



State Legislative Session Proposed Budgets – Department of Community and Human Services

Department of Community and Human Services (DCHS) reviewed the *new* Senate Proposed Striking Amendment to SB 6612 (3/15/12). Here is the comparison to the House Striking Amendment (passed 3/8/12):

Developmental Disabilities (DD) – Senate 3/15 striker has no cuts to King County DD programs. The House striker eliminates the State Only Employment funding on January 30, 2013. King County has 140 individuals funded under the program. The House striker proposal does include funding to convert people to a Center for Medicaid Services Waiver so they will not lose services. Because not everyone will meet Waiver eligibility, King County would lose a projected 70 of the individuals we currently serve with state only funding for an annual loss of **\$323,400** (average per cap of \$385/month).

Mental Health – Senate 3/15 striker and the House striker have no cuts to Medicaid, non-Medicaid or jail transition services. The Senate 3/15 striker removed the cuts to Western State Hospital wards – significant change. Optional Waiver Services are cut in both the Senate and House striker budgets, which may mean cuts to clubhouse programs. The House striker does cut the Western State Hospital traumatic brain injury and dementia wards, which will be an impact to King County of approximately **\$3.5 million**.

Substance Abuse – Senate 3/15 striker is now similar to the House striker – with one major exception – Senate 3/15 striker cuts the Disability Lifeline/Alcohol and Drug Addiction Treatment and Support Act (DL/ADATSA) program, **\$22.5M** statewide (15,000 clients statewide). This cut impact in King County is approximately **\$5.2 million** and at least 2,000 new clients a year will not receive services. The Long-Term Residential and Recovery House cuts are in both budgets, but slightly increased in the Senate 3/15 striker to **\$2.7M** statewide. The Senate 3/15 striker continues the same reduction to chemical dependency assessments by **\$188K**; a King County reduction of about **\$55,000**. The House Striker cuts the Community Mobilization program statewide by 10 percent (at least **\$12,414**), which makes it difficult to continue operation of the program.

Employment and Education Resources – **\$105,000** cut in both House and Senate budgets.

Disability Lifeline/Housing and Essential Needs (DL/HEN) – Senate 3/15 striker cuts the entire DL/HEN program. House striker does not cut DL/HEN program. King County signed a HEN contract for \$19.9M for the biennium. Due to the potential cut of the HEN program, Department of Commerce limited spending authority to \$5.6M through

3/31/12. If the Senate 3/15 striker prevails, DCHS HEN program will lose **\$14.3M** or a reduction of 72% of the original contract. This cut impacts up to 3,000 HEN eligible clients in King County.

Housing Trust Fund – House Capital Striking Amendment is **\$71.382M** statewide – \$60.082 for Housing Trust Fund projects on the LEAP list; \$8M for a Housing Competitive Pool; and \$3.3M for Quixote Village and Low Income Housing Institute. Senate budget is much less at **\$30M** statewide.

Office of Public Defense (OPD) – Senate 3/15 striker has no cuts to King County public defense services. The House striker cuts Truancy funding by \$1,341,000 statewide. The reduction reflects the elimination of the requirement that school districts file truancy petitions for truant students who are 17 years old. If this is applied on a percentage reduction basis to King County funding, the impact is 16.25% reduction of funds. For King County OPD, this is a **\$74,265** cut (a similar percentage cut will impact Superior Court and the Office of the Prosecuting Attorney).

Public Health – Seattle & King County
Legislative Update
March 27, 2012

The regular state legislative session saw the release of several budget proposals, but the legislature adjourned Sine Die on March 8th without a final budget. The Governor called the legislature into a 30-day special session beginning March 12th.

State Legislative Session: Budget

We are pleased to report that Maternity Support Services was preserved in every budget draft released by the legislature the regular session and special session.

With the release of the first House Democrats' budget, state funding (core public health funding) for local public health departments was eliminated and replaced with liquor excise tax revenue—leaving about a \$9 million gap in funding to local health departments. Thanks to much advocacy from public health, partner organizations and community leaders all state funding for local public health was restored via amendment before the House passed its budget.

While the Senate Democrats' budget protected all state funding for local public health, along with the majority of health safety net services, the Senate Republicans' budget that was ultimately passed by the Senate included a \$5 million cut to state funding for local public health, the elimination of Disability Lifeline - Medical, and significant cuts to family planning. With the release of an updated budget proposal from Senate Republicans and Senator Kastama, Senator Tom, and Senator Sheldon all state funding for local public health was restored, as well as half of the early cut to family planning (\$3 million cut in this version). However, this new version eliminates Disability Lifeline – Medical and the Alcoholism and Drug Abuse Treatment Support Act (ADATSA) medical care services programs.

