Prevention Alliance

POLICY BRIEF: CASCADE CARE – WASHINGTON'S PUBLIC OPTION & STANDARD BENEFIT PLANS

July 2019

Executive Summary:

During the 2019 legislative session, the Washington state legislature passed the first public option for health insurance in the country. The legislation, known as Cascade Care, contained three components: the establishment of standard health benefit plans, creation of a public option for individual health insurance, and researching other potential approaches to improving affordability of health insurance purchased on the individual market. The legislation was amended several times throughout the process, including cost controls relating to provider reimbursement, but the outcome was a new approach to improving accessibility and affordability of health insurance for people who access coverage through the individual market. This brief will provide some background on how this legislation came about and an overview of what ultimately passed.

Background

Following the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, Washington established and continues to operate a state-based health benefit exchange (Exchange) called Washington Healthplanfinder. Through this online health insurance marketplace, individuals and families who don't have access to health insurance through other means, such as employer-based coverage, can compare and purchase individual health insurance coverage. The enabling legislation for the Exchange, and subsequent rulemaking, put in place rules and requirements for carriers who want to sell plans in the Exchange including actuarial value (AV) tiers, also known as metal tiers (bronze, silver, gold, and platinum). Actuarial value is the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV of 80%, the patient is responsible for 20% of the costs of all covered benefits and services. For the health plans sold on the individual market, bronze plans have an AV of about 60%, silver have an AV of 70%, gold have an AV of 80%, and platinum have an AV of 90%. In addition to the established tier levels, only health insurance plans that have been certified by the Exchange as qualified health plans (QHPs) can be sold on the Exchange. QHPs must meet certain requirements such as offering the 10 essential health benefits established under the ACA, having proposed premium rates reviewed and approved by the Office of the Insurance Commissioner, meeting network adequacy requirements, and other patient protections established under the ACA.

In addition to establishing a marketplace where individual health insurance can be purchased, the ACA also sought to provide financial assistance to people meeting certain income thresholds in order to make purchasing insurance more affordable. Under the ACA, individuals and families with household incomes between 100% to 400% of the federal poverty level are eligible for premium subsidies through Exchange plans, and additional cost-sharing reductions

are available to those between 100% and 250% of the federal poverty level who purchase silver level plans. Carriers are also permitted to offer plans on the individual market, but individuals who are eligible for premium subsidies and cost-sharing reductions cannot access those supports through plans purchased outside of the Exchange.

The Exchange has been successfully operating in Washington since the first open enrollment period for plans beginning in 2014. Just under 139,000 individuals enrolled in QHPs that first year. In their most recent Health Coverage Enrollment Report, the Exchange reported that nearly 200,000 customers used the online marketplace to purchase QHP coverage for 2019. QHP enrollment make up 12% of total Exchange enrollment with the rest enrolling in Apple Health (Medicaid). While this highlights some of the progress that has been made in getting more people enrolled in health insurance coverage, the report also highlighted some of the emerging and ongoing concerns around the stability, accessibility, and affordability of the individual market:

- There was a decrease of 6% in QHP enrollment in 2019 compared to the 2018 plan year;
- There was an increase number of enrollees selecting bronze plans, which is likely at least partially due to ongoing increases in premiums;
- Residents in 14 counties were limited to a single health plan carrier option;
- The average QHP base premium cost in 2019 increased by $55 to $568 per person per month;
- Non-subsidized customers pay up to 32% of income on their premium; and
- Nearly 60,000 enrollees are in a plan with a deductible over $9,000.

In addition to such data trends, two counties in Washington nearly didn't have any plan offerings in 2018 until the Office of the Insurance commissioner intervened. Ultimately there was at least one carrier offering plans in all counties, but these combined issues led to increased concerns amongst legislators, state agencies, and stakeholders about the availability of coverage, the stability of the individual market, and the affordability of plan offerings for individuals and families. In an effort to ensure plan options in all counties and establish cost control measures, legislators and the Governor's office proposed through SB 5526 (HB 1523) the creation of a public option in Washington, called Cascade Care, the establishment of standard benefit plans, and a plan to look into options for state-funded premium subsidies and cost-sharing assistance.

Cascade Care

Standardized Plans

While much of the attention around SB 5526 was, and continues to be, focused on the public option component, the establishment of standardized health plans was also a very significant piece of the legislation. Many stakeholders have been interested standardized plans in Washington ever since it emerged as one of the top strategies coming out of the Patient Out Of Pocket Task Force, which was convened by the Department of Health as directed by SB 6569 in 2016.

