

E2SSB 5377 - H COMM AMD

By Committee on Health Care & Wellness

NOT 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 program is hereby established
7 to be administered by the exchange.

8 (2) Assistance amounts must be established through the omnibus
9 appropriations act.

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

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

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

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

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

23 (ii) Has income that is up to 500 percent of the federal poverty
24 level, or a lower income threshold determined through appropriation;

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

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

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; or

8 (b) Meets alternate eligibility criteria as established in the
9 omnibus appropriations act.

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

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

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

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

20 (iv) Voluntarily withdraws from the program; or

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

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

27 (6) The definitions in this subsection apply throughout this
28 section unless the context clearly requires otherwise.

29 (a) "Advance premium tax credit" means the premium assistance
30 amount determined in accordance with the federal patient protection
31 and affordable care act, P.L. 111-148, as amended by the federal
32 health care and education reconciliation act of 2010, P.L. 111-152,
33 or federal regulations or guidance issued under the affordable care
34 act.

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

38 (c) "Standard plan" means a standardized health plan under RCW
39 43.71.095.

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

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

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

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

12 (c) Implement or expand other exchange programs that increase
13 affordability of or access to health insurance coverage in Washington
14 state.

15 (2) If, through the process described in subsection (1) of this
16 section an opportunity to submit a waiver is identified, the
17 exchange, in collaboration with the office of the insurance
18 commissioner and the health care authority, may develop an
19 application under this section to be submitted by the health care
20 authority. If an application is submitted, the health care authority
21 must notify the chairs and ranking minority members of the
22 appropriate policy and fiscal committees of the legislature.

23 (3) Any application submitted under this section must meet all
24 federal public notice and comment requirements under 42 U.S.C. Sec.
25 18052(a)(4)(B), including public hearings to ensure a meaningful
26 level of public input.

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

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

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

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

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

1 (c) Any additional funding specifically appropriated to the
2 account.

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

5 For qualified health plans offered on the exchange, a carrier
6 shall:

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

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

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

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

18 (1)(a) For plan years 2022 and later, except as provided in (b)
19 of this subsection, a hospital system that owns or operates at least
20 four hospitals licensed under chapter 70.41 RCW must contract with at
21 least two public option plans of the hospital system's choosing in
22 each county in which the hospital system has at least one hospital
23 licensed under chapter 70.41 RCW to provide in-network services to
24 the enrollees of that plan.

25 (b) A hospital is not required to contract with two public option
26 plans in a county pursuant to (a) of this subsection unless it
27 receives an offer from at least two health carriers to provide in-
28 network services as part of a public option plan in that county for
29 the following plan year. If a hospital receives only one offer from a
30 health carrier to participate in a public option plan in a county, it
31 is only required to contract with one public option plan in that
32 county.

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

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

1 (a) The health benefit exchange, in consultation with the
2 insurance commissioner and the authority, shall analyze public option
3 plan rates paid to hospitals for in-network services and whether they
4 have impacted hospital financial sustainability. The analysis must
5 include any impact on hospitals' operating margins during the years
6 public option health plans have been offered in the state and the
7 estimated impact on operating margins in future years if enrollment
8 in public option plans increases. The analysis may examine a sample
9 of hospitals of various sizes and located in various counties. In
10 conducting its analysis, the exchange must give substantial weight to
11 any available reporting of health care provider and health system
12 costs under RCW 70.390.050; and

13 (b) The health care cost transparency board established under
14 chapter 70.390 RCW shall analyze the effect that enrollment in public
15 option plans has had on consumers, including an analysis of the
16 benefits provided to, and premiums and cost-sharing amounts paid by,
17 consumers enrolled in public option plans compared to other
18 standardized and nonstandardized qualified health plans.

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

23 (5) For the purposes of this section, "public option plan" means
24 a qualified health plan contracted by the authority under RCW
25 41.05.410.

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

28 (1) The authority, in consultation with the health benefit
29 exchange, must contract with one or more health carriers to offer
30 qualified health plans on the Washington health benefit exchange for
31 plan years beginning in 2021. A health carrier contracting with the
32 authority under this section must offer at least one bronze, one
33 silver, and one gold qualified health plan in a single county or in
34 multiple counties. The goal of the procurement conducted under this
35 section is to have a choice of qualified health plans under this
36 section offered in every county in the state. The authority may not
37 execute a contract with an apparently successful bidder under this
38 section until after the insurance commissioner has given final
39 approval of the health carrier's rates and forms pertaining to the

1 health plan to be offered under this section and certification of the
2 health plan under RCW 43.71.065.