State Legislative Session: Policy Bills

Several bills Public Health was tracking have already been signed by the Governor, or are on her desk awaiting signature:

- HB 2319 – Implementing the affordable care act
- HB 2341 – Concerning community benefits provided by hospitals
- SB 5381 – Adjusting voting requirements for emergency medical services levies
- SB 6116 – Concerning on-site sewage program management plans

Public Health was also tracking two bills that intersected health and transportation; those bills died with the end of the regular session:

- HB 1217 – Authorizing local authorities to establish maximum speed limits on certain non-arterial highways
- HB 2370 – Including health in the state transportation system policy goals

Summary of HB 2319, Implementing the Affordable Care Act
Updated March 5, 2012

In 2011, the Legislature passed SSB 5445, creating the Health Benefit Exchange, a new insurance marketplace for individuals and small businesses that will launch in 2014 as part of health reform under the Affordable Care Act (ACA). The Exchange aims to facilitate comparison-shopping for coverage, raise quality through uniform coverage standards; and offer more affordable coverage through subsidies and increased competition. While SSB 5445 authorized planning for the Exchange and created a governing board, it did not address key policy questions about Exchange operations.

This session, the Legislature has passed a bill, HB 2319, to address outstanding policy questions and strengthen the Exchange in preparation for its launch. On February 11th, the House passed a second substitute version of the bill with a 52-43 vote (see NoHLA Update from February 21st). On March 2nd, the Senate passed a striking amendment proposed by Senator Hargrove with a 27-22 vote. On March 3rd, the House concurred in the Senate amendments. The chart below summarizes the content of the final bill, which awaits action by the Governor.

HB 2319 as Passed Legislature

Issue	Content	Significance
Exchange Board & Staff	<ul style="list-style-type: none"> Removes previous language that limited Exchange Board activity to administrative matters. Allows Exchange Board to complete duties necessary to begin open enrollment by October 2013. 	Expands the authority of the Exchange Board to implement the Exchange.
	<ul style="list-style-type: none"> Health Care Authority (HCA) may hire Exchange employees via contract with the Exchange Board. Exchange employees may participate in public employee health insurance programs. 	Allows for hiring and compensation of Exchange employees.
Exchange Financing	<ul style="list-style-type: none"> Exchange must be self-sustaining—capable of operating without direct tax subsidy—or operations shall be suspended. Exchange Board must consult with insurers to recommend a funding methodology to the Legislature by 12/1/12. If the Legislature fails to act in the 2013 session, the Board may proceed with its recommendations. 	Allows the Exchange Board to consider non-state funding sources.
Affordability of Coverage/Federal Basic Health Program	<ul style="list-style-type: none"> If funding for a Federal Basic Health Program (FBHP) is provided in the operating budget, HCA must proceed on the assumption that the FBHP will be implemented. By 12/1/12, HCA must report to the Legislature on sufficiency of funding to implement a FBHP, using payment rates that will ensure an adequate provider network and health homes. The Legislature will then determine whether to proceed with the FBHP. If FBHP is adopted, it must be guided by certain principles (e.g., meet federal standards, 12-month continuous eligibility, affordability, adequate provider networks and health homes). 	Permits the state to proceed in <i>preliminary</i> planning for a new federally-financed health coverage program that would operate alongside the Exchange to make coverage more affordable for those under 200% FPL. The Legislature retains authority to make a final decision in 2013.
	<ul style="list-style-type: none"> Tribes, city and county governments, urban Indian organizations, private foundations and other entities may sponsor premiums. 	Permits organizations to assist individuals with premiums.
Qualified Health Plans	<ul style="list-style-type: none"> Requires the Exchange Board to certify qualified health plans to participate in the Exchange if the plan: <ul style="list-style-type: none"> Meets applicable state insurance laws and regulations; Meets federal ACA standards; and Includes tribal clinics and urban Indian clinics as essential community providers in network (exemption for integrated delivery systems). The Exchange Board may permit qualified health plans to provide coverage through direct primary care medical homes. 	Requires the federal minimum standards for plans in the Exchange without adding state-specific requirements.
	<ul style="list-style-type: none"> Establishes a rating system for consumers to evaluate qualified health plans based on a number of specified factors. The Exchange Board may modify these factors. 	Allows consumers to compare coverage options.
	<ul style="list-style-type: none"> Permits stand-alone dental plans to be offered in the Exchange, if offered and purchased separately from qualified health plans. 	Allows consumers to buy dental coverage if Exchange plans do not cover dental.
	<ul style="list-style-type: none"> Permits small firms offering coverage through the Small Business Health Options (SHOP) Exchange to designate a metal-level tier of coverage for employees, who may then choose any qualified health plan at that level. 	Gives employees of small businesses more choice in selecting health coverage.
Essential Health Benefits	<ul style="list-style-type: none"> Office of Insurance Commissioner (OIC), with Exchange Board & HCA input, must select the largest small group 	Chooses a benchmark benefits package from

