2024 Health Care Affordability State Policy Snapshot

WASHINGTON

CURB EXCESS PRICES IN THE SYSTEM	**PREMIUM RATE REVIEW**	**HEALTH CARE SPENDING BENCHMARKS**	**HOSPITAL PRICE REGULATION**	**PUBLIC OPTION**
IMPROVE OVERSIGHT, ACCOUNTABILITY AND TRANSPARENCY	**HEALTH SPENDING OVERSIGHT ENTITIES**	**ALL-PAYER OR MULTI-PAYER CLAIMS DATABASE**	**PRICE TRANSPARENCY**	**MEDICAL DEBT COLLECTION REGULATIONS**
ADDRESS CONSOLIDATION AND PROMOTE COMPETITION	**CONSOLIDATION ASSESSMENT AND AUTHORIZATION**	**BALANCE BILL PROTECTIONS**	**FACILITY FEE LIMITS**	**ANTI-COMPETITIVE CONTRACT PROVISIONS**
MAKE OUT-OF-POCKET COSTS AFFORDABLE	**REDUCED COST-SHARING: PRESCRIPTION DRUGS**	**REDUCED COST-SHARING: HIGH VALUE SERVICES**	**MEDICAL DEBT PREVENTION**	**EXPANDED COVERAGE**

State Has Active Legislation

State Does Not Have Active Legislation

HEALTHCARE VALUE HUB

The Health Care Value Hub ("the Hub") is proud to launch the 2024 Health Care Affordability Policy Snapshot ("Affordability Snapshot") which replaces the annual Healthcare Affordability Scorecard ("Scorecard"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other stakeholders a tool to compare their state's health policies across other states.

The categories examined in this resource explore a variety of policy options that have previously appeared in the Scorecard, as well additional policies that impact health care affordability. Policies were selected based on whether they have the potential to impact health care affordability or access to health care at the state level, whether a reputable source was available for review, and whether evidence was current within the past ten years.

Policies were examined for whether they were active, implemented to a limited degree, or not active as of July 1, 2024. Sources for this information can be found in the downloadable Data and Source Document available on the **Dashboard** page.

The Hub offers both online and hands-on support, with a staff dedicated to monitoring, translating, and disseminating evidence and connecting advocates, researchers, and policymakers to build communities and galvanize action around creating a patient-centered, high-value healthcare system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Curb Excess Prices in the System

Premium Rate Review

States can control excessive health insurance premium increases through premium rate review, where state insurance regulators scrutinize proposed rate hikes for the upcoming year to ensure that the increases are based on accurate data and realistic projections of health care costs and utilization. The Affordable Care Act (ACA) set standards for these efforts, and states meeting these standards are recognized by the Centers for Medicare and Medicaid Services (CMS) as having an effective rate review process. States may also establish the authority to approve or deny rate increases and incorporate affordability criteria into their evaluations. This section examines whether a state has an effective rate review program, as defined by CMS, the power to approve or deny rate increases, and if affordability criteria are integrated into the rate review process.

Health Care Spending Benchmarks

Health spending benchmarks aim to limit annual health care spending growth by establishing a maximum limit, or "benchmark." Benchmarks may examine overall spending or spending for specific hospitals or insurers. If the benchmark is surpassed, the overseeing state entity will often collaborate with providers to curtail spending, and some states authorize the entity to mandate performance improvement plans or impose penalties. This section examines whether a state has established a benchmark, and if so, whether the state has statutory authority to enforce the benchmark.

Hospital Price Regulation

This section assesses state efforts to reduce hospital service costs through reference-based pricing, global budgets, or a comparable program that regulates hospital pricing. Unlike reference-based benefits, which set a maximum allowed benefit for specified drugs or services, reference-based pricing establishes set service costs based on a predetermined reference rate. As of publication, each state that has implemented this model has set reimbursement as a multiple of the Medicare reimbursement rate.

Similarly, global budgeting involves setting a fixed prospective payment for a specified range of services over a defined period, rather than being paid for each service. By establishing a limit on annual spending, this model shifts the financial responsibility to providers and payers and encourages managing service delivery within the set budget. Some states have established state-specific insurance models which mirror select aspects of these strategies, which are also highlighted under "alternative hospital price regulation strategies."

Public Option

A Public Option is a state-managed health insurance model designed to enhance competition and control costs through negotiated rates. States possess a degree of flexibility in designing these coverage options, resulting in variations in cost-containment measures and provisions related to network adequacy and reimbursement. This section highlights states that have an active Public Option and those with provider participation mandates to ensure consistent access to in-network providers.

