
HOUSE BILL 2516

State of Washington 65th Legislature 2018 Regular Session

By Representatives Cody, Harris, Jinkins, Robinson, Tharinger, Caldier, and Macri

Read first time 01/10/18. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to modernizing the health benefit exchange
2 statutes by aligning statutes with current practice and making
3 clarifying changes to the health benefit exchange enabling statute;
4 amending RCW 43.71.010, 43.71.020, 43.71.030, 43.71.060, 43.71.065,
5 43.71.070, 43.71.075, 43.71.080, and 48.43.039; and repealing RCW
6 43.71.035, 43.71.040, 43.71.050, and 43.71.090.

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

8 **Sec. 1.** RCW 43.71.010 and 2013 2nd sp.s. c 6 s 1 are each
9 amended to read as follows:

10 The definitions in this section apply throughout this chapter
11 unless the context clearly requires otherwise. Terms and phrases used
12 in this chapter that are not defined in this section must be defined
13 as consistent with implementation of a state health benefit exchange
14 pursuant to (~~the affordable care act~~) applicable federal law.

15 (1) (~~"Affordable care act" means the federal patient protection
16 and affordable care act, P.L. 111-148, as amended by the federal
17 health care and education reconciliation act of 2010, P.L. 111-152,
18 or federal regulations or guidance issued under the affordable care
19 act.~~

20 (2)) "Authority" means the Washington state health care
21 authority, established under chapter 41.05 RCW.

1 (~~(3)~~) (2) "Board" means the governing board established in RCW
2 43.71.020.

3 (~~(4)~~) (3) "Commissioner" means the insurance commissioner,
4 established in Title 48 RCW.

5 (~~(5)~~) (4) "Exchange" means the Washington health benefit
6 exchange established in RCW 43.71.020.

7 (~~(6)~~) (5) "Self-sustaining" means capable of operating with
8 revenue attributable to the operations of the exchange. Self-
9 sustaining sources include, but are not limited to, federal grants,
10 federal premium tax subsidies and credits, charges to health
11 carriers, premiums paid by enrollees, and premium taxes under RCW
12 48.14.0201(5)(b) and 48.14.020(2).

13 **Sec. 2.** RCW 43.71.020 and 2012 c 87 s 3 are each amended to read
14 as follows:

15 (1) The Washington health benefit exchange is established and
16 constitutes a self-sustaining public-private partnership separate and
17 distinct from the state, exercising functions delineated in chapter
18 317, Laws of 2011. By January 1, 2014, the exchange shall operate
19 consistent with (~~the affordable care act~~) applicable federal law
20 subject to statutory authorization. The exchange shall have a
21 governing board consisting of persons with expertise in the
22 Washington health care system and private and public health care
23 coverage. The (~~initial~~) membership of the board shall be appointed
24 as follows:

25 (a) (~~By October 1, 2011,~~) Each of the two largest caucuses in
26 both the house of representatives and the senate shall submit to the
27 governor a list of five nominees who are not legislators or employees
28 of the state or its political subdivisions, with no caucus submitting
29 the same nominee.

30 (i) The nominations from the largest caucus in the house of
31 representatives must include at least one employee benefit
32 specialist;

33 (ii) The nominations from the second largest caucus in the house
34 of representatives must include at least one health economist or
35 actuary;

36 (iii) The nominations from the largest caucus in the senate must
37 include at least one representative of health consumer advocates;

38 (iv) The nominations from the second largest caucus in the senate
39 must include at least one representative of small business;

1 (v) The remaining nominees must have demonstrated and
2 acknowledged expertise in at least one of the following areas:
3 Individual health care coverage, small employer health care coverage,
4 health ((benefits)) benefit plan administration, health care finance
5 and economics, actuarial science, or administering a public or
6 private health care delivery system.

7 (b) ((By December 15, 2011,)) The governor shall appoint two
8 members from each list submitted by the caucuses under (a) of this
9 subsection. The appointments made under this subsection (1)(b) must
10 include at least one employee benefits specialist, one health
11 economist or actuary, one representative of small business, and one
12 representative of health consumer advocates. The remaining four
13 members must have a demonstrated and acknowledged expertise in at
14 least one of the following areas: Individual health care coverage,
15 small employer health care coverage, health ((benefits)) benefit plan
16 administration, health care finance and economics, actuarial science,
17 or administering a public or private health care delivery system.

