Washington State Health Care Authority

Report to the Legislature

Health Care Cost Transparency Board

Cascade Select Public Option Report

Engrossed Second Substitute Senate Bill 5377; Section 5; Chapter 246; Laws of 2021

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The Health Care Cost Transparency Board would like to thank Washington Health Benefit Exchange staff for their collaboration and important contributions to this report. This report is one component of the analysis required by E2SSB 5377(5), and is being submitted in addition to the Exchange's report on the impacts of the public option on hospital financial sustainability.

Executive summary

The Legislature established the Health Care Cost Transparency Board (Board) to reduce the state's health care cost growth and increase price transparency. In accordance with Engrossed Second Substitute House Bill 5377, the Board is also required to analyze the effect that enrollment in public option health plans has had on consumers. As required by the legislation, this report includes an analysis of:

- The benefits provided to consumers enrolled in public option plans compared to other qualified health plans (QHPs); and
- Premiums and cost-sharing amounts paid by consumers enrolled in public option plans compared to other QHPs.

The Washington Legislature created the first ever public option program in the United States, and since its creation, several states have also developed similar public option programs. In Washington, public option plans are QHPs that utilize the standard benefit design created by the Washington Health Benefit Exchange (Exchange) and are selected through a competitive procurement process by the Health Care Authority. These plans are offered exclusively through Washington Healthplanfinder and provide predictable benefits that are easy for consumers to compare through standardized plan design. Additionally, carriers' public option plans are required to meet higher quality standards and requirements regarding reimbursement rates for health care providers established in the legislation that created the public option.

This analysis finds that public option health plans show promise in increasing access to high-quality, affordable individual health coverage for Washington Healthplanfinder consumers enrolled in QHPs. Specific findings of this analysis include:

1. Public option premium affordability increases consumer access to health coverage.
    - Between 2021 and 2023, public option premium costs trended down six percent, while non-Cascade Care plan premiums on the Exchange increased 15 percent during that same time period. The difference in premium rate increases between public option plans and non-Cascade Care plans is over 20 percent over two years.
    - In 2023, average public option gross premiums are lower than all other plan premiums for the first time, including non-standard/non-Cascade Care plans.
    - Also in 2023, public option plans are the lowest-cost silver premium QHPs in 25 counties before any available consumer subsidies are applied.
    - Driven by premium affordability, more Exchange consumers are enrolling in public option plans and public option enrollees are able to purchase health plans that provide greater access to services at lower out-of-pocket costs, providing more benefits to consumers.
2. Public option plan design increases access to health care through lower cost sharing when consumers use their benefits.
    - Public option deductibles are an average of $1,000 less than other Washington Healthplanfinder deductibles.
    - Compared to popular non-public option plans on the Exchange, enrollees in public option plans

are likely to pay less out of pocket when receiving services of high clinical value such as primary care, or for a series of related health care services such as having a baby or managing a chronic health condition.

Definitions and roles

Qualified Health Plans: Under the Affordable Care Act, a qualified health plan (QHP) is an insurance plan that has been certified by *Washington Healthplanfinder* to offer quality insurance. QHPs must provide essential health benefits, follow established limits on cost-sharing (such as deductibles, co-payments, and out-of-pocket maximum amounts), and meet other requirements. Cascade Care plans, including public option plans, are qualified health plans.

Carrier: A carrier is another term for a health insurer.

Cascade Care: Created by legislation, Cascade Care, is the state's effort to make health insurance accessible and affordable for every *Washington Healthplanfinder* consumer. Cascade Care is a three-agency effort involving the Health Benefit Exchange, the Health Care Authority, and the Office of the Insurance Commissioner which includes standard benefit design that is utilized by the public option and state-funded premium assistance.

Cascade Care plans: High-quality, low-cost QHPs designed with standard benefits by the Exchange and available exclusively to *Washington Healthplanfinder* consumers. All Cascade Care plans, or plans with standard plan designs, let consumers pay less at the provider's office with more predictable costs and have the same benefit design, making it easier for consumers to shop and compare plans.

Public option plans or Cascade Select plans: Public option plans, also known as Cascade Select plans, are a type of Cascade Care plan. The state selects carriers with whom to contract to offer Cascade Select plans. Public option plans provide the same standard benefits as all other Cascade Care plans. Additionally, health insurance carriers offering public option plans are required to meet higher quality standards and must meet state-defined reimbursement rates for providers to ensure public option plans are more affordable for consumers and provide access to quality health care.

Cascade Care Savings: State-funded premium assistance program that lowers eligible consumers' premiums on *Washington Healthplanfinder*. Consumers up to 250 percent of the federal poverty level (FPL) are eligible to receive Cascade Care Savings when enrolled in Cascade Care Silver or Gold plans, including public option plans.

Office of the Insurance Commissioner (OIC): The state agency responsible for regulatory oversight of the state's insurance industry. OIC must approve all individual health plan designs and rates prior to being sold on *Washington Healthplanfinder*. OIC is responsible for approving individual market and small group health plans, including Cascade Care plans, which involves reviewing plan filings annually to ensure they meet regulatory requirements including rate review, benefit design, and network adequacy.

Washington Health Benefit Exchange (Exchange): The Exchange was established by the Legislature as a public-private partnership that operates the online marketplace called *Washington Healthplanfinder,* an online marketplace for individuals and families who do not have health and dental insurance through an employer or public programs.[1] The Exchange is the lead organization for Cascade Care. The Exchange makes Cascade Care plans available through *Washington Healthplanfinder*.

[1] More than one in four Washington residents not eligible for Medicare use Healthplanfinder's insurance marketplace to buy qualified health plans, including Cascade Care plans, or to enroll in an Apple Health (Medicaid) plan if they are low-income.

Washington State Health Care Authority (HCA): The state agency that is responsible for procuring and contracting for public option plans, which are offered on *Washington Healthplanfinder*. HCA is the largest purchaser of health care in Washington and also procures and administers Apple Health (Medicaid and the Children's Health Insurance Program), Public Employee Benefits, and School Employee Benefits.

Background

The Board was established by House Bill 2457 in 2020 under the Health Care Authority (HCA). The Board is responsible for the analysis of total health care expenditures in Washington state, identifying trends in health care cost growth, and establishing a health care cost growth benchmark. Recognizing that Washingtonians are paying more for their health care while income has not increased at the same rate, the Legislature established the Board as a part of Washington state's increased focus on health care affordability strategies, including cost containment and the public option program.

Engrossed Second Substitute Senate Bill (ESSB 5377) requires the Board to analyze the effect that enrollment in public option plans has had on consumers when enrollment statewide in public option plans is greater than 10,000 covered lives in a plan year. This must include an analysis of:

- The benefits provided to consumers enrolled in public option plans compared to other QHPs; and
- Premiums and cost-sharing amounts paid by consumers enrolled in public option plans compared to other QHPs.

In 2023, public option plan enrollment passed 10,000 lives for the first time and enrolled approximately 23,000[2] lives.[3] The Board drew primarily upon data from the Exchange, HCA and OIC, which includes enrollment, rates, and plan data. The Board adopted this report on June 21, 2023.

Additionally, as required by ESSB 5377, the Exchange must conduct a separate analysis of public option plan rates paid to hospitals for in-network services and whether those rates have impacted hospital financial sustainability. The Exchange will combine that analysis with the findings in this report and develop recommendations to the Legislature to address financial or other issues identified in the analyses. The Exchange will develop these recommendations in consultation with OIC, HCA, and interested parties including, but not limited to, associations for hospitals, insurers, and physicians.

Cascade Care background

Cascade Care was established by legislation in 2019[4] with new program components added in 2021[5] to increase the availability of quality, affordable health coverage in the individual market. This legislation recognized that unaffordable premiums stop too many Washingtonians from securing health insurance and that insurance coverage is insufficient if individuals and families cannot use their benefits to access health care because of high deductibles and out-of-pocket expenses.

The state's Cascade Care efforts aim to make health insurance accessible and affordable for every *Washington Healthplanfinder* consumer by:

- Addressing costs through lower premiums, lower deductibles, and access to services before having to pay the deductible. This includes leveraging federal and state-based financial assistance, state purchasing power, and health care provider reimbursement expectations.
- Encouraging meaningful consumer choice with products of better value and similar benefits across all carriers.
- Growing enrollment by attracting new enrollees and retaining current consumers.

[2] QHP data collected as of March 31, 2023: https://www.wahbexchange.org/content/dam/wahbe-assets/reports-data/enrollment-reports/Spring%20OE10%20Report%20Updated%202023.04.17.xlsx

[3] This followed the Exchange's tenth open enrollment period, which took place Nov. 1, 2022 through Jan. 15, 2023.

[4] Engrossed Substitute Senate Bill 5526

[5] Engrossed Second Substitute Senate Bill 5377

- Ensuring continued market health through stable carrier participation, competitive product offerings, and a larger and diverse risk pool.

In 2019, Engrossed Substitute Senate Bill 5526 (ESSB 5526) established Cascade Care plans as a type of QHP offered by health insurance carriers on *Washington Healthplanfinder*. Cascade Care plans are high-quality, low-cost, health plans with a standard benefit design set by the Exchange each year. These plans help consumers pay less at the doctor's office with more predictable costs. For example, regular check-ups and mental health office visits are covered without a deductible.

All Cascade Care plans, also known as standard plans, have the same standard benefit design, making it easier to shop and compare plans from across different carriers, offering an apples-to-apples comparison. This enables consumers to focus on premium costs and evaluate provider networks.

Public option background

In addition to establishing Cascade Care plans, ESSB 5526 (2019) created the public option, known as Cascade Select, which is the first public option program in the nation. Public option plans are intended to offer a high quality, affordable option for Washingtonians.

Public option plans use the standard benefit design of all Cascade Care QHPs. As a result, public option plans, offered exclusively through *Washington Healthplanfinder* since 2021, provide the same predictable benefits as all other Cascade Care plans. Plans provided by public option carriers are also required to meet higher quality standards and state-defined reimbursement rates for providers such as hospitals and doctors.

Through competitive procurement for plan years 2023 and contract renewal in 2024, HCA selectively contracted with three carriers to offer high-quality, affordable public option plans. This competitive selection aimed to both promote healthy competition on the Exchange and lower premiums for Washingtonians. A summary of the goals of the public option, related legislative requirements, and how those requirements achieve the desired goals is detailed in Table 1 below.

Table 1: Public option policy goals and requirements

Public option goal	Legislative requirements to achieve the goal	How the legislation advances the goal
Affordability	Provider reimbursement requirement: ESSB 5526 requires the following reimbursement targets for providers: • The total amount the QHP 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 for the same or similar services. • For services provided by rural hospitals certified by the Centers for Medicare and Medicaid Services (CMS) as critical access hospitals or sole community hospitals, the rates may not be less than 101 percent of allowable costs as defined by CMS.	• State-defined provider reimbursement requirements ensure that health care costs are controlled by creating an upper cap on provider payments. By controlling health care costs, public option plans are more affordable for Exchange consumers.

Public option goal	Legislative requirements to achieve the goal	How the legislation advances the goal
	• Reimbursement for primary care services may not be less than 135 percent of the amount that would have been reimbursed under the Medicare program for the same or similar services. <u>Requirement for state procurement</u>: ESSB 5526 required HCA to procure and contract for public option plans offered on the Exchange. This is in alignment with HCA's role of procuring and administering Apple Health, Public Employees Benefits (PEB), and School Employees Benefits (SEB) programs.	• Plans competitively procured by the State leverage stronger purchasing power to ensure access to affordable health plans for consumers.
Statewide access	<u>Hospital participation requirement</u>: E2SSB 5377 requires that hospitals (except those owned and operated by a health maintenance organization) must contract with at least one public option plan to provide in-network services to enrollees beginning plan year 2023.	• Participation requirements for hospital systems seek to ensure that all Washingtonians in every country have access to hospital care and affordable public option plans.
Quality & equity	Quality and value requirements: ESSB 5526 requires use of quality and value metrics, ongoing monitoring including adoption of recommendations by the Dr. Robert Bree Collaborative, adoption of recommendations by the Health Technology Clinical Committee, and reporting on health improvement activities, primary care expenditures, and other quality measures.	• Quality and value measurements improve access to affordable, quality health plans for Washingtonians.

