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MANAGING HEALTH REFORM

WASHINGTON: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

March 2014

**Rockefeller Institute of Government
State University of New York**

**Fels Institute of Government
University of Pennsylvania**

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Part 1 – Setting the State Context

1.1. Decisions to Date

The state of Washington is expanding its Medicaid program and operating its own health insurance marketplace, as authorized by the Patient Protection and Affordable Care Act (ACA). The state legislature made the decision to run an insurance exchange in 2011, ahead of the June 2012 Supreme Court decision on the ACA's constitutionality, and well in advance of the 2012 presidential election. On July 1, 2013, Governor Jay Inslee signed the state's biennial budget, which authorized Medicaid expansion. Thus began the formal action signaling Washington State's intent to fully implement the ACA.

These decisions were understandable given Washington's political and public policy setting, which could be characterized as largely Democratic and progressive. From a distance, Washington is viewed as a "blue" state where voters have selected the Democratic candidate in the last seven presidential elections. A majority of state voters are registered Democrats, a Democrat has held the governor's office continuously for the past twenty-seven years, and a Republican holds only one statewide office.

Yet as Washington officials considered major ACA-related options in 2011, 2012, and 2013, state policy was far from perfectly unified. Although Democrats have held a solid majority in the statehouse for the past decade, the power division in the Senate

has been more fluid. Democrats had numerical majorities during these three critical years, but their ability to set policy agendas and budget priorities was often limited by a small group of conservative senators. And, for the 2013 legislative session, two Democrats formally joined Republicans in a "Senate Majority Coalition Caucus" that shifted power to the Republicans. This caucus voiced more caution about Medicaid expansion, but did, in the end, support its implementation.

Beyond politics, effective ACA implementation depends on public management responsibilities that are spread across five separate agencies, three of which are in the executive branch, one independently elected statewide office, and a new quasi-governmental single purpose entity:

- Health Care Authority (HCA). Oversees Medicaid and the Public Employee Benefits Board (the state's top two health care purchasers).

- Department of Social and Health Services (DSHS). As Washington's umbrella social services agency, offers various medical/mental health programs to support social service efforts. It is a data systems and eligibility determination partner for the ACA.

- Department of Health (DOH). Leads state public and community health efforts and additional data systems.

- Office of Insurance Commissioner (OIC). Independently elected commissioner responsible for regulating health insurance companies doing business in Washington. Certifies providers chosen as Qualified Health Plans (QHPs) by the Health Benefit Exchange (see below).

- Health Benefits Exchange (HBE). ACA insurance marketplace created by state statute in 2011 as a public-private partnership exempt from certain state operating rules. See http://www.wahbexchange.org.

Three factors helped to create the policy environment in which these five agencies have implemented the ACA:

1. Early political consensus — and consistent political leadership — to develop a state-run exchange and expand Medicaid.

2. Relatively early framework for implementation that accepted diversity of existing authority, the need for a new entity to run the insurance exchange, and the need for high levels of coordination, communication, and executive leadership.

3. Pressure of time.

Discussions of ACA implementation during 2011 were held in a climate of political uncertainty. Democrats led both the legislative and executive branches, but they faced an election the

following year that promised close races for governor and Senate. In the face of that uncertainty, then-Governor Christine Gregoire, a Democrat, and Democratic leaders in both houses submitted legislation to create a "public-private" health benefit Exchange to "shield it from politics," that is, from a governor who might resist implementation of the reform law. Indeed, the Republican candidate, then-Attorney General Rob McKenna, was a party to the multistate suit (*NFIB v. Sebelius*) challenging the ACA's constitutionality. According to some state policy leaders, had the Democrats known that Democrat Jay Inslee would be elected governor, they would have urged creation of a cabinet-level agency to run the Exchange.

Washington State government has been planning for a state-run exchange for more than three years and received three planning grants for this purpose:

- HHS awarded an initial planning grant for $996,000 in September 2010 to the Washington State Health Care Authority. The purpose was to develop an implementation plan for a state-governed and administered health insurance exchange to be operational on January 1, 2014. The project focused on "high level requirements and fundamental business functions" and conducted an information technology (IT) infrastructure review and assessment. The planning work also produced legislative options for governance and operation of a state-run exchange.

