Washington Research Council

Policy Brief

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Implementing Washington's Health Benefit Exchange

Briefly

During this year's session, the legislature passed a bill furthering implementation of the state's health benefit exchange. Some key provisions of the bill concern essential health benefits, insurance commissioner authority, market rules, and self-sustainability.

As implementation of federal health care reform approaches, states have been working on a key part of the reform: the state health benefit exchanges. The Washington legislature has enacted legislation implementing an exchange, first with SSB 5445 in 2011 (at which point, Washington was one of six states to do so) and with E2SHB 2319 this year (15 states have now established exchanges).

Although exchange basics are outlined in the federal legislation, states have flexibility. The legislature took advantage of that by creating an exchange that regulates the health insurance market to a greater degree than is required by federal law. Most importantly, the legislation would considerably impede the market. It is important to consider that both the federal and state governments are in the midst of rulemaking. The Patient Protection and Affordable Care Act (PPACA) set the basic outlines of the exchanges, and E2SHB 2319 builds upon them, but many issues remain to be fleshed out.

Federal Health Care Reform

PPACA became Public Law 111-148 on March 23, 2010. As an overview, the law requires most Americans and U.S. residents to have health insurance (unless they can claim financial hardship or religious objections, are American Indians, lack coverage for less than three months, or are incarcerated), expands Medicaid to people with incomes up to 133 percent of the poverty level, subsidizes insurance (with premium tax credits) for families with incomes between 133 and 400 percent of the poverty level, and establishes health benefit exchanges to help people compare and purchase coverage.

PPACA sets basic rules for what the health benefit exchanges are to look like and include, but setup and specifics are left to the individual states. States must establish exchanges by January 1, 2014 (to include a telephone hotline, website, standardized presentation of plan options, and a calculator to determine cost of coverage including any premium tax credit), and the exchanges must be self-sustaining by January 1, 2015. (If a state does not create an exchange, the federal government will do so for it. Arkansas and Louisiana have decided not to create exchanges, and there has been no significant activity in another 15 states, according to the Kaiser Family Foundation.) Federal grants are available to help states plan for and establish exchanges. (Washington has received two: $22.9 million in March 2011 and $127.9 million in May 2012, for a total of $150.8 million—the most of any state.)

Under PPACA, individuals and small businesses will be able to purchase health care insurance through the exchanges. No one is required to participate in the exchange, but they are only eligible for the federal subsidies and premium tax credits if they do so.

Insurance offered in the exchanges (and qualified health plans offered outside of the exchanges in the individual and small group markets) must provide "essential health benefits" (EHB), but states may require additional benefits as well. (However, if they do require additional benefits, states must defray their costs by making payments to individuals enrolled in qualified health plans or directly, on their behalf, to the qualified health plans.)

PPACA's "essential health benefits" include, at least: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services (including behavioral health treatment), (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventative care and wellness services and chronic disease man-

agement, and (10) pediatric services (including oral and vision).

PPACA requires the Department of Health and Human Services (HHS) to define what is meant by "essential" within these categories. In a December 2011 bulletin, the Center for Consumer Information and Insurance Oversight (part of HHS) announced its proposed regulatory approach on the topic. It proposes that "EHB be defined by a benchmark plan selected by each State." The bulletin also says,

> The approach for 2014 and 2015 would provide a transition period for States to coordinate their benefit mandates while minimizing the likelihood the State would be required to defray the costs of these mandates in excess of EHB. In the transitional years of 2014 and 2015, if a State chooses a benchmark subject to State mandates—such as a small group market plan—that benchmark would include those mandates in the State EHB package.

(HHS will evaluate this approach in 2016.) One of the options for the benchmark plans is "the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market."

To offer insurance through the exchanges, companies must offer "at least one qualified health plan in the silver level and at least one plan in the gold level" and they must charge the same premium rate for a plan inside the exchange as for a plan outside the exchange. Levels of coverage are:

- Bronze: Providing "benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan." That is, 60 percent of the benefit costs are covered by the plan (and the enrollee pays the remaining 40 percent of the costs).
- Silver: 70 percent of benefit costs covered.
- Gold: 80 percent of benefit costs covered.
- Platinum: 90 percent of benefit costs covered.

Catastrophic plans in the exchanges are allowed only for individuals younger than 30 or exempt from the mandate, and only if the plan provides coverage for the EHB (but no benefits until the individual has incurred certain cost-sharing expenses) and three primary care visits. These plans may only be offered in the individual market.

E2SHB 2319

In 2011, the legislature enacted SSB 5445. The bill established the Washington health benefit exchange as a public-private partnership, with a governing board to be appointed by the governor.

During the session this year, the legislature enacted E2SHB 2319, which continues the implementation of the exchange. (Funds were provided in the 2012 supplemental operating budget for implementation of the bill.) The bill specifies that open enrollment in qualified health plans through the exchange will begin October 1, 2013. The board will establish a rating system for plans "to assist consumers in evaluating plan choices in the exchange." Some key provisions of the bill concern essential health benefits, insurance commissioner authority, market rules, and self-sustainability.

