HOUSE BILL REPORT
SSB 5445

As Passed House - Amended:
April 11, 2011

Title: An act relating to the creation of a health benefit exchange.

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 History:
Committee Activity:
Health Care & Wellness: 3/17/11, 3/23/11 [DPA];
Ways & Means: 3/30/11, 3/31/11 [DPA(HCW)].
Floor Activity:
Passed House - Amended: 4/11/11, 75-22.

Brief Summary of Substitute Bill
(As Amended by House)

- Establishes a Health Benefit Exchange with a board to be appointed by December 15, 2011, which will take over planning duties from the Health Care Authority on March 15, 2012.
- Requires the Health Care Authority, 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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. 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).

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 WAYS & MEANS

Majority Report: Do pass as amended by Committee on Health Care & Wellness. Signed by 24 members: Representatives Hunter, Chair; Darneille, Vice Chair; Hasegawa, Vice Chair; Alexander, Ranking Minority Member; Dammeier, Assistant Ranking Minority Member; Orcutt, Assistant Ranking Minority Member; Carlyle, Cody, Dickerson, Haigh, Haler, Hinkle, Hudgins, Hunt, Kagi, Kenney, Ormsby, Pettigrew, Ross, Schmick, Seaquist, Springer, Sullivan and Wilcox.

Minority Report: Do not pass. Signed by 3 members: Representatives Bailey, Assistant Ranking Minority Member; Chandler and Parker.

Staff: Erik Cornellier (786-7116).

Background:

Health Benefit Exchanges.

The federal Patient Protection and Affordable Care Act (PPACA) requires every state to establish an "American Health Benefit Exchange" (AHBE) no later than January 1, 2014. The AHBE 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 AHBE, the federal government will operate an AHBE either directly or through an agreement with a nonprofit entity.

Under the PPACA, an AHBE'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;
- 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 AHBE; and
- establishing navigator programs to help inform consumers and facilitate their enrollment in qualified health plans in the AHBE.

Health plans in the AHBE 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 AHBE, 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 AHBE; and
- charge the same premium, both inside and outside the AHBE.

Premium subsidies on a sliding scale will be available in the AHBE 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 AHBEs. For example:

- Administration: the AHBE may be administered by the state itself or a nonprofit entity.
- Basic Health Option (BHO): 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 AHBE, 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 AHBE.
- Regional or Interstate AHBEs: an AHBE may operate in more than one state. A state may also establish subsidiary AHBEs to serve geographically distinct areas within the state.
- One AHBE or Two: the state may operate separate AHBEs for the individual and small group markets, or may operate one AHBE that serves both (this is a separate issue from combining risk pools).
- Combining Risk Pools: the state may merge the individual and small group markets.
- Essential Health Benefits: 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.

State Planning Activities.

In 2010 there was a variety of planning activities relating to AHBEs. 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 AHBE. The Office of the Insurance Commissioner established a Realization Committee, which also made recommendations relating to an AHBE. Finally, the Health Care Authority (HCA) received a planning grant, which it used, in part, to develop several issue briefs relating to AHBEs.

Summary of Amended Bill:

Establishing an Exchange.

The Washington Health Benefit Exchange (Exchange) is established as a public-private partnership separate and distinct from the state, exercising functions delineated in the act. The Exchange is to begin operations by January 1, 2014, consistent with federal law and statutory authorization. The Exchange is intended to:

- increase access to quality affordable health care coverage, reduce the number of uninsured persons in Washington, and increase the availability of health care coverage through the private health insurance market to qualified individuals and small employers;

- provide consumer choice and portability of health insurance, regardless of employment status;
- create an organized, transparent, and accountable health insurance marketplace for Washingtonians to purchase affordable, quality health care coverage, to claim available federal refundable premium tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements for minimum essential coverage as provided under the PPACA;
- promote consumer literacy and empower consumers to compare plans and make informed decisions about their health care and coverage;
- effectively and efficiently administer health care subsidies and determination of eligibility for participation in publicly subsidized health care programs, including the Exchange;
- create a health insurance market that competes on the basis of price, quality, service, and other innovative efforts;
- operate in a manner compatible with efforts to improve quality, contain costs, and promote innovation;
- recognize the need for a private health insurance market to exist outside of the Exchange; and
- recognize that the regulation of the health insurance market, both inside and outside the Exchange, should continue to be performed by the Insurance Commissioner.

The Governing Board.

The Exchange must have a governing board (Board) consisting of persons with expertise in the state health care system and private and public health care coverage. Initial members of the Board must be appointed as follows:

- By October 1, 2011, each of the four caucuses in the House and Senate must submit a list of five nominees to the Governor. Persons on the list may not be legislators or government employees. Nominations from the largest caucus in the House must include one employee benefits specialist. Nominations from the second largest caucus in the House must include one health economist or actuary. Nominations from the largest caucus in the Senate must include one representative of health consumer advocates. Nominations from the second largest caucus in the Senate must include one representative of small business.
- The remaining nominations from each caucus must have demonstrated and acknowledged expertise in: individual health care coverage, small employer health care coverage, health benefits plan administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system.
- By December 15, 2011, the Governor must appoint two members from each list submitted by the caucuses, including at least one employee benefits specialist, one health economist or actuary, one representative of small business, and one representative of health consumer advocates.
- By December 15, 2011, the Governor must appoint one member to act as a chair, who will serve as a non-voting member except to break ties. The chair may not be a government employee.
- The Insurance Commissioner (or designee) and the administrator of the HCA (or designee) serve as non-voting members.

