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WA OIC Final Report on Health Care Affordability

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Prepared By
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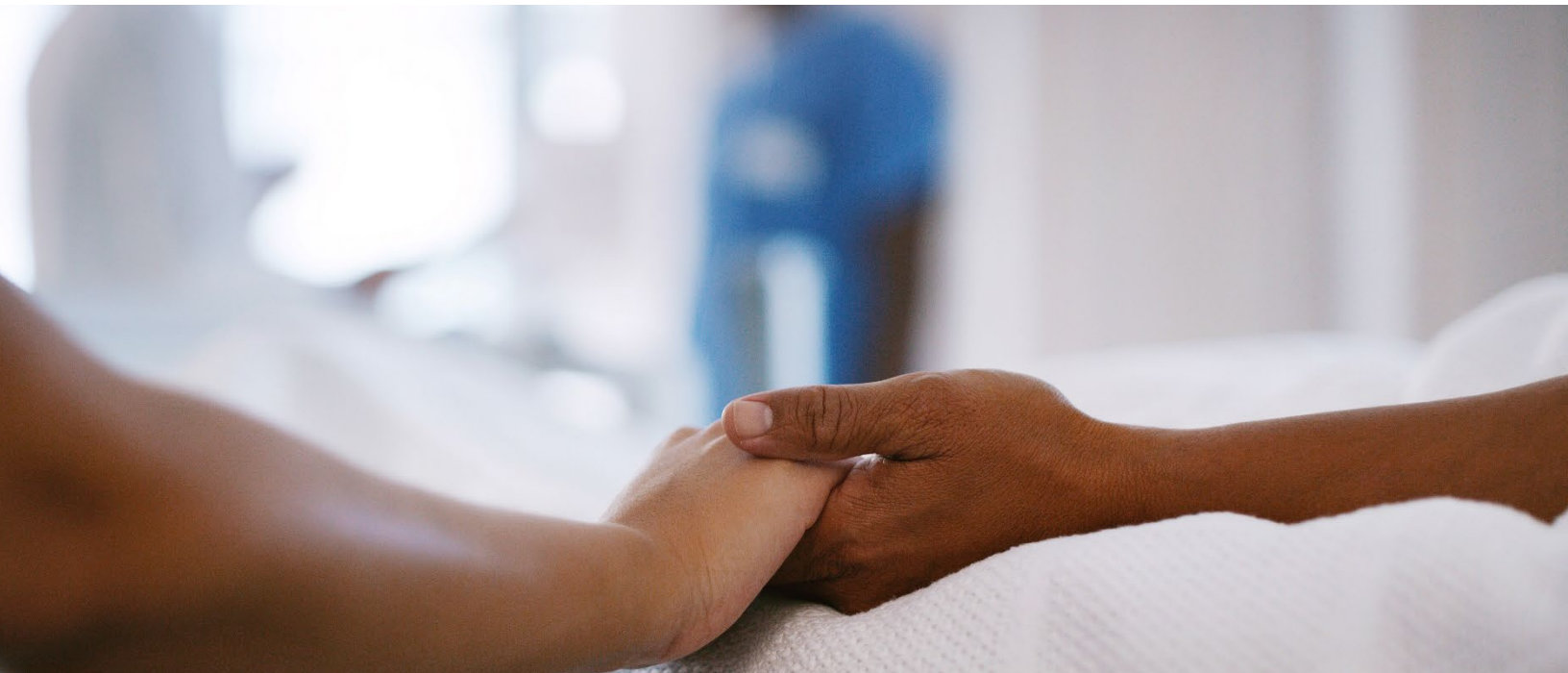

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EXECUTIVE SUMMARY

Historical health care costs in Washington have been growing at a rate higher than the benchmarks set by the Washington State Health Care Cost Transparency Board (HCCT Board).[1] This report examines five policy approaches that, if adopted, could reduce the growth in health care costs. It provides an actuarial analysis of the potential savings that four of the policies could yield. In addition, it includes economic modeling that estimates how the reductions in health insurance premiums or health care spending from all five policies would affect Washington's labor market and tax revenues.

The five policy options examined in this report are as follows:

1. **Establish a reinsurance program in the individual and small group markets.** Reinsurance programs help reduce uncertainty for insurers by paying some or all high-cost claims, based on either specific costly health conditions or individual or aggregate claim costs. The claims-based model, which all but two states with reinsurance programs use, generally pays a portion of the cost for eligible claims between a dollar threshold (i.e., the attachment point) and a dollar ceiling, known as the cap. The insurer pays all claims costs above the cap. Reinsurance affects the individual and small group markets and primarily benefits consumers who are ineligible for subsidies to help them pay for insurance. Compared with other policies, reinsurance is relatively simple to implement; however, it requires state funding and a federal waiver from the Centers for Medicare & Medicaid Services (CMS) to obtain appropriate federal funding. It has no direct effect on the prices paid for medical services.

2. **Increase the medical loss ratio (MLR) standard.** The Affordable Care Act (ACA) requires fully insured commercial market health insurers to spend a minimum amount of the premium dollars they collect on medical care or quality improvement activities. The policy option examined in this report would increase this requirement from the current levels set in the ACA—80 percent for the individual and small group markets and 85 percent for the large group market[2]—to 88 percent for all three markets. Increasing the medical loss ratio would be relatively simple to implement compared with other policy options and would apply to all fully insured employer plans and individual health plans.

[1] Washington State Health Care Authority, Health Care Spending Growth in Washington, 2017–2019: Health Care Cost Transparency Board's health care spending growth benchmark baseline brief (2023). Available at www.hca.wa.gov/assets/program/spending-growth-benchmark-report-2017-2019.pdf.

[2] The analysis considered the application of various policy options to different markets of the health care coverage space. The following markets were considered and are referenced throughout the report:

- Individual market: ACA-compliant direct purchase individual plans sold on Washington Health Benefits Exchange and outside of the exchange.
- Small group market: ACA-compliant plans for employers with 2−50 employees; the MLR policy option also includes transitional small group plans in this category.
- Fully insured large group market: The large group market includes employer-sponsored fully insured plans for employers with more than 51 employees.
- Self-funded PEBB and SEBB: These are large group self-funded plans that cover public and school employees (Public Employees Benefits Board [PEBB] and School Employees Benefits Board [SEBB]).

