

ESSB 5526 - H COMM AMD  
By Committee on Appropriations

ADOPTED AS AMENDED 04/10/2019

1 Strike everything after the enacting clause and insert the  
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 43.71  
4 RCW to read as follows:

5 (1) The exchange, in consultation with the commissioner, the  
6 authority, an independent actuary, and other stakeholders, must  
7 establish up to three standardized health plans for each of the  
8 bronze, silver, and gold levels.

9 (a) The standardized health plans must be designed to reduce  
10 deductibles, make more services available before the deductible,  
11 provide predictable cost sharing, maximize subsidies, limit adverse  
12 premium impacts, reduce barriers to maintaining and improving health,  
13 and encourage choice based on value, while limiting increases in  
14 health plan premium rates.

15 (b) The exchange may update the standardized health plans  
16 annually.

17 (c) The exchange must provide a notice and public comment period  
18 before finalizing each year's standardized health plans.

19 (d) The exchange must provide written notice of the standardized  
20 health plans to licensed health carriers by January 31st before the  
21 year in which the health plans are to be offered on the exchange. The  
22 exchange may make modifications to the standardized plans after  
23 January 31st to comply with changes to state or federal law or  
24 regulations.

25 (2)(a) Beginning January 1, 2021, any health carrier offering a  
26 qualified health plan on the exchange must offer one silver  
27 standardized health plan and one gold standardized health plan on the  
28 exchange. If a health carrier offers a bronze health plan on the  
29 exchange, it must offer one bronze standardized health plan on the  
30 exchange.

1 (b) (i) A health plan offering a standardized health plan under  
2 this section may also offer nonstandardized health plans on the  
3 exchange.

4 (ii) The exchange, in consultation with the office of the  
5 insurance commissioner, shall analyze the impact to exchange  
6 consumers of offering only standard plans beginning in 2025 and  
7 submit a report to the appropriate committees of the legislature by  
8 December 1, 2023. The report must include an analysis of how plan  
9 choice and affordability will be impacted for exchange consumers  
10 across the state.

11 (iii) The actuarial value of nonstandardized silver health plans  
12 offered on the exchange may not be less than the actuarial value of  
13 the standardized silver health plan with the lowest actuarial value.

14 (c) A health carrier offering a standardized health plan on the  
15 exchange under this section must continue to meet all requirements  
16 for qualified health plan certification under RCW 43.71.065  
17 including, but not limited to, requirements relating to rate review  
18 and network adequacy.

19 NEW SECTION. **Sec. 2.** A new section is added to chapter 42.56  
20 RCW to read as follows:

21 (1) Any data submitted by health carriers to the health benefit  
22 exchange for purposes of establishing standardized health plans under  
23 section 1 of this act are exempt from disclosure under this chapter.  
24 This subsection applies to health carrier data in the custody of the  
25 insurance commissioner for purposes of consulting with the health  
26 benefit exchange under section 1(1) of this act.

27 (2) Any data submitted by health carriers to the health care  
28 authority for purposes of section 3 of this act are exempt from  
29 disclosure under this chapter.

30 NEW SECTION. **Sec. 3.** A new section is added to chapter 41.05  
31 RCW to read as follows:

32 (1) The authority, in consultation with the health benefit  
33 exchange, must contract with one or more health carriers to offer  
34 qualified health plans on the Washington health benefit exchange for  
35 plan years beginning in 2021. A health carrier contracting with the  
36 authority under this section must offer at least one bronze, one  
37 silver, and one gold qualified health plan in a single county or in  
38 multiple counties. The goal of the procurement conducted under this

1 section is to have a choice of qualified health plans under this  
2 section offered in every county in the state. The authority may not  
3 execute a contract with an apparently successful bidder under this  
4 section until after the insurance commissioner has given final  
5 approval of the health carrier's rates and forms pertaining to the  
6 health plan to be offered under this section and certification of the  
7 health plan under RCW 43.71.065.

8 (2) A qualified health plan offered under this section must meet  
9 the following criteria:

10 (a) The qualified health plan must be a standardized health plan  
11 established under section 1 of this act;

12 (b) The qualified health plan must meet all requirements for  
13 qualified health plan certification under RCW 43.71.065 including,  
14 but not limited to, requirements relating to rate review and network  
15 adequacy;

16 (c) The qualified health plan must incorporate recommendations of  
17 the Robert Bree collaborative and the health technology assessment  
18 program;

19 (d) The qualified health plan may use an integrated delivery  
20 system or a managed care model that includes care coordination or  
21 care management to enrollees as appropriate;

22 (e) The qualified health plan must meet additional participation  
23 requirements to reduce barriers to maintaining and improving health  
24 and align to state agency value-based purchasing. These requirements  
25 may include, but are not limited to, standards for population health  
26 management; high-value, proven care; health equity; primary care;  
27 care coordination and chronic disease management; wellness and  
28 prevention; prevention of wasteful and harmful care; and patient  
29 engagement;

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

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

34 (ii) Meet national accreditation standards; and

35 (iii) Align with clinical criteria published by the authority;

36 (g)(i) The total amount the qualified health plan reimburses  
37 providers and facilities for all covered benefits in the statewide  
38 aggregate, excluding pharmacy benefits, may not exceed one hundred  
39 fifty percent of the total amount medicare would have reimbursed

1 providers and facilities for the same or similar services in the  
2 statewide aggregate;

3 (ii) Beginning in calendar year 2023, if the authority determines  
4 that selective contracting will result in actuarially sound premium  
5 rates that are no greater than the qualified health plan's previous  
6 plan year rates adjusted for inflation using the consumer price  
7 index, the director may, in consultation with the health benefit  
8 exchange, waive this subsection (2)(g) as a requirement of the  
9 contracting process under this section;

10 (h) For services provided by rural hospitals certified by the  
11 centers for medicare and medicaid services as critical access  
12 hospitals or sole community hospitals, the rates may not be less than  
13 one hundred one percent of allowable costs;

14 (i) Reimbursement for primary care services, as defined by the  
15 authority, provided by a physician with a primary specialty  
16 designation of family medicine, general internal medicine, or  
17 pediatric medicine, may not be less than one hundred thirty-five  
18 percent of the amount that would have been reimbursed under the  
19 medicare program for the same or similar services; and

20 (j) The qualified health plan must comply with any requirements  
21 established by the authority to address amounts expended on pharmacy  
22 benefits including, but not limited to, increasing generic  
23 utilization and use of evidence-based formularies.

