



# Washington Health Benefit Exchange

NAHDO

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Leah Hole-Marshall, General Counsel and Chief Strategist

# Exchange Operations

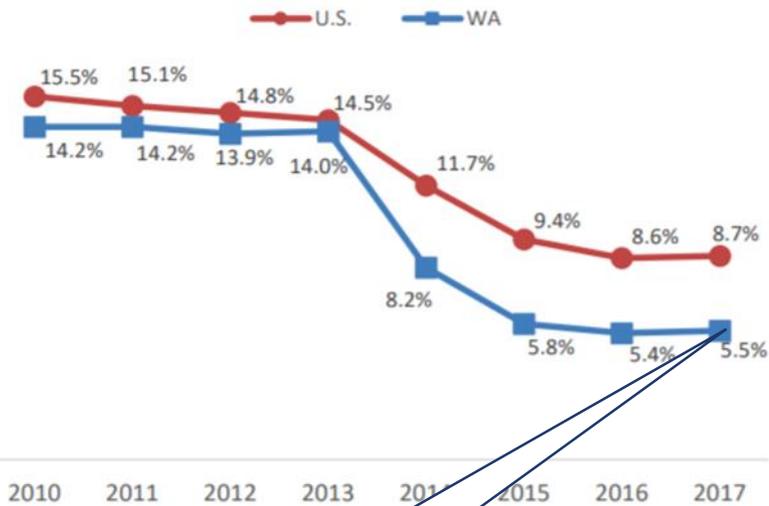
- The Exchange operates *Washington Healthplanfinder*, a single integrated online portal to apply and shop for MAGI Medicaid (1.5 million) and commercial individual market coverage (200,000)
- Quasi-governmental organization with ~135 staff reporting to bi-partisan board. Close coordination with Insurance Commissioner and Medicaid agency
- \$60 Million operating budget from carrier assessments and Medicaid
- *Washington Healthplanfinder* offers Washington state residents:
  - Tax credits or financial help to pay for co-pays and premiums
  - Local customer support – state-wide Navigator and Broker enrollment assistance programs, Spokane Call Center