Nonetheless, because most health insurers in Washington already have MLRs near, at, or above 88 percent, the potential health care cost savings are relatively modest. Increasing the medical loss ratio (MLR) does not directly affect the prices paid for medical services; in fact, one way a health insurer could meet the increased MLR requirements would be to pay health care providers higher rates for their services.

3. **Use reference-based pricing (RBP).** Reference-based pricing ties the prices for a set of health care services, such as hospital care, to defined pricing levels, such as a percentage of Medicare reimbursement rates. The percentage chosen becomes the reference rate paid for health care services. Reference-based pricing directly affects the prices paid for health care services and therefore addresses the underlying cost of those services. If the policy implemented caps the rates health insurers may pay for health care services, the policy will affect fully insured large group employer plans, individual health plans, small group health plans, and self-funded PEBB and SEBB plans (i.e., the uniform medical plan).

   This report examines the impact of setting a cap at 160 percent of Medicare reimbursement rates. Reference-based pricing could be implemented by capping what health care facilities and providers can charge. If the policy were to cap health care facility and provider charges, it could affect prices paid in the entire market, including self-funded employer plans. Reference prices also may be set at different levels for different services, making it possible to increase rates for services that the state wants to make more accessible, such as mental health, substance use disorder (SUD), and primary care services.

   This analysis finds that reference-based pricing could yield significant cost savings, but the estimates vary depending on the data and assumptions used. Designing, implementing, monitoring, and enforcing reference-based pricing is complex and would require significant state resources. A precedent for reference-based pricing has been set in Washington State specific to the Cascade Care Select (public option) program. Oregon recently adopted reference-based pricing for its public employee and teacher plans, which has produced significant savings for those plans.[3] Oregon's hospital reference-based pricing program excludes critical access and sole community hospitals.

[3] Murray RC, Whaley CM, Fuse Brown, Ryan AM. How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan. Milbank Memorial Fund. July 10, 2024. Available at: https://www.milbank.org/publications/how-payment-caps-can-reduce-hospital-prices-and-spending-lessons-from-the-oregon-state-employee-plan/#:~:text=The%20State%20of%20Oregon%20passed,out%2Dof%2Dnetwork%20prices.

4. **Hospital global budgeting (HGB).** Under hospital global budgeting, hospitals receive a prospectively determined, fixed amount for all inpatient and outpatient services provided to a patient population in any given year. Hospital global budgets are designed to incentivize hospitals to shift away from practices that increase the volume and intensity of services provided, as traditional fee-for-service reimbursement may encourage, and instead adopt measures that prevent the need for expensive care and increase efficiency. This report estimates the impact of setting budgets that limit the growth in hospital revenue to the benchmarks set by the HCCT Board. The report's estimates assume a mandatory program in which all acute care hospitals (other than critical access, psychiatric, rehabilitation, and children's hospitals) participate.

   Hospital global budgeting directly affects the revenue that hospitals receive and has the potential to reduce the underlying cost of health care by managing its growth. Unlike other policy options, hospital global budgets would affect all Washingtonians rather than only individuals in certain health insurance markets. However, designing, implementing, monitoring, and enforcing global budgets is a complex task. It would take a significant amount of time and resources to put into place. In addition, obtaining the necessary Medicare and Medicaid waivers from CMS would require substantial resources and time, and there is no guarantee that CMS would grant them.

5. **Meeting the HCCT Board cost growth benchmarks.** This report estimates the economic impact of health care cost growth meeting the benchmarks established by the HCCT Board. Achieving those benchmarks would reduce the cost of health care for consumers, businesses, and the state. Under current law, Washington relies on voluntary measures taken by participants in the health care system to reduce the growth in health care costs to meet the benchmarks. This report examines policies that could increase the likelihood of the benchmarks being met.

As noted in the preliminary report, health care affordability is a challenge that pervades all types of health insurance coverage and would likely require an overlapping set of policies to address underlying costs while maintaining access to quality care. This report explains how each of these policies could be implemented in Washington, an estimate of health care savings that could be achieved if implemented, and an estimate of the impact on the state's economy that could result from these savings. It also discusses the feasibility of adopting these policies given the financial, regulatory, and operational challenges involved.

Figure 1 describes the sources of health care coverage now available to Washingtonians. Table 1 outlines, for each policy option, the health insurance markets that would be affected and the number of people estimated to benefit from the savings that would be achieved.

