

E2SSB 5377 - H AMD 664

By Representative Cody

ADOPTED 04/08/2021

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) Subject to the availability of amounts appropriated for this
6 specific purpose, a premium assistance and cost-sharing reduction
7 program is hereby established to be administered by the exchange.

8 (2) Premium assistance and cost-sharing reduction amounts must be
9 established by the exchange within parameters established in the
10 omnibus appropriations act.

11 (3) The exchange must establish, consistent with the omnibus
12 appropriations act:

13 (a) Procedural requirements for eligibility and continued
14 participation in any premium assistance program or cost-sharing
15 program established under this section, including participant
16 documentation requirements that are necessary to administer the
17 program; and

18 (b) Procedural requirements for facilitating payments to
19 carriers.

20 (4) Subject to the availability of amounts appropriated for this
21 specific purpose, an individual is eligible for premium assistance
22 and cost-sharing reductions under this section if the individual:

23 (a) (i) Is a resident of the state;

24 (ii) Has income that is up to an income threshold determined
25 through appropriation or by the exchange if no income threshold is
26 determined through appropriation;

27 (iii) Is enrolled in a silver or gold standard plan offered in
28 the enrollee's county of residence;

29 (iv) Applies for and accepts all federal advance premium tax
30 credits for which they may be eligible before receiving any state
31 premium assistance;

1 (v) Applies for and accepts all federal cost-sharing reductions
2 for which they may be eligible before receiving any state cost-
3 sharing reductions;

4 (vi) Is ineligible for minimum essential coverage through
5 medicare, a federal or state medical assistance program administered
6 by the authority under chapter 74.09 RCW, or for premium assistance
7 under RCW 43.71A.020; and

8 (vii) Meets any other eligibility criteria established by the
9 exchange; or

10 (b) Meets alternate eligibility criteria as established in the
11 omnibus appropriations act.

12 (5) (a) The exchange may disqualify an individual from receiving
13 premium assistance or cost-sharing reductions under this section if
14 the individual:

15 (i) No longer meets the eligibility criteria in subsection (4) of
16 this section;

17 (ii) Fails, without good cause, to comply with any procedural or
18 documentation requirements established by the exchange in accordance
19 with subsection (3) of this section;

20 (iii) Fails, without good cause, to notify the exchange of a
21 change of address in a timely manner;

22 (iv) Voluntarily withdraws from the program; or

23 (v) Performs an act, practice, or omission that constitutes
24 fraud, and, as a result, an issuer rescinds the individual's policy
25 for the qualified health plan.

26 (b) The exchange must develop a process for an individual to
27 appeal a premium assistance or cost-sharing assistance eligibility
28 determination from the exchange.

29 (6) Prior to establishing or altering premium assistance or cost-
30 sharing reduction amounts, eligibility criteria, or procedural
31 requirements under this section, the exchange must:

32 (a) Publish notice of the proposal on the exchange's website and
33 provide electronic notice of the proposal to any person who has
34 requested such notice. The notice must include an explanation of the
35 proposal, the date, time, and location of the public hearing required
36 in (b) of this subsection, and instructions and reasonable timelines
37 to submit written comments on the proposal;

38 (b) Conduct at least one public hearing no sooner than 20 days
39 after publishing the notice required in (a) of this subsection; and

1 (c) Publish notice of the finalized premium assistance or cost-
2 sharing reduction amounts, eligibility criteria, or procedural
3 requirements on the exchange's website and provide the notice
4 electronically to any person who has requested it. The notice must
5 include a detailed description of the finalized premium assistance or
6 cost-sharing reduction amounts, eligibility criteria, or procedural
7 requirements and a description and explanation of how they vary from
8 the initial proposal.

9 (7) The definitions in this subsection apply throughout this
10 section unless the context clearly requires otherwise.

11 (a) "Advance premium tax credit" means the premium assistance
12 amount determined in accordance with the federal patient protection
13 and affordable care act, P.L. 111-148, as amended by the federal
14 health care and education reconciliation act of 2010, P.L. 111-152,
15 or federal regulations or guidance issued under the affordable care
16 act.

17 (b) "Income" means the modified adjusted gross income attributed
18 to an individual for purposes of determining his or her eligibility
19 for advance premium tax credits.

20 (c) "Standard plan" means a standardized health plan under RCW
21 43.71.095.