In addition to affordability requirements and the goal to reach statewide availability, public option plans are intended to incentivize high-quality care with an emphasis on primary care. As public option plans are QHPs, these plans must meet Exchange plan design standards in addition to their added quality and value requirements.[6 & 7] This section describes the design and quality requirements of public option plans, including:

- Certification requirements for all QHPs, including quality requirements.
- Standard benefit design requirements of Cascade Care plans, including public option plans.
- Quality and value contractual requirements specifically for public option plans.

[6] All QHPs are required to meet design and quality standards to be certified and offered on *Washington Healthplanfinder*.

[7] All plans offered in the Exchange must be certified by the Exchange Board as QHPs. To participate in the Exchange's QHP certification process, a carrier must submit plans and supporting documentation annually as specified for 19 criteria, summarized in Appendix C. Each criterion is reviewed and approved by OIC, the Exchange, or both. QHP certification requires that carriers report quality and health performance data to fulfill the Exchange's regulatory responsibility to oversee the clinical quality and patient experience in QHPs. The Exchange Quality Program's core components include quality measure reporting, quality improvement activities, and data collection and quality measure reporting stratified by race and ethnicity. See Appendix D for a summary of QHP Quality Program components.

The standard benefit design applicable to all Cascade Care plans sets the framework for how consumers enrolled in public option plans access health care, including how much they spend at their providers' office on deductibles, co-pays and other out-of-pocket costs. This is a critical element of Cascade Care's affordability goals because high-cost sharing is a primary barrier to Washingtonians accessing health care. Ultimately, public option plans are intended to be the highest-quality health plans on the Exchange with affordable out-of-pocket costs when consumers seek care.

Description of Cascade Care plan design requirements, principles, and approach

In accordance with the law, carriers must offer Cascade Care plans in each county where the carrier offers coverage. There are also limits on the number of non-Cascade Care plans that the carrier can offer in a county. This is to ensure that Cascade Care plans are available to every *Washington Healthplanfinder* consumer and limits overcrowding of the marketplace.

The Exchange creates the standard benefit design, which is utilized by all Cascade Care plans including public option plans, based on national models with the following guiding principles:

- Lower deductibles and access to services without having to meet the deductible first.
- Prioritize fixed dollar copayments where possible to provide cost predictability for consumers when seeking services.
- Limit premium impacts.
- Maximize tax credits with silver plan design for lower-income individuals receiving subsidies to help them pay for care.

Cascade Care plans, including public option plans, also support easier access to high-clinical value care because visits to primary care providers and mental health care providers are not subject to the deductible, therefore the deductible does not need to be paid or satisfied by consumers when visiting these providers.[8] This makes getting necessary care easier, which may enable individuals to more effectively manage their chronic health conditions and prevent an avoidable costly emergency department visit or surgery.

The Silver-level Cascade Care plan design sets the actuarial value—or the floor for all silver QHPs, which means the other Silver plans cannot have a lower actuarial value than the Silver Cascade Care plan. As the consumer's federal tax credit is based on the premium of the second lowest cost Silver plan in each county, having the Cascade Care Silver plan as the actuarial value floor ensures the federal tax credit is calculated based on a Silver plan that covers more of the consumer's expected health care costs.

Public option quality and value contractual and ongoing monitoring requirements

Public option plans have additional quality, value, and provider reimbursement standards. To ensure that public option plans demonstrate quality, ESSB 5526 requires carriers offering public option plans to align certain quality review processes with the clinical criteria published by HCA, including recommendations by the Dr. Robert Bree Collaborative and the Health Technology Clinical Committee. Additionally, public option carriers are expected to engage with HCA in ongoing monitoring including reporting on health improvement activities, primary care expenditures, the Quality Rating System,[9] and the Washington State Common Measure Set.[10]

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[8] These services are set at a copay.

[9] QRS measures are required for all plans offered on Washington Healthplanfinder. Participating public option carriers are required to report on QRS measures for their public option plan enrollment and, for administrative measures only, to report on these metrics by region, sex, and age group, and, to the extent the carrier is in possession of the data, by race, ethnicity, and language.

[10] Like Medicaid, PEB, and SEB carriers, public option carriers must report on a subset of the Washington State Common Measure Set. The Common Measure set provides the foundation for health care accountability and

HCA conducts annual validation and ongoing monitoring processes with public option carriers. This ensures carriers that are awarded contracts for the public option plans fulfill the expectations to complete annual review of their plan offerings, including alignment with the clinical criteria published by HCA.

The public option program is still in its early stages, with data available for only the first plan year (2021) for most quality reporting.[11] For the years data are available, carriers are successfully meeting public option's quality and value requirements. Carrier requirements and results for plan years 2021 and 2022, where available, are described in Appendix E.

Public Option Analysis and Evaluation

Public option plans have had a significant overall positive impact on Washingtonian individual health plan consumers. To fully evaluate the public option and reach this conclusion, the Board examined:

- Cost-sharing for consumers, including deductibles.
- Plan design of Cascade Care plans, which includes the public option, including cost-sharing scenarios.
- Consumer access challenges and opportunities.
- Public option affordability, including premiums and factors affecting affordability.
- Public option enrollment and demographic factors.

Analysis of Cascade Care plan cost-sharing and impact on consumers

A health plan's benefit design sets consumer cost sharing, which is an integral part of access to coverage and care. Unlike non-Cascade Care plans (or QHPs without standardized benefit design), which are designed by carriers and can vary in deductibles and copays, Cascade Care plans, including public option plans, have the same benefit design regardless of the carrier.

Analysis of cost sharing demonstrates that:

- The introduction of Cascade Care plans to the Exchange marketplace decreased deductibles across all Exchange plans.
- Public option deductibles are an average of $1,000 less than non-Cascade deductibles.
- Enrollees in public option plans are likely to pay less out-of-pocket when receiving services of high clinical value such as primary care, or for a series of related health care services such as having a baby or managing a chronic health condition.

Analysis of Cascade Care's deductibles and impact on consumers

Prior to offering Cascade Care plans, only one plan on *Washington Healthplanfinder* had a deductible of less than $1,000. The introduction of Cascade Care plans on the Exchange in 2021 significantly reduced the average Exchange deductible at the Silver and Gold levels. Additionally, the average non-Cascade Silver plan deductibles decreased by $700. Upon the launch of Cascade Care plans, carriers offered several new lower-deductible plans, such as Molina's $0 medical deducible Silver plan, and Kaiser Permanente Washington's Virtual Plus plans that

measuring performance. The development and ongoing evolution and implementation of a set of measures is mandated under House Bill 2572 (2013-14).**https://www.hca.wa.gov/about-hca/who-we-are/washington-state-common-measure-set**

[11] Carriers' reporting deliverables are spread over the plan year, therefore the full complement of carriers' quality reporting data for plan year 2022 are not yet available.

offered $0 cost share virtual visits. Figure 1 and Tables 2 through 6 denote the impact of Cascade Care plans' introduction to the market.

Figure 1: Impact of Cascade Care Plans on Exchange consumers' deductibles[12]

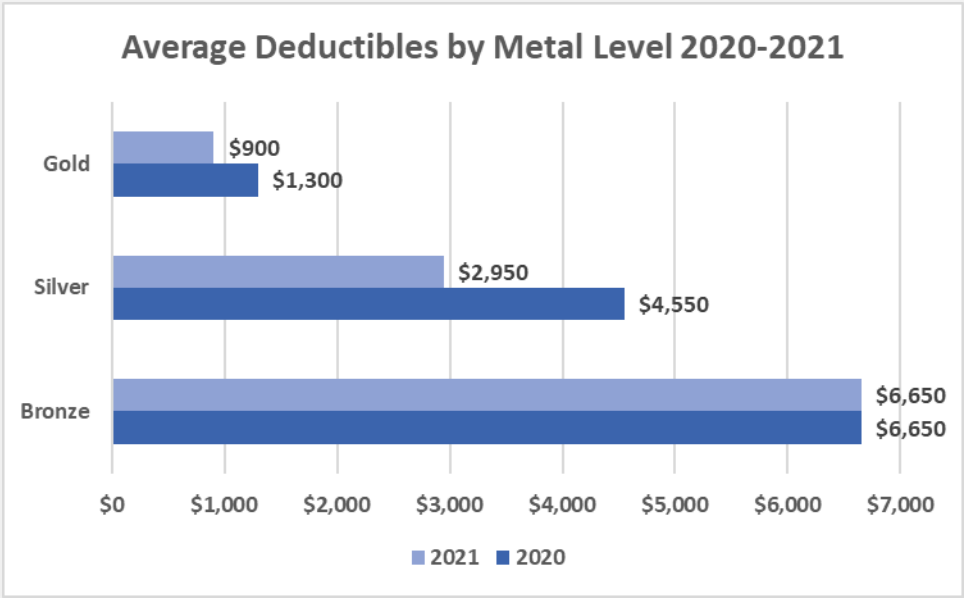

Table 2: 2020 average and median deductibles by metal level (pre-Cascade Care)[13]

Metal	Range	Average	Median
Bronze	$5,000-$8,150	$6,650	$6,650
Silver	$2,000-$7,500	$4,550	$4,000
Gold	$0-$2,925	$1,300	$1,200

Table 3: 2021 average and median deductibles by metal level, non-Cascade QHPs compared to Cascade Care plans

Metal	Range	Average Non-Cascade	Median Non-Cascade	Cascade Care
Bronze	$3,000-$8,550	$7,050	$7,200	$6,000
Silver	$800-$6,900	$3,850	$3,250	$2,000
Gold	$0-$2,925	$1,450	$1,500	$500

[12] 2021 averages include Cascade plans rounded to nearest $50 and are not weighted for enrollment or county availability. Non-integrated deductibles treated as integrated deductibles for purposes of calculating average. Each plan counted once per Plan ID in average.

[13] Tables 2-5 averages and medians round to nearest $50 on Tables 2-5; each plan counted once per Plan ID in average. Non-integrated deductibles treated as integrated deductibles for purposes of calculating average.

Table 4: 2022 average and median deductibles by metal level, non-Cascade QHPs compared to Cascade Care plans

Metal	Range	Average Non-Cascade	Median Non-Cascade	Cascade Care
Bronze	$3,000-$8,700	$7,100	$7,500	$6,000
Silver	$800-$6,900	$3,900	$3,350	$2,000
Gold	$0-$2,500	$1,500	$1,500	$500

Table 5: 2023 average and median deductibles by metal level, non-Cascade QHPs compared to Cascade Care

Metal	Range	Average Non-Cascade	Median Non-Cascade	Cascade Care
Bronze	$3,800-$8,900	$7,300	$7,300	$6,000
Silver	$750-$7,550	$3,100	$2,900	$2,500
Gold	$0-$2,000	$1,500	$1,650	$600

Cascade Care plan design compared to non-Cascade Care plan design

In addition to plan deductibles, plan design broadly defines out of pocket expenses when seeking care, thereby reducing out-of-pocket expenses. An analysis comparing the 2022 benefit design of Cascade Care plans at each metal level to three non-Cascade plans at the same metal level shows that Cascade Care plans, comparatively, offer the following:

- Strong pre-deductible coverage.
- Limited financial barriers to services such as primary care, mental health visits, lab services and x-rays through lower co-pays and/or services before the deductible.
- Require more consumer responsibility for services that can be expensive and sometimes overused such as advanced imaging.
- Have room to improve affordability of prescription drugs, such as lowering cost sharing.

