Washington Health Benefit Exchange report:

Public Option: Impact on Hospitals

Submitted Dec. 1, 2023

washington healthbenefitexchange
powering washington healthplanfinder

Executive Summary

As directed by Senate Bill 5377 (2021), Washington Health Benefit Exchange (Exchange) used data from the Washington All-Payer Claims Database (APCD) and nationally recognized tools that draw upon state and hospital-reported data to analyze whether public option plan rates have affected hospital financial sustainability.

- In partnership with the Health Care Authority (HCA) and Office of the Insurance Commissioner (OIC), the Exchange leads the state's health insurance access and affordability initiative for the individual market, called Cascade Care, and makes public option plans available through *Washington Healthplanfinder*.
- *Washington Healthplanfinder* is the online integrated eligibility and enrollment portal operated by the Exchange, which is used by over one in four Washington residents to access Washington Apple Health (Medicaid) and qualified health plans.

Main findings: Public option reimbursement rates do not have material impact on hospital operating margins. This is because:

1) The Exchange market alone is too small to impact hospital financial performance — **hospital claims for Exchange customers are about 1% of Washington state hospitals' total annual revenue**[1]; and

2) **Hospitals are paid 197% of Medicare, on average, when serving Exchange customers.**[2] This is 15% more, on average as a percentage of Medicare, than hospitals are paid when serving commercial customers. [3]

Relative Prices: What Medicare would pay for the same services at the same facilities Hospitals contract for different prices from different payers. The following illustrates what a hospital service might cost depending on the contract.		
Payment from:	**Average relative price, as a percent of Medicare:**	**Hospital is paid:**
Washington Health Benefit Exchange plans	**197%**[4]	**$1,970**
Washington state commercial plans	182%[5]	$1,820
Median commercial "break even"	129%[6]	$1,290
Medicare	100%	$1,000

The Washington State Legislature created the nation's first public option program because health care is unaffordable for too many Washingtonians. Exchange customers are disproportionately affected by the rising costs of health care. Exchange premiums

have almost doubled in the last 10 years,[7] and the Exchange population experienced the highest rate of health care cost growth from 2017 to 2021 with a 30% increase.[8]

To increase access to more affordable health plans for Exchange customers, public option plans are required to meet higher quality standards and legislatively mandated provider reimbursement requirements, including reimbursement minimums for critical access hospitals and primary care providers. Legislative mandates require that aggregate statewide public option carrier reimbursements made to all provider types for health care services must not exceed 160% of Medicare. Even if hospitals were reimbursed at this rate,[9] it would still well above both Medicare rates and the median commercial "break even" point for hospitals to operate (129% of Medicare).[10]

The Legislature asked the Exchange to analyze public option plan rates paid to hospitals for in-network services and impact on hospital operating margins. In 2021, the first year of public option plans and the only year hospital claims data through the APCD are available for this report, public option enrollment and hospital claims were small. Limited available public option data demonstrate:

- Hospitals serving Exchange customers enrolled in public option plans are paid similar rates to hospitals that did not have Exchange public option claims in 2021; and
- Hospitals with claims from public option plans have similar operating margins to hospitals that didn't have public option claims in 2021.

The Exchange's position is less than 5% of the state's overall market — and an even smaller proportion of hospital revenue. Plans continuing to pay relatively high commercial rates results in immaterial impact on hospital financials and is the foundation of this report's conclusions. Even as public option enrollment continues to grow,[11] and even if plans were only to pay hospitals the aggregate rate cap amount of 160% of Medicare, the volume of claims will remain very small and the level of reimbursement would remain at commercial rates. Taken together, available data indicate public option tools could be even further strengthened to advance affordability for Exchange customers.

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[9] Note that public option carriers determine and negotiate contracts with all facilities, beyond hospitals, to meet the statewide 160% of Medicare aggregate. For example, public option carriers could still meet the 160% statewide aggregate requirement if it paid 168% of Medicare for inpatient hospital services, 192% for outpatient hospital services, 141% for non-primary care physician services, and 135% for primary care services (illustrative example).

[10] Note that the median Washington commercial breakeven in 2021 is 129% of Medicare. The high point between 2011 and 2021 occurred in 2019 and was 150% of Medicare. National Academy for State Health Policy. NASHP Hospital Cost Tool [internet]. Washington (DC): NASHP; 2022 Nov 21 [accessed 2023 May 23]. Available at https://tool.nashp.org.

[11] To date this open enrollment, customers selecting public option plans has doubled from 2023 to 2024.

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Report to the Legislature: Requirements & Approach

Washington Health Benefit Exchange (Exchange) was directed by the Legislature in Senate Bill 5377 (2021) to analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability.

The Exchange, in consultation with the Office of the Insurance Commissioner (OIC) and Health Care Authority (HCA), was directed to analyze public option's impact on hospitals' operating margins and the estimated effect on operating margins in future years, if enrollment in public option increases; examine the income levels of public option plan enrollees over time; examine a sample of hospitals of various sizes, located in various counties; and give substantial weight to any available reporting of health care provider and system costs under RCW 70.390.050.

The Legislature required this analysis be completed by Dec. 1 of the plan year during which public option enrollment in Washington state is greater than 10,000 covered lives. Following Exchange open enrollment for the 2023 plan year — the third year of public option availability — 23,000 Exchange customers enrolled in public option plans, tripling enrollment from the previous year, and for the first time exceeding 10,000 lives.[12]

Report Data Availability and Approach

Hospital claims data from the Washington all-payer claims database available to the Exchange for this analysis are from plan year 2021. In 2021, fewer than 1,000 Exchange customers were enrolled in public option plans, and even fewer had inpatient and outpatient hospital claims.[13] As such, this report is limited because available public option data are too small for meaningful analysis. However, all Exchange market data is available and included to supplement the public option data. Below are descriptions of data sources available and used in the analysis.

