SENATE BILL REPORT
ESHB 1947

As Reported by Senate Committee On:
Health Care, March 28, 2013
Ways & Means, June 11, 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; 6/06/13, 68-25.
Committee Activity: Health Care: 3/25/13, 3/28/13 [DPA-WM, DNP, w/oRec].
Ways & Means: 4/18/13, 6/10/13, 6/11/13 [DPA, 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)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended.
Signed by Senators Hill, Chair; Honeyford, Capital Budget Chair; Bailey, Becker, Braun, Dammeier, Hewitt, Parlette, Ranker, Rivers, Schoesler and Tom.

Minority Report: Do not pass.

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.

Signed by Senator Fraser.

Minority Report: That it be referred without recommendation.

Signed by Senators Nelson, Assistant Ranking Member; Conway, Hasegawa, Keiser, Kohl-Welles and Padden.

Staff: Mich'l Needham/Michael Bezanson (786-7442/786-7449)

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, 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, 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 assessments may be made to fund the operations of the Exchange at the level appropriated by the Legislature in the Omnibus Appropriations Act.

Monies in the Exchange account may only be spent after appropriation, and expenditures may only be used for Exchange operations. The expiration date of the account is removed

The Exchange Board, in collaboration with the insurance issuers, the Health Care authority, and the Insurance Commissioner, must establish a fair and transparent process for calculating the assessment amount, no later than October 1, 2013. The assessment must be displayed on the monthly billing statements as a per member per month amount.

The process for developing the assessment must meet the following requirements:

- The assessment only applies to issuers that offer coverage in the Exchange and must be based on the number of enrollees in qualified health plans and stand-alone dental plans in the Exchange for a fiscal year;
- The assessment must be established as a flat dollar and cents amount per member per month, and the assessment for dental plans must be proportional to the premiums paid;
- Issuers must be notified of the amount in a timely way;
- If necessary, an appropriate assessment reconciliation process may be established by the Exchange if administratively efficient;
- Issuers must remit the assessment due in quarterly installments;
- A procedure must be established to allow issuers to have grievances reviewed by an impartial body; and
- A procedure for enforcement must be established if an issuer fails to remit the assessment within ten business days of the quarterly due date.

The Exchange must monitor enrollment and provide periodic reports which must be available on its website. The Board must offer all qualified health plans through the Exchange and they must not add or modify criteria for the qualified health plans beyond the requirements set in law without specific statutory direction.

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

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Recommended Amendments):

- Removes all references to the premium tax revenue (use of revenue, appropriation of revenue, dedication of portions of the revenue to the Exchange account, payment for redesign of the premium tax system, and movement of the monies between accounts. Any appropriation can be made directly from the general fund.).
- Modifies references in the Exchange Treasury Account for deposit of assessments, and corrects a reference to the federal grant.
- Modifies the assessment methodology, removing specific formulas, requiring the Board to establish a fair and transparent process for calculating the assessment amount for the fiscal year no later than October 1, 2013, in collaboration with insurance carriers, the Health Care Authority and the Office of Insurance Commissioner (calendar year references changed to fiscal year to correspond with the premium tax cycle and the appropriation cycle).
- The Exchange must monitor enrollment and post on its website.
- The Board must offer all qualified health plans through the Exchange and the Board must not add or modify criteria beyond the statutory requirements without specific statutory direction.
- Changes "carriers" to "issuers" and inserts references to the stand-alone dental plans.

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 (Health Care):
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 (Health Care): 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.

Staff Summary of Public Testimony on Bill as Amended by Health Care (Ways & Means): PRO: We support the bill out of the Senate Health Care committee. The hybrid approach, the use of the insurance premium tax and assessments to fund the Exchange, offers the most predictable and stable form of funding. The assessments will only be needed if there is a shortfall from the premium tax dedication. Relying entirely on an assessment would necessitate carriers to spread the assessment costs over their entire business including plans offered outside of the Exchange. It is critical that the Exchange have a stable funding stream; using the funds in the Exchange makes sense.

We support the language around Qualified Health Plans (QHPs). If a carrier meets the QHP criteria, then consumers should have access to those plans. The criteria cannot be left up to an informal or administrative process to modify. It is troubling that the Exchange Board can add criteria. This should be done through legislation. The Exchange Board has the autonomy to rank plans.

OTHER: The Exchange must be self sustaining by calendar year 2015. The Exchange Board recommended three potential options to the Legislature. This is the hybrid option of using both the premium tax and the assessment. The Exchange has technical concerns with Section 3 (7). The QHP language in the current bill restricts the Exchange Board's ability to address quality. The Board will not have the ability to be flexible and drive innovation. It could hamstring the Exchange's ability to be nimble in the face of a changing landscape.

We support the broadest base possible for funding – a charge across all premiums would accomplish this, rather than having it be borne by the lowest-income individuals. This bill provides the next-best option. We do support making the Exchange account appropriated and keeping legislative control over spending.

Persons Testifying (Ways & Means): PRO: Mel Sorensen, America's Health Insurance Plans; Matt Canedy, Assn. of WA Business; Scott Plack, Group Health Cooperative; Leonard Sorrin, Premera Blue Cross; Chris Bandoli, Regence Health Care.

OTHER: Pam MacEwan, Michael Arnis, WA Health Benefit Exchange; Jen Estroff, Children's Alliance; Erin Dziedzic, American Cancer Society, American Heart Assn.