18 (c) ((By December 15, 2011,)) The governor shall appoint a ninth
19 member to serve as chair. The chair may not be an employee of the
20 state or its political subdivisions. The chair shall serve as a
21 nonvoting member except in the case of a tie.

22 (d) The following members shall serve as nonvoting, ex officio
23 members of the board:

24 (i) The insurance commissioner or his or her designee; and

25 (ii) The administrator of the health care authority, or his or
26 her designee.

27 (2) Initial members of the board shall serve staggered terms not
28 to exceed four years. Members appointed thereafter shall serve two-
29 year terms.

30 (3) A member of the board whose term has expired or who otherwise
31 leaves the board shall be replaced by gubernatorial appointment. Upon
32 the expiration of a member's term, the member shall continue to serve
33 until a successor has been appointed and has assumed office. When the
34 person leaving was nominated by one of the caucuses of the house of
35 representatives or the senate, his or her replacement shall be
36 appointed from a list of five nominees submitted by that caucus
37 within thirty days after the person leaves. If the member to be
38 replaced is the chair, the governor shall appoint a new chair within
39 thirty days after the vacancy occurs. A person appointed to replace a
40 member who leaves the board prior to the expiration of his or her

1 term shall serve only the duration of the unexpired term. Members of
2 the board may be reappointed to multiple terms.

3 (4) No board member may be appointed if his or her participation
4 in the decisions of the board could benefit his or her own financial
5 interests or the financial interests of an entity he or she
6 represents. A board member who develops such a conflict of interest
7 shall resign or be removed from the board.

8 (5) Members of the board must be reimbursed for their travel
9 expenses while on official business in accordance with RCW 43.03.050
10 and 43.03.060. The board shall prescribe rules for the conduct of its
11 business. Meetings of the board are at the call of the chair.

12 (6) The exchange and the board are subject only to the provisions
13 of chapter 42.30 RCW, the open public meetings act, and chapter 42.56
14 RCW, the public records act, and not to any other law or regulation
15 generally applicable to state agencies. Consistent with the open
16 public meetings act, the board may hold executive sessions to
17 consider proprietary or confidential nonpublished information.

18 (7)(a) The board shall establish an advisory committee to allow
19 for the views of the health care industry and other stakeholders to
20 be heard in the operation of the health benefit exchange.

21 (b) The board may establish technical advisory committees or seek
22 the advice of technical experts when necessary to execute the powers
23 and duties included in chapter 317, Laws of 2011.

24 (8) Members of the board are not civilly or criminally liable and
25 may not have any penalty or cause of action of any nature arise
26 against them for any action taken or not taken, including any
27 discretionary decision or failure to make a discretionary decision,
28 when the action or inaction is done in good faith and in the
29 performance of the powers and duties under chapter 317, Laws of 2011.
30 Nothing in this section prohibits legal actions against the board to
31 enforce the board's statutory or contractual duties or obligations.

32 (9) In recognition of the government-to-government relationship
33 between the state of Washington and the federally recognized tribes
34 in the state of Washington, the board shall consult with the American
35 Indian health commission.

36 **Sec. 3.** RCW 43.71.030 and 2015 3rd sp.s. c 33 s 1 are each
37 amended to read as follows:

38 (1) The exchange has the authority to:

1 (a) Provide an application and enrollment portal for individual
2 and small group health and dental insurance and state and federal
3 health care programs;

4 (b) Certify qualified health and dental plans to be offered for
5 enrollment through the exchange;

6 (c) Provide consumer education and assistance regarding cost and
7 coverage of certified plans, plan selection, eligibility for
8 subsidies, and health insurance literacy, which must include, but not
9 be limited to, a web site, toll-free call center, and consumer
10 assistance by navigators and insurance producers;

11 (d) Determine eligibility for premium tax credits, cost-sharing
12 reductions, other available subsidies, and enrollment in state and
13 federal health care programs; and

14 (e) Provide data and assistance necessary to facilitate payments
15 of premium tax credits and other subsidies.

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

30 ~~((+2))~~ (3) The board shall develop and implement a methodology
31 to ensure the exchange is self-sustaining ~~((after December 31, 2014.~~
32 The board shall seek input from health carriers to develop funding
33 mechanisms that fairly and equitably apportion among carriers the
34 reasonable administrative costs and expenses incurred to implement
35 the provisions of this chapter. The board shall submit its
36 recommendations to the legislature by December 1, 2012. If the
37 legislature does not enact legislation during the 2013 regular
38 session to modify or reject the board's recommendations, the board
39 may proceed with implementation of the recommendations.

