Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

E2SSB 5377

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 Summary of Engrossed Second Substitute Bill

- Establishes a state premium assistance and cost-sharing reduction program for qualified health plans purchased through the Washington Health Benefit Exchange.
- Establishes requirements on standardized health plans offered through the Washington Health Benefit Exchange, including limiting the number of nonstandardized plans that may be offered by a health carrier.
- Establishes participation requirements for certain hospital systems regarding state-procured qualified health plans offered through the Washington Health Benefit Exchange.

Hearing Date: 3/17/21

Staff: Jim Morishima (786-7191).

Background:

I. Premium Assistance and Cost-Sharing Reductions for Individual Health Coverage.

Through Washington's Health Benefit Exchange (Exchange), individuals may compare and purchase qualified health plans and access premium subsidies and cost-sharing reductions. Qualified health plans are offered in the following actuarial value tiers: Bronze (60 percent

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actuarial value), Silver (70 percent actuarial value), Gold (80 percent actuarial value), and Platinum (90 percent actuarial value).

Premium subsidies (in the form of tax credits) are available for individuals purchasing qualified health plans through the Exchange on a sliding scale based on percentage of the individual's income. Under the federal Patient Protection and Affordable Care Act (ACA), individuals between 100 percent and 400 percent of the federal poverty level are eligible for such subsidies. Cost-sharing reductions are available to individuals between 100 percent and 250 percent of the federal poverty level.

The recently enacted federal American Rescue Plan Act of 2021 makes temporary changes to premium subsidy eligibility and amounts for 2021 and 2022 including:

- increasing subsidy amounts for persons already qualified for premium subsidies under the ACA;
- making individuals with incomes over 400 percent of the federal poverty level eligible for premium assistance; and
- making individuals who received unemployment benefits in 2021 eligible for the highest level of premium subsidies.

In 2020 the Exchange, in consultation with the Health Care Authority (HCA) and the Insurance Commissioner (Commissioner), was required to develop a plan to implement and fund premium subsidies for individuals with incomes of less than 500 percent of the federal poverty level. The resulting report recommended a fixed dollar subsidy program and provided different modeling based on the amount of funding available for the program.

II. Standardized Qualified Health Plans.

Health carriers offering qualified health plans on the Exchange must offer standardized health plans designed by the Exchange in consultation with the HCA and the Commissioner. The standardized plans are required to 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.

Health carriers subject to this requirement must offer at least one standardized Gold and one standardized Silver plan on the Exchange. If a carrier offers a Bronze plan on the Exchange it must offer a standardized Bronze plan. Carriers may continue to offer nonstandardized plans on the Exchange.

The Exchange, in consultation with the Commissioner, is required to analyze the impact to consumers of offering only standard plans on the Exchange beginning in 2025. The report must be submitted to the Legislature by December 1, 2023, and include an analysis of how plan choice and affordability will be impacted for Exchange customers across the state.

III. State-Procured Qualified Health Plans.

The HCA, in consultation with the Exchange, must contract with at least one health carrier to offer qualified health plans on the Exchange. A health carrier contracting with the HCA must offer at least one Bronze, one Silver, and one Gold qualified health plan in a single county or in multiple counties. The stated goal of the procurement is to have a choice of qualified health plan offered in every county.

The total amount the qualified health 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 the HCA, in consultation with the Exchange, may waive this requirement if the HCA determines that selective contracting will result in actuarially sound premium rates that are no greater than the qualified health plan's previous plan year rates adjusted for inflation using the Consumer Price Index.

The qualified health plan's reimbursement rates for critical access hospitals and sole community hospitals may not be less than 101 percent of allowable costs. The qualified health plan's reimbursement rates must be at least 135 percent of Medicare rates for primary care services designated by the HCA that are performed by physicians with a primary specialty of family medicine, general internal medicine, or pediatric medicine.

Summary of Engrossed Second Substitute Bill:

I. Premium Assistance and Cost-Sharing Reductions for Individual Health Coverage.

Subject to the availability of appropriated funds, the Washington Health Benefit Exchange (Exchange) must establish a premium assistance program. The Exchange may also establish a cost-sharing reduction program for eligible individuals.

The Exchange must annually set the amounts of premium assistance provided to eligible individuals. The amounts must be established through a fair and transparent process and must provide notice and opportunity for public comment before finalizing each year's assistance amounts. The Exchange must also establish procedural requirements for eligibility and participation, including participant documentation requirements and procedural requirements for facilitating payments to carriers.

Subject to the availability of appropriated funds, an individual is eligible for the program if he or she:

- is a Washington resident;
- has income up to 500 percent of the federal poverty level (a lower amount may be determined through appropriation);
- is enrolled in a Silver or Gold standardized plan in his or her county of residence;
- applies for and accepts all federal premium assistance prior to receiving any state

assistance;
- applies for and accepts all federal cost-sharing reductions before receiving any state cost-sharing reductions;
- is ineligible for Medicare, Medicaid, or premium assistance provided to COFA citizens; and
- meets other eligibility criteria as established by the Exchange.

Alternate eligibility criteria may be established in the Omnibus Appropriations Act.

The Exchange may disqualify an individual from the program if he or she:
- no longer meets the eligibility criteria;
- fails without good cause to notify the Exchange of a change of address in a timely manner;
- voluntarily withdraws from the program; or
- performs an act, practice, or omission that constitutes fraud that results in an issuer rescinding the individual's coverage.

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

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. 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.

The Exchange, on behalf of the state and in consultation with the Health Care Authority (HCA) and the Office of the Insurance Commissioner (OIC), must explore all opportunities to apply to the federal government for a waiver or other federal flexibilities to:
- receive federal funds for the implementation of the premium assistance or cost-sharing reduction programs;
- increase access to qualified health plans; and
- implement or expand other Exchange programs that increase affordability or access to health insurance coverage in Washington.

If the Exchange submits an application, it must notify the Legislature and meet all federal public notice and comment requirements.

<u>II. Standardized Qualified Health Plans</u>.

A health carrier offering a qualified health plan on the Exchange must offer the Silver and Gold standardized plans established by the Exchange, instead of one Silver and one Gold standardized plan. Similarly, if the carrier offers a Bronze plan on the Exchange it must offer the Bronze standardized plans established by the Exchange, instead of one Bronze standardized plan.

Beginning January 1, 2023, the number of nonstandardized plans a health carrier may offer in each county where the carrier offers a qualified health plan is limited to:

- two nonstandardized Gold and Bronze plans;
- one nonstandardized Silver plan;
- one nonstandardized Platinum plan; and
- one nonstandardized catastrophic health plan.

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 plan.

III. State-Procured Qualified Health Plans.

For plan years 2022 or later, a hospital system that owns or operates at least four licensed hospitals must contract with at least two state-procured qualified health plans (public option plans) of the hospital system's choosing in each county in a geographic rating area in which the hospital system has at least one hospital, to provide in-network services to enrollees of the plan. A hospital is exempt from this requirement unless it receives an offer from at least two health carriers to provide in-network services as part of a public option plan in that county for the following plan year. If a hospital receives only one offer from a health carrier, it is only required to contract with one public option plan. 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.

The HCA, in consultation with the OIC, may adopt rules to ensure compliance with the participation requirement, including fines and other contract actions it deems necessary. At the request of the 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 the HCA and may not enter into an agreement with a provider or third party that would restrict the plan from providing this information or data. Information or data submitted the HCA is exempt from public disclosure.

The authority for the HCA to waive provider or facility reimbursement requirements beginning in 2023 is eliminated.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on March 12, 2021.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.