Figure 1: Washington's Health Insurance Markets

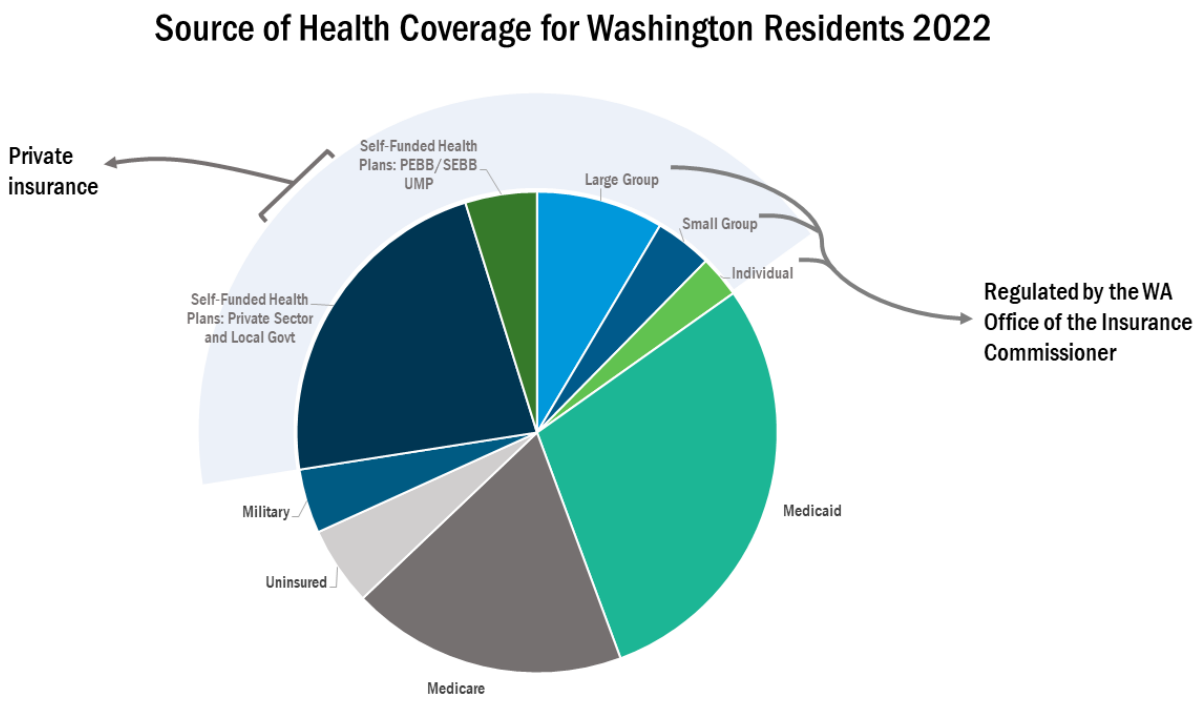


Table 1: Summary of Markets and Populations Affected by Policy Options

	Reinsurance	Medical Loss Ratio	Reference Based Pricing	Hospital Global Budgeting	HCCT Board Benchmark
Medicare/Medicaid				X	X
Individual market (unsubsidized)	X	X	X	X	X
Small group market	X	X	X	X	X
Fully insured large group market		X	X	X	X
Self-funded large group market			X (if implemented through regulation of facility/provider pricing)	X	X
Targeted population size[4]	292,000 to 344,700	1,551,000 to 1,614,000	Commercial population (4,300,000[5])	Entire state	Entire state

Tables 2A−5A summarize the results of the actuarial analysis performed to estimate the savings for 2025−2029, and Tables 2B−5B and Table 6 show the results of the economic model, estimating the impact of these cost savings on the broader Washington economy. The results are presented as a range based on assumptions made when conducting the analyses and modeling.

[4] Target population includes subsidized enrollees who, though they would not directly benefit from gross premium reductions, would be affected by the policies.

[5] The 4.3 million estimate is an approximation of the entire commercial market (both fully insured and self-insured people) using 2022 CPS (US Census) data. Theoretically, a reference pricing model could target either a segment of the commercial market (i.e., PEBB/SEBB) or any provider-commercial market relationship (i.e., the entire commercial market). The table represents the full potential of the reference-based model without CMS waivers. The ability to affect the whole market, including self-funded plans, depends on whether the program limits the amounts health insurers can pay in claims or limits the prices health care providers may charge. Absent requirements on providers, the effects would be limited to the fully insured market and state-directed plans. Wakely modeled the impact of a reference-based pricing policy on the data available in the Washington All Claims Database—primarily individual market, small group, large group, and PEBB/SEBBB data.

1. Establish a reinsurance program in the individual and small group markets

Table 2A shows the impact of implementing a reinsurance policy designed to achieve a 10 percent reduction in premiums in the individual and small group markets.

Table 2A: 10 Percent Reinsurance Impact in CY2025–2029

Impact Metric	Individual Market	Small Group Market
Average premium reduction (average per year)	$650–$879	$636–$802
Increased enrollment	1.3%–1.9%	0.5%–0.9%
State funding needed (in millions)	$42–$84	$147–$294

Table 2B shows the impact on the Washington labor market among small group employers as a result of the savings achieved through a reinsurance program.

Table 2B: Total Impact of Labor Market Effects[6] from a 10% Reduction in Premiums due to Reinsurance in 2025–2029 (Millions USD)

Total Impact of Labor Market Effects on Part Time & Full Time Employees	Total Impact After Taxes[7]	Total Impact Including Multiplier Effect [8]
$1,686	$1,306	$2,375

[6] Total impact of labor market effects refers to the combined impact of wage pass-throughs, employee transitions from part-time to full time, additional employment, and effect on households. For more information, see the report and Appendix B.

[7] Total effect after taxes is the total impact of the market on full-time and part-time employees after taxes. For details, see the report and Appendix B.

[8] The multiplier effect refers to the phenomenon in which an initial injection of spending leads to a larger increase in overall economic activity because the initial spending generates additional income and spending throughout the economy. Before calculating the multiplier effect, we accounted for the fact that employees will save some of their new earnings. We used a savings rate of 4.3 percent, which we chose because it is the average monthly savings rate for employed people in 2023 through April 2024. We did not use any numbers immediately before 2023 because COVID was still affecting those savings rates. The calculations are explained in more detail in the section on the economic impact of reinsurance, in Appendix B.

2. Increase the medical loss ratio standard

Table 3A shows the impact of increasing the MLR requirement in all commercial markets to 88 percent.

Table 3A: Impact of Increasing the MLR Requirement in 2025–2029

Impact Metric	Description
Premium Reduction	Individual Market: Up to 2.5% premium reduction, affecting 39% of enrollees purchasing coverage from health insurers with MLRs below 88% (2022) Small Group Market: Up to 2.4% premium reduction, affecting 88% of the enrollees purchasing coverage with MLRs below 88% (2022) Large Group Market: Up to 0.9% premium reduction
Increased enrollment	Individual Market: Up to 0.5% increase Small Group Market: Up to 1.0% increase Large Group Market: Up to 0.3% increase
Washingtonians Impacted	Individual Market: 189,000 to 252,000* Small Group Market: 303,000 to 304,000* Large Group Fully Insured Market: 1.06 to 1.07 million* *After the implementation of 88% MLR

Table 3B shows the effect on the labor market because of the aggregate reductions in health insurance premiums resulting from an increased MLR requirement in small and large group markets.

Table 3B: Total Impact of Labor Effects from MLR Implementation for 2025–2029 (Millions USD)

Total Impact of Labor Market Effects on Part Time & Full Time Employees	Total Impact After Taxes	Total Impact Including Multiplier Effect
$1,156	$895.2	$1,628

3. Reference-based pricing

Table 4A summarizes the range of effects of implementing reference-based pricing.