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

5 (a) The qualified health plan must be a standardized health plan
6 established under RCW 43.71.095;

7 (b) The qualified health plan must meet all requirements for
8 qualified health plan certification under RCW 43.71.065 including,
9 but not limited to, requirements relating to rate review and network
10 adequacy;

11 (c) The qualified health plan must incorporate recommendations of
12 the Robert Bree collaborative and the health technology assessment
13 program;

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

17 (e) The qualified health plan must meet additional participation
18 requirements to reduce barriers to maintaining and improving health
19 and align to state agency value-based purchasing. These requirements
20 may include, but are not limited to, standards for population health
21 management; high-value, proven care; health equity; primary care;
22 care coordination and chronic disease management; wellness and
23 prevention; prevention of wasteful and harmful care; and patient
24 engagement;

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

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

29 (ii) Meet national accreditation standards;

30 (g) ~~((+))~~ The total amount the qualified health plan reimburses
31 providers and facilities for all covered benefits in the statewide
32 aggregate, excluding pharmacy benefits, may not exceed one hundred
33 sixty percent of the total amount medicare would have reimbursed
34 providers and facilities for the same or similar services in the
35 statewide aggregate;

36 ~~((+))~~ Beginning in calendar year 2023, if the authority
37 determines that selective contracting will result in actuarially
38 sound premium rates that are no greater than the qualified health
39 plan's previous plan year rates adjusted for inflation using the
40 consumer price index, the director may, in consultation with the

1 ~~health benefit exchange, waive (g)(i) of this subsection as a~~
2 ~~requirement of the contracting process under this section;)~~

3 (h) For services provided by rural hospitals certified by the
4 centers for medicare and medicaid services as critical access
5 hospitals or sole community hospitals, the rates may not be less than
6 one hundred one percent of allowable costs as defined by the United
7 States centers for medicare and medicaid services for purposes of
8 medicare cost reporting;

9 (i) Reimbursement for primary care services, as defined by the
10 authority, provided by a physician with a primary specialty
11 designation of family medicine, general internal medicine, or
12 pediatric medicine, may not be less than one hundred thirty-five
13 percent of the amount that would have been reimbursed under the
14 medicare program for the same or similar services; and

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

19 (3)(a) At the request of the authority for monitoring,
20 enforcement, or program and quality improvement activities, a
21 qualified health plan offered under this section must provide cost
22 and quality of care information and data to the authority, and may
23 not enter into an agreement with a provider or third party that would
24 restrict the qualified health plan from providing this information or
25 data.

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

28 (4) Nothing in this section prohibits a health carrier offering
29 qualified health plans under this section from offering other health
30 plans in the individual market.

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

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

37 (a) The standardized health plans must be designed to reduce
38 deductibles, make more services available before the deductible,
39 provide predictable cost sharing, maximize subsidies, limit adverse

1 premium impacts, reduce barriers to maintaining and improving health,
2 and encourage choice based on value, while limiting increases in
3 health plan premium rates.

4 (b) The exchange may update the standardized health plans
5 annually.

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

8 (d) The exchange must provide written notice of the standardized
9 health plans to licensed health carriers by January 31st before the
10 year in which the health plans are to be offered on the exchange. The
11 exchange may make modifications to the standardized plans after
12 January 31st to comply with changes to state or federal law or
13 regulations.

14 (2)(a) Beginning January 1, 2021, any health carrier offering a
15 qualified health plan on the exchange must offer ~~((one))~~ the silver
16 ~~((standardized health plan))~~ and ~~((one))~~ gold standardized health
17 plans established under this section on the exchange in each county
18 where the carrier offers a qualified health plan. If a health carrier
19 offers a bronze health plan on the exchange, it must offer ~~((one))~~
20 the bronze standardized health plans established under this section
21 on the exchange in each county where the carrier offers a qualified
22 health plan.

23 (b)(i) ~~((A))~~ Until December 31, 2022, a health ~~((plan))~~ carrier
24 offering a standardized health plan under this section may also offer
25 nonstandardized health plans on the exchange. Beginning January 1,
26 2023, a health carrier offering a standardized health plan under this
27 section may also offer up to two nonstandardized gold health plans,
28 two nonstandardized bronze health plans, one nonstandardized silver
29 health plan, one nonstandardized platinum health plan, and one
30 nonstandardized catastrophic health plan in each county where the
31 carrier offers a qualified health plan.

32 (ii) The exchange, in consultation with the office of the
33 insurance commissioner, shall analyze the impact to exchange
34 consumers of offering only standard plans beginning in 2025 and
35 submit a report to the appropriate committees of the legislature by
36 December 1, 2023. The report must include an analysis of how plan
37 choice and affordability will be impacted for exchange consumers
38 across the state, including an analysis of offering a bronze
39 standardized high deductible health plan compatible with a health

1 savings account, and a gold standardized health plan closer in
2 actuarial value to the silver standardized health plan.

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

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

11 Correct the title.

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

(2) Requires the amount of premium assistance to be established in the Operating Budget, instead of by the Exchange.

(3) Removes cost-sharing assistance from the program.

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

(5) Removes the authority for the Exchange to establish additional program eligibility requirements.

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

(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 certain hospitals contract with public option plans within a geographic rating area, and instead requires them to contract with public option plans in the county the hospital operates.

(10) 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. 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.

(11) 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.

(12) 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.

--- **END** ---