Table 6 below shows the comparison between the 2022 benefit design for three popular non-Cascade Care plans at the Silver metal level and the 2022 Cascade Care plan benefit design at the Silver metal level. Nearly half of public option enrollees are enrolled in plans at this metal level.

Table 6: Benefits comparison chart of 2022 Cascade Silver plan to 2022 non-standard Silver plans[14]

	Cascade Care Silver offered by all Exchange carriers	Molina Constant Care Silver 1	Coordinated Care Ambetter Balanced Care 4	Kaiser WA Flex Silver
Actuarial Value (AV)	71.21%	71.75%	71.48%	71.22%
% of Total Silver Enrollment[15]	29%	26%	12%	6%

[15] Effectuated (Premium paid) Spring 2022 enrollment data.

Deductible	$2,000	Medical:$0 Drug:$800	$6,900	$1,800	
Coinsurance	30%	40%	0%	30%	
MOOP	$7,800	$8,000	$6,900	$7,900	
Emergency Room Services	After Deductible, $800	$750	After deductible, no charge	After Deductible, 30% Coinsurance	
All Inpatient Hospital Services (inc. MH/SUD)	After Deductible, $800, (per day copay, limit of 5 copays per stay)	After Deductible, $1200 (per day copay, limit of 2 copays per stay)	After deductible, no charge	After Deductible, 30% Coinsurance	
Primary Care Visit	$25	$30	$30	After Deductible, $20	Deductible waived for first 4 visits
Specialist Visit	$60	$60	$60	After Deductible, $45	
MH/SUD Outpatient Services – Office	$25	$30	$30	After Deductible, $20	
Imaging (CT/PET Scans, MRIs)	After Deductible, 30% Coinsurance	$700	After deductible, no charge	After Deductible, 30% Coinsurance	
Speech Therapy	$35	$60	After deductible, no charge	After Deductible, $45	
Occupational and Physical Therapy	$35	$60	After deductible, no charge	After Deductible, $45	
Laboratory Outpatient and Professional Services	$35	$45	After deductible, no charge	After Deductible, 30% Coinsurance	
X-rays and Diagnostic Imaging	$60	$80	After deductible, no charge	After Deductible, 30% Coinsurance	
Skilled Nursing Facility	After Deductible, $800, (per day copay)	$1200 (per day copay)	After deductible, no charge	After Deductible, 30% Coinsurance	
Outpatient Facility Fee	After Deductible, $600	$500	After deductible, no charge	After Deductible, 30% Coinsurance	
Outpatient Surgery Physician/Surgical Services	After Deductible, $200	$75	After deductible, no charge	After Deductible, 30% Coinsurance	
Generics	$20	$20	$15	$10	
Preferred Brand Drugs	$70	$60	$50	After Deductible, 40% Coinsurance	
Non-Preferred Brand Drugs	After Deductible, $250	After Drug Deductible, 40%	After deductible, no charge	After Deductible, 50% Coinsurance	

Specialty Drugs (i.e., high-cost)	After Deductible, $250	After Drug Deductible, 40%	After deductible, no charge	After Deductible, 50% Coinsurance [16]

Silver plan comparison takeaways

- Cascade Care Silver plans offer strong coverage for primary care and specialty care because these benefits are not subject to deductible. For example, in the non-Cascade Care Kaiser Flex Silver plan, the consumer is responsible for meeting the deductible after four primary and specialty care visits.
- Cascade Care plans keep costs for office visits low so that consumers can better manage their health needs as opposed to relying on expensive emergency room care. Cascade Care Silver plans offer strong coverage on lab and x-ray because these benefits are subject to a fixed dollar copay and are not subject to the deductible.
- However, compared to the other non-Cascade Care Silver plans, Cascade Care consumers are responsible for more costs of outpatient hospital care. For example, Cascade Silver consumers must meet their deductible and pay an additional copayment for facility fees and surgery costs.
- Also, some Cascade Care consumers are responsible for more of the costs of emergency room services than consumers in certain non-standard plans like Molina Constant Care Silver and KP WA Flex Sliver.
- Finally, cost sharing is higher in Cascade Care Silver plans for preferred brand drugs and generics than in some non-standard plans.

Cost scenario differences between Cascade Care and non-Cascade consumers receiving care

Consumers experience the full benefit of the Cascade Care plan design when they utilize their coverage to manage and address illness or other health conditions. Tables 7 through 10 below illustrate how consumers in Cascade Care plans may pay lower out-of-pocket costs compared to consumers in popular non-Cascade Care plans on the Exchange. These scenarios are for illustrative purposes only, as many factors can impact a patient's course of treatment and how they are billed for services.

Table 7: Consumer cost scenario for six-month outpatient treatment for uncomplicated depression (2023 plan designs)[17]

	KP WA Flex Bronze	Cascade Care Bronze
Actuarial Value (AV)	64.18%	64.21%
Deductible	$5,500	$6,000
Counseling Visits (25)	$2,196	*$1,250 (25 copays)*
Primary Care Visits for Medication Management (2)	$202 (2 copays)	*$100 (2 copays)*
Prescription for Generic Antidepressants 6-Months	*$150 (6 copays)*	*$192 (6 copays)*
Consumer Out-of-Pocket Costs	$2,548	$1,542

[16] Averages in Figures 4-7 are not weighted for enrollment or county availability. Each plan counted once per Plan ID in average.

[17] On KP WA Flex plan, 2 counseling visits are at $40 copay and 1 Primary Care Provider visit is at $40 copay, then subsequent visits subject to deductible. Visit cost estimates came from WA Health Compare using zip code 98122 used average cost of $92 for mental health therapy visit and average cost of $162 doctor office visit current patient.

Table 8: Consumer cost scenario for having a baby (2023 plan designs)[18]

	Ambetter Balanced Care 4	Cascade Care Silver
Actuarial Value (AV)	71.92%	71.53%
Deductible	$7,550	$2,500
Obstetrics Visits (15)	*$450*	*$450*
Ultrasounds (2)	$343	*$130*
Bloodwork & Other Lab Tests	$1,153	*$160*
Generic Drugs	*$5*	*$11*
Preventive Services & Vaccines	$0	$0
Inpatient Hospital Care (2 days)	$6,054	$4,100
Consumer Out-of-Pocket Costs	$8,005	$4,851

Table 9: Consumer cost scenario for managing diabetes (2023 plan designs)

	LifeWise Essential Gold	Cascade Care Gold
Actuarial Value (AV)	79.01%	81.88%
Deductible	$1,000	$600 Medical/ $0 Pharmacy
Primary Care Visits (5)	*$150*	*$75*
Lab Services (2 sets of diagnostic tests)	$122	*$40*
Generic Emergency Glucagon Kit	*$10*	*$10*
12 Months of Brand Name Insulin (state cap)	*$420*	*$420*
Blood Test Strips/Insulin Syringes	$790	$638
Consumer of Out-of- Pocket Costs	$1,492	$1,183

Table 10: Consumer cost scenario for simple fracture (2023 plan designs)

	Molina Constant Care 1	Cascade Care Silver
Actuarial Value (AV)	71.59%	71.53%
Deductible	$0 Medical/ $900 Drug	$2,500
Ambulance	*$472*	*$375*
Emergency Room Visit	*$742*	$742
2 Orthopedic Visits (Specialist)	*$120*	*$130*
X-Ray	*$95*	*$65*
Prescription for Ibuprofen for Pain	*$5*	*$5*
Crutches & Walking Boot	*$124*	$248
Evaluation and 4 Sessions of Physical Therapy	*$300*	*$200*
Consumer Out-of-Pocket Costs	$1,858	$1,765

[18] Italicized cost shares indicate benefits not subject to the deductible on Tables 7-10.

Consumer access challenges and opportunities

Access to public option plans and providers

While Cascade Care plans are available in every county of the state, public option plans have not yet reached statewide availability. In 2023, public option plans are available in 34 counties of 39 counties, up from 25 counties in 2022 and 19 counties in 2021. This growth signals increased ability of carriers and health care providers to reach contractual agreements and build public option provider networks that meet the program's quality and affordability requirements.

Exchange carriers that offer public option plans have voiced intent to offer public option plans to consumers statewide. However, this will rely on carriers' ability to secure public option networks with providers that will agree to the program's reimbursement rates to achieve the state-defined aggregate affordability standards, which has proven challenging.

While carriers are not required to offer public option plans, ESSB 5377 requires that hospitals must contract with at least one public option plan to provide in-network services to enrollees beginning plan year 2023.[19] As such, some carriers report some difficulties with providers that appear to be unwilling to agree to participate in public option networks or agree to public option reimbursement rates.[20] This means that public option plans may not be available in every county. With this anecdotal evidence, HCA, as the entity enforcing hospital participation requirements, continues to monitor the impact of the recent rulemaking on availability and accessibility for the public option.[21]

Beyond plan availability, provider participation in the public option impacts public option enrollees. Public option provider networks differ from non-public option plans on the Exchange and in comparison to non-public option plans, public option plan networks appear to be not as extensive.[22] However, all QHPs, including public option plans, must meet OIC's network access requirements.

Additionally, consumers have reported confusion navigating the different networks, particularly as they switch from a carrier's non-public option plan to the same carrier's public option plan. Network data analysis is currently underway to better understand provider networks and the effects on public option enrollees, but preliminary findings indicate differences in public option plan networks compared to other plans both in terms of the hospitals in network and key outpatient provider types such as primary care providers. The Exchange and HCA are working to collect the needed data to perform future analysis.

Public option affordability

Aggregated carrier results of public option reimbursement requirements

The 2019 legislation intended the public option to provide high quality, affordable health plans on the Exchange for the individual market. The following are reimbursement requirements for providers participating in the public option:

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[19] Except those owned and operated by a health maintenance organization.

[20] Public Option Legislative Report 2022.

[21] 182-513-1350 HCA Rulemaking Order https://www.hca.wa.gov/assets/103P-22-10-023.pdf

[22] Based on preliminary research conducted by HCA and HBE.

- The total amount the QHP 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 for the same or similar services.
- For services provided by rural hospitals certified by CMS as critical access hospitals or sole community hospitals, the rates may not be less than 101 percent of allowable costs as defined by CMS.
- Reimbursement for primary care services may not be less than 135 percent of the amount that would have been reimbursed under the Medicare program for the same or similar services.

With the program in its infancy, data for the first plan year have only recently been made available. Review of the public option reimbursement target is in the early stages. Data from initial and ongoing monitoring indicates that public option carriers with sufficient claims data for analysis slightly exceeded the aggregate statewide reimbursement target of 160 percent of Medicare in 2021 (Figure 3, Exhibit 2).[23 & 24]

Figure 2: Public Option Aggregated Reimbursement Target Review [25]

Exhibit 2
Cascade Care Public Option - Results of Reimbursement Target Review
Affordability Requirement Performance Summary
Claims Incurred from January 1, 2021 through December 31, 2021

ALL CARRIERS — Member months: 26,622

Affordability Requirement	Metric Results: Requirement	Performance	Results
A) Aggregate Percent of Medicare Reimbursement[1]	< 160%	164%	FAIL
B) Physician Primary Care Percent of Medicare Reimbursement	> 135%	139%	PASS
C) Critical Access and Sole Community Hospital Reimbursement	> 101%	160%	PASS
Summary of Affordability Requirements[2]	FAIL		

Notes
1. Inpatient hospital claims experience and percent of Medicare reimbursement rates adversely affected by several large outlier claims in late 2021.
2. Of five 2021 carriers, two carriers meet all three affordability requirements and one carrier has insufficient experience for evaluation.

Initial affordability analyses, which only includes data from the first year of public option (plan year 2021), suggests that the reimbursement targets may not be low enough, or that the aggregated cap may create negotiating difficulties for carriers, to significantly reduce premiums across public option plans.[26] However, the public option shows promise in accomplishing more affordable premiums relative to other plans on the Exchange.

