**ESSB 5526** - H COMM AMD
By Committee on Health Care & Wellness

**NOT CONSIDERED 04/10/2019**

Strike everything after the enacting clause and insert the following:

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

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

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

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

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

(d) The exchange must provide written notice of the standardized health plans to licensed health carriers by January 31st before the year in which the health plans are to be offered on the exchange.

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

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

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

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

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

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

Any data submitted by health carriers to the health benefit exchange for purposes of establishing standardized benefit plans under section 1 of this act are confidential and exempt from disclosure under this chapter.

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

(1) The authority, in consultation with the health benefit exchange, must contract with one or more health carriers to offer silver and gold qualified health plans on the Washington health benefit exchange for plan years beginning in 2021. A qualified health plan offered under this section must meet the following criteria:

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

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

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

(d) The qualified health plan may use a managed care model that includes care coordination or care management to enrollees as appropriate;

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

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

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

(ii) Meet national accreditation standards; and

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

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

(h) The qualified health plan's fee-for-service rates for providers and facilities may not exceed the medicare rates for the same or similar covered services in the same or similar geographic area. For reimbursement methodologies other than fee-for-service, the aggregate amount the qualified health plan pays to providers and facilities may not exceed the equivalent of the aggregate amount the qualified health plan would have reimbursed providers and facilities using fee-for-service medicare rates.

(2) The director, after consultation with the exchange, shall conduct procurement negotiations with health carriers and 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. A health carrier contracting with the authority under this section may offer a qualified health plan or plans in a single county or multiple counties. The goal of the procurement conducted under this section is to have health carriers contracting with the authority under this section offering at least one qualified health plan in every county in the state.

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

NEW SECTION. **Sec. 4.** (1) The Washington health benefit exchange, in consultation with the health care authority and the insurance commissioner, must develop a plan to implement and fund premium subsidies for individuals whose modified adjusted gross incomes are less than five hundred percent of the federal poverty level and who are purchasing individual market coverage on the exchange. The goal of the plan is to enable participating individuals to spend no more than ten percent of their modified adjusted gross incomes on premiums. The plan must also include an assessment of providing cost-sharing reductions to plan participants.

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

(3) This section expires January 1, 2021.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43 RCW to read as follows:

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

NEW SECTION. **Sec. 6.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2019, in the omnibus appropriations act, this act is null and void."

Correct the title.

EFFECT: Removes the requirement that the Insurance Commissioner review proposed standardized plans. Removes the requirement that Health Care Authority (HCA)-contracted qualified health plans (QHPs) reimburse critical access hospitals and sole community hospitals at 101% of allowable costs. Removes the requirement that the HCA consider factors proposed by health carriers with the goal of reducing premiums below 2019 levels. Requires HCA-contracted QHPs to pay fee for service provider rates that do not exceed Medicare rates for the same or similar covered service in the same or similar geographic area; for nonfee-for-service methodologies, the aggregate provider reimbursement amount may not exceed the equivalent of the aggregate amount the QHP would have reimbursed using fee-for-service

rates. Requires a HCA-contracted QHP to have a 90% actuarial value. Allows a carrier contracting with the HCA to offer health plans in a single county or in multiple counties.

**--- END ---**