SENATE BILL REPORT
SB 5377

As of February 19, 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, 2/12/21 [DPS-WM, DNP, w/oRec].
Ways & Means: 2/19/21.

Brief Summary of First Substitute 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 requirements in public option plans for certain hospitals.
- 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

Majority Report: That Substitute Senate Bill No. 5377 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Frockt, Vice Chair; Conway, Keiser, Randall, Robinson and Van De Wege.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Minority Report: Do not pass.
Signed by Senators Muzzall, Ranking Member; Padden and Wilson, J.

Minority Report: That it be referred without recommendation.
Signed by Senators Holy and Rivers.

Staff: Greg Attanasio (786-7410)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Sandy Stith (786-7710)

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 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 (First Substitute): 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 subsidy amounts through a fair and transparent process and allow for public comment. 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 or a lower level determined in the budget;
- be enrolled in a 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 Exchange shall apply for waivers on behalf of the state and must comply with all federal notice and comment requirements

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, hospital systems that own or operate four or more hospitals in the state must contract with at least one public option plan of the hospital's choosing in each geographic rating area in which the hospital system operates a hospital.

A health carrier may not condition negotiations or participation in a health plan on the hospital's negotiation or participation in a public option plan.

HCA may adopt rules to ensure compliance with these provisions.

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 two gold, two bronze, one silver, one platinum, and one catastrophic non-standardized health plan in each county where the carrier offers qualified health plans.

In the 2023 study on the impact of standardized health plans, the Exchange must include 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.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Requires the Exchange to establish subsidy amounts through a fair and transparent process and allow for public comment.
- Sets income eligibility at up to 500 percent of FPL or a lower threshold determined in the budget.
- Requires an individual to be enrolled in any silver or gold standard plan.
- Clarifies that the Exchange applies for waivers "on behalf of the state" and in compliance with all notice and comment requirements.
- Requires hospital systems of four or more hospitals to contract with at least one public option plan in each geographic rating area.
- Provides that a carrier may not condition hospital participation in any health plan on the hospital's participation in a public option plan.
- Limits nonstandardized plans to two gold and two bronze plans, one silver plan, one platinum plan, and one catastrophic plan in each county where a carrier offers plans.
- Requires the Exchange to study offering a bronze high deductible HSA plan and a lower end gold plan with an actuarial value closer to a silver 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.

Staff Summary of Public Testimony on Original Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: The original program is doing well with standard plans, but some additional adjustments are needed to make it work better for consumers. Subsidies would make coverage more affordable and premiums will be lower for everyone, even those who do not get subsidies. The state needs to offer an affordable coverage options for people who do not have other options for coverage. Lack of coverage causes people to leave needed but low paying jobs. Subsidies can be scaled up. Cost of premiums and out-of-pocket costs remain a main barrier for getting coverage and this bill will help address those barriers. Subsidies are an effective way to address affordability and can be implemented for next year's plan. HCA needs more tools to control costs for public option plans. Reasonable limits on plan numbers will make shopping for customers easier to understand. Consumers should have meaningful choice among standardized plans, including a high deductible plan. Many enrollees spend more than 10 percent of their income on health care premiums. Consumers

close to the cutoff for federal subsidies have a hard time affording coverage without that assistance. Customers need to understand what they are buying and Cascade Care makes that possible.

CON: This speeds up the timeline for reviewing participation that was negotiated in the original bill. Cutting revenues to hospitals from the commercial insurance market puts financial stability at risk. Hospitals must be able to negotiate a sufficient rate for public options plans. It is too soon to make changes and more stakeholder engagement is needed. Subsidies should be open to all Exchange plans. Standardized plans do not solve affordability issues. Reinsurance is another viable path for affordability that should be investigated. The bill provides too much authority to the Exchange without accountability. This bill relies on a fee for service model when it should be focused on a value based model. Subsidizing one sector of the market will result in higher costs elsewhere.

Persons Testifying (Health & Long Term Care): PRO: Senator David Frockt, Prime Sponsor; Jane Beyer, Office of the Insurance Commissioner; Sam Hatzenbeler, Economic Opportunity Institute; Emily Brice, Northwest Health Law Advocates; Pam MacEwan, CEO, Washington Health Benefit Exchange; Sue Birch, Director, Washington State Health Care Authority; Jessica Whittaker; Nicholas Martin; Carrie Glover; Jim Freeburg, Coalition of Patient Advocacy Groups; Tess Foy, Child Care Resources; Leanne Berge, Community Health Plan of Washington, Community Health Network of Washington; Erin Haick, SEIU 925; Dow Constantine, King County Executive.

CON: Chelene Whiteaker, Washington State Hospital Association; Jennifer Burkhardt, Olympic Medical Center; Timothy Reed, Yakima Valley Memorial; Chris Bandoli, Association of Washington Healthcare Plans; Sarah Kwiatkowski, Premera Blue Cross; Zach Snyder, Regence BlueShield; Meg Jones, PacificSource; Mel Sorensen, America's Health Insurance Plans; Amy Anderson, Association of Washington Business; Sean Graham, Washington State Medical Association; Courtney Smith, Kaiser Permanente.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.