Washington Health Benefit Exchange report:

Federal Funding Options for Exchange Affordability

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Report Summary

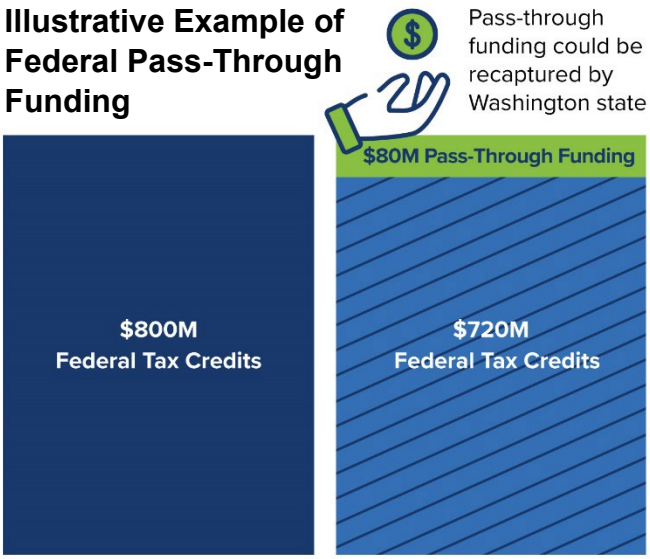
The current enacted Washington state budget requires Washington Health Benefit Exchange (Exchange), in consultation with the Health Care Authority (HCA) and the Office of the Insurance Commissioner (OIC), to submit to the Legislature an actuarial study of options for amending the existing 1332 State Innovation Waiver to generate federal funding for Washington State (referred to as "pass-through funding") to support the Exchange affordability programs established in RCW 43.71.110.[1] The study is required to focus on methods that could be most readily leveraged in Washington and considers those being used in other state public option programs.

To conduct the required actuarial analysis, the Exchange contracted with Milliman to evaluate a range of public option policies that could be included in a 1332 Waiver amendment and could generate federal pass-through funding.

Main finding: Strengthening the state's first-in-the-nation public option program and lowering public option plan premiums 10 percent could generate about $60 million to $90 million annually for the state to meaningfully address affordability and equity barriers faced by Exchange customers.[2]

Section 1332 Waivers

Section 1332 of the Affordable Care Act (ACA) allows states to waive certain provisions of the law to design and implement innovative state programs to provide residents with access to affordable, quality health care. Approved 1332 waiver innovations that result in reduced federal spending on premium tax credits create funds that can be recaptured by the state ("pass-through" funding from the federal government to the state).



Example of Before vs. After Waiver

[1] In 2021, the Legislature established Cascade Care Savings, a state premium subsidy program that helps Exchange customers up to 250% of the federal poverty level access Silver and Gold Cascade Care plans, including public option plans. The Legislature has appropriated $55 million annually for this program.

[2] The analysis models potential pass-through funding with ($90M) and without ($60M) continued enhanced federal subsidies (ARPA). See description below.

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To secure approval of a state 1332 Waiver amendment, Washington would need to:

- Identify a waivable provision of the ACA;
- Demonstrate how the waiver plan will adhere to guardrails set forth in the ACA that require the waiver program to not increase the federal deficit and to ensure coverage levels, benefits and affordability are consistent with, or better than without, the waiver program; and
- Secure state statutory and regulatory changes required to lower public option premiums, and to create waiver enforcement mechanisms that strengthen the state's likelihood of generating maximum pass-through funding.

The following illustrates a potential waiver submission timeline, using 2026 implementation as an example:

Waiver Policy Options

Key to conducting this study and achieving the goals set forth by the Legislature was identifying waiver policy options with clear and definable pass-through funding opportunities. As such, the report is focused only on state statutory and/or regulatory changes, contingent on federal waiver approval, that:

- Align with Washington state's current health insurance affordability strategies;
- Have demonstrated lower premiums and/or are included in approved 1332 Waivers in other states;
- Have a nexus to a waivable federal provision under the ACA; and
- Could demonstrably lower public option premiums, reduce federal spending on tax credits, and generate federal pass-through funding.

Through discussions with the federal Centers for Medicare and Medicaid Services (CMS) and other states, it is abundantly clear that a major barrier to securing federal pass-through funding is being able to definitively demonstrate how the savings are directly attributable to the implementation of state policy under an approved 1332 Waiver. If a state is unable to clearly illustrate the nexus between the state policy and federal savings, then pass-through funding is at risk. As such, some polices that could result in unattributable reductions in Exchange plan premiums, along with those that would require considerable state investment, were not included in this report.[3]

Milliman analyzed the following policy options, individually and in combination, which meet the criteria above. All options would require new statutory and regulatory authorities:

- **Strengthen Public Option Provider Requirements**: The state could build upon and strengthen its current public option program, which primarily relies on state-mandated health care provider reimbursement requirements. The policy options considered focus on the underlying costs of health care that drive health plan premiums. Those considered do not adjust the minimum reimbursement requirements established by the Legislature for primary care services and critical access hospitals. Options analyzed together and separately include:
    - Lowering the current public option aggregate provider reimbursement cap, which is now 160% of Medicare.
    - Establishing additional reimbursement caps to further address primary drivers of health care costs (e.g., inpatient and outpatient hospital services).
- **Introduce Public Option Carrier Premium Requirements**: While a variety of carrier-focused policy levers could be considered, the study focuses on potential premium savings and pass-through funding achieved through defined caps on public option plan administrative costs and profits (called “pricing loss ratio” requirements). Other leading states have enacted similar measures to reduce premiums, including Colorado’s public option premium rate caps established in a 1332 Waiver that generated about $245 million in pass-through for the state in 2023.[4]

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[3] Appendix A is a summary of other states’ policies, including reinsurance and Basic Health, considered out of scope for this report.
[4] Premium rate caps are the policy lever used in other states’ public option waivers. For example, Colorado’s 1332 waiver mandated public option premium reductions, with provider reimbursement floors only if premium reduction targets not met.

Milliman's analysis assumed implementation in plan year 2026. Milliman's models largely assume the enhanced premium tax credits originally created by the American Rescue Plan Act (ARPA) will expire after plan year 2025 (under current law). For a few combined scenarios, Milliman also analyzed and modeled the impact of the enhanced premium tax credits continuing into 2026.

Main Findings

Study findings indicate a range of outcomes based on the policy option and ARPA scenario combinations and provides results corresponding to whether the Legislature chooses to focus policy options on provider reimbursement, carrier premiums, or both. The expiration of enhanced federal subsidies after plan year 2025 also has a significant impact on the level of pass-through funding that could be generated. For every 1% public option premium decrease, the state could capture between $5 million and $6 million in federal pass-through funding annually, and between $8 million and $9 million annually, should enhanced subsidies continue.

Overall, strengthening public option policies in Washington state to lower public option premiums by 10% could generate $60 million to $90 million annually in federal pass-through funding for Exchange affordability programs.

- These results assume full implementation is in effect in plan year 2026; there is compliance with enforcement of the various policy levers; and relevant federal departments approve an amended 1332 Waiver. None of these assumptions are guaranteed, and it should be noted that while the current federal administration and relevant authorizing agencies have been willing to engage with Washington to discuss innovative 1332 Waiver approaches and strategies, the waiver ideas included in the report have not been evaluated by the federal government.
- A key component of being able to demonstrate the impact of any of these policy levers is data, much of which would need to come from the insurance carriers. Absent a legislative requirement for the carriers to report on the public option policy lever, being able to clearly attribute the impact will prove difficult. In addition, the study does not comment on or evaluate the implications of these policy levers on provider interest in contracting with public option plans or carrier

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Some states have applied carrier premium reduction targets to the entire individual market. For example, Massachusetts' individual and small group market MLR requirement is set at 88%. (In Washington state, the individual market MLR is set at 80%, with large group market requirements at 85% MLR.) An approach that applies carrier premium reduction targets to the entire individual market could be considered but does not appear to have a significant nexus to a waivable provision.

interest in offering the plans, nor does it assess their ability to implement the levers.[5]

If the Legislature is interested in further exploring a waiver amendment opportunity, next steps include:

- Engagement with the federal authorizing environment to discuss a potential 1332 waiver amendment.
- Identification of specific statutory and regulatory changes required to strengthen public option provider reimbursement requirements and/or introduce public option carrier premium requirements. The state would also need to identify necessary waiver enforcement mechanisms that would strengthen the state's likelihood of generating maximum pass-through funding.
- Further collaboration between the Exchange, OIC, and HCA to assess implementation details and viability.

[5] Current statute does not require public option participation by carriers or most providers. Only hospitals are required to contract with one public option plan. Participation risks could be considered in enforcement authorities, which are discussed in Milliman's study.

MILLIMAN REPORT

Washington Health Benefit Exchange

1332 Waiver Feasibility Analysis for Washington's Public Option

November 10, 2023

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I. EXECUTIVE SUMMARY

Washington Health Benefit Exchange ("the Exchange") contracted with Milliman to provide actuarial services supporting the Exchange's[1] report to the Legislature analyzing potential 1332 Waiver amendment(s) that could generate qualified health plan (QHP) premium savings and capture those savings in the form of federal pass-through funding to support affordability programs. This report provides our analysis results, assumptions, and methodology under the provider reimbursement, pricing loss ratio, and combined scenarios discussed with the Exchange.

Legislation enacted in 2019 established the nation's first public option program. Public option plans, called Cascade Select, offer a standardized set of benefits and were first offered in the 2021 plan year.[2] The public option plans are intended to increase the availability of high-quality affordable health coverage on the individual market. Cascade Select enrollment has increased steadily since its inception in 2021, but remains only 0.5% of Washington state health insurance total enrollment. The analysis in this report provides the estimated impact of modeled policy levers that could be effective as of the 2026 plan year to strengthen the current public option plan requirements.

We assume Washington's current 1332 Waiver will remain in effect for the 2026 plan year, and all results in this report represent incremental impacts to premium rates and pass-through funding under an amended waiver. Therefore, the policy changes modeled herein are in addition to any premium impacts and pass-through funding that could be generated by the existing waiver.

This report focuses on three impacts: lower public option gross premiums, changes in the second lowest cost Silver plans, and resulting pass-through funding under a 1332 Waiver. To drive lower public option premiums, the analysis detailed in this report evaluates scenarios for isolated and combined modeled policy levers related to:

1. Provider reimbursement maximums in aggregate.
2. Provider reimbursement maximums by broad provider type (professional, facility, etc.), category.
3. Changes to allowable pricing loss ratio requirements for plans.

Variations on these policy changes are modeled under two different frameworks assumed in 2026:

1. American Rescue Plan Act (ARPA) enhanced subsidies continued by the signing of the Inflation Reduction Act (IRA) expire at the end of the 2025 plan year.

