

# FINAL BILL REPORT

## ESSB 5526

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Synopsis as Enacted

**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, Lias, Nguyen, Pedersen, Rolfes, Saldaña and Van De Wege; by request of Office of the Governor).

**Senate Committee on Health & Long Term Care**  
**Senate Committee on Ways & Means**  
**House Committee on Health Care & Wellness**  
**House Committee on Appropriations**

**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 and 400 percent of the federal poverty level. Cost-sharing reductions are available to individuals between 100 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 value; and
- platinum, 90 percent actuarial value.

The actuarial value refers to the total average costs for covered benefits the plan will cover. Federal law allows a variation of 4 percent lower and 5 percent higher for bronze plans and 4 percent lower and 2 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. QHPs must be offered by licensed carriers and 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 (commissioner), and meeting network adequacy requirements.

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*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.*

Standardized Health Plans. Standardized health plans are plans offering coverage subject to specified 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 health benefit exchanges in some states, including California, Connecticut, Washington, D.C., Massachusetts, Maryland, New York, Oregon, and Vermont.

**Summary:** Standardized Health Plans. The Exchange, in consultation with the 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. The commissioner must annually review the standardized plan designs and provide written comments to the exchange and the chairs of the Senate and House health care committees by January 1st of the year prior to the plans being offered. The Exchange must provide written notice to health carriers of the standardized plans by January 31st of the year prior to the plans being offered. The Exchange may update the standardized plans annually and modify the plans based on changes to state and federal law.

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.

State-Procured Qualified Health Plan. The HCA, in consultation with the Exchange, must contract with at least one health carrier to offer bronze, silver and gold QHPs on the Exchange for plan years beginning 2021. QHPs must:

- be standardized health plans;
- meet all requirements for 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; and
- 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.

The QHP may use a managed care model or an integrated delivery system, and may be offered in a single county or in multiple counties. 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 plans that reduce premiums below the average premiums for plans in the same metal tiers in Washington during the 2019 plan year.

HCA must use a request for qualifications process to contract with the health carriers. 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. 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.

The total amount the QHP reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed 160 percent of the total amount Medicare would have reimbursed providers and facilities for the same or similar services in the statewide aggregate. The director of HCA may waive the provider rate cap if:

- a health carrier offering a QHP is unable to form a provider network that meets network access standards adopted by the OIC; and
- the health carrier is able to achieve premiums that are 10 percent lower than the previous plan year through other means.

Beginning in 2023, the director of HCA, in consultation with the Exchange, may waive the Medicare reimbursement requirement if HCA determines selective contracting will result in actuarially sound premium rates that are no greater than the QHP's previous plan year rates adjusted for inflation using the consumer price index.

The QHP's reimbursement rates for critical access hospitals and sole community hospitals may not be less than 101 percent of allowable costs. The QHP's reimbursement rates must be at least 135 percent of Medicare rates for primary care services designated by HCA that are performed by physicians with a primary specialty of family medicine, general internal medicine, or pediatric medicine.

The business and occupation tax does not apply to amounts received by a provider for services performed on patients covered by a QHP offered pursuant to a HCA contract, including reimbursement from the QHP and any amounts collected from the patient as part of their cost-sharing obligation. By December 1, 2022, HCA, in consultation with the insurance commissioner and the Exchange, must submit a report to the Legislature on the following:

- the impact on QHP choice, affordability, and market stability of linking offering a QHP pursuant to an HCA contract with participation in programs administered by the Public Employees' Benefits Board (PEBB), the School Employees' Benefits Board (SEBB), or HCA;

- the impact on QHP choice, provider networks, affordability, and market stability of linking provider participation in the networks of QHPs offered pursuant to a HCA contract with participation in provider networks of programs administered by the PEBB, the SEBB, or HCA, and other issues HCA deems relevant; and
- the Exchange's premium subsidy plan to include an assessment of the impact of premium subsidies on the uninsured rate.

Premium and Cost-Sharing Assistance. The Exchange, in consultation with HCA and the 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 commissioner must submit an annual report to the Legislature on the number of health plans available per county in the individual market.

**Votes on Final Passage:**

Senate	36	13	
House	54	38	(House amended)
Senate			(Senate refused to concur/ asked House for conference)

Conference Committee

House	56	41
Senate	27	21

**Effective:** July 28, 2019