HOUSE BILL REPORT
ESHB 1947

As Passed House:
June 6, 2013

Title: An act relating to ensuring the ongoing sustainability and vitality of the Washington health benefit exchange by providing a financing mechanism sufficient to defray the exchange's operating expenses.

Brief Description: Concerning the operating expenses of the Washington health benefit exchange.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Cody, Hunter, Jinkins and Harris).

Brief History:
Committee Activity:
Appropriations: 2/26/13, 2/28/13 [DPS].
Floor Activity:
Passed House: 3/11/13, 69-29.
First Special Session
Floor Activity:
Passed House: 6/6/13, 68-25.

Brief Summary of Engrossed Substitute Bill

- Directs insurance premium taxes collected on plans offered through the Washington Health Benefit Exchange (Exchange) and on premiums for clients enrolling in the Medicaid expansion to the Health Benefit Exchange Account (Account) starting January 1, 2014.
- Removes the premium tax exemption for dental plans and benefits sold through the Exchange.
- Authorizes the Exchange to charge assessments on medical and dental plans sold through the Exchange to fund Exchange operations.
- Specifies that moneys in the Account may only be spent after appropriation, and expenditures may only be used to fund Exchange operations and the identification, collection, and distribution of the premium taxes that go into the Account.

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.

- Makes the Exchange exempt from the business and occupation tax until July 1, 2023.
- Requires the State Auditor to conduct a performance review by July 1, 2016, on the cost of Exchange operations and make recommendations for improvements in cost performance and adoption of best practices.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 23 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Buys, Carlyle, Cody, Dahlquist, Dunshee, Green, Haigh, Harris, Hudgins, Hunt, Jinkins, Kagi, Maxwell, Morrell, Pedersen, Pettigrew, Ross, Schmick, Seaquist, Springer and Sullivan.

Minority Report: Do not pass. Signed by 8 members: Representatives Alexander, Ranking Minority Member; Chandler, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Fagan, Haler, Parker, Pike and Taylor.

Staff: Erik Cornellier (786-7116).

Background:

Insurance Premium Tax.
With some exceptions, insurance companies must pay a 2 percent insurance premiums tax to the state. The tax is imposed on the total amount of all premiums and prepayments for health care services collected or received by the insurer during the preceding calendar year. Insurers must prepay their tax obligations. By June 15 insurers must pay 45 percent of their tax obligations. On September and December 15 they must pay 25 percent. Revenues from the tax are deposited in the State General Fund. Dental plans and benefits provided by health care services contractors are exempt from the premium tax.

Expenditure Limit.
The State General Fund is subject to a spending limit. The State Expenditure Limit Committee (Committee) was established in 2000 for the purpose of determining and adjusting the state expenditure limit. Each November, the Committee adjusts the limit for the previous and current fiscal years, and projects a limit for the following two years.

If the cost of a state program or function is shifted from the State General Fund to another source of funding, or if funds are transferred from the State General Fund to another fund or account, the Committee must lower the expenditure limit to reflect the shift.

Health Benefit Exchange.
The Washington Health Benefit Exchange (Exchange) will be an online marketplace for individuals, families, and small businesses in Washington to compare and enroll in health insurance coverage and gain access to tax credits, reduced cost sharing, and public programs

such as Medicaid. The Exchange will begin enrolling consumers on October 1, 2013, for health insurance coverage beginning on January 1, 2014.

The Exchange was established as a self-sustaining public-private partnership that is separate and distinct from the state. To be "self-sustaining," the Exchange must be capable of operating without direct state tax subsidy. Self-sustaining sources of revenue include federal grants, federal premium tax subsidies and credits, charges to health carriers, and premiums paid by enrollees.

Development of the Exchange is funded primarily through federal grants that end before 2015. The Exchange was directed to report to the Governor and the Legislature with recommendations for development of sustainable funding for administration of the Exchange starting in 2015. The Exchange provided three options: increase the current insurance premium tax, apportion to the Exchange the premium taxes collected on all premiums for health care services attributable to the Exchange, and/or assess a service charge on plans sold through the Exchange.

