

Cascade Care Workgroup

May 13, 2025



Cascade Care Workgroup Agenda

Time	Topic	Facilitator
1:00	Welcome and Introductions	Laura Kate Zaichkin, <i>Director of Market Competition & Affordability (she/her)</i>
1:10	Legislative Session Wrap Up <ul style="list-style-type: none">Affordability highlights	Shirley Prasad, <i>Director of Government Affairs (she/her)</i>
1:25	Sharpening Cascade Care Tools	Laura Kate Zaichkin
1:45	2027 Cascade Care Plan Design Direction	Kristin Villas, <i>Senior Policy Analyst (she/her)</i> Dimitra Politi, <i>Acumen Senior Research Manager</i>
2:25	Next Steps and Adjourn	Laura Kate Zaichkin



Cascade Care

Cascade Care makes health insurance accessible and affordable for every *Washington Healthplanfinder* customer.



- 
-  **Lower premiums**
 -  **Higher quality benefits**
 -  **Lower copays**
 -  **Easier plan shopping**
 -  **Available in all counties**
 -  **Extra savings for those who qualify**

AFFORDABILITY HIGHLIGHTS

Legislative session wrap up





Session snapshot

Budget overview

▶ 5167: final 2025-27 operating budget

- ▶ Funds \$78B in state services
- ▶ Increases spending by \$7.4B from the 2023-25 biennium
- ▶ Adopts \$5.9B in cuts and \$9.3B in new revenue over 4 years

- ▶ Focuses on maintaining human services
- ▶ Not drain the Budget Stabilization Account – rainy day fund
- ▶ Maintains collective bargaining agreements; not furlough state workers; includes 6% reduction for many agencies
- ▶ Invests in education, housing, public safety

Post session key dates

- ▶ **May 20:** bills passed within the last 5 days of session, Governor has 20 days (exclude Sundays) to sign or veto (if Governor takes no action, bill passes)
 - ▶ As of May 9, the Governor has not signed any major tax bills or budget
- ▶ **July 1:** beginning of state fiscal year 2026
- ▶ **July 27:** unless otherwise specified, bills are in effect 90 days from the end of session
- ▶ **Special session?**
 - ▶ To address federal budget impacts on the state or any assumed revenue that will not be realized (due to Gov veto, litigation or other factors)



Budget priorities & highlights

Budget priorities

▶ Cascade Care Savings

- ▶ **Description:** funded through PY26 at \$55 million
- ▶ **Looking ahead:** ongoing stakeholder engagement; explore non general fund state funding sources; request funds in the 2026 supplemental budget for PY27

Budget provisos

**State only program
(immigrant health)
(HBE)**

**Facilitated
enrollment (HBE)**

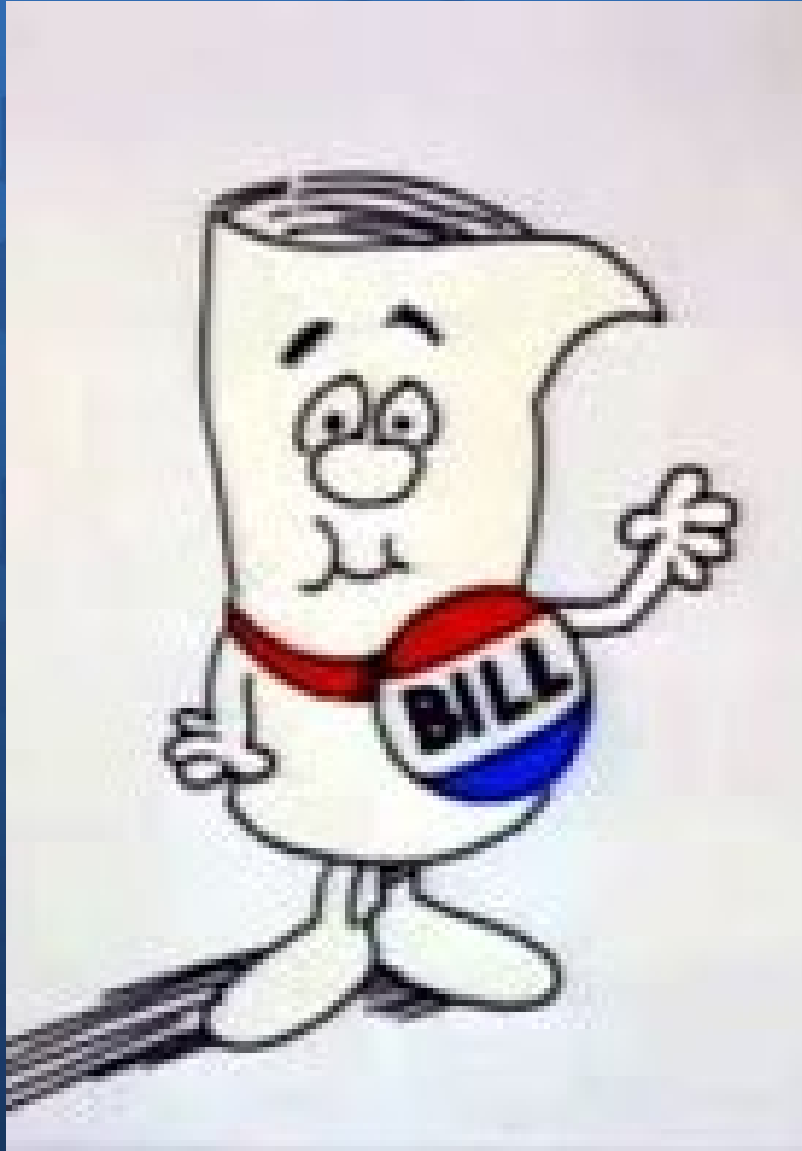
**Health data privacy
(HCA + others)**

**Gender affirming
care defrayal (OIC)**

Budget highlights – Medicaid

- ▶ **Acupuncture:** pauses new benefit that was due to start Jan 1, 2025
- ▶ **Alien emergency medical:** moves patients from fee-for-service to managed care
- ▶ **Apple Health Expansion:** funding continues at current levels
- ▶ **Chiropractic:** pauses new benefit that was due to start Jan 1, 2025
- ▶ **Dental rates - adults and pediatric:** reduces previous dental rate increase by 50%
- ▶ **Labs:** sets fee-for-service lab rates at 80% of Medicare, starting Jan 1, 2026; requires MCOs to use fee-for-service schedule as a ceiling
- ▶ **MCO physical health capitation rate:** reduces Medicaid MCO capitation rate for physical health services by 1%, effective Jan 1, 2026

(not include any cuts or funding to behavioral health)



Policy priorities & highlights

Policy priorities – cost containment

- ▶ **5083: Establish a reference-based pricing model for PEBB and SEBB plans - PASSED**
 - ▶ **Description:** adopts a reference-based pricing model for acute care hospitals that provide inpatient and outpatient services for public employee and school employee health plans
 - ▶ **Looking ahead:** continue to explore how public option plan's reference-based pricing model can be refined based on learnings from PEBB and SEBB plans (part of broader efforts to sharpen Cascade Care)

Policy priorities – transparency

- ▶ **1686: Create a health care entity registry - PASSED**
 - ▶ **Description:** requires the DOH to develop and plan and provide recommendations to the legislature on how to create a comprehensive and user-friendly registry of health care entities in Washington. Progress report due Dec 31, 2027, and final report due Nov 1, 2028
 - ▶ **Looking ahead:** monitor progress of registry planning

Policy priorities – transparency

▶ 5084: Carriers' primary care expenditure reporting - **PASSED**

▶ **Description:** the OIC may require carriers to annually report primary care expenditures in the previous or upcoming calendar year. In determining form and content, OIC will consider the HCCTB definition and targets, as well as HCA's primary care expenditure reporting system.