1 in 4 WA residents use Healthplanfinder to obtain medical and dental coverage

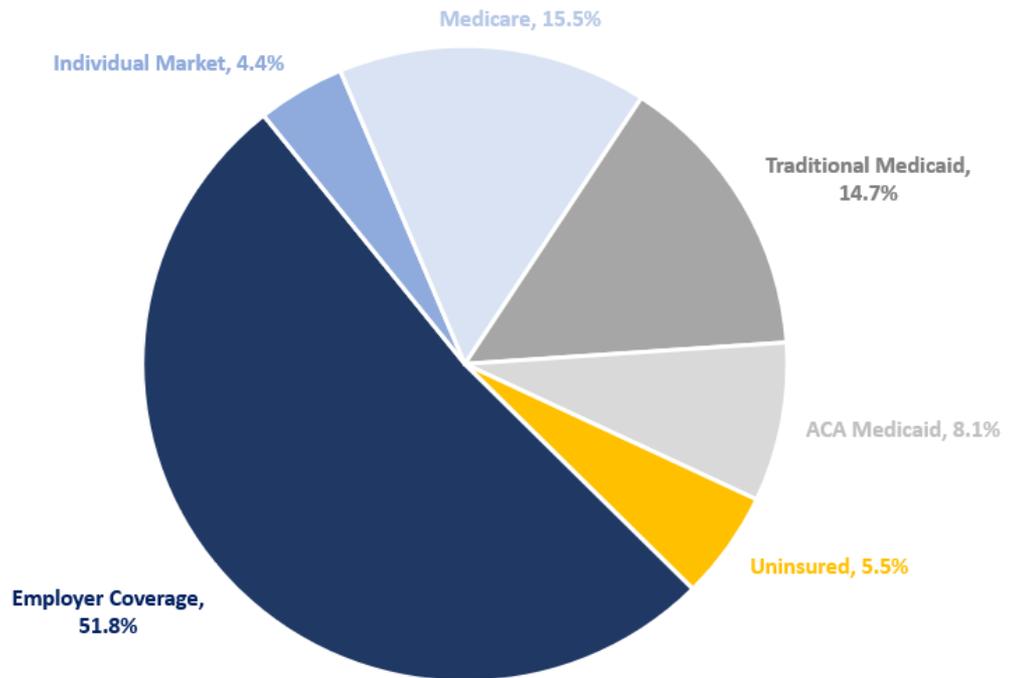
# Health Coverage in Washington

Chart 1. Washington and U.S. Uninsured Rates: Total Population, 2010-17



Roughly 400,000 WA residents remain uninsured

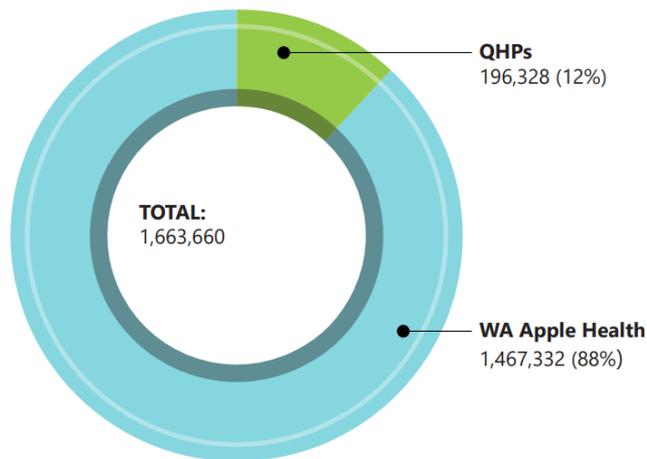
HEALTH COVERAGE IN WASHINGTON STATE, 2017



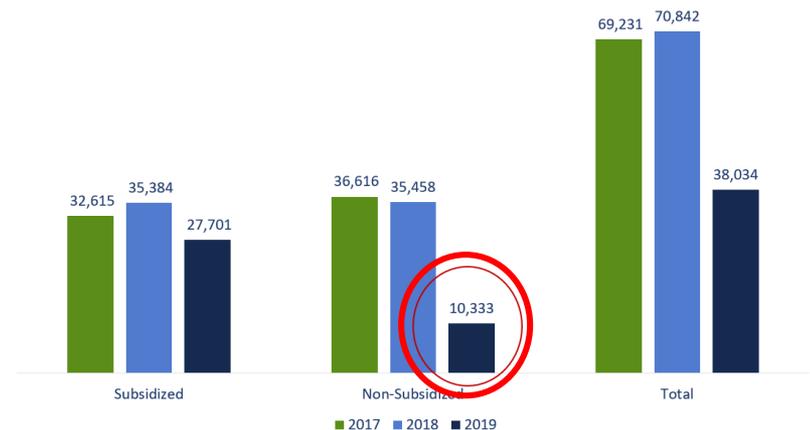
# Enrollment Through *Washington Healthplanfinder*

Year	QHP Enrollment	Total Enrollment
2014 OE 1	139,700	604,247
2015 OE 2	152,517	1,599,811
2016 OE 3	166,098	1,697,500
2017 OE 4	204,334	1,760,122
2018 OE 5	209,802	1,725,780
2019 OE 6	196,328	1,663,660

