State Premium Assistance Policy

May 10, 2022

Section 1. State Premium Assistance Program

The 2021 Washington State Legislature enacted Engrossed Second Substitute Senate Bill 5377 which, among other provisions, directed the Exchange to establish a state premium assistance program for Washington residents. The Legislature included in Engrossed Substitute Senate Bill 5092 (Operating Budget), $50 Million in state funding for the Exchange to implement the premium assistance program for plan year 2023, for individuals with income up to 250 percent of the federal poverty level. In 2022, in Engrossed Substitute Senate Bill 5693 (Supplemental Operating Budget), the Legislature included an additional $5 Million in state premium assistance funding for the non-federally subsidized (contingent on 1332 waiver approval[1]) for a total potential annual appropriation of $55 Million.

The Legislature directed the Exchange to establish, consistent with the current Operating Budget:

1. Procedural requirements for eligibility and continued participation in any premium assistance program, including participant documentation requirements that are necessary to administer the program;
2. Procedural requirements for facilitating payments to health issuers;
3. Eligibility criteria, in addition to eligibility requirements established by RCW 43.71.110 and the Operating Budget; and
4. A process for an individual to appeal a premium assistance eligibility determination.

The requirements set forth in this Policy are established pursuant to and consistent with RCW 43.71.110 and the parameters established in the omnibus appropriations act and govern the Exchange's implementation and administration of the Program.

Section 2. Policy Effective Dates

This Policy, governing the administration of the State Premium Assistance Program, is effective beginning for coverage effective in plan year 2023. The Exchange may update this policy annually or more frequently as needed.

Section 3. Definitions

The definitions in this section apply throughout this Policy unless the context clearly requires otherwise.

[1] The state is applying for a federal Section 1332 Waiver that, if approved, would expand state residents' access to Qualified Health Plans (QHP(s)), including stand-alone Qualified Dental Plans (QDP(s)), and the state premium assistance program. The waiver, if approved, would be in effect starting for the 2024 coverage year. More 1332 Waiver information is available at: https://www.wahbexchange.org/about-the-exchange/what-is-the-exchange/legislation/1332-waiver-information/.

1. "Advanced Premium Tax Credit (APTC)" means the premium assistance amount determined in accordance with the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal health care and education reconciliation act of 2010, P.L. 111-152, and subsequent legislation, and with federal regulations and guidance issued under the affordable care act.
2. "Cascade Care Plan" means any standardized qualified health plan (QHP) developed pursuantto RCW 43.71.095, sold on *Washington Healthplanfinder*, and marketed as either a Cascade or Cascade Select plan.
3. "Eligible Enrollee" means any individual that meets all premium assistance eligibility requirements established in section 4 of this policy.
4. "Eligible Household" means a tax-filing household that includes one or more individuals who are eligible enrollees.
5. "Enrollment Group" means a group of individuals enrolled in the same qualified health plan within the same insurance policy.
6. "Exchange" means the Washington health benefit exchange established in RCW 43.71.020.
7. "Federal Poverty Level" (FPL) means a measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels[2] are used to determine individuals' eligibility for certain programs and benefits.
8. "Grace Period" means a period — either one month or three months — after an enrollee's monthly health insurance payment is due and a binding payment has been made. The grace period for health insurance is three months if an enrollee is subsidized by at least one of the following: 1) advance payments of the premium tax credit; or 2) state premium assistance. The grace period for health insurance is one month for enrollees not receiving APTC or state premium assistance.
9. "Income" has the same meaning as "household income" as defined in 26 U.S.C. § 36B(d)(2).
10. "Non-subsidized Enrollment" means an enrollment that does not receive APTC or state premium assistance.
11. "Operating Budget" means Engrossed Substitute Senate Bill 5092, passed by the Washington State legislature and signed by the Governor during the 2021 State Legislative Session.
12. "Policy" means the State Premium Assistance Program requirements and guidance set forth in this document.
13. "Premium assistance eligible plan" means a:
    - Silver or Gold Cascade Care plan; or
    - Any QHP in which an American Indian or Alaska Native eligible for a zero-dollar cost-sharing plan under 42 U.S.C. §18071(d)(1) is enrolled.
14. "Presiding Officer" means an impartial person who is not involved in original eligibility decisions and who is appointed by the Washington health Benefit Exchange (Exchange) to conduct appeal proceedings for state premium assistance.

[2] Federal Poverty Level (FPL) as specified in Code section 36B(d)(3)(B) and implementing regulations.