▶ **Looking ahead:** monitor any outcomes from data collection

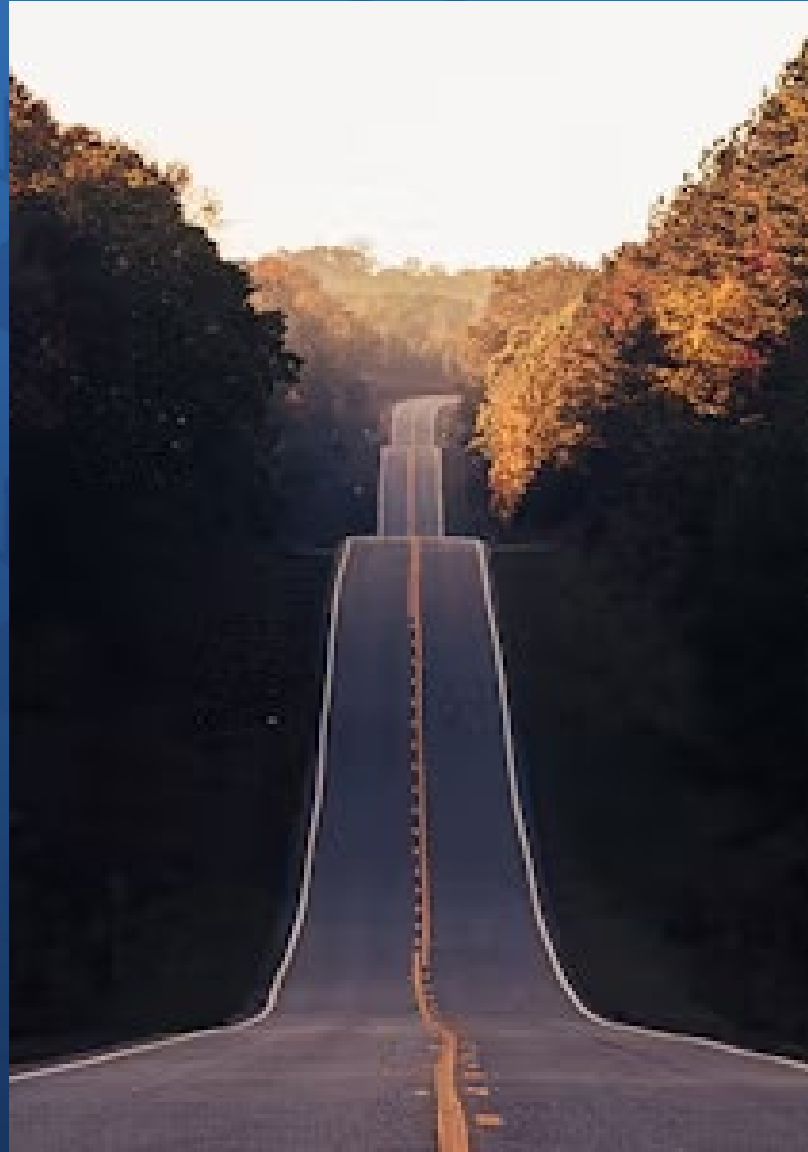
Policy highlights - continued

- ▶ **1392: Create the Medicaid access program (covered lives assessment) - PASSED**
 - ▶ **Description:** creates a covered-lives assessment on Medicaid managed care organizations and carriers on the group and individual markets; proceeds to be used to increase the Medicaid professional services rate up to Medicare rates. Implementation requires CMS approval
 - ▶ **Looking ahead:** monitor HCA's application of CMS waiver or state plan amendment – must be submitted by Sep 1, 2025; act expires if CMS does not grant waiver by Jan 1, 2027; once assessment implemented, assess impact on QHP premiums

Policy bills of interest – **NOT PASSED**

▶ Insurance

- ▶ 2073 / 5808: funding health insurance premium assistance
 - ▶ Impose an annual 3% assessment on non-profit carriers that hold surplus funds of more than 600% of risk-based capital requirements
 - ▶ Proceeds to be used to fund Cascade Care Savings



The road ahead

Interim – continuing themes

- ▶ **Cascade Care:** further exploration on how to strengthen Cascade Care, including standard plans and refining referenced-based pricing models in Cascade Select
- ▶ **Affordability / cost containment:** exploring affordability levers in a challenging fiscal and policy environment
 - ▶ Includes tracking work of the Health Care Cost Transparency Board and the Universal Health Care Commission
- ▶ **Responding to federal actions:**
 - ▶ Any Medicaid funding cuts (federal match rates, per capita caps, provider tax rates) or policy changes (work requirements, increase eligibility verification)
 - ▶ Policy changes impacting ACA marketplaces
 - ▶ Enhanced premium tax credit reauthorization

POLICY EXPLORATION

Sharpening Cascade Care tools



2024 Exchange Board direction

Focus on sharpening Cascade Care tools



“[Exchange] strives to become a steward for our customers and public resources by maintaining a healthy individual market that provides Washingtonians with access to high-quality, affordable coverage.”

► Exchange Board Strategic Plan

Sharpening Cascade Care tools



State subsidy



Standard plans



Public option

Sharpening Cascade Care tools

Goals and opportunities to advance access & affordability for customers



State Subsidy:

- More than **100,000** low-income customers reduce monthly premiums with Cascade Care Savings.
- As **rates increase and ePTC expires**, subsidies cannot stretch as far.
- **Maintain and maximize** publicly-funded affordability supports.



Standard Plans:

- **Nearly 80%** of Exchange customers enrolled in standard plans today.
- **Variation** in plan offerings is confusing and overwhelming.
- **Differentiate** plans based on what matters most to customers — premium, network, quality and customer service.



Public Option:

- Public option **statewide** in 2025.
- Customers experience **access barriers**.
- Current policies not resulting in meaningfully **lower premiums**.
- Drive **healthy competition** on price and quality.

Since we last discussed Cascade Care tools...

- ▶ Changes impacting affordability of coverage
- ▶ Changes impacting Medicaid & Marketplace
- ▶ Changes impacting equitable access to coverage



FEDERAL
CHANGE

Discussion & next steps: Sharpening Cascade Care tools

Picking up discussion where we left off and in context of increased market risks



State Subsidy:

- Sustain funding.
- Further explore quality and affordability expectations for plans eligible for subsidy.



