SENATE BILL REPORT
SB 5377

As of February 1, 2021

Title: An act relating to increasing affordability of standardized plans on the individual market.

Brief Description: Increasing affordability of standardized plans on the individual market.

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

Brief History:
Committee Activity: Health & Long Term Care: 2/03/21.

Brief Summary of Bill

- Establishes, subject to availability of funds, a premium assistance program for individuals purchasing health insurance on the Health Benefit Exchange (Exchange).
- Establishes network participation and hospital reimbursement rates for public option plans.
- Requires carriers to offer all the standardized plans designed by the Exchange and limits the number of non-standardized plans a carrier may offer.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Greg Attanasio (786-7410)

Background: Through Washington's Health Benefit Exchange (Exchange), individuals may compare and purchase individual health coverage and access premium subsidies and cost-sharing reductions. Federal premium subsidies are available to individuals whose income is between 100 and 400 percent of the federal poverty level. Cost-sharing reductions are available to individuals whose income is between 100 and 250 percent of the

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federal poverty level.

Only health plans certified by the Exchange as qualified health plans (QHPs) may be offered on the Exchange. QHPs must be offered by licensed carriers and must meet requirements generally applicable to all individual market health plans, including offering the essential health benefits, having their premium rates reviewed and approved by the insurance commissioner, and meeting network adequacy requirements.

In 2019, the Legislature passed ESSB 5526, which created standardized health plans on the Exchange. The Exchange, in consultation with the Health Care Authority (HCA) designed standardized plans at the bronze, silver, and gold metal tiers. The standardized plans are designed to reduce deductibles, make more services available before the deductible, provide predictable cost sharing, maximize subsidies, limit adverse premium impacts, and encourage choice based on value, while limiting increases in health plan premium rates.

Beginning on January 1, 2021, any health carrier offering a QHP on the Exchange must offer one standardized silver plan and one standardized gold plan on the Exchange. If a health carrier offers a bronze plan on the Exchange, it must offer one bronze standardized plan on the Exchange. Carriers may continue to offer non-standardized plans on the Exchange, but a non-standardized silver plan may not have an actuarial value less than the actuarial value of the silver standardized plan with the lowest actuarial value.

ESSB 5526 also established state-procured QHPs, or public option plans. These plans are standardized plans that must meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing, including standards for population health management, high value and proven care, health equity, primary care, care coordination and chronic disease management, wellness and prevention, prevention of wasteful and harmful care, and patient engagement.

The total amount a public option plan reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed 160 percent of the total amount Medicare would have reimbursed providers and facilities for the same or similar services in the statewide aggregate. Beginning in 2023, the director of HCA, in consultation with the Exchange, may waive the Medicare reimbursement requirement if HCA determines selective contracting will result in actuarially sound premium rates that are no greater than the plan's previous plan year rates adjusted for inflation using the consumer price index. The public option plan's reimbursement rates for critical access hospitals and sole community hospitals may not be less than 101 percent of allowable costs.

The Exchange, in consultation with HCA and the commissioner, was required to develop a plan to implement and fund premium subsidies for individuals whose modified adjusted gross incomes are less than 500 percent of the federal poverty level and who are purchasing individual market coverage on the Exchange. In 2020, the Exchange released its report on

premium subsidies, recommending a fixed dollar subsidy program and providing analysis and modeling for a $200 million, $150 million, and $100 million program.

Summary of Bill: Premium and Cost-Sharing Subsidies. Subject to the availability of amounts appropriated for this specific purpose, the Exchange must establish a premium assistance program, and it may establish a cost-sharing reduction program. The Exchange must establish the procedural requirements for eligibility and participation in the program and requirements for facilitating payments to carriers.

To be eligible for the program, an individual must:

- be a resident of the state;
- have an income up to 500 percent of the Federal poverty level;
- be enrolled in the lowest cost bronze, silver, or gold standardized plan offered in their county;
- apply for and accept all advanced premium tax credits;
- be ineligible for minimum essential coverage through Medicare, Medicaid, or Compact of Free Association islander premium assistance; and
- meet other criteria established by the Exchange.

Alternatively, eligibility criteria may be established in the budget.

The Exchange, in consultation with HCA and the Office of the Insurance Commissioner, must explore all opportunities to apply for federal waivers to:

- receive federal funds for the implementation of the subsidies program;
- increase access to qualified health plans; and
- implement or expand other Exchange programs to increase affordability or access to health insurance.

The state health care affordability account is created in the state treasury to hold funds for premium and cost sharing assistance programs. A carrier must accept payments for premium or cost-sharing assistance provided through the subsidies program and must clearly communicate premium assistance amounts to enrollees as part of the invoice and payment process.

Public Option Participation and Reimbursement. Beginning in plan year 2022, at the request of a public option plan, an ambulatory surgical facility or a hospital that receives payment for services provided to enrollees in Public Employees Benefits Board, School Employees Benefits Board, or Medicaid, must contract with the public option plan to provide in-network services to enrollees of that plan.

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. The rate formula must be based on a percentage of the Medicare reimbursement rates, with the base reimbursement rate for hospitals not exceeding 135 percent of the amount Medicare would

have reimbursed the hospital. The reimbursement rate may be adjusted as follows:

- 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; and
- 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.

By December 1, 2022, HCA, in collaboration with the Exchange, must establish the hospital reimbursement rate in rule. HCA may adopt rules to ensure compliance with participation and reimbursement requirements and may take action against a hospital or ambulatory surgical facility that fails to comply with the requirements.

By December 15, 2024, HCA, in consultation with the Health Care Cost Transparency Board and the 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.

HCA's authority to waive the 160 percent of Medicare reimbursement benchmark requirement if it determines selective contracting will result in actuarially sound premium rates that are no greater than the plan's previous plan year rates, is repealed.

Cost and Quality of Care Data Collection. At the request of HCA or the Exchange, for monitoring, enforcement, or program and quality improvement activities, a public option plan must provide cost and quality of care information and data to HCA and the Exchange, and may not enter into an agreement with a provider or third party that would restrict the provision of this data. All submitted data is exempt from public disclosure.

Standardized and Non-Standardized Plans. Any carrier offering a QHP on the Exchange must offer the silver and gold standardized plans designed by the Exchange and if a carrier offers a bronze plan, it must offer the bronze standardized plans designed by the Exchange.

Beginning January 1, 2023, a health plan offering a standardized health plan on the Exchange may also offer up to one non-standardized bronze, silver, and gold plan.

Appropriation: The bill contains a section or sections to limit implementation to the availability of amounts appropriated for that specific purpose.

Fiscal Note: Requested on January 29, 2021.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.