Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1523

Brief Description: Increasing the availability of quality, affordable health coverage in the individual market.

Sponsors: Representatives Cody, Macri, Riccelli, Stonier, Tharinger, Ormsby, Davis, Frame, Robinson, Thai, Doglio, Stanford and Valdez; by request of Office of the Governor.

Brief Summary of Bill

- Requires the Washington Health Benefit Exchange to develop standardized health plans.
- Requires the Health Care Authority to contract with health carriers to offer standardized qualified health plans.
- Requires the Health Care Authority to develop a plan for premium subsidies for individuals purchasing coverage on the Washington Health Benefit Exchange.

Hearing Date: 1/30/19

Staff: Jim Morishima (786-7191).

Background:

Individual Market Coverage through the Health Benefit Exchange.

Through Washington's Health Benefit Exchange (Exchange), individuals may compare and purchase individual health coverage and access premium subsidies and cost-sharing reductions. Premium subsidies are available to individuals between 100 percent and 400 percent of the federal poverty level. Cost-sharing reductions are available to individuals between 100 percent and 250 percent of the federal poverty level. Health plans are offered in the following actuarial value tiers: Bronze (60 percent actuarial value), Silver (70 percent actuarial value), Gold (80 percent actuarial), and Platinum (90 percent actuarial value). Federal law allows a variation of four percent lower and five percent higher for Bronze plans and four percent lower and two

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percent higher for Silver, Gold and Platinum plans. Carriers offering coverage on the Exchange must offer at least one Silver and one Gold plan.

Only health plans certified by the Exchange as qualified health plans (QHPs) may be offered on the Exchange. Qualified health plans must be offered by licensed carriers and therefore must meet requirements generally applicable to all individual market health plans, including offering the essential health benefits, having their premium rates reviewed and approved by the Insurance Commissioner, and meeting network adequacy requirements.

Standardized Health Plans.

Standardized health plans are plans that offer coverage subject to specified coverage requirements, such as actuarial values, cost sharing, and benefits. Pursuant to state and federal law, standardized Medicare supplemental insurance plans are offered in Washington. Standardized individual market health plans are offered on the health benefit exchanges in some states, including California, Connecticut, Washington DC, Massachusetts, Maryland, New York, Oregon, and Vermont, but not in Washington.

Summary of Bill:

Standardized Health Plans.

The Exchange, in consultation with the Insurance Commissioner, the Health Care Authority (HCA), an independent actuary, and stakeholders, must establish up to three standardized plans for each of the Bronze, Silver, and Gold actuarial value tiers. The standardized 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. The Silver standardized health plan must have an actuarial value between 68 and 70 percent. Any data submitted by health carriers to the Exchange for purposes of establishing the standardized benefit plans are confidential and exempt from public disclosure.

Before finalizing the standardized plans, the Exchange must provide notice and a public comment period. The Exchange must provide written notice of the standardized plans for the year by January 31 in the year prior. The Exchange may update the standardized plans annually.

Beginning on January 1, 2021, any health carrier offering a QHP on the Exchange must offer one standardized Silver plan and one standardized Gold plan on the Exchange. If a health carrier offers a Bronze plan on the Exchange, it must offer one Bronze standardized plan on the Exchange. A health carrier offering a standardized plan must meet all requirements relating to QHP certification, including requirements relating to rate review and network adequacy.

Carriers may offer non-standardized plans on the Exchange as follows:

- A non-standardized Silver plan may not have an actuarial value that is less than the actuarial value of the Silver standardized plan.
- For plan years 2021 and 2022, a health plan may offer an unlimited number of non-standardized plans.

- For plan years 2023 and 2024, a health plan may offer no more than three non-standardized plans in each of the Bronze, Silver, and Gold levels.
- For plan years beginning 2025, a health plan may not offer non-standardized plans on the Exchange.

State-Procured Qualified Health Plan.

The HCA, in consultation with the Exchange, must contract with at least one health carrier to offer Silver and Gold QHPs on the Exchange for plan years beginning 2021. The QHPs must:

- be standardized health plans;
- meet all requirements for QHP certification, including requirements relating to rate review and network adequacy;
- incorporate recommendations of the Bree Collaborative and the Health Technology Assessment Program; and
- 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 non-fee-for-service reimbursement methodologies, the aggregate amount paid to providers and facilities may not exceed the equivalent of the aggregate amount the QHP would have reimbursed providers and facilities using fee-for-service Medicare rates.

The HCA must use a request for qualifications process to contract with the health carriers. The HCA must review the qualifications of health carriers seeking to offer QHPs and may negotiate with the health plans to the extent necessary to refine the carriers' responses. The HCA must contract with all carriers who meet the minimum qualifications. A health carrier offering a state-procured QHP may continue to offer other health plans in the individual market.

Premium and Cost-Sharing Assistance.

The Exchange, in consultation with the HCA and the Insurance Commissioner, must develop a plan to implement and fund premium subsidies for individuals whose modified adjusted gross incomes are less than 500 percent of the federal poverty level and who are purchasing individual market coverage on the Exchange. The goal of the plan must be to enable participating individuals to spend no more than 10 percent of their modified adjusted gross incomes on premiums. The plan must also include an assessment of providing cost-sharing reductions to plan participants.

The Exchange must submit the plan, along with proposed implementing legislation, to the appropriate committees of the Legislature by November 15, 2020.

Appropriation: None.

Fiscal Note: Requested January 28, 2019.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.