RAND Hospital Price Transparency Study.[14] This study, conducted by RAND, is an ongoing employer-led initiative to measure and report publicly the prices paid for hospital care at the hospital- and service-line levels. RAND has conducted this study since 2019. The study collects claims data from self-funded employers and all-payer claims databases to assess hospital prices paid by private health plans and by Medicare for the same services. Price data are available from hospitals in all 50 states.

Starting in 2021, the Exchange contracted with RAND to examine the Exchange's market in Washington as part of the study. The Exchange provided RAND with Exchange customer claims data from the APCD, and received Exchange-specific reports that included for 2018 through 2021, total allowed amounts paid:

- To all hospitals for inpatient and outpatient care; for facility and professional care; and relative price for each service as a percent of what Medicare would have paid for the same services from the same hospitals;
- Per service for hospital care and relative price compared to Medicare, and relative to average commercial rates; and
- To individual hospitals and hospital systems identified by name, and price relative to Medicare reimbursement for that same set of services.

Washington state and Exchange-specific data from RAND was used in this analysis to assess plan rates paid to hospitals for in-network services.

National Academy for State Health Policy Hospital Cost Tool.[15] The nationally recognized Hospital Cost Tool provides payers and regulators with data on thousands of hospitals nationwide to better understand and address hospital costs. The tool identifies costs using data hospitals report to the federal government annually. The Hospital Cost Tool includes data about hospitals' commercial breakeven, or the payment level a hospital needs to receive from commercial payers, including the Exchange, to cover maximum hospital expenses for hospital inpatient and outpatient services, without margin. It includes commercial patient hospital operating costs; shortfall or overage from public health programs; charity care and uninsured patient hospital costs; Medicare disallowed costs; and other income and expenses, such as investment income, donations and contributions, and cafeteria operations.

The tool expresses commercial breakeven as multiples of Medicare rates for comparability with data from the RAND Hospital Price Transparency Study. The median commercial breakeven for Washington state hospitals in 2021 is 129% of Medicare. In the last 10 years, the highest median commercial breakeven for Washington state hospitals was 150% of Medicare in 2019.

Information from Washington hospitals, provided for and analyzed using the hospital cost tool, is used in this report to assess hospital operating margins.

Use of the commercial breakeven rate provides a benchmark on adequacy of reimbursement by Exchange plans and customers but does not suggest that this benchmark should become the reimbursement rate or that hospitals do not require a margin to operate. The commercial breakeven is a benchmark that uses hospital reported data about their revenue and costs and includes hospitals that are relatively efficient (e.g., making a profit while operating below the average commercial break even) and those that are not. Another benchmark considered are Medicare rates. The Medicare Payment Advisory Committee (MedPAC) uses a different methodology to assess adequacy — focusing on reimbursement for costs of serving Medicare patients and using indicators, such as beneficiary access to care and provider access, to capital and provider costs. According to MedPAC's most recent report to Congress, most payment adequacy indicators remained positive or improved. Specific to hospital

reimbursement, “In 2021, Medicare’s payments to hospitals continued to be below hospitals’ costs in aggregate but near costs among relatively efficient hospitals.” Overall, the Medicare margin was -6.2% when including federal relief funds and -8.3% exclusive of those funds.[16] These benchmarks provide context when assessing adequacy of Exchange and public option reimbursement rates. Since using Medicare would result in a slightly negative margin and because the Exchange plans are commercial plans, this report uses the commercial breakeven. The Washington State Hospital Association indicated a fair rate should give hospitals more than a breakeven amount, and industry standard for a healthy margin is at least 4% to sustain ongoing services.[17] Hospital returns or profits are used to purchase necessary equipment, provide staff raises, and make updates to aging buildings, e.g., roof replacement.

Health Care Authority. HCA procures and manages public option plan contract requirements. For ongoing monitoring of compliance with public option provider reimbursement requirements, HCA’s actuarial consultant Milliman collects and assesses paid claims data twice yearly from public option carriers. The percent of Medicare reimbursement is produced by dividing the total carrier allowed amount by the amount Medicare would have allowed for the same services. HCA made available information from the review of 2021 public option reimbursement targets (Figure 1). Given the limited information available publicly from affordability reviews, the Exchange consulted with HCA for this analysis of public option impact on hospital financial sustainability.

Figure 1:
Public Option Aggregated Reimbursement Target Review, 2021[18]

Exhibit 2
Cascade Care Public Option - Results of Reimbursement Target Review
Affordability Requirement Performance Summary
Claims Incurred from January 1, 2021 through December 31, 2021

ALL CARRIERS — Member months: 26,622

Affordability Requirement	Metric Results: Requirement	Performance	Results
A) Aggregate Percent of Medicare Reimbursement[1]	< 160%	164%	FAIL
B) Physician Primary Care Percent of Medicare Reimbursement	> 135%	139%	PASS
C) Critical Access and Sole Community Hospital Reimbursement	> 101%	160%	PASS
Summary of Affordability Requirements[2]	FAIL		

Notes
1. Inpatient hospital claims experience and percent of Medicare reimbursement rates adversely affected by several large outlier claims in late 2021.
2. Of five 2021 carriers, two carriers meet all three affordability requirements and one carrier has insufficient experience for evaluation.

HCA also staffs the Health Care Cost Transparency Board, which identifies cost trends and cost drivers in the health care system.[19] The Board’s recent cost driver analysis by market informed the report and found that Exchange customers experienced the highest rate of health care cost growth — 30% over five years.[20]

[17] The Exchange consulted with interested parties — including the Washington State Hospital Association, Washington State Medical Association, customer advocate groups, and Exchange carriers and their associations — to inform this report to the Legislature and Exchange recommendations.