Policy	Status as of July 1, 2024	Summary
Premium Rate Review	● Has an effective rate review process. ● Has the authority to modify or reject premium rate increases. ● Incorporates affordability criteria into premium rate review.	Washington has the authority to approve or deny proposed premium rate increases in the individual and small group markets, with authority to hold public hearings to solicit stakeholder engagement in the process. In the large group market, the state has the authority to approve or deny proposed premium rate increases in HMOs only. When reviewing rates, the Washington State Department of Insurance considers whether benefits are not reasonable in relation to the premiums charged and whether rates are contrary to the public interest. It also has the authority to review contracts and other relevant documents.
Health Care Spending Benchmarks	● Has health care spending benchmark for providers and/or insurers. ⊗ Does not have enforcement mechanism for healthcare spending benchmark.	Washington State's Health Care Cost Transparency Board set average health care growth targets at 3.2% from 2021-2023, 3.0% for 2024-2025, and has proposed 2.8% for 2026-2039. Performance against the benchmark is measured at the state level, at the insurance market level including Medicare, Medicaid, and commercial insurers, by carrier, and by large provider entity. The benchmark does not have an enforcement mechanism.
Hospital Price Regulation	⊗ Has not implemented hospital reference-based pricing or rate-setting. ⊗ Has not implemented hospital global budgets. ● Has implemented alternative hospital price regulation strategies.	The legislation that established Cascade care, Washington's Public Option, requires the state to contract with one or more health insurance carriers to offer qualified health plans on the state health insurance Marketplace. These plans are required to set an aggregate cap on payments to providers and facilities at 160% of Medicare rates.
Public Option	● Has an active Public Option. ● Public option includes a provider participation mandate.	Launched in 2021, Washington's Cascade Care offers standardized Public Option health insurance plans through the Marketplace, with state-funded premium assistance available to all residents, including undocumented individuals under a 1332 waiver. Provider participation challenges led to legislative changes requiring select hospitals to accept at least one Public Option plan. Provider

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Improve Oversight, Accountability, and Transparency

Health Spending Oversight Entities

Health Spending Oversight Entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, few have established oversight entities with enforcement powers. This section examines whether a state has a health spending oversight entity reviewing primary care, hospital, or prescription drug spending, and if upper payment limits for prescription drugs have been implemented.

All-Payer or Multi-Payer Claims Database

All-payer claims databases (APCDs) compile diverse health care data, that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation. However, some claims databases have been voluntarily developed by independent entities, limiting oversight.

This section examines whether a state has an active all-payer or multi-payer claims database, if the database is facilitated and managed by the state or by third-party entities, if the data is free and accessible without institutional review board approval, and if the database is required to capture race and ethnicity demographic information.

Price Transparency

This section evaluates state efforts to provide access to health care price data through a publicly available and easily accessible tool. To be credited, the tool must show negotiated prices for various services and be accessible without fees, IRB approval, or legislative restrictions. Additionally, this section reviews whether a state requires prescription drug price data to be reported to a state entity and if a state has another form of price transparency regulation.

Medical Debt Collection Regulations

This section examines how a state regulates providers' ability to collect medical debt once it has been incurred. It reviews whether a state: prohibits providers from sending debts to collections while a patient is actively pursuing efforts to address the bill (e.g., appealing to insurance, applying for financial assistance, negotiating the bill, in a payment plan); prohibits spouses or other persons from being held liable for another adult's debt; limits collections' ability to garnish wages; prohibits collections from initiating home foreclosure; prohibits collections from initiating actions that would lead to an individual's arrest due to medical debt; prohibits collections from seizing a bank account.