Standard Plans:

- Fully standardize cost sharing on the Exchange.
- Allow flexibility to respond to market conditions and customer needs. Suggested criteria:
 - Meaningful difference
 - Responsiveness to market risks/failures
 - Maximize enrollment & affordability



Public Option:

- Directionally align with [SB 5083](#).
- Address barriers to customer access to in-network public option providers.
- Consider approaches that balance market power and distinct approaches for rural regions and providers.

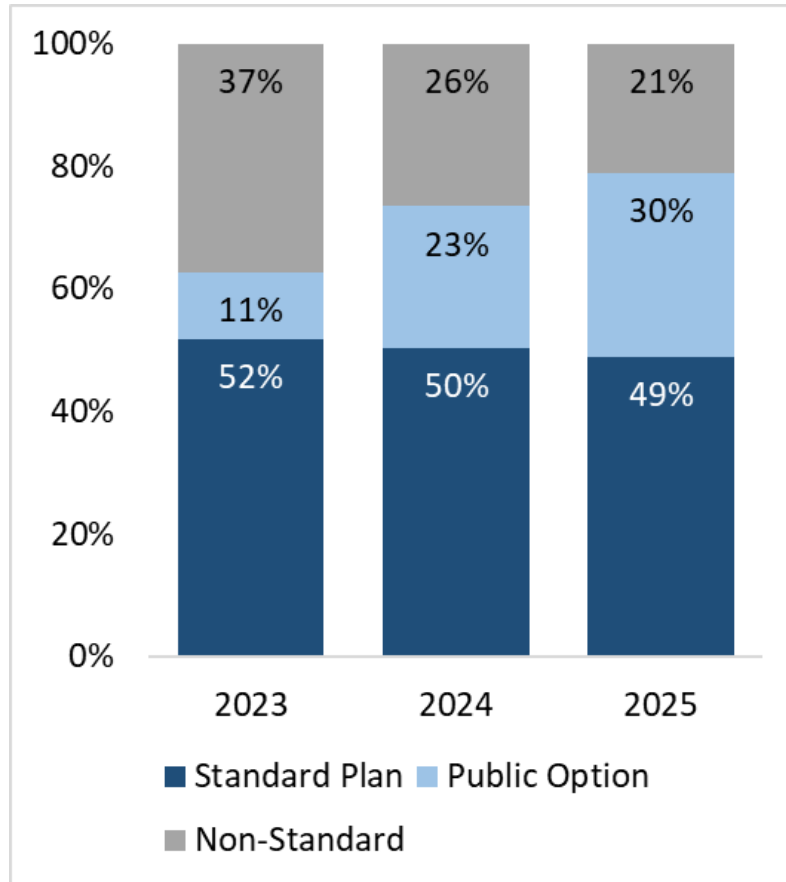
PY 2027 DIRECTION

Standard plan design



Market continues to move to standard plans

Enrollment by Cascade Type 2023-2025



- ▶ Nearly 80% of Exchange customers are in standard plans.
- ▶ Growth in standard plans is driven by increase in public option enrollment.
- ▶ Standard plans are popular among all income brackets of customers.

Premium alignment opportunity in Washington




- ▶ OIC issued an emergency rule to standardize Silver loading factors for PY 2026 rates.
- ▶ Upshot: Estimated \$110M/year in additional premium support to offset the loss of enhanced premium tax credits (~\$275M/year).
- ▶ The Exchange is supporting OIC's uniform Silver loading approach.










Premium alignment for 2026 offsets loss of enhanced tax credits

- **Premium impact:** Gross Silver plan premiums become *more expensive* while gross Gold and Bronze plan premiums *decrease*.

Legend

Helped:	
No effect:	
Should change plans:	

	APTC-eligible	Not APTC-eligible
Bronze		
Silver	 	
Gold		

Summary of key 2026 standard plan changes to respond to federal uncertainty

Standard Plan Metal	Change
Complete Gold	Increased deductible from \$600 to \$1,000 to keep MOOP stable
Vital Gold	New low gold plan
Silver	Decreased primary care/mental health copay from \$30 to \$20
Bronze	Put Specialty Care before the deductible; decreased primary care/mental health copay from \$50 to \$40

76% AV Gold plan allowed under proposed rule

- ▶ Both options raise deductible by \$100 and raise some outpatient services copays by \$5.
- ▶ Compared to approved design:
 - ▶ Option 1 raises MOOP by an additional \$800 and generics by \$5; and
 - ▶ Option 2 raises MOOP by an additional \$700 and generics by \$10.

Benefits	Vital Gold		
	Approved 2026	Option 1	Option 2
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles (\$)	\$1,900	\$2,000	\$2,000
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP (\$)	\$8,800	\$9,600	\$9,500
Office Visits			
Preventive Care/Screening/Immunization	\$0	\$0	\$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	\$15	\$15	\$15
Specialist Visit	\$40	\$40	\$40
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	\$15	\$15	\$15
Emergency/Urgent Care Services			
Emergency Care Services	\$800	\$800	\$800
Urgent Care	\$35	\$35	\$35
Ambulance	\$375	\$375	\$375
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$350	\$350	\$350
Outpatient Surgery Physician/Surgical Services	\$75	\$75	\$75
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	\$15	\$15	\$15
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	\$30	\$35	\$35
X-rays and Diagnostic Imaging	\$30	\$35	\$35
Advanced Imaging (CT/PET Scans, MRIs)	\$300	\$300	\$300
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	\$650*	\$650*	\$650*
Skilled Nursing Facility	\$350**	\$350**	\$350**
Pharmacy			
Generics	\$10	\$15	\$20
Preferred Brand Drugs	\$75	\$75	\$75
Non-Preferred Brand Drugs	\$200	\$200	\$200
Specialty Drugs (i.e. high-cost)	\$200	\$200	\$200
All Other Benefits			
Speech Therapy	\$30	\$35	\$35
Occupational and Physical Therapy	\$30	\$35	\$35
Durable Medical Equipment (DME)	20%	20%	20%
Home Health	\$15**	\$15**	\$15**
Hospice	\$15**	\$15**	\$15**
All Other Benefits	20%	20%	20%
AV	78.06%	76.54%	76.04%

Blue shaded items are not subject to deductible.

* Per day copay, maximum of five copays per stay

** Per day copay

*** Eligible for two visits at \$1 copay, after which stated cost-sharing applies

Stakeholder feedback and potential changes for 2026

- ▶ Most carriers supportive of moving to a 76% AV Vital Gold plan.
 - ▶ Carriers estimate 76% plan options will have 1%-4% lower premium compared to approved Vital Gold Plan.
 - ▶ Either no preference or preference for option 2 as plan will have lower premium.
 - ▶ Option 2 will have estimated (\$5-\$15 lower premium compared to approved Vital Gold).
- ▶ Timing of plan changes critical — much easier to modify filings post initial rate filing deadline.
- ▶ Exchange investigating with OIC possibility of pivoting to lower premium 76% AV Vital Gold if rule finalized in next few months.