15. "State Premium Assistance Program" or "Program" means the premium assistance program established in RCW 43.71.110. This program is branded and known to consumers as Cascade Care Savings.
16. "Subsidized Enrollment" means an enrollment that receives APTC and/or state premium assistance.
17. "Qualified Health Plan" or "QHP" means a health plan that is certified by an exchange. To be certified in Washington, a health plan must be approved by OIC, satisfy the certification criteria specified in RCW 43.71.065, satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts 155 and 156, and be certified by the governing board of the Exchange.
18. "Tax Filing Household" means a federal tax filing unit

Section 4. Eligibility

1. *Program Eligibility*. As required in, or established under the Exchange's authority pursuant to, RCW 43.71.110(4), consistent with the Operating Budget, and subject to Section 11(2) of this policy, an individual is an eligible enrollee ifthe individual:
    a. Is a resident of Washington State;
    b. Is QHP eligible
    c. Has income up to 250% of the Federal Poverty Level;
    d. Enrolls in a premium assistance eligible plan;
    e. Applies for and accepts all APTC for which the individual's household is eligible;
    f. Is ineligible for minimum essential coverage through a federal or state medical assistance program, including Washington Apple Health; the Compact of Free Association (COFA) Islander Premium Assistance Program; or the Washington State Health Care Premium Assistance Program for Employees of Child Care Facilities (also known as the Child Care Sponsorship Program).
    g. Is not enrolled in minimum essential coverage through Medicare.

2. *Multiple-Enrollment Eligibility*. For households with individuals enrolled in multiple enrollment groups, only those eligible individuals within the household enrolled in a premium assistance eligible plan will be able to have state premium assistance applied to their health plan premium.

3. *Insurance Affordability Programs*. To be eligible for state premium assistance, individuals must receive an eligibility determination for insurance affordability programs, including for:
    a. Washington Apple Health
    b. Advanced Premium Tax Credits
    c. Cost-sharing Reduction Subsidies

4. *Conditional Eligibility Verification*. The Exchange will verify data matching

inconsistencies with existing Conditional Eligibility Verification processes. An individual may be requested to provide documents that verify application information not able to be confirmed via available electronic sources for:

a. Attested citizenship/lawful presence status
b. Incarceration
c. Eligibility for MEC through Washington Apple Health, health coverage programs for COFA Islanders Premium Assistance Program, or the Child Care Sponsorship Program, or enrollment in Medicare
d. Income
e. Tribal status

5. *Duration of Eligibility*. An eligible enrollee will remain eligible for the Program for the remainder of the plan year, until coverage is otherwise terminated, or until an eligible enrollee reports a change that makes the individual no longer eligible for the Program pursuant to the requirements of this section.

6. *Change Reporting*. Eligible enrollees are required to report changes in circumstances to their application, in accordance with federal guidelines (45 CFR §155.330).

7. *Program Disqualification*. Pursuant to RCW 43.71.110(5), an eligible enrollee may be disqualified from the Program by the Exchange if the eligible enrollee:
   a. No longer meets the eligibility criteria established in subsection 1 of this section.
   b. Fails, without good cause, to comply with procedural or documentation requirements established by the Exchange, including requirements for timely notification of changes impacting eligibility;
   c. Voluntarily withdraws from the Program; or
   d. Performs an act, practice, or omission that constitutes fraud, and, as a result, an issuer rescinds the individual's policy for the QHP.

8. *Income*. Income, for purposes of determining eligibility for the Premium Assistance Program under subsection 1 of this section, shall be determined at the tax-filing household level.

9. *American Indian and Alaska Natives*. American Indian and Alaska Natives are not required to select a gold or silver Cascade Care plan in order to be eligible for state premium assistance.

Section 5. Premium Assistance Amount

1. *Calculation of premium assistance amounts.* Annual state premium assistance amounts for eligible households will be calculated as follows, subject to appropriated funding levels and parameters established in the omnibus appropriations act, and pursuant to the following:

a. Up to 10% of appropriated funding will be held in a reserve to account for enrollment uncertainty.
b. Base fixed-dollar premium assistance amounts will be calculated annually based on the appropriated budget and after the reserve is established, for the federally subsidized population and non-federally subsidized population, based on an actuarial analysis that includes considerations of uptake assumptions for the projected eligible enrollees in the federally subsidized and non-federally subsidized populations for that plan year, qualified health plan rates, and federal 1332 guardrail requirements (contingent on 1332 waiver approval), within the allocation amounts for each population[3].
c. A household premium assistance amount will then be calculated by multiplying the base fixed-dollar assistance amount by the number of eligible enrollees in the eligible household.
d. An eligible household's premium assistance amount calculated pursuant to subsection 1 of this section will be reduced so as not to exceed the lesser of:
    i. The household's net premiums after first applying all advance premium tax credits for which the household is eligible; or
    ii. The net premium all eligible enrollees in the household would pay if each eligible enrollee in the household were enrolled in the lowest cost Cascade Care silver plan in the household's county of residence.
e. If there are multiple enrollment groups within an eligible household, the household's full premium assistance amount will be available to be applied across the enrollment groups' premiums for enrollments in Premium Assistance eligible plans.

