S-3646.1

SENATE BILL 6376

State of Washington 65th Legislature 2018 Regular Session

By Senators Cleveland, Rivers, Conway, Keiser, Kuderer, Chase, and Saldaña

Read first time 01/15/18. Referred to Committee on Health & Long Term Care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) <u>The exchange has the authority to:</u>

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

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

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

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

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

(2) The exchange may, in exercising its authority 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~~)) perform other duties necessary ((~~to begin open~~)) for enrollment in ((~~qualified health plans~~)) health coverage through the exchange ((~~beginning October 1, 2013~~)).

((~~(2)~~)) (3) The board shall develop and implement 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)~~)).

(4) 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 and cost sharing on behalf of qualified individuals.

((~~(4)~~)) (5) 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)~~)) (6) 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~~)) applicable federal law. 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)~~)) (7) The exchange shall report its activities and status to the governor and the legislature as requested, and no less often than annually.

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

(a) A report of all expenses;

(b) Beginning and ending fund balances, by fund source;

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

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

(e) A per member per month metric, per qualified health plan enrollee and apple health enrollee, calculated by dividing funds allocated for the exchange over the 2015-2017 biennium by the number of enrollees in both qualified health plans and apple health during the year.

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

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

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

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

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

(iii) Strategy for achieving enrollment and reenrollment targets;

(iv) Detailed stakeholder and external communication plans; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Assessments authorized under RCW 43.71.080; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Enrollee satisfaction;

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

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

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

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

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

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

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

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

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

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

(3) For the purposes of this section((,)):

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

(b) "Navigator" means 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 applicable federal law.

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

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

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

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

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

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

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

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

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

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

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

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

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

(3)(a) ((~~Beginning January 1, 2017,~~)) T<u></u>he exchange may require each issuer writing premiums for stand-alone family dental plans offered through the exchange to pay an assessment in an amount necessary to fund the operational costs of offering family dental plans in the exchange, applicable to operational costs incurred beginning January 1, 2017.

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

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

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

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

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

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

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

(4) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

Sec. 9. RCW 48.43.039 and 2015 3rd sp.s. c 33 s 4 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;

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

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

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

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

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

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

(4) ((~~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.~~

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

((~~(6)~~)) (5) 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.

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

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

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

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

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

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