Table 4A: Summary of Impact of Reference-Based Pricing in 2027

Impact Metric	Description
Cost savings	3% to 19% reduction in medical spending
Enrollment impact	Higher Enrollment (exact enrollment change dependent on size and scope of program)
Washingtonians affected	Up to entire commercial market (4.3 million), depending on how the program is designed

Table 4B shows the impact on the labor market as a result of the reduction in medical spending that would result from implementation of reference-based pricing. The table presents the total economic impact, including the multiplier effect.

Table 4B: Total Impact of Labor Market Effects from Reference-Based Pricing Set at 160% of Medicare for 2027 (Millions USD)

Total Impact of Labor Market Effects on Part Time & Full Time Employees	Total Impact After Taxes	Total Impact Including Multiplier Effect
$227.80	$176.43	$320.81

4. Hospital global budgeting

Table 5A summarizes the potential effects of hospital global budgeting in Washington. The policy analyzed is similar in scope to Maryland's hospital global budget program as it was designed and operated from 2014 to 2018. It encompasses revenue related to Medicare, Medicaid, and commercial lines of business. The specific policy and implementation decisions for hospital global budgeting will affect all facets of the program, including potential savings.

Table 5A: Summary of Impact of Hospital Global Budgeting in 2026–2029

Impact Metric	Description
Cost savings	0% to 7.1% reduction in hospital payments
Enrollment impact	Higher enrollment (exact enrollment change dependent on size and scope of program)
Washingtonians affected	All

Table 5B shows the impact on the Washington labor market of implementing hospital global budgets, with the potential effect varying depending on how the policy is designed and the extent of savings achieved.

Table 5B: Total Impact of Labor Market Effects from Hospital Global Budgeting over 2026–2029 (Millions USD)

Total Impact of Labor Market Effects on Part Time & Full Time Employees	Total Impact After Taxes	Total Impact Including Multiplier Effect
$4,370	$3,384	$6,154

5. Meeting the HCCT Board cost growth benchmarks

Though no actuarial analysis was conducted, an economic analysis was. Table 6 shows the impact on the Washington labor market if the cost growth benchmarks established by the HCCT Board are met as a result of enforcing the benchmarks or other policies or changes adopted.[9] The table presents the total economic impact, including the multiplier effect.

Table 6: Total Impact of Labor Market Effects from Benchmarks in 2025−2029 (Millions USD)

Total Impact of Labor Market Effects on Part Time & Full Time Employees	Total Impact After Taxes	Total Impact Including Multiplier Effect
$7,433	$5,757	$10,468

Wakely actuaries are responsible for the actuarial analysis of reinsurance, medical loss ratio, reference-based pricing, and hospital global budgeting, as described in this report. Appendix A summarizes the methodology, assumptions, and results of these analyses and complies with the applicable actuarial standards of practice. Jack Meyer, an independent health economist, performed the economic analysis. Appendix B describes the methodology used to model the broader economic impacts and the results of that modeling methodology.

[9] Changes to the health care delivery system that could reduce the growth in the cost of healthcare, such as adoption of alternative payment models, are beyond the scope of this report.

INTRODUCTION

Washington State employees and businesses have experienced double-digit health care cost increases over the last decade. From 2010 through 2020, the total average premium for a single worker rose by 49 percent, and the deductible rose by 78.5 percent.[10] From 2014 to 2024, average premiums for health plans purchased through the Washington Health Benefit Exchange more than doubled to $629 from $295 per month. An analysis of the commercial health insurance market commissioned by Washington's Office of the Insurance Commissioner (OIC) in 2022 showed that health care costs in the state increased by 13 percent, nearly double the rate of inflation (7%), between 2016 and 2019.

A survey of 1,300 Washingtonians in November 2022 found that 62 percent of respondents had experienced at least one health care affordability burden in the past year, including rationing medication, delaying or forgoing care, and depleting savings, and 81 percent worried about affording health care in the future.[11]

Two factors drive health care costs: 1) the type and number of services people use, and 2) the price paid for those services. Washington State policymakers have attempted to address these challenges, most recently through the Health Care Cost Transparency Board (HCCT Board), which has offered more transparency into why costs are increasing and created voluntary cost growth benchmarks. In addition, the state has adopted policies to lessen the impact of rising health care costs on consumers. Additional premium subsidies have helped make coverage more affordable for people who buy individual health plans on the Washington Health Benefit Exchange. The state legislature has passed laws limiting or prohibiting consumer cost-sharing—the portion of costs for covered services that consumers must pay out of pocket—for certain benefits in commercial health plans, such as insulin and EpiPens. Though many consumers have benefited from these policies, they have only an indirect impact on the prices charged for health care services. Excessive growth in spending persists. Cost growth benchmarks are unlikely to be met through transparency and voluntary actions alone.

In response to the growing and persistent health care affordability challenges for individuals, families, employers, and taxpayers, in 2023 the state legislature directed the OIC and the Attorney General's Office (AGO) to analyze further policy options, in addition to those already enacted, to improve affordability. Sec. 144(13)(a) of the 2023 biennial operating budget[12] directed the OIC and the AGO to prepare preliminary and final reports for the legislature. The first part of this analysis included two preliminary reports, one from the OIC and one from the AGO, released in December 2023. The OIC's preliminary report provided the following:

[10] Collins SR, Radley DC, Baumgartner JC. State Trends in Employer Premiums and Deductibles, 2010−2020. The Commonwealth Fund. January 12, 2022. Available at: https://www.commonwealthfund.org/publications/fund-reports/2022/jan/state-trends-employer-premiums-deductibles-2010-2020.

[11] Healthcare Value Hub. Washington Consumer Healthcare Experience State Survey. Arnold Ventures.

Available at: https://www.healthcarevaluehub.org/advocate-resources/washington-consumer-healthcare-experience-state-survey.

[12] State of Washington. Sec. 144(13)(a) of Engrossed Substitute Senate Bill 5187: Washington State 2023−2025 Biennial Operating Budget. Effective May 16, 2023. Available at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20231117085318.