- In May 2011, the HCA received a Level One Establishment Grant of $23 million to develop options and recommendations on significant policy decisions. The grant supported creation of a detailed operational plan and development of a health information technology system to support its exchange.

- The federal government awarded the State Health Benefit Exchange a Level Two Establishment Grant of $128 million in May 2012. The grant helped the exchange accelerate operations, including hiring staff and continuing development of its IT system, with the goals of meeting certification requirements in January 2013, providing coverage to enrollees by January 2014, and becoming self-sustainable by January 2015.

Although substantial, these planning efforts could not solve all problems nor settle all issues. Given the newness and complexities of the ACA and uncertainties of the times, few would expect perfection. But the state's organizational structure to implement the ACA is not designed to simplify. Washington's multiagency arrangement was called by one close observer "an institutional mess," and we found intermittent concerns over the sometimes highly independent nature of HBE, and occasional attempts of that agency to "go it alone." All of this adds complexity to the

already complex challenges associated with integrating data from various federal agencies into state IT systems.

Yet, we were also told repeatedly of "great coordination" across agencies, with three factors facilitating this success. First, interviewees spoke of the power of necessity: the task of implementing the ACA was large and the timeframe short, exacerbated by federal delays in rule-making and guidance. Second, a wide range of observers noted the important role of convener played by the governor's policy office. This office brought key actors together, set agendas, and adjudicated disagreements among the agencies. Finally, by January 2013, when the new Inslee administration took over, many of the big decisions about implementation, such as HCA's role in Medicaid expansion and the exchange, had already been made. And many of the details of implementation, such as IT development, training, and outreach, while enormously challenging and time-sensitive, were in the hands of experienced, professional staff of agencies and their community and local government partners.

Finally, and possibly most important to forging coherent policy in this complex and challenging environment, leaders in various state agencies had years of experience — in many cases dating back to the last era of health system reform in the early 1990s — and long-standing relationships with each other. Each agency chief has strong substantive knowledge of the complex parts of the ACA and each expresses similar values, not surprising given personal histories in state government, working relationships, and political preferences. And each agency has built dedicated, knowledgeable, and experienced staffs who know what they need to do. They may not sing in perfect harmony, but they sing the same tune.

1.2. Goal Alignment

Washington's response to the ACA has been fully affirmative in keeping with the state's sustained leadership at the forefront of efforts to reform the health system, expand coverage, and alter the fragmented structure of health care delivery — all goals of the ACA. Washington's Basic Health Plan, a state program of subsidized health insurance for uninsured, low-income residents, started in 1988 and was the largest state-only "gap" program in the country when it reached 130,000 enrollees in the early 2000s. The state's Medicaid program was an early adopter of managed care, expanding from a few pilot projects in the 1980s to a statewide program in 1993. And the state legislature passed a comprehensive reform law, the Washington Health Services Act, in 1993 that encompassed many of the ACA's goals, including universal coverage, an individual mandate, insurance reforms, and a regulated marketplace for health plans offering uniform benefits (the law was largely repealed by 1995).

As noted above, most political leadership of the state supported the Patient Protection and Affordable Care Act even before

it was signed into law in 2010. Then-governor Gregoire and the Democratically led state house and senate — notably Senator Karen Keiser and Representative Eileen Cody, long-standing chairs of their respective health care committees — strongly supported the reform law, as did the state's U.S. Senators Patty Murray and Maria Cantwell. The one exception among state leaders was then-state Attorney General McKenna, who joined the national suit against the law. McKenna ran for governor and lost to Inslee; Inslee had voted for the Patient Protection and Affordable Care Act (PPACA) as a congressman and continued to voice that support when he resigned his House seat to seek, successfully, the governor's mansion.

The early discussions and legislation (see discussion in 1.1, above) to structure a state-run insurance exchange and, later, to expand Medicaid eligibility, created momentum that allowed the state to move relatively quickly once the U.S. Supreme Court upheld the ACA's constitutionality. This momentum was slowed only somewhat by the tenuous balance of power in the state Senate during the 2013 session (see discussion in 1.1, above).

Part 2 – Implementation Tasks

2.1. Exchange Priorities

The mission of the Washington Health Benefit Exchange (WHBE) is to redefine people's experience with health care by improving the process of securing health insurance, using innovative and practical solutions, and emphasizing the values of integrity, respect, equity, and transparency.