40 ~~(3))~~.

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

5 ~~((4))~~ (5) The employees of the exchange may participate in the
6 public employees' retirement system under chapter 41.40 RCW and the
7 public employees' benefits board under chapter 41.05 RCW.

8 ~~((5))~~ (6) Qualified employers may access coverage for their
9 employees through the exchange for small groups under ~~((section 1311~~
10 ~~of P.L. 111-148 of 2010, as amended))~~ applicable federal law. The
11 exchange shall enable any qualified employer to specify a level of
12 coverage so that any of its employees may enroll in any qualified
13 health plan offered through the small group exchange at the specified
14 level of coverage.

15 ~~((6))~~ (7) The exchange shall report its activities and status
16 to the governor and the legislature as requested, and no less often
17 than annually.

18 ~~((7))~~ (8) By January ~~((1, 2016))~~ 1st of each year, the exchange
19 must submit to the legislature, the governor's office, and the board
20 ~~((a five-year spending plan))~~ an annual financial report that
21 identifies ~~((potential reductions in exchange per member per month~~
22 ~~spending below the per member per month levels based on a calculation~~
23 ~~from the 2015-2017 biennium appropriation))~~ the annual cost of
24 operating the exchange. The report must identify specific reductions
25 in spending in the following areas: Call center, information
26 technology, and staffing. The exchange must provide annual updates on
27 the reduction identified in the spending plan. The report must
28 include:

- 29 (a) A report of all expenses;
30 (b) Beginning and ending fund balances, by fund source;
31 (c) Any contracts or contract amendments signed by the exchange;
32 (d) An accounting of staff required to operate the exchange
33 broken out by full-time equivalent positions, contracted employees,
34 temporary staff, and any other relevant designation that indicates
35 the staffing level of the exchange; and
36 (e) A per member per month metric, per qualified health plan
37 enrollee and apple health enrollee, calculated by dividing funds
38 allocated for the exchange over the 2015-2017 biennium by the number
39 of enrollees in both qualified health plans and apple health during
40 the year.

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

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

19 ~~(10))~~ (9)(a) The exchange shall prepare and annually update a
20 strategic plan for the development, maintenance, and improvement of
21 exchange operations for the purpose of assisting the exchange in
22 establishing priorities to better serve the needs of its specific
23 constituency and the public in general. The strategic plan is the
24 exchange's process for defining its methodology for achieving optimal
25 outcomes, for complying with applicable state and federal statutes,
26 rules, regulations, and mandatory policies, and for guaranteeing an
27 appropriate level of transparency in its dealings. The strategic plan
28 must include, but is not limited to:

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

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

33 (iii) Strategy for achieving enrollment and reenrollment targets;

34 (iv) Detailed stakeholder and external communication plans; and

35 (v) Identification of funding sources, and a plan for how it will
36 fund and allocate resources to pursue desired goals and outcomes(~~+~~
37 ~~and~~

38 ~~(vi) A detailed report including:~~

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

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

6 ~~(C) A report of all expenses;~~

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

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

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

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

20 **Sec. 4.** RCW 43.71.060 and 2013 2nd sp.s. c 6 s 2 are each
21 amended to read as follows:

22 (1) The health benefit exchange account is created in the state
23 treasury. Moneys in the account may be spent only after
24 appropriation. Expenditures from the account may only be used to fund
25 the operation of the exchange and identification, collection, and
26 distribution of premium taxes collected under RCW 48.14.0201(5)(b)
27 and 48.14.020(2).

28 (2) The following funds must be deposited in the account:

29 (a) Premium taxes collected under RCW 48.14.0201(5)(b) and
30 48.14.020(2);

31 (b) Assessments authorized under RCW 43.71.080; and

32 (c) Amounts transferred by the pool administrator as specified in
33 the state omnibus appropriations act pursuant to RCW 48.41.090.

34 (3) All receipts from federal grants received (~~(under the~~
35 ~~affordable care act))~~) may be deposited into the account. Expenditures
36 from the account may be used only for purposes consistent with the
37 grants.