22 NEW SECTION. **Sec. 2.** A new section is added to chapter 43.71
23 RCW to read as follows:

24 (1) The exchange, in close consultation with the authority and
25 the office of the insurance commissioner, must explore all
26 opportunities to apply to the secretary of health and human services
27 under 42 U.S.C. Sec. 18052 for a waiver or other available federal
28 flexibilities to:

29 (a) Receive federal funds for the implementation of the premium
30 assistance or cost-sharing reduction programs established under
31 section 1 of this act;

32 (b) Increase access to qualified health plans; and

33 (c) Implement or expand other exchange programs that increase
34 affordability of or access to health insurance coverage in Washington
35 state.

36 (2) If, through the process described in subsection (1) of this
37 section an opportunity to submit a waiver is identified, the
38 exchange, in collaboration with the office of the insurance
39 commissioner and the health care authority, may develop an

1 application under this section to be submitted by the health care
2 authority. If an application is submitted, the health care authority
3 must notify the chairs and ranking minority members of the
4 appropriate policy and fiscal committees of the legislature.

5 (3) Any application submitted under this section must meet all
6 federal public notice and comment requirements under 42 U.S.C. Sec.
7 18052(a)(4)(B), including public hearings to ensure a meaningful
8 level of public input.

9 NEW SECTION. **Sec. 3.** A new section is added to chapter 43.71
10 RCW to read as follows:

11 (1) The state health care affordability account is created in the
12 state treasury. Expenditures from the account may only be used for
13 premium and cost-sharing assistance programs established in section 1
14 of this act.

15 (2) The following funds must be deposited in the account:

16 (a) Any grants, donations, or contributions of money collected
17 for purposes of the premium assistance or cost-sharing reduction
18 programs established in section 4 of this act;

19 (b) Any federal funds received by the health benefit exchange
20 pursuant to section 2 of this act; and

21 (c) Any additional funding specifically appropriated to the
22 account.

23 NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43
24 RCW to read as follows:

25 For qualified health plans offered on the exchange, a carrier
26 shall:

27 (1) Accept payments for enrollee premiums or cost-sharing
28 assistance under section 1 of this act or as part of a sponsorship
29 program under RCW 43.71.030(4). Nothing in this subsection expands or
30 restricts the types of sponsorship programs authorized under state
31 and federal law;

32 (2) Clearly communicate premium assistance amounts to enrollees
33 as part of the invoicing and payment process; and

34 (3) Accept and process enrollment and payment data transferred by
35 the exchange in a timely manner.

36 NEW SECTION. **Sec. 5.** A new section is added to chapter 41.05
37 RCW to read as follows:

1 (1) If a public option plan is not available in each county in
2 the state during plan year 2022 or later, the following requirements
3 apply for all subsequent plan years:

4 (a) At the request of a public option plan, a hospital licensed
5 under chapter 70.41 RCW that receives payment for services provided
6 to enrollees in the public employees' benefits program or school
7 employees' benefits program, or through a medical assistance program
8 under chapter 74.09 RCW, must contract with the public option plan to
9 provide in-network services to enrollees of that plan; and

10 (b) The authority shall contract, under RCW 41.05.410, with one
11 or more health carriers to offer at least one standardized bronze,
12 one standardized silver, and one standardized gold qualified health
13 plan in every county in the state or in each county within a region
14 of the state.

15 (2) Health carriers and hospitals may not condition negotiations
16 or participation of a hospital licensed under chapter 70.41 RCW in
17 any health plan offered by the health carrier on the hospital's
18 negotiations or participation in a public option plan.

19 (3) By December 1st of the plan year during which enrollment in
20 public option plans statewide is greater than 10,000 covered lives:

21 (a) The health benefit exchange, in consultation with the
22 insurance commissioner and the authority, shall analyze public option
23 plan rates paid to hospitals for in-network services and whether they
24 have impacted hospital financial sustainability. The analysis must
25 include any impact on hospitals' operating margins during the years
26 public option health plans have been offered in the state and the
27 estimated impact on operating margins in future years if enrollment
28 in public option plans increases. It must also examine the income
29 levels of public option plan enrollees over time. The analysis may
30 examine a sample of hospitals of various sizes and located in various
31 counties. In conducting its analysis, the exchange must give
32 substantial weight to any available reporting of health care provider
33 and health system costs under RCW 70.390.050;

34 (b) The health care cost transparency board established under
35 chapter 70.390 RCW shall analyze the effect that enrollment in public
36 option plans has had on consumers, including an analysis of the
37 benefits provided to, and premiums and cost-sharing amounts paid by,
38 consumers enrolled in public option plans compared to other
39 standardized and nonstandardized qualified health plans; and

1 (c) The health benefit exchange, in consultation with the
2 insurance commissioner, the authority, and interested stakeholders,
3 including, but not limited to, statewide associations representing
4 hospitals, health insurers, and physicians, shall review the analyses
5 completed under (a) and (b) of this subsection and develop
6 recommendations to the legislature to address financial or other
7 issues identified in the analyses.