2. ARPA enhanced subsidies continued by the signing of the IRA continue into the 2026 plan year.

The levers and corresponding scenarios were modeled to illustrate a broad range of potential options and are not intended as recommendations. The estimates in this report are subject to significant uncertainty and rely upon assumptions that incorporate our most current and best estimates of healthcare costs, premiums and enrollment on the Exchange, carrier offerings, and other information related to the Washington individual market. It is a certainty that there will be material changes in the health care environment between the current basis for these estimates and the 2026 projection period. Therefore, actual health care premiums, claims costs, membership, and pass-through funding will differ from the estimates shown here. It is also a certainty that with the emergence of additional information related to the assumptions used would change and produce different estimates than those presented here.

In discussion with the Exchange, we understand there are various enforcement mechanisms that are yet to be determined and would require state statutory and / or regulatory changes. The outcomes in this report are predicated on the assumption that the state will be able to enact such enforcement levers to support the policies modeled in this report. If this is not the case, the results in this report, including but not limited to premium changes and pass-through-savings calculated, will not be viable. We discuss variations on potential enforcement levers in Section IV-E.

A. SUMMARY OF RESULTS

Table 1 summarizes the 2026 public option premium decreases and the estimated additive pass-through savings in total for the state of Washington by scenario under an amended 1332 Waiver. Section III contains more detail on the specific provider reimbursement and pricing loss ratio assumptions associated with the respective scenarios.

[1] https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20231017142042, Sec. 214(4)(b)
[2] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5377-S2.SL.pdf?q=20210615170717

Each waiver scenario is compared to a baseline which varies based on the status of ARPA enhanced subsidies, as continued by the signing of the IRA (and henceforth referred to as ARPA subsidies). Both baselines assume that the existing 1332 Waiver will remain in effect for the 2026 plan year with no changes.

The public option premium decrease is calculated by comparing the age 21 premium per member per month (PMPM) for public option plans under the baseline scenario to each respective scenario. In other words, this represents the relative change in the public option plan premium PMPM that will be realized by any individual enrollee, which does not vary by age due to the CMS mandated age curve. This does not represent a change in total premium dollars under each scenario. The estimated pass-through savings is presented on a total dollar basis, and is described in more detail in Section II-C.

Table 1
Washington Health Benefit Exchange
1332 Waiver Actuarial Analysis
Public Option Premium Decreases and Pass-Through Funding Savings by Scenario

Scenario	Framework	Description of Provider Payment and / or Allowable Pricing Loss Ratio Requirements	Public Option Premium Decrease	Estimated Pass-Through Savings Relative to Baseline (000's)
Aggregate Provider Reimbursement				
1	No ARPA	136% Aggregate Cap	10.0%	$59,817
2	No ARPA	148% Aggregate Cap	5.0%	$29,389
3	No ARPA	158% Aggregate Cap	1.0%	$5,671
Disaggregate Provider Reimbursement				
4	No ARPA	150% Inpatient Cap	1.7%	$9,720
5	No ARPA	160% Outpatient Cap	4.2%	$24,635
6	No ARPA	160% Inpatient / 175% Outpatient Caps	3.0%	$17,678
7	No ARPA	125% Non-PC Physician Cap	2.3%	$13,457
Pricing Loss Ratio				
8	No ARPA	90% Pricing Loss Ratio	10.0%	$59,877
9	No ARPA	85% Pricing Loss Ratio	4.7%	$27,680
Combination				
10a	No ARPA	136% Aggregate Cap / 90% Pricing Loss Ratio	20.8%	$131,500
10b	ARPA[1]	136% Aggregate Cap / 90% Pricing Loss Ratio	20.8%	$197,802
11a	No ARPA	160% IP / 175% OP / 150% Aggregate Cap / 88% Pricing Loss Ratio	12.9%	$79,199
11b	ARPA[1]	160% IP / 175% OP / 150% Aggregate Cap / 88% Pricing Loss Ratio	12.9%	$119,139
12a	No ARPA	155% Aggregate Cap / 85% Pricing Loss Ratio	6.9%	$40,862
12b	ARPA[1]	155% Aggregate Cap / 85% Pricing Loss Ratio	6.9%	$61,324

[1] *Baseline used for comparison also assumes extension of ARPA subsidies.*

Each section of this report provides support for and additional detail related to summary results:

- Section II provides background on Washington's previously enacted public option legislation, the coverage landscape of the on-exchange individual market premiums for the 2024 plan year, and information on the calculation of subsidies and subsequent pass-through savings.
- Section III describes the modeled scenarios in detail, including isolated and combined policy levers under various frameworks.
- Section IV contains the results of the actuarial analysis for each of these scenarios, including premium decreases for public option plans and associated pass-through funding based on the second lowest cost Silver plans.
- Section V details the data sources and adjustments, assumption, and methodology underlying the analysis.
- Appendix I displays the results of each scenario in more detail.
- Appendix II displays the difference between each scenario results and the comparison baseline.

B. DATA RELIANCE AND IMPORTANT CAVEATS

This report has been prepared for the use of and is to be relied upon by the management of Washington Health Benefit Exchange ("the Exchange"). We understand that this report will be made public, and we consent to the distribution of this report. Third parties are instructed to place no reliance on this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to you. Any reliance on the Milliman report is entirely at your own risk. Milliman shall not be liable for any loss, damage, or expense of any nature caused by your reliance upon the Milliman report.

Milliman makes no representations or warranties to any third party. Material events may have occurred between the preparation of this report and its publication or may occur after the date of the Milliman report. Any such events will not be reflected in the Milliman report. Milliman has no responsibility to update this report, make changes, corrections or supplementations.

In performing this analysis, Milliman relied on data and other information provided by the Exchange, as well as publicly available information. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of Milliman's analysis may likewise be inaccurate or incomplete.

Differences between Milliman's projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual future experience will not conform exactly to the assumptions used in this analysis. Projected results will differ from actual results to the extent that actual experience deviates from expected experience. Moreover, actual pass-through funding is dependent on CMS approval of a waiver application from the State of Washington and the pass-through calculations performed by CMS and the Department of Treasury. There is uncertainty related to both of these events. Milliman's estimation of pass-through funding should not be construed to mean a Section 1332 Waiver for purposes of capturing pass-through funding will or will not be approved. Our estimates are provided under the assumption of approval and do not contemplate the Exchange's usage of these pass-through funds for additional premium subsidies or other marketplace actions that might otherwise result in enrollment or morbidity changes to the individual market in Washington state.

This analysis does not constitute an actuarial certification for purposes of gaining approval of a 1332 Waiver application from CMS. Nothing in this report should be construed to mean that such a waiver application, if submitted, would or would not be approved by CMS.

II. BACKGROUND: WASHINGTON INDIVIDUAL HEALTH COVERAGE AND CASCADE CARE LANDSCAPE

A. WASHINGTON CASCADE CARE AND STATE REQUIREMENTS

Cascade Care Legislation

Engrossed Substitute Senate Bill 5526 (Chapter 364, Laws of 2019)[3] instituted standard plan requirements beginning January 1, 2021, in order to increase the availability and quality of affordable health coverage in Washington's ACA individual market. Engrossed Second Substitute Senate Bill 5377 (Chapter 246, Laws of 2021)[4] expanded upon the initial legislation and established criteria for state based-premium and cost-sharing subsidies.

Cascade Care Plan Offerings

Washington's standard plans, also known as Cascade Care plans, include both standard (Cascade) and public option (Cascade Select) plans. The Cascade and Cascade Select plans mandate benefit designs for Bronze, Silver, and Gold metal levels and are identical between Cascade and Cascade Select plans. These benefits are intended to reduce out-of-pockets costs for consumers within the requirements of each metal level and provide more predictable costs via copay requirements (rather than deductible and coinsurance requirements). Cascade Select plans are required to meet additional higher quality and premium affordability standards when compared to Cascade plans and are the first of their kind in the nation.

Cascade Select enrollment has increased steadily since its inception in 2021 but remains a small portion of Washington state health insurance total enrollment. On-exchange market enrollment represents about 4% of the total insured population in the state of Washington, and public option enrollment currently represents about 0.5%.

Carriers must offer Silver and Gold Cascade Care plans and must also offer a Cascade Care Bronze plan in any county where a non-Cascade Bronze plan is offered as a requirement to participate on the Exchange. The Health Care Authority procures and contracts for Cascade Select plans, and hospitals must contract with at least one carrier. Public option coverage is intended to be available in every county in the state.

Cascade Select Provider Reimbursement Requirements

Cascade Select plans have specific provider reimbursement requirements not applicable to Cascade or non-Cascade plans. The Cascade Select provider reimbursement values may not exceed 160% of Medicare for medical services in aggregate by carrier at a statewide level. The provider reimbursement requirements also include a minimum of 135% of Medicare for primary care and a minimum of 101% of cost for critical access hospitals.

Cascade Care Subsidies

Consumers up to 250% of the federal poverty level can access state-based premium assistance in Cascade and Cascade Select Silver and Gold plans offered on the Exchange. State premium assistance is offered in addition to any available federal subsidies. This state-based premium assistance ranges from $1 to $155 PMPM in 2023 for all eligible consumers, and in 2024 ranges from $1 to $155 PMPM for those eligible for federal subsidies and $1 to $250 PMPM for consumers not eligible for federal subsidies. Under Washington's current Section 1332 Waiver, starting in 2024, all Washingtonians regardless of immigration status and not eligible for federal subsidies may also receive state-based premium assistance.

B. CURRENT WASHINGTON COVERAGE LANDSCAPE

We base the analysis in this report on Washington's individual market premium offerings as filed by each carrier for the 2024 plan year. This 2024 rate filing data shows three carriers offering public option plans: Community Health Plan of Washington, Coordinated Care Corporation, and LifeWise Health Plan of Washington.

- Cascade Select plans are offered by three carriers approved by the state, consistent with 2023, and a decrease from five in 2021 and 2022.
- Cascade Select plans are available from at least two carriers in all rating areas.

[3] https://app.leg.wa.gov/billsummary?BillNumber=5526&Year=2019&Initiative=false
[4] https://app.leg.wa.gov/billsummary?BillNumber=5377&Initiative=false&Year=2021

- Cascade Select Silver plans are the lowest priced on-exchange Silver plan in all rating areas, and the second lowest priced Silver plan in six rating areas. Two different carriers have the lowest priced Cascade Select Silver plan.
  - Community Health Plan of Washington has the lowest priced Silver plan in six of nine rating areas.
  - Coordinated Care Corporation (Ambetter) has the lowest priced Silver plan in three of nine rating areas.
- Cascade Select is offered in 37 out of 39 counties in 2024. The Cascade Select Silver is the lowest premium Silver plan in 31 out of the 39 counties.
- As of 2023, 65% of Exchange covered lives are enrolled in a Cascade or Cascade Select plan.

Table 2 shows the lowest and second lowest cost on-exchange Silver plans and age 21 premium rates from 2024 filing information. Cascade Select plans are highlighted green.