- A detailed description of Washington's existing health insurance and care delivery structure, with a focus on vertical integration and horizonal consolidation among health insurers, hospitals, pharmacy benefit managers, and providers, and an overview of private equity health care investment trends in the state
- An overview of potential policy options to address underlying health care costs informed by experience in Washington and other states that have implemented the policies
- A description of the proposed economic model that is incorporated in this final report, along with actuarial analysis, to evaluate the effects of a select set of policy options

The AGO's companion report offered a detailed analysis of antitrust laws and policy options related to health care merger and acquisition oversight and provisions of health insurer/provider contracts that hurt market competition.

The OIC's preliminary report found that Washington's health care landscape has changed significantly because of horizontal consolidation and vertical integration across health care providers, facilities, pharmacy benefit managers, and insurers. In the last three decades, hospital resources and care in Washington have become more concentrated as hospitals have closed or become part of multi-hospital systems. Forty of the 101 Washington hospitals are affiliated with the five largest hospital systems in the state. Another 15 belong to smaller multi-hospital systems. Hence, these systems control a substantial portion of available beds and employ many hospital-based physicians in the state. More specifically:

- Eight multi-hospital systems provide more than 90 percent of licensed beds and more than 65 percent of staffed beds at hospitals in the state.
- Eight multi-hospital systems employ more than 65 percent of the physicians and physician assistants who have hospital-based practices in the state.
- Most multi-hospital systems own and operate hospital-affiliated clinics, as well as many freestanding clinics and other health care facilities.

At the same time, health insurers have integrated with several other sectors of the health care industry. The three largest pharmacy benefit managers (PBMs), which collectively account for 89 percent of the prescription drug market, are Express Scripts (part of the Cigna Group), CVS Caremark (part of CVS Health, which includes Aetna), and Optum Rx (part of UnitedHealth Group), consistent with national trends. Through their holding companies and subsidiaries, among the five insurers with the largest market share in Washington:

- Four own companies that provide pharmacy services (retail, specialty and/or pharmacy benefit managers).
- Four own and operate clinical facilities, including medical clinics, home health agencies, laboratory services, and other entities. All function as third-party administrators (TPAs) for self-funded employer health plans under administrative services only (ASO) contracts.

The preliminary report also described the growth of private equity ownership in the health care market. In 2014, four private equity acquisitions occurred. By 2023, the total number of acquisitions had grown to 97.

The information in the preliminary report on Washington State's care delivery structure was based upon examination of public information available at that time. Under current state law, Washington health systems or private equity firms are not required to report details of their financial structure or their owned or affiliated entities to the state. Access to this information would establish a better understanding of the current extent of consolidation, as well as trends in acquisitions or changes in corporate structure and affiliations. It also would provide an opportunity to assess the impact that legislative policy changes could have on health care affordability and access to services.

The preliminary report described several other policies that have the potential to improve health care affordability:

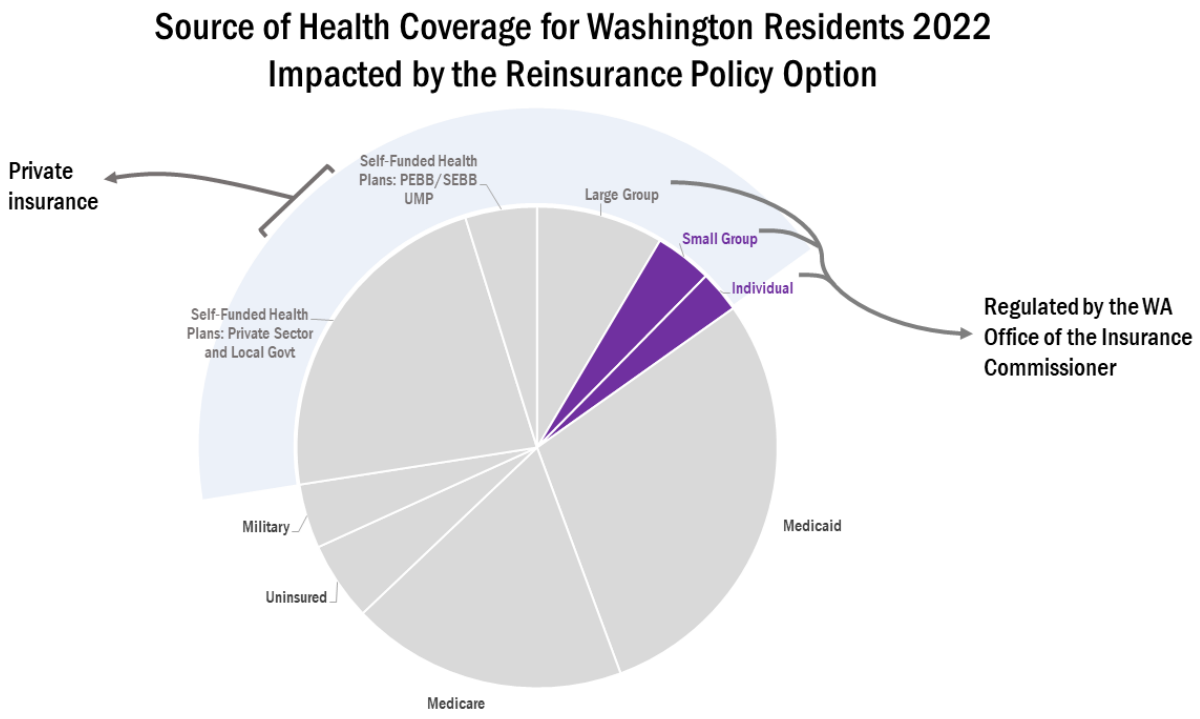
- Establish prescription drug pricing regulations
- Enhance health insurance rate review
- Establish a reinsurance program in the individual and small group markets
- Increase the medical loss ratio standard
- Use reference-based pricing
- Implement facility fee reform (e.g., site-neutral payment requirements)
- Offer public option health plans
- Implement additional premium subsidies through the Washington Health Benefit Exchange
- Enact a state individual mandate
- Create an all-payer model for hospital services, as in Maryland (referred to as "hospital global budgeting" in this report)

Following publication of the preliminary report, OIC staff consulted with state legislators, the Office of the Governor, the Office of Financial Management, the Health Care Authority, the Washington Health Benefit Exchange, and other key stakeholders to identify policies for further study through actuarial and economic analysis. The authorizing legislation required that hospital global budgeting be one of the policies further analyzed. Other policies were selected based on providing a mix of policy options that could affect different aspects of the health care system, including health insurers, hospitals, and providers and different health insurance markets (large and small employer, individual, self-insured plans including the Public Employees Benefits Board [PEBB] and School Employees Benefits Board [SEBB], and Medicaid). The choice of policy options also was influenced by whether full actuarial analysis was possible for a given policy. In addition to hospital global budgeting, the policies selected for further analysis include:

- Establish a reinsurance program in the individual and small group markets
- Increase the medical loss ratio standard
- Use reference-based pricing
- Evaluate cost savings that would result from meeting the HCCT Board expenditure growth targets.

