SENATE BILL REPORT
E2SSB 5377

As Amended by House, April 8, 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: 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).

Brief History:

Committee Activity: Health & Long Term Care: 2/03/21, 2/12/21 [DPS-WM, DNP, w/oRec].

Ways & Means: 2/19/21, 2/22/21 [DP2S, DNP, w/oRec].

Floor Activity: Passed Senate: 3/2/21, 30-18.

Passed House: 4/8/21, 55-43.

Brief Summary of Engrossed Second 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.

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.

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

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

Majority Report: That Second Substitute Senate Bill No. 5377 be substituted therefor, and the second substitute bill do pass.
Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Capital; Robinson, Vice Chair, Operating & Revenue; Carlyle, Conway, Darneille, Dhingra, Hasegawa, Hunt, Keiser, Liias, Mullet, Pedersen, Van De Wege and Wellman.

Minority Report: Do not pass.
Signed by Senators Wilson, L., Ranking Member; Brown, Assistant Ranking Member, Operating; Braun and Gildon.

Minority Report: That it be referred without recommendation.
Signed by Senators Honeyford, Assistant Ranking Member, Capital; Schoesler, Assistant Ranking Member, Capital; Muzzall, Rivers, Wagoner and Warnick.

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 Engrossed Second Substitute 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 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 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, 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 two public option plans of the hospital's choosing in each geographic rating area in which the hospital system operates a hospital. A hospital system is not required to comply with the contracting requirement in a county unless it receives offers to contract from at least two carriers, and if the hospital only receives one offer, it is only required to contract with one plan.

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

HCA, in consultation with the Office of the Insurance Commissioner, may adopt rules to ensure compliance with these provisions, including levying fines.

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, 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.

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.

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

Fiscal Note: Available.

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.

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: This is an update to the program. People are migrating to lower coverage with high deductibles. This will help ensure hospitals participate in the public option. This would give a lot of choice of plans. This layers on a subsidy to the APTC.

Washington is in crisis and the uninsured rate is on the rise. This helps make insurance more affordable. The requirement for hospitals is important. This protects patients, improves costs, and improves networks. Affordability is the largest concern. This is scalable. The cost for the Exchange to stand this up are not general fund. Consumers cannot afford to wait. This market is a safety net. This plan makes insurance more

affordable and strikes a balance on choice that the OIC supports. This is a pathway to affordable health care. This is a critical step to reduce barriers to health care. It encourages people to purchase appropriate health plans. We encourage support for subsidies going to standard plans.

CON: This bill will cause costs to go up for employer sponsored insurance.

OTHER: Subsidies should be open to all Exchange plans. Standardized plans do not solve affordability issues. This version made significant strides on our concerns. It mandates hospitals and carriers to work together to make health care affordable. There is still work to be done on the bill. There should be a funding source provided in the bill for subsidies. The waiver belongs with the Office of the Insurance Commissioner. This is how it is being done in other states. Section 5 should be tied to PEB and SEB. Markets with more choice result in lower cost.

Persons Testifying (Ways & Means): PRO: Sam Hatzenbeler, Economic Opportunity Institute; Emily Brice, Northwest Health Law Advocates; Jim Freeburg, Coalition of Patient Advocacy Groups; Dekkar Dirksen, Community Health Plan of WA, Community Health Network of Washington; Pam MacEwan, CEO, Washington Health Benefit Exchange; Sue Birch, Director, Washington Health Care Authority; Jane Beyer, Senior Health Policy Advisor, Office of Insurance Commissioner.

CON: Amy Anderson, Association of Washington Business; Courtney Smith, Kaiser Permanente.

OTHER: Chelene Whiteaker, WSHA; Chris Bandoli, Association of Washington Healthcare Plans; Gary Strannigan, Premera Blue Cross; Zach Snyder, Regence Blue Shield.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.

EFFECT OF HOUSE AMENDMENT(S):

- Requires the subsidy program to be administered by the Exchange, instead of being established by the Exchange.
- Requires the amounts of premium assistance and cost-sharing reductions to be established by the Exchange within the parameters established in the operating budget.
- Requires procedural requirements for the subsidy program to be consistent with the operating budget.
- Allows the income eligibility threshold for the subsidy program to be established through appropriation or by the Exchange if no income threshold is determined by appropriation, instead of being set at 500 percent of the federal poverty level or a lower level established by appropriation.
- Clarifies that the appeals process established by the Exchange applies to all individuals, not only eligible individuals.

- Requires the Exchange, prior to establishing or altering premium assistance or cost-sharing reduction amounts, eligibility criteria, or procedural requirements, to provide public notice of the proposal, conduct at least one public hearing, accept written comments, and provide public notice of the finalized amount, criteria, or requirements.
- Requires any federal waiver application to be developed by the Exchange and submitted by the Health Care Authority, instead of being developed and submitted by the Exchange.
- Clarifies that the requirement for carriers to accept payments from sponsorship programs does not expand or restrict the types of sponsorship programs authorized under state or federal law.
- Removes the requirement that hospital systems with four or more hospitals contract with at least two public option plans in counties where they operate hospitals.
- Requires, if a public option plan is not available in each county of the state during plan year 2022 or later, the following for all subsequent plan years:
    1. upon an offer from a public option plan, hospitals, except hospitals owned and operated by health maintenance organizations, receiving payments from Medicaid or PEBB/SEBB must contract with at least one public option plan to be an in network provider; and
    2. the HCA must contract with one or more health carriers to offer public option plans in every county of the state or in each county within a region of the state.
- Requires the Exchange, once public option enrollment reaches or exceeds 10,000 covered lives, to analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability.
- Requires the analysis to include any impact on hospitals' operating margins and the estimated margins in future years if enrollment increases.
- Requires the analysis to examine the income levels of public option plan enrollees over time.
- Allows the analysis to examine a sample of hospitals of various sizes and locations.
- Requires the Exchange to give substantial weight to any available reporting of health care provider and health care system costs by the Health Care Cost Transparency Board.
- Requires the Health Care Cost Transparency Board, once public option enrollment reaches or exceeds 10,000 covered lives, to 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 nonstandardized qualified health plans.
- Requires the Exchange, in consultation with the Insurance Commissioner, the Health Care Authority, and interested stakeholders to review the analyses completed by the Exchange and the Health Care Cost Transparency Board and develop recommendations to the Legislature to address financial or other issues identified in the analyses.
- Makes a technical change to clarify that the ability of health carriers to offer nonstandardized plans on the Exchange is not affected prior to January 1, 2023.