SENATE BILL REPORT
ESHB 1947

As Reported by Senate Committee On:
Health Care, March 28, 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: Passed House: 3/11/13, 69-29.
Committee Activity: Health Care: 3/25/13, 3/28/13 [DPA-WM, DNP, w/oRec].

SENATE COMMITTEE ON HEALTH CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Becker, Chair; Dammeier, Vice Chair; Keiser, Ranking Member; Cleveland, Frockt and Schlicher.

Minority Report: Do not pass.
Signed by Senators Bailey and Ericksen.

Minority Report: That it be referred without recommendation.
Signed by Senator Parlette.

Staff: Mich'l Needham (786-7442)

Background: 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,

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federal premium tax subsidies and credits, charges to health carriers, and premiums paid by enrollees.

Development of the Exchange is funded 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.

The Health Benefit Exchange Account (account) held by the state Treasurer, holds all receipts from federal grants. 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 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 Affordable Care Act, 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

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.

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. There are many exemptions for specific types of business activities, and certain deductions and credits are permitted under the B&O tax statutes. The B&O tax does not apply to any health maintenance organization, health care service contractor, or certified health plan in respect to premiums taxable under the 2 percent premium tax.

Summary of Bill (Recommended Amendments): 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. All health carriers that may offer dental pediatric benefits are included in the definition of tax payer for the premium tax purposes, and the pediatric oral services offered as essential health benefits are made subject to the premium tax for the pediatric dental plans inside and outside the Exchange.

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. 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.

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 assessment of dental plans must be proportional to the premiums paid to the Exchange. 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 from the Exchange, and nothing must prohibit the health and dental carriers from including the assessment on a monthly billing statement to enrollees.

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 Board must establish procedures allowing carriers subject to the assessment to have grievances reviewed by an impartial body and reported to the Exchange Board. The Board must establish procedures to ensure that all qualified health plans are available to consumers through the Exchange, and the Exchange must not restrict consumer choices of qualified health plans without specific authority conferred by statute. The Board must not take any action to add or redefine qualified health plan criteria without specific statutory direction.

Monies in the Exchange 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.

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.

The requirement that the state expenditure limit 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 Exchange is exempt from the B&O tax until July 1, 2023. The exemption applies both prospectively and retrospectively.

EFFECT OF CHANGES MADE BY HEALTH CARE COMMITTEE (Recommended Amendments): Nothing prohibits a health or dental plan from displaying the amount of the assessment on their monthly bills. The assessment of dental plans must be proportional to the premiums paid to the Exchange. The Board must establish procedures to ensure that all qualified health plans are available to consumers through the Exchange, and the Exchange must not restrict consumer choices of qualified health plans without specific authority conferred by statute. The Board must not take any action to add or redefine qualified health plan criteria without specific statutory direction. All health carriers that may offer dental pediatric benefits are included in the definition of tax payer for the premium tax purposes, and the pediatric oral services offered as essential health benefits outside the Exchange are made subject to the premium tax – parallel with the pediatric dental plans inside the Exchange.

Appropriation: None.

Fiscal Note: Available.
[OFM requested ten-year cost projection pursuant to I-960.]

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Engrossed Substitute House Bill: PRO: The Exchange submitted options for funding and this bill represents option B with a hybrid financing. The key factor is that the Legislature retains budget authority over the Exchange spending level, and it utilizes the premium tax that will be newly generated by the Exchange business with the newly covered population. We support the fiscal accountability built into this bill with Legislative budget controls, and we support the funding source. It makes good use of the broadened funding that will be available as a result of the federal law and expansion of coverage. It captures the additional sources with the Medicaid expansion and the dental coverage in the Exchange. Overall the financing methods will result in lower per member per month fees than otherwise. We support this bill and offer some amendments for your consideration that would delay the date for the assessment. We also ask that the premium tax for the standalone dental plan inside the exchange be made equitable with the standalone outside the Exchange. And we would like to add the assessment outside as a line item on carriers' bills for transparency. We would prefer a fee instead of an assessment so it becomes a pure user fee. We support having the standalone dental plans pay our fair share in the Exchange; however, we have some concerns with a straight per member per month calculation since the dental plans only represent a portion of the expense and we are working on an alternative multiplier that ensures we do not overpay for our portion of the expense. We want to ensure that the Exchange has sustainable funding and prefer a user fee approach.

There is an option to delay the assessment and provide time to generate the premium tax the Exchange will need. Consider a sunset of the assessment. The Commissioner strongly supports sustainable funding for the Exchange. We heard about some proposed amendments and we have technical concerns with some areas to ensure the tax reporting and base for calculating are consistent with other laws and all other tax reporting. It is currently on a written base instead of an earned base. We want to make sure the tax language is clear and does not result in double jeopardy. The new reporting will require significant modification to the tax-reporting system with new categories of sub-premiums that are not broken out today. It will require the segregation of the premium based on whether it was inside the Exchange or outside.

OTHER: We provided a report with options to make the Exchange self sustaining and the Board supports a broad-based financing option like the hybrid. This also adds in the Medicaid and dental plans processed through the Exchange. We are offering some amendments with technical fixes to address the cash-flow timing and accounting approaches. We support the broadest-based assessment to share the cost and benefit across the whole market. Short of that approach, we support this hybrid as a middle ground. We are concerned with the proposal that there will be a user fee instead of an assessment and we will investigate if there are impacts on the subsidy application for the enrollees.

Persons Testifying: PRO: Representative Cody, prime sponsor; Joe King, Group Health; Len Sorrin, Premera Blue Cross; Chris Bandoli, Regence BlueShield; Melissa Johnson, Willamette Dental Group; Matt Canady, Assn. of WA Business; Drew Bouton, Office of Insurance Commissioner.

OTHER: Pam MacEwan, Exchange; Erin Dziedzic, Healthy WA.