Summary of Washington’s Request for Applications for Public Option Procurement

On Thursday, February 27, the Washington Health Care Authority (HCA) released a request for applications (RFA) from carriers interested in offering public option plans on the individual market for coverage beginning January 1, 2021.

Washington defines public option plans as qualified health plans (QHPs) that have a standard benefit design and meet additional quality, value, and affordability standards. Interested carriers must offer at least one bronze, one silver, and one gold public option plan in a single county or in multiple counties. HCA intends to award one or more contracts for public option plans in each county.

Application

Phase 1 Response (Due April 17, 2020)

- Applicant’s proposed service areas and projected enrollment for each county (extra points are awarded for plans participating in rural areas, see Exhibit C);
- Quality and value strategies, including steps taken to implement Bree Collaborative recommendations; evidence-based coverage decision process, value-based payment and integrated care strategies, and use of a common measure set;
- Description of how applicants will work with Indian Health Care Providers;
- Plan to assist providers in identifying payments that will be exempted from the state-business and occupation (B&O) tax;
- Attestation of standards to value, quality, and affordability requirements (the methodology for calculating Medicare-equivalent payment rates are provided in Appendix 4; most major supplemental payments, such as those for indirect medical education (IME) and disproportionate share hospitals (DSH), are included; and
- Health Technology Clinical Committee (HTCC) decision matrix in order to establish baseline levels of coverage compliance for selected health technologies.

Phase 2 Response (Due May 22, 2020)

- Planned premium rates for a 40-year old, non-smoker for plan year 2021 public option plans at the gold, silver, and bronze metal levels for each county the applicant intends to participate in. Applicants must describe how their premium rates meet one or more of the following affordability options:
  - A proposed premium rate that is at least 5 percent lower than the applicant’s lowest-cost plan of the same metal level plan in play year 2020;
  - A proposed premium rate that is at least 10 percent lower than the proposed rate of the applicant’s standard plan of the same metal level for plan year 2021; or
  - For an applicant that did not participate in the individual market in plan year 2020, and does not propose a non-public option plan, the applicant must have a premium rate that is at least equal to, or lower than, the new carrier benchmark premium rate established by HCA (see Appendix 3).

- Sample contracts from the current 2021 public option plan year and include an explanation of how they demonstrate value-based payment arrangements and unit cost reductions in contracting with providers. Applicants must also confirm that at least 30 percent of provider
contracts for the public option plans include value-based payment arrangements as defined by the Centers for Medicare and Medicaid Services (CMS) Health Care Payment Learning and Action Network.

**Incentives and Flexibilities**

Washington State is providing several incentives and flexibilities intended to increase provider and carrier participation. Payments received by providers (from QHPs or through cost-sharing) for treating public option plan enrollees will be exempt from the B&O tax. The exemption is intended to help dull the impact of the reimbursement cap set at 160 percent of Medicare.

Applicants will have the option to participate in a safe harbor that allows them to conduct a retrospective review of actual provider reimbursement without facing a penalty. HCA will provide applicants with alternative reimbursement targets, by designated geographic rating areas, based on 2018 market averages that meet the reimbursement cap. Participating applicants will receive additional flexibility through adjusted safe harbor reimbursement targets, provided at least 30 percent of provider contracts include value-based payment arrangements.

**Evaluation and Contract Award**

Applications that meet an initial review for completeness by the RFA Coordinator will be given to evaluation teams made up representatives of HCA and the Health Benefit Exchange (HBE). These teams will review and score applications using a two-phase weighted scoring system. After the evaluation of Phase 1 criteria, the RFA Coordinator will communicate individually in writing to applicants whether their application passed Phase 1. Those who pass Phase 1 will then be required to submit their Phase 2 response.

Total scores will consist of an applicant’s scores for Phase 1, Phase 2, and their response to Executive Order 18-03 (points will be awarded to carriers who do not require its employees, as a condition of employment, to sign mandatory arbitration clauses or a class or collective action waiver). The maximum points possible across all three elements is 360. Unsuccessful applicants who attend a debriefing conference are able to protest awards on the basis of: bias, discrimination, or conflict of interest on the part of an evaluator; errors in computing the score; or non-compliance with procedures described in the RFA or HCA requirements.

**Next Steps**

- March 13, 2020 – Letters of intent to apply and non-disclosure agreements due
- April 17, 2020 – Phase 1 responses due
- May 22, 2020 – Phase 2 responses due
- July 7, 2020 – HCA announces apparent successful applicants (subject to completion of contract negotiations and execution of a written contract)
- July-September 2020 – Contract negotiations
- November 1-December 15, 2020 – Open enrollment
- January 1, 2021 – Coverage start date