38 (~~(4) During the 2013-2015 fiscal biennium, the legislature may~~
39 ~~transfer from the health benefit exchange account to the state~~

1 ~~general fund such amounts as reflect the excess fund balance of the~~
2 ~~account.))~~

3 **Sec. 5.** RCW 43.71.065 and 2012 c 87 s 8 are each amended to read
4 as follows:

5 (1) The board shall certify a plan as a qualified health plan to
6 be offered through the exchange if the plan is determined by the:

7 (a) Insurance commissioner to meet the requirements of Title 48
8 RCW and rules adopted by the commissioner pursuant to chapter 34.05
9 RCW to implement the requirements of Title 48 RCW;

10 (b) Board to meet the requirements of ~~((the affordable care act))~~
11 applicable federal law for certification as a qualified health plan;
12 and

13 (c) Board to include tribal clinics and urban Indian clinics as
14 essential community providers in the plan's provider network
15 consistent with federal law. If consistent with federal law,
16 integrated delivery systems shall be exempt from the requirement to
17 include essential community providers in the provider network.

18 (2) Consistent with ~~((section 1311 of P.L. 111-148 of 2010, as~~
19 ~~amended))~~ applicable federal law, the board shall allow stand-alone
20 dental plans to offer coverage in the exchange beginning January 1,
21 2014. Dental benefits offered in the exchange must be offered and
22 priced separately to assure transparency for consumers.

23 (3) The board may permit direct primary care medical home plans,
24 consistent with ~~((section 1301 of P.L. 111-148 of 2010, as amended))~~
25 applicable federal law, to be offered in the exchange ~~((beginning~~
26 ~~January 1, 2014))~~.

27 (4) Upon request by the board, a state agency shall provide
28 information to the board for its use in determining if the
29 requirements under subsection (1)(b) or (c) of this section have been
30 met. Unless the agency and the board agree to a later date, the
31 agency shall provide the information within sixty days of the
32 request. The exchange shall reimburse the agency for the cost of
33 compiling and providing the requested information within one hundred
34 eighty days of its receipt.

35 (5) A decision by the board denying a request to certify or
36 recertify a plan as a qualified health plan may be appealed according
37 to procedures adopted by the board.

1 **Sec. 6.** RCW 43.71.070 and 2012 c 87 s 9 are each amended to read
2 as follows:

3 The board shall establish a rating system consistent with
4 (~~section 1311 of P.L. 111-148 of 2010, as amended~~) applicable
5 federal law, for qualified health plans to assist consumers in
6 evaluating plan choices in the exchange. Rating factors established
7 by the board may include, but are not limited to:

8 (1) Affordability with respect to premiums, deductibles, and
9 point-of-service cost-sharing;

10 (2) Enrollee satisfaction;

11 (3) Provider reimbursement methods that incentivize health homes
12 or chronic care management or care coordination for enrollees with
13 complex, high-cost, or multiple chronic conditions;

14 (4) Promotion of appropriate primary care and preventive services
15 utilization;

16 (5) High standards for provider network adequacy, including
17 consumer choice of providers and service locations and robust
18 provider participation intended to improve access to underserved
19 populations through participation of essential community providers,
20 family planning providers and pediatric providers;

21 (6) High standards for covered services, including languages
22 spoken or transportation assistance; and

23 (7) Coverage of benefits for spiritual care services that are
24 deductible under section 213(d) of the internal revenue code.

25 **Sec. 7.** RCW 43.71.075 and 2014 c 220 s 3 are each amended to
26 read as follows:

27 (1) A person or entity functioning as a navigator (~~consistent~~
28 ~~with the requirements of section 1311(i) of P.L. 111-148 of 2010, as~~
29 ~~amended,~~) shall not be considered soliciting or negotiating
30 insurance as stated under chapter 48.17 RCW.

31 (2)(a) A person or entity functioning as a navigator may only
32 request health care information that is relevant to the specific
33 assessment and recommendation of health plan options. Any health care
34 information received by a navigator may not be disclosed to any third
35 party that is not part of the enrollment process and must be
36 destroyed after enrollment has been completed.

37 (b) If a person's health care information is received and
38 disclosed to a third party in violation of (a) of this subsection,
39 the navigator must notify the person of the breach. The exchange must

1 develop a policy to establish a reasonable notification period and
2 what information must be included in the notice. This policy and
3 information on the exchange's confidentiality policies must be made
4 available on the exchange's web site.

