SENATE BILL REPORT
SB 5142

As Reported by Senate Committee On:
Health Care, February 9, 2015

Title: An act relating to modifying health benefit exchange provisions related to the aggregation or delegating the aggregation of funds that comprise the premium for a health plan.

Brief Description: Modifying health benefit exchange provisions related to the aggregation or delegating the aggregation of funds that comprise the premium for a health plan.

Sponsors: Senators Becker, Bailey, Rivers, Brown and Keiser.

Brief History:
Committee Activity: Health Care: 1/26/15, 2/09/15 [DPS-WM, DNP, w/oRec].

SENATE COMMITTEE ON HEALTH CARE

Majority Report: That Substitute Senate Bill No. 5142 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Becker, Chair; Dammeier, Vice Chair; Angel, Bailey, Brown, Parlette and Rivers.

Minority Report: Do not pass.
Signed by Senators Jayapal and Keiser.

Minority Report: That it be referred without recommendation.
Signed by Senators Frockt, Ranking Minority Member; Cleveland and Conway.

Staff: Mich'l Needham (786-7442)

Background: The Health Benefit Exchange (Exchange) is established in statute as a public-private partnership to serve as an insurance marketplace for individuals, families, and small employers. The Exchange, through the Washington Healthplanfinder, provides access to multiple insurance plans and federal premium tax credits for individuals with incomes between 138 percent to 400 percent of the federal poverty level.

The original powers and duties established for the Exchange provided authority to aggregate or delegate the aggregation of funds for the premium of a health benefit plan, and the program design and resulting infrastructure were built upon that assumption, so individuals enrolling in the Exchange health plans paid premiums directly through the Exchange.

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.

Coverage for individuals purchasing a health plan through the Exchange began January 1, 2014. Throughout the first year of operations, the Exchange encountered a number of computer system difficulties including transmission of payment information to health plans that resulted in a number of coverage and claims problems for individuals and carriers.

The Exchange Board retained Cambria Solutions Inc. to review premium aggregation and alternatives. Cambria examined options to retain premium aggregation, transition to the Exchange as initial payment facilitator, referring all payments directly to carriers, and having a third-party administrator process payments. In December the Board voted to cease premium aggregation and remove premium collection and invoicing from the individual Exchange. The project planning and system redesign have been initiated for the 2016 plan year and the fall open enrollment period.

Summary of Bill (Recommended Substitute): Except for the small business health options program, the Exchange must not aggregate funds that comprise the premium for any enrollee, beginning with the 2016 open enrollment period.

The Exchange must collect detailed enrollment and demographic data each month and post it to the website, including detailed reports on enrollee plan changes, loss of eligibility, or movement between Medicaid and an Exchange plan. The Exchange must report twice yearly with a detailed analysis of enrollment changes using survey or additional data, with information about movement between plans and gaps in coverage based on contributing factors that include incarceration, issues with affordability, and offers of employer-sponsored insurance. The Exchange must ensure qualified health plans report data back to the Exchange on enrollees that have entered the grace period.

The Exchange, jointly with the Office of Insurance Commissioner and the Health Care Authority, must monitor the process of moving from premium aggregation, and report back to the Joint Select Committee on Health Care Oversight in the June 2015 meeting or the next regularly scheduled meeting.

EFFECT OF CHANGES MADE BY HEALTH CARE COMMITTEE (Recommended Substitute):

- Except for the small business health options program, the Exchange must not aggregate funds for any enrollee.
- The Exchange, jointly with the Office of Insurance Commissioner and the Health Care Authority, must monitor the process of moving from premium aggregation, and report back to the Joint Select Committee on Health Care Oversight.
- The Exchange must collect detailed enrollment data each month and post it to the website, including detailed reports on enrollment changes or churn.
- The Exchange must report twice yearly with detailed analysis using survey or additional data, about plan or program movement and gaps in coverage based on contributing factors that include incarceration, issues with affordability, and offers of employer-sponsored insurance.
- The Exchange must ensure health plans report data back to the Exchange on enrollees that have entered the grace period.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed; except Sections 1 and 2 are effective January 1, 2016.

Staff Summary of Public Testimony on Original Bill: PRO: We held meetings over the interim with the Joint Select Committee and we heard about premium problems at every meeting. Thousands of people have had their care impacted by these payment problems. The Board voted to move the premium collection to the carriers and this bill will ensure there is stability with that decision and that the Board does not reverse the decision. Carriers already collect premiums for plans offered outside the Exchange – we have years of experience and this change will help eliminate payment problems. Preparing for the change is a big investment and we want assurance the change will continue. We are thrilled the Board showed the leadership to remove the aggregation and we strongly support this bill.

OTHER: The Board acted in December to remove the aggregation and move all payment-related transactions to the carriers for next open enrollment. It is a complex shift and a significant investment. We applied for and received a federal grant to support the change which was estimated initially at $4 million. We are in the detailed design phase now to meet the aggressive schedule to dismantle the program. Many carriers can readily do the premium collection but some will have more work to prepare for the functions since they have not done that function. We do want to clarify that the aggregation change is only for the individual plans since we are required by federal law to retain the aggregation for the small employer plans and we would like to retain it for the dental plans.

Persons Testifying: PRO: Senator Becker, prime sponsor; Sheela Tallman, Premera Blue Cross; Chris Bandoli, Regence BlueShield; Sheri Nelson, Assn. of WA Business.

OTHER: Pam MacEwan, WA Health Benefit Exchange.