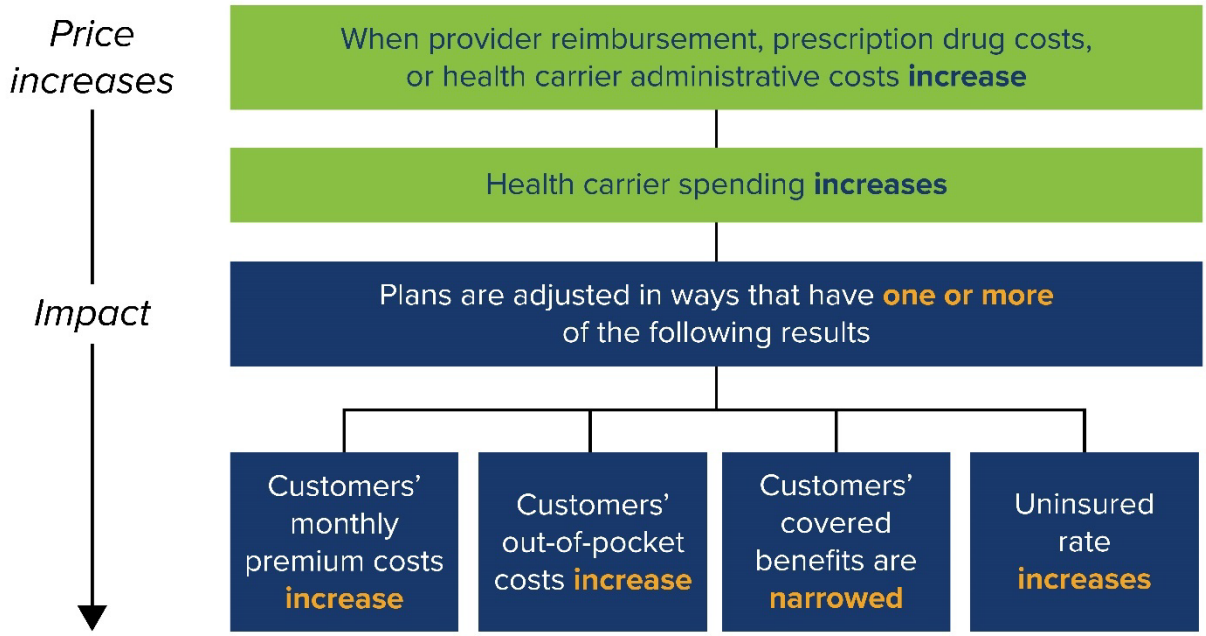
Cascade Care Background and Overview

Established by the Legislature in 2019, Cascade Care aims to make health insurance accessible and affordable for every *Washington Healthplanfinder* customer. Unaffordable premiums stop too many Washingtonians from accessing health insurance. And while health coverage is necessary, it is insufficient if customers cannot use their benefits to access affordable and high-quality health care.

Cascade Care works to improve access, affordability, quality, and health equity by:

- Addressing costs through lower premiums, lower deductibles, and providing access to services before having to pay the deductible. This includes leveraging federal and state-based financial assistance, State purchasing power, and health care provider reimbursement expectations.
- Encouraging more informed and meaningful customer choice with products of better value and like benefits across all participating carriers.
- Growing enrollment by attracting new enrollees and retaining current customers.
- Ensuring continued market health through stable carrier participation, competitive product offerings, and a larger and more diverse risk pool.

Figure 2:
The effect rising costs have across the health care industry



Through Cascade Care, the Legislature established the nation's first public option. Public option plans are selected by HCA and are intended to be the most affordable plans for *Washington Healthplanfinder* customers. Public option plans, called Cascade Select, are required to meet higher quality standards and legislatively mandated provider reimbursement requirements. Coupled with legislative targets for provider reimbursement and competitive procurement, HCA can be selective in contracting with Exchange carriers interested in competing to offer public option plans that are highest quality and offer the lowest monthly premiums. This promotes healthy competition on the Exchange and lower premiums for customers.

Figure 3:
Public Option Requirements

Health Care Provider Reimbursement

- All providers and facilities for all covered benefits: May not exceed 160% of Medicare in statewide aggregate.
- Critical access hospital or sole community hospital services: May not be less than 101% of Medicare.
- Primary care services: May not be less than 135% of Medicare.

Hospital Participation

Hospitals must contract with at least one public option plan.

Carrier Quality & Value

- Incorporate recommendations of the Bree Collaborative and Health Technology Assessment program.

- Standardized benefit design.
- Meet all QHP participation requirements.

Public option plans are high-quality, low-cost, Exchange-designed plans available exclusively to *Washington Healthplanfinder* customers. Unlike plans designed by the health insurance carrier and vary in deductibles and copays, public option plans are

designed to have the same standard benefits, regardless of the carrier. All public option plans help customers pay less at the doctor's office with more predictable costs. For example, regular checkups, mental health office visits, and generic prescription drugs are covered without a deductible.

Public option shows promise in making health insurance accessible and affordable for Exchange customers. As a result of improvements the Legislature made in the 2021 session, the reach and value of public option continues to grow.

- Public option plans are the lowest-premium qualified health plans (QHPs) in most counties.
- Public option enrollment has tripled every year since its 2021 launch. About 23,000 QHP customers selected a public option plan in 2023.
- In 2024, public option plans will be available in 37 counties, up from 34 counties in 2023.

Customer movement to public option plans paired with legislative limits on the number of plans without standard benefit design carriers can offer is advancing Cascade Care's goals all Exchange products offer customers high-quality, meaningful choice. Individuals and families enrolled in public option plans generally pay less out of pocket when using their benefits to access health care compared to non-Cascade Care plan enrollees on the Exchange.[21]

Public Option Enrollee Demographics

Public option enrollees are consistently slightly younger than non-public option Exchange enrollees (Figure 4). Spending on health care for commercial market enrollees tends to increase with age.[22] Public option enrollees have lower incomes than other Exchange enrollees, with 50% of public option enrollees at an income below 250% of the federal poverty level (FPL), compared to about 40% of non-public option customers with incomes below 250% FPL (Figure 5).