Analysis of 2021-2023 public option premiums

This analysis of public option premiums shows:

- While public option plan premiums were initially higher than non-Cascade plan premiums on the Exchange, public option premiums have consistently trended downward at all metal levels.

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[23] For ongoing monitoring of compliance with these requirements, HCA's actuarial consultant, Milliman, collects and assesses paid claims data twice yearly from public option carriers. The percent of Medicare reimbursement is produced by dividing the total carrier allowed amount by the amount Medicare would have allowed for the same services. In the final analysis for all quarters in 2021, one carrier still had reimbursement targets in excess of 160 percent of Medicare. Two of the four carriers with claims data had aggregate statewide reimbursement targets below 160 percent of Medicare. If outlier medical claims for a carrier whose reimbursements exceeded the target were removed, the average across all carriers would have met the 160 percent reimbursement target.

[24] "Cascade Select Public Option," Dec. 1, 2022: https://www.hca.wa.gov/assets/program/cascade-select-leg-report-20221216.pdf

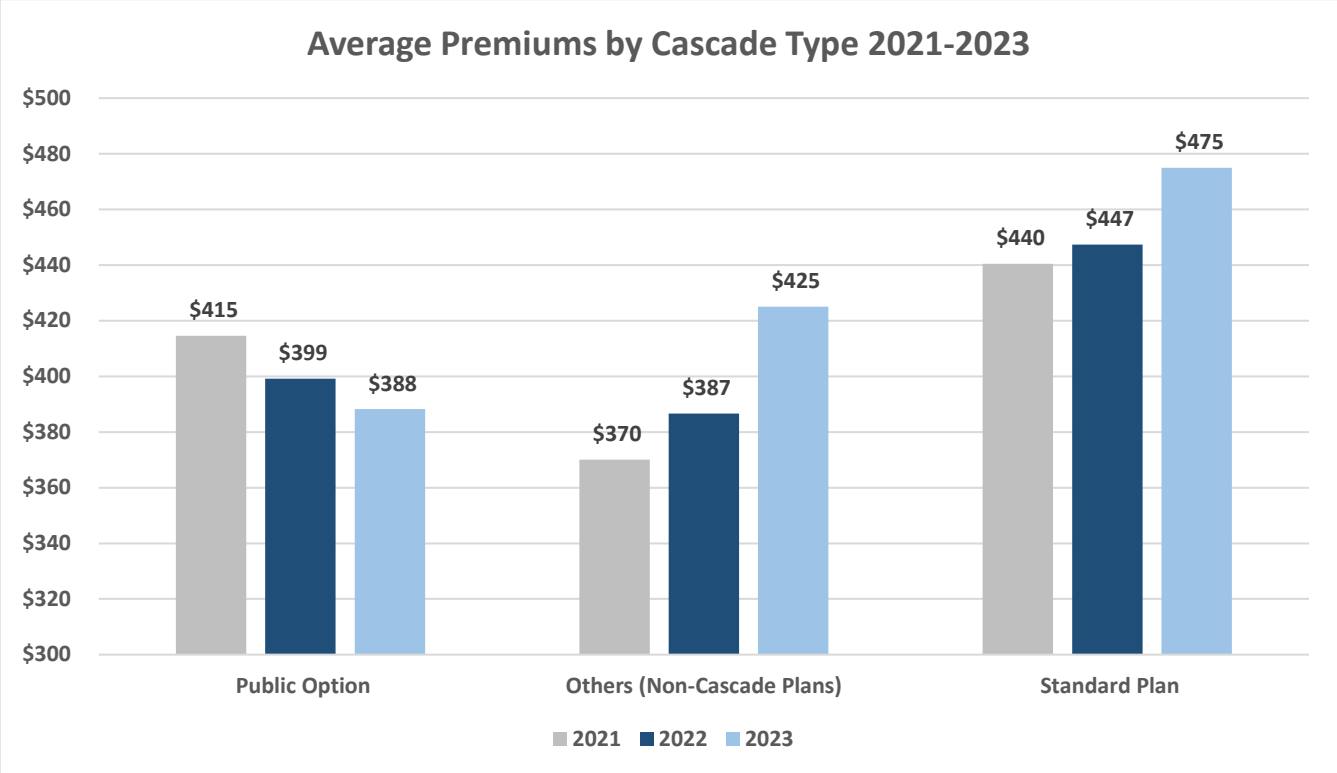
[25] Ibid.

[26] Ibid.

- Public option plans are the most affordable QHP in many Washington counties (25 out of the 34 counties where public option plans are available).[27]
- HCA's competitive and selective public option procurement in 2023 (compared to a process for the 2021-2022 plan years that allowed all interested carriers to offer the public option) was a driver of 2023 advancements in affordability, statewide availability, and healthy market competition.
    - Public option plans are the lowest-cost Silver premium offering on the Exchange in 25 counties in 2023, up from 13 counties in 2022.
    - The average public option premium rate in plan year 2023 decreased by three percent compared to average rate increases of more than nine percent for non-public option health plans on the Exchange.

In plan year 2023, average public option plan premiums across all metal levels were lower than non-Cascade Care premiums for the first time. These advances are promising indicators that a comprehensive set of benefits can be offered at a lower premium when paired with requirements that address underlying cost drivers of premium rates. Figures 3 through 6 below denote premium comparisons of public option plans and non-public option plans for plan years 2021-2023.

Figure 3: Average premiums by type on the Exchange 2021-2023 for a 40-year-old nonsmoker.



[27] Public option premiums for a 40-year-old nonsmoker are the lowest-premium silver QHPs in 25 counties in 2023.

Figure 4: Average plan rates by plan type for Bronze on the Exchange 2021-2023 for a 40-year-old nonsmoker

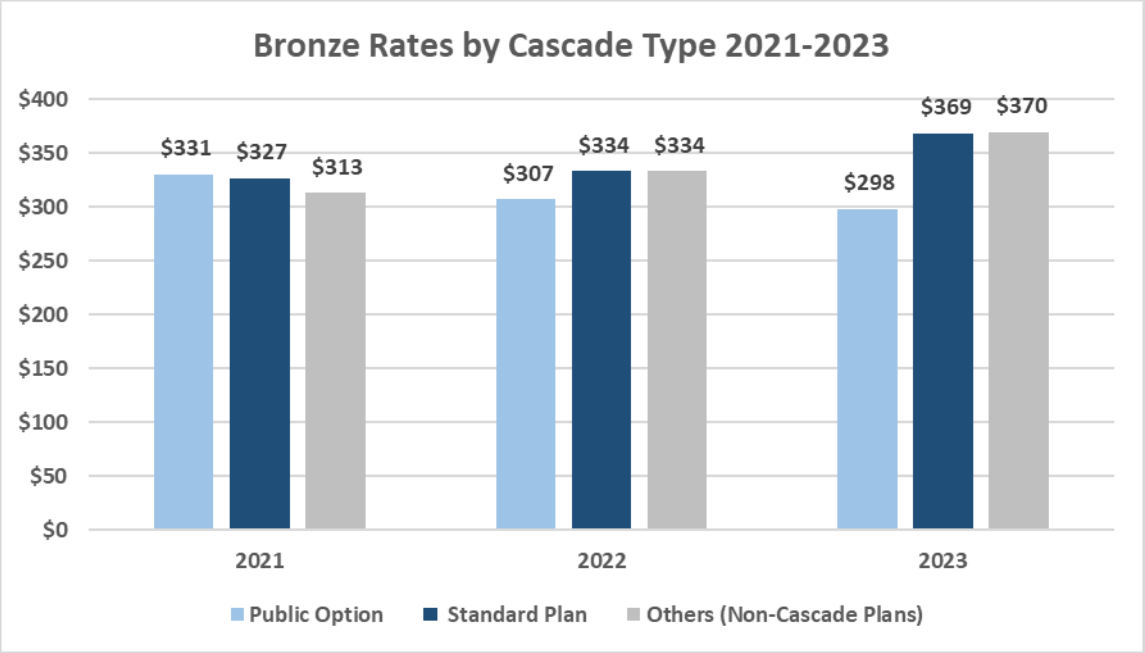


Figure 5: Average plan rates for Silver by plan type on the Exchange 2021-2023 for a 40-year-old nonsmoker

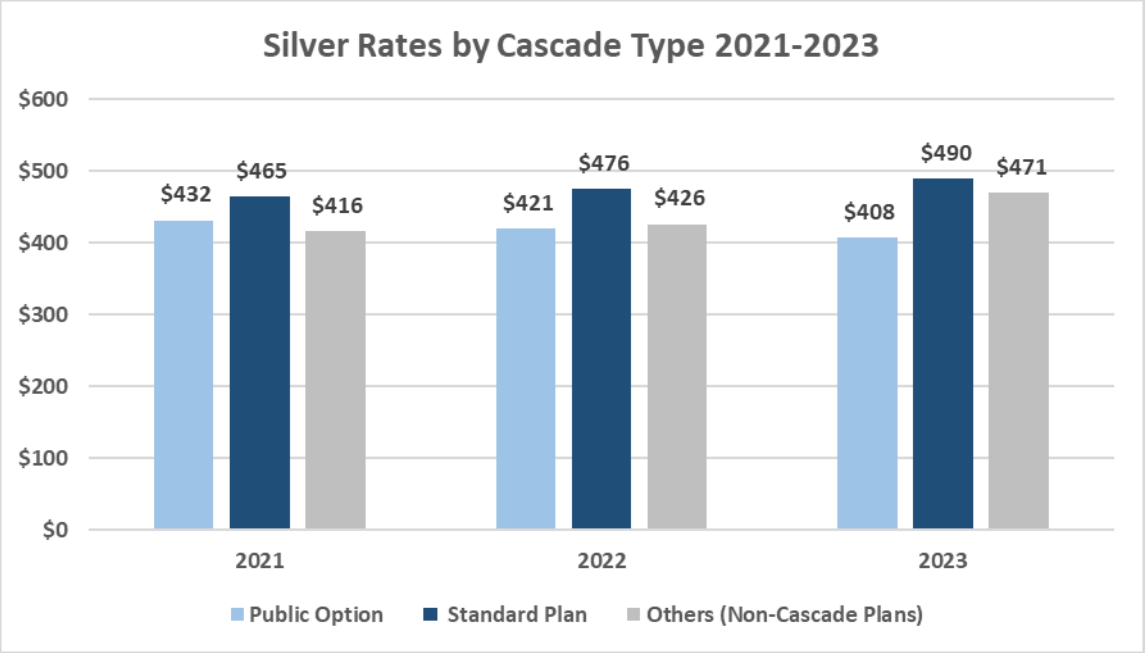
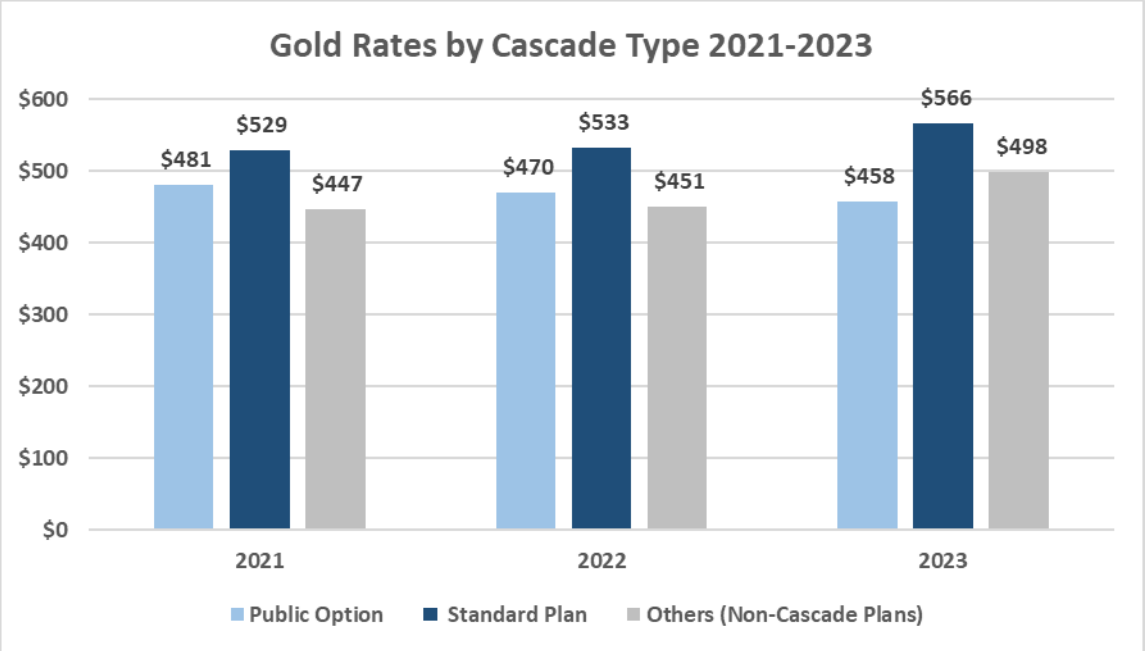