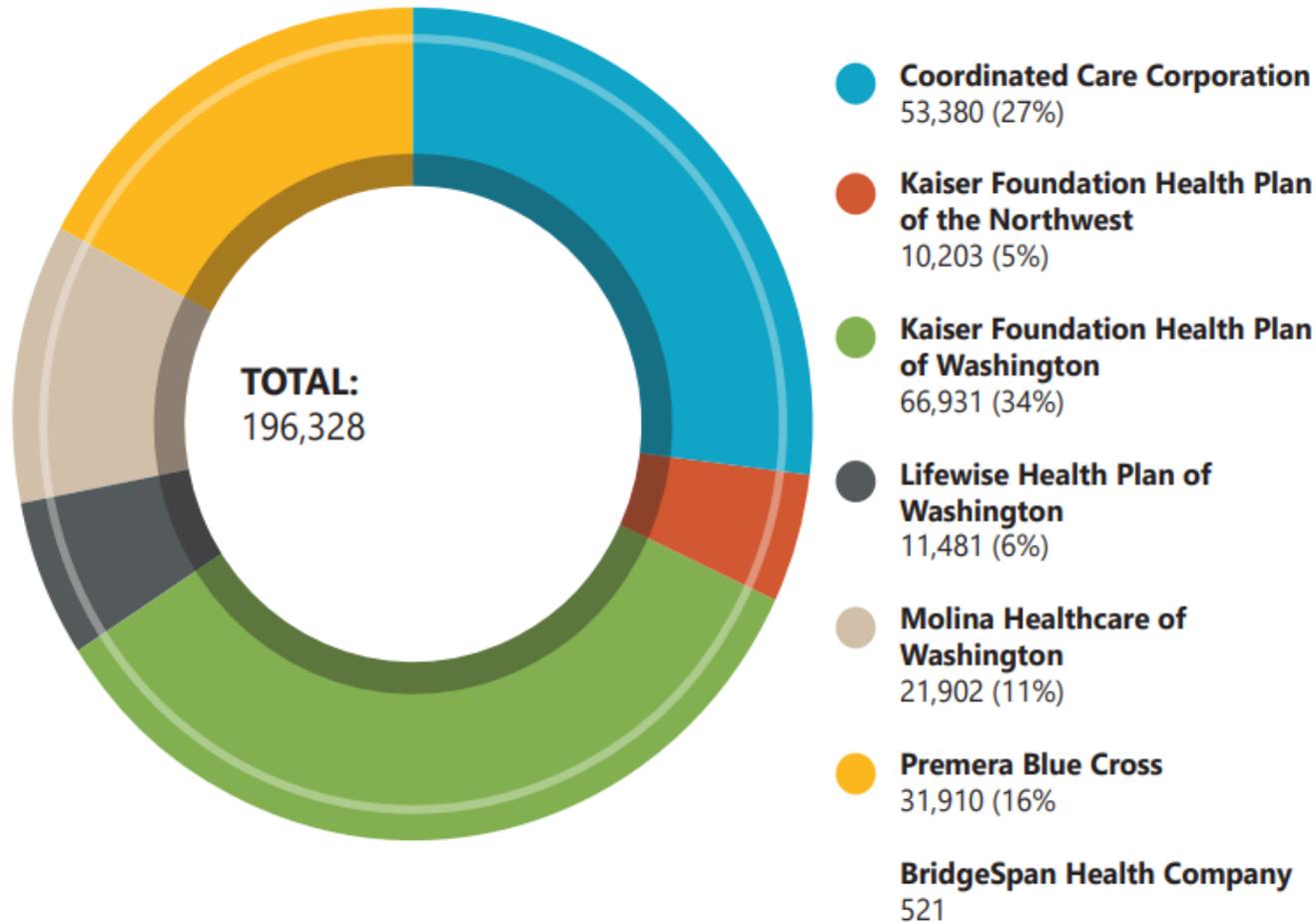
## By Coverage Type



## QHP Decrease Driven by Decline in New Enrollees (Particularly Non-Subsidized)



# 7 Carriers Currently Participate in Exchange Market



Source: HBE Health Coverage Enrollment Report, Spring 2019, available at:  
<https://www.wahbexchange.org/about-the-exchange/reports-data/enrollment-reports-data/>