Table 2
Washington Health Benefit Exchange
2024 Age 21 Silver Plan Premium PMPM by Area

Rating Area	Lowest Cost Silver (LCS) Plan Name	Premium PMPM	Second Lowest Cost Silver (SLCS) Plan Name	Premium PMPM
1	Community Health Plan of Washington Cascade Select Silver	$309.06	Ambetter Cascade Select Silver	$312.50
2	Ambetter Cascade Select Silver	$302.75	Ambetter Balanced Care 4	$303.55
3	Ambetter Cascade Select Silver	$278.19	Ambetter Balanced Care 4	$278.92
4	Community Health Plan of Washington Cascade Select Silver	$297.22	Ambetter Cascade Select Silver	$300.85
5	Community Health Plan of Washington Cascade Select Silver	$296.20	Ambetter Cascade Select Silver	$304.75
6	Community Health Plan of Washington Cascade Select Silver	$297.47	Ambetter Cascade Select Silver	$301.16
7	Community Health Plan of Washington Cascade Select Silver	$325.32	Ambetter Cascade Select Silver	$339.38
8	Community Health Plan of Washington Cascade Select Silver	$297.22	Ambetter Cascade Select Silver	$303.19
9	Ambetter Cascade Select Silver	$297.25	Ambetter Balanced Care 4	$298.04

C. SUBSIDY CALCULATION UNDER 1332 WAIVER

We calculate an estimate of the pass-through savings by comparing the statewide total of federal premium subsidy amounts paid under each respective scenario to the total statewide federal premium subsidy amount for the associated baseline scenario (i.e., pre-waiver versus post-waiver).[5] The subsidy calculation for each household is based on the second lowest cost Silver plan in each rating area[6] and federal poverty level based on reported household size, consistent with ACA regulations and CMS / Department of Treasury methodologies. Any policy lever changes that do not impact the second lowest cost Silver plan in a given area will not change the subsidy amount calculated; therefore, produces no pass-through-funding under a waiver.

Expanded federal premium subsidies became available under the American Rescue Plan Act (and were extended under the Inflation Reduction Act) to a larger portion of the individual-eligible population, resulting in significant increases in total subsidies paid. This includes increased subsidies for those already eligible, as well as expanded eligibility for those with income levels not previously eligible for subsidies. These expanded subsidies are currently scheduled to expire at the end of the 2025 plan year. The impact of either the extension or expiration of these subsidies on pass-through funding under a waiver is included in certain scenario comparisons in Section IV-D of this report.

[5] Pass-through savings are calculated as the difference in premium tax credits with offsets for any reductions in federal revenue or other increases in federal spending (deficit neutrality). These offsets are negligible and we ignore them with no material loss of accuracy.

[6] Actual subsidies are based on the county of residence. Using rating area does not diminish accuracy.

III. DESCRIPTION OF SCENARIOS

A. MODULAR POLICY SCENARIOS

We modeled the impact, in isolation, of each of the following policy levers as directed by the Exchange:

- Lowering the aggregate provider reimbursement cap, currently set at 160% of Medicare.
- Disaggregated provider reimbursement caps by the broad provider service categories of inpatient facility (IP), outpatient facility (OP) and non-primary care professional.[7]
- An increase to the allowable pricing loss ratio[8] for public option plans.

We present modeling results for several different scenarios as requested by the Exchange, from more aggressive to conservative, for each of the policy lever changes to produce a range of possible impacts. We modeled each of these isolated policy levers assuming ARPA subsidies will expire prior to 2026 and that there will be no changes to current carrier plan portfolios.

We did not model results assuming enhanced subsidies continue for the modular policy scenarios. Results are shown for the 2026 projected year. We note these scenarios are not recommendations of provider reimbursement caps or pricing loss ratio requirements, but rather illustrative examples to contextualize the changes associated with a range of assumptions under each policy lever.

B. POLICY COMBINATION SCENARIOS

We then modeled the combined impact of selected policy levers (aggregate or disaggregate provider reimbursement caps combined with a revised pricing loss ratio) as requested by the Exchange. We modeled three combination scenarios to produce a range of possible impacts resulting from more aggressive to more conservative policy changes. As noted above, these combined scenarios are not recommendations of specific provider reimbursement caps with pricing loss ratio requirements, but rather illustrative examples to contextualize the changes associated with a range of assumptions under the policy levers.

In addition to the combinations of policy levers noted above, we modeled results under two different assumptions related to ARPA subsidies: Expiration at the end of 2025 (current law) or extension into 2026. This produces the following framework variations within the three combination scenarios:

1. ARPA subsidies expire at the end of the 2025 plan year.
2. ARPA subsidies continue into the 2026 plan year.

[7] Inpatient facility includes the non-professional charges for hospitals and SNFs. Outpatient facility includes the non-professional charges for outpatient hospital claims, urgent care, outpatient surgical centers and other institutional charges for non-inpatient claims. Professional includes charges for professionals at inpatient and outpatient facilities, as well as office-based charges.

[8] A pricing loss ratio is defined as 1 minus the percentage built into premiums to cover administrative expenses and profit. For example, if the load for administration and profit combined is 12%, this implies a pricing loss ratio of 88%. A higher pricing loss ratio implies lower charges for administration and profit, as well as lower premium rates, all else equal.

All modeled scenarios are summarized in Table 3 below.

Table 3
Washington Health Benefit Exchange
1332 Waiver Actuarial Analysis
Scenarios

Scenario	Framework	Description of Provider Payment and / or Allowable Pricing Loss Ratio Requirements
Aggregate Provider Reimbursement		
1	No ARPA	136% Aggregate Cap
2	No ARPA	148% Aggregate Cap
3	No ARPA	158% Aggregate Cap
Disaggregate Provider Reimbursement		
4	No ARPA	150% Inpatient Cap
5	No ARPA	160% Outpatient Cap
6	No ARPA	160% Inpatient / 175% Outpatient Caps
7	No ARPA	125% Non-PC Physician Cap
Pricing Loss Ratio		
8	No ARPA	90% Pricing Loss Ratio
9	No ARPA	85% Pricing Loss Ratio
Combination		
10a	No ARPA	136% Aggregate Cap / 90% Pricing Loss Ratio
10b	ARPA	136% Aggregate Cap / 90% Pricing Loss Ratio
11a	No ARPA	160% IP / 175% OP / 150% Aggregate Cap / 88% Pricing Loss Ratio
11b	ARPA	160% IP / 175% OP / 150% Aggregate Cap / 88% Pricing Loss Ratio
12a	No ARPA	155% Aggregate Cap / 85% Pricing Loss Ratio
12b	ARPA	155% Aggregate Cap / 85% Pricing Loss Ratio

Each scenario is compared to a baseline which varies based on the continuance of ARPA subsidies.

Policy lever changes will result in three primary impacts: lower public option gross premiums, changes in the second lowest cost Silver plans in most regions and resulting pass-through funding under a 1332 Waiver. We assume policy levers are applied or required only for public option plans, and therefore, assume all other plans are unaffected and that carriers do not make any incremental changes to pricing in response to any of the policy levers being implemented. We discuss the implications of these modeling assumptions in subsequent sections of this report.

Each assumption used in our scenarios is developed independently based on our best estimates; however, actual experience relative to each assumption will most likely differ to varying degrees. Furthermore, the amount of time between this analysis and the potential policy lever changes in 2026 introduces additional variability to the projected impact on enrollment and costs because it extends the duration of the projection and the opportunity for unforeseen events.

We apply a 15% reduction to the pass-through funding estimates to reflect cumulative conservatism across all assumptions. The potential variances between the estimates of pass-through funding calculated herein and actual pass-through funding include, but are not limited to, enrollment volume and distribution by age and metal level, carrier competitive actions, public option availability and actual selection and enrollment by consumers, regulatory changes, utilization and cost trend, and member agency.

In addition, the 15% reduction incorporates more conservatism than similar waiver analyses due to:

- The nature of the enforcement levers on actions that drive pass-through funding.
- Participation of both providers and carriers in public option networks and offerings, respectively.
- The ability of public option carriers to meet the proposed requirements in practice.

- The use of aggregate, state-wide assumptions on reimbursement reductions as opposed to local, provider specific assumptions. Data and time constraints prevent this level of detailed analysis.

Additional details about the data sources, methodology, and assumptions used to model each of these scenarios are provided in Section V of this report.

ARPA Enrollment and Morbidity

CMS open enrollment information does not show a significant difference in the age distribution between pre-ARPA (2020) and emerging 2023 enrollment in the state of Washington. Additionally, the Exchange's findings[9] on the impact of expanded ARPA subsidies indicated overall age demographics changed only slightly despite a significant growth in the number of total covered enrollees. Milliman's internal data supports these findings, and we reviewed internal research about the impact to market morbidity resulting from the population shifts due to ARPA subsidy expiration. Morbidity is not expected to change so we applied no additional adjustment to claims.

We define morbidity net of demographics, such that a younger population alone does not indicate lower morbidity when compared to an older population. This is consistent with the CMS definition in the most recent exchange filing instructions, which defines morbidity, "Where all demographic (e.g., age, gender, and region) and product mix, and all provider network contracts and time parameters (i.e., trends = 0) are held constant on the population."[10]

[9] PHE Special Enrollment and American Rescue Plan Implementation Snapshot Feb 15-August 15, 2021
[10] https://www.cms.gov/files/document/urr-py23-instructions.pdf

IV. ACTUARIAL ANALYSIS

This section details the results of the actuarial analysis by modeling the impact of policy lever changes. Table 3 in Section III above provides detailed scenario descriptions. We present the results from Scenarios 1 through 9 first to show the isolated impacts. We then discuss the results of the actuarial analysis from two perspectives:

- Provider impact related to provider reimbursement changes.
- Carrier impact related to pricing loss ratio changes.

We then show the results from the combined policy lever modeling under the two different ARPA frameworks. Finally, we discuss important considerations when reviewing results.

As mentioned in Section III above, we present different scenarios for each of the policy lever changes to give a range of possible impacts resulting from more aggressive to more conservative policy changes as requested by the Exchange. The ranges presented are not exhaustive of the policy lever options and it is possible actual experience may result in premium changes and pass-through funding savings outside these ranges.

Each scenario is compared to a baseline which varies based on the continuance of ARPA enhanced subsidies. Both baselines assume that the current 1332 Waiver will remain in effect for the 2026 plan year with no changes. Modeling directly focuses on the impact to public option plan premiums, since we assume potential policy levers will be enforceable to these plans alone. The modeling in any one scenario takes the following general approach when projecting the 2026 market:

- Apply the parameters of the policy lever to public option plans only and recalculate the premiums for all public option plans and membership.
- Review revised Silver plan premiums in each rating area and redetermine the second lowest cost Silver plan upon which to base subsidies.
- Recalculate the subsidy for each member based on the revised second lowest cost Silver plan premium.
- Sum up the total revised subsidies in the market and compare to the baseline scenario with no policy levers enacted to determine the pass-through savings.

A. MODULAR IMPACT

Aggregate Provider Reimbursement

We adjusted the percent of Medicare provider reimbursement levels for public option plans only to determine the premium impact of aggregate provider reimbursement changes. We derived the baseline percent of Medicare provider reimbursement amounts based on a combination of the RAND reports provided by the Exchange reflecting data from 2018 through 2021 and internal Milliman research from the Milliman *Health Cost Guidelines*™ *(HCGs)* specific to the state of Washington commercial market. Section V-B describes the provider reimbursement sources and considerations in additional detail. The starting assumptions of 168% inpatient / 192% outpatient / 141% non-PC physician provider reimbursements for public option plans are uniformly decreased to determine the impact of changing the current 160% provider reimbursement amount. We maintain the primary care physician provider reimbursement as 135%, consistent with current legislation designating this as the floor for primary care physicians. We also maintain the minimum 101% of cost for critical access hospitals. We assumed no changes associated with prescription drug contracting, as the current 160% of Medicare provider reimbursement requirement is associated with medical (non-prescription drug) claims only.

