SENATE BILL REPORT
SB 6178

As Reported by Senate Committee On:
Health & Long-Term Care, February 1, 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 affordable care act.

Sponsors: Senators Keiser, Conway, Shin, Frockt, Kline, Pflug and Chase; by request of Governor Gregoire and Insurance Commissioner.

Brief History:
Committee Activity: Health & Long-Term Care: 1/16/12, 2/01/12 [DPS, w/oRec].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 6178 be substituted therefor, and the substitute bill do pass.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Frockt, Kline, Pflug and Pridemore.

Minority Report: That it be referred without recommendation.
Signed by Senators Becker, Ranking Minority Member; Parlette.

Staff: Mich'l Needham (786-7442)

Background: The federal Affordable Care Act (ACA), passed in 2010, includes a number of modifications that broadly impact medical insurance. These modifications include the introduction of health plans that will be available without health screening in 2014, the requirement for states to establish health insurance exchanges (Exchange) to facilitate the purchase of individual insurance and small group insurance, and new rating and coverage requirements for all products in the individual and small group markets except for those plans that qualify as grandfathered under the ACA. The benefit plans in the individual and small group markets must include the essential benefits package with the ten defined coverage categories, and must align with new actuarial value levels identified as platinum (90 percent), gold (80 percent), silver (70 percent), bronze (60 percent), or a catastrophic health benefit package.

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 2011 Legislature passed SSB 5445, which established a Washington Health Benefit Exchange as one of the steps toward implementing some of the requirements of the ACA. The state established an Exchange as a public-private partnership separate and distinct from the state, with a Governing Board that was recently appointed by the Governor. The Exchange Board is scheduled to take over the development and operations of an Exchange beginning March 15, 2012, with the limited powers and duties outlined in statute. The bill also directed the Health Care Authority (HCA) to collaborate with the Joint Select Committee on Health Reform Implementation and the Office of Insurance Commissioner (OIC) to complete analysis and submit recommendations to the Legislature on a broad range of policy options and design features for the Exchange and other issues impacting the individual and small group markets as well as the state's high risk pool, the Washington State Health Insurance Pool (WSHIP). Joint recommendations of the Governor and the OIC have been packaged as request legislation.

Summary of Bill (Recommended Substitute): Responsibilities of the Exchange are modified to allow the Exchange and the Exchange board to operate and administer the program, and complete other duties as may be necessary under the ACA. The Exchange must report to the Governor and the Legislature on activities at least annually, and the Exchange must prepare recommendations to the Legislature on the future opportunity to establish a regionally administered multistate Exchange, and provide their recommendations on the effective implementation of risk management methods. It is clarified that the Exchange is self-sustaining with no state tax subsidy.

Insurance market standards are established for health insurance carriers to sell individual and small group products in the Exchange and outside the Exchange. Health insurance carriers may not offer a bronze plan outside the exchange unless they also offer a silver and gold outside. The commissioner, in consultation with the Exchange and the HCA, may adopt rules requiring a carrier to offer a bronze plan outside the exchange if they offer a bronze plan inside the exchange. These two market rules expire January 1, 2016. The commissioner may authorize a public plan option and pursue the waiver option in the ACA if he finds the consumers in the exchange do not have an adequate choice of plan options. All health plans offered outside the exchange, except catastrophic plans, must conform with bronze, silver, gold, or platinum levels consistent with the values specified in the ACA.

The Exchange Board must certify a health plan as a qualified health plan for the Exchange if the plan requirements established in insurance statute, if the Board determines the plan meets the requirements of the ACA, and if the plan includes tribal clinics and urban Indian clinics as essential community providers in the plan’s network. The Board must allow a stand-alone dental plan to offer coverage in the exchange. The Board must establish a rating system for the qualified health plans as a consumer rating guide. Rating factors must include affordability, provider reimbursement methods that incentivize care coordination, promotion of primary care and preventive services, and high standards for provider network adequacy.

A process for finalizing the essential health benefits and benchmark plan decisions, consistent with the federal Health and Human Services guidelines, is assigned to the Commissioner, in consultation with the Board and the HCA. The OIC must select a benchmark plan from a set of regulated plans, choosing from largest small group plans based on enrollment or the largest health maintenance organization plan in the state's commercial

market, by enrollment. If the benchmark plan does not include all of the ten benefit categories required by federal law, the OIC must supplement the benefits as needed through rule to ensure the benchmark plan meets the requirements of the ACA. Plans may not be offered unless the OIC finds they are substantially equal to the benchmark plan, and must ensure the plan covers all ten benefit categories, does not create a significant risk of biased selection based on health status, and contains meaningful benefits in each of the categories. The OIC must evaluate prescription drug benefits for variation that may result in adverse selection, and may adopt rules to assure substantial equivalence in prescription drug benefits. The OIC must ensure they provide a transparent, public process that involves sharing information and allows public comments and testimony.

