Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

ESSB 5526

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

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Frockt, Cleveland, Kuderer, Randall, Keiser, Dhingra, Conway, Wellman, Darneille, Hunt, Hobbs, Das, Liias, Nguyen, Pedersen, Rolfes, Saldaña and Van De Wege; by request of Office of the Governor).

Brief Summary of Engrossed Substitute 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.
- Requires the Insurance Commissioner to submit an annual report on the number of health plans available per county on the individual market.

Hearing Date: 3/26/19

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

---

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

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 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. 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. By January 1 in the year prior to the year the standardized plans are to be offered on the Exchange, the Insurance Commissioner must review the standardized health plan designs and provide written comments to the Exchange and the chairs of the health care committees of the House of Representatives and the Senate. The Exchange must provide written notice of the standardized plans for the year by January 31 in the year prior to the year they are to be offered on the Exchange. 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 continue to offer non-standardized plans on the Exchange. A non-standardized Silver plan may not have an actuarial value that is less than the actuarial value of the Silver standardized plan with the lowest actuarial value. The Exchange and the Insurance Commissioner must analyze the impact to consumers of offering only standard plans on the Exchange beginning in 2025. The report must be submitted to the Legislature by December 1, 2020, and include an analysis of how plan choice and affordability will be impacted for Exchange customers across the state.

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 may use a managed care model that includes care coordination and care management to enrollees as appropriate and 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;
- meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing, including standards for population health management, high value and proven care, health equity, primary care, care coordination and chronic disease management, wellness and prevention, prevention of wasteful and harmful care, and patient engagement;
- employ utilization management processes that meet national accreditation standards, align with criteria published by the HCA, and focus on care that has high variation, high cost, or low evidence of clinical effectiveness; and
- pay at least 101 percent of allowable costs for services provided by rural hospitals certified by the federal Centers for Medicare and Medicaid Services as critical access hospitals or sole community hospitals.

The HCA, after consulting with the Exchange, must 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. The goal of the procurement is to have health carriers contracting with the HCA to offer at least one QHP in every county in the state. The HCA must consider the rates, utilization management policies, pharmaceutical costs, and other factors proposed by the carrier or carriers with the goal of negotiating for qualified health plans that reduce premiums below the average premiums for qualified health plans in the same metal tier in Washington during the 2019 plan year.

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.

Individual Market Plans.

The Insurance Commissioner must submit an annual report to the Legislature on the number of health plans available per county in the individual market.

Appropriation: None.

Fiscal Note: Not requested.

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