We take the following steps in order to value the impact of this change on public option plan premium levels:

- We first determined incurred claims for each plan using the 2024 Unified Rate Review Template (URRT) as a starting point, which contains projected 2024 claims information for all carriers by plan associated with their 2024 rate filings.
- We segregated the incurred claims into service categories, i.e., inpatient, outpatient, physician (PCP and other), and prescription drug using a combination of URRT and internal Milliman research information.

- We scaled the service category claims using the percent of Medicare provider reimbursement relativities to the baseline to determine the resulting claims under each scenario.

- We applied administrative expenses as a percent of premium of 19%, as discussed in the pricing loss ratio subsection below, to the baseline claims to determine the estimated administrative expense PMPMs for each plan. The 19% total administrative expenses is comprised of 2.5% percent of premium for taxes and fees and 16.5% for general administrative expenses (inclusive of commissions, quality improvement, reinsurance, etc.), and profit and risk margin.

- We added the general administrative expense PMPMs to incurred claims PMPMs for the baseline percent of Medicare provider reimbursement and each provider reimbursement scenario and then apply the 2.5% of premium for taxes and fees to determine premium PMPMs by plan. We used a constant administrative expense PMPM amount for general administrative expenses and not a percent of premium amount under each scenario, with the assumption that each carrier has administrative expense requirements that may not be met under a percent of premium allocation (said another way, we did not assume a carrier could reduce administrative expenses as result of reductions in provider reimbursement relative to the baseline scenario).

- The reduction in premium PMPM by plan is calculated as the ratio of each scenario premium PMPM to the baseline premium PMPM.

- The reductions are applied to all public option plans by rating area to determine the impact to the second lowest cost Silver plan, which determines the impact to subsidies. We apply an additional 15% reduction to the pass-through funding estimates to reflect cumulative conservatism across all assumptions.

Table 4 shows the impact on public option premium rates and associated pass-through funding savings of changing the aggregate provider reimbursement assumption for public option plans from the current 160% of Medicare to 136%, 148%, and 158% of Medicare. These scenarios assume the expiration of ARPA enhanced subsidies at the end of the 2025 plan year. Additional detail regarding the results can be found in the appendices.

Table 4
Washington Health Benefit Exchange
Premium Changes to Public Option Plans and Pass-Through Funding Savings
Reduced Aggregate Provider Reimbursement Cap

	Scenario 1	Scenario 2	Scenario 3
Current Cap	160% of Medicare Provider Reimbursement		
Scenario Assumption	136 % of Medicare	148 % of Medicare	158 % of Medicare
Public Option Premium Decrease	10.0%	5.0%	1.0%
Estimated Pass-Through Savings Relative to Baseline (000's)	$59,817	$29,389	$5,671

Disaggregate Provider Reimbursement

We varied the percent of Medicare provider reimbursement amounts for specific service categories for public option plans only to determine the premium impact of disaggregated provider reimbursement changes. The starting assumptions of 168% inpatient / 192% outpatient / 141% non-PC physician provider reimbursements for public option plans are decreased in isolation to determine the impact of changing the current 160% provider reimbursement amount. We maintain the primary care physician provider reimbursement as 135%, consistent with current legislation designating this as the floor for primary care physicians. We also maintain the minimum 101% of cost for critical access hospitals.

The premium change development is consistent with the steps outlined in the Aggregate Provider Reimbursement subsection above, with only the percent of Medicare provider reimbursement inputs changing as defined in the scenario descriptions.

Table 5 shows the impact on public option premium rates and associated pass-through funding savings of decreasing the provider reimbursement assumption for public option plans from the current 168% inpatient / 192% outpatient / 141% non-PC physician provider reimbursements, which reflect a composite medical provider reimbursement of 160% prior to any changes. These scenarios assume the expiration of ARPA enhanced subsidies at the end of the 2025 plan year. Additional detail regarding the results can be found in the appendices.

Table 5 Washington Health Benefit Exchange Premium Changes to Public Option Plans and Pass-Through Funding Savings Disaggregate Provider Reimbursement Cap				
	Scenario 4	**Scenario 5**	**Scenario 6**	**Scenario 7**
Starting Assumption	168% Inpatient / 192% Outpatient / 135% PCP / 141% Non-PC Physician			
Scenario Assumption	150% Inpatient	160% Outpatient	160% IP / 175% OP	125% Non-PC Physician
Public Option Premium Decrease	1.7%	4.2%	3.0%	2.3%
Estimated Pass-Through Savings Relative to Baseline (000's)	$9,720	$24,635	$17,678	$13,457

Allowable Pricing Loss Ratio

The pricing loss ratio is the implied percentage of premium assumed to be allocated to covering medical care and prescription drugs. One minus this ratio is then allocated to administrative costs and profit. Requirements for public option plans to be priced at a loss ratio higher than non-public option plans will, all else equal, limit the administration and profit charges on public option plans and reduce public option plan premiums.

We varied the pricing loss ratio assumption for public option plans only to determine the premium impact of pricing loss ratio changes. The starting assumption of an 81% current pricing loss ratio for each carrier is increased to determine the impact of various scenarios.

We determined the impact of this change to each public option plan's premium by taking the following steps:

- We first determined incurred claims for each plan using the 2024 URRT as a starting point, similar to the provider reimbursement scenarios.
- We applied administrative expenses as a percent of premium for each respective pricing loss ratio scenario to the baseline claims to determine the estimated administrative expense PMPMs for each plan.
- We added the administrative expense PMPMs for each pricing loss ratio scenario to the baseline incurred claims PMPMs to determine premium PMPMs by plan for each scenario.
- The reduction in premium PMPM by plan is calculated as the ratio of each scenario premium PMPM to the baseline premium PMPM.
- The reductions are applied to all public option plans by rating area to determine the impact to the second lowest cost Silver plan, which determines the impact to subsidies. We apply an additional 15% reduction to the pass-through funding estimates to reflect cumulative conservatism across all assumptions.

Table 6 shows the impact on public option premium rates and associated pass-through funding savings of changing the pricing loss ratio assumption for public option plans from the current 81%. We assume a pricing loss ratio of 81% for public option plans after reviewing filed pricing loss ratio information for Community Health Plan of Washington, Coordinated Care Corporation, and LifeWise Health Plan of Washington in the 2024 URRTs. These carriers show pricing loss ratios specific to their public options plans of 82.1%, 78.4%, and 81.6%, respectively, in total across all metal levels. These scenarios assume the expiration of ARPA enhanced subsidies at the end of the 2025 plan year. Additional detail regarding the results can be found in the appendices.

We note that for this testing, pricing loss ratio is defined as incurred claims over the sum of premium and risk transfer. This definition places limitations on expense and profit loads for public option plans that will occur through the rate review process.

Table 6 Washington Health Benefit Exchange Premium Changes to Public Option Plans and Pass-Through Funding Savings Pricing Loss Ratio		
	Scenario 8	**Scenario 9**
Starting Assumption	81% Pricing Loss Ratio	
Scenario Assumption	90% Pricing Loss Ratio	85% Pricing Loss Ratio
Public Option Premium Decrease	10.0%	4.7%
Estimated Pass-Through Savings Relative to Baseline (000's)	$59,877	$27,680

B. PROVIDER IMPACT

The impact to providers in the modular portion of this analysis is limited to the provider reimbursement scenario, with the pricing loss ratio scenario having no direct impact on provider revenue. The aggregate provider reimbursement scenarios impact hospital and non-PC physicians by similar factors, while the disaggregate provider reimbursement scenarios impact targeted combinations of inpatient, outpatient, and non-PC physician. Provider reimbursement impacts for each scenario are calculated as the ratio of each respective service category to the baseline. These impacts are shown in Table 7.

Table 7 Washington Health Benefit Exchange Aggregate and Disaggregate Percent of Medicare Scenarios Changes to Provider Reimbursement Caps					
Scenario	**Inpatient**	**Outpatient**	**PCP**	**Non-PC Physician**	**Total Medical**
Percent of Medicare Provider Reimbursements					
Baseline	168%	192%	135%	141%	160%
1	141%	161%	135%	117%	136%
2	155%	177%	135%	129%	148%
3	166%	189%	135%	138%	158%
4	150%	192%	135%	141%	156%
5	168%	160%	135%	141%	151%
6	160%	175%	135%	141%	153%
7	168%	192%	135%	125%	154%
Change in Percent of Medicare Provider Reimbursements from Baseline					
1	-16.4%	-16.4%	0.0%	-16.4%	-14.8%
2	-8.2%	-8.2%	0.0%	-8.2%	-7.4%
3	-1.6%	-1.6%	0.0%	-1.6%	-1.4%
4	-10.9%	0.0%	0.0%	0.0%	-2.4%
5	0.0%	-16.9%	0.0%	0.0%	-5.6%
6	-5.0%	-9.1%	0.0%	0.0%	-4.1%
7	0.0%	0.0%	0.0%	-11.1%	-3.9%

These provider reimbursement impacts are limited to public option plans only. Public option plan enrollment represents approximately 14% of the Washington on-exchange ACA individual market in 2023. The on-exchange ACA individual market had approximately 270,000 unique members enrolled at some point in 2023, though this number greatly varied by month depending on Medicaid redeterminations and month of enrollment. As of 2021, Washington was estimated to have 93.5% of the population insured and as of 2023 the Washington Office of Financial Management estimated a population of 7.95 million people. Consequently, the on-exchange market represents about 4% of the total insured population in the state of Washington, and public option enrollment currently represents about a half a percent.

C. CARRIER IMPACT

The impact to carriers in the modular portion of this analysis spans the provider reimbursement and pricing loss ratio scenarios, but the pricing loss ratio scenario, in particular, will impact overall carrier revenue. The provider reimbursement scenario will impact each public option carrier's premium development in that their starting claims assumption[11] will be lower due to improved contracting from the public option provider reimbursement requirements, resulting in the lower public option premiums discussed above. Carrier impacts for each pricing loss ratio scenario are:

- Scenario 8: A decrease in administrative expenses of 9% of premium (approximately $47 PMPM when considering 2024 filed premium information for public option plans).
- Scenario 9: A decrease in administrative expenses of 4% of premium (approximately $21 PMPM when considering 2024 filed premium information for public option plans).

ACA regulations necessitate a certain portion of administrative expenses contribute to federal and state taxes and fees. In Washington for the 2024 plan year, these consist of a 2.00% state premium tax, a $3.00 PMPM state exchange fee, and a $0.27 PMPM federal Patient Centered Outcomes Research Institute (PCORI) fee. Under the 90% pricing loss ratio scenario, this requires approximately one quarter of a carrier's allowable administrative expenses to be attributable to these federal and state taxes and fees.