Considerations for 2027 standard plan design

▶ Challenges coming for customer affordability

- ▶ Expiration of enhanced federal subsidies in 2026.
- ▶ Uncertainty regarding state subsidy funding.
 - ▶ Anticipate ongoing high demand.
- ▶ Ongoing customer struggle with choice overload.
- ▶ Proposed federal rule could impact risk pool and raise premiums.

▶ AV calculator limitations

- ▶ Lowering cost share on one benefit usually necessitates increased cost shares on another benefit.
- ▶ Receive next year's AV calculator after designs are near final.



Seeking direction on approaches to 2027 standard plan design

- ▶ Changes to support premium alignment environment.
 - ▶ Adjustments to standard Silver given nearly all enrollment in this metal will be in cost-sharing reduction (CSR) tiers 5 and 6 (<200% FPL).
 - ▶ Moving Cascade Vital (low Gold) to 76% if rule not finalized in time for 2026.
- ▶ Promote access to high-clinical value services (e.g., reducing facility fees, lowering primary care cost-sharing).
- ▶ Additional standardization for a consistent customer experience (e.g., formulary, Plan and Benefits Templates).
- ▶ Further market standardization.
- ▶ Others?



Revisiting standard Silver plan in premium alignment environment

- ▶ Few customers will be in 70% AV standard plan in 2026.
 - ▶ Bulk of enrollment will be in 87% AV and 94% AV silver variants.
 - ▶ What changes would best support these customers in 2027?

Blue shaded items are not subject to deductible.

* Per day copay, maximum of five copays per stay

** Per day copay

*** Eligible for two visits at \$1 copay, after which stated cost-sharing applies.

Benefits	Silver		
	Base	87% AV	94% AV
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles (\$)	\$2,500	\$750	\$0
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP (\$)	\$9,750	\$2,850	\$2,400
Office Visits			
Preventive Care/Screening/Immunization	\$0	\$0	\$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	\$20***	\$5***	\$1
Specialist Visit	\$65	\$30	\$15
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	\$20***	\$5***	\$1
Emergency/Urgent Care Services			
Emergency Care Services	\$800	\$425	\$150
Urgent Care	\$65	\$30	\$15
Ambulance	\$375	\$175	\$75
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$600	\$325	\$100
Outpatient Surgery Physician/Surgical Services	\$200	\$120	\$25
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	\$30	\$10	\$5
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	\$40	\$20	\$5
X-rays and Diagnostic Imaging	\$65	\$40	\$15
Advanced Imaging (CT/PET Scans, MRIs)	30%	20%	15%
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	\$800*	\$425*	\$100*
Skilled Nursing Facility	\$800**	\$425**	\$100**
Pharmacy			
Generics	\$25	\$12	\$5
Preferred Brand Drugs	\$75	\$35	\$12
Non-Preferred Brand Drugs	\$250	\$160	\$35
Specialty Drugs (i.e. high-cost)	\$250	\$160	\$35
All Other Benefits			
Speech Therapy	\$40	\$20	\$5
Occupational and Physical Therapy	\$40	\$20	\$5
Durable Medical Equipment (DME)	30%	20%	15%
Home Health	\$30**	\$10**	\$5**
Hospice	\$30**	\$10**	\$5**
All Other Benefits	30%	20%	15%
AV	71.84%	87.87%	94.86%

Directives on facility fees to improve access to high-clinical value services



Instead of focusing on facility fee cost share amount, give directives on customer cost-share applicability

Facility fees

- Customer anticipates a provider copay only for an “office visit,” receives a facility bill.
- What services are and are not appropriate for a customer to receive a facility fee?
- Provide direction in Standard Plan Appendix on services where customer cost-sharing may apply/may not apply for a facility fee.
 - Carrier responsible for covering any facility fees for services Cascade Care Workgroup decides are inappropriate so customer responsibility at \$0.
- Working with Acumen on feasibility to do research in APCD on specific medical services.

Additional value-based insurance design (VBID) changes to improve access

- ▶ VBID concepts for plan changes.
 - ▶ Additional upfront primary care and mental health visits.
 - ▶ Lowered copay on these services in 2026 Silver and Bronze plans.
 - ▶ Decrease generic drug copay or create high-value generics tier.
 - ▶ Decrease cost shares on services to treat specific chronic conditions (e.g., diabetes).
 - ▶ Others?



Standardization of customer experience

Ensuring consistency and predictability of customer experience across carriers

- ▶ Standardizing cost shares at benefit level.
 - ▶ Carriers may interpret and reflect standard plan benefit categories differently in filings, results in inconsistent benefit administration.
 - ▶ Standardized half of PBT entries for 2026 (can standardize more for 2027).
 - ▶ Formulary – **New opportunity**
 - ▶ Formularies at discretion of carrier (subject to federal/state regulations).
 - ▶ Formularies often changing and drugs not in expected cost sharing tier drugs (e.g., generic drugs not in generic drug cost-sharing tier).
 - ▶ Large variation in number of drugs in a category covered and placement in cost sharing tier so member with same condition has very different coverage depending on carrier.



Formulary investigation - Background

- ▶ Research question: Is there variation in formulary placement among standard plans?
 - ▶ Differences across plans in coverage and tier placement of drugs could lead to different enrollee experience depending on plan choice.
- ▶ Investigation: Analyze carrier drug coverage for selected chronic conditions to understand differences in carrier formularies for standard silver plans.*
 - ▶ Data: 2021 EDGE LDS data, 2023 standard Silver plan formularies.
 - ▶ Methodology:
 - ▶ Calculate the percentage of drug claims covered by for each chronic condition.
 - ▶ Show the distribution of covered drugs across tiers.

*Chronic conditions and associated drugs are selected based on the 2023 QHP tool.



Formulary investigation – Overall coverage

Condition	Range of Coverage (% of Claim Counts)	Range of Coverage (% of Allowed Spending)
Asthma	67% - 100%	43% - 100%
Bipolar Disorder	97% - 100%	61% - 100%
Breast Cancer	91% - 100%	24% - 100%
Diabetes	77% - 100%	52% - 100%
HIV	61% - 100%	66% - 100%
Hepatitis C	34% - 100%	19% - 100%
Multiple Sclerosis	78% - 100%	40% - 100%
Opioid Use Disorder	40% - 100%	17% - 98%
Prostate Cancer	85% - 100%	38% - 100%
Rheumatoid Arthritis	85% - 100%	69% - 100%
Schizophrenia	93% - 100%	49% - 100%

- ▶ There are substantial differences across standard Silver plans in overall drug coverage for chronic conditions.
- ▶ Coverage is measured using two approaches:
 1. The percentage of drug **claim counts** covered by each carrier's formulary, showing the breadth of the formulary.
 2. The percentage of drug claim **allowed spending** covered by each carrier's formulary, focusing on drugs with higher costs and/or drugs with higher utilization.
- ▶ Some carriers' coverage is reduced to a lower percentage when measured by the percentage of allowed spending.
 - ▶ Coordinated Care and UHC's drug coverage for bipolar lowers from 97% to 61% due to not covering some high-cost drugs such as Vraylar.

