ESB 6089 - S AMD **485**
By Senator Becker

ADOPTED 6/28/2015

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 43.71.030 and 2012 c 87 s 4 are each amended to read as follows:

(1) The exchange may, consistent with the purposes of this chapter: (a) Sue and be sued in its own name; (b) make and execute agreements, contracts, and other instruments, with any public or private person or entity; (c) employ, contract with, or engage personnel; (d) pay administrative costs; (e) accept grants, donations, loans of funds, and contributions in money, services, materials or otherwise, from the United States or any of its agencies, from the state of Washington and its agencies or from any other source, and use or expend those moneys, services, materials, or other contributions; (f) aggregate or delegate the aggregation of funds that comprise the premium for a health plan; and (g) complete other duties necessary to begin open enrollment in qualified health plans through the exchange beginning October 1, 2013.

(2) The board shall develop a methodology to ensure the exchange is self-sustaining after December 31, 2014. The board shall seek input from health carriers to develop funding mechanisms that fairly and equitably apportion among carriers the reasonable administrative costs and expenses incurred to implement the provisions of this chapter. The board shall submit its recommendations to the legislature by December 1, 2012. If the legislature does not enact legislation during the 2013 regular session to modify or reject the board's recommendations, the board may proceed with implementation of the recommendations.

(3) The board shall establish policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified individuals.

(4) The employees of the exchange may participate in the public employees' retirement system under chapter 41.40 RCW and the public employees' benefits board under chapter 41.05 RCW.

(5) Qualified employers may access coverage for their employees through the exchange for small groups under section 1311 of P.L. 111-148 of 2010, as amended. The exchange shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the small group exchange at the specified level of coverage.

(6) The exchange shall report its activities and status to the governor and the legislature as requested, and no less often than annually.

(7) By January 1, 2016, the exchange must submit to the legislature, the governor's office, and the board a five-year spending plan that identifies potential reductions in exchange per member per month spending below the per member per month levels based on a calculation from the 2015-2017 biennium appropriation. The report must identify specific reductions in spending in the following areas: Call center, information technology, and staffing. The exchange must provide annual updates on the reduction identified in the spending plan.

(8) By January 1, 2016, the exchange must develop metrics, with actuarial support and input from the health care authority, office of insurance commissioner, office of financial management, and other relevant agencies, that capture current spending levels that include a per member per month metric; establish five-year benchmarks for spending reductions; monitor ongoing progress toward achieving those benchmarks; and post progress to date toward achieving the established benchmark on the exchange public corporate web site. Quarterly updates must be provided to relevant legislative committees and the board.

(9) For biennia following 2015-2017, the exchange must include additional detail capturing the annual cost of operating the exchange, per qualified health plan enrollee and apple health enrollee per month, as calculated by dividing funds allocated for the exchange over the 2015-2017 biennium by the number of enrollees in both qualified health plans and apple health during the year. The data must be tracked and reported to the legislature and the board on an annual basis.

(10)(a) The exchange shall prepare and annually update a strategic plan for the development, maintenance, and improvement of exchange operations for the purpose of assisting the exchange in establishing priorities to better serve the needs of its specific constituency and the public in general. The strategic plan is the exchange's process for defining its methodology for achieving optimal outcomes, for complying with applicable state and federal statutes, rules, regulations, and mandatory policies, and for guaranteeing an appropriate level of transparency in its dealings. The strategic plan must include, but is not limited to:

(i) Comprehensive five-year and ten-year plans for the exchange's direction with clearly defined outcomes and goals;

(ii) Concrete plans for achieving or surpassing desired outcomes and goals;

(iii) Strategy for achieving enrollment and reenrollment targets;

(iv) Detailed stakeholder and external communication plans;

(v) Identification of funding sources, and a plan for how it will fund and allocate resources to pursue desired goals and outcomes; and

(vi) A detailed report including:

(A) Salaries of all current employees of the exchange, including starting salary, any increases received, and the basis for any increases;

(B) Salary, overtime, and compensation policies for staff of the exchange;

(C) A report of all expenses;

(D) Beginning and ending fund balances, by fund source;

(E) Any contracts or contract amendments signed by the exchange; and

(F) An accounting of staff required to operate the exchange broken out by full-time equivalent positions, contracted employees, temporary staff, and any other relevant designation that indicates the staffing level of the exchange.

(b) The strategic plan and its updates must be submitted to the authority, the appropriate committees of the legislature, and the board by September 30th of each year beginning September 30, 2015; the report of expenses for items identified in (a)(vi)(C) through (F) of this subsection must be submitted to the appropriate committees of the legislature and the board on a quarterly basis.