[21] A complementary report to the Legislature about the impact of public option on customers shows public option premiums and cost-sharing are lower than other non-public option qualified health plans on the Exchange: https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCCTB%20Cascade%20Select%20Public%20Option%20Report_cc9df888-ee2a-4d92-9dfd-6030a5f2b9ea.pdf.

Figure 4:
Age distribution of public option enrollees vs non-public option enrollees, 2023

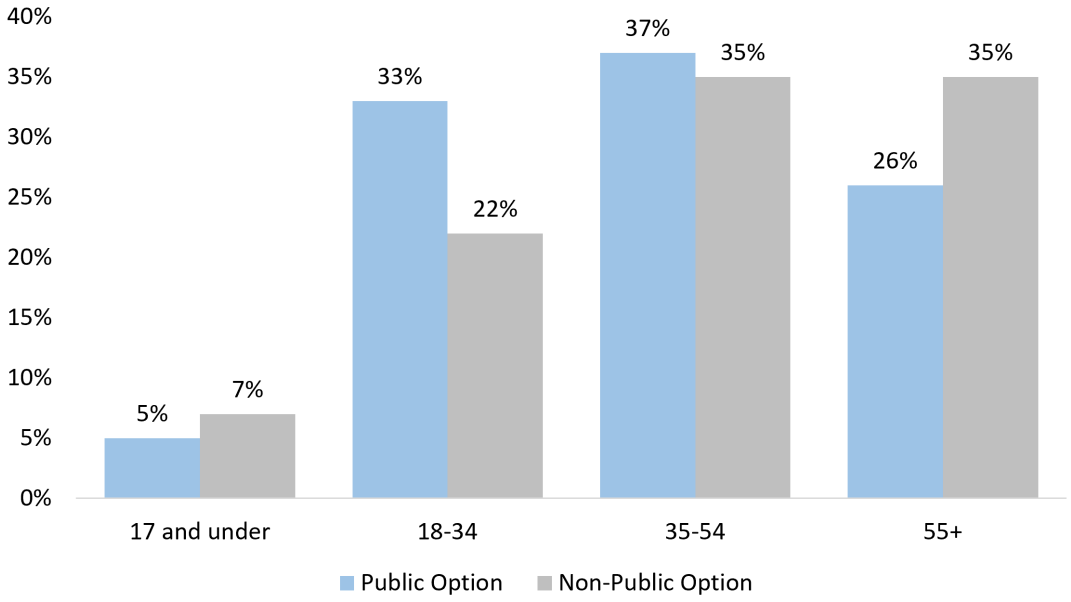
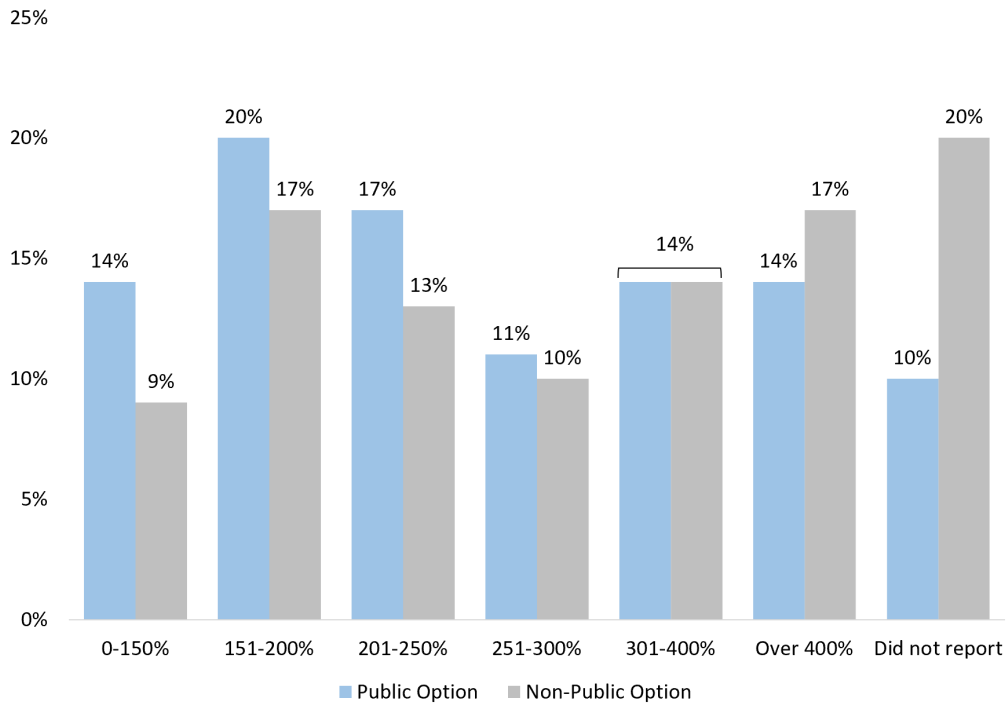


Figure 5: Income distribution of public option vs non-public option enrollees, 2023

