SENATE BILL REPORT
SB 5142

As Reported by Senate Committee On:
Health Care, February 9, 2015
Ways & Means, February 27, 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. [**Revised for 2nd Substitute:** Addressing the health benefit exchange aggregation of funds and collection of data.]

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].
Ways & Means: 2/25/15, 2/27/15 [DP2S].

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)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5142 be substituted therefor, and the second substitute bill do 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 Senators Hill, Chair; Braun, Vice Chair; Dammeier, Vice Chair; Honeyford, Vice Chair, Capital Budget Chair; Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Ranker, Ranking Minority Member, Operating; Bailey, Becker, Billig, Brown, Conway, Fraser, Hasegawa, Hatfield, Hewitt, Kohl-Welles, O'Ban, Padden, Parlette, Rolfes and Schoesler.

Staff: Sandy Stith (786-7710)

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. 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 Second 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 enrollment and demographic data each month and post it to the website, including summary level enrollment reports, including movement between Medicaid and an Exchange plan. The Exchange must report twice yearly with detailed demographic data. The Exchange must provide detailed churn analysis, or analysis of movement between Medicaid and an Exchange plan, that must be completed in coordination with the Health Care Authority with a federal grant. An annual survey must be completed by the Centers for Medicare and Medicaid Services. The Exchange must collect and report 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 WAYS & MEANS COMMITTEE (Recommended Second Substitute): Modifies the detailed enrollment reporting required by the Health Care Authority and the Health Benefit Exchange. The following modified reporting is required:

- monthly summary level enrollment report, including churn data;
- twice-yearly, detailed enrollment demographic data;
- detailed churn analysis that must be completed in coordination with the Health Care Authority with a federal grant;
- an annual survey that must be completed by the Centers for Medicare and Medicaid Services; and
- data allowing reporting on enrollees that entered the grace period.

EFFECT OF CHANGES MADE BY HEALTH CARE COMMITTEE (Recommended First 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 (Health Care): 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 (Health Care): 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.

Staff Summary of Public Testimony on Substitute (Ways & Means): PRO: The plans were never in support of premium aggregation for the individual market within the Exchange. That did not work as smoothly as it could have. We agree with the fiscal note that there will be savings. The plans are familiar with enrollment and collecting premiums. They have been doing this and those that haven't can begin.

OTHER: Our Board is moving forward with the decision to remove premium aggregation. It's complex and expensive. The cost is a few million in federal dollars. This is mostly credit card fees. We are working to improve our data reporting. We are doing a deeper dive on our reporting. The bill has a $1 million cost impact for added reporting. This doesn't leverage current reporting but adds new functions. We are working with the Health Care Authority and the Department of Social and Health Services on a cost-neutral alternative.

Persons Testifying (Ways & Means): PRO: Mel Sorensen, America's Health Insurance Plans.

OTHER: Joan Altman, WA Health Benefit Exchange.