- Initial members of the Board may serve staggered terms of up to four years. Members appointed thereafter serve two year terms.
- Members who leave the Board must be replaced in the same manner they were appointed; i.e., through appointment from a list submitted by the caucuses or, in the case of the chair, by direct gubernatorial appointment. Board members may serve multiple terms.

No Board member may be appointed if his or her participation in the decisions of the Board could benefit his or her own financial interests or the financial interests of an entity he or she represents. A Board member who develops such a conflict must resign or be removed from the Board.

The Board must establish an advisory committee to allow for the views of the health care industry and other stakeholders. The Board may establish technical advisory committees and to consult with experts. In recognition of the government-to-government relationship between the state and the federally recognized Indian tribes, the Board must consult with the American Indian Health Commission.

Members of the Board are 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.

The Exchange and the Board are subject to the Open Public Meetings Act and the Public Records Act, but are not subject to any other law or regulation generally applicable to state agencies. Consistent with the Open Public Meetings Act, the Board may hold executive sections to consider proprietary or confidential non-published information.

Powers of the Exchange and the Board.

The Exchange has the authority to sue and be sued; make and execute agreements, contracts, and other instruments; employ, contract with, or engage personnel; pay administrative costs; and accept grants, donations, loans, and contributions from the federal government, the state, and other sources. 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 necessary to begin operating the Exchange by January 1, 2014. Any actions relating to substantive policy decisions must be made consistent with statutory direction.

Federal Grants.

The HCA must apply for establishment and planning grants under the PPACA in collaboration 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, in collaboration with the Joint Select Committee on Health Care Reform Implementation, must implement any grants received by the federal government.

Exchange Options.

By January 1, 2012, the HCA, in collaboration 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; 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 or 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;
- the extent and circumstances under which benefits for spiritual care services that are tax deductible under federal law will be made available under the Exchange; 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.

Consultation With Other Entities.

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; health care providers and facilities; 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, and expend appropriated funds.

Transfer of Powers and Duties to the Exchange and the Board.

On March 15, 2012, the powers and duties of the HCA with respect to establishing the Exchange are transferred to the Exchange and the Board. Prior to the transfer, the Board may make independent recommendations to the Joint Select Committee on Health Reform Implementation.

Appropriation: None.

Fiscal Note: Available.

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

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

(In support) The date upon which the state must operate an Exchange is rapidly approaching. The goal of this bill is to put the infrastructure of the Exchange in place. The bill reflects a bi-partisan consensus that the state will establish its own Exchange. The timing of establishing the Board will be beneficial toward the receipt of federal funds, which is predicated upon a legal structure and a defined role for the Exchange. Decisions about operating the Exchange would be reflected in the collaborative process with the Legislature and in any legislation that would be passed next year. The Exchange should drive cost reductions, not cost containment. Health spending is rising rapidly in the United States, especially compared to other countries. Costs are higher in the United States too and this country is not getting the value for its money. There should be stronger conflict of interest language in this bill; the conflict of interest provisions in this bill and the House version should be combined. The Insurance Commissioner should be more involved in this process. The Board should be established later this year, as opposed to next year. Consumer literacy should be addressed; it is the best predictor of health outcomes. Another consumer representative and a labor representative should be added to the Board. This legislation should require the establishment of an advisory committee. The BHO should be pursued; the BHO should be combined with Medicaid. Consumers should be able to select options based on cultural competency and access. Low-income populations should be able to access care seamlessly and be provided universal access. The Exchange should have a "no wrong door" policy. The Exchange will be a critical piece for older people who are ineligible for Medicare.

(In support with concerns) This legislation should establish an Exchange that is an active purchaser and administratively operates for both the individual and small group markets. The state should move forward on issues that have general consensus; e.g., operating a single exchange and aggregating funds. The Exchange should serve as a "single door" for people accessing the health care system. This legislation should require the establishment of an advisory committee. The Board should be established later this year, as opposed to next year.

(In support with amendment) The House version of this bill is preferable to this one; it represents a thoughtful, deliberate, bi-partisan approach with the Joint Select Committee on Health Care Reform Implementation in the lead. The conflict of interest provisions in this bill are too restrictive.

(With concerns) The House version of this bill is preferable to this one.

(Opposed) The House version of this bill is preferable to this one; the language in the House version was worked out with stakeholders. The Board should not move forward until the Legislature has approved its structure.

Staff Summary of Public Testimony (Ways & Means):

(In support) None.

(In support with concerns) This legislation is necessary to keep implementation of health reform moving forward. The amendment from the Health Care and Wellness Committee is significantly better than language from the Senate. The appointment of members is concerning. The Governor appoints seven, and the Legislature appoints two. The conflict of interest language restricts members that have a "potential" conflict of interest. Attempting to find an actuary or economist that does not have a "potential" conflict may be impossible, so self-disclosure of conflicts is preferable. The starting date of the Health Benefits Exchange Board should be moved forward.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Senator Keiser, prime sponsor; Jonathon Seib, Governor's Office; Sean Corry, Realization Committee; Rud Browne, Ryzex Inc. and Realization Committee; Sofia Aragon, Washington State Nurses Association; Misha Werschkul, Service Employees International Union 775 NW; Pamela Crone, Community Health Network of Washington; and Ingrid McDonald, Association for the Advancement of Retired Persons.

(In support with concerns) Jennifer Allen, Healthy Washington Coalition.

(In support with amendment) Dave Knutson, United HealthCare.

(With concerns) Donna Steward, Association of Washington Business; and Chris Bandoli, Regence BlueShield.

(Opposed) Patrick Connor, National Federation of Independent Business; and Scott Dahlman, Washington Farm Bureau.

Persons Testifying (Ways & Means): Dave Knutson, United Health Care; and Lonnie Johns-Brown, Healthy Washington Coalition.

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

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