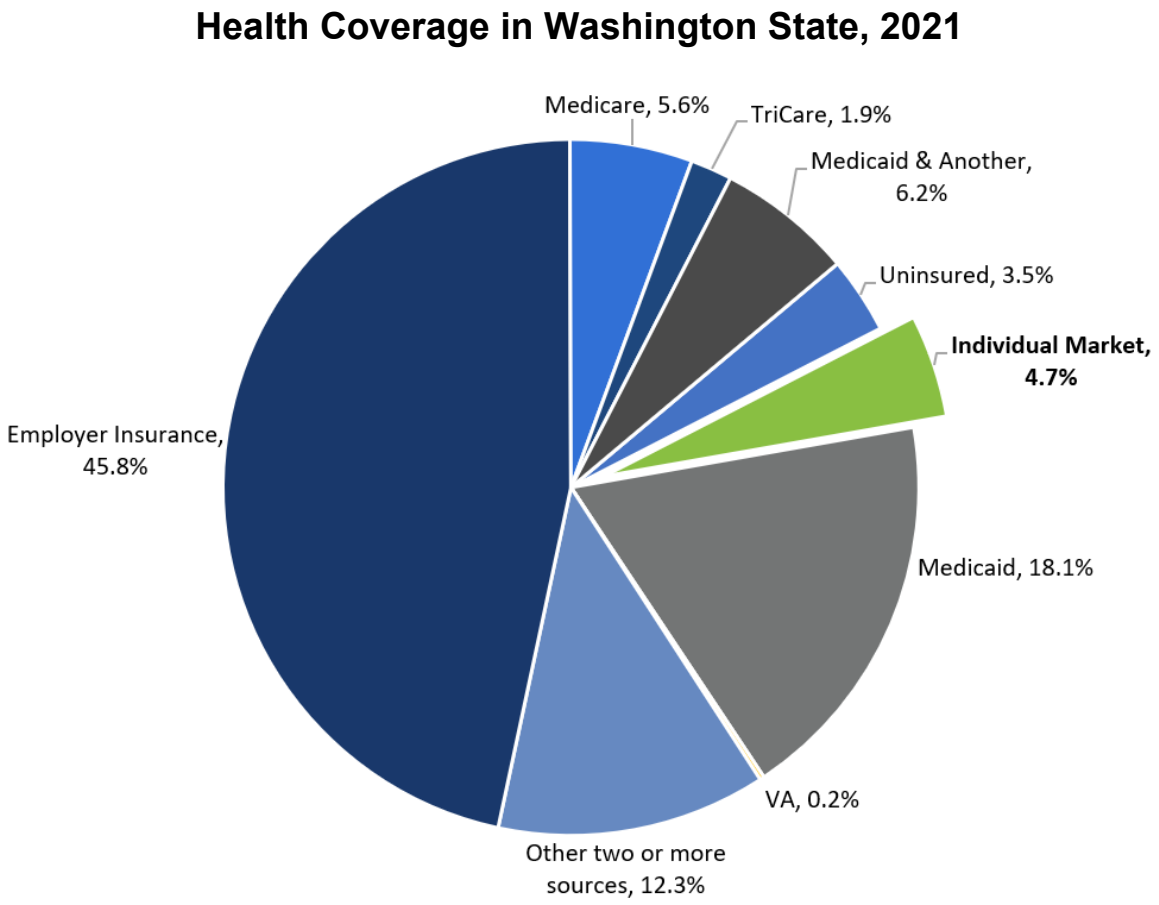


Public Option's Impact on Hospital Financial Sustainability

Public option reimbursement rates do not have material impact on hospital operating margins — and will not in the future even as public option enrollment continues to increase. This is because 1) the Exchange market alone is too small to impact hospital financial performance, and 2) the amount Exchange plans contract to pay hospitals — including public option plans — are commercial rates.

The individual market is less than 5% of the overall health coverage market in Washington state (Figure 6).[23] This is small compared to other public and commercial insurance markets, such as employer insurance that makes up more than 45% of the market. Public option — a subset of the Exchange market — in 2023 represents about half a percent (0.5%) of the state's health coverage market.

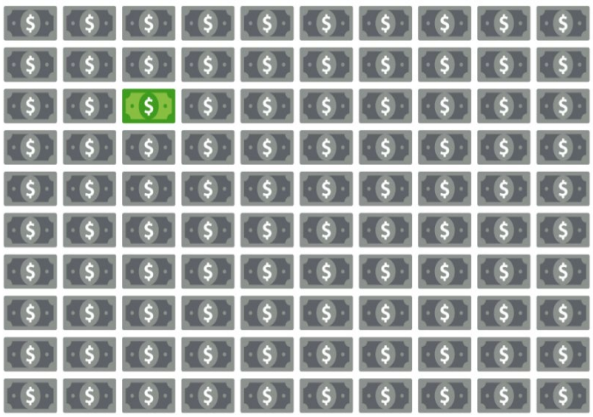
Figure 6: The Individual market is less than 5% of the overall health coverage market in Washington state



The presence of the Exchange in the state's health coverage market is beneficial to hospitals. The Exchange contributes to more Washingtonians being insured, therefore mitigating charity care hospitals must provide. In addition, the Exchange is a part of the state's commercial health coverage market, which pays providers higher rates for health care services than public programs, such as Medicaid.

However, the Exchange market alone is too small to have material impact on hospital financial performance. According to RAND, hospital allowed amounts paid for Exchange customers in 2021 were about $166 million.[24] The sum of Washington hospitals' net patient revenue that same year totaled almost $26 billion, according to NASHP data.[25] Therefore, hospital claims for Exchange customers are about 1% of Washington state hospitals' revenue (Figure 7).

Figure 7: Hospital claims for Exchange customers are about 1% of Washington state hospitals' revenue



Public option enrollment has tripled annually since its 2021 launch, from less than 1 percent of Exchange enrollment in 2021 to nearly 15 percent of Exchange enrollment in 2023. Stakeholders have indicated concern that the aggregate cap on public option provider rates and a requirement enacted in 2023 that all hospitals must contract with at least one public option plan could result in financial strains if public option enrollment increases in future years. This report reaches the following conclusions:

- If public option enrollment became the entirety of the Exchange market, which is not expected, the individual market is less than 5 percent of the overall health coverage market in Washington state, is about 1% of total hospitals' revenue, and is too small to have a bearing on hospital financial performance.
- If hospitals were reimbursed at the 160% of Medicare required on aggregate for all public option health care services, this is a commercial rate that is well above the median commercial break-even reimbursement rate for hospitals to operate.[26] [27]

[26] Note that public option carriers determine and negotiate contracts with all facilities, beyond hospitals, to meet the statewide 160% of Medicare aggregate. For example, public option carriers could still meet the 160% statewide aggregate requirement if it paid 168% of Medicare for inpatient hospital services, 192% for outpatient hospital services, 141% for non-primary care physician services, and 135% for primary care services (illustrative example only).

