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**SENATE BILL 5626**

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**State of Washington 64th Legislature 2015 Regular Session**

**By** Senators Frockt, Jayapal, Keiser, Conway, Kohl-Welles, and Hasegawa

AN ACT Relating to detailed enrollment data for the health benefit exchange; amending RCW 48.43.039; and adding a new section to chapter 43.71 RCW.

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

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

(1) The exchange must capture detailed enrollment and demographic data for enrollment processed for qualified health plans and medicaid plans, and post monthly enrollment reports to the web page. Detailed enrollment information must include the following statewide and county-level enrollment for qualified health plans and medicaid: Enrollment by income bands measured by federal poverty level, 0-138%, 138-150%, 150-200%, 200-250%, 250-400%, and above; enrollment by county, by health plan, and by gender, race, language, and age.

(2) The exchange must also provide this detail for reports on changes that cause medicaid and health benefit exchange plan enrollees to lose eligibility or move between coverage as follows:

(a) Monthly reports that detail the movement of enrollment between health benefit exchange plans and medicaid based on contributing factors that can be determined from health benefit exchange data including pregnancy, family and individual income changes, and other changes of circumstances.

(b) Twice yearly reports, end of second and fourth quarter, that analyze enrollment changes using survey or additional data, which must provide information about movement of enrollment between health benefit exchange plans and medicaid and gaps in coverage based on contributing factors that include incarceration, issues with affordability, and offers of employer-sponsored insurance. All survey and other primary data collection activities used to provide information must be representative of the Washington state residents and priority subpopulations (such as county, race/ethnicity, age, etc.) through the use of appropriate sampling methods.

(3) If the exchange discontinues premium aggregation and direct billing of consumers, the exchange must ensure the qualified health plans report data back to the exchange on enrollees that may enter the grace period as defined in RCW 48.43.039 and P.L. 111-148 of 2010, as amended.

**Sec.**  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) Notify the health benefit exchange of enrollees in a grace period.

(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) 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) 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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