Standardized health plans are when a plan design is established by the Exchange and other relevant stakeholders that all insurers who sell in the Exchange are required to sell. Several states already have standardized health plans including Massachusetts and California. Standardized plans are designed to have standardized cost sharing for covered health services and are typically designed to have lower or no upfront cost sharing for a specified set of services. In other words, the standard plans are designed to have defined cost-sharing (either co-pay or co-insurance) and that certain benefits are available outside of the deductible. All standard plans have the same (defined or identical) benefit design and cost sharing regardless of carrier. The consumer choice between carriers then becomes about the provider networks that they have, their quality ratings, and other innovation efforts to differentiate their plans.

The goal of standardized plans is to increase patient access to their health benefits, make more consistency across plans, make it easier for patients to compare and shop for plans, and improve transparency around coverage and cost sharing. Some of the common barriers that consumers face include:

- **High deductibles:** Much attention is often focused on rising premiums, but less focus has been on the impact of high deductibles. While high premiums can make it difficult for people to purchase insurance, high deductibles make it difficult for people to actually use their insurance and access their health benefits. Especially for patients with low and moderate incomes, high deductibles pose significant barriers to accessing health care and patients often end up delaying or forgoing necessary care which can lead more serious health problems and poor health outcomes.
- **High Number of Plan Options**: Instinctively people often thing more choice is better. But consumer experience has shown that too many plan options make it difficult to pick a plan. It is often difficult for consumers to easily see the differences between the various plans, especially within the same metal tier.
- **High Out of Pocket Costs**: The way a plan is designed can result in high out of pocket costs that create barriers to accessing care. For example, the average consumer may not understand the implications of having a plan with co-insurance rather than co-pay and co-insurance plans can be less predictable in out of pocket cost impact, especially for prescription drugs. Consumers also don't typically plan for the worst. A healthy person usually doesn't shop for a plan thinking about what their costs would be if they had a heart attack or if they got a cancer diagnosis. But if a diagnosis comes, high out of pocket costs can be a significant barrier to early identification and treatment.

Standardized health plans can help address all of these issues – a plan can be designed to have more benefits available before deductible, comparing standard plans can be easier because consumers can be assured consistent benefits regardless of carrier, and plans can be designed to maximize cost sharing reductions for those who are eligible and bring down out of pocket costs for health services and/or prescription drugs.

As passed, SB 5526 directed the Exchange, in consultation with the Office of the Insurance Commissioner (OIC), the Health Care Authority (HCA), an independent actuary, and stakeholders to establish up to three standardized plans for each of the bronze, silver, and gold tiers. The legislation stated that the plans "must 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."

Under the legislation, 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. Health carrier offering a standardized plan must meet all requirements relating to QHP certification, including requirements relating to rate review and network adequacy. Carriers are permitted to continue offering non-standardized plans on the Exchange.

Finally, the legislation requires that a non-standardized silver plan may not have an actuarial value that is less than the actuarial value of the silver standardized plan with the lowest actuarial value. The reason for this requirement is that the federal advanced premium tax credits are based off of the second-lowest priced silver plan. Having the standardized plan serve as the lowest plan allows the Exchange to design and price that plan to maximize tax credits for consumers.

Public Option

State-Procured Plans

The establishment of a public option was the second major component of SB 5526. This is the first public option to pass in the country and as a result is drawing widespread interest nationally, from other states, and among health advocates. However, the public option approach in Washington is different than proposals that have been put forward in other states. Rather than being a true government run health plan like Medicaid or Medicare, the public option in Washington will be state-procured QHPs. In other words, the Health Care Authority, in consultation with the Exchange, will contract with at least one private health carrier to offer bronze, silver and gold QHPs on the Exchange. The public option plans will be offered for plan years beginning in 2021. By having the state procure the health plans, the state has the ability to negotiate with carriers applying to be a public option plan, competition for being chosen can help bring down costs, and there can be a level of accountability to the state. So while the public option in Washington won't be government-run, the government does play the role of picking and choosing which plans get contracted with.

The goal of state-procured plans is for consumers to have plan options in every county of the state. HCA is directed to consider the rates, utilization management policies, pharmaceutical costs, and other factors proposed by the carrier or carriers, with the goal of negotiating for plans that reduce premiums below the average premiums for plans in the same metal tiers in Washington during the 2019 plan year.

The legislation put in place certain requirements around the public option plans. The plans that HCA procures must:

- Be standardized health plans;
- Meet all requirements for certification, including requirements relating to rate review and network adequacy;
- Incorporate recommendations of the Bree Collaborative and the Health Technology Assessment program;
- 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; and
- Employ utilization management processes that meet national accreditation standards, align with criteria published by the HCA, and focus on care that has high variation, high cost, or low evidence of clinical effectiveness.