Figure 6: Average plan rates for Gold by plan type on the Exchange 2021-2023 for a 40-year-old nonsmoker



Between 2021 and 2023, public option premiums decreased by six percent. This is compared to 15 percent premium increases in non-Cascade Care plans on the Exchange during that same time period, as illustrated by Table 11 below. Additionally, before subsidies, public option plans are the lowest-premium silver qualified health plans in 25 counties in 2023 (Table 12 and Figure 7).

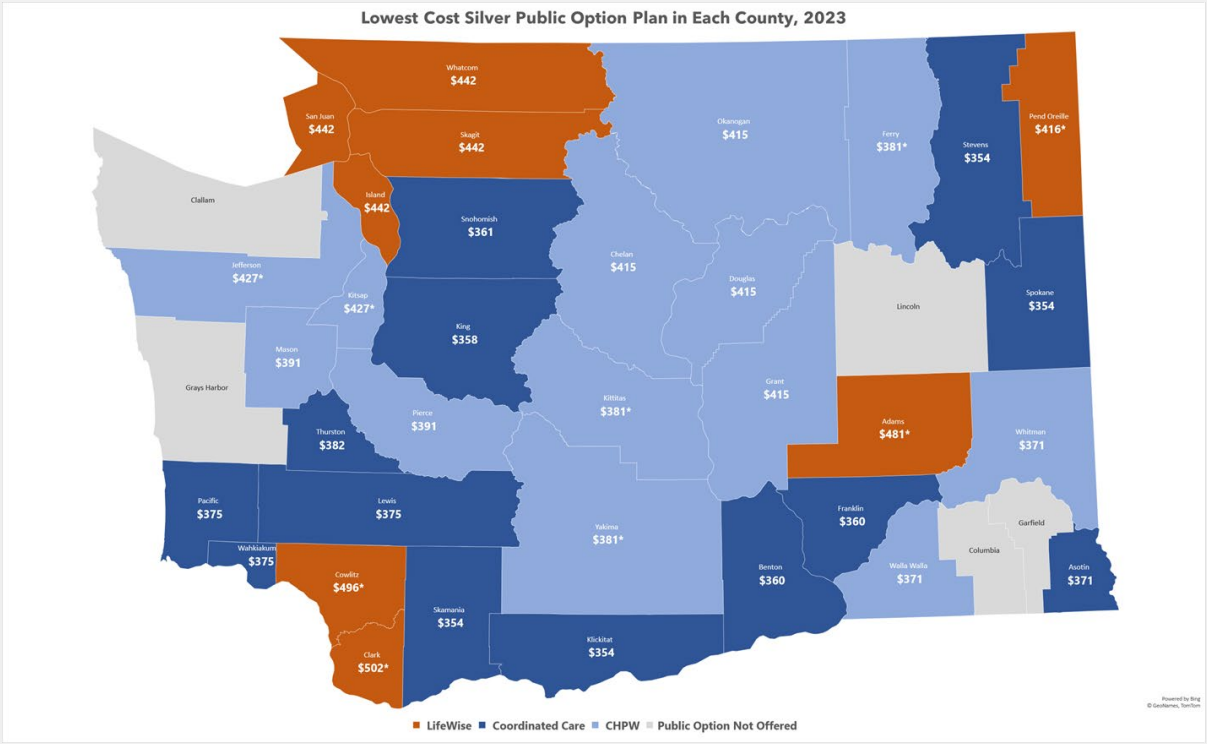
Table 11: Rate percentage change by plan type 2021-2023 for a 40-year-old nonsmoker, all metal levels

	Rate Change % 2021-2022	Rate Change % 2022-2023	Rate Change % 2021-2023
Public Option	-4%	-3%	-6%
Others (Non-Cascade Plans)	4%	10%	15%
Standard Plan	2%	6%	8%

Table 12: Number of counties where public option is the lowest cost QHP by metal level, 2021-2023

	Bronze	Silver	Gold
2021	1	1	4
2022	14	13	8
2023	24	25	1

Figure 7: 2023 lowest cost public option Silver plan premium and carrier by county, 40-year-old nonsmoker[28]



Other market factors affecting consumer premiums

Washington's public option launched only recently in 2021 and has grown during a time of significant change in health coverage and the health care landscape. Of note, the COVID-19 pandemic and related interventions changed consumer access to health insurance and financial assistance in Washington. Additionally, in 2021, the passage of ESSB 5377 established state-funded premium assistance for low-income Exchange consumers enrolled in Cascade Care plans, including public option plans.

Effects of the pandemic on access and affordability

In response to the COVID-19 pandemic, the Exchange opened a Public Health Emergency (PHE) Special Enrollment Period (SEP) for consumers beginning February 15 extending to August 15, 2021. The American Rescue Plan (ARPA), a federal COVID-19 relief law passed in March 2021 includes enhanced premiums subsidies to help consumers pay for individual market coverage. Under ARPA, consumers are expected to contribute a lower percentage of their income on health care than under the Affordable Care Act and receive additional federal tax credits until 2026 so that their premium contribution is within the newly lower limits.[29] Within two months, Washington's Exchange was among the first in the country to implement the new savings available under ARPA, including extra premium subsidies for those reporting unemployment income.

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[28]*Asterisk next to premium amount on map indicates where public option plan is not lowest cost silver qualified health plan in county.

[29] Cox, Cynthia and Krutika Amin, "Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums," Kaiser Family Foundation, 2021, available at: https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/.

From May to August 2021, 28,000 new consumers signed up for Exchange coverage. Approximately 500 consumers also enrolled in public option plans during this time. As of August 15, 2021, 78 percent of Exchange consumers were receiving subsidies, up from 61 percent pre-ARPA. Additionally, nearly half of all QHP consumers paid less than $100 per month for coverage. Subsidized QHP consumers with an annual income over 400 percent FPL (23,000 enrollees) previously not eligible for subsidies paid nearly $200 less per month for premiums. The additional subsidization through ARPA resulted in important gains in affordability for consumers. [30]& [31]

During the PHE, individuals covered by Medicaid remained covered under Medicaid because Medicaid eligibility redeterminations were paused.[32] Washington's uninsurance rate decreased to a record low of 5.3 percent in 2021, driven by the enhanced ARPA subsidies and continuous Medicaid coverage.[33] However, some of the gains in coverage and affordability are at risk now that federal requirements for Medicaid redeterminations restarted in 2023. In addition, the enhanced federal subsidies are only available through the end of calendar year 2025.

Cascade Care Savings

A $50 million annual state-funded premium subsidy, called Cascade Care Savings, was established by the Washington Legislature in 2021 and made available to consumers starting January 2023.[34] Cascade Care Savings is available to Washingtonians with income up to 250 percent FPL who are not eligible for existing state and federal coverage programs such as Washington Apple Health (Medicaid) or Medicare. To receive Cascade Care Savings, consumers must enroll in a Cascade Care Gold or Silver plan, which include public option plans.

Cascade Care Savings maximizes all available federal tax credits and helps consumers who do not qualify for federal subsidies. The state premium subsidies, in tandem with federal subsidies, provide an unprecedented opportunity for uninsured, low-income Washington residents to get health care coverage. The exact amount of savings received is displayed to consumers in *Washington Healthplanfinder* and is based on where the consumer lives, their age and income.

To date, more than 50,000 consumers are receiving Cascade Care Savings to lower their monthly premiums. About 75 percent of consumers enrolled in Silver and Gold Cascade Care plans—including public option plans—are receiving state-funded premium assistance and pay less than $100 for their monthly premiums. Of these consumers, 25 percent have a $0 monthly premium.

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[30] Washington Health Benefit Exchange, Public Health Emergency Special Enrollment and American Rescue Plan Act Implementation, August 31, 2021, available at: https://www.wahbexchange.org/content/dam/wahbe/2021/02/ARPA%200815%20Final.pdf.

[31] Public option plans are some of the lowest premiums in many counties in 2023 and may impact the amount of the federal tax credit. The federal tax credit is based on the second lowest-cost Silver plan in a county. When the premium of the second lowest-cost Silver plan decreases, the amount of federal subsidies a consumer receives also decreases. Public option plans may create more distinction in the range of premiums on the Exchange, with lower-premium public option plans sometimes defining federal tax credit availability and non-public option plan premiums continuing to increase at a greater rate.

[32] A Medicaid redetermination is where individuals must show proof of their eligibility for Medicaid to remain covered.

[33] See Appendix A for a comparison of WA and US uninsured rates between 2010-2021.

[34] In 2022, the Exchange applied for and received approval for a first-in-kind Section 1332 State Innovation Waiver to provide access to QHP and QDP through Washington Healthplanfinder to people who were previously ineligible to purchase coverage due to their immigration status. During the 2023 legislative session, the Legislature appropriated an additional $5 million in annual state-funded premium assistance for consumers who are ineligible for federal premium tax credits but otherwise meet Cascade Care Savings eligibility criteria for coverage starting in plan year 2024.