Formulary investigation – Tier placement

Common Tiers	Range of Coverage (% of Claim Counts)	Range of Coverage (% of Allowed Spending)
	Asthma	
\$25	43% - 86%	5% - 27%
\$75	9% - 43%	23% - 46%
\$250 After Deductible	2% - 32%	27% - 66%
	Breast Cancer	
\$0 Cost Preventive	0% - 78%	0% - 6%
\$25	15% - 98%	0.2% - 19%
\$250 After Deductible	0.3% - 13%	8% - 97%
	Opioid Use Disorder	
\$25	0.2% - 100%	0.1% - 100%
\$250 After Deductible	0% - 59%	0% - 81%

- ▶ Tier placement varies largely by carrier.
 - ▶ Examples using the claim count measure:
 - ▶ **Asthma drugs:** Premera and LifeWise have about 30% of claim counts in the \$250 after deductible tier. UHC puts 43% of claim counts into the \$75 tier. All other carriers have at least 67% of claim counts in the \$25 tier.
 - ▶ **Opioid Use Disorder drugs:** UHC and Kaiser WA place 50% of covered drugs on the \$250 after deductible tier. Other put them in the \$25 tier.
 - ▶ Examples using the allowed spending measure:
 - ▶ **Breast Cancer drugs:** Only Kaiser WA has 88% of allowed spending in their special \$65 tier. Most carriers have about 81% of allowed spending in the \$250 after deductible tier.

Formulary investigation – Top drugs

Top Drugs* (Condition)	\$25	\$75	\$250 After Deductible
Albuterol Sulfate (Asthma)	PacificSource, CHPW, BridgeSpan, Regence BCBS, Kaiser WA, Molina, Regence BS	Kaiser NW, UHC	Premera, LifeWise, Coordinated Care
	\$0 Cost Preventive	\$75	\$250 After Deductible
Descovy (HIV)	BridgeSpan, Regence BCBS, Regence BS	CHPW, Kaiser NW, Molina	PacificSource, LifeWise, Premera, Kaiser WA
	\$25		\$250 After Deductible
Buprenorphine sublingual film (OUD)	PacificSource, CHPW, LifeWise, Premera, BridgeSpan, Coordinated Care, Regence BCBS, Molina, Regence BS		UHC, Kaiser WA

- ▶ Same drugs are placed into tiers with different cost-sharing.
 - ▶ **Albuterol Sulfate** (Asthma): Premera, LifeWise, and Coordinated Care place this drug in the \$250 after deductible tier, while Kaiser NW and UHC place it in the \$75 tier. All other carriers categorize this drug in the \$25 copay tier.
 - ▶ **Descovy** (HIV): Coordinated Care and UHC don't cover this drug. BridgeSpan, Regence BCBS, and Regence BS place it in the \$0 cost share tier. Other carriers put it in either the \$75 or the \$250 after deductible tier.
 - ▶ **Buprenorphine sublingual film** (OUD): Kaiser NW doesn't cover this drug. UHC and Kaiser WA put it into the \$250 after deductible tier, while all other carriers place it in the \$25 tier.

*Drugs and tiers are based on the allowed spending measure

Formulary investigation

▶ Key takeaways

- ▶ There is substantial variation in drug coverage and tier placement across standard Silver plans.
- ▶ Same drugs are placed into different tiers with varying cost-sharing for the same standard plan.
- ▶ Customers with chronic conditions may experience significantly different coverage and cost-sharing, depending on their choice of specific carrier.

▶ Workgroup feedback

- ▶ Questions or comments on the methodology and results.
- ▶ Other suggested analyses to understand differences in carrier formularies.
- ▶ How might we address this variation?

Discussion: Approaches to 2027 standard plan design

- ▶ Reassess each metal level with new enrollment distribution across metal levels.
- ▶ Promote access to high-clinical value services (e.g., reducing facility fees, lowering primary care cost sharing).
- ▶ Additional standardization for a consistent customer experience (e.g., formulary).



Next steps: Milestones for 2027 standard plan design

- ▶ **Spring 2025:** Develop plan design goals and focus
- ▶ **Summer/fall 2025:** Develop and refine different design concepts and options
- ▶ **Oct.-Nov. 2025:** Public comment period on proposed 2027 Cascade Care plan designs
- ▶ **Nov. 2025:** Anticipate CMS will release Draft 2027 AV Calculator
- ▶ **Dec. 2025:** Exchange Board approval of 2027 Cascade Care plan designs

Cascade Care Workgroup

Next steps

- ▶ **Cascade Care plan design:** PY 2027 design conversations will continue through summer and fall.
- ▶ **Public option:** PY 2026 renewal applications due to HCA this month.
- ▶ **Cascade Care Savings:** PY 2026 PMPM methodology development begins this summer.

Next Cascade Care Workgroup meeting: 1 p.m., June 10



- Cascade Care Workgroup roster
- Background information:
- 2025 legislative session priorities
- 2025 legislative session budget/policy highlights details
- Sharpening Cascade Care tools stakeholder feedback summary
- Standard plan design formulary investigation

Appendix



Cascade Care Workgroup members

- ▶ Jane Beyer, *Office of the Insurance Commissioner*
- ▶ Jennifer Brackeen, *Washington State Hospital Association*
- ▶ Emily Brice, *Northwest Health Law Advocates*
- ▶ John-Pierre Cardenas, *Kaiser Permanente*
- ▶ Dekker Dirksen, *Community Health Plan of Washington*
- ▶ Jim Freeburg, *Patient Coalition of Washington*
- ▶ Stu Freed, *Confluence Health retired*
- ▶ Carrie Glover, *Dziedzic Public Affairs*
- ▶ Sean Graham, *Washington State Medical Association*
- ▶ Rhonda Hauff, *Yakima Neighborhood Health Services*
- ▶ David Iseminger, *Health Care Authority*
- ▶ Kristin Meadows, *Premera/Lifewise*
- ▶ Daphne Pie, *Public Health-Seattle & King County*
- ▶ Susanne Towill, *Coordinated Care*

2025 session focus

▶ Drive affordability – Cascade Care Savings

▶ Problem

- ▶ Rising health care premiums
- ▶ Uncertainty of enhanced premium tax credits
- ▶ **Cascade Care Savings only funded through plan year 2025**

▶ Solution

- ▶ **Continue Cascade Care Savings and modestly enhance funding**
- ▶ Disproportionate impact on,
 - ▶ Rural residents
 - ▶ Communities of color
 - ▶ People transitioning from Medicaid to commercial coverage