24 (3) Nothing in this section prohibits a health carrier offering  
25 qualified health plans under this section from offering other health  
26 plans in the individual market.

27 NEW SECTION.

**Sec. 4.**

(1) The health care authority, in  
28 consultation with the insurance commissioner and the Washington  
29 health benefit exchange, must submit a report and recommendations to  
30 the legislature by December 1, 2022, regarding:

31 (a) The impact on qualified health plan choice, affordability,  
32 and market stability of linking offering a qualified health plan  
33 under section 3 of this act with participation in programs  
34 administered by the public employees' benefits board, the school  
35 employees' benefits board, or the health care authority;

36 (b) The impact on qualified health plan choice, qualified health  
37 plan provider networks, affordability, and market stability of  
38 linking provider participation in the provider networks of qualified  
39 health plans offered under section 3 of this act with provider

1 participation in provider networks of programs administered by the  
2 public employees' benefits board, the school employees' benefits  
3 board, or the health care authority; and

4 (c) Other issues the health care authority deems relevant to the  
5 successful implementation of this act.

6 (2) This section expires January 1, 2023.

7 NEW SECTION. **Sec. 5.** (1) The Washington health benefit  
8 exchange, in consultation with the health care authority and the  
9 insurance commissioner, must develop a plan to implement and fund  
10 premium subsidies for individuals whose modified adjusted gross  
11 incomes are less than five hundred percent of the federal poverty  
12 level and who are purchasing individual market coverage on the  
13 exchange. The goal of the plan is to enable participating individuals  
14 to spend no more than ten percent of their modified adjusted gross  
15 incomes on premiums. The plan must also include an assessment of  
16 providing cost-sharing reductions to plan participants and must  
17 assess the impact of premium subsidies on the uninsured rate.

18 (2) The Washington health benefit exchange must submit the plan,  
19 along with proposed implementing legislation, to the appropriate  
20 committees of the legislature by November 15, 2020.

21 (3) This section expires January 1, 2021.

22 NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43  
23 RCW to read as follows:

24 The commissioner shall submit an annual report to the appropriate  
25 committees of the legislature on the number of health plans available  
26 per county in the individual market.

27 NEW SECTION. **Sec. 7.** If specific funding for the purposes of  
28 this act, referencing this act by bill or chapter number, is not  
29 provided by June 30, 2019, in the omnibus appropriations act, this  
30 act is null and void."

31 Correct the title.

EFFECT: Standardized Plans: Allows the Exchange to make  
modifications to standardized plans based on changes to state and  
federal law. Removes the requirement that the Insurance Commissioner  
review proposed standardized plans. Makes data submitted by health  
carriers to the Exchange exempt from the Public Records Act only,  
instead of being both confidential and exempt from the Public Records

Act. Exempts from the Public Records Act data in the custody of the Insurance Commissioner for purposes of consulting with the Exchange.

HCA Procurement: Requires health carriers contracting with the Health Care Authority (HCA) to offer at least one bronze, one silver, and one gold qualified health plan (QHP) in a single county or in multiple counties. Changes the goal of the procurement to having a choice of QHP in every county in the state (instead of having HCA-contracted carriers in every county in the state). Prohibits the HCA from executing a contract with a health carrier until after the Insurance Commissioner and the Exchange perform the requirements necessary for QHP certification. Allows an HCA-contracted QHP to use an integrated delivery system. Requires an HCA-contracted QHP to comply with HCA requirements relating to pharmacy benefits, including increasing generic utilization or use of evidence-based formularies. Exempts data submitted by health carriers for purposes of the procurement from the Public Records Act.

HCA-Procured Health Plan Provider Rates: Prohibits the total amount an HCA-procured health plan reimburses providers and facilities in the statewide aggregate, excluding pharmacy benefits, from exceeding 150% of the total amount Medicare would have reimbursed for the same or similar services in the statewide aggregate. Allows, beginning in 2023, the HCA to suspend the provider rate limit if it finds that selective contracting will lead to actuarially sound premium rates that increase at a rate no greater than the rate of inflation calculated using the consumer price index. Requires primary care services to be reimbursed at 135% of the Medicare rate for the same or similar service. Removes the requirement that the HCA consider factors proposed by health carriers with the goal of reducing premiums below 2019 levels.

Studies and Reports: Requires the Exchange to consult with the Insurance Commissioner when studying the impact of offering only standardized plans on the Exchange, instead of requiring the study to be performed jointly by the Exchange and the Insurance Commissioner. Requires the HCA, in consultation with the Insurance Commissioner to study the impact of linking HCA-contracted QHPs with participation in public health programs administered by the Public Employees' Benefits Board, the School Employees' Benefits Board, and the HCA. Requires the Exchange's premium subsidy plan to include an assessment of the impact of premium subsidies on the uninsured rate.

Miscellaneous: Adds a null and void clause.

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