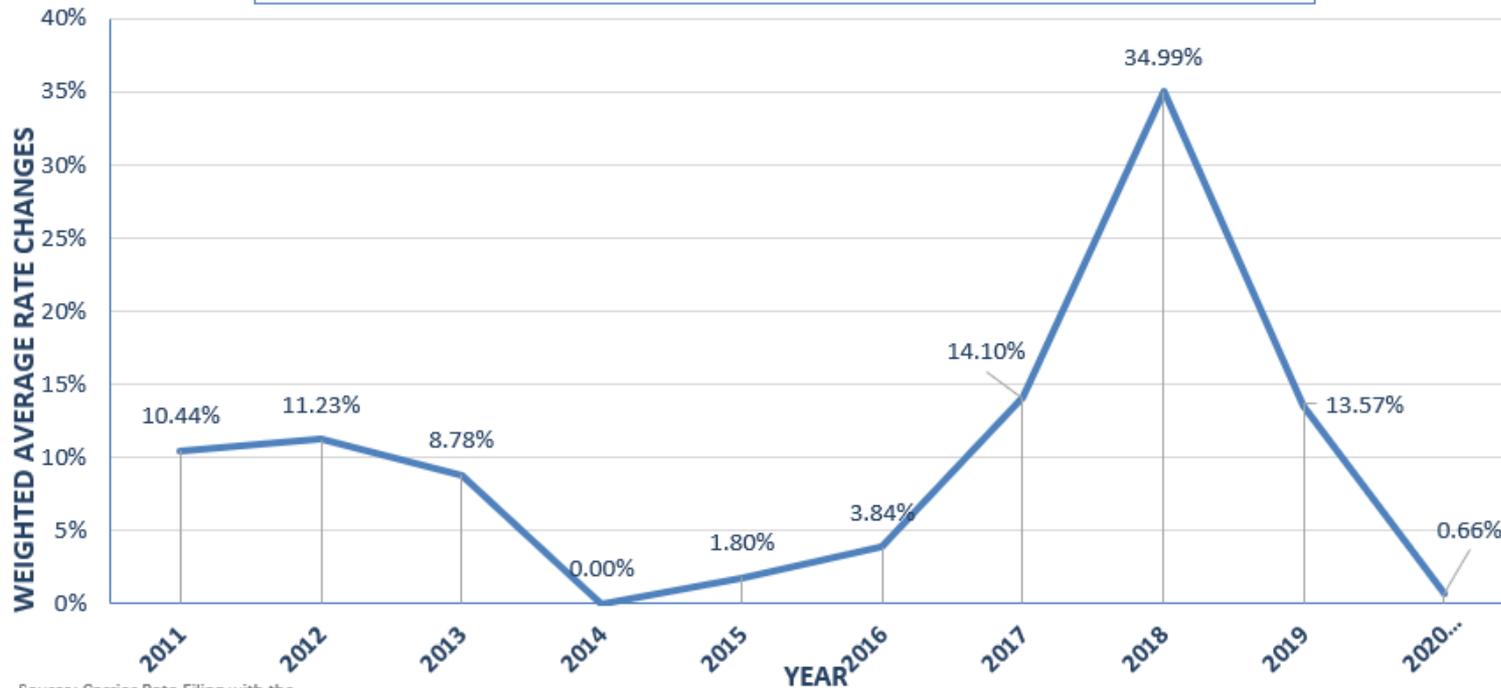


# Market Challenges: Instability

Federal Action	WA Proposed or Final Response
Limit open enrollment period and reduce ACA marketing	State response: Extend Open Enrollment and use state funding for marketing
Cost-sharing reduction (CSR) payments to carriers terminated	State response: Allow carriers to build cost of CSR's into silver plan premiums
Expanding short-term limited duration (STLD) insurance policies	State response: <a href="#">OIC rules</a> to limit STLD medical plans to 3 months. Minimum standards set.
Zeroing out of individual mandate penalty	<i>State mandate proposed in 2018 and 2019 session – not successful</i>
Discontinuation of federal reinsurance program	<i>State reinsurance program proposed in 2018 session - Not successful based on financing</i>
Expand association health plans	OIC emergency rules and WA in multi-state legal challenge.
Allow use of HRA to pay for individual health plans	Under review.
Repeal non-discrimination rule ( <i>Section 1557</i> )	Existing WA State law does not allow discrimination based on gender identity.
Public Charge Rule and Presidential Proclamation	WA leads multi-state legal challenge.



WA INDIVIDUAL MARKET WEIGHTED AVERAGE RATE CHANGES



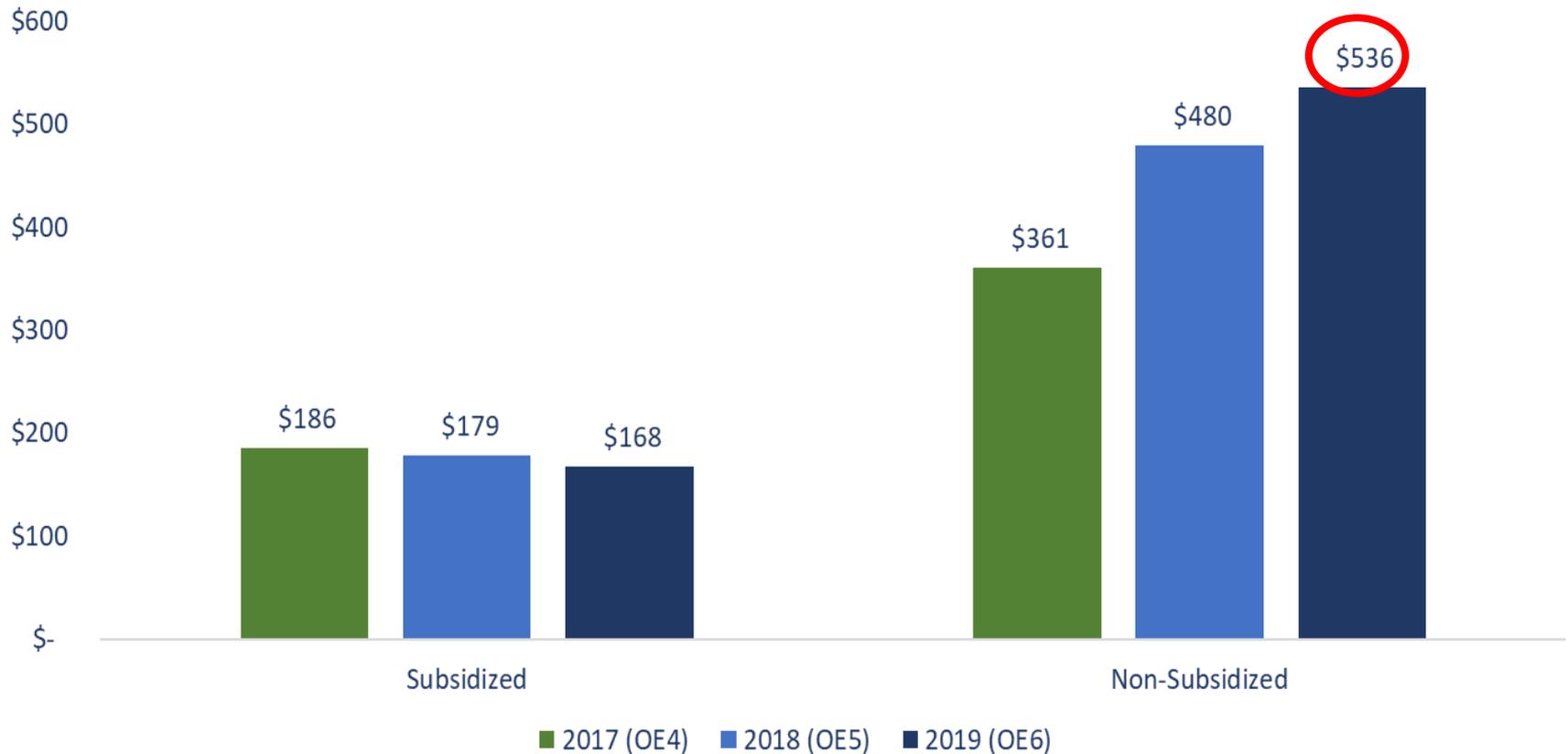
Source: Carrier Rate Filing with the  
 OIC