Relative Prices: What Medicare would pay for the same services at the same facilities Hospitals contract for different prices from different payers. The following illustrates what a hospital service might cost depending on the contract.		
Payment from:	**Average relative price, as a percent of Medicare:**	**Hospital is paid:**
Medicare	100%	$1,000
Washington Health Benefit Exchange plans	**197%[28]**	**$1,970**
Washington state commercial plans	182%[29]	$1,820
Exchange public option reimbursement requirements (aggregate for all providers and all services; not specific to hospital payment)	160%	$1,600 (in scenario where hospital paid required aggregate rate)
Median commercial "break even"	129%[30]	$1,290

Data Analysis

The Exchange's position as less than 5% of the state's overall market and its immaterial impact on hospital financials is the foundation of this report's conclusions. The Legislature also asked the Exchange to analyze public option plan rates paid to hospitals for in-network services and public option's impact on hospital operating margins.

Fewer than 1,000 Exchange customers were enrolled in public option plans in 2021, and even fewer utilized hospital services. As a result, the available data are limited in providing analysis of public option's effect on hospitals. Limited public option data demonstrate:

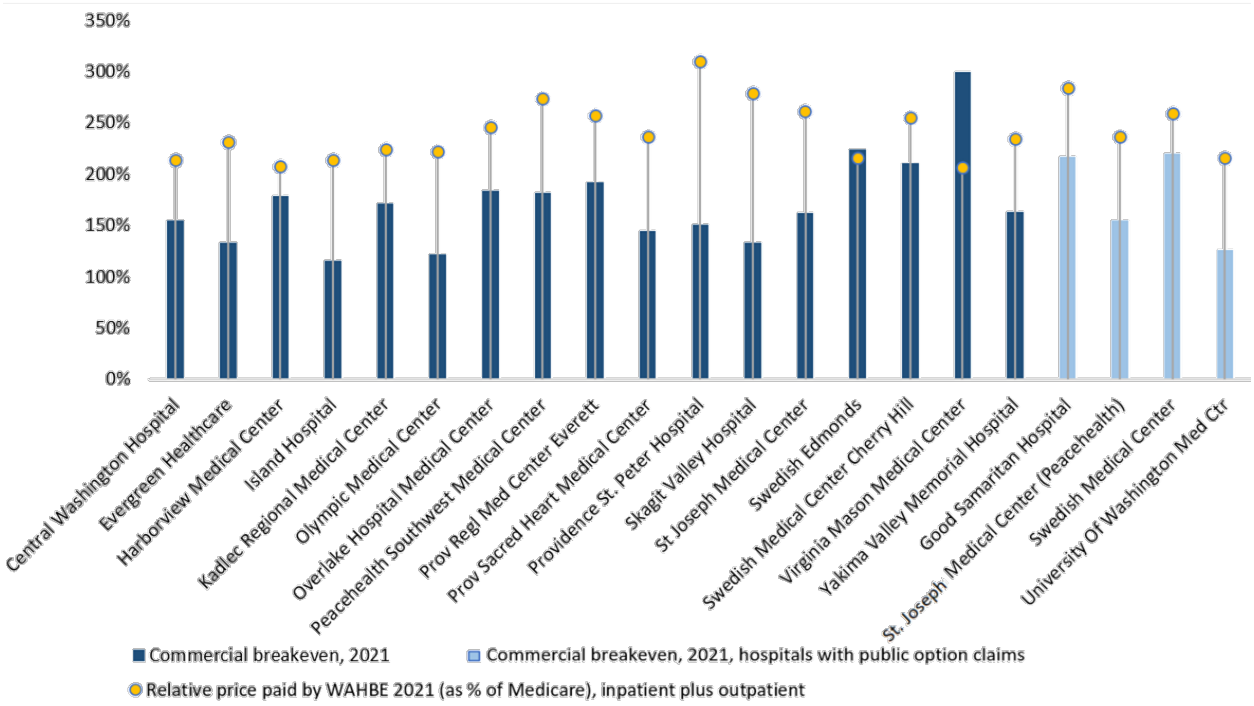
- Hospitals serving Exchange customers enrolled in public option plans are paid similar rates to hospitals without Exchange public option customer claims in 2021; and
- Hospitals with claims from public option plans have similar operating margins to hospitals that didn't have public option claims in 2021.

Figure 8 shows the top 20 hospitals used by Exchange customers based on spend. University of Washington Medical Center, Swedish Medical Center, St. Joseph Medical Center, and Good Samaritan Hospital — which is the 22nd most used hospital by Exchange customers by spend — are the only hospitals that had public option claims in 2021.[31]

For the Exchange market, Figure 8 illustrates:

- The 2021 relative prices paid to hospitals for all Exchange customers' inpatient and outpatient hospital services are on average 197% of Medicare.[32]
- On average, relative prices paid to hospitals for Exchange customers exceed the amount of revenue these 21 hospitals require from commercial insurers to break even by 69%. For the hospitals with public option claims in 2021, prices paid for serving Exchange customers also exceeded breakeven by 69% on average.[33]