5 (3) For the purposes of this section((τ)):

6 (a) "Health care information" has the meaning provided in RCW
7 70.02.010.

8 (b) "Navigator" means a person or entity certified by the
9 exchange to provide culturally and linguistically appropriate
10 education and assistance and facilitate enrollment in qualified
11 health plans and federal and state health care programs, in a manner
12 consistent with applicable federal law.

13 **Sec. 8.** RCW 43.71.080 and 2016 c 133 s 3 are each amended to
14 read as follows:

15 (1)(a) Beginning January 1, 2015, the exchange may require each
16 issuer writing premiums for qualified health benefit plans or stand-
17 alone pediatric dental plans offered through the exchange to pay an
18 assessment in an amount necessary to fund the operations of the
19 exchange, applicable to operational costs incurred beginning January
20 1, 2015.

21 (b) The assessment is an exchange user fee (~~as that term is used~~
22 ~~in 45 C.F.R. 156.80)). Assessments of issuers may be made only if the~~
23 amount of expected premium taxes, as provided under RCW
24 48.14.0201(5)(b) and 48.14.020(2), and other funds deposited in the
25 health benefit exchange account in the current calendar year
26 (excluding premium taxes on stand-alone family dental plans and the
27 assessment received under subsection (3) of this section applicable
28 to stand-alone family dental plans) are insufficient to fund exchange
29 operations in the following calendar year at the level authorized by
30 the legislature for that purpose in the omnibus appropriations act
31 plus three months of additional operating costs.

32 (c) (~~If the exchange is charging an assessment, the exchange~~
33 ~~shall display the amount of the assessment per member per month for~~
34 ~~enrollees.)) A health benefit plan or stand-alone dental plan may
35 identify the amount of the assessment to enrollees, but must not bill
36 the enrollee for the amount of the assessment separately from the
37 premium.~~

38 (2) The board, in collaboration with the issuers, the health care
39 authority, and the commissioner, must establish a fair and

1 transparent process for calculating the assessment amount. The
2 process must meet the following requirements:

3 (a) The assessment only applies to issuers that offer coverage in
4 the exchange and only for those market segments offered and must be
5 based on the number of enrollees in qualified health plans and stand-
6 alone dental plans in the exchange for a calendar year;

7 (b) The assessment must be established on a flat dollar and cents
8 amount per member per month, and the assessment for stand-alone
9 pediatric dental plans must be proportional to the premiums paid for
10 stand-alone dental plans in the exchange;

11 (c) Issuers must be notified of the assessment amount by the
12 exchange on a timely basis;

13 (d) An appropriate assessment reconciliation process must be
14 established by the exchange that is administratively efficient;

15 (e) Issuers must remit the assessment due to the exchange in
16 quarterly installments after receiving notification from the exchange
17 of the due dates of the quarterly installments;

18 (f) A procedure must be established to allow issuers subject to
19 assessments under this section to have grievances reviewed by an
20 impartial body and reported to the board; and

21 (g) A procedure for enforcement must be established if an issuer
22 fails to remit its assessment amount to the exchange within ten
23 business days of the quarterly installment due date.

24 (3)(a) (~~Beginning January 1, 2017,~~) The exchange may require
25 each issuer writing premiums for stand-alone family dental plans
26 offered through the exchange to pay an assessment in an amount
27 necessary to fund the operational costs of offering family dental
28 plans in the exchange, applicable to operational costs incurred
29 beginning January 1, 2017.

30 (b) The assessment is an exchange user fee (~~as that term is used~~
31 ~~in 45 C.F.R. Sec. 156.80~~). Assessments of issuers may be made only
32 if the amount of expected premium tax received from stand-alone
33 family dental plans, as provided under RCW 48.14.0201(5)(b) and
34 48.14.020(2), in the current year is insufficient to fund the
35 operational costs estimated to be attributable to offering such
36 stand-alone family dental plans in the exchange, including an
37 allocation of costs to proportionately cover overall exchange
38 operational costs, in the following calendar year, plus three months
39 of additional operating costs.

1 (c) If the exchange is charging an assessment, the exchange shall
2 display the amount of the assessment per member per month for
3 enrollees. A stand-alone family dental plan may identify the amount
4 of the assessment to enrollees, but must not bill the enrollee for
5 the amount of the assessment separately from the premium.