Carriers who apply to have a public option plan can offer it in a single county or in multiple counties, and more than one carrier may be contracted with by HCA to offer public option plans. Carriers that are selected to offer a public option plan are still permitted to offer other health plans on the Exchange.

Provider Reimbursement Cap

The most controversial part of the legislation was establishing a cap on provider reimbursement. The goal of capping rates is to bring down plan costs. The original bill capped provider reimbursement at the Medicare level. This received widespread criticism from the provider community. Different proposals were considered as the bill moved through session, and ultimately what passed was that the reimbursement to providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed 160% of the total amount Medicare would have reimbursed for the same or similar services. Two exceptions to the rate cap were established through the legislation: rates for critical access hospitals and sole community hospitals may not be less than 101% of allowable costs under existing federal programs (including Medicare), and the rate for primary care service must be at least 135% of Medicare rates for primary care services. The HCA is permitted to waive the 160% of Medicare provider rate cap if the contracted health carrier is unable to form a provider network that meets network adequacy standards under the OIC, and if the carrier is able to achieve premiums that are 10% lower than the previous plan year through other means besides the established rate cap. Starting in 2023, the HCA director is also permitted to waive the rate cap if it is determined that selective contracting will result in premium rates that are no greater than the previous plan year rates adjusted for inflation.

The Exchange estimates that private plans currently pay 174% of Medicare rates. So the cap established under the bill is a reduction from current rates, but still significantly higher than the original proposal. As a result, premium rates are anticipated to come down and lower

deductibles can hopefully be achieved, though likely not as low as if the lower rate cap had been set. However, by having the compromised higher rate cap, the hope is that providers will accept patients who are covered by a public option plans and carriers will be able to establish provider networks that meet network adequacy requirements.

B&O Tax Exemption for Participating Providers
As an incentive for providers to accept patients who are covered by a public option plan, the legislation established a business & occupation (B&O) tax exemption for participating providers. Under the exemption, the B&O tax does not apply to any payments received by a provider for services performed on patients covered by a public option plan. Payments received includes both reimbursement from the carrier as well as any payment made by the patient as part of their cost-sharing obligation under the plan.

Premium and Cost-Sharing Assistance
The third component of SB 5526 was a directive for the Exchange, in consultation with the HCA and OIC, to develop a plan to implement and fund premium subsidies for people who purchase coverage through the Exchange and whose modified adjusted gross incomes is less than 500% of the federal poverty level (FPL) Current premium subsidies available under the ACA are for people who make 100-400% FPL, so this plan would provide additional premium to individuals who are currently receiving premium tax credits as well as those with slightly higher incomes between 400-500% FPL who are not currently receiving any premium subsidies. Under the bill, the goal of the subsidy plan is to enable participating individuals to spend no more than 10% of their modified adjusted gross incomes on premiums.

In addition to premium subsidies, the plan put forth by the Exchange must also include an analysis of providing cost-sharing reductions (CSRs) to plan participants. CSRs are discounts that help lower the amount a patient has to pay out of pocket for deductibles, copayments, and coinsurance. CSRs were established for people with incomes of 100-250% FPL under the ACA and were paid by the federal government between 2014-2017. In 2017 the Trump administration ceased payments of the CSRs after an earlier ruling by a federal judge ruled in favor of the GOP in the *House v. Price* case that argued the CSR subsidies were discretionary spending and therefore subject to annual appropriation by Congress. While the Obama administration had appealed the case, the Trump administration made the decision to end payments. Despite the lack of CSR payments, carriers were still required under the ACA to reduce copayments and deductibles. To maintain that requirement without the CSR payments, premiums were increased to offset the losses. Under SB 5526, the Exchange, OIC, and HCA must do an assessment of the state providing CSRs to individuals and must evaluate the impact on premium subsidies and the uninsured rate.

The premium subsidy and CSR plan developed by the Exchange, as well as proposed implementing legislation, is due to the health care committees of the legislature by November 15, 2020.

Summary

The passage of SB 5526 is one of the most significant pieces of legislation that has passed in Washington in recent years. The establishment of standardized plans, the creation of the first public option in the country, and the directive to develop a plan around additional premium subsidies and cost sharing reductions together all creates a path to make significant changes in the individual health insurance market in Washington. The hope is that these pieces, once implemented, will improve the affordability of insurance plans, allow patients to better access health care, drive down out of pocket costs, and ensure there is plan choice in every county in Washington. But passage of the legislation was just the beginning. There is much work that lies ahead in designing the standard health plans, procuring the public option plans, and doing analysis and planning around premium and cost-sharing assistance. The legislation included several pieces around ongoing analysis and required reports to the legislature regarding various components of the bill, so there will be ongoing opportunity to evaluate progress and impact and hopefully work toward creating a more affordable, accessible, and stable individual marketplace in Washington.