

**SSB 5526 - S AMD 398**  
By Senator Frockt

**ADOPTED AS AMENDED 03/13/2019**

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.

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

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

31 (ii) The exchange and the office of the insurance commissioner  
32 shall analyze the impact to exchange consumers of offering only

1 standard plans beginning in 2025 and submit a report to the  
2 appropriate committees of the legislature by December 1, 2023. The  
3 report must include an analysis of how plan choice and affordability  
4 will be impacted for exchange consumers across the state.

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (ii) Meet national accreditation standards; and

14 (iii) Align with published criteria published by the authority;  
15 and

16 (g) For services provided by rural hospitals certified by the  
17 centers for medicare and medicaid services as critical access  
18 hospitals or sole community hospitals, the rates may not be less than  
19 one hundred one percent of allowable costs.

20 (2) The director, after consultation with the health benefit  
21 exchange, shall conduct procurement negotiations with health carriers  
22 and selectively contract with a health carrier or carriers to offer a  
23 qualified health plan or plans that offer the optimal combination of  
24 choice, affordability, quality, and service. The goal of the  
25 procurement conducted under this section is to have health carriers  
26 contracting with the authority under this section offering at least  
27 one qualified health plan in every county in the state. The director  
28 shall consider the rates, utilization management policies,  
29 pharmaceutical costs, and other factors proposed by the carrier or  
30 carriers, with the goal of negotiating for qualified health plans  
31 that reduce premiums below the average premiums for qualified health  
32 plans in the same metal tier in Washington during plan year 2019.

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

36 NEW SECTION. **Sec. 4.** (1) The Washington health benefit  
37 exchange, in consultation with the health care authority and the  
38 insurance commissioner, must develop a plan to implement and fund  
39 premium subsidies for individuals whose modified adjusted gross

1 incomes are less than five hundred percent of the federal poverty  
2 level and who are purchasing individual market coverage on the  
3 exchange. The goal of the plan is to enable participating individuals  
4 to spend no more than ten percent of their modified adjusted gross  
5 incomes on premiums. The plan must also include an assessment of  
6 providing cost-sharing reductions to plan participants.

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

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

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

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

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16 On page 1, line 2 of the title, after "market;" strike the  
17 remainder of the title and insert "adding a new section to chapter  
18 43.71 RCW; adding a new section to chapter 42.56 RCW; adding a new  
19 section to chapter 41.05 RCW; adding a new section to chapter 48.43  
20 RCW; creating a new section; and providing an expiration date."

EFFECT: (1) Removes the phase-out of nonstandardized plans  
offered on the Health Benefit Exchange (Exchange) and instead allows  
nonstandardized plans to be offered on the Exchange without  
limitation.

(2) Requires the Exchange and the Office of the Insurance  
Commissioner to analyze the impact to Exchange consumers of offering  
only standard plans beginning in 2025. Requires that the actuarial  
value of nonstandardized silver health plans offered on the Exchange  
be no greater than the actuarial value of the standardized silver  
plan with the lowest actuarial value.

(3) 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; and (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. 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 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. Directs HCA to consider the rates, utilization management policies, pharmaceutical costs, and other factors proposed by the carrier or carriers, with the goal of negotiating for plans that reduce premiums below the average premiums in Washington during plan year 2019.

(4) Removes the requirement that the contracted qualified health plans reimburse providers and facilities at a rate equal to the Medicare rate.

(5) Directs HCA to negotiate premium rates, with the goal of reducing premiums below the average premiums of the same metal tier in Washington during plan year 2019.

(6) Requires the Insurance Commissioner to submit an annual report to the Legislature on the number of health plans available per county in the individual market.

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