FINAL BILL REPORT
SHB 2516

C 44 L 18
Synopsis as Enacted

Brief Description: Updating health benefit exchange statutes.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Harris, Jinkins, Robinson, Tharinger, Caldier and Macri).

House Committee on Health Care & Wellness
Senate Committee on Health & Long Term Care

Background:

Health Benefit Exchange.
The Affordable Care Act (ACA) required every state to have a health insurance exchange established by January 1, 2014. The Washington Health Benefit Exchange (Exchange) was established pursuant to the ACA and is an online marketplace for individuals, families, and small businesses in Washington to compare and enroll in health insurance coverage and gain access to tax credits, reduced cost sharing, and public programs such as Medicaid. The Exchange began enrolling consumers on October 1, 2013, for health insurance coverage beginning on January 1, 2014. The Exchange's governing board consists of 11 members, who serve two-year terms and may be reappointed to multiple terms.

The Health Care Authority was provided with a number of duties and authorities to set up the Exchange including developing the budget, applying for grants under the ACA, developing operations and administration plans, and entering into information sharing agreements. Once established, these duties and authorities generally transferred to the Exchange.

The Exchange was established as a self-sustaining public-private partnership that is separate and distinct from the state. To be "self-sustaining" the Exchange must be capable of operating with revenue attributable to the operations of the Exchange. Beginning January 1, 2015, the Exchange was allowed to impose an assessment on health and dental plans sold through the Exchange in an amount necessary to fund the operations of the Exchange in the following calendar year. The Exchange may only impose the assessment if the expected insurance premium taxes and other funds deposited in the Health Benefit Exchange Account are insufficient to fund the Exchange's operations in the following calendar year at the level appropriated by the Legislature in the omnibus appropriations act.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

The Exchange is required to prepare an annual strategic plan and report that includes the salaries and compensation for Exchange staff, all expenses, fund balances by source, and an accounting of staff required to operate the Exchange.

The Exchange must notify enrollees who are delinquent on payment of premiums that they may report a change in income or circumstances, which may result in a change in the premium amount or program eligibility. The Exchange must also notify health plans and perform eligibility checks on enrollees in the grace period to determine eligibility for Medicaid. For plans sold on the market place to those receiving premium tax credits, individuals are given a 90-day grace period before coverage may end. Each year the Exchange must report to the Legislature on the number of individuals entering the grace period, the average length individuals are in the grace period, and the number who are terminated due to nonpayment. As of September 2015, the Exchange no longer has payment related responsibilities, which were transitioned to the insurers. Accordingly, any data the Exchange collects or reports on the grace period is received from the plans on an annual basis.

Health Reimbursement Arrangements.
In 2016 the 21st Century Cures Act created Qualified Small Employer Health Reimbursement Arrangements (QSEHRA), sometimes called Small Business HRAs. A QSEHRA allows certain small employers that do not offer a group health plan to provide a monthly allowance that is used to reimburse employees for personal medical expenses.

Summary:

All references to the Affordable Care Act (ACA) found in the Health Benefit Exchange (Exchange) statutes are replaced with "applicable federal law" or similar language. Reference to the ACA's definition of Navigator is removed and is defined as a person or entity certified by the Exchange to provide culturally and linguistically appropriate education and assistance, and facilitate enrollment in qualified health plans and federal and state health care programs, in a manner consistent with federal law.

Members of the Exchange's Board are required to serve until a successor has assumed office, following the expiration of the member's term.

The Exchange's authorities and powers are condensed and clarified, including the authority to certify qualified health and dental plans offered through the Exchange, provide consumer education, determine eligibility to tax credits, cost sharing reductions, and state and federal health care programs, and provide data necessary to facilitate subsidies. Authorities and powers originally granted to the Health Care Authority to establish the Exchange are repealed or removed. Other requirements only pertaining to the establishment of the Exchange or with dates that have already past are also removed.

The assessment on insurers fund Exchange operations for the following calendar year may include three months of additional operating costs.

The annual strategic plan and report no longer includes the salary and compensation data of Exchange staff.

The Exchanges is no longer required to notify enrollees who have entered the grace period, to perform eligibility checks on those in the grace period for Medicaid, and to produce an annual report on the grace period.

Votes on Final Passage:

House	58	40
Senate	37	12

Effective: June 7, 2018