SENATE BILL REPORT
E2SHB 2319

As Reported by Senate Committee On:
Health & Long-Term Care, February 22, 2012

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: Passed House: 2/11/12, 52-43.
Committee Activity: Health & Long-Term Care: 2/20/12, 2/22/12 [DPA, DNP].

Brief Summary of Engrossed Second Substitute Bill
(As Amended by Senate)

- The Exchange is named the Evergreen Health Marketplace, duties are modified, and employees are authorized to participate in the state retirement program and health insurance benefits.
- The Exchange Board members are restricted from lobbying, and beginning December 1, 2013, the chair serves at the pleasure of the Governor.
- Market rules are established for individual and small group plans sold inside and outside the Exchange.
- Creates a process for certifying a qualified health plan for participation in the Exchange, and creates a consumer rating system.
- Establishes a process for designating the benchmark plan and essential health benefits that must be offered inside and outside the Exchange.
- Creates a process for identifying if a state-mandated benefit results in federally imposed costs to the state.
- Requires the development of the federal Basic Health option if certain findings are made by the Governor.
- Provides authority to develop the federal reinsurance and risk adjustment programs.

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 WSHIP to submit recommendations in December 2012, on continued eligibility, screening tools, and assessments; and establishes premium rating and subsidies for 2014.
- Requires the state to apply for a wellness demonstration project for the individual market.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Frockt, Kline, Pflug and Pridemore.

Minority Report: Do not pass.
Signed by Senators Becker, Ranking Minority Member; Carrell and Parlette.

Staff: Mich'l Needham (786-7442)

Background: Health Benefit Exchange. The federal Affordable Care Act (ACA), passed in 2010, requires every state to establish a Health Benefit Exchange (Exchange) to facilitate the purchase of individual and small group coverage. 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. Legislation passed in 2011 established the 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.

Market Rules. The ACA specifies four categories of plans must 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). In addition, 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.

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.

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 benefits in the ten categories required in the ACA: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

The United States Department of Health and Human Services (HHS) 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 ten categories of essential health benefits. Health plans would have the option to adjust benefits as long as all ten categories were still covered and the value of the plan is substantially equal.

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 of the federal poverty level through a federal Basic Health option. Individuals in the Basic Health option will not participate in the Exchange, but the state will receive federal funding for the Basic Health option equal to 95 percent of the tax credits and cost-sharing reductions the individuals would have received in the Exchange.

Reinsurance and Risk Adjustment. 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.

The Washington State Health Insurance Pool (WSHIP). 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 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.

Wellness Demonstration. Under the ACA, HHS must establish a ten-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 Bill (Recommended Amendments): Health Insurance Exchange. The Exchange is named the Evergreen Health Marketplace. 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 1, 2013. The Exchange may charge 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 establish 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. Exchange employees are authorized to participate in state health benefit and retirement programs.

Market Rules. 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. A carrier offering a small group health benefit plan must offer the identical plan inside and outside the Exchange. Catastrophic plans (as defined in the ACA) may only be sold inside the Exchange. The Insurance Commissioner, in consultation with the Exchange Board, may adopt a rule that prohibits a carrier from offering a Bronze plan outside the Exchange unless it offers the same plan inside the Exchange. If there is insufficient choice of plans for consumers, the Exchange Board may authorize the offering of a public option. By December, 1, 2016, the Exchange Board, in consultation with the Commissioner, must complete a review of the market rules and submit a recommendation to the Legislature on the need to sunset or continue the market rules.

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

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 must be exempt from the essential community provider requirement if consistent with federal law. The Board must allow stand-alone dental plans to be offered in the Exchange. Dental benefits offered in the Exchange must be priced separately to assure transparency for consumers.

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 language spoken or transportation assistance; and
- coverage of benefits for tax-deductible spiritual care services.

Essential Health Benefits. The Insurance Commissioner must select the largest small group plan in the state by enrollment as the benchmark plan for determining the essential health for the individual and small group markets. 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 ten 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.

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. During

any period of time funds are not appropriated, the mandate is suspended and may not be enforced.

Basic Health Option. The HCA must provide the necessary certifications to the federal government to establish the federal Basic Health option, unless, by September 1, 2013, the Governor finds anticipated federal funding will be insufficient to cover the essential health benefits through 2019, and meet the federal requirements for the Basic Health program, and that sufficient funds are not available to support the design and development work necessary for the program to begin providing coverage beginning January 1, 2014. If established, guiding principles are provided for the Basic Health program.