As a part of its mission, the exchange has four key objectives:

- Increase access to affordable health plans.
- Organize a transparent and accountable insurance market to facilitate consumer choice.
- Provide an efficient, accurate, and customer-friendly eligibility determination process.
- Enhance health plan competition on value: price, access, quality, service, and innovation.

The exchange launched Washington Healthplanfinder (motto, "Click. Compare. Covered."), the online marketplace where individuals, families, and small businesses can shop for health plans, on October 1, 2013.

During the initial postlaunch period, the Healthplanfinder was taken offline three times to address technical issues. Richard Onizuka, CEO for the exchange, released public statements detailing each period of downtime, emphasizing the exchange's steadfast commitment to a positive customer experience and timely improvements to the online marketplace. As of October 25, 2013, the exchange reported that nearly 49,000 residents had successfully enrolled in health coverage:

Enrollments Completed	
Qualified Health Plans	6,390
Medicaid Newly Eligible/Coverage January 1	26,336
Medicaid/Immediate Coverage	16,269
Total	**48,995**

An additional 53,000 applications were completed, representing 92,000 individuals, with payment pending.

2.2. Leadership – Who Governs?

The exchange was created, with bipartisan support, as a "quasi-governmental entity" by Substitute Senate Bill 5445 in 2011 (under RCW 43), and is built on a "state-based exchange model." SB 5445 established an independent Health Benefit Exchange Board with governing and operational authority over the exchange. The legislation limited the Board's authority to those powers and duties "necessary to apply for and administer grants, establish information technology infrastructure, and undertake additional administrative functions necessary to begin operation of the exchange by January 1, 2014." SB 5445 also directed the Board to develop a business plan and timeline to establish and implement the exchange.

Enacted in 2012, House Bill 2319 removed limitations on the Board's authority, effectively transferring governance from the Health Care Authority to the HBE Board. This law also further defined the duties and responsibilities of the exchange, including the requirement, consistent with the ACA, that the exchange be financially self-sustaining (that is, operational without direct state subsidy) by January 1, 2015. The Board was charged with developing policy options for funding the exchange and submitting a report to the legislature by December 1, 2012.

A more detailed explanation of the powers and duties of the Board may be found in chapter 43.71 RCW.

The eleven-member Board comprises health care industry experts and includes a chair and eight members appointed by the governor from among nominees chosen from each legislative caucus (Republican and Democratic causes in each house), and two ex-officio nonvoting members — the director of the Health Care Authority and the insurance commissioner. The current Board members are as follows:

- Margaret Stanley (chair), former executive director, Puget Sound Health Alliance; also held leadership positions at Regence BlueShield and with public employee benefits programs in Washington and California.

- Ben Danielson, medical director, Odessa Brown Children's Clinic.

- Bill Baldwin, partner, The Partners Group.

- Don Conant, general manager, Valley Nut and Bolt in Olympia; assistant professor of business, St. Martin's University.

- Bill Hinkle, executive director, Rental Housing Association and former state legislator.

- Melanie Curtice, partner, employee benefits section, law firm of Stoel Rives LLP.

- Phil Dyer, senior vice president at Kibble & Prentice/USI; former state legislator.

- Hiroshi Nakano, CEO, South Sound Neurosurgery.

- Teresa Mosqueda, legislative and policy director, Washington State Labor Council; chair of the Healthy Washington Coalition.

- Ex-officio: Dorothy Teeter, administrator, Washington State Health Care Authority.

- Ex-officio: Mike Kreidler, Washington state insurance commissioner.

More information on the Board and its meetings can be found at the exchange Web site.

On March 15, 2012, the Board appointed two committees, the Policy Committee and the Operations Committee. The Policy Committee deliberates on topics assigned or delegated by the Board. The Operations Committee monitors activities relating to the administration of the exchange, including operations, finance, and IT.

In addition to the two committees, and consistent with SB 5445, the exchange established an Advisory Committee and five Technical Advisory Committees (TACs) to represent the views of various stakeholders:

- The Advisory Committee provides expertise, experience, and professional perspectives on a variety of issues passed down from the Board. Following deliberation on each topic, the Advisory Committee provides comments to the Board committees.

- The Agents & Brokers TAC provides experience and professional perspectives on the role of agents and brokers in the exchange.

