CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5377

67th Legislature
2021 Regular Session

Passed by the Senate April 19, 2021
Yeas 28 Nays 21

President of the Senate

Passed by the House April 8, 2021
Yeas 55 Nays 43

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 SECOND SUBSTITUTE SENATE BILL 5377** 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 SECOND SUBSTITUTE SENATE BILL 5377

AS AMENDED BY THE HOUSE

Passed Legislature - 2021 Regular Session

State of Washington 67th Legislature 2021 Regular Session

By Senate Ways & Means (originally sponsored by Senators Frockt, Keiser, Conway, Das, Dhingra, Hunt, Kuderer, Liias, 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, a premium assistance and cost-sharing reduction
10 program is hereby established to be administered by the exchange.
11 (2) Premium assistance and cost-sharing reduction amounts must be
12 established by the exchange within parameters established in the
13 omnibus appropriations act.
14 (3) The exchange must establish, consistent with the omnibus
15 appropriations act:
16 (a) Procedural requirements for eligibility and continued
17 participation in any premium assistance program or cost-sharing
18 program established under this section, including participant
19 documentation requirements that are necessary to administer the
20 program; and

1 (b) Procedural requirements for facilitating payments to
2 carriers.
3 (4) Subject to the availability of amounts appropriated for this
4 specific purpose, an individual is eligible for premium assistance
5 and cost-sharing reductions under this section if the individual:
6 (a)(i) Is a resident of the state;
7 (ii) Has income that is up to an income threshold determined
8 through appropriation or by the exchange if no income threshold is
9 determined through appropriation;
10 (iii) Is enrolled in a silver or gold standard plan offered in
11 the enrollee's county of residence;
12 (iv) Applies for and accepts all federal advance premium tax
13 credits for which they may be eligible before receiving any state
14 premium assistance;
15 (v) Applies for and accepts all federal cost-sharing reductions
16 for which they may be eligible before receiving any state cost-
17 sharing reductions;
18 (vi) Is ineligible for minimum essential coverage through
19 medicare, a federal or state medical assistance program administered
20 by the authority under chapter 74.09 RCW, or for premium assistance
21 under RCW 43.71A.020; and
22 (vii) Meets any other eligibility criteria established by the
23 exchange; or
24 (b) Meets alternate eligibility criteria as established in the
25 omnibus appropriations act.
26 (5)(a) The exchange may disqualify an individual from receiving
27 premium assistance or cost-sharing reductions under this section if
28 the individual:
29 (i) No longer meets the eligibility criteria in subsection (4) of
30 this section;
31 (ii) Fails, without good cause, to comply with any procedural or
32 documentation requirements established by the exchange in accordance
33 with subsection (3) of this section;
34 (iii) Fails, without good cause, to notify the exchange of a
35 change of address in a timely manner;
36 (iv) Voluntarily withdraws from the program; or
37 (v) Performs an act, practice, or omission that constitutes
38 fraud, and, as a result, an issuer rescinds the individual's policy
39 for the qualified health plan.

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

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

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

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

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

(7) 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 close consultation with the authority and the office of the insurance commissioner, must explore all

1 opportunities to apply to the secretary of health and human services
2 under 42 U.S.C. Sec. 18052 for a waiver or other available federal
3 flexibilities to:
4 (a) Receive federal funds for the implementation of the premium
5 assistance or cost-sharing reduction programs established under
6 section 1 of this act;
7 (b) Increase access to qualified health plans; and
8 (c) Implement or expand other exchange programs that increase
9 affordability of or access to health insurance coverage in Washington
10 state.
11 (2) If, through the process described in subsection (1) of this
12 section an opportunity to submit a waiver is identified, the
13 exchange, in collaboration with the office of the insurance
14 commissioner and the health care authority, may develop an
15 application under this section to be submitted by the health care
16 authority. If an application is submitted, the health care authority
17 must notify the chairs and ranking minority members of the
18 appropriate policy and fiscal committees of the legislature.
19 (3) Any application submitted under this section must meet all
20 federal public notice and comment requirements under 42 U.S.C. Sec.
21 18052(a)(4)(B), including public hearings to ensure a meaningful
22 level of public input.

23 NEW SECTION. **Sec. 3.** A new section is added to chapter 43.71
24 RCW to read as follows:
25 (1) The state health care affordability account is created in the
26 state treasury. Expenditures from the account may only be used for
27 premium and cost-sharing assistance programs established in section 1
28 of this act.
29 (2) The following funds must be deposited in the account:
30 (a) Any grants, donations, or contributions of money collected
31 for purposes of the premium assistance or cost-sharing reduction
32 programs established in section 4 of this act;
33 (b) Any federal funds received by the health benefit exchange
34 pursuant to section 2 of this act; and
35 (c) Any additional funding specifically appropriated to the
36 account.