Health Benefit Exchange Account.
The Health Benefit Exchange Account (Account) holds all receipts from federal grants received under the federal Affordable Care Act (ACA), and funds in the account may only be used for purposes consistent with those grants. The Exchange may authorize expenditures from the Account. The Account expires on January 1, 2014.

Medicaid Expansion.
Medicaid is a health care program for qualifying low-income and needy people, including children, the elderly, and persons with disabilities. The program is a federal-state partnership established under the federal Social Security Act, and implemented at the state level with federal matching funds. Each state program must establish a plan that meets specified requirements mandated by the federal Centers for Medicare and Medicaid Services.

Under the ACA, states have the option to expand their Medicaid programs to include individuals between the ages of 19 and 64 with family incomes at or below 138 percent of the federal poverty level. During the first three years of the expansion, the federal government will provide 100 percent matching funds for the newly eligible group's medical costs. The match rate decreases gradually starting in 2017 until it reaches 90 percent in 2020.

Business and Occupation Tax.
Almost all businesses located or doing business in Washington are subject to the state business and occupation (B&O) tax. The B&O tax is imposed on the gross receipts of business activities conducted within the state. Revenues are deposited in the State General Fund.

The classification and rate of the B&O tax is based on the type of business activity. The most common types of activities include retailing, wholesaling, manufacturing, and services and other activities, such as sales commissions. There are several rate categories, and a business may be subject to more than one B&O tax rate, depending on the types of activities conducted. There are many exemptions for specific types of business activities, and certain deductions and credits are permitted under the B&O tax statutes.

Summary of Engrossed Substitute Bill:

Insurance Premium Tax.
Beginning January 1, 2014, insurance premium taxes collected on medical and dental plans offered through the Exchange and on premiums for managed care plans provided to newly eligible clients enrolling in the Medicaid expansion must be deposited in the Account.

The requirement that the Committee must reduce the expenditure limit to reflect any transfers from the State General Fund to other funds or accounts does not apply to the dedication of insurance premium taxes to the Account.

The premium tax exemption for dental plans and benefits is removed for business conducted through the Exchange.

Health Benefit Exchange.
"Self-sustaining" is defined to mean capable of operating with revenue attributable to the operation of the Exchange, and insurance premium taxes are included in the list of self-sustaining sources.

Beginning January 1, 2014, the Exchange may impose an assessment on health and dental plans sold through the Exchange in an amount necessary to fund the operations of the Exchange in the following calendar year. The Exchange may only impose the assessment if the expected insurance premium taxes and other funds deposited in the Account are insufficient to fund the Exchange's operations in the following calendar year at the level appropriated by the Legislature in the omnibus appropriations act.

The assessment is calculated by dividing the shortfall in revenues in the Account necessary to operate the Exchange at the appropriated level by the total number of expected covered lives in the Exchange for the calendar year that the assessment will be collected in. The Exchange must collect the assessments on a quarterly basis and deposit proceeds in the Account. Upon calculation of the assessment, the Exchange must notify carriers of the due dates of the quarterly installments. The amount of the assessment per member per month must be shown on monthly billing statements. At the end of the calendar year of the assessment, the Exchange must reconcile assessments based on the actual number of covered lives that each carrier covered in the Exchange during that calendar year.

The Exchange is required to establish procedures allowing carriers to have grievances reviewed by an impartial body and reported to the Exchange.

By July 1, 2016, the State Auditor must conduct a performance review of the cost of Exchange operations and make recommendations to the Exchange and the health care committees of the Legislature addressing improvements in cost performance and adoption of best practices. The review must include an evaluation of the potential cost and customer service benefits of regionalization with other state exchanges or partnership with the federal government. The Exchange must pay for the cost of the review.

Health Benefit Exchange Account.

Moneys in the Account may only be spent after appropriation, and expenditures may only be used for Exchange operations and the identification, collection, and distribution of premium taxes that go into the Account.

Insurance premium taxes and Exchange assessments are included in the list of funds that must be deposited in the Account.

The expiration date of the Account is removed.

