HOUSE BILL REPORT
HB 2594

As Reported by House Committee On:
Health Care & Wellness
Appropriations

Title: An act relating to developing and authorizing the federal basic health program.

Brief Description: Requiring the health care authority to develop a blueprint for the establishment of a federal basic health program.

Sponsors: Representatives Riccelli, Jinkins, Cody, Moscoso, Morrell, Fitzgibbon, Ryu, Tarleton, Farrell, Van De Wege, Robinson, Habib, Ormsby, Tharinger, Freeman, Walkinshaw, Hudgins, Gregerson, Pettigrew, Reykdal, Roberts, Carlyle, Moeller, Stanford, Goodman, Seaquist, Appleton, Clibborn, Bergquist, Kagi, Sells, Pollet and Green.

Brief History:
Committee Activity:
Health Care & Wellness: 2/3/14, 2/5/14 [DP];
Appropriations: 2/10/14 [DPS].

Brief Summary of Substitute Bill

- Directs the Health Care Authority to begin econometric modeling to analyze program enrollment and the costs and impacts of implementing the federal Basic Health Program.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 9 members: Representatives Cody, Chair; Riccelli, Vice Chair; Clibborn, Green, Jinkins, Moeller, Morrell, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 8 members: Representatives Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; DeBolt, G. Hunt, Manweller, Rodne, Ross and Short.

Staff: Chris Blake (786-7392)

Background:

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.

Under the federal Patient Protection and Affordable Care Act, a state may contract with private insurers to provide coverage for low-income individuals who are below 200 percent federal poverty level and do not qualify for Medicaid. Individuals in the Basic Health Program (BHP) will not participate in the Health Benefit Exchange (Exchange), but the state will receive federal funding for the BHP equal to 95 percent of the tax credits and cost-sharing reductions the individuals would have received in the Exchange.

In September 2013 the federal Department of Health and Human Services (DHHS) issued proposed regulations for the administration of the federal BHP. The proposed regulations recommend that states seeking to establish a BHP submit a BHP blueprint for the Secretary of DHHS to certify. Under the proposal, the BHP blueprint must describe the minimum benefits offered, the competitive process to contract for health plans, methods to coordinate with other affordable insurance programs, premiums, cost-sharing, eligibility standards, fiscal policies, and accountability procedures. A state must seek public comment on the BHP blueprint prior to submission. The proposed regulations also recommend that the BHP blueprint be accompanied by a funding plan that identifies funding sources required to cover projected expenditures.

Summary of Bill:

The Health Care Authority (Authority) must develop a blueprint to establish a federal Basic Health Program (BHP). The Authority must engage stakeholders in the blueprint development process. The blueprint must be submitted to the Governor for approval and submitted to the federal Centers for Medicare and Medicaid Services (CMS) for certification. The blueprint must be submitted in time to allow for enrollment in the BHP to begin on October 1, 2015, and coverage to begin on January 1, 2016. Once the CMS has certified the blueprint, the Authority is authorized to operate the BHP.

The blueprint must identify the federal regulatory requirements for the program and specifically address:

- program eligibility;
- essential health benefits;
- assurance that enrollee premiums and cost-sharing will not exceed the amounts that BHP enrollees would have paid in the Health Benefit Exchange (Exchange);
- administrative procedures;
- fiscal policies and accountability procedures;
- a competitive process to contract with standard health plans;
- BHP trust fund trustees;
- the operational agency responsible for program administration, operations, and financial oversight;
- a funding plan that identifies funding sources; and
- other federal requirements.

The Authority must consult with the Exchange and other impacted programs to identify system design requirements to implement and operate the program and develop an initial

system project timeline and funding estimate. Funding estimates must be shared with the fiscal committees of the Legislature.

Appropriation: None.

Fiscal Note: Requested on February 6, 2014.