Table 13: Cascade Care Savings recipient enrollee count by net premium, Spring 2023[35]

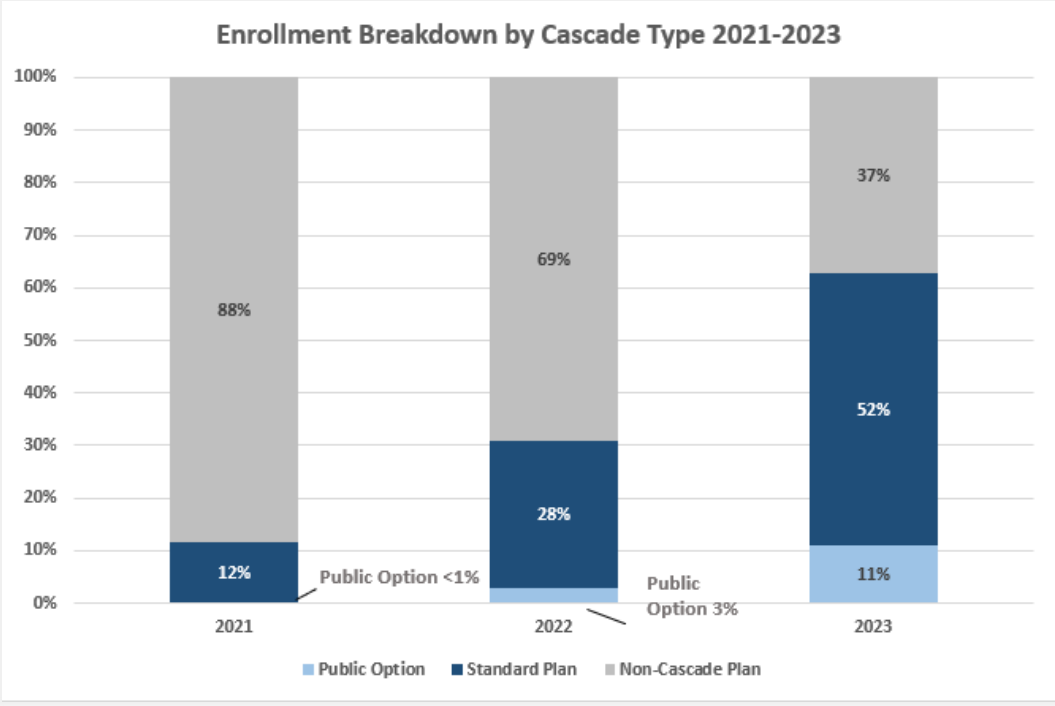
Net Premium	Cascade Care Savings Enrollees
$0	10,656
$1-50	10,969
$51-100	8,995
$101+	11,138
Grand Total	41,758

Impact of premium affordability on exchange consumers

Consumer enrollment in public option plans

Since the launch of Cascade Care in 2021, most Exchange consumers have shifted their enrollment to Cascade Care plans, including public option plans. As of March 2023, two-thirds of Exchange enrollees are in Cascade Care plans, including the public option. Public option plans currently represent more than 10 percent of Exchange enrollment, with nearly 25,000 enrollees. Figure 8 below illustrates the market shift to Cascade Care plans.

Figure 8: Market shift to Cascade Care plans by percentage of total exchange enrollment 2021-2023



Primary drivers of enrollment in public option plans include the following:

- Public option plans are the lowest-cost premium plan for many consumers.
- New enrollees are more likely to enroll in public option plans as they actively shop for a plan as opposed to renewing enrollees who auto-renew into the same health plan.

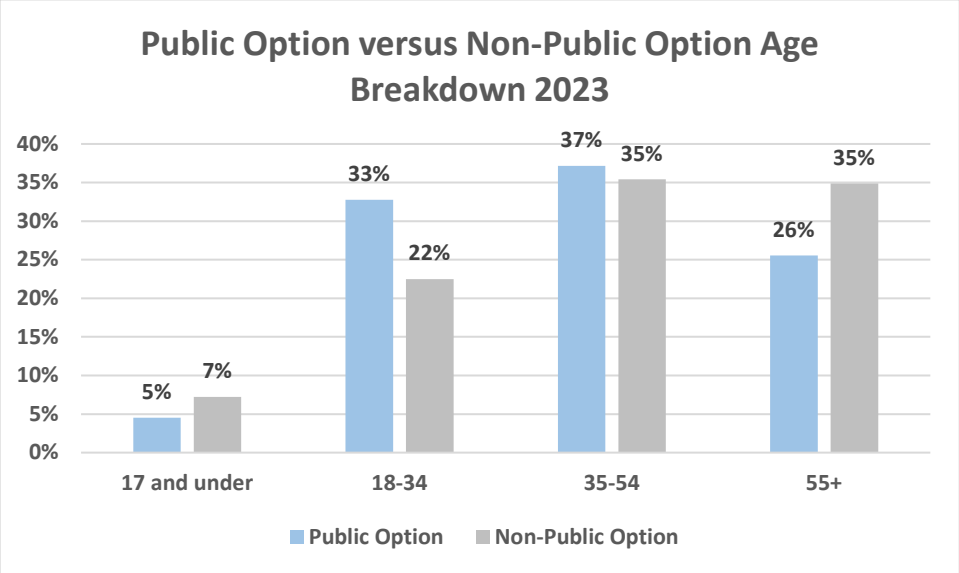
[35] WAHBE 2023 Spring Enrollment Report Available at: https://www.wahbexchange.org/content/dam/wahbe-assets/reports-data/enrollment-reports/Spring%20OE10%20Report%20Updated%202023.07.17.xlsx.

- Annual plan mapping results in renewing enrollees into public option plans.[36]

Public option enrollee demographics

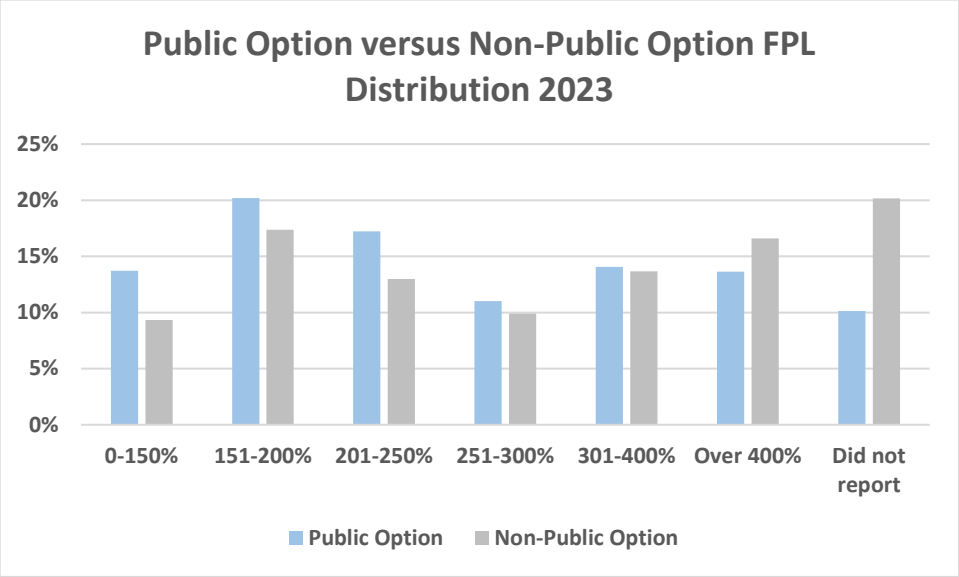
Public option enrollees are consistently slightly younger than non-public option Exchange enrollees. In 2021 and 2023, public option enrollees were more likely to be lower income compared to non-public option enrollees, though there was no difference in income levels between the two groups in 2022. This suggests additional years of enrollment are needed to establish a clear trend. Figure 9 and Figure 10 illustrate differences in FPL distribution between public option and non-public option enrollees in plan year 2022 and plan year 2023 respectively.

Figure 9: Differences in FPL distribution between public option and non-public option enrollees in 2022



[36] Annual plan mapping is a process that includes the Exchange and health plan carriers moving renewing enrollees into different plans and most often occurs when consumers' existing plans are no longer available in the next plan year.

Figure 10: Differences in FPL distribution between public option and non-public option enrollees in 2023



Consumer shifting to higher benefit plans

With the introduction of premium affordability measures paired with public option plan premiums being lower than other plan types, Exchange enrollees are selecting plans with more comprehensive benefits. All Exchange health plans are available in four metal levels—Bronze, Silver, Gold, and Platinum. The difference between the metal levels is the percentage of care covered, e.g., Bronze plans cover 60 percent of the costs of care, and Gold plans cover 80 percent. Each year since 2021, marketplace composition has shifted from Bronze metal level enrollment to Silver and Gold plans.

The introduction of both enhanced federal subsidies in 2021 and state premium assistance in 2023 made it possible for many consumers to purchase more comprehensive plans. Public option enrollees are even more likely than their non-public option counterparts to enroll in a Silver or Gold plan; a trend observed even before state premium assistance became available in 2023. Figures 11, 12, and 13 illustrate the comparison of public option to non-public option QHP metal level selection from 2021, 2022, and 2023 respectively.

Figure 11: Public option to non-public option QHP metal level selection trends in 2021

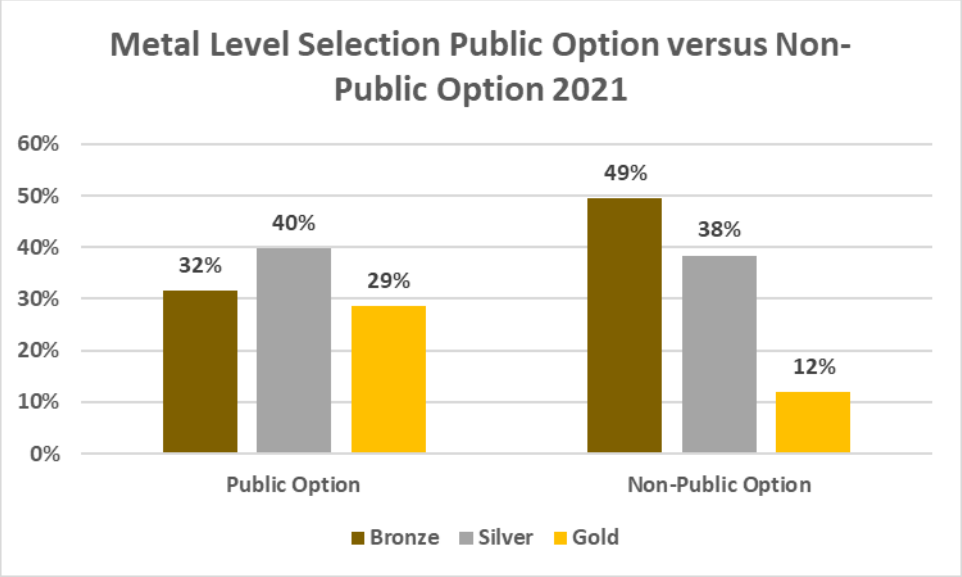


Figure 12: Public option to non-public option QHP metal level selection trends in 2022

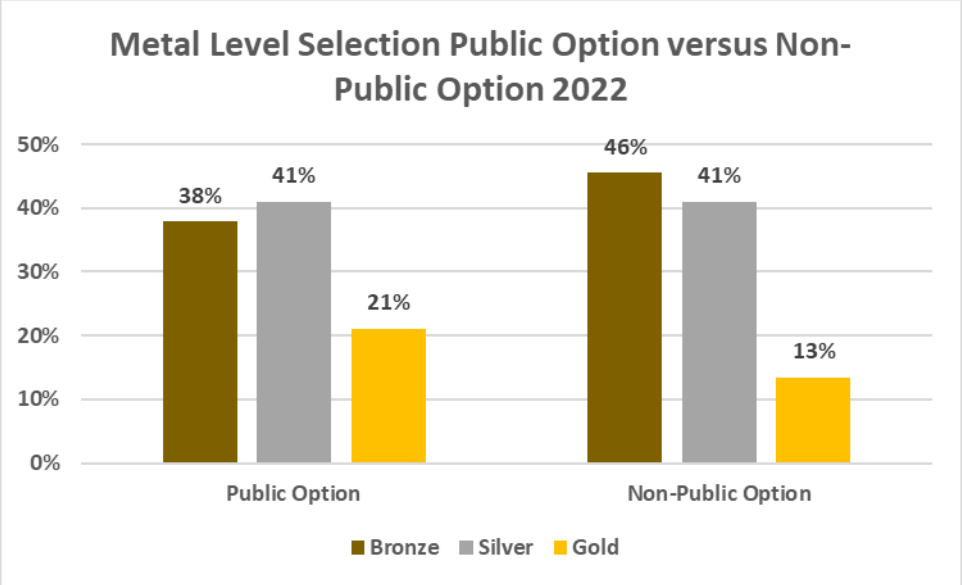
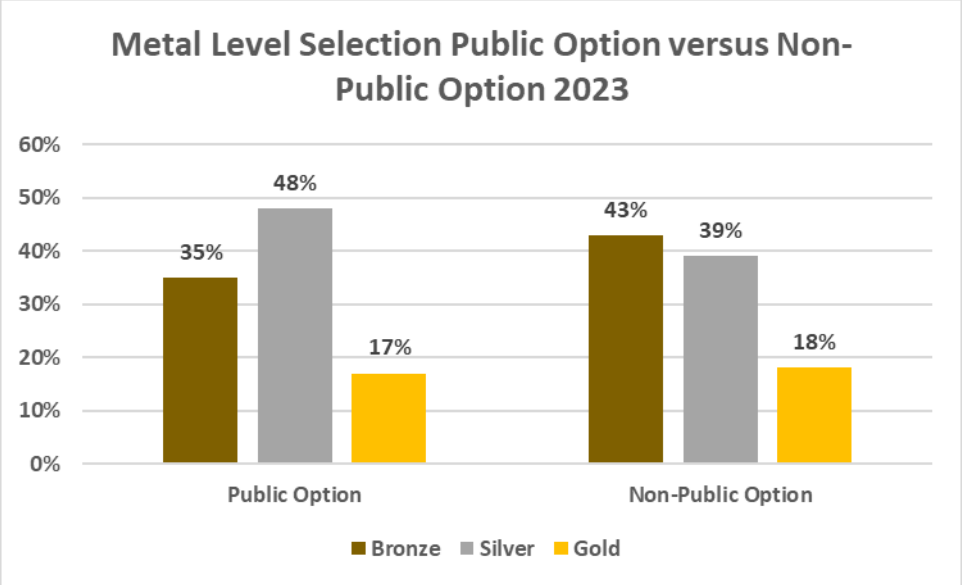