NEW SECTION. **Sec. 2.** A new section is added to chapter 43.71 RCW to read as follows:

As part of eligibility verification responsibilities, the exchange shall verify that a person seeking to enroll in a qualified health plan or qualified dental plan during a special enrollment period has experienced a qualifying event as established by the office of the insurance commissioner and shall require reasonable proof or documentation of the qualifying event.

Sec. 3. RCW 43.71.090 and 2014 c 84 s 1 are each amended to read as follows:

(1) The exchange must support the grace period by providing electronic information to an issuer of a qualified health plan or a qualified dental plan that complies with 45 C.F.R. Sec. 156.270 (2013) and 45 C.F.R. Sec. 155.430 (2013).

(2) If the health benefit exchange notifies an enrollee that he or she is delinquent on payment of premium, the notice must include information on how to report a change in income or circumstances and an explanation that such a report may result in a change in the premium amount or program eligibility.

(3) The exchange shall perform eligibility checks on enrollees who are in the grace period to determine eligibility for medicaid. The exchange, in collaboration with the health care authority, shall conduct outreach to eligible individuals with information regarding medicaid.

Sec. 4. RCW 48.43.039 and 2014 c 84 s 3 are each amended to read as follows:

(1) For an enrollee who is in the second or third month of the grace period, an issuer of a qualified health plan shall:

(a) Upon request by a health care provider or health care facility, provide information regarding the enrollee's eligibility status in real-time; ((~~and~~))

(b) Notify a health care provider or health care facility that an enrollee is in the grace period within three business days after submittal of a claim or status request for services provided; and

(c) If the health care provider or health care facility is providing care to an enrollee in the grace period, the provider or facility shall, wherever possible, encourage the enrollee to pay

delinquent premiums to the issuer and provide information regarding the impact of nonpayment of premiums on access to services.

(2) The information or notification required under subsection (1) of this section must, at a minimum:

(a) Indicate "grace period" or use the appropriate national coding standard as the reason for pending the claim if a claim is pended due to the enrollee's grace period status; and

(b) Except for notifications provided electronically, indicate that enrollee is in the second or third month of the grace period.

(3) No earlier than January 1, 2016, and once the exchange has terminated premium aggregation functionality for qualified health plans offered in the individual exchange and issuers are accepting all payments from enrollees directly, an issuer of a qualified health plan shall:

(a) For an enrollee in the grace period, include a statement in a delinquency notice that concisely explains the impact of nonpayment of premiums on access to coverage and health care services and encourages the enrollee to contact the issuer regarding coverage options that may be available; and

(b) For an enrollee who has exhausted the grace period, include a statement in a termination notice for nonpayment of premium informing the enrollee that other coverage options such as medicaid may be available and to contact the issuer or the exchange for additional information;

(c) For a delinquency notice described in this subsection, the issuer shall include concise information on how a subsidized enrollee may report to the exchange a change in income or circumstances, including any deadline for doing so, and an explanation that it may result in a change in premium or cost-sharing amount or program eligibility.

(4) By December 1, 2014, and annually each December 1st thereafter, the health benefit exchange shall provide a report to the appropriate committees of the legislature with the following information for the calendar year: (a) The number of exchange enrollees who entered the grace period; (b) the number of enrollees who subsequently paid premium after entering the grace period; (c) the average number of days enrollees were in the grace period prior to paying premium; and (d) the number of enrollees who were in the grace period and whose coverage was terminated due to nonpayment of

premium. The report must include as much data as is available for the calendar year.

((~~(4)~~)) (5) Upon the transfer of premium collection to the qualified health plan, each qualified health plan must provide detailed reports to the exchange to support the legislative reporting requirements.

(6) For purposes of this section, "grace period" means nonpayment of premiums by an enrollee receiving advance payments of the premium tax credit, as defined in section 1412 of the patient protection and affordable care act, P.L. 111-148, as amended by the health care and education reconciliation act, P.L. 111-152, and implementing regulations issued by the federal department of health and human services."

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On page 1, line 1 of the title, after "Relating to" strike the remainder of the title and insert "the health benefit exchange; amending RCW 43.71.030, 43.71.090, and 48.43.039; and adding a new section to chapter 43.71 RCW."

EFFECT: Additional reporting responsibilities are created for the Health Benefit Exchange including: A five-year spending plan that identifies potential spending reductions; 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 Exchange must verify qualifying documentation for enrollees seeking special enrollment due to a qualifying event.

Related to the grace period:

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;

Issuers of qualified health plans must include a statement in a delinquency notice 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, and how to report changes in income or circumstances;

Each qualified health plan must provide detailed reports on the grace period data to enable the Exchange to complete reports to the Legislature.

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