Essential Health Benefits. The insurance commissioner must select the largest small group plan by enrollment in Washington to be the benchmark plan for purposes of establishing EHB. It must include the ten benefits from PPACA (by rule if not already present). Washington currently has a number of state-mandated health benefits. (According to the Council for Affordable Health Insurance, Washington has 58—the ninth most in the nation.) Under the bill, the commissioner will have to submit an annual list to the legislature of these mandates that go beyond the federal essential benefits list, including costs of each mandate. Further, "the commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs." (The Health Care Authority contracted with Milliman to make recommendations as to how to select the benchmark. In a February 2012 report, Milliman recommended Washington choose the largest small group product/plan by enrollment. Doing so, Milliman said, "ensures that the State will not need to subsidize coverage of 'additional benefits' in excess of EHBs.") The provision of EHBs is an area of PPACA in which there is still a great deal of uncertainty. In 2016, HHS may decide to be more specific about what exactly must be considered to be EHBs.

Insurance Commissioner Authority. E2SHB 2319 gives the insurance commissioner broad authority to determine which plans are "substantially equal to the benchmark plan" and are, therefore, allowed to be offered. In making the determination, he may consider "whether the health plan con-

tains meaningful scope and level of benefits in each of the ten essential health benefit categories." The bill also allows the commissioner to "assure substantial equivalence of prescription drug cost-sharing" if he determines that "variation in prescription drug benefit cost-sharing, both inside and outside the exchange in both the individual and small group markets results in adverse selection." In all, the legislature has granted the insurance commissioner considerable authority over the market.

Market Rules. Beginning January 1, 2014, if insurance carriers offer plans at the bronze level outside of the exchange, the legislation requires that they also offer individual or small group plans at the silver and gold levels outside of the exchange. This is not required by PPACA. Under E2SHB 2319, catastrophic plans for those under 30 or exempt will only be allowed to be sold within the exchange (again, not required by PPACA). E2SHB 2319 requires a review of how these provisions impact "the health and viability of the markets inside and outside the exchange" by December 1, 2016, including recommending whether or not to let them expire.

Additionally, the bill requires that *all* health plans (except catastrophic) offered outside of the exchange conform to the bronze, silver, gold and platinum actuarial value tiers. (PPACA only requires plans sold in the exchange and in the individual and small group markets to do so.) This provision applies to existing plans that are grandfathered under PPACA (meaning they were not required by the federal law to comply with the benefit tiers) and to large group plans. Consequently, there will be no option to enroll in a plan (other than catastrophic) with an actuarial value below bronze (60 percent of benefit costs covered). In Washington currently, some of the most popular plans in the individual market have actuarial values in the 40 to 50 percent range. Those plans will no longer be available under the bill. Also, many large employers offer high-deductible plans which are not likely to meet the 60 percent threshold.

Self-Sustaining. As noted above, PPACA requires exchanges to be self-sustaining by January 1, 2015 (before then they are supported by federal grants). E2SHB 2319 amends the 2011 language establishing the exchange to call it a "self-sustaining" public-private partnership, and it defines "self-sustaining" as "capable of operating without direct state tax subsidy. Self-sustaining sources include, but are not limited to, federal grants, federal premium tax subsidies and credits, charges to health carriers, and premiums paid by enrollees." The exchange board is required to

> develop a methodology to ensure the exchange is self-sustaining after December 31, 2014. The board shall seek input from health carriers to develop funding mechanisms that fairly and equitably apportion among carriers the reasonable administrative costs and expenses incurred to implement the provisions of this chapter. The board shall submit its recommendations to the legislature by December 1, 2012.

In May 2012, the Washington Health Benefit Exchange released a report (an analysis by Wakely Consulting Group) that looks at various options for financing exchange operations. The report estimates that expenses in 2015 could range from $44.5 million to $60.3 million. The options for financing range from a narrow assessment on exchange enrollment to a broad-based assessment on the health care market (or even on a source that is not linked to the health care market). An additional section in the bill read, "If at any time the exchange is no longer self-sustaining . . . the operations of the exchange shall be suspended." That section was vetoed by Gov. Gregoire who said it was redundant and that the "at any time" phrase could lead to litigation and uncertainty.

Discussion

The market rules imposed by the state legislation go well beyond the requirements of PPACA, and they could have serious consequences on the insurance market in Washington. Options are considerably reduced. Both inside and outside of the exchange, many enrollees will be forced into richer, costlier plans than they may need or want. Also, carriers of large group plans and existing plans that PPACA had grandfathered are required to adhere to the benefits tier. While the legislation follows federal guidance on creation of a benchmark plan which would encompass the EHBs, it gives the insurance commissioner unprecedented authority over plan design.

The U.S. Supreme Court heard arguments on the constitutionality of PPACA in March. A decision is expected this month. Even if some aspects of PPACA are ruled unconstitutional, the exchange could still remain operational, but in what form or for what purpose would remain to be seen.

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