Figure 13: Public option to non-public option QHP metal level selection trends in 2023

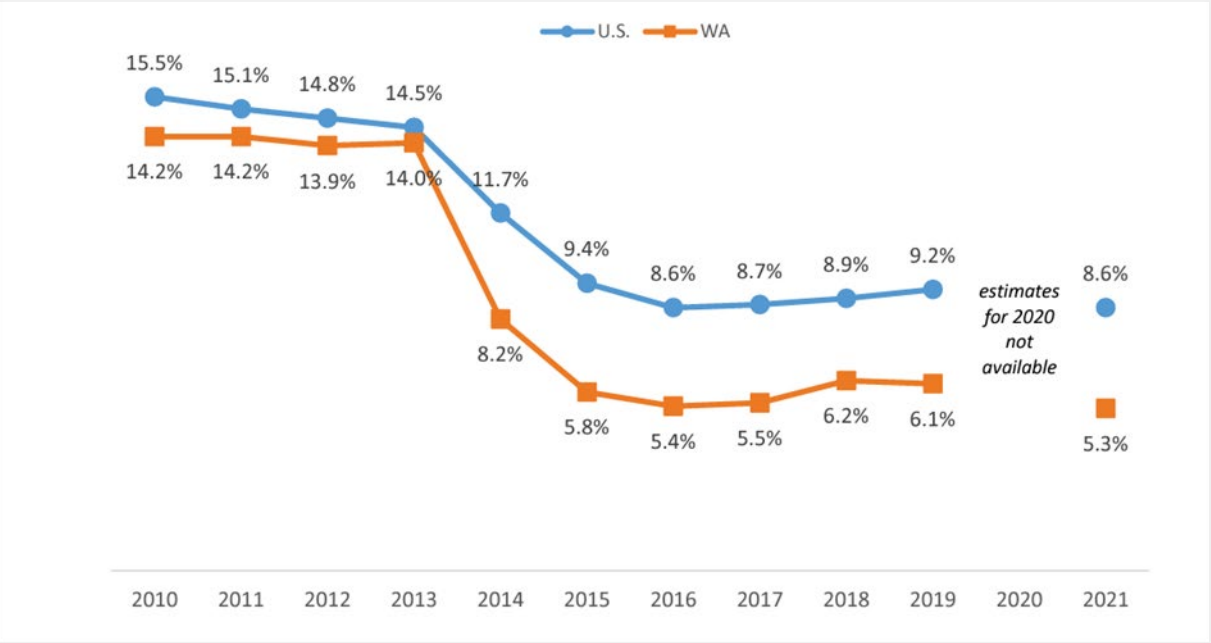


Conclusion

Cascade Care and the state's first-in-the-nation public option presents a unique opportunity to increase the availability of and access to quality, affordable health coverage on the Exchange marketplace. Addressing barriers and risks to consumer access relies on maintaining and strengthening public option tools to achieve meaningfully lower premiums, provider participation in the public option statewide, and high-quality, meaningful plan choice.

The public option shows promise in increasing access to high-quality, affordable health coverage for all *Washington Healthplanfinder* consumers. Public option premiums are currently the most affordable QHPs in many Washington counties, increasing consumer access to health insurance coverage. Additionally, the public option's high-value benefit design allows enrollees to pay less out of pocket when using their benefits to access care.

Appendix A: Comparison of WA and US uninsured rate, 2010-2021[37]



[37] Yen, Wei, OFM, "Record low uninsured rate in 2021 amid COVID-19 pandemic, December 2022, Available at: https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief108.pdf Medicaid Expansion and WAHBE first offered plans in 2014. Yen, Wei and Thea Mounts, OFM, "Medicaid Growth Under the ACA: A Game-Changer in Reducing Washington's Uninsured in 2014; April 2016", Available at: https://ofm.wa.gov/sites/default/files/public/legacy/researchbriefs/2016/brief076.pdf.

Appendix B: Health plan types offered on Washington Healthplanfinder

2023 Health Plans Offered on *Washington Healthplanfinder*				
			Cascade Care Plans	
		Non-Cascade plans	Cascade plans	Cascade Select plans
Meets all QHP requirements	Requirements for all QHPs in 2023: • All plans must meet all requirements under RCW 43.71.065. • Carriers must offer gold and silver Cascade Care health plans to participate in *Washington Healthplanfinder*. • Carriers offering a non-Cascade bronze plan on *Washington Healthplanfinder* must also offer one bronze Cascade Care health plan on *Washington Healthplanfinder* in any county where it offers a bronze plan. • Carriers offering Cascade Care health plans may offer up to two non-Cascade gold plans, two non-Cascade bronze plans, one non-Cascade silver health plan, one non-Cascade platinum health plan, and one non-Cascade catastrophic health plan in each county where the carrier offers a qualified health plan.	X	X	X
Eligible for tax credits		X	X	X
Eligible for Cascade Care Savings state premium subsidy for residents earning up to 250% FPL.			X	X
Includes standard health plan benefit design set by the Exchange.			X	X
Includes quality, value, and provider reimbursement requirements set by the Legislature and Health Care Authority.				X
Hospital participation requirements set by the Legislature.				X
Procured through the Health Care Authority.				X

Appendix C: QHP certification criteria

The following chart summarizes the nineteen criteria applied in the certification process of a QHP. Each criterion is reviewed and approved by OIC, the Exchange, or both.

Exchange Plan Certification Criteria[38]

[38] WAHBE, Guidance for Participation, 2024, Available at: https://www.wahbexchange.org/content/dam/wahbe-assets/plan-certification-workgroup/Final%202024%20QHP%20Guidance%20for%20Participation.pdf.

Number	Criteria Level	Criteria	OIC or Exchange Review	Initial Certification Criteria	Recertification Criteria
1	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	Exchange	Yes	Yes
3	Issuer	Issuer must comply withthe risk adjustment program	OIC	Yes	Yes
4	Issuer	Issuer must comply with market rules on offering plans, including participation in State Premium Assistance Program*	OIC/ Exchange*	Yes	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
6	Issuer	Issuer must be accreditedby an entity that HHS recognizes for accreditation of health plans	Exchange	Yes	Yes
7	Product	QHP must meet marketing requirements	Exchange	Yes	Yes
8	Product	QHP must meet networkaccess requirements, including ECPs	OIC	Yes	Yes
9	Product	Issuer must submit provider directory data	Exchange	Yes	Yes
10	Product	Issuer must implement a quality improvement strategy	Exchange	Yes	Yes

11	Product	Issuer must submit health plan data to be used in standard format for presenting health benefit plan options	Exchange	Yes	Yes
12	Product	Issuer must report qualityand health performance data	Exchange	No	Yes
13	Product	Issuer must use the Exchange enrollment application	Exchange	Yes	Yes
14	Product	Issuer may only contract with a hospital with morethan 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Yes	Yes
15	Product	Services provided under aQHP through a direct primary care medical home must be integrated with the QHP issuer	OIC	Yes	Yes
16	Plan	A QHP must comply withbenefit design standards(e.g., cost-sharing limits, "metal level," EHB, standard plan design*)	OIC/Exchange*	Yes	Yes
17	Plan	Issuer must submit a QHP's service area andrates for a plan year	OIC	Yes	Yes
18	Plan	Issuer must post justifications for QHP premium increases	OIC	No	Yes
19	Plan	Issuer must submit QHP benefit and rate data forpublic disclosure	Exchange/OIC	Yes	Yes

Appendix D: QHP quality program

QHP certification requires that carriers report quality and health performance data. This is the vehicle of the Exchange's Quality Program where the Exchange leverages opportunities to receive additional reporting from carriers. The Exchange has a regulatory responsibility to oversee the clinical quality and patient experience in QHPs offered to consumers. The Exchange Quality Program's core components include quality measure reporting, quality improvement activities, and data collection and quality measure reporting stratified by race and ethnicity.

- **Quality Rating System (QRS)**
  - Health plans submit data to CMS on 39 quality measures (mix of administrative or medical record and survey data).
  - CMS creates quality star rating displayed to consumers shopping on Healthplanfinder.
  - Exchange also receives QRS measure data directly from carriers and uses data to inform quality program focus areas.
- **Quality Improvement Strategy (QIS) program**
  - HBE/carriers pick from among federal focus areas (e.g., health disparities, hospital readmissions), develop activities to improve quality in those areas, include a consumer- or provider-directed financial incentive for improvement, and report on progress.
    - Market incentives for providers through bonus payments and patients through gift cards.
  - Carriers submit annual progress reports using an HBE-specific form.
- **Additional quality requirements**
  - HBE uses the quality certification criteria to engage with carriers on quality initiatives beyond federally-required QRS and QIS such as:
    - Race/ethnicity data collection.
    - Quality measure stratification by race and ethnicity and urban/rural areas.
    - Meeting performance targets for quality measure improvement.
    - Requiring carriers to implement a Bree primary care strategy.
    - Reporting on primary care spend as a proportion of total spend.
    - Reporting of claims data to WA Health Alliance for custom quality reporting.

Appendix E: Public option quality & value requirements

To ensure that public option plans are quality health plans for Washington consumers, Senate Bill 5526, requires participating public option carriers to align certain quality review processes with the clinical criteria published by the HCA, such as recommendations by the Dr. Robert Bree Collaborative (Bree Collaborative), and the Health Technology Clinical Committee (HTCC). Additionally, Cascade Select carriers are expected to engage with HCA for ongoing monitoring including reporting on health improvement activities, primary care expenditures, Quality Rating System (QRS),[39] and the Washington State Common Measure Set.[40]

HCA conducts annual and ongoing validation and renewal processes with public option carriers. This ensures carriers that are awarded contracts for public option fulfill the expectations for their plan offerings, including alignment with the clinical criteria published by HCA.

The program is still in its early stages with data only being available for the first plan year (2021) for most quality reporting.[41] Carriers' full reporting results for plan year 2021, the first year Cascade Select was offered, are described in this report.[42] However, results for Bree and HTCC reporting are available for both plan years 2021 and 2022 and are described in those respective sections below.

Bree Collaborative

The Bree Collaborative is a statewide public-private consortium established in 2011 by the Legislature "to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."[43] Annually, the Bree Collaborative identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes.

Recommendations from the Bree Collaborative help HCA guide state purchasing for programs like Apple Health, Public Employee Benefits (PEB), and School Employee Benefits (SEB). Carriers participating in or bidding for Cascade Select contracts must also align with Bree recommendations selected by HCA for reporting and evaluation.