Methodology: This graph represents the annual change in rate for continuing plans on the individual market as approved (rather than requested) by OIC. Year 2020 weighted average rate change is projected based on the market share of 2019. The average rate changes are weighted by observed enrollment as of March of the earlier year and expected enrollment for the following year.



# Affordability at Risk

## Significant Premium Increases for Non-Subsidized



- Nearly 60k Enrollees in Plan with >\$9k Deductible
- 37% of consumers who dropped coverage reported that it didn't meet their budget



# Public Option

Cascade Care ([Chap. 364, Laws of 2019](#))

Response to rising premiums and deductibles and declining enrollment in the individual market and failure to enact reinsurance

- Standard Plans: Goal to make care more accessible by lowering deductibles, making cost-sharing more transparent, and providing more services before the deductible.
- Public Option Plans: Goal to make more affordable (lower premium) options available across the state, that also include additional quality and value requirements
- Subsidy Study: Goal to develop and submit a plan for implementing premium subsidies through Exchange for individuals up to 500% FPL (report due Nov. 15, 2020)



# Three Different Types of Health Plans in the Exchange in 2021: Non-Standard Plans, Standard Plans, and Public Option Plans

	Non-Standard Plans	Standard Plans	Public Option Plans (Standard Plans Plus)
Offered through the Exchange and eligible for federal tax subsidies	✓	✓	✓
Subject to full regulatory review by OIC, including network adequacy and rate review requirements	✓	✓	✓
Adheres to 19 Exchange certification criteria for QHPs	✓	✓	✓
Meets federal actuarial value requirements for metal levels	✓	✓	✓
Includes Essential Health Benefits	✓	✓	✓
Uses plan design with deductibles, co-pays, and co-insurance amounts set by Exchange for each metal level (bronze, silver, gold)		✓	✓
Some services guaranteed to be available before the deductible		✓	✓
Allows consumers to easily compare plans based on premium, network, quality, and customer service		✓	✓
Procured by HCA (Could result in one or more plans per county)			✓
Required to incorporate Bree Collaborative and Health Technology Assessment program recommendations			✓
Caps aggregate provider reimbursement at 160% of Medicare			✓
Subject to a floor on reimbursement for primary care services (135% of Medicare) and reimbursement of rural hospitals (101% of cost)			✓
Requires carriers to offer a bronze plan (in addition to silver and gold)			✓
Carriers required to offer to participate in the Exchange		✓	10

# Public Option Details:

## Reimbursement Rate Requirements

- Public Option plans will be private health plans that are selected by state agency and then listed on the Exchange
- Carrier and provider participation is voluntary
- Carriers must meet additional requirements focused on increasing quality and value
- Provider reimbursement rates are tied to Medicare rates, expected to lower premiums
  - Aggregate Cap: Total amount carrier reimburses providers and facilities cannot exceed 160% of Medicare
  - Primary Care Physician Floor: Reimbursement for primary care services (defined by HCA) may not be less than 135% of Medicare
  - Rural Floor: Reimbursement for services provided by rural hospitals (critical access hospitals or sole community hospitals) may not be less than 101% of Medicare (allowable costs)



# Preliminary Analysis Attributes

WA-APCD medical claims for WAHBE members in 2016 were \$752,352,778 total allowed amounts (including pharmacy).

The analysis linked to publicly available Medicare fee for service schedules for professional, inpatient, and outpatient services using the WA state modifier where applicable.

The analysis linked 46% of total WAHBE spend in the following:

- 3,964 inpatient stays (279 MS-DRGs)
- 118,856 outpatient hospital facility services (200 APCs)
- 951,282 professional medical services (3,871 CPTs)



# Overview of APCDs in WA

The WA-APCD was established in 2015 by the WA Legislature to increase quality and effectiveness of health care delivered in WA. Managed by a WA state agency.

This database includes required participants:

- Commercial market
- Medicaid
- Medicare
- L&I
- PEBB
- Individual Market

Historical claims data from 1/1/14

WA Health Alliance APCD was formed in 2004. The purpose was to stem rising cost of care, reduce the misuse of care and improve quality, rather than cut benefits or shift costs to employees (initial focus on King County).