2025 session focus

Contain the cost of health care



Reference-based pricing



Shift resources to primary care



Organizational ownership transparency

2025 session focus

Protect equity
gains –
noncitizen health
coverage



Access to health and dental plans
on Washington Healthplanfinder

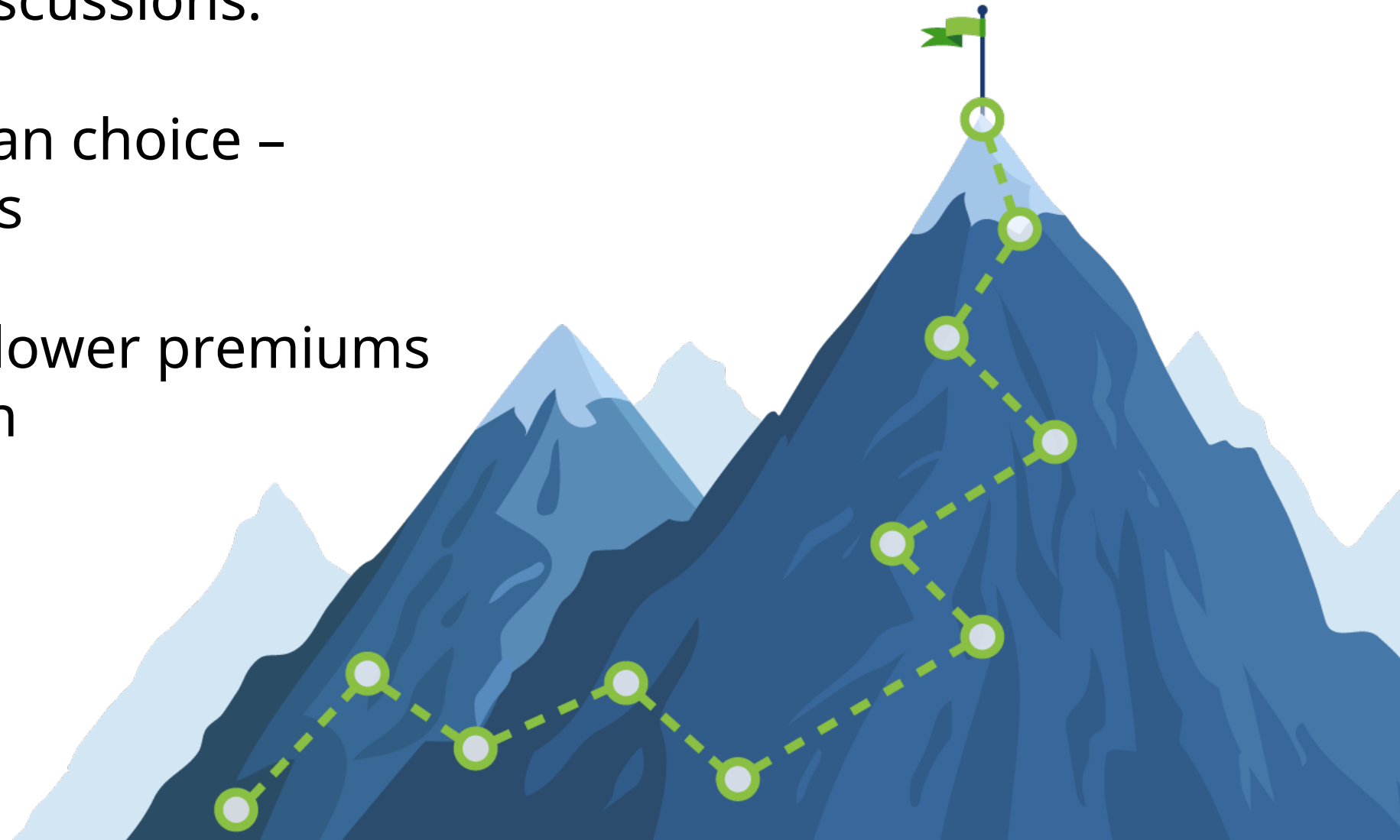
DACA recipients

Apple Health Expansion

Cascade Care improvements remain a priority

2025 interim discussions:

- ▶ Simplifying plan choice – standard plans
- ▶ Meaningfully lower premiums – public option



Proviso - state only program

- (a) \$10,000,000 of the state health care affordability account—state appropriation is provided solely to provide premium assistance for customers ineligible for federal premium tax credits who meet the eligibility criteria established in subsection (3)(a) and (b) of this section, and is contingent upon continued approval of the applicable waiver described in RCW 43.71.120.
- (b) In the event the applicable waiver described in RCW 43.71.120 is suspended, terminated, or otherwise ended, \$10,000,000 of the state health care affordability account—state appropriation is provided solely to:
 - (i) Implement a state program with coverage comparable to individual market plans, for customers who would have been eligible under the waiver; and
 - (ii) Provide state premium assistance to state program customers who meet the eligibility criteria established in subsection (3) of this section.
- (c) The exchange may establish or designate a separate entity to administer the state program. Administration of the state program must include, but is not limited to, establishing requirements for eligibility, continued participation, and carrier payments.
- (d) Moneys collected for premiums written on qualified health benefit plans and qualified dental plans offered through the state program must be deposited in the state health care affordability account under RCW 43.71.130, through a procedure established by the exchange that aligns with the requirements of RCW 48.14.0201(5)(b), 48.14.020(2), and 43.71.080. 38.
- (e) The exchange, and any entity involved in implementing this program, is subject to RCW 43.17.425.

Proviso - facilitated enrollment

\$1,000,000 of the health benefit exchange account—state appropriation for fiscal year 2027 is provided solely for the exchange, in collaboration with stakeholders, to begin development starting January 1, 2027, of an automated solution to ensure continuous health care coverage through qualified health plans for medicaid beneficiaries losing medicaid coverage through Washington healthplanfinder and is subject to the conditions, limitations, and review requirements of section 701 of this act.

Proviso - health data privacy

The health care authority shall promptly notify the office of the attorney general upon the receipt of a request from or on behalf of a federal agency or a federal, state, or local law enforcement authority for the health care information, as defined in RCW 70.02.010, program eligibility information for individuals, information that may identify a health care provider's or facility's delivery of health care services to noncitizens, or the delivery of protected health care services as defined in RCW 7.115.010 where the request may impact the expenditure for such services. The authority shall require contracted entities to notify the authority promptly upon the receipt of a request from a federal agency or law enforcement authority as described in this subsection.

(in addition to HCA, similar provisions applicable to: DSHS, DOH, DCYF, L&I, and higher education)

Proviso - gender affirming care defrayal

\$300,000 of the general fund—state appropriation for fiscal year 2026 and \$800,000 of the general fund—state appropriation for fiscal year 2027 are provided solely to the office of the insurance commissioner to defray costs during plan year 2026 incurred by carriers for coverage in qualified health plans of state-mandated health benefits included in the state essential health benefits benchmark plan as approved by the federal centers for medicare and medicaid services on October 7, 2024, that are not permitted to be treated as an essential health benefit under federal law or regulation.

