on by each caucus.

Board members may not have any conflicts of interest relating to the work of the Board. Board members who develop such conflicts must be removed. The Board may establish technical advisory committees and consult with experts.

The Board is immune from civil or criminal liability for actions taken, or not taken, in the performance of their official duties, as long as they are acting in good faith. However, this immunity does not prohibit legal actions to enforce the Board's statutory or contractual duties or obligations.

Federal Grants.

The Health Care Authority (HCA) and the Board must apply for establishment and planning grants under the PPACA in consultation with the Joint Select Committee on Health Care Reform Implementation. Whenever possible, the grant applications must allow for using grant funds to partially fund the activities of the Joint Select Committee on Health Care Reform Implementation. The HCA and the Board, in consultation with the Joint Select Committee on Health Care Reform Implementation, must implement any grants received by the federal government.

Exchange Options.

By December 1, 2011, the HCA and the Board, in consultation with the Joint Select Committee on Health Reform Implementation, must develop a broad range of options for establishing and implementing a state-administered Exchange. The options must include recommendations on:

- the structure of the public-private partnership that will administer the Exchange, operations of the Exchange, and administration of the Exchange, including: the goals and principles of the Exchange; the creation and implementation of a single, state-administered Exchange for all geographic areas of the state that operates for both individual and small group markets; whether and under what circumstances the state should consider establishing a multi-state Exchange after implementation of a single state-administered Exchange; whether the Exchange should serve as an aggregator of funds that compromise the premium for a health plan in the Exchange; the administrative, fiduciary, accounting, contracting, and other services to be provided by the Exchange; coordination with other state programs; development of sustainable funding as of January 1, 2015; and recognizing the need for expedience in determining the structure of needed information technology, the necessary information technology to support implementation of Exchange activities;
- whether to adopt and implement the BHO, whether the BHO should be administered by the entity that administers the Exchange, and whether the BHO should merge risk pools with any portion of the state's Medicaid program;

- individual and small group market impacts, including whether to: merge the risk pools in the individual and small group markets; and increase the small group market to firms with up to 100 employees;
- creation of a competitive purchasing environment for qualified health plans in the Exchange;
- certifying, selecting, and facilitating the offer of individual and small group plans in the Exchange;
- the role of navigators, including the option to use private insurance market brokers as navigators;
- effective implementation of risk management methods, including reinsurance, risk corridors, and risk adjustment;
- participating in innovative cost-containment efforts;
- providing federal refundable premium tax credits and reduced cost-sharing subsidies through the Exchange, including the processing and entity responsible for determining eligibility;
- the staff, resources, and revenues necessary to operate and administer the Exchange for the first two years; and
- any other areas identified by the Joint Select Committee on Health Reform Implementation.

In collaboration with the Joint Select Committee on Health Reform Implementation, the HCA must develop a work plan for the development of the options in discrete, prioritized stages.

<u>Consultation with Other Entities</u>.

The HCA must consult with the Insurance Commissioner, the Joint Select Committee on Health Reform Implementation, and stakeholders when carrying out its responsibilities, including consumers; individuals and entities with experience facilitating enrollment in health insurance coverage; representatives of small businesses, employees of small businesses, and self-employed individuals; advocates for enrolling hard-to-reach populations and populations enrolled in publicly subsidized health programs; publicly subsidized health care programs; and members of the American Academy of Actuaries. The HCA may enter into information sharing agreements with federal and state agencies and interdepartmental agreements with other state agencies. The HCA must also provide staff and resources, manage grant and other funds, expend appropriated funds, and adopt necessary rules.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.