- The Dental Plan TAC provides experience and professional perspectives on the participation of dental plans in the exchange.

- The Health Equity TAC provides experience and professional perspectives related to health equity, with a focus on language access, health literacy, hard-to-reach populations, cultural sensitivity, and other general access to coverage issues.

- The Navigator TAC provides experience and professional perspectives related to the exchange navigator program.

- The Small Business Health Options Program (SHOP) TAC provides experience and professional perspectives related to SHOP, now known as Washington Healthplanfinder Business.

The Board receives additional input and guidance from four workgroups:

- The Consumer Workgroup provides a venue for community members and organizations to offer input on issues relating to the Healthplanfinder.
- The Outreach Workgroup seeks to inform strategic, effective outreach activities for the exchange's open enrollment period and to provide long-term outreach recommendations.
- The Plan Management Workgroup provides a venue for representatives of Washington's health insurers to provide input on how to offer individual and small group health plans through the exchange.
- The Enrollment & Billing Workgroup provides a venue for representatives of Washington's health insurers to provide input on the data interactions between carriers and the exchange.

The Board is also required to work with the state's Indian tribes.

2.3. Staffing

During its first year, the Health Care Authority helped the Exchange Board get started by providing staff and other resources. After governance transferred from the HCA to the HBE Board on March 15, 2012, the exchange began to build its staffing complement, consistent with the plans included in its federal Level II Grant Application Budget narrative:

WHBE Department	2012	2013	2014
Senior Executives	2	2	2
Administration & Finance	18	18	19
Communications	11	11	11
IT	3	7	7
Legal	3	7	7
Operations (NG)	14	18	18
Operations (SHOP)	5	5	5
Policy	5	7	7
Total Full-Time Equivalent (FTE) Positions	**104**	**114**	**115**

The Exchange leadership staff comprises nine individuals with considerable experience and expertise:

- *Richard Onizuka, chief executive officer* — The exchange's first CEO, Onizuka served as the assistant director for health policy for the Washington State Health Care Authority for more than nine years, overseeing programs and initiatives aimed at improving the quality and cost efficiency in the state's health care system.

- *Pam MacEwan, chief of staff* — Prior to joining the exchange, MacEwan served as executive vice president for public affairs and governance for Group Health Cooperative, where she directed Medicare and Medicaid program performance and strategy, government relations, public policy, communications, and consumer governance.

- *Bob Nakahara, chief financial officer* — Nakahara, a CPA, was the CFO for Qliance Medical Management, Inc., and held leadership positions in several health care companies.

- *Molly Voris, director of policy* — Before joining the exchange, Voris was a program director at the National Governors Association Center for Best Practices, where she helped create state-to-state learning opportunities in Medicaid, private insurance, and delivery system reform.

- *Beth Walter, director of operations* — Walter previously served as program director of the Washington State Health Care Authority's Health Insurance Partnership (HIP), where she led program development and implementation while managing strategic planning and developing policy priorities.

- *Curt Kwak, chief information officer* — Kwak joined the exchange after serving as CIO at Providence Health & Services.

- *Michael Marchand, director of communications* — Marchand oversaw communications and stakeholder engagement for the state's Medical Electronic Health Records Incentive Program and served as director with Microsoft's Health Solutions Group.

- *Keith Bell, director of the Small Business Health Options Program (SHOP)* — Prior to joining HBE, Bell was director for national Medicare sales and marketing at Essence Health Care and the assistant vice president for Medicare programs at Community Health Plan of Washington.

- *Brian Peyton, director of legal services* — Peyton previously served as director of the Office of Policy, Legislative and Constituent Relations at the Washington State Department of Health and as director of regulatory affairs for the University of Washington Medical Center.

2.4. Outreach and Consumer Education

Multiple forms of exchange outreach are underway. The exchange wants to track more than enrollment numbers and to work with other state health agencies to develop better quality and performance measures and link those indicators to payment incentives for organizations providing outreach. The Governor's Office is working with various state agencies and other stakeholder groups to develop a consensus group of performance indicators.

Between April and June 2013, the exchange produced and ran an eight-part Webinar series, "Countdown to Coverage," to educate consumers on the Affordable Care Act, the new Healthplanfinder, and coverage options to be available in 2014. In the same period, the exchange launched the Healthplanfinder Web site, including a cost-estimate calculator.