Policy	Status as of July 1, 2024		Summary
Health Spending Oversight Entity	●	Has a Prescription Drug Affordability Board reporting on	The Washington Prescription Drug Affordability Board has the authority to review the affordability of certain drugs and establish upper payment limits for up to 12 drugs. Washington's Health Care Cost Transparency Board, established in 2020, monitors and reports on hospital and primary care spending. The Board's Advisory Committee on Primary Care provides expert advice related to the state's primary care spending target for the board's review.
	●	Enforces prescription drug prices through Upper Payment	
	●	Monitors and reports on hospital spending.	
	●	Monitors and reports on primary care spending.	
All-Payer or Multi-Payer Claims Database	●	Has an all-payer or multi-payer claims database.	Washington's APCD represents 70% of the Washington population. Age, ethnicity, gender, race, and zip code are also included in the APCD.
	●	Database is operated by the state.	
	●	Database does not include access restrictions.	
	●	Database is required to capture demographic information.	
Price Transparency	●	Has a price transparency tool showing negotiated rates.	The Washington *HealthCareCompare t*ool shares the total amount paid for many services and procedures by provider. Additionally, Washington requires health plans to annually report to the Health Care Authority the 25 most-prescribed drugs, the 25 costliest drugs, and the 25 drugs with the highest increase in spending. Drug manufacturers must also annually report factors to increase the wholesale acquisition cost (WAC) of the drug and the amount of the increase. This only applies to drugs that enter the market with a WAC of $10,000 or more or for drugs currently on the market with a WAC of $100 or more and the WAC increase by 20% in one year or 50% in three years. Additionally, manufacturers must provide 60 days advance notice of a qualifying price increase.
	●	Has a Prescription Drug price transparency reporting	
	⊗	Does not have any other price transparency regulation.*	
Medical Debt Collection Regulations	●	Prohibits providers from sending debts to collections while	
	⊗	Does not prohibit other persons being held liable for	
	⊗	Does not prohibit collections from initiating home lien or	
	●	Exceeds federal wage garnishment protections.	
	●	Prohibits actions that would lead to an individual's arrest	
	⊗	Does not prohibit collections from initiating bank account seizure due to medical debt.	

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Address Consolidation and Promote Competition

Consolidation Assessment and Authorization

This section examines whether relevant parties are required by law or statute to notify the state of hospital consolidation transactions beyond the federal requirements, and whether the state has the authority to review these transactions; to approve, reject, or modify conditions of the transaction; and if consumer affordability or price growth are included in the review criteria

Balance Bill Protections

The federal No Surprises Act (NSA) protects patients from balance bills, which are unexpected costs from out-of-network providers. Under the federal legislation, patients receiving emergency care or who are unknowingly treated by out-of-network providers during an in-network procedure are only required to pay the in-network cost-sharing amount for services provided. Effective January 1, 2022, the No Surprises Act applies to most health plans but not all care sites and services. States can legislate additional protections for balance bills not covered under the NSA, such as for ground ambulances, or services provided at urgent care locations, hospice facilities, and birthing centers.

Facility Fee Limits

Facility fees are charges for services provided in outpatient and physician office settings that hospitals own. These fees increase the out-of-pocket costs for care and are becoming increasingly more common as the rate of health system consolidation has accelerated. This section explores whether a state prohibits facility fees under certain circumstances, if they have imposed regulations to protect consumers against out-of-pocket costs from facility fees, and if they require hospitals to report facility fee data.

Anti-Competitive Contract Provisions

Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. This section evaluates whether states prohibit four types of anti-competitive contracting practices in the health system:

- Most Favored Nation Clauses: Health systems agree not to offer lower prices to competing insurers, preventing them from offering the same service at a lower price. These provisions may allow insurers and providers to collude to raise prices.
- All-or-Nothing Clauses: Health systems require plans to contract with all providers in their system or none of them, even if those providers are low-value or high-cost.
- Non-Compete Clauses: Doctors are prohibited from working at competing hospitals within a certain distance for a certain period of time.
- Anti-Tiering or Anti-Steering Clauses: Insurers must place favored providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).