This final report analyzes the potential of these policy options to reduce growth in health care costs, improve affordability for Washingtonians, and affect the state's economy. These policies address affordability in different ways. Establishing a reinsurance program or increasing health insurers' minimum required medical loss ratio would decrease premiums. Reference-based pricing would address the underlying cost of health care services by lowering payments to health care facilities and providers, and hospital global budgeting would slow the rate of growth in hospital costs. This report is intended to inform conversations centered on a path forward to address the persistent and growing challenges of health care affordability.

ESTABLISH A REINSURANCE PROGRAM IN THE INDIVIDUAL AND SMALL GROUP MARKETS



Background

Reinsurance is a risk stabilization program that many states use to limit the volatility of premium increases and to promote financial stability and predictability in the individual and small group markets, which tend to feel the effects of high-cost and volatile claims activity. These programs are federal-state partnerships enabled and partially funded by states and the federal government through 1332 state innovation waivers.[13] Reinsurance programs help mitigate uncertainty for insurers by paying for some or all high-cost claims, based upon either specific costly health conditions or aggregate claim costs.

[13] Per CMS's website, a Section 1332 State Innovation Waiver "permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA." https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers

Under the conditions-based model, claims for specific health conditions are paid in total or partially. The claims-based model, meanwhile, generally pays a portion of the eligible claims, known as the coinsurance rate, between the threshold (i.e., the attachment point) and the ceiling, known as the cap. The insurer is responsible for the full cost of claims that exceed the cap. At present, 17 states[14] have 1332 waivers for reinsurance; all but Alaska and Idaho use a claims-based model.[15]

In the individual market, reinsurance has the greatest impact on people who are ineligible for ACA premium tax credits and therefore are responsible for the full premium cost of their health plan. These unsubsidized consumers bear the full brunt of yearly premium increases, unlike subsidized consumers who are shielded, in part or entirely, from premium increases. The American Rescue Plan Act (ARPA) expanded federal premium subsidies[16] for consumers with higher income levels who previously were ineligible for subsidies; these expanded subsidies are due to expire at the end of 2025. In the small group market, both employers and employees might benefit from a reinsurance program through lower premium contributions, depending on the division of premium payments between the employer and its employees.

Reinsurance requires state funding, which in other states has come from the general fund, through an assessment on health insurers, or a combination of the two sources. The amount of state funding needed for a reinsurance program in the individual market can be reduced through a 1332 waiver that provides for federal pass-through funding equivalent to the savings to the federal government from the reduction in federal subsidies paid for coverage of enrollees on the exchange as provided in the ACA. Reinsurance for the small group market is significantly more expensive because of the lack of federal pass-through funding.

A claims-based reinsurance program can be designed in a variety of ways, with a range of different parameters. How the attachment point, coinsurance rate, and cap are set will determine the extent of the premium reduction and the funds needed to implement the program. States with reinsurance programs have used a range of attachment points (from $18,500 to $100,000), cap amounts (from $61,500 to $1 million), and coinsurance percentages (from 40% to 80%) to achieve premium reductions ranging from 5 percent to 30 percent.[17]

If Washington chooses to implement a reinsurance program, the parameters could be developed to match the targeted premium reduction and available funds. The following considerations are recommended:

- Ideally, coinsurance would be between 50 percent and 80 percent to incentivize health insurers to continue to manage the care of high-cost individuals.[18]

[14] Centers for Medicare & Medicaid Services. Data Brief on State Innovation Waivers: Section 1332 Waivers. *CCIIO Data Brief Series*. April 2024.Available at: https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf.

[15] The Preliminary Report, at p. 57, erroneously stated that only Alaska and Idaho use a claims-based model for their reinsurance programs; in fact, those states are the only two that do not.

[16] As part of the ARPA, premium tax credits were made more generous and expanded to new populations. The enhanced subsidies were initially scheduled to only be in effect for 2021 and 2022. The Inflation Reduction Act (IRA) extended these enhanced subsidies for three years until the end of 2025. For simplicity's sake the enhanced subsidies are referred to as ARPA expanded subsidies.

[17] Data Brief on State Innovation Waivers: Section 1332 Waivers.

[18] Given a set amount of funding available, a higher coinsurance amount will require a higher attachment point and/or a lower cap.

- A cap of no more than $1 million should be used to avoid overlap with the US Department of Health and Human Services (HHS) risk-adjustment methodology for high-cost pooling reimbursement, which has an effective attachment point of $1 million in 2025.[19]
- Insurers may have private reinsurance that should be considered to avoid overlap of private and state-funded reinsurance. Private reinsurance typically has relatively high attachment points, but any overlap should be confirmed before finalizing any parameters.

Actuarial Analysis of Implementing Reinsurance

The following analysis assumes adoption of a claims-based reinsurance program that targets a decrease in overall premiums of 10 percent compared with what they would be without the program. The impact of the administrative costs of running the program are not included in this analysis.[20] The results herein reflect changes solely resulting from a reduction in paid claims because a portion of those claims was paid through reinsurance. This report presents several funding options for this program. The specific parameters of the reinsurance program, such as attachment point, coinsurance rate, and cap, are excluded from these exhibits, as they could be designed in a variety of ways to achieve the goal of reducing premiums by 10 percent.

The 10 percent decrease in premiums associated with the introduction of the reinsurance program in individual and/or small group markets is expected to increase market enrollment, typically attracting healthier uninsured members. The analysis shows the estimated range of enrollment increases for each market.