This database includes voluntary participants:

- Commercial market (inc. Self-funded)
- Medicaid
- PEBB

Historical claims data from 2004 for earliest participants.



# Reimbursement Rate Analysis

- Leveraged early access to WA APCD; compared data to Medicare fee schedule and preliminary findings from other major state purchasers

WA State Program - 2016	Population	Annual Spend	Ratio to Medicare
Exchange-Ind. Mkt	166K	\$752M	174%
Public Emp-Ump only	182K	\$1B	163%
Workers Compensation	152K	\$545M	156%
Medicaid	1.6M	\$7.4B	68%

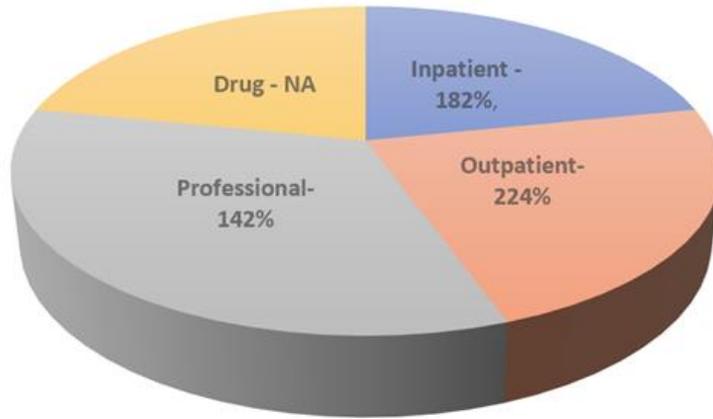
Note: findings are preliminary and agency methods varied

- HBE estimated that a 150% of Medicare cap on non-drug medical spend would reduce premiums 5-10%
- Milliman study (commissioned by Association of Washington Health Plans) estimated that a 100% of Medicare cap would reduce premiums 20% - 35%



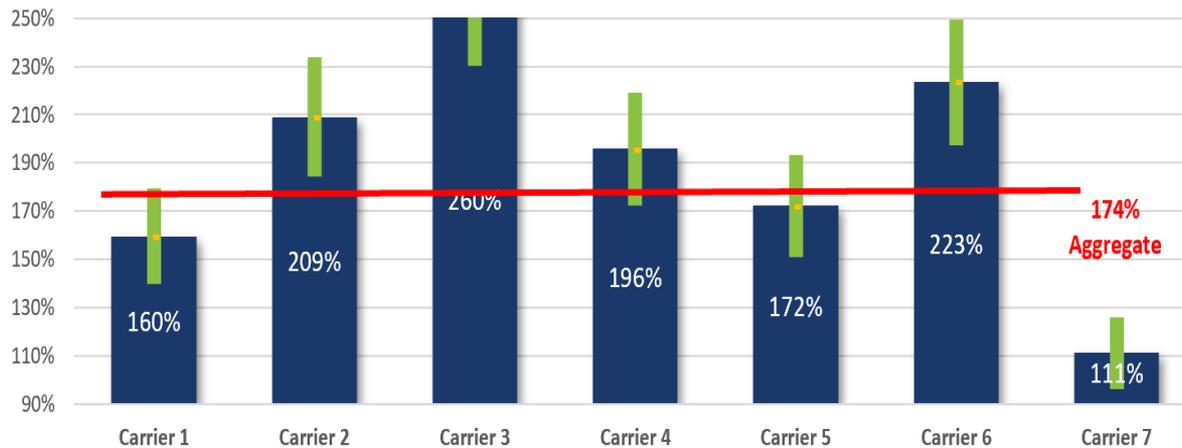
# Reimbursement Rate Analysis

WA HBE - Medicare Ratio by Provider Type



WA commercial reimbursement is 140% to 190% for professional and 200% to 350% for facility, with Individual market estimated lower. *AWHP Milliman Report.*

2017 Medical Cost Percentage Above Medicare Rates - By Carrier  
(5% Confidence interval)



*Note: HBE estimated carrier variation by comparing carriers public rate submission files, normalized to the APCD medical cost aggregate*



# Sample WAHBE Inpatient Services Comparison

MS-DRG	MS-DRG Description	WAHBE Discharges	WAHBE Total Allowed Amount	WAHBE Average Allowed Amount	Medicare Average Payment	Percent Difference WAHBE to Medicare
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	388	\$11,048,680	\$28,476	\$16,751	70%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	140	\$4,152,204	\$29,659	\$14,184	109%
460	SPINAL FUSION EXCEPT CERVICAL W/O MCC	66	\$3,268,167	\$49,518	\$34,535	43%
853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	41	\$3,099,789	\$75,605	\$45,200	67%
330	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	64	\$2,370,093	\$37,033	\$21,258	74%