37 NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43
38 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). Nothing in this subsection expands or restricts the types of sponsorship programs authorized under state and federal law;

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

(a) Upon an offer from a public option plan, a hospital licensed under chapter 70.41 RCW that receives payment for services provided to enrollees in the public employees' benefits program or school employees' benefits program, or through a medical assistance program under chapter 74.09 RCW, must contract with at least one public option plan to provide in-network services to enrollees of that plan. This subsection (1)(a) does not apply to a hospital owned and operated by a health maintenance organization licensed under chapter 48.46 RCW; and

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

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

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

(a) The health benefit exchange, in consultation with the insurance commissioner and the authority, shall analyze public option plan rates paid to hospitals for in-network services and whether they

have impacted hospital financial sustainability. The analysis must include any impact on hospitals' operating margins during the years public option health plans have been offered in the state and the estimated impact on operating margins in future years if enrollment in public option plans increases. It must also examine the income levels of public option plan enrollees over time. The analysis may examine a sample of hospitals of various sizes and located in various counties. In conducting its analysis, the exchange must give substantial weight to any available reporting of health care provider and health system costs under RCW 70.390.050;

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

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

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

(5) For the purposes of this section, "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

1 section is to have a choice of qualified health plans under this
2 section offered in every county in the state. The authority may not
3 execute a contract with an apparently successful bidder under this
4 section until after the insurance commissioner has given final
5 approval of the health carrier's rates and forms pertaining to the
6 health plan to be offered under this section and certification of the
7 health plan under RCW 43.71.065.

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

10 (a) The qualified health plan must be a standardized health plan
11 established under RCW 43.71.095;

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

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

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

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

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

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

34 (ii) Meet national accreditation standards;

35 (g)((~~(i)~~)) The total amount the qualified health plan reimburses
36 providers and facilities for all covered benefits in the statewide
37 aggregate, excluding pharmacy benefits, may not exceed one hundred
38 sixty percent of the total amount medicare would have reimbursed
39 providers and facilities for the same or similar services in the
40 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)(a) At the request of the authority 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 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 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

1 establish up to three standardized health plans for each of the
2 bronze, silver, and gold levels.
3 (a) The standardized health plans must be designed to reduce
4 deductibles, make more services available before the deductible,
5 provide predictable cost sharing, maximize subsidies, limit adverse
6 premium impacts, reduce barriers to maintaining and improving health,
7 and encourage choice based on value, while limiting increases in
8 health plan premium rates.
9 (b) The exchange may update the standardized health plans
10 annually.
11 (c) The exchange must provide a notice and public comment period
12 before finalizing each year's standardized health plans.
13 (d) The exchange must provide written notice of the standardized
14 health plans to licensed health carriers by January 31st before the
15 year in which the health plans are to be offered on the exchange. The
16 exchange may make modifications to the standardized plans after
17 January 31st to comply with changes to state or federal law or
18 regulations.
19 (2)(a) Beginning January 1, 2021, any health carrier offering a
20 qualified health plan on the exchange must offer ((~~one~~)) the silver
21 ((~~standardized health plan~~)) and ((~~one~~)) gold standardized health
22 plans established under this section on the exchange in each county
23 where the carrier offers a qualified health plan. If a health carrier
24 offers a bronze health plan on the exchange, it must offer ((~~one~~))
25 the bronze standardized health plans established under this section
26 on the exchange in each county where the carrier offers a qualified
27 health plan.
28 (b)(i) ((~~A~~)) Until December 31, 2022, a health ((~~plan~~)) carrier
29 offering a standardized health plan under this section may also offer
30 nonstandardized health plans on the exchange. Beginning January 1,
31 2023, a health carrier offering a standardized health plan under this
32 section may also offer up to two nonstandardized gold health plans,
33 two nonstandardized bronze health plans, one nonstandardized silver
34 health plan, one nonstandardized platinum health plan, and one
35 nonstandardized catastrophic health plan in each county where the
36 carrier offers a qualified health plan.
37 (ii) The exchange, in consultation with the office of the
38 insurance commissioner, shall analyze the impact to exchange
39 consumers of offering only standard plans beginning in 2025 and
40 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, including an analysis of offering a bronze standardized high deductible health plan compatible with a health savings account, and a gold standardized health plan closer in actuarial value to the silver standardized health plan.

(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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