8 (4) The authority may adopt program rules, in consultation with
9 the office of the insurance commissioner, to ensure compliance with
10 this section, including levying fines and taking other contract
11 actions it deems necessary to enforce compliance with this section.

12 (5) For the purposes of this section, "public option plan" means
13 a qualified health plan contracted by the authority under RCW
14 41.05.410.

15 **Sec. 6.** RCW 41.05.410 and 2019 c 364 s 3 are each amended to
16 read as follows:

17 (1) The authority, in consultation with the health benefit
18 exchange, must contract with one or more health carriers to offer
19 qualified health plans on the Washington health benefit exchange for
20 plan years beginning in 2021. A health carrier contracting with the
21 authority under this section must offer at least one bronze, one
22 silver, and one gold qualified health plan in a single county or in
23 multiple counties. The goal of the procurement conducted under this
24 section is to have a choice of qualified health plans under this
25 section offered in every county in the state. The authority may not
26 execute a contract with an apparently successful bidder under this
27 section until after the insurance commissioner has given final
28 approval of the health carrier's rates and forms pertaining to the
29 health plan to be offered under this section and certification of the
30 health plan under RCW 43.71.065.

31 (2) A qualified health plan offered under this section must meet
32 the following criteria:

33 (a) The qualified health plan must be a standardized health plan
34 established under RCW 43.71.095;

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

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

4 (d) The qualified health plan may use an integrated delivery
5 system or a managed care model that includes care coordination or
6 care management to enrollees as appropriate;

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

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

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

19 (ii) Meet national accreditation standards;

20 (g) ~~((+))~~ The total amount the qualified health plan reimburses
21 providers and facilities for all covered benefits in the statewide
22 aggregate, excluding pharmacy benefits, may not exceed one hundred
23 sixty percent of the total amount medicare would have reimbursed
24 providers and facilities for the same or similar services in the
25 statewide aggregate;

26 ~~((+ii) Beginning in calendar year 2023, if the authority
27 determines that selective contracting will result in actuarially
28 sound premium rates that are no greater than the qualified health
29 plan's previous plan year rates adjusted for inflation using the
30 consumer price index, the director may, in consultation with the
31 health benefit exchange, waive (g)(i) of this subsection as a
32 requirement of the contracting process under this section;))~~

33 (h) For services provided by rural hospitals certified by the
34 centers for medicare and medicaid services as critical access
35 hospitals or sole community hospitals, the rates may not be less than
36 one hundred one percent of allowable costs as defined by the United
37 States centers for medicare and medicaid services for purposes of
38 medicare cost reporting;

39 (i) Reimbursement for primary care services, as defined by the
40 authority, provided by a physician with a primary specialty

1 designation of family medicine, general internal medicine, or
2 pediatric medicine, may not be less than one hundred thirty-five
3 percent of the amount that would have been reimbursed under the
4 medicare program for the same or similar services; and

5 (j) The qualified health plan must comply with any requirements
6 established by the authority to address amounts expended on pharmacy
7 benefits including, but not limited to, increasing generic
8 utilization and use of evidence-based formularies.

9 (3)(a) At the request of the authority for monitoring,
10 enforcement, or program and quality improvement activities, a
11 qualified health plan offered under this section must provide cost
12 and quality of care information and data to the authority, and may
13 not enter into an agreement with a provider or third party that would
14 restrict the qualified health plan from providing this information or
15 data.

16 (b) Pursuant to RCW 42.56.650, any cost or quality information or
17 data submitted to the authority is exempt from public disclosure.

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

21 **Sec. 7.** RCW 43.71.095 and 2019 c 364 s 1 are each amended to
22 read as follows:

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

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

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

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

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

1 exchange may make modifications to the standardized plans after
2 January 31st to comply with changes to state or federal law or
3 regulations.

