Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

SB 6488

Brief Description: Directing the health care authority to apply for a federal innovation waiver to expand an employer-based coverage option with a portable health care account.

Sponsors: Senators Becker, Parlette, Dammeier, Schoesler, Brown, Bailey, Honeyford and King.

Brief Summary of Bill

- Requires the Health Care Authority to apply for a federal waiver to integrate certain employer health care arrangements with individual market policies.

Hearing Date: 2/24/16

Staff: Jim Morishima (786-7191).

Background:

Employer Health Care Arrangements.

Guidance issued by the federal government indicates that an employer health care arrangement involving an employer reimbursing its employees for their purchase of individual market policies is considered to be group health coverage. Such an arrangement is therefore subject to market reforms under the Affordable Care Act (ACA), including the prohibition on annual limits for essential health benefits and the requirement to provide preventive services without cost-sharing. This type of arrangement may satisfy the market reforms if it is integrated with a group health plan, but it may not be integrated with individual market policies to satisfy the market reforms. An employer who participates in this type of arrangement may be subject to federal tax penalties. In addition, an employee who participates in this type of arrangement would be ineligible for premium tax credits, because he or she would be considered to be covered by a group health plan.

Second-Party Payments.

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.

Issuers must accept payments made by a second-party payment process, and these payments may be made with any legal tender denominated in United States dollars. "Second-party payment process" means a process in which:

- an individual has an account in his or her name at a financial institution that is managed by either the institution or an entity that has established the account on the individual's behalf and with his or her express agreement;
- the account is funded with funds from the individual or his or her family members or in a manner otherwise consistent with federal law; and
- the account is under the control of the covered person so that he or she may authorize payments from the account.

An issuer is not required to accept payment by a second-party payment process if the second-party payer is controlled by, or receives funding from, an entity that may be reimbursed by an issuer for providing health care services, or if the account is funded by such an entity, except for the third-party entities from which federal law requires the issuer to accept payment.

Section 1332 Waivers.

Section 1332 of the ACA authorizes states to apply to the Secretary of Health and Human Services (HHS) and the Secretary of the Treasury for a waiver from certain provisions of the ACA for plan years beginning in 2017. A waiver may be granted if the state plan will provide coverage that is at least as comprehensive and affordable as coverage under the ACA to at least a comparable number of people, without increasing the federal deficit. The application must include a description of the state legislation and program to implement a plan meeting the requirements for a waiver, as well as a 10-year budget plan that is budget neutral for the federal government.

Summary of Bill:

The Health Care Authority (HCA), in consultation with the Office of the Insurance Commissioner, must apply for a federal waiver to integrate employer health care arrangements with individual market policies. The health care arrangements must be account-based plans that:

- require transfer of employer and employee contributions to an account owned or controlled by the employee with the account being portable from employer to employer;
- ensure the accounts are maintained or operated in a way that account funds are used to pay only qualified medical expenses under the Internal Revenue Code to the extent account funds are tax deductible under federal law;
- authorize any funds in the account to be used to pay any share of the premium for a policy purchased through a health benefit exchange for which a refundable tax credit is paid pursuant to the ACA or any individual market plan available outside of the health benefit exchange;
- provide that all employees and employee family members for whom an employer is not providing coverage are eligible to make tax deductible contributions and receive employer contributions to the account, including all part-time and seasonal employees;
- authorize the account to be combined with other accounts established on behalf of a family to make premium payments and other health care expenditures;

- require the account to be structured to receive funds electronically, including funds from multiple employers on behalf of an individual or family and to aggregate funds for paying premiums and other health care expenses;
- require the electronic payment process to include an audit trail to track and verify premium payments and is reconciled no less frequently than monthly to ensure that funds received from employers and employees are properly credited to accounts; and
- require payments made from the accounts to be considered second party payments.

When preparing the application, the HCA must provide documentation necessary to support the estimates included in the waiver, including actuarial analyses and actuarial certifications, economic analyses, data assumptions, targets, an implementation timeline, and a 10-year budget. The documentation must meet the following requirements, as required by federal law:

- The proposal must assess whether a comparable number of individuals will have coverage, including low-income individuals, elderly individuals, and those with serious health issues. The analysis and supporting data must include information on the number of individuals covered by income, health status, and age groups, under current law and under the waiver, including year-by-year estimates.
- The affordability of coverage for state residents must compare residents' net out-of-pocket expenses including premium contributions and any cost sharing, such as deductibles, copays, and coinsurance. Spending on health care services that are not covered by a plan may also be taken into account if they are affected by the waiver proposal. The assessment of the affordability must also take into account the effects across different groups of state residents, including vulnerable residents, low-income individuals, elderly individuals, and those with serious health issues. The information must include estimated individual out-of-pocket costs by income, health status, and age groups, absent the waiver and with the waiver.
- To meet the requirement for comprehensiveness under the waiver, the application must compare coverage under the waiver to the state's essential health benefits benchmark plan, and the application must demonstrate the number of individuals with coverage that satisfies the essential health benefit requirements is not reduced.
- To meet the requirement for deficit neutrality for the federal spending, the application must demonstrate the net federal spending under the waiver is equal to or lower than projected federal spending in the absence of the waiver. Estimated impacts may include changes in the premium tax credit and health coverage tax credit, individual shared responsibility payments, employer shared responsibility payments, the excise tax on high-cost employer sponsored plans, the credit for small businesses offering health insurance, and changes in income and payroll taxes. Waivers may not increase the federal deficit over the five-year period of the waiver or in total over the ten-year budget plan that is required to be submitted with the waiver application.

The HCA must provide public notice and opportunity for comment to the public, including a separate process for consulting with federally recognized Tribes. The HCA must provide status reports to the Joint Select Committee on Health Care Oversight upon request. Upon receipt of the waiver, the HCA must notify the Governor and the Legislature.

The act is null and void, unless specific funding is provided by July 1, 2016, in the omnibus operating appropriations act.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.