S-0584.3

SENATE BILL 5482

State of Washington 63rd Legislature 2013 Regular Session

By Senators Keiser, Becker, Cleveland, Nelson, Ranker, Darneille, Conway, Chase, Hasegawa, Kohl-Welles, and Kline

Read first time 01/31/13. Referred to Committee on Health Care .

AN ACT Relating to health care options under the affordable care act; amending RCW 43.71.030 and 70.47.250; and creating a new section.

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

NEW SECTION. **Sec. 1.** The federal patient protection and affordable care act creates an array of coverage options to ensure residents have access to insurance. Section 1331 provides state flexibility to establish a federal basic health program option for individuals with family income up to two hundred percent of the federal poverty level, who are not otherwise eligible for medicaid. The federal basic health option is an alternative to the health benefit exchange for certain eligible individuals and offers an opportunity to demonstrate effective and efficient purchasing of coverage, with the potential for lower out-of-pocket expenses for low-income enrollees.

It is the intent of the legislature that the federal basic health option remain a viable alternative for implementation in Washington. Accordingly, the legislature intends there to be active monitoring of enrollment in the health benefit exchange and to establish a trigger for the creation of the federal basic health option if enrollment in

the health benefit exchange is not successfully reaching uninsured, low-income individuals with income up to two hundred percent of the federal poverty level.

Sec. 2. 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)(a) The exchange shall monitor enrollment, by income and uninsured status, and share enrollment reports with the health care authority and the health care committees of the legislature. The first report must be completed by January 30, 2015, and must be published annually thereafter. At a minimum, the annual enrollment reports must reflect the end of year enrollment, monthly lives covered, enrollment by the following income brackets: Zero to one hundred thirty-eight percent, one hundred thirty-nine to two hundred percent, two hundred one to three hundred percent, three hundred one to four hundred percent, and four hundred one percent above the federal poverty level; plan choices in the individual and small group products, application inquiries and percent of enrollment captured, and the success reaching the uninsured populations. To the degree possible, the exchange shall also monitor enrollee success accessing care once enrolled.

(b) The office of the insurance commissioner shall report the rate of uninsured among the state population under sixty-five years of age, beginning January 30, 2014, and annually thereafter.

(c) If the population with income between one hundred thirty-nine percent and two hundred percent of the federal poverty level is uninsured at a rate more than ten percent the development of the federal basic health option, consistent with section 1331 of P.L. 111-148 of 2010, as amended, will be triggered, and the agency must implement the basic health option no later than twelve months from the trigger finding.

Sec. 3. RCW 70.47.250 and 2012 c 87 s 15 are each amended to read as follows:

(1) ((~~On or before December 1, 2012, the director of the health care authority shall submit a report to the legislature on whether to proceed with implementation of a federal basic health option, under section 1331 of P.L. 111-148 of 2010, as amended. The report shall address whether:~~

~~(a) Sufficient funding is available to support the design and development work necessary for the program to provide health coverage to enrollees beginning January 1, 2014;~~

~~(b) Anticipated federal funding under section 1331 will be sufficient, absent any additional state funding, to cover the provision of essential health benefits and costs for administering the basic health plan. Enrollee premium levels will be below the levels that would apply to persons with income between one hundred thirty-four and two hundred percent of the federal poverty level through the exchange; and~~

~~(c) Health plan payment rates will be sufficient to ensure enrollee access to a robust provider network and health homes, as described under RCW 70.47.100.~~

~~(2) If the legislature determines to proceed with implementation of a federal basic health option, the director shall provide the necessary certifications to the secretary of the federal department of health and human services under section 1331 of P.L. 111-148 of 2010, as amended, to proceed with adoption of the federal basic health program option.~~

~~(3) Prior to making this finding, the director shall:~~

~~(a) Actively consult with the board of the Washington health benefit exchange, the office of the insurance commissioner, consumer advocates, provider organizations, carriers, and other interested organizations;~~

~~(b) Consider any available objective analysis specific to Washington state, by an independent nationally recognized consultant that has been actively engaged in analysis and economic modeling of the federal basic health program option for multiple states.~~

~~(4) The director shall report any findings and supporting analysis made under this section to the governor and relevant policy and fiscal committees of the legislature.~~

~~(5) To the extent funding is available specifically for this purpose in the operating budget, the health care authority shall assume the federal basic health plan option will be implemented in Washington state, and initiate the necessary design and development work. If the legislature determines under subsection (1) of this section not to proceed with implementation, the authority may cease activities related to basic health program implementation.~~

~~(6)~~)) The director of the health care authority shall monitor enrollment reports provided by the commissioner. If the population with income between one hundred thirty-nine percent and two hundred percent of the federal poverty level is uninsured at a rate more than ten percent the development of the federal basic health option, consistent with section 1331 of P.L. 111-148 of 2010, as amended, will be triggered, and the agency must implement the basic health option no later than twelve months from the trigger finding.

(2) The director shall seek clarification to demonstrate the federal funding under section 1331 of P.L. 111-148 of 2010, as amended will be sufficient to cover the provision of essential health benefits and costs for administering the basic health plan; submit a detailed development plan to the legislature with any necessary statutory changes to reflect the federal requirements; and submit detailed development plans to the health benefit exchange for coordination of enrollment and programming changes.

(3) If implemented, the federal basic health program must be guided by the following principles:

(a) Meeting the minimum state certification standards in section 1331 of the federal patient protection and affordable care act;

(b) To the extent allowed by the federal department of health and human services, twelve-month continuous eligibility for the basic health program, and corresponding twelve-month continuous enrollment in standard health plans by enrollees; or, in lieu of twelve-month continuous eligibility, financing mechanisms that enable enrollees to remain with a plan for the entire plan year;

(c) Achieving an appropriate balance between:

(i) Premiums and cost-sharing minimized to increase the affordability of insurance coverage;

(ii) Standard health plan contracting requirements that minimize plan and provider administrative costs, while incentivizing improvements in quality and enrollee health outcomes; and

(iii) Health plan payment rates and provider payment rates that are sufficient to ensure enrollee access to a robust provider network and health homes, as described under RCW 70.47.100; and

(d) Transparency in program administration, including active and

ongoing consultation with basic health program enrollees and interested organizations, and ensuring adequate enrollee notice and appeal rights.

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