SENATE BILL REPORT
2ESB 6089

As Passed Senate, June 28, 2015

Title: An act relating to health benefit exchange sustainability.

Brief Description: Concerning the health benefit exchange.

Sponsors: Senator Hill.

Brief History:
Committee Activity: Ways & Means: 3/31/15, 4/01/15 [DP, DNP].
Passed Senate: 4/03/15, 26-22.
Third Special Session: Passed Senate: 6/28/15, 41-3.

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass.
Signed by Senators Hill, Chair; Braun, Vice Chair; Dammeier, Vice Chair; Honeyford, Vice Chair, Capital Budget Chair; Bailey, Becker, Brown, Hewitt, O'Ban, Padden, Parlette, Schoesler and Warnick.

Minority Report: Do not pass.
Signed by Senators Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Ranker, Ranking Minority Member, Operating; Billig, Conway, Fraser, Hasegawa, Hatfield, Kohl-Welles and Rolfes.

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 businesses. The Exchange, through the Washington Healthplanfinder, provides access to multiple insurance plans and federal premium tax credits for individuals with incomes between 138 and 400 percent of the federal poverty level.

RCW 43.71.030 requires the Exchange be self-sustaining after December 31, 2014. Self-sustainability includes federal grants, federal premium tax subsidies and credits, charges to health carriers, premiums paid by enrollees, and premium taxes paid on qualified health plans.

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.

Other than federal grants, the Legislature determines the expenditure level allowed by the Exchange. The Exchange is funded with premium taxes on qualified health plans sold through the Exchange and federal Medicaid funds. If the total funds generated through premium tax and other funds deposited in the dedicated account, along with other funds authorized by the Legislature, such as Medicaid, do not provide the level of funding authorized by the Legislature to fund the operations of the Exchange, the Exchange is allowed to collect assessments from qualified health plan carriers to make up the difference between the amount authorized by the Legislature and the amount available through premium tax and other available funds. The Legislature currently appropriates premium taxes and Medicaid funding, but not federal grants.

The original duties of the Exchange allowed for aggregation of premiums collected from individuals purchasing qualified health plans. These premiums were collected at the Exchange and forwarded to carriers. This process began January 1, 2014. Throughout the first year of operations, the Exchange encountered a number of system difficulties including transmission of payment information to health plans that resulted in coverage and claims problems for individuals and carriers.

In December 2014, after review of several options, the Exchange board voted to cease premium aggregation and remove premium collection and invoicing from the individual Exchange. The project planning and system redesign have begun for the 2016 open enrollment period.

Summary of Second Engrossed Bill: Additional reporting responsibilities are created for the Health Benefit Exchange, including a five-year spending plan that identifies potential reductions in Exchange spending; metrics that capture the current spending levels and five-year benchmarks for spending reductions; detail capturing the annual cost of operating per enrollee; and a strategic plan for the development, maintenance, and improvement of Exchange operations that include comprehensive five-year and ten-year plans with defined outcomes and goals, as well as detailed salary and expense reports.

The five-year spending plans must identify specific reductions in the following areas: call center, information technology, and staffing, and must be submitted by January 1, 2016, to the Legislature, the Governor's Office, and the Board, with annual updates. The metrics must be developed by January 1, 2016, and must be posted on the web site, and quarterly updates must be provided to the appropriate committee of the Legislature and the Board. Additional budget detail with the annual cost of operating, per enrollee, must be tracked and reported to the Legislature and the Board on an annual basis.

The strategic plan for the development, maintenance, and improvement of Exchange operations must be developed and must include comprehensive five-year and ten-year plans with defined outcomes and goals; plans for achieving the outcomes; strategy for achieving enrollment and reenrollment targets; stakeholder and external communication plans; the identification of funding sources and a plan for allocation; a detailed report on salaries of all current employees; salary, overtime, and compensation policies; expense reports with beginning and ending fund balance by fund source; any contracts or contract amendments; and a description of staff required for operation of the program broken out by full-time positions, contracted employees and temporary staff. The strategic plan must be submitted

by September 30, 2015, and annually thereafter, and the expense reports must be submitted quarterly.

The Exchange must verify qualifying documentation for enrollees seeking special enrollment due to a qualifying event as established by the Insurance Commissioner.

Notification requirements are modified related to enrollees that enter a grace period, as defined in federal law for Exchange enrollees who receive a premium tax credit and miss premium payments. The Exchange must check eligibility for enrollees in the grace period to determine if the enrollee may be eligible for Medicaid, and must conduct outreach with Medicaid information. Health care providers may encourage the enrollee in a grace period to pay delinquent premiums and provide information on the impact of nonpayment of premiums on access to health care services. Issuers of qualified health plans must include a statement in a delinquency notice to the enrollee explaining the impact of nonpayment of premiums, and include a statement in the termination notice when the grace period is exhausted about other coverage options such as Medicaid, and how to report changes in income or circumstances and any deadlines. Upon transfer of premium collection to the qualified health plans, each qualified health plan must provide detailed reports on enrollees in the grace period data to enable the Exchange to complete reports to the Legislature.

Appropriation: None.

Fiscal Note: Not requested.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony: CON: We really appreciate Section (2). We would like to replace it with Senate Bill 5142, which is the removal of premium aggregation from the Exchange. We are concerned that this policy will shift costs to carrier assessments; these increases will be added to plan premiums impacting businesses in the state. The 2 percent premium tax equates to a $2 million impact. This bill creates a costly burden for consumers by shifting a significant cost to those purchasing benefits on the Exchange. This is a significant change to the health insurance marketplace. Stakeholders need a chance to examine this. By shifting these costs to consumers this bill threatens the viability of the health insurance marketplace. This bill puts employers in an impossible position with insurance filings coming up on April 24th. This effectively gives carriers a week to set rates for the next year. This will result in losses for the next biennium. This bill will increase enrollees' health benefit costs considerably. The original Exchange mechanism was set up to be sustainable using premium tax dollars that are generated exclusively by plans sold through the exchange in addition to a carrier assessment, as necessary. It was intended to lessen the impact on consumers and the broader insurance market. Moving the funds from the Exchange to the general fund will result in a quadrupling of the assessment. More people will look to buy plans outside the Exchange. We would be unable to incorporate into rates for 2015. It is estimated that there would be an impact of over $8 million of unrecovered cost over 2015 and roughly $16 million in 2016. When combined with the budget, these assessments will be used as the Medicaid state match which creates a concern that

commercial market enrollment will be paying a fee inside and outside the Exchange. People who pay this fee would not receive a benefit through Medicaid or the Exchange for this fee. This bill will destabilize the Exchange by driving increased costs to the plans that participate in the Exchange and consumers inside and outside the Exchange. For every premium tax dollar transferred to the general fund, it is estimated that there would be a new assessment dollar imposed on the health plans. This adding a layer of additional assessment that have to be borne by the taxpaying public. All these additional taxes add costs to insurance-buying public.

Persons Testifying: CON: Leonard Sorrin, Premera Blue Cross; Sheri D Nelson, Assn. of WA Business; Chris Bandoli, Regence BlueShield; Mel Sorenson, America's Health Insurance Plans, WA Assn. of Health Underwriters; Jon Brumbach, Columbia United Providers.

Persons Signed in to Testify But Not Testifying: No one.