2. *Coverage of non-Essential Health Benefits*. The household premium assistance amount can be applied to the entire net premium including portions that are not attributable to essential health benefits (e.g., adult vision benefits, voluntary termination of pregnancy).

3. *Application of advance premium tax credits*. If determined eligible for advance premium tax credits (APTCs), any APTCs for which an eligible household is eligible must be applied to the household's premiums before application of any state premium assistance amounts.

4. *Opt-out*. Eligible enrollees who are awarded state premium assistance pursuant to this section may contact the Exchange call center to disenroll from the state premium assistance program.

[3] For 2023, the allocation is currently projected to be $34.5M for the federally subsidized population and $10.5M for the non-federally subsidized population (resulting in a single fixed maximum PMPM subsidy amount for both populations). For 2024, there will be separate fixed maximum PMPM subsidy amounts for the federally subsidized and non-federally subsidized populations and an additional $5M in funding appropriated by the Legislature for the non-federally subsidized population contingent on the waiver being approved.

Section 6. Notice and Appeals Rights

1. Individuals apply for state premium assistance with the same application form used to apply for Washington Apple Health, Qualified Health Plan coverage, and Advanced Payments of the Premium Tax Credit (APTC). Only if an applicant is determined eligible for Qualified Health Plan (QHP) coverage will there be a decision about eligibility for state premium assistance. Applicants may appeal the following state premium assistance eligibility decisions made by the Exchange to a Presiding Officer:
    a. Not eligible for state premium assistance.
    b. Eligible for state premium assistance, but the amount is wrong.

2. Appeals of eligibility for state premium assistance shall follow the Procedural Rules for Washington Health Benefit Exchange Appeals. The Procedural Rules implement the federal regulations in 45 CFR subpart F that govern appeals of Exchange determinations. The Exchange anticipates that most state premium assistance appeals will also be appeals of QHP/APTC eligibility determinations, because a majority of individuals who qualify for state premium assistance will also qualify for federal subsidies. The Exchange will update the Procedural Rules to include state premium assistance throughout and will add new provisions to govern second level appeals for state premium assistance (since QHP/APTC second level appeals are currently performed by HHS) and appeals of additional state premium assistance eligibility criteria (e.g. the requirement to enroll in a premium assistance eligible plan). These updates to the Procedural Rules will be available for review and comment.

Section 7. Exchange Responsibility as Administrator of State Premium Assistance Program

1. *Data Transmission*. The Exchange will transmit state premium assistance amounts to issuers through the Health Insurance Exchange (HIX) 820 format on a monthly basis for the duration of the premium assistance program.

2. *Payments*. The Exchange will make monthly payments to issuers on behalf of the state, for state premium assistance amounts awarded to eligible households enrolled in QHP coverage with that issuer.
    a. Monthly payments will be made in the aggregate for all premium assistance amounts awarded to all eligible households receiving state premium assistance enrolled in QHP coverage with that issuer.
    b. Monthly payments will include amounts owed to the issuer for the previous month net of any recoupments or discrepancies resulting from over- or under-payments from prior months of the plan year.

Section 8. Issuer Responsibility - Premium Assistance Payments

1. *Data Transmission*. Pursuant to RCW 48.43.795, issuers offering QHPs on the Exchange

must accept and process enrollment and payment data transferred by the Exchange as part of the Program.

2. *Payments*. Pursuant to RCW 48.43.795, issuers offering QHPs on the Exchange must accept payments for enrollee premiums as a condition of certification as a QHP offered on the Exchange.

3. *Plan Confirmation and Effectuation*. Issuers offering QHPs on the Exchange must comply with all requirements in the *2023 Guidance for Participation of Health Plans in the Washington Health Benefit Exchange* for confirming enrollments and effectuating coverage for eligible enrollees, including in the circumstance of an eligible enrollee or household with a zero-dollar monthly enrollee responsibility.