Policy	Status as of July 1, 2024		Summary
Consolidation Assessment & Authorization	●	Requires certain healthcare providers to notify the state of consolidation transactions.	Washington requires the Department of Health (DOH) be notified of acquisitions of nonprofit hospitals with authority to approve, set conditions for, or disapprove transactions, with criteria including access to affordable care. The Attorney General (AG) must also be notified of material changes in hospitals, hospital systems, or provider organizations of 7+ providers, and submits opinions to the DOH. SB 5241, which did not pass, would have authorized the AG to approve or disapprove mergers that reduce access to services, including reproductive and end-of-life care. WA also requires that the Certificate of Need program be notified of sales, purchases, or leases of hospitals with authority to approve, set conditions for, or disapprove transactions, with criteria including impact on the cost of and charges for health services.
	●	Has authority to approve, set conditions, or disapprove consolidation transactions.	
	●	Includes consumer affordability and/or price growth in review criteria or approval conditions.	
Balance Bill Protections	⊗	Does not prohibit balance billing for out-of-network ground ambulance services.	Effective January 1, 2025, Washington state will prohibit balance billing for both public and private ground ambulance services. Washington has also enacted balance bill protections for emergency services provided by behavioral health providers.
	●	Prohibits balance billing for out-of-network services at specific facilities not included in the NSA (see notes).	
Facility Fee Limits	●	Prohibits facility fees for specified procedures and/or care settings.	Washington prohibits facility fees for distant sites, hospitals that are the originating site for audio-only telemedicine services, and any other site not outlined in legislation. Additionally, hospitals are required to report facility fee data on an annual basis.
	⊗	Does not have codified protections against out-of-pocket costs from facility fees.*	
	●	Requires hospitals to report facility fee data.	
Anti-Competitive Contract Provisions	⊗	No law restricting Most Favored Nation contract provisions.	Washington state prohibits Most Favored Nation clauses in contracts between healthcare providers and certified health plans, though it's unclear if any certified health plans are still available in the state or if this statute applies to other health benefit plans. Washington also limits the enforceability of noncompete agreements, recognizing them as valid only if the employee earns more than $120,559.99 annually, or $301,399.98 if the worker is an independent contractor. Noncompete agreements exceeding eighteen months post-termination are presumed unreasonable unless proven otherwise by clear and convincing evidence.
	⊗	No law restricting all-or-nothing contract provisions.	
	⊗	No law restricting anti-tiering or anti-steering contract provisions.	
	◉	Non-competes for physicians limited by statute.	

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Make Out-of-Pocket Costs Affordable

Reduced Cost Sharing: Prescription Drugs

This section examines whether states have passed legislation reduce the amount a consumer pays out-of-pocket for select prescriptions drugs including insulin, epinephrine, oral oncology medications and asthma inhalers. This section also examines state-level legislation prohibiting copay accumulator programs, which are payer strategies that limit the impact of manufacturer cost-sharing assistance programs on consumer out-of-pocket costs.

Reduced Cost-Sharing: High Value Services

This section provides an overview of state efforts aimed at reducing consumer cost burdens for high-value services. Specifically, it identifies states which have enacted legislation mandating coverage without cost-sharing for: primary care services recommended by the United States Preventive Services Task Force (USPSTF); various cancer screening and diagnostic services; and annual mental health exams. It also evaluates state efforts to expand access to affordable maternal and reproductive health care by highlighting the states that mandate private insurers cover in-vitro fertilization, fertility preservation, doula services and abortion care. The section concludes with a review of whether a state has incorporated equity-focused initiatives in their state-regulated insurance design.

Medical Debt Prevention

This section reviews state laws aimed at preventing medical debt, including mandates for hospitals and health care providers to offer financial assistance policies, screen patients for insurance and charity care eligibility, and inform patients of charity care policies before collecting payment. It also assesses whether states have extended Medicaid benefits retroactively for 90 days; expanded general presumptive eligibility for Medicaid to all adults; prohibited short-term, limited duration health plans; and if the state has established annual reporting requirements on community benefit spending.

Expanded Coverage

This section evaluates policies aimed at expanding access to and improving the affordability of health insurance, including whether a state has expanded Medicaid eligibility to adults with incomes up to 138% of the federal poverty level (FPL); authorized 12-month continuous Medicaid eligibility for all adults; extended postpartum Medicaid coverage to 12 months following delivery; established a Basic Health Plan; initiated a program providing state-funded premium subsidies for residents ineligible for Medicaid; explicitly authorizes coverage for gender-affirming care under Medicaid; has authorized the provision of Medicaid coverage to individuals transitioning from incarceration; and if the state has extended Medicaid coverage to include dental, hearing, and vision benefits, including eye exams and glasses, beyond what is deemed medically necessary following injury or surgery. Beyond these policy options, this section also reviews state efforts to extend coverage to children, pregnant residents, and non-pregnant adults regardless of immigration status. This includes waiving the five-year required waiting period for immigrant children and legally residing pregnant residents (the "five-year bar"); offering alternative coverage options regardless of citizenship status; and opting into the From-Conception-to-End-of-Pregnancy (FCEP) option under the Children's Health Insurance Program (CHIP), previously known as the CHIP Unborn Child option.