As noted above, these allowable pricing loss ratio scenarios are not recommendations and may be difficult for carriers to achieve. Restricting administrative expenses could also cause unintended consequences, such as less funding available for utilization and care management services, which has the potential for increases in projected claims. We do not include these potential impacts in the results of this analysis.

We note that in practice, the pricing loss ratio scenario will likely impact each carrier differently as not every carrier will start from the same administrative expense assumptions. These pricing loss ratio impacts are limited to public option plans only within the ACA individual market, which currently impacts three carriers. Public option plan enrollment represents approximately 100%, 28%, and 25% of the total 2023 on-exchange ACA individual market for Community Health Plan of Washington, Coordinated Care Corporation, and LifeWise Health Plan of Washington, respectively. Additionally, it is possible that carriers that do not offer a public option plan will choose to reduce administrative expenses in order to remain competitive, resulting in a secondary impact to all carriers in the state.

D. COMBINED IMPACT

For providers and carriers to share the financial responsibility created when lowering public option premiums, it will require a combination of lowering the provider reimbursement cap in some fashion with an increase to the allowable pricing loss ratio. We model three scenarios that combine selected policy levers (aggregate or disaggregate provider reimbursement combined with pricing loss ratio) as chosen by the Exchange to display a range of possible impacts.

Substantial uncertainty exists surrounding the continuation of ARPA subsides past their 2025 expiration date, so we model each scenario in a framework both with and without extended ARPA subsidies, comparing pass-through savings to a comparable ARPA versus no ARPA continuation baseline.

In developing these scenarios, the premium change development is consistent with the steps outlined in the Aggregate and Disaggregate Provider Reimbursement subsections above, up until the calculation and application of the administrative expenses. At that point we take the following steps:

- We applied administrative expenses as a percent of premium for each respective pricing loss ratio scenario to the recalculated provider reimbursement claims to determine the premium PMPMs for each plan.
- The reduction in premium PMPM by plan is calculated as the ratio of each scenario premium PMPM to the baseline premium PMPM.
- The reductions are applied to all public option plans by rating area to determine the impact to the second lowest cost Silver plan, which determines the impact to subsidies. We apply an additional 15% reduction to the pass-through funding estimates to reflect cumulative conservatism across all assumptions.

[11] The ACA is required to use the combined claims experience of the entire risk pool (the single risk pool requirement). However, the ACA allows for plan level adjustments to account for network configurations. The public option plans would assume lower starting claims through the use of this factor.

Table 8 shows the impact on public option premium rates and associated pass-through funding savings of changing the aggregate provider reimbursement assumption for public option plans from the current 160% of Medicare to 136% combined with changing the pricing loss ratio assumption for public option plans from the current 81% to 90%.

Table 8 Washington Health Benefit Exchange Premium Changes by Scenario – Public Option Plans Scenario 10 - Combined 136% of Medicare and 90% Pricing Loss Ratio Caps		
Framework	**10a**	**10b**
ARPA Subsidies Continue Through 2026?	**No**	**Yes**
Current Aggregate Provider Reimbursement Cap	160% of Medicare Provider Reimbursement	
Starting Pricing Loss Ratio Assumption	81% Pricing Loss Ratio	
Scenario Aggregate Provider Reimbursement Assumption	136 % of Medicare	
Scenario Pricing Loss Ratio Assumption	90% Pricing Loss Ratio	
Public Option Premium Decrease	20.8%	20.8%
Estimated Pass-Through Savings Relative to Baseline (000's)	$131,500	$197,802

Table 9 shows the impact on public option premium rates and associated pass-through funding savings of changing the current 168% inpatient / 192% outpatient provider reimbursements to 160% inpatient / 175% outpatient and then changing the non-PC physician provider reimbursements in order to meet a 150% aggregate, combined with changing the pricing loss ratio assumption for public option plans from the current 81% to 88%. Please note, in order to meet the 150% of Medicare aggregate provider reimbursement, this requires changing non-PC physician from 141% to 131%.

Table 9 Washington Health Benefit Exchange Premium Changes by Scenario – Public Option Plans Scenario 11 - Combined 150% of Medicare with 160% Inpatient / 175% Outpatient and 88% Pricing Loss Ratio Caps		
Framework	**11a**	**11b**
ARPA Subsidies Continue Through 2026?	**No**	**Yes**
Current Aggregate Provider Reimbursement Cap	160% of Medicare Provider Reimbursement	
Current Provider Reimbursements	168% Inpatient / 192% Outpatient / 135% PCP / 141% non-PC Physician	
Scenario Provider Reimbursement Assumption by Service Category	160% Inpatient / 175% Outpatient / 135% PCP / 131% non-PC Physician	
Scenario Aggregate Provider Reimbursement Assumption	150 % of Medicare	
Scenario Pricing Loss Ratio Assumption	88% Pricing Loss Ratio	
Public Option Premium Decrease	12.9%	12.9%
Estimated Pass-Through Savings Relative to Baseline (000's)	$79,199	$119,139

Table 10 shows the impact on public option premium rates and associated pass-through funding savings of changing the aggregate provider reimbursement assumption for public option plans from the current 160% of Medicare to 155% combined with changing the pricing loss ratio assumption for public option plans from the current 81% to 85%.

Table 10 Washington Health Benefit Exchange Premium Changes by Scenario – Public Option Plans Scenario 12 - Combined 155% of Medicare and 85% Pricing Loss Ratio Caps		
Framework	**12a**	**12b**
ARPA Subsidies Continue Through 2026?	**No**	**Yes**
Current Aggregate Provider Reimbursement Cap	160% of Medicare Provider Reimbursement	
Starting Pricing Loss Ratio Assumption	81% Pricing Loss Ratio	
Scenario Aggregate Provider Reimbursement Assumption	155 % of Medicare	
Scenario Pricing Loss Ratio Assumption	85% Pricing Loss Ratio	
Public Option Premium Decrease	6.9%	6.9%
Estimated Pass-Through Savings Relative to Baseline (000's)	$40,862	$61,324

E. CONSIDERATIONS

We note these results are dependent on several assumptions that are highly uncertain, including but not limited to: filed rate increases by plan from 2024 to 2026, the steps taken by carriers to negotiate lower provider reimbursements, carrier entrants or exits between 2024 and 2026, enrollment shifting between 2024 and 2026 (including but not limited to between carriers, between metal levels, and between Cascade Select versus Cascade versus non-Cascade), and legislative changes impacting subsidies or other plan attributes. We discuss the implications of these considerations in further detail below.

Premium Rate Relativities and Competitive Positioning

The results of this analysis are based on 2024 premium positioning, which includes the determination of the second lowest cost Silver plan. Furthermore, while this analysis is based on 2024 rates, the census is based on 2023 enrollment. Competitive positioning between carriers has already shifted between 2023 (the basis of the census) and 2024 (the basis of the premiums). It is not possible to predict how consumers will react when open enrollment begins. These premium relativities and membership by plan and carrier will almost certainly change by the 2026 plan year. As new information becomes available, the results of this analysis are subject to change.

It is possible carriers will attempt to make changes to their non-public option plans based on these policy changes to offset lower administrative expenses under the pricing loss ratio policy change or that non-public option carriers will reduce administrative expenses to remain competitive. We do not model changes to non-public option plans, which could have an impact on enrollment and ultimately the pass-through funding calculated in this analysis.

Provider Reimbursement Negotiations

Provider reimbursement reductions will impact premiums in some areas more than others. The data underlying this analysis does not have the information necessary to take existing differences between provider reimbursements at the rating area or county level into account, nor does it consider which facilities and providers have the most opportunity for cost reduction. Each carrier will likely take different rate actions at the rating area level to meet statewide provider reimbursement targets, and it is difficult to predict how carrier and provider negotiations will impact any one area in particular.

Additionally, the hospital participation requirements in the current public option statute will likely contribute to differences in rate action by carrier by rating area. Hospitals must contract with at least one public option plan, but are not required to do so with all public option carriers.

The provider reimbursements assumed for public option plans are estimates. To the degree that these estimates differ from actual provider reimbursements, this will impact the premium changes and subsequently the pass-through funding. These estimates may differ from actual provider reimbursements due to the methodology for the determination of the Medicare reimbursement amounts for public option plans, among other reasons. The current methodology[12] is subject to ongoing updates as needed to support changes in carrier payment and Medicare reimbursement policies. Starting reimbursement assumptions are based on available reports and information at this time. Recent developing public option reimbursement experience may have since changed, but current resources[13] indicate that a starting aggregate

[12] https://www.hca.wa.gov/assets/program/RFA%202020HCA1-Appendix%204.pdf

[13] https://www.hca.wa.gov/assets/program/cascade-select-leg-report-20221216.pdf

reimbursement of 160% is reasonable. We apply an additional 15% reduction to the pass-through funding estimates to reflect cumulative conservatism across all assumptions.

Furthermore, since we assume no changes associated with prescription drug contracting, prescription drugs remain a large portion of claims with no modeled policy changes.

Second Lowest Cost Silver

Subsidy calculations are driven by the second lowest cost Silver plan in any given rating area. Plan relativities by rating area are essential to the Exchange's goal of widespread public option access as the second lowest Silver plan. Table 11 shows the current 2024 lowest and second lowest Silver plans by rating area. In rating areas 2, 3, and 9, where the public option plan is not the second lowest cost Silver plan in 2024, we show the ratio of the second lowest cost Silver plan to the next available public option plan. In order to achieve an increase in pass-through funding for these areas, public option plans need to be reduced by 8.7%, 32.0%, and 1.4%, respectively.

Table 11
Washington Health Benefit Exchange
2024 Silver Plans by Area

Rating Area	Lowest Cost Silver (LCS)	Second Lowest Cost Silver (SLCS)	SLCS Difference from Next Public Option Plan
Rating Area 1	Community Health Plan of Washington Cascade Select Silver	Ambetter Cascade Select Silver	N/A
Rating Area 2	Ambetter Cascade Select Silver	Ambetter Balanced Care 4	-8.7%
Rating Area 3	Ambetter Cascade Select Silver	Ambetter Balanced Care 4	-32.0%
Rating Area 4	Community Health Plan of Washington Cascade Select Silver	Ambetter Cascade Select Silver	N/A
Rating Area 5	Community Health Plan of Washington Cascade Select Silver	Ambetter Cascade Select Silver	N/A
Rating Area 6	Community Health Plan of Washington Cascade Select Silver	Ambetter Cascade Select Silver	N/A
Rating Area 7	Community Health Plan of Washington Cascade Select Silver	Ambetter Cascade Select Silver	N/A
Rating Area 8	Community Health Plan of Washington Cascade Select Silver	Ambetter Cascade Select Silver	N/A
Rating Area 9	Ambetter Cascade Select Silver	Ambetter Balanced Care 4	-1.4%

In the modular results shown in Section IV-A above, we show the decrease in premium to Cascade Select plans. In the baseline scenario that these results compare to (no ARPA subsidies), as seen in the Table above, a Cascade Select plan is the lowest and second lowest cost Silver in rating areas 1 and 4 through 8, meaning that the premium decreases shown also translate to the decrease in the second lowest cost Silver plan. However, rating areas 2, 3, and 9 have a non-standardized plan as the second lowest cost Silver plan. Ultimately, savings in pass-through funding is tied to the movement of the second lowest cost Silver plan premium. As a result, not all rating areas will be able to achieve the second lowest cost Silver public option plan without significant legislative changes, which may not be feasible.

