Reference to ACA in Ch. 43.71	Analysis of Current Provision	Potential Amendments
43.71.005 - Finding—Intent (1) The legislature finds that **the affordable care act** requires the establishment of health benefit exchanges. The legislature intends to establish an exchange, including a governance structure. There are many policy decisions associated with establishing an exchange that need to be made that will take a great deal of effort and expertise. It is therefore the intent of the legislature to establish a process through which these policy decisions can be made by the legislature and the governor by the deadline established in the affordable care act. (2) The exchange is intended to: (a) Increase access to quality affordable health care coverage, reduce the number of uninsured persons in Washington state, and increase the availability of health care coverage through the private health insurance market to qualified individuals and small employers; (b) Provide consumer choice and portability of health insurance, regardless of employment status; (c) Create an organized, transparent, and accountable health insurance marketplace for Washingtonians to purchase affordable, quality health care coverage, to claim available federal refundable premium tax credits and cost-sharing subsidies, **and to meet the**	Expresses intent in creating the Exchange, and the goals of Exchange operation. The section mentions the ACA explicitly and echoes its goals for Exchanges and expanded coverage. Intent sections are usually not interpreted as substantive law. This section does show the HBE tie to the ACA and its individual insurance mechanisms (marketplace, advance tax credits, cost sharing reductions, e.g.) and the intent that it operate under the ACA.	Remove text that references the ACA.

Reference to ACA in Ch. 43.71	Analysis of Current Provision	Potential Amendments
personal responsibility requirements for minimum essential coverage as provided under the federal affordable care act; (d) Promote consumer literacy and empower consumers to compare plans and make informed decisions about their health care and coverage; (e) Effectively and efficiently administer health care subsidies and determination of eligibility for participation in publicly subsidized health care programs, including the exchange; (f) Create a health insurance market that competes on the basis of price, quality, service, and other innovative efforts; (g) Operate in a manner compatible with efforts to improve quality, contain costs, and promote innovation; (h) Recognize the need for a private health insurance market to exist outside of the exchange; and (i) Recognize that the regulation of the health insurance market, both inside and outside the exchange, should continue to be performed by the insurance commissioner.		
43.71.010 -- Definitions. 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**	Through the definition in .010(1), chapter 43.71 RCW in general, and the operations of the Exchange are tied directly to the ACA as passed in 2010 and the subsequent regulations. In addition, the language	Remove the text regarding consistency with ACA, and the definition of ACA in .010(1).

Reference to ACA in Ch. 43.71	Analysis of Current Provision	Potential Amendments
this section must be defined as consistent with implementation of a state health benefit exchange pursuant to the affordable care act. (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**	regarding interpreting terms and phrases as consistent with implementation of the ACA clearly states the intent to operate the Exchange as an ACA exchange, not some generic insurance marketplace. To the extent the new administration uses new regulations to reinterpret the ACA, the Exchange has the authority to implement them.	
43.71.020 -- Washington health benefit exchange. (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** subject to statutory authorization.	Clear and strict legal requirement that the Exchange operate as required and defined by the ACA and implementing regulations. Requires operation consistent with federal law and limits (or prohibits) other activity. To the extent the new administration uses new regulations to reinterpret the ACA, the Exchange has the authority to implement them.	Add independent state law authority and functions. (For example, a list of specific plan certification, marketing, and enrollment activities.).
43.71.030 – Powers and Duties (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	References operation of a SHOP program, which the ACA and its regulations make mandatory. Future of SHOP in Washington is uncertain due to lack of carrier participation.	Repeal ACA citation, or entire subsection (5).

Reference to ACA in Ch. 43.71	Analysis of Current Provision	Potential Amendments
through the small group exchange at the specified level of coverage.		
43.71.065 -- Qualified health plans—Certification—Criteria stand-alone dental plans—Direct primary care medical home plans—Appeals. (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 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**, the board shall allow stand-alone dental plans to offer coverage in the exchange beginning January 1, 2014. Dental benefits offered in the exchange	Requires the certification of plans and dental benefits as required by the ACA. If the ACA were repealed or substantially modified, the board would lose its ability to regulate plans offered through the exchange. It would be unclear how plans would gain permission to sell on the Exchange.	Repeal the references to the ACA, and replace it with state plan certification requirements (or authority for the board to establish criteria).

Reference to ACA in Ch. 43.71	Analysis of Current Provision	Potential Amendments
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**, 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.		
43.71.070 -- Rating system—Rating factors. The board shall establish a rating system **consistent with section 1311 of P.L. 111-148 of 2010, as amended,** for qualified health plans to assist consumers in evaluating plan choices in the exchange.	Requires a federally prescribed rating system	Remove the ACA reference

Reference to ACA in Ch. 43.71	Analysis of Current Provision	Potential Amendments
43.71.075 --Navigator not soliciting or negotiating insurance—Health care information—Protection—Disclosure—Notification. (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.	This section provides an exemption from relevant insurance laws for activity under the ACA definition of "navigator". If the entire ACA, or section 1311, was repealed, the exemption would effectively disappear.	Establish and define a state navigator role with the same exemption. Also, consider granting the entire Exchange operation the same exemption, to clarify the unique role it plays in the marketplace and to eliminate any confusion about Exchange functions and insurance solicitation.
43.71.080 -- Assessment to fund exchange—Generally—Stand-alone dental plans—Performance review. (1)(b) The assessment is an exchange user fee as that term is used in **45 C.F.R. 156.80**. (3) (b) The assessment is an exchange user fee as that term is used in **45 C.F.R. Sec. 156.80**. (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	The federal regulation cited implements the ACA exchange definition and function and is subject to substantial amendment or repeal, rendering the two clauses inoperative. The dental coverage offered through the Exchange is tied directly to requirements in the ACA (and implementing regulations.) If repealed there would be no benefit structure to implement.	Remove reference to ACA and regulations. Replace with new reference to benefit scope and structure.

Reference to ACA in Ch. 43.71	Analysis of Current Provision	Potential Amendments
coverage requirement **under P.L. 111-148 (2010), as amended.** (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**.		