On September 17, 2013, the exchange launched a comprehensive marketing campaign, including grassroots activities, social media, business outreach, and cooperation with partners and media outlets across the state. Advertisements appeared on television, online, over the radio, in printed publications, across billboards, and on buses. Based on consumer research and target-audience testing, the advertisements were designed to emphasize unique aspects of the Healthplanfinder, including the availability of low-cost plans, the ability to make apples-to-apples comparisons between plans, and the new financial assistance available to lower the costs of premiums and copays.

2.5. Navigational Assistance

The exchange has funded the state's navigator program with nearly $6 million in grant funds from the U.S. Department of Health and Human Services. The exchange has contracted with ten lead organizations across the state to build, train, fund, and monitor networks of navigators and in-person assistors (IPAs):

- Benton Franklin Community Action Connections: Serving Benton, Franklin, and Walla Walla counties.
- CHOICE Regional Health Network: Serving Clallam, Grays Harbor, Jefferson, Lewis, Mason, Pacific, and Thurston counties.
- Clark County Public Health: Serving Clark, Klickitat, and Skamania counties.
- Cowlitz Family Health Center: Serving Cowlitz and Wahkiakum counties.
- Empire Health Foundation: Serving Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Garfield, Grant, Lincoln, Okanogan, Pend Oreille, Stevens, Spokane, and Whitman counties.
- Kitsap Public Health District: Serving Kitsap County.

- Public Health – Seattle & King County: Serving King County.
- Tacoma-Pierce County Health Department: Serving Pierce County.
- Whatcom Alliance for Health Advancement: Serving Island, San Juan, Skagit, Snohomish, and Whatcom counties.
- Yakima Neighborhood Health Services: Serving Kittitas and Yakima counties.

The exchange requires certification for all IPAs and leads the curriculum development and training efforts to educate each organization, ensuring consistency across the state. All in-person assistors must pass a certification exam before working with consumers, and each organization is responsible to train their partner networks.

Healthplanfinder in-person assisters are trained and certified to:

- Provide impartial information to individuals, families, and small businesses to help them identify which health insurance option best fit their needs.
- Provide communications through in-person meetings, phone calls, or interactive electronic means to assist consumers to identify their eligibility for reduced premiums and assist them in the enrollment process.
- Offer tailored support for those with cultural, linguistic, disability, or other special needs.

On July 12, 2013, the Centers for Medicare & Medicaid Services (CMS) established certified application counselors (CACs) as a type of assistance available to help consumers learn about and enroll in health insurance coverage. Washington CACs must be employed by an organization that agrees to bear responsibility for coordination and oversight of CACs and has entered into an agreement with the exchange.

The exchange unveiled its customer support program, operated by Faneuil, for the Healthplanfinder on September 3, 2013. The program includes a toll-free customer support center (1-855-WAFINDER, customersupport@wahbexchange.org) in Spokane, which provides assistance in up to 175 languages on weekdays from 7:30 A.M. to 8:00 P.M. High volumes and long wait times have led HBE to seek to hire dozens of new customer support staff.

Additionally, as a part of its tribal assister program, the exchange awarded $420,000 to five organizations to assist tribal members, their families, and other community members compare and enroll in health coverage through the Healthplanfinder. These organizations include a coalition of tribes and tribal-affiliated organizations.

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. See 1.1, above.

2.6(b) Intergovernmental Relations. See 1.1, above.

2.6(c) Federal Coordination. See 1.1, above. Interviewees noted substantial federal attention to, and interest in, Washington's exchange, which was considered "both good and distracting." They also reported a high level of interaction with the Centers for Medicare & Medicaid Services and Center for Consumer Information and Insurance Oversight over the past year. Illustrative of these timely, if time consuming, interactions between state and federal implementers, Washington was one of two states selected by the Center for Consumer Information and Insurance Oversight for IT system testing in February 2013. The testing was conducted by the federal government in April in order to assess the Healthplanfinder's infrastructure and its ability to integrate with federal data systems.

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). In June of 2012, the Exchange Board approved nineteen criteria to form the framework for health insurers seeking to participate in the exchange. These criteria are based on specifications outlined in the ACA and reflected the exchange's intention to allow all QHPs meeting the minimum standards to participate in the exchange in 2014.