The analysis also shows the range of total annual funding that would be needed to implement the program, broken down into the amount of Section 1332 waiver federal pass-through funding (see description of federal 1332 waivers below) that could be obtained and the range of state funding that would be needed. The range of the assessment on health insurance premiums that would be needed if the state chose to fund the program entirely through an assessment is also shown. These results are displayed in Table 7.

[19] Centers for Medicare & Medicaid Services. HHS Notice of Benefit and Payment Parameters for 2025, page 97. Available at: https://www.cms.gov/files/document/cms-9895-p-patient-protection-final.pdf.

[20] Federal pass-through funding may be used to pay for the administrative costs of running the program; this would cause the reduction in premiums to be less.

Table 7. Impact of Claims-Based Reinsurance Programs, 2025–2029

Impact Metric: Reduction of health care premiums in the individual and small group markets	**Description**: 10% reduction compared with baseline
Estimated Annual Cost	Individual Market: $153 million–$194 million Small Group Market: $147 million–$294 million
Estimated Pass-Through Funding	Individual Market: $94 million–$140 million, 56%–76% of total costs (due to reduction in federal premium subsidy payments)
Estimated Cost to State for Reinsurance Payments	Individual Market: $42 million–$84 million Small Group Market: $147 million–$294 million
Range of Funding Assessment on Fully Insured Markets	Individual Market: 0.4%–0.7% of fully insured premium Small Group Market: 1.2%–2.1% of fully insured premium
1332 Waiver Required?	Individual Market Only: Not required for a reinsurance program but recommended so the state can receive federal pass-through funding
Who Benefits?	Individual Market: Unsubsidized enrollees (middle-income) Small Group Market: All market enrollees statewide, on and off the Exchange
Market Enrollment Impacts	Individual Market: 1.3%–1.9% increase in enrollment Small Group Market: 0.5%–0.9% increase in enrollment
Washingtonians Affected	Individual Market: 192,000–289,000* Small Group Market: 215,000–279,000* *Total market size after the implementation of reinsurance.

Funding Needs

Total annual funding needed to implement a reinsurance program targeting a 10 percent decrease in premiums (approximately $750 to $1,200 per person per year) is estimated to range from $153 million to $194 million for the individual market and from $147 million to $294 million for the small group market. For the individual market, a portion of these funds may be obtained from the federal government through a Section 1332 waiver under the ACA.[21]

[21] Office of the Legislative Counsel. Patient Protection and Affordable Care Act Health-Related Portions of the Healthcare and Education Reconciliation Act of 2010. Sec. 1332.Waiver for State Innovation. US House of Representatives. May 2010. Available at: https://housedocs.house.gov/energycommerce/ppacacon.pdf.

This analysis estimates the funds needed to achieve an average statewide 10 percent reduction in premiums. It then estimates the amount of federal pass-through funding that the State might be eligible to receive because of savings in the cost of federal subsidies from implementation of the reinsurance program (see Table 8). For a full explanation of the methodology used to estimate reinsurance's impact on premiums, see Appendix A.

Table 8: High-Level Results of 10 Percent Reinsurance in the Individual Market, 2025–2026

Metric	2025 (ARPA[22])	2026 (No ARPA)
2025 Enrollment Without Reinsurance	251,000	188,000
2025 Enrollment Post Reinsurance	255,000	192,000
Total Premiums	$1,765,100,000	$1,555,300,000
Approximate Reinsurance Dollars Needed	$176,000,000	$153,000,000
Approximate Net Federal Savings	$134,100,000	$93,900,000
Approximate State Dollars Needed	$41,900,000	$59,100,000
Pass-Through Savings Percent	76%	61%

Several factors can vary the impact of funding needed for a reinsurance program as well as the pass-through savings that may be achieved. The following factors (all in the individual market) have the biggest impact:

- **Average Premium Per Member Per Month (PMPM) and Total Market Enrollment.** The overall estimated market premium amount (defined as average premium PMPM multiplied by total individual market enrollment) is the total premium expected for the market. The amount of funding required to lower premiums by a certain percentage is that percent multiplied by the total premium expected for the market. An increase in either the average premium PMPM or the total individual market enrollment would increase the total funding needed to reduce premiums by a set percentage.
- **Second Lowest Cost Silver Plan Premium (SLCSP).** The amount of advanced premium tax credits (APTCs) that the federal government pays as subsidies are tied to the SLCSP. Because savings in APTCs determine the amount of federal pass-through funds, the SLCSP premium impacts the amount of federal pass-through funds the State may receive. In particular, the relationship between the SLCSP premium and the overall market premium affects the possible amount of federal pass-through funds.

[22] The American Rescue Plan Act (ARPA) enhanced APTC subsidies beginning in April 2021, increasing the absolute amount of APTC paid and thereby boosting the federal pass-through amounts by nearly 30 percent. The enhanced ARPA subsidies are due to expire at the end of 2025. Assuming that they are not extended, federal pass-through funding will be lower in 2026 than in 2025.

- A larger (in an absolute sense) decrease in the SLCSP premium due to any program initiative that meets 1332 requirements can increase the total pass-through funding a state can receive. If the reduction in the SLCSP relative to the overall premium reduction is larger, the State can expect a relatively higher federal pass-through amount. [23]
- The ARPA[24] enhanced APTC subsidies beginning in April 2021, which increased the absolute amount of APTC paid, thereby increasing the federal pass-through amounts by nearly 30 percent. The enhanced ARPA subsidies are scheduled to expire at the end of 2025. Assuming they are not extended, federal pass-through funding will be lower in 2026 than in 2025.
- **Proportion of Individual Market Receiving APTC.** Related to the SLCSP, the proportion of the population that receives APTC affects the amount of pass-through funds that can be anticipated. The higher the proportion of people purchasing coverage who receive APTC subsidies, the relatively higher the potential pass-through savings, as a reduction in subsidy amounts will have a greater impact if more enrollees are receiving subsidies.
- **Change in Morbidity of the Market Population from Reinsurance**. This is a smaller factor than the issues previously mentioned. However, with a reduction of premiums, it is expected that the number of healthier enrollees entering the market will increase. As a result, less funding will be needed to fully support the program.

