1523-PS AMH HCW MORI 005

By Representative Schmick

PSHB 1523 - H COMM AMD (TO H-1731.1/19)
By Committee on Health Care & Wellness

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The commissioner shall establish up to three standardized health plans for each of the bronze, silver, and gold levels.

(2) 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.

(3) The silver standardized health plan must have an actuarial value between sixty-eight and seventy percent.

(4) The commissioner may update the standardized health plans annually.

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

(6) The commissioner 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.

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

(1) 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.

(2) A health carrier offering a standardized health plan under this section may also offer nonstandardized health plans on the exchange subject to the following:

(a) For plan years 2021 and 2022, a health carrier may offer an unlimited number of nonstandardized health plans on the exchange;

(b) For plan years beginning 2023, a health carrier may not offer more than three nonstandardized health plans in each of the bronze, silver, and gold levels on the exchange; and

(c) 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.

(3) 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. 3.** A new section is added to chapter 42.56 RCW to read as follows:

Any data submitted by health carriers to the insurance commissioner for purposes of establishing standardized benefit plans under section 1 of this act are confidential and exempt from disclosure under this chapter.

NEW SECTION. **Sec. 4.** (1) A legislative task force on health coverage in the individual market is established with members as provided in this subsection.

(a) The president of the senate shall appoint two members from each of the two largest caucuses of the senate.

(b) The speaker of the house of representatives shall appoint two members from each of the two largest caucuses of the house of representatives.

(c) The governor shall appoint three members representing the health care authority, the commissioner, and the health benefit exchange.

(d) The appointees must have appropriate knowledge and experience regarding health care coverage and financing, or other relevant experience.

(2) Members of the task force must be appointed by August 1, 2019.

(3) The task force shall prepare an analysis to determine the feasibility of a public health insurance plan option to increase competition and choice for health care consumers. The analysis must, at a minimum, include:

(a) An actuarial and economic analysis of a public health insurance plan;

(b) A plan to expand the participation of public health plans, including state-licensed county organized health systems and local plans;

(c) A state-developed public health insurance plan;

(d) A list of necessary federal waivers, if any, for a state-developed public insurance plan;

(e) A discussion of potential funding and state costs for a public health insurance plan; and

(f) An analysis of the extent to which a new public health insurance plan option could address the underlying factors that limit health plan choices in some regions.

(4) When preparing the analysis under subsection (3) of this section, the task force shall consult with key stakeholders, including, but not limited to, advocates, health care providers, and health plans, including county organized health systems and local health plans.

(5) The task force shall submit the feasibility study to the legislature and the governor by October 1, 2020.

(6) Staff support for the task force must be provided by the senate committee services and the house office of program research.

(7) Legislative members of the task force are reimbursed for travel expenses in accordance with RCW 44.04.120. Nonlegislative members are not entitled to be reimbursed for travel expenses if they are elected officials or are participating on behalf of an employer, governmental entity, or other organization. Any reimbursement for other nonlegislative members is subject to chapter 43.03 RCW.

(8) The expenses of the task force must be paid jointly by the senate and the house of representatives. Task force expenditures are subject to approval by the senate facilities and operations committee and the house of representatives executive rules committee, or their successor committees.

(9) Nothing in this section authorizes the task force to apply for a waiver under section 1332 of 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 any amendments to, or regulation or guidance issued under, those acts.

(10) This section expires January 1, 2021.

NEW SECTION. **Sec. 5.** (1) The insurance commissioner shall 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.

(2) The insurance commissioner 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."

Correct the title.

EFFECT: Requires the Insurance Commissioner (Commissioner), instead of the Health Benefit Exchange (HBE), to establish the standardized plans. Requires the standardized silver plan to have an actuarial value between 68 and 70 percent. Removes the prohibition against offering non-standardized plans on the Exchange. Removes the requirement that the Health Care Authority contract with health carriers to offer standardized qualified health plans on the HBE. Creates the Legislative Task Force on Health Coverage in the Individual Market to analyze the feasibility of a public health insurance option to increase competition and choice for health care consumers. Requires the analysis to include an actuarial and economic analysis, a plan to expand the participation of public health plans, a state-developed health insurance plan, a list of necessary federal waivers, a discussion of potential funding and costs, and an analysis of whether the new public health insurance plan option could address the underlying factors that limit health plan choices in some regions. Requires the Commissioner, instead of the HBE, to develop a plan for premium subsidies for individuals purchasing coverage on the HBE.

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