In February 2013, the exchange released guidance that further detailed requirements for QHP participation in the Healthplanfinder and announced that twenty-four notifications had been received from health and dental insurance carriers intending to participate in the Healthplanfinder.

The process of certifying QHPs for the October 1, 2013, enrollment opening was delayed by decisions of the state's Office of the Insurance Commissioner (OIC). The OIC has the responsibility and authority to review the "readiness" of health insurers to meet the ACA's benefit requirements, as well as the state's requirements for network adequacy and financial solvency.

The HBE Board was originally scheduled to certify QHPs and Qualified Dental Plans on August 21, 2013. The OIC, however, decided on August 1, 2013, to approve thirty-one plans from only four insurers for the exchange. This decision was met with considerable disappointment by many stakeholders, especially because none of approved plans were offered by insurers that also served Medicaid beneficiaries. Advocates argued that if Medicaid plans were not available on the exchange, individuals or families whose income fluctuated during the year could be forced to change plans and, potentially, health care providers.

Several health insurers appealed the insurance commissioner's decision, and on August 30, 2013, the OIC announced a settlement with two health plans (Kaiser Health Plan and Community Health Plan of Washington) that contracted with Medicaid, which added ten additional options for exchange customers. A week later, the

OIC added two more products offered by Medicaid-serving Molina Healthcare of Washington and three offered by Coordinated Care, also a Medicaid contractor.

On September 4, 2013, the Exchange Board certified seven health insurers to offer thirty-five QHPs, four carriers to offer pediatric Qualified Dental Plans (QDPs), and one carrier to offer plans in the small business market:

- BridgeSpan — King, Kitsap, Pierce, Skagit, Snohomish, Thurston, and Spokane counties
- Community Health Plan of Washington — Adams, Benton, Chelan, Clark, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, King, Kitsap, Lewis, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima counties
- Group Health Cooperative — Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, and Yakima counties
- LifeWise – All thirty-nine counties
- Molina Healthcare of Washington, Inc. — King, Pierce, and Spokane counties
- Premera Blue Cross — All counties except Clark
- Kaiser Foundation Health Plan of the Northwest — Clark and Cowlitz counties (both small business and individual markets)
- Delta Dental of Washington, Kaiser Foundation Health Plan of the Northwest, LifeWise, Premera Blue Cross — Pediatric Dental Only

Information on QHPs offered through the Healthplanfinder for 2014, including county, rating area, and age-linked premiums can be found here.

2.7(b) Clearinghouse or Active Purchaser Exchange. Washington's exchange marketplace, the Healthplanfinder, is functioning as a clearinghouse where all QHPs meeting the qualifying criteria will be offered through the new marketplace.

2.7(c) Program Articulation. See 2.7(a), above, regarding the ability of individuals and families to choose a QHP that serves both exchange and Medicaid customers. In addition, the state HCA has developed "Apple Health Plus" to provide a bridge to assure coverage continuity for remaining adults whose incomes fluctuate above and below 133 percent of the federal poverty level and children of parents covered by the exchange.

2.7(d) States That Did Not Expand Medicaid. Washington is moving forward with the expansion of Medicaid.

2.7(e) Government and Markets. Local news outlets have reported on cases of, and concerns about, the effects of the ACA on employment (see, for example, "Will Obamacare Mean Fewer

Jobs?"). No data exist yet, however, to support or dispel this concern.

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

Only one health insurer, Kaiser Foundation Health Plan of the Northwest, submitted a plan offering and was certified for the state's SHOP (see 2.7(a), above.) As a result, the SHOP in 2014 will only be operating in Cowlitz and Clark counties in southwest Washington.

Part 4 – Summary Analysis

4.1 Policy Implications

Compared with the national rollout of the ACA and in many states, implementation in Washington appears to be a marked success. Interagency collaboration — even in the face of differing levels of accountability — reflects a high level of political consensus in support of health care reform. Any political fallout from technical problems with the federal insurance exchange or the continued criticisms of the ACA raining down on the Obama administration seems unlikely to cloud the political leadership in this state. As such, the early implementation of the ACA in Washington is unlikely to affect political alignment, influence, or power in the near term.