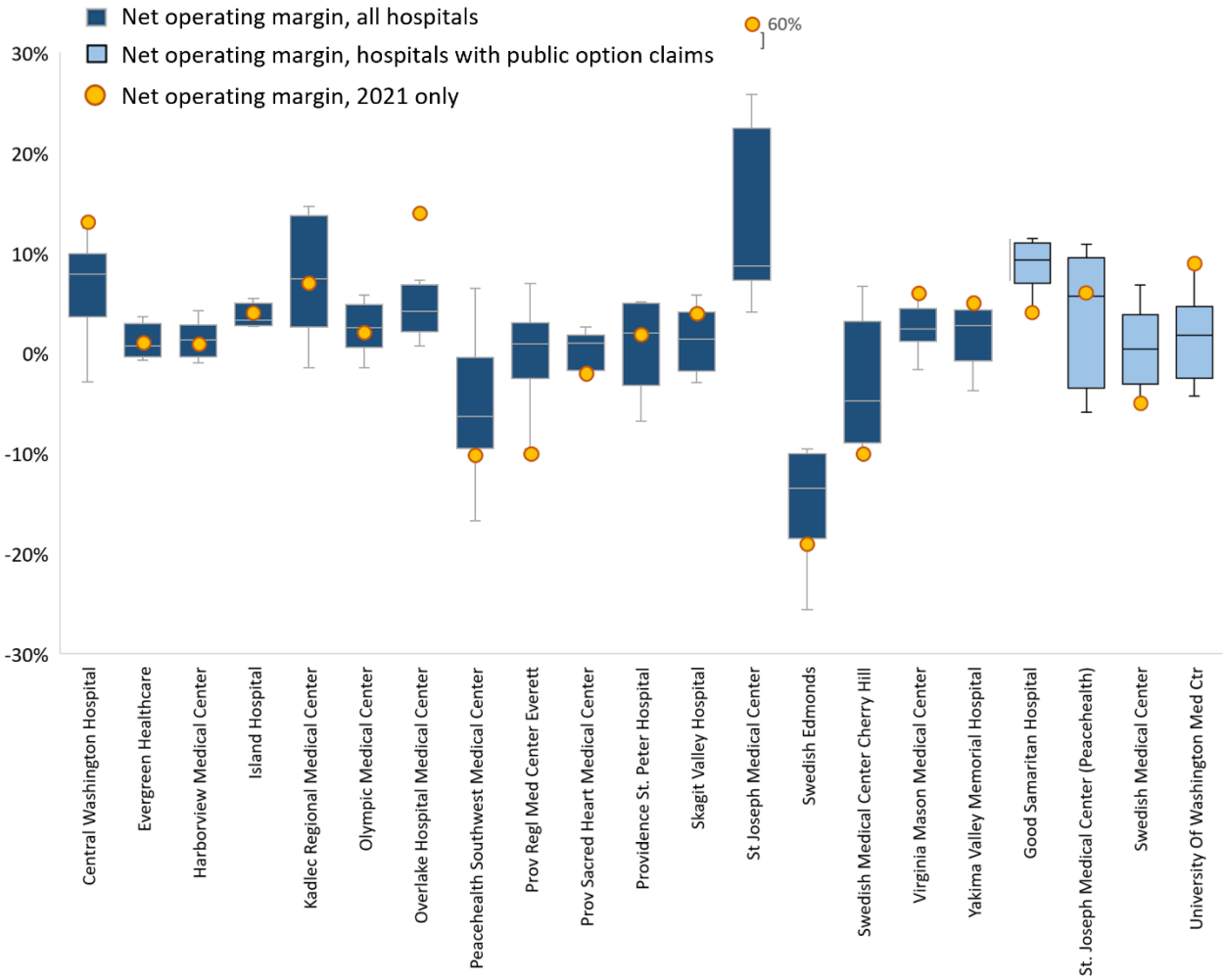
Figure 8: Exchange Hospital Rates and Commercial Breakeven for Hospitals Used By Exchange Customers



[31] The percent of WAHBE spend for public option claims (inpatient and outpatient) averaged 0.6% or ranged from 0.1%-1.9% as a percent of all Exchange claims for each of the four hospitals with 2021 public option claims.

Figure 9 shows net operating margins for hospitals serving Exchange customers vary widely across hospitals and throughout the years.[34] There is not a notable difference in net operating margins for hospitals with public option claims in 2021 compared to hospitals without public option claims in the Exchange market.

Figure 9: Variation in Net Operating Margin, Top Hospitals by Spend, 2014-2021 Summary Statistics



The Exchange looked to additional data sources to understand the impact of public option on hospital financials.

Public option provider reimbursement requirements. Public option carriers' 2021 and 2022 claims data submitted to HCA's actuarial consultant demonstrate public option provider reimbursement targets were generally met by participating public option carriers. Additionally, the reimbursement floors set by the Legislature for rural hospitals and primary care providers are working. (See Figure 1.)

- Rural hospitals may be benefitting from the legislatively required minimum public option reimbursement targets for critical access hospitals and sole community hospitals. Average reimbursement rates for services provided at these hospitals to public option enrollees remain above the minimum floor.
- Public option carriers are meeting the required minimum 135% reimbursement for primary care providers, and for some carriers the Legislative requirements may be resulting in increasing reimbursement for primary care providers.

Cost shifting: The requirement that public option carriers reach an aggregate provider reimbursement target of 160% of Medicare raised questions about provider cost shifting from Exchange public option plans to other markets. If this occurred, affordability for non-public option QHPs and other markets could be compromised in the long term. The argument that price variation is caused by hospitals being compelled to charge higher prices to privately insured patients to offset underpayment by Medicaid and Medicare was tested in the RAND Hospital Price Transparency Round 4.0 study. RAND investigated variation in facility and professional prices for the commercially insured population. The study failed to find a relationship between hospital prices and the share of patients covered by either Medicaid or Medicare and found limited objective evidence supporting the cost shifting argument.[35] A much stronger relationship was found between provider market share and higher price.

Conclusions

Public option reimbursement rates do not have material impact on hospital operating margins. Even if public option enrollment increased to a majority of Exchange enrollment in future years, the Exchange market as a whole is small and pays hospitals commercial rates. Hospitals are reimbursed an average of 15% more (as a percentage of Medicare) to serve Exchange customers than the average commercial customer. And these commercial rates paid to hospitals for Exchange customers exceed what hospitals need to financially break even by more than 65%.

Exchange customers are disproportionately affected by the rising costs of health care. The Exchange provides a safety net option for Washingtonians who do not have health insurance through an employer and are not eligible for public programs like Medicaid.