4 (2)(a) Beginning January 1, 2021, any health carrier offering a
5 qualified health plan on the exchange must offer ~~((one))~~ the silver
6 ~~((standardized health plan))~~ and ~~((one))~~ gold standardized health
7 plans established under this section on the exchange in each county
8 where the carrier offers a qualified health plan. If a health carrier
9 offers a bronze health plan on the exchange, it must offer ~~((one))~~
10 the bronze standardized health plans established under this section
11 on the exchange in each county where the carrier offers a qualified
12 health plan.

13 (b)(i) ~~((A))~~ Until December 31, 2022, a health ~~((plan))~~ carrier
14 offering a standardized health plan under this section may also offer
15 nonstandardized health plans on the exchange. Beginning January 1,
16 2023, a health carrier offering a standardized health plan under this
17 section may also offer up to two nonstandardized gold health plans,
18 two nonstandardized bronze health plans, one nonstandardized silver
19 health plan, one nonstandardized platinum health plan, and one
20 nonstandardized catastrophic health plan in each county where the
21 carrier offers a qualified health plan.

22 (ii) The exchange, in consultation with the office of the
23 insurance commissioner, shall analyze the impact to exchange
24 consumers of offering only standard plans beginning in 2025 and
25 submit a report to the appropriate committees of the legislature by
26 December 1, 2023. The report must include an analysis of how plan
27 choice and affordability will be impacted for exchange consumers
28 across the state, including an analysis of offering a bronze
29 standardized high deductible health plan compatible with a health
30 savings account, and a gold standardized health plan closer in
31 actuarial value to the silver standardized health plan.

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

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

EFFECT: (1) Requires the program to be administered by the Exchange, instead of being established by the Exchange.

(2) Requires the amounts of premium assistance and cost-sharing reductions to be established by the Exchange within the parameters established in the Operating Budget.

(3) Requires procedural requirements for the program to be consistent with the Operating Budget.

(4) Allows the income eligibility threshold to be established through appropriation or by the Exchange if no income threshold is determined by appropriation (instead of being set at 500 percent of the federal poverty level or a lower level established by appropriation).

(5) Clarifies that the appeals process established by the Exchange applies to all individuals, not only eligible individuals.

(6) Requires the Exchange, prior to establishing or altering premium assistance or cost-sharing reduction amounts, eligibility criteria, or procedural requirements, to provide public notice of the proposal, conduct at least one public hearing, accept written comments, and provide public notice of the finalized amount, criteria, or requirements.

(7) Requires any federal waiver application to be developed by the Exchange and submitted by the Health Care Authority, instead of being developed and submitted by the Exchange.

(8) Clarifies that the requirement for carriers to accept payments from sponsorship programs does not expand or restrict the types of sponsorship programs authorized under state or federal law.

(9) Removes the requirement that hospital systems with four or more hospitals contract with at least two public option plans in counties where they operate hospitals.

(10) Imposes, if a public option plan is not available in each county of the state during plan year 2022 or later, the following requirements for all subsequent plan years: (a) at the request of a public option plan, a hospital receiving payments from Medicaid or PEBB/SEBB must contract with the public option plan to be an in-network provider and (b) the health care authority must contract with one or more health carriers to offer standardized health plans in every county of the state or in each county within a region of the state.

(11) Requires, once public option enrollment reaches or exceeds 10,000 covered lives, the Exchange to analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability. Requires the analysis to include any impact on hospitals' operating margins and the estimated margins in future years if enrollment increases. Requires the analysis to examine the income levels of public option plan enrollees over time. Allows the analysis to examine a sample of hospitals of various sizes and locations. Requires the Exchange to give substantial weight to any available reporting of health care provider and health care system costs by the Health Care Cost Transparency Board.

(12) Requires, once public option enrollment reaches or exceeds 10,000 covered lives, the Health Care Cost Transparency Board to analyze the effect that enrollment in public option plans has had on consumers, including an analysis of the benefits provided to, and premium and cost-sharing amounts paid by, consumers enrolled in

public option plans compared to other standardized and nonstandardized qualified health plans.

(13) Requires the Exchange, in consultation with the Insurance Commissioner, the Health Care Authority, and interested stakeholders to review the analyses completed by the Exchange and the Health Care Cost Transparency Board and develop recommendations to the Legislature to address financial or other issues identified in the analyses.

(14) Makes a technical change to clarify that the ability of health carriers to offer nonstandardized plans on the Exchange is not affected prior to January 1, 2023.

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