5083 - reference-based pricing model

Hospital / In-Network Service	For PEBB/SEBB plans as of Jan 1, 2027
WA acute care hospital - for inpatient and outpatient services	Reimbursed at the lesser of: <ul style="list-style-type: none"> - Billed charges - Contractor's contracted rate, or - 200% of Medicare rate for same or similar services
Exceptions:	
Seattle Children's - for inpatient and outpatient services	Reimbursed at the lesser of: <ul style="list-style-type: none"> - Billed charges - Contractor's contracted rate, or - 150% of hospital-specific Medicaid cost to charge ratio, as est. by HCA
Mary Bridge Children's - for inpatient and outpatient services	Reimbursed at the lesser of: <ul style="list-style-type: none"> - Billed charges - Contractor's contracted rate, or - 190% of hospital-specific Medicaid cost to charge ratio, as est. by HCA

5083 - reference-based pricing model

Hospital / In-Network Service	For PEBB/SEBB plans as of Jan 1, 2027
Exceptions – continued:	
Critical access hospitals	Reimbursed not less than 101% allowable costs as defined by CMS cost reporting
Primary care services	Services as defined by HCA, reimbursed not less than 150% of Medicare for similar services
Non-facility-based behavioral health services	Services as defined by HCA, reimbursed not less than 150% of Medicare for similar services

5083 - reference-based pricing model

Hospital / Out-of-Network Service	For PEBB/SEBB plans as of Jan 1, 2027
WA acute care hospital – for inpatient and outpatient services	Reimbursed at the lesser of: <ul style="list-style-type: none"> - Billed charges, or - 185% of Medicare rate for same or similar services
Exceptions:	
Seattle Children’s, acute care hospital – for inpatient and outpatient services	Reimbursed lesser of <ul style="list-style-type: none"> - Billed charges; or - 135% of hospital-specific Medicaid inpatient ratio of cost to charge, as established by HCA
Mary Bridge Children’s, acute care hospital – for inpatient and outpatient services	Reimbursed lesser of <ul style="list-style-type: none"> - Billed charges; or - 175% of hospital-specific Medicaid inpatient ratio of cost to charge, as established by HCA

5083 - reference-based pricing model

Hospital	For PEBB/SEBB plans as of Jan 1, 2027
Exceptions (other than critical access hospital requirements noted above):	
Sole community providers or critical access hospitals, not owned or operated by a health system with more than two acute care hospitals	Referenced-based pricing model does not apply
Island Health	Referenced-based pricing model does not apply
Astria Toppenish	Referenced-based pricing model does not apply

5083 - other provisions

- ▶ Providers cannot charge or collect from patients any amounts in excess to what is reimbursed through this model
- ▶ Hospitals can still be reimbursed through a non-fee-for-services payment methodology, as long as payments incentivize higher quality or improved health outcomes and complies with the reimbursement payment models in this bill
- ▶ Premiums must reflect this reimbursement model
- ▶ HCA can request data for monitoring, enforcement and quality improvement and contract language cannot restrict access to data
- ▶ By Dec 31, 2030, and Dec 31, 2034, submit reports about impact on network access, premium and cost sharing, state expenditures
- ▶ Inpatient and outpatient services does not include charges for professional services
- ▶ HCA may adopt any necessary rules for enforcement

Sharpening Cascade Care Tools – Summary of Feedback

In its continued commitment to customer affordability and access, Washington Health Benefit Exchange Board is interested in opportunities to sharpen Cascade Care tools. Cascade Care aims to make health insurance accessible and affordable to all Exchange customers. Through its state subsidies, standard plans, and the nation’s first public option, Cascade Care supports Exchange customers with lower premiums, lower costs at the doctor’s office, and easier shopping for high-quality benefits that matter most to individuals and their families.

Goals & opportunities to advance access & affordability for customers



State Subsidy:

- More than **100,000** low-income customers reduce monthly premiums with Cascade Care Savings.
- As **rates increase**, subsidies cannot stretch as far.
- **Target** subsidies to customers who need them to get and stay covered.



Standard Plans:

- **Three out of four** Exchange customers enrolled in standard plans today.
- **Variation** in plan offerings is confusing and overwhelming.
- **Differentiate** plans based on what matters most to customers: premium, network, quality, customer service.



Public Option:

- Public option **statewide** in 2025.
- Customers experience **access barriers**.
- Current policies not resulting in meaningfully **lower premiums**.
- Drive **healthy competition** on price and quality.

The Exchange requested stakeholder feedback in September and October about options and proposals for state subsidy policy, fully standardizing cost sharing on the Exchange, and strengthening public option. The following are feedback themes about policies for public option and fully standardizing cost sharing on the Exchange. Feedback about PY 2026 Cascade Care Savings policy options continue to be gathered via a [public comment period](#) through Nov. 20. Feedback was received from Exchange partners including carriers, consumer advocates, assisters, hospitals, providers, and state agencies.

Policy Topic	Feedback Themes
<p>Options to fully standardize cost sharing on Exchange:</p> <p>1. Standard plans only at Silver and limit non-standard to one each at other metal</p>	<ul style="list-style-type: none"> • A majority of stakeholders support the policy direction to offer only standard plans on the Exchange. • Given expected disruption from the expiration of enhanced federal tax credits in plan year (PY) 2026, stakeholders are supportive of this policy change in PY 2027, several encouraging full standardization at once (vs continued phased approach). • Many stakeholders suggest that a prescriptive approach requiring the Exchange to design and offer a specific number of standard

Policy Topic	Feedback Themes
<p>levels (<i>aligned with ESHB 2361</i>)</p> <p>2. Phased approach to only standard plans, starting with Silver (<i>aligned with HB 2361/SB 6258</i>)</p> <p>3. Only standard plans; Exchange designs two standard plans at each metal level</p>	<p>plans is not flexible enough to respond to dynamic market needs. They encourage the Exchange to consider an approach that allows flexibility to respond to market conditions and customer needs without legislative approval. Criteria for this kind of flexibility might include meaningful difference in plan choice, responsiveness to market risks or failures, and maximization of Exchange enrollment and affordability.</p> <ul style="list-style-type: none"> • While analysis demonstrates the value of the Exchange designing additional standard plans based on the above illustrative criteria, stakeholders are opposed to or question the value of a second standard plan at the silver metal level. • The few stakeholders opposed to fully standardizing cost sharing on the Exchange cite the value of carrier innovation and plan options for customers, particularly those who are higher income.
<p>Public option proposal:</p> <ul style="list-style-type: none"> • Strengthen provider participation <ul style="list-style-type: none"> ○ All public option plans offering good faith contract ○ Hospital systems • Add targeted pricing caps <ul style="list-style-type: none"> ○ Hospital inpatient/outpatient ○ Behavioral health floor 	<ul style="list-style-type: none"> • Directional support for additional provider participation and affordability criteria centers on opportunities to lower public option premiums and increase customer access to in-network public option providers. Many stakeholders particularly focus on equitable access to care for this relatively small subset of Washingtonians. • A few stakeholders have significant policy concerns citing provider revenue impacts, administrative burden, and lack of critical flexibility in contract terms and negotiations. • Several stakeholders cite analysis that large, consolidated hospital systems have substantial negotiating power that does not serve consumers. However, caution is needed to ensure policies do not place outsized power with carriers. • All stakeholders have questions about definitions and implementation, and suggest careful scenario testing before solidifying in statute. Some suggest that targeted policies to address specific existing affordability and access concerns would be more effective than broad-brush policy. • Many stakeholders suggest considering distinct approaches for rural areas, citing geographic market distinctions and the importance of rural hospital sustainability. • Stakeholders express interest in opportunities to better advance public option’s market competition and consumer access goals through HCA authorities, including targeted and parsimonious public option plan selection, carrier contract management, hospital participation enforcement, and carrier requirements to align and standardize network provider contract terms. • There is interest in continued alignment between public option affordability and access policies and PEBB/SEBB policies.