But affordability remains the primary barrier to more Washingtonians being insured and getting access to care. Recent access and affordability efforts at the state and federal levels — such as the introduction of enhanced federal tax credits and new state premium subsidies — have demonstrated that when health coverage is more affordable, more customers enroll. Continued advancements in customer access, affordability, and health equity could be achieved through enhancements to public option to help address underlying costs of care and meaningfully lower premiums for Exchange customers.

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[1] Actual allowed amount paid by WAHBE, all 2021 claims, accessed from Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: Private Employer-Specific Report, 2018-2021. Santa Monica, CA: RAND Corporation, 2022.; And Sum of net revenue for all Washington state hospitals, accessed from National Academy for State Health Policy. NASHP Hospital Cost Tool [internet]. Washington (DC): NASHP; 2022 Nov 21 [accessed 2023 May 23]. Available from https://tool.nashp.org.

[2] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: Private Employer-Specific Report, 2018-2021. Santa Monica, CA: RAND Corporation, 2022.

[3] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: Private Employer-Specific Report, 2018-2021. Santa Monica, CA: RAND Corporation, 2022. And Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1144-1.html.

[4] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: Private Employer-Specific Report, 2018-2021. Santa Monica, CA: RAND Corporation, 2022.

[5] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1144-1.html.

[6] National Academy for State Health Policy. NASHP Hospital Cost Tool [internet]. Washington (DC): NASHP; 2022 Nov 21 [accessed 2023 May 23]. Available at https://tool.nashp.org.

[7] Office of the Insurance Commissioner, health plan filing data, 2014-2024.

[8] Kinner, Amy, Health Care Cost Transparency Board Presentation: Cost Growth Driver Study, 2022. OnPoint Health Data, 2022. Available at https://www.hca.wa.gov/assets/program/hcctb-board-book-20221214.pdf

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[11] To date this open enrollment, customers selecting public option plans has doubled from 2023 to 2024.

[12] 2023 Exchange Spring Enrollment Report, https://www.wahbexchange.org/content/dam/wahbe-assets/reports-data/enrollment-reports/2023%20Spring%20Enrollment%20Report%202023.04.19.pdf.

[13] 2021 Exchange Spring Enrollment Report, https://www.wahbexchange.org/content/dam/wahbe/2021/02/Spring%20OE8%20Report%20Final.xlsx
[14] Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: https://www.rand.org/health-care/projects/price-transparency.html
[15] National Academy for State Health Policy, NASHP Hospital Cost Tool: https://nashp.org/commercial-breakeven/
[16] Medicare Payment Advisory Committee. Report to Congress: Medicare Payment Policy. March 2023. Available from https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf
[17] The Exchange consulted with interested parties — including the Washington State Hospital Association, Washington State Medical Association, customer advocate groups, and Exchange carriers and their associations — to inform this report to the Legislature and Exchange recommendations.
[18] "Cascade Select Public Option," Dec. 1, 2022: https://www.hca.wa.gov/assets/program/cascade-select-leg-report-20221216.pdf
[19] Second Substitute House Bill 2457
[20] Kinner, Amy, Health Care Cost Transparency Board Presentation: Cost Growth Driver Study, 2022. OnPoint Health Data, 2022. Available from https://www.hca.wa.gov/assets/program/hcctb-board-book-20221214.pdf

[21] A complementary report to the Legislature about the impact of public option on customers shows public option premiums and cost-sharing are lower than other non-public option qualified health plans on the Exchange: https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCCTB%20Cascade%20Select%20Public%20Option%20Report_cc9df888-ee2a-4d92-9dfd-6030a5f2b9ea.pdf
[22] Kinner, Amy, Health Care Cost Transparency Board Presentation: Cost Growth Driver Study, 2022. OnPoint Health Data, 2022. Available from https://www.hca.wa.gov/assets/program/hcctb-board-book-20221214.pdf
[23] Office of Financial Management, 2022.
[24] Actual allowed amount paid by WAHBE, all 2021 claims, accessed from Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: Private Employer-Specific Report, 2018-2021. Santa Monica, CA: RAND Corporation, 2022.
[25] Sum of net revenue for all Washington state hospitals, accessed from National Academy for State Health Policy. NASHP Hospital Cost Tool [internet]. Washington (DC): NASHP; 2022 Nov 21 [accessed 2023 May 23]. Available from https://tool.nashp.org.
[26] Note that public option carriers determine and negotiate contracts with all facilities, beyond hospitals, to meet the statewide 160% of Medicare aggregate. For example, public option carriers could still meet the 160% statewide aggregate requirement if it paid 168% of Medicare for inpatient hospital services, 192% for outpatient hospital services, 141% for non-primary care physician services, and 135% for primary care services (illustrative example only).
[27] Note that the median WA commercial breakeven in 2021 was 129% of Medicare. The high point between 2011 and 2021 occurred in 2019 and was 150% of Medicare. National Academy for State Health Policy. NASHP Hospital Cost Tool [internet]. Washington (DC): NASHP; 2022 Nov 21 [accessed 2023 May 23]. Available from https://tool.nashp.org .
[28] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: Private Employer-Specific Report, 2018-2021. Santa Monica, CA: RAND Corporation, 2022.
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[30] National Academy for State Health Policy. NASHP Hospital Cost Tool [internet]. Washington (DC): NASHP; 2022 Nov 21 [accessed 2023 May 23]. Available from https://tool.nashp.org.

[31] The percent of WAHBE spend for public option claims (inpatient and outpatient) averaged 0.6% or ranged from 0.1%-1.9% as a percent of all Exchange claims for each of the four hospitals with 2021 public option claims.
[32] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: Private Employer-Specific Report, 2018-2021. Santa Monica, CA: RAND Corporation, 2022.
[33] National Academy for State Health Policy. NASHP Hospital Cost Tool [internet]. Washington (DC): NASHP; 2022 Nov 21 [accessed 2023 May 23]. Available from tool.nashp.org.
[34] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative: Private Employer-Specific Report, 2018-2021. Santa Monica, CA: RAND Corporation, 2022.
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