6 (d) The board, in collaboration with the family dental issuers
7 and the commissioner, must establish a fair and transparent process
8 for calculating the assessment amount, including the allocation of
9 overall exchange operational costs. The process must meet the
10 following requirements:

11 (i) The assessment only applies to issuers that offer stand-alone
12 family dental plans in the exchange and must be based on the number
13 of enrollees in such plans in the exchange for a calendar year;

14 (ii) The assessment must be established on a flat dollar and
15 cents amount per member per month;

16 (iii) The requirements included in subsection (2)(c) through (g)
17 of this section shall apply to the assessment described in this
18 subsection (3).

19 (e) The board, in collaboration with issuers, shall annually
20 assess the viability of offering stand-alone family dental plans on
21 the exchange.

22 (4) For purposes of this section:

23 (a) "Stand-alone family dental plan" means coverage for limited
24 scope dental benefits meeting the requirements of section
25 9832(c)(2)(A) of the internal revenue code of 1986 and providing
26 pediatric oral services that qualify as coverage for the minimum
27 essential coverage requirement under ((P.L. 111-148 (2010), as
28 amended)) applicable federal and state law.

29 (b) "Stand-alone pediatric dental plan" means coverage only for
30 pediatric oral services that qualify as coverage for the minimum
31 essential coverage requirement under P.L. 111-148 (2010), as amended.

32 (5) The exchange shall deposit proceeds from the assessments in
33 the health benefit exchange account under RCW 43.71.060.

34 (6) The assessment described in this section shall be considered
35 a special purpose obligation or assessment in connection with
36 coverage described in this section for the purpose of funding the
37 operations of the exchange, and may not be applied by issuers to vary
38 premium rates at the plan level.

1 (7) This section does not prohibit an enrollee of a qualified
2 health plan in the exchange from purchasing a plan that offers dental
3 benefits outside the exchange.

4 (8) This section does not prohibit an issuer from offering a plan
5 that covers dental benefits that do not meet the requirements of a
6 stand-alone family dental plan outside the exchange.

7 (9) The exchange shall monitor enrollment and provide periodic
8 reports which must be available on its web site.

9 (10) The board shall offer all qualified health plans through the
10 exchange, and the exchange shall not add criteria for certification
11 of qualified health plans beyond those set out in RCW 43.71.065
12 without specific statutory direction. Nothing shall be construed to
13 limit duties, obligations, and authority otherwise legislatively
14 delegated or granted to the exchange.

15 ~~((11) The exchange shall report to the joint select committee on
16 health care oversight on a quarterly basis with an update on budget
17 expenses and operations.~~

18 ~~(12) By July 1, 2016, the state auditor shall conduct a
19 performance review of the cost of exchange operations and shall make
20 recommendations to the board and the health care committees of the
21 legislature addressing improvements in cost performance and adoption
22 of best practices. The auditor shall further evaluate the potential
23 cost and customer service benefits through regionalization with other
24 states of some exchange operation functions or through a partnership
25 with the federal government. The cost of the state auditor review
26 must be borne by the exchange.))~~

27 **Sec. 9.** RCW 48.43.039 and 2015 3rd sp.s. c 33 s 4 are each
28 amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 ~~((6))~~ (5) For purposes of this section, "grace period" means
7 nonpayment of premiums by an enrollee receiving advance payments of
8 the premium tax credit, as defined in section 1412 of the patient
9 protection and affordable care act, P.L. 111-148, as amended by the
10 health care and education reconciliation act, P.L. 111-152, and
11 implementing regulations issued by the federal department of health
12 and human services.

13 NEW SECTION. **Sec. 10.** The following acts or parts of acts are
14 each repealed:

15 (1) RCW 43.71.035 (Eligibility verification) and 2015 3rd sp.s. c
16 33 s 2;

17 (2) RCW 43.71.040 (Authority, joint select committee on health
18 reform, and board—Collaboration—Report—Responsibilities and duties)
19 and 2011 c 317 s 5;

20 (3) RCW 43.71.050 (Authority—Powers and duties) and 2011 c 317 s
21 6; and

22 (4) RCW 43.71.090 (Grace period notice to issuer—Notice to
23 enrollees delinquent on premium payments—Medicaid eligibility checks
24 and outreach) and 2015 3rd sp.s. c 33 s 3 & 2014 c 84 s 1.

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