4. *Invoicing*. Pursuant to Senate Bill 5377, issuers must clearly communicate premium assistance amounts to enrollees as part of the invoicing and payment process by using the Cascade Care Savings name and should coordinate with the Exchange regarding how this information is presented in invoices.

5. *Compliance with Exchange Premium Sponsorship Program Policy*. The Exchange is administering state premium assistance on behalf of Washington State. Issuers shall comply with all issuer requirements and responsibilities included in the *WAHBE PremiumSponsorship Program Policy*, including requirements related to premium refunds and Medical Loss Ratio (MLR) rebates. For purposes of issuers distributing MLR rebates on behalf of enrollees receiving state premium assistance, the pro rata portion of the MLR rebate based on the state premium assistance paid towards the enrollee's premium shall be distributed directly to the Exchange, on behalf of Washington State. If a customer is eligible for both federal subsidies and state subsidies, federal subsidies will be applied prior to the application of state subsidies and any remaining net premium may be eligible for premium reduction through sponsorship programs.

6. *Compliance with Enrollee Grace Period Requirements*. Issuers shall apply a three-month consecutive grace period for an enrollee, who when failing to timely pay premiums, is receiving state premium assistance. For enrollees receiving APTC, federal grace period rules supersede state grace period rules. For enrollees not receiving APTC, state grace period rules apply and align with federal grace period rules under 45 CFR 156.270, including the requirements for issuers to:
    - Notify the enrollee that they are delinquent on premium payment.
    - Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.
    - Continue to collect payments of the state premium assistance from the

Exchange on behalf of the enrollee during the three-month grace period.

- In the event an enrollee exhausts the three-month grace period:
  - Terminate the enrollee's enrollment through the Exchange on the last day of the first month of the grace period (if claims were pended in the second and third months of the grace period); and
  - Return payments of the state premium assistance to the Exchange for the second and third months of the grace period (if claims were pended in the second and third months of the grace period).

Section 9. Special Enrollment Period –

1. *Special Enrollment Period*. Pursuant to the Exchange's Exceptional Circumstances Special Enrollment Period (SEP) Policy and authority granted to the Exchange under federal regulations (45 CFR § 155.420(d)(9) and (16)), individuals with income up to 250% FPL that are not enrolled in a Silver or Gold Cascade Care plan will be eligible for a monthly SEP.
   a. To be granted a SEP under this section, an individual must be a Washington state resident, meet all QHP eligibility requirements, have income up to 250% of the federal poverty level, and not be currently enrolled in a Cascade Care Silver or Gold plan.
   b. An individual granted this SEP must enroll in a Cascade Care Silver or Gold plan.
   c. An individual granted a SEP under this section may switch issuers, or change plans within the same issuer.
   d. An individual granted a SEP under this section that changes plans and remains enrolled with the same issuer will not lose any cost accumulators accrued while in the previous plan.
   e. The Exchange will verify eligibility for this SEP. The issuer may not separately verify eligibility for this SEP.

2. *Effective date*. For a QHP selection by an individual under a special enrollment period under this section, coverage will be effective the first day of the month after plan selection.

Section 10. Premium Assistance Audit

1. The Exchange will annually contract with an independent CPA firm selected through a competitive procurement process to audit the financial statements of the Program.
2. The Exchange will distribute findings of the Program audit to the Exchange's Audit and Compliance Committee, the Exchange Board, organizations to whom the Exchange is required to submit a copy, and the legislature.

Section 11. Contingency for Low Funds

1. *Tracking Available Funds*. Beginning in January 2023 and monthly thereafter, the Exchange will track total expected State Premium Assistance Program expenditures for the plan year. If, the Exchange determines that State Premium Assistance Program expenditures are at risk of exceeding available funds for the current plan year, newly eligible households not already receiving state premium assistance may not receive state premium assistance for the remainder of the plan year. Eligible households may qualify for state premium assistance in the subsequent plan years, subject to available funds.
2. *Impact to Premium Assistance Eligibility*. Individuals and households who would otherwise be eligible for state premium assistance pursuant to Section 4 of this policy but for a determination that State Premium Assistance Program expenditures are at risk of exceeding the available funding level may be determined ineligible for state premium assistance as determined by the Exchange.
3. *Impact to Premium Assistance Recipients*. If it is determined at any time, based on projected premium assistance distribution through the Program, that premium assistance expenditures would be below available program funds, the monthly amount of premium assistance any eligible household or eligibleenrollee is currently receiving through the Program may be adjusted to increase recipients' state premium assistance amounts to best utilize available appropriations subject to parameters established consistent with RCW 43.71.110 and in the omnibus appropriations act.