

---

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5377

---

State of Washington

67th Legislature

2021 Regular Session

By Senate Ways & Means (originally sponsored by Senators Frockt, Keiser, Conway, Das, Dhingra, Hunt, Kuderer, Lias, Lovelett, Wilson, C., Nguyen, Pedersen, Saldaña, and Salomon)

READ FIRST TIME 02/22/21.

1 AN ACT Relating to increasing affordability of standardized plans  
2 on the individual market; amending RCW 41.05.410 and 43.71.095;  
3 adding new sections to chapter 43.71 RCW; adding a new section to  
4 chapter 48.43 RCW; and adding a new section to chapter 41.05 RCW.

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

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

8 (1) Subject to the availability of amounts appropriated for this  
9 specific purpose, the exchange:

10 (a) Shall establish a premium assistance program and annually set  
11 the amount of premium assistance provided to eligible individuals;  
12 and

13 (b) May establish a cost-sharing reduction program to provide  
14 cost-sharing assistance to eligible individuals.

15 (2) The exchange must establish assistance amounts through a fair  
16 and transparent process and must provide notice and opportunity for  
17 public comment before finalizing each year's assistance amounts.

18 (3) The exchange must establish:

19 (a) Procedural requirements for eligibility and continued  
20 participation in any premium assistance program or cost-sharing  
21 program established under this section, including participant

1 documentation requirements that are necessary to administer the  
2 program; and

3 (b) Procedural requirements for facilitating payments to  
4 carriers.

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

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

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

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

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

16 (v) Applies for and accepts all federal cost-sharing reductions  
17 for which they may be eligible before receiving any state cost-  
18 sharing reductions;

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

23 (vii) Meets other eligibility criteria as established by the  
24 exchange; or

25 (b) Meets eligibility criteria as established in the omnibus  
26 appropriations act.

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

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

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

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

37 (iv) Voluntarily withdraws from the program; or

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

1 (b) The exchange must develop a process for an eligible  
2 individual to appeal a premium assistance or cost-sharing assistance  
3 eligibility determination from the exchange.

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

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

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

15 (c) "Standard plan" means a standardized health plan under RCW  
16 43.71.095.

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

19 (1) The exchange, on behalf of the state and in consultation with  
20 the authority and the office of the insurance commissioner, must  
21 explore all opportunities to apply to the secretary of health and  
22 human services under 42 U.S.C. Sec. 18052 for a waiver or other  
23 available federal flexibilities to:

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

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

28 (c) Implement or expand other exchange programs that increase  
29 affordability of or access to health insurance coverage in Washington  
30 state.

31 (2) If the exchange submits an application under this section,  
32 the board must notify the chairs and ranking minority members of the  
33 appropriate policy and fiscal committees of the legislature.

34 (3) If the exchange submits an application under this section,  
35 pursuant to 42 U.S.C. Sec. 18052(a)(4)(B), it must meet all federal  
36 public notice and comment requirements, including public hearings,  
37 sufficient to ensure a meaningful level of public input.

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

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

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

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

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

13        (c) Any additional funding specifically appropriated to the  
14   account.

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

17        For qualified health plans offered on the exchange, a carrier  
18   shall:

19        (1) Accept payments for enrollee premiums or cost-sharing  
20   assistance under section 1 of this act or as part of a sponsorship  
21   program under RCW 43.71.030(4);

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

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

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

28        (1)(a) For plan years 2022 and later, except as provided in (b)  
29   of this subsection, a hospital system that owns or operates at least  
30   four hospitals licensed under chapter 70.41 RCW must contract with at  
31   least two public option plans of the hospital system's choosing in  
32   each county in a geographic rating area in which the hospital system  
33   has at least one hospital licensed under chapter 70.41 RCW to provide  
34   in-network services to the enrollees of that plan.

35        (b) A hospital is not required to contract with two public option  
36   plans in a county pursuant to (a) of this subsection unless it  
37   receives an offer from at least two health carriers to provide in-  
38   network services as part of a public option plan in that county for

1 the following plan year. If a hospital receives only one offer from a  
2 health carrier to participate in a public option plan in a county, it  
3 is only required to contract with one public option plan in that  
4 county.

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

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

13 (4) For the purposes of this section, "public option plan" means  
14 a qualified health plan contracted by the authority under RCW  
15 41.05.410.

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

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

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

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

36 (b) The qualified health plan must meet all requirements for  
37 qualified health plan certification under RCW 43.71.065 including,  
38 but not limited to, requirements relating to rate review and network  
39 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))~~ Beginning January 1, 2023, a health ~~((plan))~~ carrier  
14 offering a standardized health plan under this section may also offer  
15 ~~((nonstandardized health plans on the exchange))~~ up to two  
16 nonstandardized gold and bronze health plans, one nonstandardized  
17 silver health plan, one nonstandardized platinum health plan, and one  
18 nonstandardized catastrophic health plan in each county where the  
19 carrier offers a qualified health plan.

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

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

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

--- END ---