Issue	Content	Significance
	<p>plan as the benchmark benefits package for the individual and small group market. If this plan does not cover the ACA's ten required benefit categories, OIC must supplement.</p> <ul style="list-style-type: none"> • Prohibits a plan from being offered in the state unless the OIC determines that it is substantially equivalent to the benchmark. (Exception for Medicaid and Federal Basic Health Program plans). <ul style="list-style-type: none"> ○ OIC <i>must</i> consider whether the plan covers the ACA's ten required benefit categories in a meaningful way. ○ OIC <i>may</i> consider whether the plan creates a significant risk of biased selection or contains a meaningful scope and level of benefits in each of the ten categories. • OIC must report to Legislature about any financial risks to the state from mandated benefits and any statutory changes needed if the Legislature wishes to discontinue a mandate. OIC may only enforce a mandate that places the state at financial risk if funds are specifically appropriated. 	<p>among ten federal options. The benchmark will apply to enrollees in the individual and small group markets (inside and outside the Exchange), but will not apply to Medicaid or FBHP. Authorizes the OIC to ensure compliance with the benchmark and protect the state from financial risks associated with the benchmark.</p>
<p>Insurance Market Rules</p>	<p><u>Rules with 12/1/16 sunset unless Legislature determines otherwise based on OIC recommendation:</u></p> <ul style="list-style-type: none"> • Insurers may not offer catastrophic plans for young adults outside the Exchange. • Insurers offering bronze-level plans outside the Exchange must also offer silver- and gold-level plans outside the Exchange. • OIC may adopt rules to ensure substantial equivalence in prescription drug benefits if benefit designs contribute to adverse selection. <p><u>Rules without a sunset provision:</u></p> <ul style="list-style-type: none"> • Insurers offering plans outside the Exchange must comply with ACA metal-level actuarial value tiers. 	<p>Takes steps to level the playing field between insurers offering plans inside and outside the Exchange. The goal is to prevent the "adverse selection" of high-risk individuals into the Exchange by constraining insurers' ability to offer low-quality, low-cost plans outside the Exchange and spreading the costs of high-risk individuals across the insurance market.</p>
<p>Reinsurance</p>	<ul style="list-style-type: none"> • OIC (with Exchange Board input) may adopt rules to establish ACA's reinsurance program, and to obtain the data needed. • OIC must analyze an "invisible" high risk pool option to determine if this would: (1) be allowed under federal regulations, (2) provide comprehensive coverage, and (3) be designed to ensure carriers ceding risk would provide care management to high risk/cost enrollees. • OIC must contract with one or more nonprofit entities to administer risk adjustment and reinsurance programs. 	
<p>Washington State Health Insurance Pool</p>	<ul style="list-style-type: none"> • By 12/1/12, WSHIP Board must evaluate and make recommendations on: <ul style="list-style-type: none"> ○ Populations that may need ongoing access to WSHIP in 2014; and ○ Pool assessments that may be needed for federal reinsurance, and whether assessments should be adjusted for fairness/equity reasons. • WSHIP may contract with OIC to administer risk management functions. • WSHIP may conduct pre-operational/planning activities, financed by federal funds or reinsurance assessments. 	<p>Authorizes WSHIP Board to assess the ongoing need for WSHIP after the Exchange launches and potentially continue as a risk management mechanism.</p>
<p>Navigators</p>	<ul style="list-style-type: none"> • Navigators will not be regulated as insurance producers for activities consistent with the ACA. 	<p>Permits individuals to serve as Navigators without broker licensing.</p>
<p>Wellness Project</p>	<ul style="list-style-type: none"> • HCA must pursue application for state to participate in individual market Wellness Program demonstration. 	<p>Allows state to seek ACA wellness activities funding.</p>