The HCA must continue exploring the federal Basic Health option. The HCA must provide certifications for the adoption of the federal Basic Health option unless by July 1, 2013, the Governor finds that anticipated federal funding will be insufficient, absent additional funding from the state, to provide the essential health benefits and meet the federal requirements for the federal Basic Health, and that sufficient funds are available to support the design and development work for the program to begin. The HCA must actively consult with the Board, the OIC consumers, provider organizations, carriers, and other interested organizations; consider objective analysis from a nationally recognized consultant with Washington specific data; and report findings and supporting analysis to the Legislature. If implemented, guiding principles for the Basic Health program are provided.

The OIC, in consultation with the Board, must adopt rules establishing the reinsurance program required in the ACA. At a minimum, the rules must establish a mechanism to collect reinsurance contribution funds, a reinsurance payment formula and a mechanism to disburse reinsurance payments. The rules must compensate carriers in the Exchange for the possibility of increased risk and incentivize carrier participation with modifications to the payment formula that may include a lower attachment point, a higher reinsurance cap inside the Exchange, eliminating the cap inside the Exchange, or establishing a a higher coinsurance rate inside the Exchange. The OIC must adopt rules regarding the data needed to support operation of the reinsurance program, and may adjust rules as needed to preserve a healthy market inside and outside the Exchange.

The WSHIP statutes are modified to allow the high risk pool to continue to serve enrollees after January 1, 2014, for those enrolled prior to December 31, 2013. The standard health questionnaire that is used to screen applicants for the individual market is removed effective January 1, 2014, when health plans may no longer deny coverage due to a pre-existing health condition. A number of WSHIP program changes are made January 1, 2014, including a discontinuation of eligibility for new enrollees; the premium discount arrangement with the HCA is removed, pre-existing condition waiting periods are discontinued after December 31, 2013, and the rating of the plans is modified. For policies renewed beginning January 1, 2014, rates may be no more than the average individual standard rate charged for coverage comparable to the pool coverage by the five largest individual plans offering such coverage in the state. In the event that five plans do not offer such coverage, rates may be no more than the standard risk rate established using reasonable actuarial techniques and must reflect anticipated experience and expenses for such coverage in the individual market. The WSHIP premium rates must be reduced to provide an enrollee with a premium subsidy equivalent to the subsidies the enrollee would have received in the Exchange if the enrollee has income

below 400 percent, is not enrolled in Medicare, and does not have an offer of minimum essential coverage. The subsidies must be funded through member plan assessments.

The WSHIP Board must evaluate the populations that may need on-going access to the pool coverage after January 2014, paying particular attention to those populations that may be excluded from coverage in 2014, and submit recommendations to the Legislature by December 1, 2012. The Board must complete an analysis of the pool assessments in relation to the assessments for the reinsurance program and the risk management functions and submit recommendations on any changes for the assessment or any credits. The WSHIP is provided authority to perform all or part of the risk management functions required in the ACA, including conducting preoperational and planning activities related to the programs, and defining the legal structure to administer and coordinate the programs. OIC may adopt rules to implement this section. Funding for the transitional reinsurance program provided through assessments may be increased to cover the administrative costs. The pool must report to the Legislature December 15, 2012, and December 15, 2013, on the risk management activities.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended Substitute): Responsibilities of the Exchange are modified, and references are inserted to clarify the Exchange is self-sustaining with no state tax subsidy. Market rules for insurance carriers offering individual and small group products are modified: Health insurance carriers may not offer a bronze plan outside the exchange unless they also offer a silver and gold outside; the commissioner, in consultation with the exchange and the HCA, may adopt rules requiring a carrier to offer a bronze plan outside the exchange if they offer a bronze plan inside the exchange; these market rules expire January 1, 2016; references to the sale of catastrophic coverage only inside the exchange are removed; the commissioner may authorize a public plan option and pursue the waiver option in the ACA if he finds the consumers in the exchange do not have an adequate choice of plan options; and all health plans offered outside the exchange, except catastrophic plans, must conform with bronze, silver, gold, or platinum levels consistent with the values specified in the ACA.

