S-0637.1

# SENATE BILL 5377

**State of Washington 67th Legislature 2021 Regular Session**

**By** Senators Frockt, Keiser, Conway, Das, Dhingra, Hunt, Kuderer, Liias, Lovelett, Wilson, C., Nguyen, Pedersen, Saldaña, and Salomon

Read first time 01/28/21. Referred to Committee on Health & Long Term Care.

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

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) Subject to the availability of amounts appropriated for this specific purpose, the exchange:

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

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

(2) The exchange must establish:

(a) Procedural requirements for eligibility and continued participation in the premium assistance program, including participant documentation requirements that are necessary to administer the program; and

(b) Procedural requirements for facilitating payments to carriers.

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

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

(ii) Has income that is up to 500 percent of the federal poverty level;

(iii) Is enrolled in the lowest cost bronze, silver, or gold standard plan offered in the enrollee's county of residence;

(iv) Applies for and accepts all advance premium tax credits for which they may be eligible;

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

(vi) Meets other eligibility criteria as established by the exchange; or

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

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

(i) No longer meets the eligibility criteria in subsection (3) of this section;

(ii) Fails, without good cause, to comply with any procedural or documentation requirements established by the exchange in accordance with subsection (2) of this section;

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

(iv) Voluntarily withdraws from the program; or

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

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

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

(a) "Advance premium tax credit" means the premium assistance amount determined in accordance with the federal patient protection and affordable care act, P.L. 111-148, as amended by the federal

health care and education reconciliation act of 2010, P.L. 111-152, or federal regulations or guidance issued under the affordable care act.

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

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

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

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

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

(b) Increase access to qualified health plans; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) For plan years 2022 and later, at the request of a public option plan, an ambulatory surgical facility or a hospital that receives payment for services provided to enrollees in the public employees' benefits program, school employees' benefits program, or through a medical assistance program under chapter 74.09 RCW, must contract with the public option plan to provide in-network services to enrollees of that plan.

(2) A hospital reimbursement rate formula is established for inpatient and outpatient hospital services provided to enrollees of a public option plan on or after January 1, 2023.

(3)(a) The hospital reimbursement rate formula must be based on a percentage of the medicare reimbursement rates. The base reimbursement rate for hospitals may not exceed 135 percent of the amount medicare would have reimbursed the hospital.

(b) The reimbursement rate for a hospital shall be adjusted as follows:

(i) A hospital with a percentage of medicaid patients that exceeds the statewide average must receive up to a five point increase in its base reimbursement rate, with the actual increase to be determined based on the hospital's percentage share of medicaid patients.

(ii) A hospital that is efficient in managing the underlying cost of care, factoring the hospital's total margins, operating costs, and

net patient revenue, must receive up to a five point increase in its base reimbursement rate.

(4) By December 1, 2022, the authority, in collaboration with the health benefit exchange, shall establish in rule the hospital reimbursement rate formula and corresponding carrier reimbursement rates to hospitals for inpatient and outpatient hospital services provided to enrollees of a public option plan.

(5)(a) The authority may adopt program rules to ensure compliance with this section and may take one or more of the following actions against an ambulatory surgical facility or hospital that fails to comply with this section:

(i) Levy fines;

(ii) Take contract actions;

(iii) Refuse to contract with an ambulatory surgical facility or hospital; or

(iv) Prohibit a health carrier contracted with the public employees' benefits program or school employees' benefits program from contracting with an ambulatory surgical facility or hospital.

(b) The authority shall publish a list of all enforcement actions taken under this subsection.

(c) If the authority levies any fine under this section, it must provide notice and opportunity to participate in an adjudicative proceeding in accordance with chapter 34.05 RCW.

(6) By December 15, 2024, the authority, in consultation with the health care cost transparency board and the health benefit exchange, must submit a report to the legislature with recommendations on any adjustments to the base reimbursement rate or other factors to be considered in the hospital reimbursement rate formula.

(7) For purposes of this section:

(a) "Adjusted discharge" means the number of hospital discharges multiplied by the ratio of total gross revenue to inpatient gross revenue and multiplied by the case-mix index and the wage index.

(b) "Ambulatory surgical facility" means an ambulatory surgical facility licensed under chapter 70.230 RCW.

(c) "Hospital" means hospitals licensed and regulated under chapter 70.41 RCW.

(d) "Public option plan" means a qualified health plan contracted by the authority under RCW 41.05.410.

**Sec. 6.** RCW 41.05.410 and 2019 c 364 s 3 are each amended 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 RCW 43.71.095;

(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) Beginning in calendar year 2023, for services provided by hospitals, rates shall be defined pursuant to the formula in section 4 of this act. 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)(a) At the request of the authority or the health benefit exchange for monitoring, enforcement, or program and quality improvement activities, a qualified health plan offered under this section must provide cost and quality of care information and data to the authority and the exchange, and may not enter into an agreement

with a provider or third party that would restrict the qualified health plan from providing this information or data.

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

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

**Sec. 7.** RCW 43.71.095 and 2019 c 364 s 1 are each amended 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~~)) the silver ((~~standardized health plan~~)) and ((~~one~~)) gold standardized health plans established under this section on the exchange. If a health carrier offers a bronze health plan on the exchange, it must offer ((~~one~~)) the bronze standardized health plans established under this section on the exchange.

(b)(i) ((~~A~~)) Beginning January 1, 2023, a health plan offering a standardized health plan under this section may also offer

((~~nonstandardized~~)) up to one nonstandardized bronze, silver, and gold health ((~~plans~~)) plan 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.

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