CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE SENATE BILL 5526

66th Legislature
2019 Regular Session

Passed by the Senate April 27, 2019
Yeas 27 Nays 21

President of the Senate

Passed by the House April 27, 2019
Yeas 56 Nays 41

Speaker of the House of Representatives

Approved

Governor of the State of Washington

CERTIFICATE

I, Brad Hendrickson, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 5526** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

Secretary of State
State of Washington

ENGROSSED SUBSTITUTE SENATE BILL 5526

AS AMENDED BY THE CONFERENCE COMMITTEE

Passed Legislature - 2019 Regular Session

State of Washington 66th Legislature 2019 Regular Session

By Senate 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)

READ FIRST TIME 02/21/19.

AN ACT Relating to increasing the availability of quality, affordable health coverage in the individual market; adding a new section to chapter 43.71 RCW; adding a new section to chapter 42.56 RCW; adding new sections to chapter 41.05 RCW; adding new sections to chapter 48.43 RCW; adding a new section to chapter 82.04 RCW; creating new sections; and providing expiration dates.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

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

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

(a) The standardized health 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.

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

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

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

(2)(a) Beginning January 1, 2021, any health carrier offering a qualified health plan on the exchange must offer one silver standardized health plan and one gold standardized health plan on the exchange. If a health carrier offers a bronze health plan on the exchange, it must offer one bronze standardized health plan on the exchange.

(b)(i) A health plan offering a standardized health plan under this section may also offer nonstandardized health plans on the exchange.

(ii) The exchange, in consultation with the office of the insurance commissioner, shall analyze the impact to exchange consumers of offering only standard plans beginning in 2025 and submit a report to the appropriate committees of the legislature by December 1, 2023. The report must include an analysis of how plan choice and affordability will be impacted for exchange consumers across the state.

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

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

NEW SECTION. **Sec. 2.** A new section is added to chapter 42.56 RCW to read as follows:

(1) Any data submitted by health carriers to the health benefit exchange for purposes of establishing standardized health plans under section 1 of this act are exempt from disclosure under this chapter. This subsection applies to health carrier data in the custody of the

insurance commissioner for purposes of consulting with the health benefit exchange under section 1(1) of this act.

(2) Any data submitted by health carriers to the health care authority for purposes of section 3 of this act are exempt from disclosure under this chapter.

NEW SECTION. **Sec. 3.** A new section is added to chapter 41.05 RCW to read as follows:

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

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

(a) The qualified health plan must be a standardized health plan established under section 1 of this act;

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

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

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

(e) The qualified health plan must meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing. These requirements may include, but are not limited to, standards for population health

management; high-value, proven care; health equity; primary care; care coordination and chronic disease management; wellness and prevention; prevention of wasteful and harmful care; and patient engagement;

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

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

(ii) Meet national accreditation standards;

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

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

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

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

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

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

NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05 RCW to read as follows:

The director may, in his or her sole discretion, waive the requirements of section 3(2)(g)(i) of this act if he or she finds that:

(1) A health carrier offering a qualified health plan under section 3 of this act is unable to form a provider network that meets the network access standards adopted by the insurance commissioner due to the requirements of section 3(2)(g)(i) of this act; and

(2) The health carrier is able to achieve actuarially sound premiums that are ten percent lower than the previous plan year through other means.

NEW SECTION. **Sec. 5.** (1) The health care authority, in consultation with the insurance commissioner and the Washington health benefit exchange, must submit a report and recommendations to the legislature by December 1, 2022, regarding:

(a) The impact on qualified health plan choice, affordability, and market stability of linking offering a qualified health plan under section 3 of this act with participation in programs administered by the public employees' benefits board, the school employees' benefits board, or the health care authority;

(b) The impact on qualified health plan choice, qualified health plan provider networks, affordability, and market stability of linking provider participation in the provider networks of qualified health plans offered under section 3 of this act with provider participation in provider networks of programs administered by the public employees' benefits board, the school employees' benefits board, or the health care authority;

(c) Whether the utilization review processes employed by a health carrier offering a qualified health plan under section 3 of this act should align with clinical criteria published by the health care authority; and

(d) Other issues the health care authority deems relevant to the successful implementation of this act.

(2) This section expires January 1, 2023.

NEW SECTION. **Sec. 6.** (1) The Washington health benefit exchange, in consultation with the health care authority and the insurance commissioner, must develop a plan to implement and fund premium subsidies for individuals whose modified adjusted gross incomes are less than five hundred percent of the federal poverty level and who are purchasing individual market coverage on the exchange. The goal of the plan is to enable participating individuals to spend no more than ten percent of their modified adjusted gross incomes on premiums. The plan must also include an assessment of providing cost-sharing reductions to plan participants and must assess the impact of premium subsidies on the uninsured rate.

(2) The Washington health benefit exchange must submit the plan, along with proposed implementing legislation, to the appropriate committees of the legislature by November 15, 2020.

(3) This section expires January 1, 2021.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW to read as follows:

The commissioner shall submit an annual report to the appropriate committees of the legislature on the number of health plans available per county in the individual market.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43 RCW to read as follows:

A carrier may not require a provider or facility participating in a qualified health plan under section 3 of this act to, as a condition of participation in a qualified health plan under section 3 of this act, accept a reimbursement rate for other health plans offered by the carrier at the same rate as the provider or facility is reimbursed for a qualified health plan under section 3 of this act.

NEW SECTION. **Sec. 9.** A new section is added to chapter 82.04 RCW to read as follows:

This chapter does not apply to amounts received by a health care provider for services performed on patients covered by a qualified health plan offered under section 3 of this act, including reimbursement from the qualified health plan and any amounts collected from the patient as part of his or her cost-sharing obligation.

NEW SECTION. **Sec. 10.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2019, in the omnibus appropriations act, this act is null and void.

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