Carrier Consistency

We assumed no changes in the Washington exchange carriers between 2024 and 2026. This includes consistency in the three carriers offering public option plans (Community Health Plan of Washington, Coordinated Care Corporation, and LifeWise Health Plan of Washington). Any new entrants or withdrawals could have a significant impact on the results of this analysis.

Enrollment

We have not modeled significant changes in enrollment by plan or metal level resulting from the proposed policy changes in each scenario. We modeled enrollment changes as detailed above for the ARPA scenarios, but these are not a direct result of the premium impact resulting from any of the scenarios. Shifts in public option premiums are also applied to Gold and Bronze public option plans, but we do not model any membership shifts between metal tiers as a

result of the premium changes. Any membership shift between plans and metallic distribution shifts will impact the overall pass-through funding savings greatly.

Legislative Changes

We assumed there will be no significant legislative changes to Cascade Care between the 2024 and 2026 plan years, with the exception of the modeled scenarios discussed above. Any additional changes may impact enrollment, administrative expenses, subsidies, or other items that could have a material impact on premium and pass-through funding.

Enforcement Levers

Any provider reimbursement or allowable pricing loss ratio changes will require enforcement levers to ensure premium reductions are realized and pass-through savings result under the amended waiver. These enforcement levers are critical to both realizing the pass-through savings and the Exchange's ability to attribute future savings to the recommended policies.

In discussions with the Exchange, various enforcement levers were discussed, but no final course of action is contemplated or recommended at this time. Most if not all would require statutory and / or regulatory changes. The possible levers include but are not limited to:

- Carrier reporting requirements.
  - Standardized reporting requirements will help ensure consistency across carriers when calculating pass-through savings and provide the Exchange with the necessary information to attribute these savings to the waiver policies.
- Hospital and provider group participation requirements. The Health Care Authority currently manages hospital participation enforcement.
  - Current legislation requires a given hospital to contract with only one public option carrier. Expanding this participation requirement would assist carriers in meeting the provider reimbursement caps discussed in this report, which are highly dependent on each carrier's ability to lower their current inpatient and outpatient facility percent of Medicare provider reimbursement contracts.
  - Requiring all providers within the system to be in-network would increase carrier ability to lower current provider reimbursement contracts.
- Strengthen public option contract requirements. The Health Care Authority currently manages contracts for public option carriers.
  - Require carrier contracts with providers to prohibit all or nothing contracting, anti-tiering or anti-steering, most favored nation clause, and gag clauses.
  - Require carrier contract to include a low value / wasteful care discount with providers.
  - Require carrier contract with PBM to follow NASHP / WA purchasing consortia model (pass thru rebates; transparent pricing; etc.).
  - Require carrier contract to limit physician administration fee for biosimilars to a flat rate or percent of lowest cost biosimilar.
  - Require all carriers participating in other State programs (Medicaid, PEBB, SEBB) to submit proposals to offer public option plan, with no requirement for HCA to award contract.
- Public option premium requirements.
  - Mandating public options plans to be the lowest and second lowest cost Silver plans in any given county would give the Exchange more control over future pass-through savings due to subsidy calculations being based on the second lowest cost Silver plan by county.

  - This would require enhanced Exchange authority in their certification of QHPs to be able to certify only plans that meet these requirements.

- Allowable pricing loss ratio requirements.

  - Mandating the pricing loss ratio minimum for public option plans would require enforcement from the Office of the Insurance Commissioner, and requires additional consideration in regard to the definition of pricing loss ratio. We define the pricing loss ratio in this report as incurred claims over the sum of premium and risk transfer, and this definition places limitations on expense and profit loads for public option plans that could occur through the rate review process in conjunction with the active procurement process of Health Care Authority. In addition, any needed legislation will need to be clear about this definition and take into consideration carrier strategies to achieve the pricing loss ratio requirements.

V. DATA AND METHODOLOGY

A. DATA SOURCES AND ADJUSTMENTS

Health Care Coverage and Enrollment

The Exchange provided 2022 and 2023 enrollment data as of August 2023 along with membership expected through the remainder of 2023. The Exchange data included the following elements:

- Member start and end date
- Date of birth and age
- Plan information (carrier, plan name, metal level)
- Health Insurance Oversight System (HIOS) issuer identifier
- Premium
- Advanced premium tax credit (APTC) amount
- Net Premium after APTC
- Federal Poverty Level (FPL Percentage)
- FPL group size
- Income in total and per member
- Zip code
- County
- Cascade Care and Cascade Care Select Identifiers

We reviewed the Exchange data for reasonableness and compared against publicly available sources. We summarized the key fields by various cohorts to gauge the overall reasonableness of the data.

Publicly Available Data

- Open enrollment PUFs
- Benefits and cost-sharing PUFs
- American Community Survey (ACS)
- National Health Expenditures (NHE) projections
- Commercial medical loss ratio form data submitted to CMS

Provider Reimbursement Information

- Proprietary Milliman Research and Models including the Milliman *HCGs*
- RAND research information on prices paid for hospital services provided to enrollees covered by the Exchange as provided by the Exchange

Other

- 2022 through 2024 filing information, including recently finalized 2024 URRTs and premium rates
- 2022 through 2024 second lowest cost Silver plan by county
- 2023 Medicaid redetermination counts by month
- 2023 to 2024 plan mapping information
- Washington 1332 public option background information and studies

B. ASSUMPTIONS

Public Option Carriers

2024 rate filing data provided by the Exchange shows three carriers offering public option plans: Community Health Plan of Washington, Coordinated Care Corporation, and LifeWise Health Plan of Washington. We assume there will be no additional public option entrants and no withdrawals between the 2024 and 2026 plan years.

Percent of Medicare Provider Reimbursements

We derive the baseline percent of Medicare provider reimbursement amounts based on a combination of the RAND reports provided by the Exchange reflecting data from 2018 through 2021 and internal Milliman research from the *HCGs* specific to the state of Washington commercial market. These combined sources result in the following percent of Medicare assumptions by provider service category:

- Non-public option: 186% inpatient / 212% outpatient / 135% primary care physician / 155% non-PC physician / 175% in aggregate.
- Public option: 168% inpatient / 192% outpatient / 135% primary care physician / 141% non-PC physician / 160% in aggregate.

Aggregate provider reimbursements are composited using estimated Medicare allowed totals by service category developed from internal Milliman research from the *HCGs* specific to the state of Washington commercial market.

The provider reimbursements assumed for public option plans are estimates. The data underlying these estimates is limited to the sources available for the purposes of this analysis and does not include the data the Health Care Authority's Milliman contractor receives from public option carriers. As a result, these estimates may differ from actual experience. Recent developing public option reimbursement experience may have since changed, but current resources[14] indicate that a starting aggregate reimbursement of 160% is reasonable.

Allowable Pricing Loss Ratio

We utilize 2024 incurred claims as reported in the 2024 URRTs provided by the Exchange as the starting point for the pricing loss ratio changes to public option plans.

We assume a pricing loss ratio of 81% for public option plans after reviewing filed pricing loss ratio information for Community Health Plan of Washington, Coordinated Care Corporation, and LifeWise Health Plan of Washington in the 2024 URRTs. These carriers show pricing loss ratios specific to their public options plans of 82.1%, 78.4%, and 81.6%, respectively, in total across all metal levels.

For the purposes of this testing, pricing loss ratio is defined as incurred claims over the sum of premium and risk transfer. This definition places limitations on expense and profit loads for public option plans that will occur through the rate review process. We note the definition of pricing loss ratio in any proposed legislation will be important to determining the premium impact into this scenario, as the federal minimum medical loss ratio including quality improvement adjustments will likely be higher than the 81% used in this analysis.

Enrollment and Demographics

The Exchange's 2023 census data is the basis for the starting enrollment and demographic information (age, rating area, FPL, metal and plan distribution) in this analysis.

We make the following adjustments to the 2023 enrollment data when projecting forward to the 2026 plan year:

- Population increases by year that are aligned with US Census data specific to the state of Washington.
- Enrollment increases for ongoing Medicaid redetermination, which vary by FPL.
- Enrollment decreases for the current expiration of expanded ARPA subsidies in 2026, which vary by FPL. These decreases are applied only in appropriate baselines and scenarios, and therefore, assume no membership decrease is assumed in the framework where ARPA subsidies continue in 2026.
- We evaluate changes to enrollment based on mapping information and guidelines provided by the Exchange.

We assume a consistent distribution of members by age and rating area in 2024 and beyond as compared to the 2023 census data provided by the Exchange in all scenarios. We reviewed internal research about the impact to market morbidity resulting from the population shifts due to ARPA subsidy expiration and Medicaid redetermination and applied no additional adjustment to claims.

[14] https://www.hca.wa.gov/assets/program/cascade-select-leg-report-20221216.pdf

Projected Premium

We base projected 2026 premium rates on filed 2024 premium rates provided by the Exchange for this analysis, trended at 5.0% annually. We assume all plan relativities are unchanged between final filed 2024 premium rates and projected 2026 premium rates, meaning all premium increases of 5.0% will be consistent across plans and carriers with the exception of public option plan changes as modeled in this analysis. As such, results are highly susceptible to uncertainly due to future rate action taken by each respective carrier.

Additionally, we model no changes in benefits to any existing plans, assuming that cost sharing does not change from 2024 to 2026. Reductions are likely to occur though we would assume all issuers make similar changes over time.

Subsidies

We develop subsidies using publicly available federal subsidy parameters. We use the 2023 FPL level for 2024 plan selection trended at 2.5% per year thereafter. Income and household levels come directly from the Exchange's 2023 census data. We do not take Washington state subsidies into account.

C. METHODOLOGY

We summarize the 2023 enrollment and 2024 premium information to create baselines, grouped by metallic, rating area, age band, FPL, and contract size to produce approximately 35,000 modeled cells. We establish two baselines for scenario comparisons dependent on whether or not ARPA subsidies are assumed to continue in 2026 or expire:

- ARPA extension subsidies expire at the end of the 2025 plan year.
- ARPA extension subsidies continue into the 2026 plan year.

This means that Scenarios 1 through 9, 10a, 11a, and 12a all compare to a baseline with no policy levers enacted and no ARPA subsidies in 2026, while Scenarios 10b, 11b, and 12b compare to a baseline with no policy levers enacted and ARPA subsidies extended into 2026. Both baselines assume that the current 1332 Waiver will remain in effect for the 2026 plan year with no changes.

When performing the modeling of the isolated policy levers as shown in Section IV-A above, we use only the first ARPA expiration framework listed above. When combining policy levers as shown in Section IV-D, we model two listed frameworks as shown in Section III.

We shift plan membership as described in the Enrollment and Demographics Assumption section above.