Policy	Status as of July 1, 2024	Summary
Reduced Cost-Sharing: Prescription Drugs	● Prohibits copay accumulator programs. ● Caps the price of insulin or diabetes supplies. ● Caps the price of other prescription drugs or medical devices (see notes).	Insurers in Washington must apply any payments made by or on behalf of an enrollee for a covered prescription toward their cost-sharing obligations when no generic is available, or when a generic is available but the enrollee accesses a brand-name drug through prior authorization, step therapy, or the insurer's exemptions and appeals process. The state also limits the out-of-pocket cost for a 30-day supply of prescription insulin to $35.00. Additionally, Washington requires insurers to cover prenatal vitamins and any medically necessary medications for conditions resulting from a sexual assault without cost-sharing. Starting in January 2025, Washington will also prohibit cost-sharing for postexposure prophylaxis and cap the cost-sharing for a 30-day supply of asthma inhalers and a twin pack of epinephrine auto-injectors at $35.00.
Reduced Cost-Sharing: High Value Services	● Mandates private insurers cover USPSTF recommended ⊗ Does not waive or reduce cost-sharing for an annual ● Provides coverage and/or waives or reduces cost-sharing ● Mandates coverage for some cancer screening services ⊗ Insurance design does not include cost-saving measures	Washington will begin reimbursing doulas for services provided to Medicaid enrollees in early 2025, with the supplemental operating budget enacting a reimbursement rate of up to $3,500.00 per doula—the highest in the nation. Washington also requires all health benefit plans to cover abortion services without cost-sharing. Insurers in Washington that cover diagnostic and supplemental breast examinations are prohibited from imposing cost-sharing requirements for those screening services. Similarly, insurers are also required to cover well-person preventive reproductive health visits outlined in HRSAs Women's Preventive Services Guidelines without cost-sharing, which may include cancer screenings contingent on health and risk factors, for women, transgender, nonbinary, and intersex individuals.
Medical Debt Prevention	● Mandates hospitals and other health care providers provide free or discounted care with set eligibility criteria ● Mandates health care providers screen patients for ● Mandates health care providers notify patients of charity ● Retroactively extends Medicaid benefits ninety days prior ⊗ Has not authorized all qualified entities to provide ● Has prohibited or effectively eliminated short-term, limited ● Requires transparency in spending for community benefit programs.	Hospitals in Washington are required to provide free charity care to patients up to 300% FPL, and discounted care for those earning between 301% and 400% FPL. STLD health plans aren't explicitly banned in the state, but strict regulations have effectively removed them from the market.

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Policy	Status as of July 1, 2024	Summary
Expanded Coverage—Medicaid and Other Options	● Expanded Medicaid income eligibility to 138% FPL. ⊗ Does not offer a basic health plan or other affordable coverage option for residents with incomes below 200% FPL.* ⊗ Has not authorized 12-month continuous eligibility for adult Medicaid enrollees. ● Includes 12 months of postpartum care in Medicaid benefits. ● Provides select Medicaid services to justice-involved people up to 90 days before release. ● Medicaid policy explicitly includes coverage for gender-affirming services. ◉ Offers some, but not an extensive amount of dental, vision, or hearing coverage in Medicaid benefits (see notes). ● Offers state-based premium subsidies.	Washington Medicaid covers eye exams, but not eyeglasses, for adults; covers hearing aids and other hearing devices for adults; and offers some dental coverage for extraction, dentures, root canals, restorative (fillings and crowns), preventive, and diagnostic services. Washington offers state-based premium subsidies (Cascade Care Savings) for enrollees with incomes up to 250% FPL when they select a standardized Silver or Gold exchange plan. Under the Washington Medicaid Transformation Project 2.0 1115 Demonstration, incarcerated residents are eligible to receive select Medicaid benefits, including case management and counseling, three-months prior to release. Washington's Medicaid agency, Apple Health, covers a comprehensive list of gender affirmation services under the Apple Health Transhealth program.
Expanded Coverage—Immigrant Coverage	● Offers coverage for lawfully residing immigrant children or pregnant people without a five-year bar. ● Covers pregnancy-related services through the CHIP "From-Conception-to-End-of-Pregnancy" (FCEP) Option. ● Offers an affordable coverage option for undocumented immigrant children. ● Offers an affordable coverage option for undocumented immigrant adults.	Starting Fall 2023, Washington State allows people to enroll in marketplace coverage regardless of immigration status, with state-based premium subsidies for those earning less than 250% FPL. Washington has appropriated $110 million over two years to fund state premium subsidies for all marketplace enrollees, $10 million of which is earmarked for people ineligible for federal subsidies because of their immigration status. Effective July 1, 2024, Washington expanded its Apple Health Medicaid program to cover undocumented immigrant adults as well (enrollment cap set at 13,000). Washington's Apple Health for Kids program offers Medicaid-like coverage for uninsured children with incomes at or below 317% FPL regardless of immigration status, and offers one year of post-pregnancy coverage for people with incomes below 198% FPL regardless of immigration status.

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