Summary of Washington’s Draft Procurement Standards for a Public Option Plan

Background

Senate Bill 5526 (see our legislative summary here) passed the Washington State Legislature in May 2019, authorizing the Washington Health Care Authority (the Authority), which administers Medicaid and other programs in the state, to procure public option plans in partnership with the Health Benefit Exchange (HBE) and the Washington Office of the Insurance Commissioner (OIC). The legislation specifies that the state must contract with at least one insurer to offer a public option plan at each metal level in at least one county in 2021. Here we summarize Washington’s draft procurement standards for its public option program, also known as “Cascade Care.” The state intends to use the finalized procurement standards in its request for proposal (RFP), which it plans to release in February 2020.

Figure 1. Washington’s Core Goals and Drivers of the Public Option Program

Washington’s Public Option

Affordability. Per the authorizing legislation, Washington’s procurement standards for affordability require reimbursement for health care services (excluding pharmacy benefits) be capped at an aggregate 160 percent of Medicare for each plan, with primary care services reimbursed at no less than 135 percent of Medicare, and critical access hospitals and sole community hospitals reimbursed at no less than 101 percent of Medicare. The state estimates premiums will decline by 5 to 10 percent due to the difference between the current market rate (174 percent) and the reimbursement cap (160 percent). Notably, Washington can choose to waive the reimbursement cap under certain scenarios, for example, if doing so, by 2023 or later, would not increase premiums, or if the insurer

Public Option Institute
718 7th Street, NW | Washington, DC 20001 | info@publicoptioninstitute.org | 202-309-0796
www.publicoptioninstitute.org
can achieve premiums that are 10 percent less than the previous plan year through other means. The legislation also indicates that plans may be required to meet standards for promoting generic drug utilization and using evidence-based formularies; however, the draft procurement standards do not directly require this.

In addition to seeking an overall premium reduction through the reimbursement cap, HBE is developing and submitting a plan for implementing state premium subsidies for Washington Healthplanfinder consumers with income up to 500 percent Federal Poverty Level (FPL). The report is due to the legislature on November 15, 2020.

Coverage and Access. Washington defines public option plans as qualified health plans (QHPs) that have a standard benefit design and meet additional quality and value requirements. Carriers interested in offering public option plans must offer at least one bronze, one silver, and one gold public option plan in a single county or in multiple counties. Enrollment is open to everyone who is eligible for the individual market, including those purchasing plans off of the state’s exchange. The HBE Board approved the standard plan designs for 2021 plans on December 5, 2019.

For the most part, Washington’s approach assumes providers, hospitals, and insurers will choose to participate in its public option program. It does not mandate participation by any party, nor does it allow insurers to require provider participation at the rate (160 percent of Medicare) set by the state. The authorizing legislation does, however, permit the state to waive the reimbursement cap on health services under several scenarios, including if an insurer is unable to form a provider network. State officials have also floated the possibility of passing new legislation to encourage or mandate participation if initial provider or plan participation is inadequate.

Quality and Value. While affordability standards are specified in the authorizing legislation, quality and value requirements were outlined only generally. The state has proposed several standards for quality and value, which include mandatory reporting of key clinical and technology metrics, as well as efforts to reduce barriers to care, improve health, and align value-based purchasing with state priorities. The specific quality and value requirements detailed below could change after the Authority receives feedback on its draft procurement standards from stakeholders.

Participating public option plans must implement Bree Collaborative value-based purchasing (VBP) recommendations. All carriers will be required to report on 8 out of the 22 total Bree recommendations for year one, including, elective total knee and total hip replacement bundle and warranty, hospital readmissions, and opioid use disorder treatment.

Public option plans must also report on alignment with Health Technology Clinical Committee (HTCC) decisions. Carriers are required to provide a baseline report describing alignment of their coverage criteria HTCC decisions in their procurement response. Alignment of at least 50 percent is expected for year one, and carriers must submit a plan for achieving full alignment.
In addition to the Quality Rating System (QRS) measures required for all QHPs, public option carriers are required to report on a set of additional quality metrics from the [Washington State Common Measure Set](#), reporting each metric by region, sex, and age group, and, by race, ethnicity, and language to the extent possible. Carriers must also submit and implement a plan to collect race, ethnicity, and language data if they are not in possession of it.

Public option carriers must meet added participation requirements to lower barriers to sustaining and improving health and align to state agency value-based purchasing, which may include any number of strategies, including standards for utilization management, population health management, primary care, etc. For year one, carriers will meet these requirements by taking HCA’s annual Paying for Value Survey and completing the Authority’s Primary Care Expenditure template for enrolled population. Carriers will also be required to submit a report describing use or enactment of nine specific strategies to reduce administrative burden and increase transparency and clinical effectiveness.