We calculate subsidies based on the member's selected premium, premium of the second lowest cost Silver plan available, household FPL, and current premium limits depending on if ARPA subsidies are assumed to continue or not. We project enrollment and premium changes through 2026 depending on if ARPA subsidies are assumed to continue or not.

In each ARPA subsidy framework, we calculate revised subsidies and premiums for each model cell and year based on that scenario's provider reimbursement and pricing loss ratio parameters. The difference between the total subsidies in each scenario is compared to the corresponding baseline framework to calculate the additional estimated pass-through funding. Actual pass-through funding calculations consider additional fiscal impacts of the policy and whether or not those impacts reduce federal revenues or increase federal expenses. These secondary federal fiscal impacts are beyond the scope of this report and not included in the calculation of pass-through funding.

Aggregate Provider Reimbursement

We adjust the percent of Medicare provider reimbursement levels for public option plans only to determine the premium impact of the aggregate provider reimbursement scenario. The starting assumptions of 168% inpatient / 192% outpatient / 141% non-PC physician provider reimbursements for public option plans are uniformly decreased to determine the impact of changing the current 160% provider reimbursement amount. We maintain the primary care physician provider reimbursement as 135%, consistent with current legislation designating this as the floor for primary care physicians.

We take the following steps in order to value the impact of this change on public option plan premium levels:

- We first determine incurred claims for each plan using the 2024 URRT as a starting point.

- We segregate the incurred claims into service categories, i.e., inpatient, outpatient, physician (PCP and other), and prescription drug using a combination of URRT and internal Milliman research information.
- We scale the service category claims using the percent of Medicare provider reimbursement relativities to the baseline to determine the resulting claims under each scenario.
- We apply administrative expenses as a percent of premium of 19%, as discussed in the pricing loss ratio subsection below, to the baseline claims to determine the estimated administrative expense PMPMs for each plan. The 19% total administrative expenses is comprised of 2.5% percent of premium for taxes and fees and 16.5% for general administrative expenses and profit and risk margin.
- We add the general administrative expense PMPMs to incurred claims PMPMs for the baseline percent of Medicare provider reimbursement and each provider reimbursement scenario and then apply the 2.5% of premium for taxes and fees to determine premium PMPMs by plan. We use a constant administrative expense PMPM amount for general administrative expenses and not a percent of premium amount under each scenario, with the assumption that each carrier has administrative expense requirements that may not be met under a percent of premium allocation.
- The reduction in premium PMPM by plan is calculated as the ratio of each scenario premium PMPM to the baseline premium PMPM.
- The reductions are applied to all public option plans by rating area to determine the impact to the second lowest cost Silver plan, which determines the impact to subsidies. We apply an additional 15% reduction to the pass-through funding estimates to reflect cumulative conservatism across all assumptions.

Disaggregate Provider Reimbursements

We vary the percent of Medicare provider reimbursement amounts for specific service categories for public option plans only to determine the premium impact of the disaggregated provider reimbursement scenario. The starting assumptions of 168% inpatient / 192% outpatient / 141% non-PC physician provider reimbursements for public option plans are decreased in isolation to determine the impact of changing the current 160% provider reimbursement amount. We maintain the primary care physician provider reimbursement as 135%, consistent with current legislation designating this as the floor for primary care physicians.

The premium change development is consistent with the steps outlined in the Aggregate Provider Reimbursement subsection above, with only the percent of Medicare provider reimbursement inputs changing as defined in the scenario descriptions.

Allowable Pricing Loss Ratio

We vary the pricing loss ratio assumption for public option plans only to determine the premium impact of the pricing loss ratio scenario. The starting assumption of an 81% pricing loss ratio for each carrier, as discussed in the pricing loss ratio subsection of the Assumptions section above, is increased to determine the impact of various pricing loss ratio scenarios.

We determine the impact of this change to each public option plan's premium by taking the following steps:

- We first determine incurred claims for each plan using the 2024 URRT as a starting point, similar to the provider reimbursement scenarios.
- We apply administrative expenses as a percent of premium for each respective pricing loss ratio scenario to the baseline claims to determine the estimated administrative expense PMPMs for each plan.
- We add the administrative expense PMPMs for each pricing loss ratio scenario to the baseline incurred claims PMPMs to determine premium PMPMs by plan for each scenario.
- The reduction in premium PMPM by plan is calculated as the ratio of each scenario premium PMPM to the baseline premium PMPM.

- The reductions are applied to all public option plans by rating area to determine the impact to the second lowest cost Silver plan, which determines the impact to subsidies. We apply an additional 15% reduction to the pass-through funding estimates to reflect cumulative conservatism across all assumptions.

Provider Reimbursement and Allowable Pricing Loss Ratio Combined Scenarios

We vary the percent of Medicare provider reimbursement amounts and the pricing loss ratio assumption for public option plans only to determine the premium impact of the combined provider reimbursement and pricing loss ratio scenario. The starting assumptions of 168% inpatient / 192% outpatient / 141% non-PC physician provider reimbursements for public option plans are decreased to determine the impact of changing the current 160% provider reimbursement amount. We maintain the primary care physician provider reimbursement as 135%, consistent with current legislation designating this as the floor for primary care physicians.

The premium change development is consistent with the steps outlined in the Aggregate and Disaggregate Provider Reimbursement subsections above, up until the calculation and application of the administrative expenses. At that point we take the following steps:

- We apply administrative expenses as a percent of premium for each respective pricing loss ratio scenario to the recalculated provider reimbursement claims to determine the premium PMPMs for each plan.
- The reduction in premium PMPM by plan is calculated as the ratio of each scenario premium PMPM to the baseline premium PMPM.
- The reductions are applied to all public option plans by rating area to determine the impact to the second lowest cost Silver plan, which determines the impact to subsidies.

APPENDIX I

Appendix I
Washington Health Benefit Exchange
1332 Waiver Actuarial Analysis
Exchange Market Totals by Scenario

		Total			PMPM		
Scenario	Member Months	Enrollee Gross Premiums	Enrollee Net Premiums	APTC	Enrollee Gross Premiums	Enrollee Net Premiums	APTC
Baseline No ARPA	2,496,571	$1,707,281,462	$1,204,370,022	$502,911,440	$684	$482	$201
1	2,496,571	$1,687,769,230	$1,244,674,787	$443,094,443	$676	$499	$177
2	2,496,571	$1,697,525,346	$1,224,002,592	$473,522,754	$680	$490	$190
3	2,496,571	$1,705,377,830	$1,208,137,300	$497,240,529	$683	$484	$199
4	2,496,571	$1,704,026,077	$1,210,834,817	$493,191,259	$683	$485	$198
5	2,496,571	$1,699,098,099	$1,220,822,130	$478,275,968	$681	$489	$192
6	2,496,571	$1,701,398,438	$1,216,165,448	$485,232,990	$681	$487	$194
7	2,496,571	$1,702,792,999	$1,213,338,176	$489,454,823	$682	$486	$196
8	2,496,571	$1,687,751,488	$1,244,717,505	$443,033,984	$676	$499	$177
9	2,496,571	$1,698,090,886	$1,222,859,832	$475,231,054	$680	$490	$190
10a	2,496,571	$1,666,613,237	$1,295,201,612	$371,411,625	$668	$519	$149
11a	2,496,571	$1,682,080,087	$1,258,367,704	$423,712,383	$674	$504	$170
12a	2,496,571	$1,693,723,730	$1,231,673,889	$462,049,841	$678	$493	$185
Baseline ARPA	2,826,709	$1,937,400,380	$1,062,902,368	$874,498,012	$685	$376	$309
10b	2,826,709	$1,889,801,932	$1,213,105,520	$676,696,412	$669	$429	$239
11b	2,826,709	$1,907,904,469	$1,152,545,891	$755,358,578	$675	$408	$267
12b	2,826,709	$1,921,532,291	$1,108,358,193	$813,174,098	$680	$392	$288

APPENDIX II

Appendix II
Washington Health Benefit Exchange
1332 Waiver Actuarial Analysis
Differences from Baseline by Scenario

		Total			PMPM		
Scenario	Member Months	Enrollee Gross Premiums	Enrollee Net Premiums	APTC	Enrollee Gross Premiums	Enrollee Net Premiums	APTC
Baseline No ARPA	0	$0	$0	$0	$0	$0	$0
1	0	-$19,512,233	$40,304,765	-$59,816,997	-$8	$16	-$24
2	0	-$9,756,116	$19,632,569	-$29,388,686	-$4	$8	-$12
3	0	-$1,903,632	$3,767,278	-$5,670,911	-$1	$2	-$2
4	0	-$3,255,385	$6,464,795	-$9,720,181	-$1	$3	-$4
5	0	-$8,183,364	$16,452,108	-$24,635,472	-$3	$7	-$10
6	0	-$5,883,024	$11,795,426	-$17,678,450	-$2	$5	-$7
7	0	-$4,488,463	$8,968,153	-$13,456,617	-$2	$4	-$5
8	0	-$19,529,974	$40,347,483	-$59,877,456	-$8	$16	-$24
9	0	-$9,190,576	$18,489,810	-$27,680,386	-$4	$7	-$11
10a	0	-$40,668,226	$90,831,590	-$131,499,815	-$16	$36	-$53
11a	0	-$25,201,375	$53,997,682	-$79,199,057	-$10	$22	-$32
12a	0	-$13,557,733	$27,303,867	-$40,861,599	-$5	$11	-$16
Baseline ARPA	0	$0	$0	$0	$0	$0	$0
10b	0	-$47,598,448	$150,203,151	-$197,801,600	-$17	$53	-$70
11b	0	-$29,495,911	$89,643,523	-$119,139,434	-$10	$32	-$42
12b	0	-$15,868,089	$45,455,824	-$61,323,914	-$6	$16	-$22

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Appendix A: Waiver Policy Considerations

The current enacted Washington state budget requires Washington Health Benefit Exchange (Exchange) to submit to the Legislature an actuarial study of options for amending the existing 1332 Waiver to generate federal funding for Washington state. The amendment options must focus on methods that could be most readily leveraged in Washington and considers those being used in other state public option programs. This appendix provides details on affordability and 1332 Waiver policies that were considered but ultimately not included for further study and analysis by the Exchange's actuarial contractor. The reasoning varies by policy lever, but broadly, initiatives not considered viable for pursuit, and as such not included in the actuarial study, did not meet all of the following criteria:

- Align with Washington state's current health insurance affordability strategies;
- Have demonstrated lower premiums and/or are included in approved 1332 waivers in other states;
- Have a nexus to a waivable federal provision under the ACA; and
- Could demonstrably lower public option premiums, reduce federal spending on tax credits, and generate federal pass-through funding.

Waiver policy levers pursued in other states, and considered but not put forward to the actuarial study, included:

- The Basic Health Program;
- Reinsurance in the individual market as well as in a merged individual and small group market; and
- Mandating premium reductions. While the actuarial report studies premium reduction levers, it does not directly replicate policy levers used in other states' public option programs.

The considerations and rational behind not studying each policy lever is detailed below.