Next steps: Action on proposed policies to strengthen public option and fully standardize cost sharing on the Exchange would require statutory changes. The Exchange is developing its 2025 legislative priorities in November, in addition to its established key priorities to maintain and enhance customer premium subsidies. It is doing this in close collaboration with the Exchange Board, considering stakeholder feedback and changes to the federal and state authorizing environments.

Following the December Board meeting, the Exchange will share next steps for sharpening Cascade Care tools with partners, including at the Cascade Care Workgroup's [December meeting](#).

Please do not hesitate to contact cascadecare@wahbexchange.org with questions or additional feedback.

Formulary investigation - Appendix

- ▶ Method 1: Examine **the percent of drug claim counts** covered by each carrier's formulary in each tier.
 - ▶ This method checks the breadth of the formulary, which focuses on the range of different drugs for each condition included in a carrier's formulary.
- ▶ Asthma
 - ▶ 67% - 100% of claim counts for drugs covered by carriers.
 - ▶ CHPW (67%), Kaiser NW (68%) and Coordinated Care (71%) have relatively narrow formularies.
 - ▶ Most carriers have 70%-80% of drug claims in the \$25 copay tier. Premera and Lifewise have 30% of claim counts in the \$250 after deductible tier.
 - ▶ Among the top five drugs by claim count, Albuterol Sulfate (costing \$30-\$40 per claim) exhibits the greatest variation in cost sharing. Premera and Lifewise place it in the \$250 after deductible tier, while UHC places it in the \$75 tier. All other carriers categorize this drug in the \$25 copay tier.

Formulary investigation - Appendix

▶ Breast cancer

- ▶ All carriers have wide coverage with over 90% of claim counts covered.
- ▶ CHPW, Kaiser NW, Coordinated Care, UHC and Molina place the majority of drugs on the \$25 tier, while PacificSource, LifeWise, Premera, BridgeSpan, Regence BCBS and Regence BS place most of the drugs into the zero cost share preventive tier.
- ▶ Drugs in the preventive tier are mainly estrogen inhibiting drugs to treat and prevent breast cancer.

▶ Diabetes

- ▶ 77% – 100% of claim counts for drugs covered by carriers.
- ▶ Kaiser NW and UHC have relatively low coverage (77% claim counts).
- ▶ Most carriers place diabetes drugs on the \$25 or \$75 tier. Kaiser WA place some drugs on the \$250 after deductible tier.
- ▶ Despite covering all types of drugs, Kaiser WA places Lantus Solostar on the \$250 tier, while other carriers put it on the \$75 tier. Kaiser WA also puts a few other drugs on the \$250 tier such as Trulicity and Ozempic, which are put on the \$75 tier by other carriers.

Formulary investigation - Appendix

▶ HIV

- ▶ 61%-100% of claim counts for drugs covered by carriers.
- ▶ UHC has the lowest coverage of 61%.
- ▶ Lifewise, Premera, Coordinated Care, UHC, and Kaiser WA place many common drugs on the \$250 after deductible tier. Others place most drugs on the \$75 tier.

▶ Hepatitis C

- ▶ 34% – 100% of claim counts for drugs covered by carriers.
- ▶ Molina has the lowest coverage of 34%.
- ▶ Kaiser NW put most of the covered drugs on the \$75 tier. All other carriers place almost all drugs on the \$250 after deductible tier.

Formulary investigation - Appendix

- ▶ Opioid use disorder
 - ▶ 40%-100% of claim counts for drugs covered by carriers.
 - ▶ Kaiser NW has the lowest coverage of 40%. All other carriers are above 87%
 - ▶ UHC and Kaiser WA place 50% of covered drugs on the \$250 after deductible tier. Others put them in the \$25 tier.
- ▶ Schizophrenia
 - ▶ 92% - 100% of claim counts for drugs covered by carriers.
 - ▶ Molina is the only carrier putting top three covered drugs in the \$250 after deductible tier. All other carriers use the \$25 tier for all top 25 drugs.
- ▶ Bipolar disorder, multiple sclerosis, prostate cancer and rheumatoid arthritis
 - ▶ Coverage and tiering are fairly consistent across carriers.

Formulary investigation - Appendix

- ▶ Example of how Asthma drugs are covered by each carrier and the tier distribution for covered drugs:

Asthma	Coverage	\$25	\$75	\$250 After Deductible	\$65 (Kaiser WA only)	Zero Cost Share Preventive Tier	Medical Service Drugs
PacificSource	93.84%	78.13%	19.03%	2.84%	N/A	0.00%	0.00%
CHPW	67.28%	86.34%	10.98%	2.69%	N/A	0.00%	N/A
Kaiser NW	68.11%	74.64%	16.08%	9.28%	N/A	N/A	N/A
LifeWise	89.02%	50.93%	17.40%	31.60%	N/A	0.00%	0.07%
Premera	89.02%	50.93%	17.40%	31.60%	N/A	0.00%	0.07%
BridgeSpan	86.11%	73.80%	23.85%	2.35%	N/A	0.00%	N/A
Coordinated Care	71.35%	66.57%	14.29%	19.14%	N/A	0.00%	N/A
UHC	91.51%	43.06%	43.28%	13.59%	N/A	0.00%	0.07%
Regence BCBS	86.11%	73.80%	23.85%	2.35%	N/A	0.00%	N/A
Kaiser WA	99.93%	70.28%	11.25%	18.40%	0.00%	0.00%	0.08%
Molina	84.60%	76.51%	9.42%	14.07%	N/A	0.00%	0.00%
Regence BS	86.11%	73.80%	23.85%	2.35%	N/A	0.00%	N/A

Formulary investigation - Appendix

- ▶ Method 2: Examine **the percent of drug claim allowed spending** covered by each carrier's formulary in each tier.
 - ▶ This method assigns greater weight to drugs that are more expensive and to those with higher utilization.
 - ▶ Patterns for HIV and Hepatitis C look similar compared to the previous results using the claim count method, while patterns for other conditions change .
- ▶ Bipolar
 - ▶ Coordinated Care and UHC's coverage become much narrower (from 96% to 61%) because they don't cover Vraylar.
- ▶ Breast cancer
 - ▶ Kaiser WA mainly uses their special \$65 tier, while the other issuers mainly use the \$250 tier.

Formulary investigation - Appendix

▶ Diabetes

- ▶ Kaiser WA has about 79% of covered drugs on the \$250 tier, while other carriers mostly use the \$75 tier.

▶ Opioid use disorder

- ▶ Kaiser NW has low coverage. UHC and Kaiser WA place many covered drugs on the \$250 tier, whereas others keep most covered drugs in the \$25 tier.

▶ Schizophrenia

- ▶ Molina is no longer an outlier when looking at allowed spending, but there are more differences in tiering across carriers.



washington
healthplanfinder

click. compare. covered.

www.wahealthplanfinder.org

| www.wahbexchange.org

| 1-855-923-4633