SENATE BILL REPORT
SSB 5445

As Amended by House, 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 & Long-Term Care: 2/03/11, 2/07/11, 2/21/11 [DPS-WM, DNP, w/oRec].
Passed Senate: 3/02/11, 27-22.
Passed House: 4/11/11, 75-22.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5445 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Keiser, Chair; Conway, Vice Chair; Becker, Ranking Minority Member; Kline, Murray, Pflug and Pridemore.

Minority Report: Do not pass.
Signed by Senator Carrell.

Minority Report: That it be referred without recommendation.
Signed by Senator Parlette.

Staff: Mich'l Needham (786-7442)

Background: The federal Patient Protection and Affordable Care Act (PPACA), passed in March 2010, requires states to establish health insurance exchanges (Exchange) by January 1, 2014, to facilitate the purchase of individual insurance and small employer group insurance, and provide access to premium tax credits and cost-sharing reductions for individuals with family incomes between 133 percent and 400 percent of the Federal Poverty Level (FPL). Individuals with income below 133 percent will have access to expanded Medicaid programs. The federal subsidies for individuals will only be available through the Exchange, or through a federal Basic Health option that states may choose to have available for individuals with family income between 133 percent and 200 percent of the FPL.

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.

The Exchanges are responsible for a number of functions or services, including:

- certifying qualified health plans that may offer products;
- seamless linking with Medicaid eligibility and enrollment;
- verifying income and citizenship status;
- ensuring the benefit packages offered include the essential health benefits and are available at four benefit values – 60 percent, 70 percent, 80 percent and 90 percent;
- applying risk adjustment and reinsurance;
- operating a toll free hotline and consumer portal that allows comparison shopping and premium calculation and facilitates enrollment; and
- adjudicating appeals.

Exchanges may be administered by public agencies, private nonprofit entities, or some combination. States have a number of policy decisions about the structure and focus of the Exchange, and must demonstrate good progress toward development of an Exchange by January 1, 2013, as certified by the federal Department of Health and Human Services (HHS). HHS has made grant funding available to all states to help with the research and planning, and has recently announced the availability of additional grant opportunities to fund the development and implementation. HHS will establish an Exchange for residents and small employer groups in states that choose not to establish their own Exchange.

Summary of Substitute Bill: The state must establish an Exchange consistent with PPACA intending to:

- increase access to quality affordable health care coverage;
- recognize the need for a private health insurance market to exist outside the Exchange and for a regulatory framework that applies both inside and outside the Exchange;
- create an organized insurance marketplace that provides access to federal subsidies;
- recognize the regulation of the insurance market should continue to be performed by the Insurance Commissioner;
- strengthen the health care delivery system;
- promote quality improvement, cost containment and innovative payment structures;
- increase the availability of private health insurance;
- encourage health insurance carrier competition based on price and quality, and not on risk selection;
- promote consumer literacy;
- effectively administer subsidies and determination of eligibility for all subsidized programs;
- seamlessly direct consumers to information and assist with enrollment;
- enhance portability of insurance coverage and ensure seamless coverage options for enrollees with income and eligibility changes; and
- create opportunities to address possible future changes in federal law and funding challenges.

The Health Benefit Exchange Board (Board) is created as a nonprofit, public-private partnership consisting of nine members. By September 1, 2011, the Governor must appoint representatives of the following groups: two employee benefits specialists, a health economist or actuary, small businesses, health care consumer advocates, the administrator of the HCA, the Insurance Commissioner or designee as nonvoting, and two appointments from

a list of recommendations submitted by each legislative chamber, with mutually agreed on names from each caucus.

By December 1, 2011, the Board and HCA, 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 health benefit exchange. The options must develop a broad range of options for establishing and implementing a state-administered health benefit exchange. The options must include analysis and recommendations on the array of policy choices and design features for the Exchange, including:

- the governance, operations, and administration;
- the goals and principles;
- the option of a single state-administered exchange serving all geographic areas and serving individuals and small groups;
- whether the state should consider future development of a regional multi-state Exchange;
- whether the exchange can serve as an aggregator of funds to gather premium contributions from multiple entities;
- the development of sustainable funding for administration by 2015;
- the structure needed for information technology to support the implementation of exchange activities;
- whether to adopt a federal Basic Health option, who should administer the option, and whether to merge the risk pool with Medicaid;
- whether to merge the individual and small group risk pools in the Exchange and in the private market;
- whether the small group size should increase to 100 prior to 2016;
- the role of producers and navigators, including the option of using private insurance market brokers as navigators;
- effective implementation of risk management methods; and
- other business recommendations, such as staffing and resources to administer an exchange.

