HOUSE BILL REPORT
SSB 5445

As Reported by House Committee On:
Health Care & Wellness

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].

Brief Summary of Substitute Bill
(As Amended by House)

- Establishes a Health Benefit Exchange, and a Health Benefit Exchange Board, by July 1, 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).

Background:

Health Benefit Exchanges.

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

Under the PPACA, an Exchange's functions include:

- facilitating the purchase of qualified health plans by individuals and small groups;
- certifying health plans as qualified health plans based on federal guidelines;
- providing information to individuals about their eligibility for public programs like Medicaid and the Children's Health Insurance Program and enrolling eligible individuals in those programs;
- operating a telephone hotline and website to assist consumers in the Exchange; and
- establishing navigator programs to help inform consumers and facilitate their enrollment in qualified health plans in the Exchange.

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

In order to be qualified to sell insurance in an Exchange, a carrier must:

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

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

The PPACA provides states with some flexibility when implementing the Exchanges. For example:

- Administration: the Exchange 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 Exchange, but the state will receive federal funding for the BHO equal to 95 percent of the tax credits and cost-sharing reductions the individuals would have received in the Exchange.

- Regional or Interstate Exchanges: an Exchange may operate in more than one state. A state may also establish subsidiary Exchanges to serve geographically distinct areas within the state.
- One Exchange or Two: the state may operate separate Exchanges for the individual and small group markets, or may operate one Exchange that serves both (this is a separate issue from combining risk pools).
- 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 Exchanges. For example, the Legislature established the Joint Select Committee on Health Reform Implementation, which established an advisory group to consider issues relating to establishing an Exchange. The Office of the Insurance Commissioner established a Realization Committee, which also made recommendations relating to an Exchange. Finally, the Health Care Authority (HCA) received a planning grant, which it used, in part, to develop several issue briefs relating to Exchanges.

Summary of Amended Bill:

Establishing an Exchange.

The state must establish, by statute, an Exchange to begin operations no later than January 1, 2014. 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 the need for a regulatory framework that applies both inside and 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 Exchange must be established no later than July 1, 2012, as a quasi-governmental, public-private partnership with a Health Benefit Exchange Board (Board) the membership of which will be appointed by the Governor by July 1, 2012. The membership of the Board must be as follows:

- two employee benefits specialists;
- a health economist or actuary;
- small businesses;
- health care consumer advocates;
- the administrator of the HCA;
- the Insurance Commissioner (as an ex-officio member); and
- two members from a list of four recommendations submitted by the Legislature. Each chamber of the Legislature must submit two names, which must be mutually agreed on by each caucus. The persons on the list must have expertise in at least one of the following areas: individual health care coverage; small employer health care coverage; health benefits plan administration; health care finance and economics; actuarial science; administering a public or private health care delivery system; or purchasing health plan coverage.

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. Neither the Exchange nor the Board may begin operating the Exchange or make substantive decisions regarding the Exchange unless specifically authorized to do so by statute.

Board members may not be employed by, a consultant to, a member of the board of directors of, or otherwise a representative of or a lobbyist for an entity in the business of, or potentially in the business of, selling items or services of significant value to the Exchange.

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 on an ongoing basis.

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.

Neither the Exchange nor the Board are officially established until all the members of the Board are appointed. Prior to the establishment of the Exchange, the HCA has the powers and duties of the Exchange and the Board.

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.

Once the Exchange and the Board are officially established, the powers and duties delegated to the HCA are transferred to the Exchange and the Board.

Amended Bill Compared to Substitute Bill:

The amended bill:
- requires that the Exchange be established by statute;
- requires the Exchange to be established by July 1, 2012, as a quasi-governmental, public-private partnership with a Board;
- limits the powers and duties of the Exchange and the Board 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;
- prohibits the Exchange and the Board from beginning exchange operations or making substantive policy decisions unless specifically authorized to do so by statute;
- prohibits the Exchange or the Board from being established until all of the members of the Board are appointed;
- requires the Exchange and the Board, once established, to assume the duties and responsibilities of the HCA with respect to establishing the Exchange;
- removes the following items 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;
- changes the following items on the list of what the Exchange is intended to do: 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"); and 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");
- requires the Board members appointed from the list submitted by the Legislature to have expertise in one of the following areas: individual health coverage; small employer health care coverage; health benefits plan administration; health care finance and economics; actuarial science; administering a public or private health care delivery system; or purchasing health plan coverage;
- removes the prohibition against members of the Board having any conflicts of interest —instead, Board members are prohibited from being employed by, a consultant to, a member of the board of directors of, or otherwise a representative of or a lobbyist for an entity in the business of, or potentially in the business of, selling items or services of significant value to the Exchange;
- requires the Board to establish an advisory committee to allow for the views of the health care industry and other stakeholders;
- requires the Board to consult with the American Indian Health Commission on an ongoing basis;
- provides qualified immunity to members of the Board, instead of to the Board itself;
- requires the HCA (or the Exchange and the Board, once established) to "collaborate" (instead of "consult") with the Joint Select Committee on Health Reform Implementation when conducting its activities under the act;
- requires the options developed by the HCA (or the Exchange and the Board, once established) to be completed by January 1, 2012 (instead of December 1, 2011);
- requires the options to include the operations and administration of the Exchange (instead of the structure of the public-private partnership that will govern the Exchange, operations of the Exchange, and administration of the Exchange);
- removes language stating that a multi-state Exchange is an option only after the state-administered Exchange is established;
- requires the options to include 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;
- requires the HCA (or the Exchange and the Board, once established) to consult with health care providers and facilities;
- removes the HCA's rule-making authority; and
- makes changes to the intent section.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on March 24, 2011.

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:

(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.

Persons Testifying: (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 Signed In To Testify But Not Testifying: None.