

2SHB 1523 - H AMD 272

By Representative Cody

ADOPTED 03/08/2019

1 On page 3, line 17, after "plan" strike "must" and insert "may"

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3 On page 3, line 19, after "appropriate;" strike "and"

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5 On page 3, line 20, after "(e)" insert "The qualified health plan  
6 must meet additional participation requirements to reduce barriers to  
7 maintaining and improving health and align to state agency value-based  
8 purchasing. These requirements may include, but are not limited to,  
9 standards for population health management; high-value, proven care;  
10 health equity; primary care; care coordination and chronic disease  
11 management; wellness and prevention; prevention of wasteful and  
12 harmful care; and patient engagement;

13 (f) To reduce administrative burden and increase transparency, the  
14 qualified health plan's utilization review processes must:

15 (i) Be focused on care that has high variation, high cost, or low  
16 evidence of clinical effectiveness;

17 (ii) Meet national accreditation standards; and

18 (iii) Align with published criteria published by the authority;

19 (g) The qualified health plan's medical loss ratio must meet or  
20 exceed ninety percent, as determined by the insurance commissioner in  
21 the rate review process; and

22 (h)"

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24 On page 3, beginning on line 28, after "(2)" strike all material  
25 through "qualifications" on line 34 and insert "The director, after  
26 consultation with the exchange, shall conduct procurement negotiations  
27 with health carriers and selectively contract with a health carrier or

1 carriers to offer a qualified health plan or plans that offer the  
2 optimal combination of choice, affordability, quality, and service. A  
3 health carrier contracting with the authority under this section may  
4 offer a qualified health plan or plans in a single county or multiple  
5 counties. The goal of the procurement conducted under this section is  
6 to have health carriers contracting with the authority under this  
7 section offering at least one qualified health plan in every county in  
8 the state"

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EFFECT: Allows, instead of requires, a qualified health plan offered pursuant to a Health Care Authority (HCA) contract to use a managed care model. Requires a qualified health plan offered pursuant to a HCA contract to: (a) meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing; (b) employ utilization review processes that meet national accreditation standards, align with HCA-published criteria, and are focused on care that has high variation, high cost, or low evidence of clinical effectiveness; and (c) have a medical loss ratio of at least 90%. Removes the request for qualifications process in which the HCA must contract with all health carriers that meet the minimum qualifications. Instead, requires the HCA, after consulting with the Health Benefit Exchange, to selectively contract with a health carrier or carriers to offer a qualified health plan or plans that offer the optimal combination of choice, affordability, quality, and service. Allows a health carrier contracting with the HCA to offer qualified health plans in single or multiple counties. States that the goal of the procurement is to have health carriers contracting with the HCA to offer at least one qualified health plan in every county of the state.

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