The Board must consult with the Joint Select Committee, the Office of the Insurance Commissioner, and stakeholders including consumers, health insurance carriers, producers and navigators, small businesses, employees, publicly subsidized health care programs, actuaries, and others.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill: PRO: We feel this is the best next step in maintaining progress toward development of an Exchange, helping us get it done right and get it done on time. We anticipate this is the first step of a three-step process to design the program and identify the legislative changes to implementation. We endorse the creation

of a robust development board that allows different people than we might want for a governance board. The principles captured are the right principles. It is important to maintain local state control of the development of an Exchange. We suggest the Board may need additional representatives of small business, labor and others, and should include a no conflict of interest clause for board members, and the role of stakeholders should be more clearly articulated. The intent should more clearly direct the Exchange to be an active purchaser and it should be more clear that the state should develop one administrative entity to serve both the individual and small group markets. We suggest it should be a governance board not a development board and there should be more discussion about where it is housed. It appears it is house at the HCA. The bill should indicate where recommendations go and the next steps. We would like the option to purchase a public option through the Exchange. The Board should be subject to the open public meetings act to ensure transparency. The Board appointment process should be modified to allow a model more like the WSHIP Board. We support the offering of the federal Basic Health option and would like it to be administered by the Medicaid agency with similar or identical benefits to ensure seamless transitions.

CON: There is no need to work on this now and we should continue discussions through the Joint Select Committee which offers a bipartisan forum with broader perspectives than can be captured through a board. We should not spend the money now to develop this – let the federal government do it. The federal requirements are not out yet. It is a moving target to chase and we should let the federal government do it.

Persons Testifying: PRO: Jonathan Seib, Governor's Office; Molly Voris, Health Care Authority; Karen Merrikin, Group Health; Misha Werschkul, SEIU 775; Jennifer Alan, Healthy Washington Coalition; David Knutson, United Health Care; Molly Moon Neitzel, Molly Moon Ice Cream, Main Street Alliance; Sofia Aragon, Washington State Nurses Association; Mike Tucker, AARP; John Paul, Washington Community Action Network; Teresa Mosqueda, Washington State Labor Council; Molly Belozer Firth, Community Health Plan, Community Health Network of Washington.

CON: Patrick Connor, National Federation of Independent Business; Gary Smith, Independent Business Association.

House Amendment(s): The intent section is modified:

- The following items are removed from the list of what the Exchange is intended to do: strengthen the state health care delivery system and maximize existing efficiencies within the system; seamlessly direct consumers to information about, and enrollment in, programs in addition to those related to health care that are available to lower income individuals and families; create opportunities and flexibility to address possible future changes in federal law and funding challenges; and recognize the need for a regulatory framework that applies both inside and outside the exchange.
- Items the Exchange is intended to do are modified: operate in a manner compatible with efforts to improve quality, contain costs, and promote innovation (as opposed to "promote quality improvement, cost containment, and innovative payment structures"); create a health insurance market that competes on the basis of price, quality, service, and other innovative efforts (as opposed to "encourage carrier competition based on price and quality, not on risk selection"); provide consumer choice and portability of health

insurance (as opposed to "enhance portability of insurance coverage and encourage seamless coverage options for enrollees with income and eligibility changes").

The Exchange is established as a public-private partnership separate and distinct from the state, exercising functions delineated by the act. By January 1, 2014, the Exchange must be operational, consistent with federal law, and subject to statutory authorization. Gives the Exchange the authority to sue and be sued; make and execute agreements and contracts; employ or contract with personnel; pay administrative costs; and accept grants, donations, and other funding. 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 consistent with statutory direction.

The appointments to the Board are modified:

By October 1, 2011, each of the four caucuses of 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 one of the following: 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. The Governor must appoint an additional member to act as chair, who will serve as a nonvoting 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 will serve as nonvoting members.

Members who leave the Board must be replaced in the same manner they were appointed. Board members may serve multiple terms. Board member conflict of interest language was modified to prohibit a Board member from being 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 the entity the Board member represents. Board members that develop a conflict of interest must resign or be removed.

The Board must establish an advisory committee to allow for the views of the health care industry and other stakeholders, and the Board must consult with the American Indian Health Commission. The Board must comply with the public records act (in addition to the open public meetings act) but the Board is exempt from any other law or regulation generally applicable to state agencies. Board members are provided qualified immunity, instead of the Board itself.

The HCA must collaborate (rather than consult) with the Joint Select Committee on Health Reform Implementation. In addition to the list of areas to be studied, the HCA must develop information for the federal Department of Health and Human Services, including a budget for the development and operation of the Exchange; an initial plan to achieve financial sustainability; a plan to prevent fraud, waste, and abuse; and a plan describing how capacity for assisting individuals and small business will be created, continued, or expanded, including provision for a call center. The policy analysis and recommendations are due January 1, 2012, instead of December 1, 2011. The policy options to be examined are modified: removed language stating that a multistate Exchange is an option only after the state-administered Exchange is established; added language requiring the options to consider the extent and circumstances under which benefits for spiritual care services that are tax deductible under federal law will be available under the Exchange.

The HCA and the Board must consult with health care providers and facilities (in addition to the Joint Select Committee, the Commissioner, and other listed stakeholders). Beginning March 15, 2012, the Exchange and the Board are responsible for the duties assigned to HCA in this act. A non-appropriated account is created to receive federal grant funds, and the HCA may authorize expenditures initially and the Board may authorize expenditures beginning March 15, 2012. The authority for HCA to make rules is removed, and a federal severability clause is inserted.