# Sample WAHBE Outpatient Services Comparison

APC	APC Description	WAHBE Services	WAHBE Total Allowed Amount	WAHBE Average Allowed Amount	Medicare Average Payment	Percent Difference WAHBE to Medicare
05361	LEVEL 1 LAPAROSCOPY	600	\$5,036,697	\$8,394	\$4,001	110%
05024	LEVEL 4 TYPE A ED VISITS	6,313	\$4,972,558	\$788	\$327	141%
05312	LEVEL 2 LOWER GI PROCEDURES	2,532	\$3,832,109	\$1,513	\$753	101%
05532	LEVEL 2 ULTRASOUND AND RELATED SERVICES	8,324	\$3,131,172	\$376	\$154	145%
05123	LEVEL 3 MUSCULOSKELETAL PROCEDURES	315	\$3,128,526	\$9,932	\$4,969	100%
05023	LEVEL 3 TYPE A ED VISITS	5,880	\$3,085,816	\$525	\$196	168%
05025	LEVEL 5 TYPE A ED VISITS	2,577	\$2,922,672	\$1,134	\$486	133%
05213	LEVEL 3 ELECTROPHYSIOLOGIC PROCEDURES	84	\$2,534,779	\$30,176	\$15,561	94%
05572	LEVEL 2 COMPUTED TOMOGRAPHY WITH CONTRAST AND COMPUTED TOMOGRAPHY ANGIOGRAPHY	1,718	\$2,271,135	\$1,322	\$348	280%



# Sample WAHBE Professional Services Comparison

CPT	CPT Description	WAHBE Services	WAHBE Total Allowed Amount	WAHBE Average Allowed Amount	Medicare Average Payment	Percent Difference WAHBE to Medicare
99214	OFFICE OUTPATIENT VISIT 25 MINUTES	108,005	\$16,975,483	\$157	\$116	36%
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	113,941	\$12,202,774	\$107	\$79	36%
90837	PSYCHOTHERAPY PATIENT &/ FAMILY 60 MINUTES	54,892	\$6,721,003	\$122	\$131	-7%
99203	OFFICE OUTPATIENT NEW 30 MINUTES	23,411	\$3,981,696	\$170	\$116	47%
99204	OFFICE OUTPATIENT NEW 45 MINUTES	14,891	\$3,686,870	\$248	\$175	41%
99215	OFFICE OUTPATIENT VISIT 40 MINUTES	11,723	\$2,346,865	\$200	\$155	29%
99285	EMERGENCY DEPT VISIT HIGH SEVERITY&THREAT FUNCJ	7,244	\$2,166,265	\$299	\$177	69%
59400	OB CARE ANTEPARTUM VAG DLVR & POSTPARTUM	485	\$1,746,908	\$3,602	\$2,155	67%
99205	OFFICE OUTPATIENT NEW 60 MINUTES	4,895	\$1,458,284	\$298	\$219	36%



# Public Option Implementation Challenges



Defining benchmark calculation (160%)



Carrier participation



Provider participation/network adequacy



Premium impact



Ongoing federal and regulatory activity and impact on consumers



# Questions?



# Appendix

# How the Exchange plans to Use APCD

## 1. Exchange v. other markets

- a) How does the risk profile of the on-Exchange market compare to the off-Exchange market and other relevant markets?
- b) What are the monthly and yearly claims costs (PMPM), and how do they compare across market segments?

## 2. Variability within the Exchange Market

- a. Is the market at risk in certain geographic regions due to high claims (examining both utilization and the price of services)?

## 3. Longitudinal Analysis of Exchange Enrollees/Examining Continuity of Coverage

- a) Where do Exchange enrollees come from? Where do they go? When are they leaving?
- b) Does utilization vary as individuals move into and out of the Exchange/individual market?