Reinsurance and Risk Adjustment. The Insurance Commissioner, in consultation with the Board, must adopt rules establishing the reinsurance and risk adjustment programs required by the ACA. In consideration for rule making, the commissioner must include analysis of an invisible high risk pool option and whether the option is permitted under federal reinsurance program regulations. 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 Insurance Commissioner must contract with one or more nonprofit entities to administer the risk adjustment and reinsurance programs and must identify the data needed to support operation of the reinsurance program, the sources of the data, and other requirements related to their collection, validation, interpretation, and retention.

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

- 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;
- 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; and
- 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 pool may contract with the OIC to administer risk management functions and may conduct pre-operational activities. Reasonable costs for the pre-operational planning may be reimbursed from federal funds or from assessments collected to pay the administrative costs of the reinsurance program.

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

provided in conjunction with the hospital services, and (3) excludes or substantially limits outpatient physician services and those services usually provided in an office setting, is eliminated. For non-grandfathered health plans issued on or after January 1, 2014, a catastrophic health plan is defined as a health plan that meets the definition in the ACA; or a health benefit plan offered outside the Exchange that requires a calendar year deductible or out-of-pocket expenses for covered benefits that requires a calendar year deductible of at least $1,880 for individuals ($3,760 for multiple persons) and an annual out-of-pocket expense required for covered benefits of $3,760 for individuals ($6,450 for multiple persons).

Wellness Demonstration. 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 prepares the state to apply for the demonstration projection once it is announced by the federal government.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended Amendments): The changes to the Exchange Board members are removed. Market rules are modified. The criteria for the qualified health plans is modified slightly and the list of areas to be included in the consumer rating guide is modified. It is clarified the benchmark plan for essential health benefits is for the individual and small group market and criteria for finalizing the essential health benefit offerings is modified. The date for the Basic Health decision is moved from September 2012, to September 2013. The commissioner must examine an invisible high risk pool option in consideration of reinsurance and risk adjustment rules. The WSHIP is given authority to contract with the OIC to administer the risk management functions and may have pre-operational planning reimbursed from federal funds or assessments. The section establishing premium rating requirements for the pool in 2014 is removed. An emergency clause is added to allow the employees of the Exchange to participate in PERS and PEBB before June.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed, except for sections 4 and 19-23 which contain an emergency clause and take effect immediately.

Staff Summary of Public Testimony as Heard in Committee: PRO: The state will apply for level 2 grant funding to support the Exchange through 2014. This bill contains the components we need to qualify for the level 2 funding. The legislation passed last year included specific limitation on the Exchange authority and we need to broaden that authority to demonstrate to HHS that the program has the capacity to get up and running for 2014 and for their certification, by January 2013, that the Exchange is ready to operate by October 2013. The bill also includes options that customize the Exchange to meet the interests of this state. The Governor does not want to defer the development of the Exchange to the federal government. The ACA lays out a number of options to address adverse selection, but the tools in the ACA are not sufficient to protect the Exchange from adverse selection. The tools in the ACA help protect providers but not the Exchange. Waiting for adverse selection to

occur before we take action is too late, the damage will be done. There are numerous studies of experience across the country that indicate it is important to provide a level playing field and allow healthy risk to be spread across the market and not steered into one market over another. As a self-employed business owner, I really value the Basic Health program. It is very difficult to buy on the open insurance market. The Exchange will help small businesses search for and purchase insurance and allow me to compare products much more easily. The opportunity to purchase through the Exchange should encourage more entrepreneurs to start a small business and assist them with accessing insurance. The ACA provides a great option with a new tax credit for small businesses offering insurance for the first time. I am purchasing for the first time for my small group of employees and it is very intimidating; the choices are overwhelming and confusing. The Exchange will help provide us with an apples-to-apples comparison.

