

CERTIFICATION OF ENROLLMENT
SECOND ENGROSSED SENATE BILL 6089

Chapter 33, Laws of 2015

64th Legislature
2015 3rd Special Session

HEALTH BENEFIT EXCHANGE--PLANNING AND REPORTS

EFFECTIVE DATE: 10/9/2015

Passed by the Senate June 28, 2015
Yeas 41 Nays 3

PAM ROACH

President of the Senate

Passed by the House June 29, 2015
Yeas 96 Nays 2

FRANK CHOPP

Speaker of the House of Representatives

Approved July 6, 2015 4:16 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Hunter G. Goodman, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SECOND ENGROSSED SENATE BILL 6089** as passed by Senate and the House of Representatives on the dates hereon set forth.

HUNTER G. GOODMAN

Deputy Secretary

FILED

July 7, 2015

**Secretary of State
State of Washington**

SECOND ENGROSSED SENATE BILL 6089

Passed Legislature - 2015 3rd Special Session

State of Washington

64th Legislature

2015 Regular Session

By Senator Hill

Read first time 03/31/15. Referred to Committee on Ways & Means.

1 AN ACT Relating to the health benefit exchange; amending RCW
2 43.71.030, 43.71.090, and 48.43.039; and adding a new section to
3 chapter 43.71 RCW.

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

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

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

20 (2) The board shall develop a methodology to ensure the exchange
21 is self-sustaining after December 31, 2014. The board shall seek

1 input from health carriers to develop funding mechanisms that fairly
2 and equitably apportion among carriers the reasonable administrative
3 costs and expenses incurred to implement the provisions of this
4 chapter. The board shall submit its recommendations to the
5 legislature by December 1, 2012. If the legislature does not enact
6 legislation during the 2013 regular session to modify or reject the
7 board's recommendations, the board may proceed with implementation of
8 the recommendations.

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

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

16 (5) Qualified employers may access coverage for their employees
17 through the exchange for small groups under section 1311 of P.L.
18 111-148 of 2010, as amended. The exchange shall enable any qualified
19 employer to specify a level of coverage so that any of its employees
20 may enroll in any qualified health plan offered through the small
21 group exchange at the specified level of coverage.

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

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

34 (8) By January 1, 2016, the exchange must develop metrics, with
35 actuarial support and input from the health care authority, office of
36 insurance commissioner, office of financial management, and other
37 relevant agencies, that capture current spending levels that include
38 a per member per month metric; establish five-year benchmarks for
39 spending reductions; monitor ongoing progress toward achieving those
40 benchmarks; and post progress to date toward achieving the

1 established benchmark on the exchange public corporate web site.
2 Quarterly updates must be provided to relevant legislative committees
3 and the board.

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

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

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

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

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

27 (iv) Detailed stakeholder and external communication plans;

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

30 (vi) A detailed report including:

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

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

36 (C) A report of all expenses;

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

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

39 and

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

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

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

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

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

21 (1) The exchange must support the grace period by providing
22 electronic information to an issuer of a qualified health plan or a
23 qualified dental plan that complies with 45 C.F.R. Sec. 156.270
24 (2013) and 45 C.F.R. Sec. 155.430 (2013).

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

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

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

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

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

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

9 (c) If the health care provider or health care facility is
10 providing care to an enrollee in the grace period, the provider or
11 facility shall, wherever possible, encourage the enrollee to pay
12 delinquent premiums to the issuer and provide information regarding
13 the impact of nonpayment of premiums on access to services.

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

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

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

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

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

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

36 (c) For a delinquency notice described in this subsection, the
37 issuer shall include concise information on how a subsidized enrollee
38 may report to the exchange a change in income or circumstances,
39 including any deadline for doing so, and an explanation that it may

1 result in a change in premium or cost-sharing amount or program
2 eligibility.

3 (4) By December 1, 2014, and annually each December 1st
4 thereafter, the health benefit exchange shall provide a report to the
5 appropriate committees of the legislature with the following
6 information for the calendar year: (a) The number of exchange
7 enrollees who entered the grace period; (b) the number of enrollees
8 who subsequently paid premium after entering the grace period; (c)
9 the average number of days enrollees were in the grace period prior
10 to paying premium; and (d) the number of enrollees who were in the
11 grace period and whose coverage was terminated due to nonpayment of
12 premium. The report must include as much data as is available for the
13 calendar year.

14 ~~((4))~~ (5) Upon the transfer of premium collection to the
15 qualified health plan, each qualified health plan must provide
16 detailed reports to the exchange to support the legislative reporting
17 requirements.

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

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