# Sample Utilization Findings (2017)

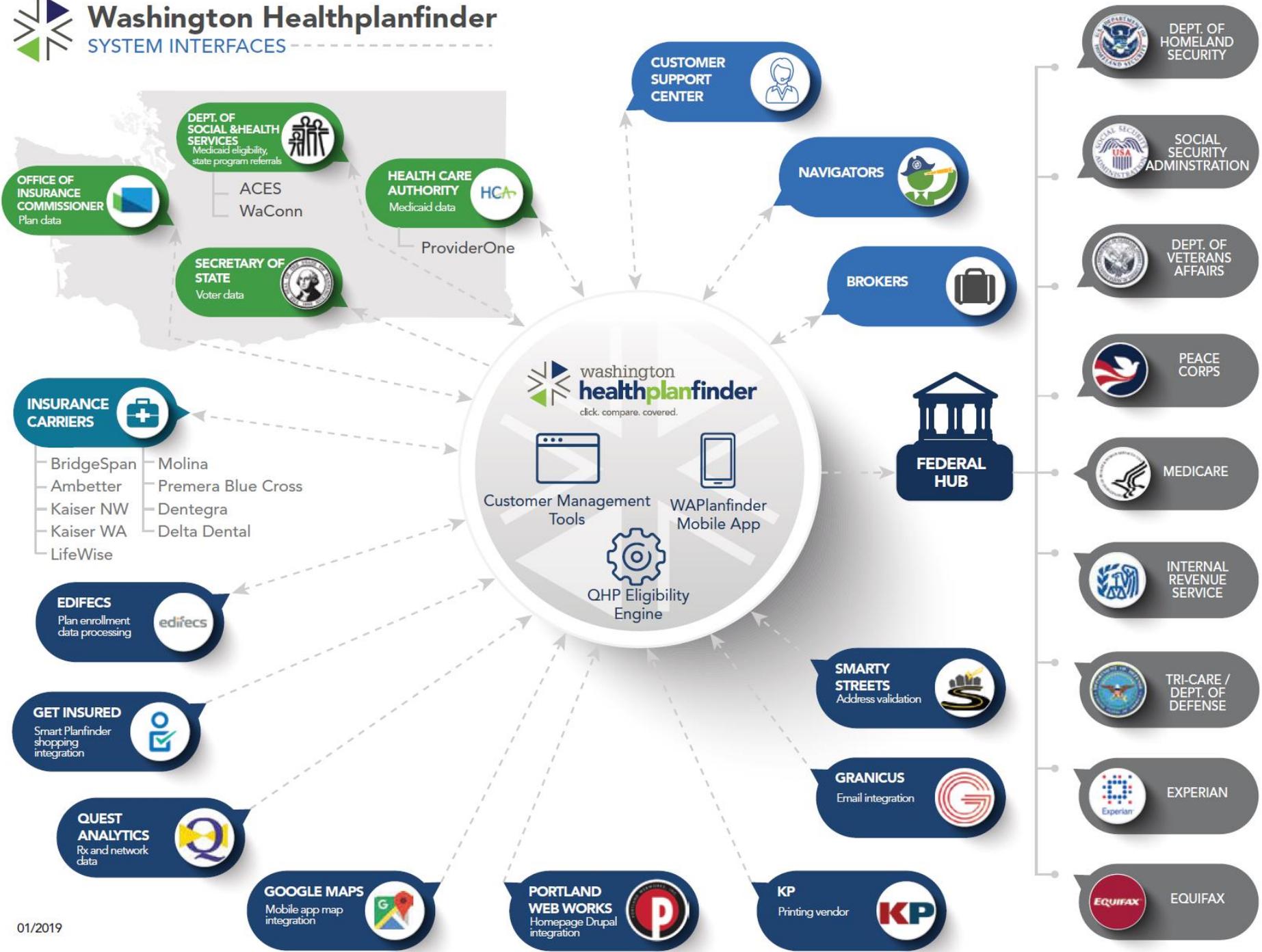
- About 171,500 Enrollees with \$615 Million in spend
- 72% of Enrollees had claim costs under \$1,500
  - Includes ~46,000 or 27% of Enrollees with no claims
- 5% of QHP enrollees accounted for **72%** of total medical claim costs
  - Equals ~12,500 enrollees with median claim cost of ~\$19,000
- Utilization and rates vary significantly by geographic region

County	Utilization Rate	Average Cost per claim
Statewide Average	53%	\$524
Franklin	29%	\$849
Pacific	64%	\$825
Lewis	21%	\$800
Cowlitz	71%	\$762
Grays Harbor	69%	\$724



# Washington Healthplanfinder

## SYSTEM INTERFACES



# 2020 Exchange QHPs - Metal Level Overview

9 QHP Issuers | 66 QHPs

## Gold

76%-82% AV

- 9 Issuers
- 15 Plans

## Silver

66%-72% AV

CSRs available

- 9 Issuers
- 21 Plans

## Bronze

56%-65% AV

- 9 Issuers
- 26 Plans

## Catastrophic

Only through the Exchange  
Under age 30 or hardship  
No tax credits

- 4 Issuers
- 4 Plans



# Deductibles for 2020

	2019	2020
<b>GOLD</b>		
Deductible Range	\$0 - \$2,925	\$0 - \$2,925
Median Deductible	\$1,175	\$1,200
<b>SILVER</b>		
Deductible Range	\$2,000 - \$7,150	\$2,000 - \$7,500
Median Deductible	\$4,500	\$4,750
<b>BRONZE</b>		
Deductible Range	\$4,750 - \$6,500	\$5,000 - \$7,000
Median Deductible	\$5,600	\$6,350

Deductibles shown are for an individual.

Silver deductibles presented in this graph are for a standard silver plan (no cost sharing reductions).





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click. compare. covered.