Basic Health Program

Under the Affordable Care Act (ACA), states have an option to submit a Section 1331 Waiver allowing them to implement a Basic Health Program (BHP). The BHP option was modeled after Washington's original BHP and envisioned as a mechanism to offer more affordable coverage and a smoother transition between Medicaid and commercial coverage for the population with incomes at or above 133% and up to 200% of the federal poverty level (FPL).

The BHP would do this by reallocating 95% of the federal funding that would be made available to eligible individuals between 133% and 200% FPL through the advance premium tax credit (APTC) and cost-sharing reductions (CSR) to the state to directly purchase coverage for that portion of the population rather than having those individuals shop and purchase coverage on their own through the Exchange. Minnesota and New York both have BHPs, which replaced pre-ACA coverage programs with dedicated funding sources that were leveraged to pay the state's share of program costs.

There are several factors for Washington to consider when contemplating a BHP option relative to other coverage expansion options — including cost of coverage, consumer experience, individual market disruption and implementation challenges. A core reason for implementation is its potential to improve affordability of coverage for low-income individuals and families by leveraging both state and federal funding. Washington is already on a path to improve affordability of coverage for a similar population through state-funded direct subsidies within the Cascade Care Savings program, and by selectively procuring lower-cost, high-quality plans through the Cascade Select public option program. In addition, the Cascade Care approach allows consumers to utilize their full APTC toward premium costs while the BHP captures only 95% of estimated APTC for eligible individuals within the income and residency status requirements.

Another area for consideration of the BHP is the potential for improving the consumer experience by providing a higher degree of continuity between Medicaid coverage and BHP coverage (which must be similar to Medicaid coverage) than would be experienced when moving to a qualified health plan (QHP). However, similar continuity could be achieved by aligning the Cascade Select public option plans with the Washington Apple Health (Medicaid) program. Further, expanding coverage through Cascade Care preserves consumer choice more than a BHP approach, due to the requirement that individuals up to 200% of FPL are ineligible for QHP coverage under the BHP. Under Cascade Care, individuals can still receive federal subsidies even if they select a non-standard QHP.

Another crucial consideration is the potential costs to implement a BHP, as well as dedicated state funding to pay for operational and benefit costs not covered by federal funding. It is likely that a significant portion of this work would be net new to the state and not subject to Medicaid matching funds or BHP funding and thus require additional state funding. A final issue for consideration in evaluating the costs and benefits of adopting a BHP is the potential for market disruption. With a BHP, eligible individuals would be wholly removed from the individual market, which could result in higher QHP rates. Alternatively, under Cascade Care, potentially more individuals would enter the individual market as premium support lowers the cost to purchase coverage.

While the BHP option might offer a pathway to achieve some important goals for Washington's health care consumers, it was determined that the current path the state is on could be strengthened and enhanced to achieve the same goals for a larger swath of the population while not incurring additional state costs and potentially disrupting the current health care markets.

Individual Market Reinsurance

Reinsurance is a risk stabilization program utilized by many states to limit premium increases and to promote financial stability and predictability in markets impacted by high-cost and volatile claims activity. These programs are federal-state partnerships enabled and partially funded by the federal government through 1332 State Innovation Waiver pass-through funding.[1] States are required to contribute to the cost of these programs and do so through premium assessments, individual mandate revenues,[2] other fees, and general appropriations. All states that have implemented these programs have done so in the individual market only, except for Maine, which has extended the program to small employers through a merged individual and small group market.[3]

Reinsurance programs help mitigate uncertainty by providing a financial backstop to participating insurers by paying for some or all high-cost claims, defined through program design and the 1332 Waiver application as specific costly conditions, or aggregate claims exceeding a certain threshold and up to a ceiling. The conditions-based model pays for a specific set of conditions, either in total or partially. The claims-based model generally pays a portion of the eligible claims, known as the coinsurance rate, between the threshold, called the attachment point, and the ceiling, known as the cap. The insurer resumes paying the full cost of claims above the cap. Seventeen states[4] have approved 1332 Waivers for reinsurance; of those states, only Alaska and Idaho utilize the claims-based model.

In the individual market, reinsurance has the greatest impact on customers who are ineligible for the ACA premium tax credits and are therefore responsible for paying the full monthly price of their plan. These unsubsidized customers bear the full brunt of yearly premium increases, unlike subsidized customers who are shielded, in part or entirely, from paying premium increases because of the corresponding increase in tax credit value.

Washington considered reinsurance legislation in 2018, but it was not enacted due to concerns related to funding the state share of program costs. Generally, the federal and state contributions to reinsurance are split similarly to the percentage of individual market consumers receiving premium tax credits and those who are not. The federal funding is generated by how much the program will reduce premium tax credits, so the

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[1] CMS Section 1332: State Innovation Waivers. https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers

[2] Rhode Island has a state-based individual mandate requiring residents to have health insurance or pay a penalty on their state taxes. Individual mandate penalties fund the state's share of their 1332 state innovation waiver for reinsurance in the individual market.

[3] Federal Government Approves Maine's Plan to Improve Health Insurance for Small Businesses. https://www.maine.gov/governor/mills/news/federal-government-approves-maines-plan-improve-health-insurance-small-businesses-2022-07-15

[4] State Roles Using 1332 Health Waivers. https://www.ncsl.org/health/state-roles-using-1332-health-waivers

generosity is dependent on the number of consumers receiving tax credits. As a result of American Rescue Plan Act enhancements to the premium tax credits, the share of unsubsidized customers has decreased in recent years, which would likely decrease the state's share of the cost of a 1332 Waiver reinsurance program, although not to an immaterial amount. In addition, the impact of a reinsurance program is likely to have decreased as well, as there are fewer unsubsidized customers to reap the program benefits. Finally, federal pass-through funding to the state generated by reinsurance programs must be invested back into the program and it does not allow for flexibility investments in other state affordability programs.

Merged Market Reinsurance

Another reinsurance model, currently utilized by Maine, can be achieved by merging the individual and small group markets. Maine decided to merge the markets and pool the covered lives in the interest of long-term market stability and extending the benefits of reinsurance to small employers. Maine's 1332 Waiver generates pass-through funding by reducing federal spending on consumers qualified for premium tax credits which is used to pay for the federal share of the reinsurance program which in turn reduces premiums for individuals, families and small businesses.

While dependent on the size and relative risk profiles of each market, the general effect of pooling the markets is to lower premiums for individuals purchasing their health insurance directly while simultaneously increasing premiums for small employers, driven by the relatively healthier risk mix of the small group market. In plan year 2023, the first year of the pooled markets in Maine, the reinsurance program was projected to reduce premiums from what they would have been without the waiver by 8% for individuals and 6% for small employers.[5] The reinsurance program is funded through a combination of federal pass-through funding and state funding generated through a $4 per member per month assessment on fully insured and self-insured commercial health insurance markets. Total state funding allocated to the reinsurance program was $27 million in 2023.

While this approach could have a meaningful impact on the affordability of coverage in the small group market, there is still limited potential for improving affordability for subsidized individual market consumers as well as the required state investment to administer and maintain the program.

Mandated Premium Reductions

Since the Washington State Legislature created the nation's first public option program, two other states have enacted legislation creating public option plans. In 2023, Colorado launched public option plans in the individual and small group markets and Nevada has

[5] Maine: State Innovation Waiver – Amendment. https://www.cms.gov/files/document/1332-me-amendment-fact-sheet.pdf

enacted legislation creating a public option that will be implemented on their exchange in 2026. However, these states differ from Washington in their approach to achieving cost savings by mandating premium reductions from insurers, whereas Cascade Select's cost savings are created by an aggregate cap on provider reimbursement levels.

Colorado's public option plan, known as the Colorado Option,[6] is designed to improve access and affordability, and reduce racial health disparities for consumers in the individual and small group markets through standard plan and premium reduction requirements. Starting in 2023, in any county in which insurers offer individual or small group plans, they are required to offer the public option plans and decrease premiums by 15% over three years (5% each year) from a 2021 baseline. In addition, these public option plans must adhere to standard plan designs which limit out of pocket spending and barriers to care. Colorado's 1332 Waiver combines the public option premium reductions with a reinsurance program to generate pass-through funding to support the funding of reinsurance as well as the state subsidy program.[7] The waiver generated $245 million in pass-through funding in 2023.[8]

Nevada enacted legislation in 2021 to create a public option plan on the state-based exchange by 2026 to improve affordability and access to quality health plans for individuals and families purchasing health insurance in the individual market. The legislation mandated premiums be reduced by 15% over four years from a 2024 reference price[9] and allowed the state to direct Medicaid managed care organizations to propose a good faith offer of a public option plan achieving these premium reductions.[10] The legislation authorized the state to submit a 1332 State Innovation Waiver to implement the program and to use pass-through funds generated by the public option premium reductions to further reduce consumer affordability barriers.

The initial waiver application is due Jan. 1, 2024, and the current Governor and his administration recently announced a change in strategy and approach. They plan to leverage the public option-created pass-through funding to fund a market stabilization program to bring "… greater stability to Nevada's individual market for health insurance

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[6] Colorado Option 2023 Standard Plans. https://drive.google.com/file/d/1HcCxoBi76XCHEwVN3O3qKbPUa6vdkFAk/view

[7] https://content.naic.org/sites/default/files/national_meeting/Colorado%27s%201332%20Waiver%20Amendment_NAIC.pdf

[8] CMS Colorado 1332 Pass-through Funding Final Letter. https://www.cms.gov/files/document/1332-co-2023-ptf-final-letter.pdf

[9] Defined as "…the average second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity."

[10] Fact Sheet - Nevada Public Option. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Resources/PublicOption/NV%20Public%20Option%20Fact%20Sheet%2010-14-2022.pdf

by reinvesting 1332 Waiver funds back into the marketplace and provider system."[11] As proposed, the marketplace stabilization program will create and fund:

- A reinsurance program in the individual market;
- A quality incentive program to reward insurers offering the public option who meet quality and access measures and to prevent cost-shifting the financial burden of the premium reduction requirements to providers; and
- A provider workforce loan repayment and scholarship program to grow the health care workforce in Nevada.

Actuarial analysis studying this change in 1332 Waiver approach has not been released.

A mandated premium reduction approach was not selected for further study in this report because of concerns related to being able to clearly define and attribute pass-through funding in the 1332 Waiver application. Centers for Medicare & Medicaid Services (CMS) has made it clear that savings not directly attributable to the policy lever in the 1332 Waiver will not count toward pass-through allocations. Since mandated premium reductions can force or induce other market behaviors, such as non-public option premium decreases, parsing directly attributable from indirectly attributable could be challenging with such an approach. Reducing premiums through other levers, such as limiting an insurer's administrative expenses and profit, or by directly reducing provider reimbursement levels was determined to be a cleaner, and easier to isolate mechanism for generating pass-through funding.

[11] Transforming the Nevada Public Option into a Market Stabilization Program. https://mynews4.com/resources/pdf/9c151416-b1b1-4f75-b70a-0a5bf5364c50-GovernorJoeLombardoAnnouncesPlantoTransformtheNevadaPublicOptionintoMarketStabilizationProgram_Memo.pdf