This bill is a notable improvement over the earlier versions of the bill. The market rules are very modest and appropriate, and much less stringent than the first version. Bronze coverage will be attractive to the healthy populations and if we only offer Bronze outside, it will drive all the unhealthy risk inside the Exchange for more comprehensive coverage. There are many areas of agreement with this bill, including the choice of the small group plan as the benchmark for the essential health benefits, and with the qualified health plan criteria that relies on meeting the state insurance laws and the ACA requirements. We also agree the state must move quickly to develop the reinsurance and risk adjustment programs – there is much work to be done and it must start quickly. The issues with WSHIP need careful review and the studies assigned to WSHIP will be helpful for ensuring access in 2014, and for revising how that risk is shared. The Exchange will allow low-income populations broader access to insurance and it will be important to consider the continuity of coverage and care for the populations that enroll. The Basic Health option will provide a more affordable option for enrollees and would result in higher take up rates of coverage, and thus less uncompensated care. The transitions between the Basic Health option and Medicaid could be smoother and more likely ensure access to the same providers to ensure continuity in care. The Urban Institute analysis indicates the Basic Health option still leaves 300,000 new lives in the Exchange so would still be a viable size. This bill does a nice job of establishing market rules that encourage carriers to participate without adverse risk. We like the consumer rating information and think the Board should also include existing quality measures like NCQA. We support a state run Exchange and the creation of a federal Basic Health option for those that won't fit into the Exchange. It will also reduce the churn of enrollees that is so common in families under 200 percent of the federal poverty level. This population is the largest portion of those expected to gain coverage. They have needs very similar to those in Medicaid; the provider networks for Medicaid are set up to assist them with their broad needs. Half of the AARP membership is under 64 and very interested in the access the Exchange may provide. The market rules are a very modest step. The OIC wants stronger market rules and the NAIC continues to have discussions about how states can offer more protections to avoid adverse selection. The consumer rating system will be helpful and it should help consumers find and purchase coverage. The tribes appreciate the inclusion of the language allowing sponsorship into the Exchange. It is a model that has worked well with the Basic Health program. The language in the bill that bans the Exchange Board members from speaking to legislators conflicts with the first amendment of the Constitution. Board members must be allowed to speak. This language results in an outright ban on the volunteers that serve the Board from working and speaking on other topics separate from the

Board. My brother worked in the service industry and was unable to afford insurance on his modest income. As a result he was unable to access medical care and his heart issue went untreated and he died at age 23. He needed access to affordable insurance like the coverage that may be available in the Exchange. We support the concept of an Exchange but have some concerns with the offering of the Basic Health option since providers already take a loss in provider patients care. The program should only be developed if the Governor demonstrates there is enough funding for all obligations of the program which includes paying providers better rates.

CON: We very much want a bill to pass but the details in this bill are still problematic. We support an Exchange but believe we should focus on simple compliance with the ACA and not offer any discretionary options beyond the requirements. The market rules should not exceed the ACA. The Qualified Health Plan criteria should remain at the ACA standards. Policy decisions should not be delegated to agencies to develop rules. We do want a vibrant and competitive Exchange and we agree we need a bill this year, but we continue to have concerns with this version. The reinsurance provisions should not provide different options for those inside and outside the Exchange; there should be a level playing field for the reinsurance. We should allow the reinsurance and risk-adjustment mechanisms to prove themselves inadequate before we further address any adverse selection that may occur. The purchaser community for small business has different concerns than the carrier. We understand carriers will likely offer products in the individual Exchange because it will be attractive with the subsidies, but there may be very little choice of small group options and we want to ensure more carriers can offer small group products. We believe that adding any requirements may preclude the interest of carriers offering the small group products. The federal Basic Health option is a diversion to managed care that may risk destabilizing the Exchange. The Legislature needs to retain the control over the funding and not allow the Exchange to determine the assessment. The sunset of the rules in the Senate version is good. We remain concerned with the Basic Health option and the delegation to the Governor to determine if there is sufficient funding to develop the program. The bill should not grant rulemaking authority to agencies.

OTHER: The Basic Health option should have different trigger language that ensures we have the answers on the funding, including funding sufficient provider rates, before any program development decisions are made. We have concerns with the funding of the Exchange and the Basic Health and the development of rules. The changes for the WSHIP to study are good additions to ensure populations have access to coverage. The language is not clear enough in providing the pool the authority to administer the risk adjustment or reinsurance programs, and it needs to be clear so it can start this year.

Persons Testifying: PRO: Jonathan Seib, Governor's Office; Barbara Flye, OIC; Sharon Shaw, Eric Smitey, self-employed business owners; Makini Howell, Main Street Alliance; Scott Plack, Group Health; Molly Belozer Firth, Community Health Plan of WA, Community Health Centers; Eric Hanna, Keiser Permanente; Davor Djurasic, Molina Health Care; Mary Clogston, AARP, Academy of Family Physicians; Lonnie Johns-Brown, Amercian Indian Health Commission; Shankar Narayan, ACLU; Jaydra Cope, Spokane resident; Katie Kolan, WA State Medical Assn.

CON: Mel Sorensen, WA Assn of Health Underwriters, National Assn. of Insurance and Financial Advisors; Chris Bandoli, Regence Blue Shield; Len Sorrin, Premera Blue Cross; Patrick Connor, National Federal of Independent Businesses; Donna Steward, Assn. of WA Businesses.

OTHER: Lisa Thatcher, WA State Hospital Assn.; Gerry Smith, Independent Business Assn.; Karen Larsen, WSHIP.