Qualified health plans criteria is modified and kept to federal requirements: references to the OIC writing additional rules with additional requirements at the request of the Board are removed; inserts a reference to plans including tribal clinics and urban Indian clinics as essential community providers in the plan's network; inserts a reference to allowing a stand-alone dental plan to offer coverage in the exchange; and requires the Exchange board to establish a rating system for the qualified health plans as a consumer rating guide. Essential Health Benefits section added: the Commissioner, in consultation with the board and the HCA, must select a benchmark plan from plans regulated by the OIC, choosing from largest small group plans based on enrollment or the largest HMO plan in the state; if the benchmark plan does not include all of the ten benefit categories required by federal law, the OIC must supplement the benefits as needed; plans may not be offered unless the OIC finds they are substantially equal to the benchmark plan; the OIC must ensure the plan covers all ten benefit categories, does not create a significant risk of biased selection based on health status, and contains meaningful benefits in each of the categories; the OIC must evaluate prescription drug benefits for variation that may result in adverse selection and may adopt rules to assure substantial equivalence in benefits; and the OIC must ensure they provide a transparent, public process that involves sharing information and allows public comments and testimony.

The Basic Health Option section is added: HCA shall provide certifications for the adoption of the federal Basic Health option unless by July 1, 2013, the Governor finds that anticipated federal funding will be insufficient, absent additional funding from the state, to provide the essential health benefits and meet the federal requirements for the federal Basic Health, and reasonable administrative costs for Basic Health; and that sufficient funds are available to support the design and development work for the program to begin. The HCA must actively consult with the Board, the OIC consumers, provider organizations, carriers, and other interested organizations; and consider objective analysis from a nationally recognized consultant with Washington specific data; and report findings and supporting analysis to the Legislature. If implemented, guiding principles for the Basic Health program are provided.

A reinsurance section is added: the OIC in consultation with the Board, shall adopt rules establishing the reinsurance program. At a minimum the rules must establish a mechanism to collect reinsurance contribution funds, a reinsurance payment formula and a mechanism to disburse reinsurance payments. The rules must compensate carriers in the Exchange for the possibility of increased risk and incentivize carrier participation with modifications to the payment formula that may include a lower attachment point, a higher reinsurance cap inside the Exchange or eliminating the cap inside the Exchange, or a higher coinsurance rate inside the Exchange. The OIC must adopt rules regarding the data needed to support operation of the reinsurance program.

The WSHIP section is modified: the WSHIP premium rates must be reduced to provide an enrollee with a premium subsidy equivalent to the subsidies the enrollee would have received in the Exchange if the enrollee has income below 400 percent, is not enrolled in Medicare, and does not have an offer of minimum essential coverage. The subsidies shall be funded through member assessments. The WSHIP Board must evaluate the populations that may need on-going access to the pool coverage after January 2014 and submit recommendations to the Legislature by December 1, 2012. The Board must complete an analysis of the pool assessments in relation to the assessments for the reinsurance program and the risk management functions and whether to submit recommendations on any changes for the assessment or any credits. The WSHIP is provided authority to perform all or part of the risk management functions, including conducting preoperational and planning activities related to the programs, and defining the legal structure to administer and coordinate the programs. The OIC may adopt rules to implement this section. Funding for the transitional reinsurance program may be increased to cover the administrative costs. The pool must report to the Legislature December 15, 2012, and December 15, 2013, on the risk management activities.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Sections 4 and 5 take effect immediately; Section 16, 18, and 20 take effect January 1, 2014.

Staff Summary of Public Testimony on Original Bill: PRO: The bill you passed last year provided a good start on the Exchange and has allowed the appointment of an Exchange Board that is well qualified and ready to begin work. This bill takes the next steps in moving the state toward development and the ability to meet critical milestones in 2013, such as federal certification of a program, and having a program and benefit design ready before 2013 to allow carriers to develop products and be ready for 2013 open enrollment and coverage in 2014. There are some topics not yet in the bill while further work is done to prepare options for the decision making on essential health benefits, further discussion of administration of reinsurance and risk adjustment, and further discussion on the federal Basic Health option. ACA allows state flexibility to address many areas, including provisions that may safeguard the insurance market and ensure a level playing field for all carriers offering products in the Exchange and outside the Exchange, in the individual and small group markets. The recommendations for product offerings provide a framework to protect carriers from cherry picking or adverse risk that may result without additional protections that are not included in ACA. The protections for adverse risk provided in ACA with risk adjustment and reinsurance are not strong enough and require good solid data that does not exist for the thousands of uninsured lives that are expected to enroll in the Exchange.