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) People can get meaningful coverage that they can afford by implementing the federal Basic Health Program (BHP) option. The BHP has worked in Washington for over 20 years. Washington is uniquely positioned to capitalize on the BHP option. This bill will help low-wage workers who have high out-of-pocket costs that discourage them from seeking care. This bill will provide an affordable health care option for lawfully present immigrants. This bill will provide a safety net for the self-employed who have fluctuations in income. While expanding Medicaid and creating the Health Benefit Exchange (Exchange) are helpful, some people will fall through the cracks, such as low-wage workers, part-time workers, self-employed workers, and lawfully-present immigrants. Many people with income just above Medicaid levels may not be able to afford coverage in the Exchange, and the BHP would be more affordable. This is a cost-effective way to use public funds. Adopting the BHP will not increase costs for those in the Exchange because most enrollees will have tax credits and the pooling of risk across the whole individual market. This bill will help Native Americans purchase health care and continuity of care, especially those in urban areas. The BHP can be a stepping stone for people trying to be independent of state assistance. Many farmers are uninsured because it is unaffordable, and they are just one accident away from financial ruin. Many immigrants and refugees work in dangerous industries but do not have health insurance available to them.

The BHP will allow individuals to keep their same providers since the program would be aligned with Medicaid. Lack of continuity of care is the enemy of quality and lower costs because it puts people in a different set of health plans, provider networks, and formularies. The churning of people off of Medicaid is a constant problem.

(With concerns) There are no assurances that the BHP will work for physicians. Reimbursements in Medicaid do not cover the costs of care, and the BHP may look too similar to the Medicaid structure for reimbursement. The bill should look to increasing reimbursement rates for providers, specifically physicians. The BHP adds another administrative layer at a time when the state has been trying to consolidate and integrate funding streams. By pulling people out of the commercial market, the administrative costs could markedly increase for those left in the Exchange. Under this bill, affordability for consumers could hinge on lower reimbursement for providers.

(Opposed) Implementing the BHP option at this time will negatively impact all key stakeholders, including the Exchange. If the BHP were to be implemented, it would decimate the Exchange pool and require purchasers to pay considerably higher fees to pay for the costs of the Exchange. The BHP would present operational challenges for the Exchange to implement it while still stabilizing the Exchange system. The BHP would impose disruption on consumers who would have to change health plans and could lose the continuity of care. This bill creates a third "churn point" as people move between Medicaid, the BHP, and the Exchange. The state should remain focused on increasing enrollment in the Exchange.

Persons Testifying: (In support) Representative Riccelli, prime sponsor; Pam Crone, Community Health Plan of Washington and Healthy Washington Coalition; Janet Varon, Northwest Health Law Advocates; Ed Fox, S'Klallam Tribe of Washington; Bryan Edenfield; Mark Secord, Neighborcare Health; Nicholas Martin; Dick Carkner; Emily Murphy, One America; and Mauricio Ayon, Washington CAN.

(With concerns) Katie Kolan, Washington State Medical Association; and Lisa Thatcher, Washington State Hospital Association.

(Opposed) Len Sorrin, Premera Blue Cross; and Chris Bandoli, Regence Blue Shield.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 18 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Carlyle, Cody, Dunshee, Green, Haigh, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, Morrell, Pettigrew, Seaquist, Springer, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 12 members: Representatives Chandler, Ranking Minority Member; Ross, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Christian, Fagan, Haler, Harris, G. Hunt, Parker, Schmick and Taylor.

Staff: Erik Cornellier (786-7116).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

The Appropriations Committee removed the requirement that the HCA develop a blueprint and identify system design requirements for implementing the BHP. It also removed the authority for operating the BHP.

Appropriation: None.

Fiscal Note: Requested on February 6, 2014.

Effective Date of Substitute 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 bill authorizes the state to submit a blueprint to the federal Centers for Medicare and Medicaid Services to move forward with the federal Basic Health Plan. This is a federally funded option available under the Affordable Care Act. We applaud the Medicaid expansion and the Health Benefit Exchange (Exchange), but people can fall through the cracks in terms of affordability and income fluctuation. Affordability and continuity of care are critical. Having more people with affordable coverage is good for the state so people do not have uncompensated care or go longer without care, both of which increase costs. Administrative costs are low. The program is funded by 95 percent of the federal tax credits that would have gone to individuals in the Exchange. This should generate cost efficiencies and better services for lower-income clients.

(Opposed) None.

Persons Testifying: Pamela Crone, Community Health Plans Network of Washington and Healthy Washington Coalition.

Persons Signed In To Testify But Not Testifying: None.