FINAL BILL REPORT
E2SSB 5377

C 246 L 21
Synopsis as Enacted

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

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Frockt, Keiser, Conway, Das, Dhingra, Hunt, Kuderer, Liias, Lovelett, Wilson, C., Nguyen, Pedersen, Saldaña and Salomon).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

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.

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.

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 insurance 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: Premium and Cost-Sharing Subsidies. Subject to the availability of amounts appropriated for this specific purpose, a premium assistance and cost-sharing reduction program is established to be administered by the Exchange. Premium assistance and cost-sharing reduction amounts must be established by the Exchange within parameters established in the operating budget. Consistent with the operating budget, 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 income up to a threshold determined through appropriation or by the Exchange if no threshold is determined through appropriation;

- be enrolled in a silver or gold standardized plan offered in their county;
- apply for and accept all advanced premium tax credits for which they are eligible;
- 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 may disqualify an individual from the program if they:
- no longer meet the eligibility criteria;
- fail, without good cause, to notify the Exchange of a change of address in a timely manner;
- voluntarily withdraw from the program; or
- perform an act, practice, or omission that constitutes fraud resulting in an issuer rescinding the individual's coverage.

The Exchange must develop a process for an individual to appeal a premium assistance or cost-sharing determination from the Exchange.

Prior to establishing or altering premium assistance or cost-sharing reduction amounts, eligibility criteria, or procedural requirements relating to the program, the Exchange must:
- publish notice of the proposal on its website and electronically to any person who has requested it, which must include an explanation of the proposal, the date, time, and location of the public hearing on the proposal, and instructions and reasonable timelines to submit written comments;
- conduct at least one public hearing no sooner than 20 days after publishing the notice; and
- publish notice of the finalized proposal on its website and electronically to any person who has requested it, which must include a description of the finalized proposal and an explanation of how it differs from the initial proposal.

The Exchange, in close consultation with HCA and the Office of the Insurance Commissioner (OIC), must explore all opportunities to apply for federal waivers to:
- receive federal funds for 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.

If the Exchange identifies an opportunity to submit a waiver, it may develop an application to be submitted by HCA. If a waiver application is submitted, HCA must notify the Legislature and meet all federal public 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. For qualified health plans offered on the

Exchange, a carrier must accept state premium or cost-sharing assistance or payments as part of an authorized sponsorship program. This neither expands nor restricts the types of sponsorships programs authorized under state and federal law. Such a carrier must also clearly communicate premium assistance amounts to enrollees as part of the invoicing and payment process and must accept and process enrollment and payment data transferred by the Exchange in a timely manner.

Public Option Participation and Reimbursement. If a public option plan is not available in plan year 2022 or later, a hospital that receives payment from Medicaid or a public or school employee benefits program must, upon an offer from a public option plan, contract with at least one public option plan to provide in-network services to enrollees of the plan. A hospital owned and operated by a health maintenance organization is exempt from the contracting requirement. HCA must also contract with one or more carriers to provide public option plans in every county of the state or in each county within a region of the state.

Health carriers and hospitals may not condition negotiations or participation of a hospital in any health plan offered by a carrier on the hospital's negotiations or participation in a public option plan.

HCA, in consultation with OIC, may adopt rules to ensure compliance with the contracting requirement, including fines and other contract actions it deems necessary.

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

- the Exchange must analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability;
    1. The analysis must include any impact on hospitals' operating margins, the estimated margins in future years if enrollment increases, and the income levels of public option plan enrollees over time.
    2. The analysis may examine a sample of hospitals of various sizes and locations.
    3. The Exchange must give substantial weight to any available reporting of health care provider and health care system costs by the Health Care Cost Transparency Board.
- the Health Care Cost Transparency Board must analyze the effect that enrollment in public option plans has had on consumers, including an analysis of the benefits provided to, and premium and cost-sharing amounts paid by, consumers enrolled in public option plans compared to other standardized and non-standardized qualified health plans; and
- the Exchange, in consultation with the Insurance Commissioner, HCA, and interested stakeholders, must review the analyses and develop recommendations to the Legislature to address financial or other issues identified therein.

The authority for HCA to waive provider or facility reimbursement requirements beginning

in 2023 is eliminated.

Cost and Quality of Care Data Collection. At the request of HCA, 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 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.

The report due to the Legislature on December 1, 2023, is expanded to 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.

Votes on Final Passage:

Senate	30	18	
House	55	43	(House amended)
Senate	28	21	(Senate concurred)

Effective: July 25, 2021