Still, this first "era" of the ACA has been felt by some key actors:

- The Health Benefit Exchange, though at times having a "rogue" reputation among some observers, has come off as a competent and transparent manager of the state's exchange. For example, when it discovered a "system error" that overestimated the subsidies (tax credits) some applicants would receive, exchange CEO Onizuka quickly issued an apology and explanation, and the exchange implemented a fix within twenty-four hours. The HBE also showed notable flexibility by delaying its QHP certification decisions until the insurance commissioner could work out disagreement with some Medicaid contractors so they could be offered on the exchange (see below).

- Insurance Commissioner Kreidler was severely criticized by some health insurance carriers and low-income advocates for initially refusing to allow any of the state's current Medicaid health insurers to operate on the exchange. He did voice his commitment to work with these companies to help them prepare for the 2015 coverage year, recognizing the importance of having such insurers offer products on the exchange. In the face of criticism (and formal appeals), Kreidler negotiated

settlements that allowed four such carriers to offer products on the exchange in 2014, which drew praise from his former critics.

- The opportunity to "play" in the insurance exchange will test the ability of some carriers to transform themselves from Medicaid-only insurers. What effects this will have on market shares in the commercial market remains to be seen.

- The extent to which the ACA rollout in Washington State continues successfully will validate Governor Inslee's vocal support for this program during last year's electoral campaign. It could also bolster his growing reputation as a successful, hands-on leader of state policy.

- The November 2013 election could affect the balance of power in the state Senate. As noted, the Senate was run during the 2013 session by a "majority coalition" when two Democrats joined forces with the Republican caucus. What effect, if any, the relatively smooth rollout of the ACA will have on the specific races that could affect the Senate majority remains to be seen.

4.2. Possible Management Changes and Their Policy Consequences

The focus in Washington is on successful management of the ACA's coverage expansions, and evidence to date suggests the management structures have been up to the task. As elsewhere, observers have expressed some apprehension about who will actually purchase insurance in the exchange, and the answer to that question will be an important topic for the next report. Efforts at the OIC and HBE are already underway to expand the health plan choices in 2015, especially in the SHOP, with it meager one carrier offering coverage in only two counties.

Meanwhile, the state is working on a State Health Care Innovation Plan (SHCIP), what some have called "health care reform 2.0." The draft plan, which the HCA issued for public comment on October 31, 2013, seeks to move beyond the coverage expansions and insurance market reforms in the ACA to affect the "fragmentation, wasteful care delivery and payment models, and unaligned silos within the public and private sectors." That is, the plan hopes to translate the rhetoric around the ACA — moving from volume- to value-based purchasing, affecting underlying cost drivers, and improving health outcomes — into reality.

The draft plan calls for:

- The state to lead by example in its roles as major purchaser and market regulator;

- Creation of "Accountable Communities of Health" to coordinate health care delivery with community assets, such as education, social services, and public health;

- Support for transforming health care practice by creating a "primary health regional extension system" in the mold of agricultural extensions;

- Greater performance measurement and price transparency by building an "all-payer" claims database, strengthening the use of "big data" geographic information systems, and using "hot spotting" to address health inequities with targeted initiatives;

- Expansion of delivery models that integrate behavioral and physical health and reform benefits design to promote quality and value; and

- Development of tools and resources to support more "engagement" and informed decisionmaking by individuals and families.

How such initiatives will affect key stakeholders is unclear. Washington has been in the throes of a hospital consolidation boom for several years, which could either facilitate some of the innovations in the draft SHCIP or hinder them. Also, much of the hoped-for success of these plans rests on the continued collaboration among health insurers, providers, purchasers, and government agencies; that too could fall in a number of directions.

At this early point in ACA implementation, Washington has benefited from an alignment of political preferences and policy choices motivated by a widely shared desire to solve macro health system problems. This consensus — developed from the mid-1980s to the present, spanning changes in state leadership, public priorities, and economic cycles — has allowed state policymakers to avoid the political dissonance evident in other states and to devote their attention to shaping and enacting health reforms. Policy and political continuity have given agency leaders a foundation upon which to craft, implement, and evaluate program enhancements and innovative strategies (e.g., auto-assignment of new Medicaid recipients described above).

It is still early in the ACA's history with many hurdles to overcome, but if the state's momentum in health policy reform remains the focus of state elected and appointed leaders, as well their implementation partners, the drive to expand health reform will likely prove resilient to unavoidable critiques, elections surprises, and potential coattail effects of any ACA battles in national politics.