Business and Occupation Tax.
The Exchange is exempt from the B&O tax until July 1, 2023. The exemption applies both prospectively and retrospectively.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) If carriers decide they want to include the costs of the assessments in premiums for plans outside of the Exchange they can, and the bill gives them that flexibility. This bill is based on "option two" for self-sustainability proposed by the Exchange. There was a lot of desire to keep costs within the Exchange plans, which is what "option two" attempts to achieve.

The bill attempts to do two things. First, it provides legislative control and accountability over the Exchange. Second, it broadens the funding base by including premium tax revenues from health plans sold in the Exchange and health plans for clients enrolling in the Medicaid expansion, neither of which would exist but for the passage of the Affordable Care Act (ACA).

If one assumes that the proposed Exchange budget stays as is and that enrollment estimates stay as they are, the Exchange would charge plans $12.50 per member per month (PMPM). By allowing the Exchange to use these premium taxes, the PMPM is $2.50. This is a significant benefit to the Exchange that will help make it work.

(In support with amendment(s)) The hybrid approach in "option two" is the best approach for creating a viable and stable Exchange. This option places the least amount of pressure on health premium rates. The guiding principle should be that the Exchange is funded from revenue attributed to operations of the Exchange, and costs should not be borne by the outside market.

The premium taxes from the Medicaid expansion should be used to fund Exchange operations because the "no wrong door" policy, eligibility verification, and customer service for the expansion will be handled through the Exchange.

The bill would be better with three clarifications. First, the assessment should be based on business in the Exchange. It should only be collected on plans sold inside the Exchange without being spread on the rest. Second, the cost of the assessment should be transparent to customers at the time of purchase. Like any tax or fee, it should be passed through to the purchaser in the Exchange. The bill should include language that contains the impact of the assessments within the Exchange. Third, in the calculation of medical loss ratios, the Exchange assessment should be considered a fee.

A user fee within the Exchange instead of an assessment on health plans would force the Exchange to provide value to consumers commensurate with its operations. A user fee would inject transparency so users can understand the costs of purchasing through the Exchange.

(Other) The Exchange was directed to create a report making recommendations about financial self-sustainability. The Exchange Board reviewed the issue and discussed it at length, and the Board decided not to take a position on which option to endorse. This bill is largely consistent with "option two," a hybrid option that combines premium taxes related to the Medicaid expansion and plans sold in the Exchange with assessments on plans sold in the Exchange. There are some changes from the hybrid recommendation, but the Exchange has no official position on the bill. The Exchange does have concerns related to the timing of revenue collection and the B&O tax. There is some confusion about how assessments will be spread across the market and how the Exchange may or may not charge people in the Exchange.

(With concerns) The broad based assessment under "option one" would have resulted in a lower assessment on every plan sold in state. It would also have been a more stable source of funding, and everyone will benefit from expanded access. "Option one" is not viable, and "option three" is undesirable because the entire cost of the Exchange would fall on clients in the Exchange. Those are the people that can least afford it, and they are the sickest.

The requirement that the Legislature provide an appropriation for Exchange operations in the budget will help because these clients are the ones that can afford it the least. Clients with chronic disease will buy in the Exchange, so having a legislative hand on the budget will help.

The Medicaid expansion premium taxes should not go to the Exchange. The Exchange is already allocating Medicaid costs to Medicaid. The Exchange is built for Exchange enrollees and Medicaid clients will not have the same options as other clients. Mixed status families will not have tools for continuity of coverage and care. The premium tax money could be put to more appropriate uses.

The bill is overly reliant on unpredictable enrollment numbers. It is unclear how much funding will actually come in.

(Opposed) None.

Persons Testifying: (In support) Representative Cody, prime sponsor; and Joe King, Group Health.

(In support with amendment(s)) Sheela Tallman, Premera Blue Cross; Carrie Tellefson, Regence Blue Shield; and Matt Canedy, Association of Washington Business.

(Other) Pam MacEwan, Health Benefit Exchange.

(With concerns) Erin Dziedzic, Healthy Washington and American Cancer Society Cancer Action Network; and Dekker Dirksen, Community Health Plan of Washington.

Persons Signed In To Testify But Not Testifying: None.