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[39] QRS measures are required for all plans offered on Washington Healthplanfinder. Participating Cascade Select Carriers are required to report on QRS measures for their Cascade Select plan enrollment and, for administrative measures only, to report on these metrics by region, sex, and age group, and, to the extent the Carrier is in possession of the data, by race, ethnicity, and language.

[40] Like Medicaid, PEB, and SEB carriers, Cascade Select carriers must report on a subset of the Washington State Common Measure Set. The Common Measure set provides the foundation for health care accountability and measuring performance. The development and ongoing evolution and implementation of a set of measures is mandated under House Bill 2572 (2013-14).**https://www.hca.wa.gov/about-hca/who-we-are/washington-state-common-measure-set**

[41] Carriers' reporting deliverables are spread over the plan year, therefore the full complement of carriers' quality reporting data for plan year 2022 are not yet available.

[42] Two of the five contracted carriers' enrollment was less than 500 in plan years 2021 and 2022. These carriers were not required to report on Bree, Common Measures, HTCC, primary care expenditures, or QRS due to the respective carriers' reporting sample size. However, these carriers were required to report on health improvement activities and aggregate provider reimbursement rates.

[43] RCW 70.250.

During the procurement process, public option bidders are required to describe actions and steps their organization has taken to implement the mandatory Bree topics, as well as any planned activities for the next plan year. Bidders must also submit details regarding progress implementing these recommendations.

Carriers must first complete a baseline report to determine their current alignment with Bree recommendations. Each subsequent report measures against the performance goals carriers select to work towards each plan year.

2021 and 2022 reporting results

Participating carriers' reporting data on Bree recommendations are available for both plan years 2021 and 2022. All carriers required to report[44] met Bree reporting requirements.

Carriers reported on progress and implementation of Bree recommendations on the selected mandatory topics. Of the current Bree recommendations, the following topics were selected to align with other statewide initiatives and priorities for plan years 2021 and 2022:

- Avoidable readmissions
- Behavioral health integration
- Low back pain
- Opioid use disorder
- Total knee and hip replacement.

Health Technology Clinical Committee (HTCC)

This committee was established by law to make coverage determinations for selected health technologies based on available scientific evidence.[45] HTCC is composed of community health care practitioners and is supported by HTA.[46] HTA develops scientific, evidence-based reports on selected medical devices, procedures, and tests, and HTCC uses the reports to determine the conditions for coverage.

The director of HCA selects technologies for review by HTCC in consultation with other agencies and the committee itself. The determinations of HTCC are followed by state purchased health care programs including Apple Health, the Uniform Medicare Plan (UMP), and the Department of Labor and Industries. HTCC decisions are also incorporated into the ongoing Cascade Select reporting requirements of carriers currently participating, as well as for carriers bidding for contracts during procurement years.

During the procurement process, bidders must complete and submit the HTCC Decisions Matrix, a reporting tool designed by HCA. This matrix establishes baseline levels of bidders' alignment with existing HTCC decisions and is utilized to continue to track progress in subsequent reports required of carriers.

In the procurement for plan year 2023, bidders were required to provide information based on current alignment and any expected changes for the upcoming plan year. Bidders were scored on the content and submission of their respective HTCC Decisions Matrix. During the contracting term, the successful bidders will continue to submit reports for tracking against the initial submission to ensure progress and success.

Participating carriers are required to report annually on alignment of their coverage criteria with HTCC

[44] Not including two low-enrollment carriers.
[45] RCW 70.14.090.
[46] HTA supports HTCC which makes coverage decisions that apply to state purchased health care programs.

decisions. Carriers must first complete a baseline report to determine their current alignment with HTCC Decisions. For HTTC Decisions where carriers are fully aligned, each subsequent report is intended to monitor carriers' alignment with HTCC. In areas where carriers are not fully aligned, carriers are required to describe their progress and plans to reach full alignment.

For plan year 2023, carriers are required to be aligned with at least 50 percent of HTTC decisions and submit a plan for increasing alignment with additional HTCC decisions in subsequent years. HCA will evaluate these reports (clinical and program teams, including value-based purchasing). If not fully aligned, carriers will be required to describe where their policies are or are not aligned, as well as whether those policies are beyond the scope of HTCC. Additionally, if not aligned, HCA (clinical and/or program teams) will provide verbal or written feedback, which may include the development of an improvement plan, to ensure carriers are supported and equipped to meet quality reporting requirements.

2021 and 2022 reporting results

Participating carriers' reporting data on HTCC are available for both plan years 2021 and 2022. All carriers required to report[47] met HTCC reporting requirements. These carriers reported on a range of over 70 HTCC decisions. Some HTCC topics include:

- Breast MRI
- Glucose monitoring
- Non-invasive cardiac imaging
- Vitamin D screening and testing.

Additional Cascade Select-specific quality measures

Certain quality reporting metrics required of bidding and participating Cascade Select carriers are not required of other qualified health plans on the Exchange. Cascade Select carriers must also annually report on the Washington State Common Measure Set, Health Improvement Activities, and primary care expenditures.

Washington State Common Measure Set

The Washington State Common Measure Set (WSCMS) was created by the Performance Measures Coordinating Committee (PMCC) as directed by legislation in 2014 and is intended to minimize variation in how the health care delivery system is measured and monitored.[48] The PMCC provides oversight of the WSCMS and meets quarterly to continue to evaluate and update the measure set, as needed. The WSCMS is used by HCA to promote quality improvement efforts in Medicaid, PEB, SEB, and Cascade Select. The WSCMS captures carriers' quality performance in areas such as primary care and prevention, behavioral health, and effective management of chronic illness.

Washington State Common Measure Set 2021 reporting results

Carriers' reporting deliverables are spread over the plan year and all carriers met the requirements for reporting of the WSCMS for 2021 plan year.[49] Carriers' WSCMS reporting results for plan year 2022 will be

[47] Not including two low-enrollment carriers.
[48] Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. https://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431
[49] Not including the two low-enrollment carriers for plan years 2021 and 2022.

available in plan year 2023, at which point HCA can evaluate carriers' quality reporting over two full plan years.

Carriers awarded Cascade Select contracts for plan year 2021 reported on a subset of the WSCMS. The selected measures from the WSCMS are relevant to the individual market, allow efficiency in carrier reporting, and align with measures in state purchasing contracts. Some of the measures Cascade Select carriers reported on include:

- Asthma medication ratio
- Follow-up after emergency department visit for mental illness
- Patient experience with primary care: how well providers communicate with patients
- Statin therapy for patients with cardiovascular disease
- Use of spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease (COPD)

Carriers were also required to report on two measures by race/ethnicity. These measures included:[50]

- Antidepressant medication management (both acute phase treatment and continuation phase treatment)
- Breast cancer screening

Health Improvement Activities

Participating Cascade Select carriers must annually report on health improvement activities selected by HCA to reduce barriers to maintaining and improving health. These requirements include, but are not limited to:

- Standards for utilization management to reduce administrative burden and increase transparency and clinical effectiveness
- Population health management
- High-value, proven care
- Health equity
- Primary care
- Care Coordination and chronic disease management
- Wellness and prevention
- Prevention of wasteful and harmful care
- Patient engagement

Health Improvement Activities 2021 reporting results

Carriers' reporting deliverables are spread over the plan year and all carriers met the requirements for health improvement activities reporting for plan year 2021.[51] Carriers' health improvement activities reporting results for plan year 2022 will be available in plan year 2023, at which point HCA can evaluate carriers' quality reporting over two full plan years.

Contracted carriers were required to submit a health improvement activities report including descriptions on

[50] Carriers not in possession of race, ethnicity, and language data for their Qualified Health Plan (QHP) population were required to submit and implement a plan to collect this data for their population enrolled in a procured QHP.

[51] All five contracted carriers for plan year 2021 were required to report on health improvement activities.

utilizing and/or implementing the following:

- Utilization review selection criteria and process, and which national accreditation standard(s) were achieved
- Complex case and chronic condition management
- Population health management strategies, including closure of care gaps and promotion of preventive services
- Web-based or other tools utilized to encourage patient engagement, such as application to allow patients to schedule appointments, refill prescriptions, and other functions
- Shared Decision Making programs
- Approach to encourage provider use of certified Electronic Health Record (EHR) systems as defined by the Office of the National Coordinator and providers' contribution of clinical data from its EHR system to the state Clinical Data Repository (CDR) hosted by OneHealthPort
- Programs to support active participation of providers in at least one Accountable Community of Health (ACH), including various workgroups and committees
- Participation in Multi-Payer Primary Care Transformation Model, other state or national multi-payer efforts, and data sharing initiatives to reduce variation in care, improve value and reduce overall cost of care
- Behavioral Health/Substance Use Disorder services
- Pharmacy benefits/programs

Primary care expenditures

One of the goals of the Cascade Select program is to incentivize high-quality care with an emphasis on primary care. Improving primary care is the key to better care, smarter spending, and healthier people and communities.

There is no target percentage for primary care spend for Cascade Select plans. Rather, carriers annually report on primary care expenditures for partnering Cascade Select agencies to better understand the level of primary care expenditures and investments in the public option program and to inform future primary care strategies and activities.[52]

Carriers must submit primary care expenditures in aggregate for their Cascade Select plans.[53] This includes primary care payments data using both narrow and broad definitions of primary care, and both narrow and broad definitions of primary care services.[54]

Carriers also report on all payments made to Washington facilities and providers, regardless of where the member resides, during the reporting period.[55] This is reported in three components:

- All prescription drug costs paid through the Medical benefit

[52] HCA utilizes a similar template in its state-financed programs, including Medicaid, PEB, and SEB.
[53] Payments include total plan incurred and paid payments, including deductibles, coinsurance, or copays by patients. Carriers are asked to exclude secondary payer medical payments from all definitions in their reporting.
[54] The narrow and broad definitions for each are exclusive, e.g., the broad definition does not include or repeat the providers or services included in the narrow definition.
[55] Payments must be reported as dollars spent during the reporting period. Carriers must exclude from medical primary care payments, vision, dental, lab, imaging services and prescription drugs.

- All prescription or pharmacy costs paid through a Pharmacy Benefits Manager (PBM) or paid through the pharmacy benefit
- All other medical payments, including all payments described above excluding prescription drugs, e.g., hospitals or physician services.

Finally, carriers must describe their approach to calculating primary care related non-claims-based payments.[56] For example, data sources such as provider contracts, methods to attribute payments to primary care providers, and any barriers encountered.

2021 reporting results

Carriers' reporting deliverables are spread over the plan year and results for primary care expenditures reporting for plan year 2022 have not yet been evaluated. However, for plan year 2021, all carriers met the requirements for primary care expenditures reporting.[57] Carriers' primary care expenditure reporting results for plan year 2022 will be available in plan year 2023, at which point HCA can evaluate carriers' quality reporting over two full plan years.

Continued monitoring and evaluation of carriers' ongoing reporting

The program is still in its early stages, with data only being available for only the first plan year (2021) for most quality reporting. Carriers' full reporting results for plan year 2022 will be available near the end of plan year 2023, at which point HCA can evaluate carriers' quality reporting over two full plan years.

[56] Total non-claims-based payments include all payments for: capitated or salaried arrangements with providers or practices not billed or captured through claims; risk-based reconciliation for arrangements with providers or practices not billed or captured through claims; payments to National Committee for Quality Assurance (NCQA) or equivalent Patient-Centered Primary Care Homes, Patient-Centered Medical Homes, or based upon that recognition or payments for participation in proprietary or other multi-payer medical home or specialty care practice initiatives; financial incentive payments to providers or practices earned in a value-based payment arrangement conditioned on the quality of services provided.

[57] Two carriers were not required to report on primary care expenditures due to low enrollment, however one of the low-enrollment carriers volunteered to submit primary care expenditures despite no requirement to do so.