This bill is a good next step to building the Exchange. It is reasonable that one gold and one silver plan be available in and out of the Exchange. We would like the market requirements to be applied on a company-wide approach so the company can offer in and outside the Exchange by their line of business with different networks. WSHIP assessment is a concern, as it continues to hit regulated carriers with a disproportionate burden on the individual and small group plans, and we suggest plans be allowed to take a credit on WSHIP assessment paid against the new reinsurance assessment. The tribes support this bill and believe it will provide an opportunity to cover the many uninsured tribal members, and we hope there may be opportunity for the tribes to sponsor coverage in the Exchange and to require the Exchange plans to use tribal providers as essential community providers.

These changes will create a viable, sustainable, and consumer friendly Exchange that promotes competition and helps with the complexity of purchasing insurance today. The uniformity of the approach will help provide a level playing field. We support changing the small group definition to 100 now, rather than waiting to 2016. There are important safeguards for people with pre-existing conditions, and we suggest that the essential health (EHB) decisions will also be important in that discussion. We will need to look deeper into EHB designs for limitations in areas like the prescription benefits to ensure coverage of emerging new drugs that target cancer and other illnesses. The criteria for the qualified health plans are some of the most important elements, since the state provides the stamp of approval for consumers and the stamp should indicate that the plan has met quality standards and ensures consumer protections.

The Exchange provides opportunity for seamless coverage, and the federal Basic Health option would provide the best opportunity to ensure seamless coverage and appears to reduce the churn between coverage options as families experience income changes. It is important for families to have the same coverage, and a Basic Health option may afford the best linkage with plans for children and their parents. We need discussion of special pediatric services that need to be added to EHB to ensure they are robust and that the process for developing the benefits is transparent and inclusive. The federal Basic Health option may provide the

most cost-effective care for enrollees and allow more take-up of insurance. If the premiums in the Exchange are too high, then people will remain uninsured. The Basic Health option allows the best opportunity to create an integrated bridge with Medicaid. Please leave the option to develop the Basic Health option open and add it to the bill.

CON: There was opportunity to develop the Exchange as a true market organizer, but this bill goes in the opposite direction and manipulates markets and health plans. The risk adjustment mechanisms in ACA provide protection. The Legislature should retain oversight of the Exchange and the criteria for the qualified health plans and not add to the federal requirements. Association products fill an important niche for many. We have concerns with the requirements for the products to be offered in and outside of the Exchange, and negative impacts on competition. This will limit choice for small businesses, and we are concerned that small businesses will be confused and drop coverage. We do support development of an Exchange, but we believe ACA provisions for adverse selection are enough to ensure a vibrant marketplace. We support the development of a health Exchange and the continuation of WSHIP, and believe the WSHIP Board should coordinate all the risk mechanisms called for in ACA. We have concern this bill provides the Board and OIC too much authority to make broad based policy decisions that should be in the hands of the Legislature. The federal requirements in ACA are enough, and the state should not exceed those standards.

OTHER: The WSHIP Board asks that if you make it the administrator of the risk adjustment and reinsurance mechanisms, you do it this year to allow us time to develop the program or else it will be a recipe for failure.

Persons Testifying: PRO: Jonathan Seib, Governor's Office; Barbara Flye, OIC; Molly Voris, HCA; Scott Plack, Group Health Cooperative; Ed Fox, American Indian Health Commission; Teresa Mosqueda, WA State Labor Council, Healthy WA Coalition; Erin Deziedzic, American Cancer Society; Misha Wershkul, Service Employees International Union 775, 1199 NW; Kate White Tudor, WA State Nurses Assn.; Jen Estroff, Children's Alliance; Janet Varon, NW Health Law Advocates.

CON: Donna Steward, Assn. of WA Business; John Stuhlmiller, WA Farm Bureau; Gary Smith, Independent Business Assn.; Chris Bandoli, Regence Blue Shield; Len Sorrin, Premera Blue Cross; Mel Sorenson, WA Health Insurance Underwriters, National Assn. of Insurance and Financial Advisors.

OTHER: Karen Larsen, WSHIP.