Federal Funding for Reinsurance Program—Section 1332 Waiver

The ACA permits states to waive certain provisions in the ACA to increase access to affordable coverage. For the waiver to attain CMS approval, the State must demonstrate that it does not interfere with four guardrails:

1. **Coverage:** At least a comparable number of individuals must receive coverage under the waiver.
2. **Affordability:** The waiver must not increase consumer out-of-pocket spending, including premiums and cost sharing.
3. **Comprehensiveness:** The waiver should not decrease the number of individuals with coverage who meet the essential health benefits (EHB) benchmark.
4. **Deficit neutrality:** The waiver must not increase the federal deficit.

States may receive pass-through funding from the federal government equal to the savings that the federal government experiences as the result of lower subsidies paid as a result of the reduced premiums the State waiver achieves.

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[23] Centers for Medicare & Medicaid Services. Data Brief on State Innovation Waivers: State-Based Reinsurance Programs. December 2022. Available at: https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-data-brief-dec2022.pdf. Accessed November 27, 2023.

[24] 117th US Congress. American Rescue Plan Act of 2021. Government Printing Office. Available at: https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf. Accessed November 27, 2023. See also: https://www.congress.gov/bill/117th-congress/house-bill/1319/text.

State Funding Needed for Reinsurance Program

States that have implemented reinsurance programs have used various funding sources. Most states rely on their general fund and/or an assessment on health insurers. Several states apply funds obtained from penalties assessed on individuals who fail to obtain health insurance in violation of a state mandate. Other states assess fees on health care providers. Table A1 in Appendix A summarizes the latest information on state sources of funding for reinsurance programs. The analysis in this report estimates the assessment on health insurance premiums in all markets that would be needed if assessments were the sole source of the state funding for the program.

Impact of Reinsurance on Consumers

When considering whether to adopt an affordability program such as reinsurance, it is important to weigh which populations will benefit from the program. Table 9 presents a summary of considerations when comparing several types of affordability programs across the individual and small group markets.

The main advantage of a reinsurance program is the ability to leverage federal funding to assist middle-income consumers in the individual market who do not receive a significant benefit through APTC subsidies. Lower-income, federally subsidized individuals are protected from premium increases because of the federal APTC subsidies for which net premiums are indexed annually to income thresholds based on a percentage of the federal poverty level (FPL) but which otherwise remain relatively flat. Reinsurance leads to lower premiums for health plan members who are not benefiting from the APTC subsidies without reducing affordability for lower-income, APTC-eligible consumers.

ARPA enhanced subsidies by making them available to people with higher incomes who previously were ineligible for them. These enhanced subsidies are set to expire in 2025. The largest increases in net premiums (relative to income level) will affect people with incomes between 139 percent and 250 percent FPL and those with incomes greater than 400 percent FPL. To date, Washington lawmakers have provided additional state funding for subsidies through the Cascade Care Savings (CCS) premium subsidy program. The introduction of a reinsurance program in the individual market is expected to neither significantly affect the CCS program nor result in savings because the APTC subsidies are based on the premium rates for the second lowest cost Silver plan. A reduction in the premium as a result of the reinsurance program also would result in a reduction in the APTC subsidy, keeping the utilization of the CCS subsidy of similar magnitude as it would be without the reinsurance program.

An analogous program in New Mexico funds a direct 10 percent premium reduction in the small group market. Since the program's introduction in July 2022, small group market enrollment has remained relatively unchanged.

Table 9: Consumers Receiving Greatest Benefit by Policy

Market	Reinsurance	CCS Premium State Subsidy
Individual	Non-federally subsidized individuals (middle income and post ARPA, those over 400% FPL)	Low-income members up to 250% FPL; includes federally subsidized and unsubsidized individuals, undocumented residents.
Small Group	Benefit is shared between small business employers and employees	N/A

Impact of Reinsurance on Health Insurers

Though the goal of the program is to reduce average premiums by 10 percent, the degree of reduction in premiums for each health insurer may vary significantly for multiple reasons:

- **Claims costs:** Some health insurers may be more conservative in their estimate of reduced claims costs. If a reinsurance program is implemented, the OIC should ensure that the value of the program is included in health insurers' proposed rates.
- **Risk adjustment:** Changes in the statewide average premium will affect ACA risk-adjustment transfers, which will further impact premiums under the reinsurance program. Health insurers with more high-cost enrollees will receive more reinsurance payments and will likely receive risk-adjustment transfers, with the amount of those transfers slightly lower because of the lower statewide average premium.[25]
- **Non-benefit expenses:** The fixed non-benefit expenses (e.g., fixed administrative costs) that health insurers incur will not decrease because of implementation of a reinsurance program. This tends to mute the impact of the reinsurance program, but the amount will vary by insurer.

Program parameters may be set to minimize the variability of program impact between health insurers, which ensures that the reinsurance program does not change overall market dynamics. If Washington pursues a reinsurance program, the OIC should review various parameter options to find one that meets the various goals of the state.

[25] Risk adjustment in ACA markets involves a budget-neutral transfer of a portion of the issuers' premium revenue based on their relative portion of unratable risk. Hence, issuers with higher unratable risk profile-enrolled members will receive risk adjustment transfer amounts from the issuers that have enrolled members with a lower unratable risk profile. The transfer payments are based on the market-wide average premium dampened for administrative expenses. Thus, if the average premiums decrease, so will the absolute amounts of the risk adjustment transfer amounts."

Economic Impact of a 10 Percent Reduction in Premiums Through a Reinsurance Program in the Small Group Market

A 10 percent reduction in premiums achieved through the implementation of a reinsurance program will affect the Washington State economy in a variety of ways. This section estimates the increases in wages that would result from this reduction in premiums and then applies these wage increases to employees in Washington who participate in the small group market.

For our economic analysis, we started with the total number of individuals from the actuarial analysis. To refine our analysis, we adjusted these figures to focus specifically on the employees covered by their employers, excluding dependents and non-household members.

We based this adjustment on data from the Kaiser Family Foundation (KFF), which reported that in March 2023, 164.7 million people in the United States had employer-sponsored health insurance (ESI). Among these, 84.2 million were covered through their own employment, as opposed to having coverage as a dependent of the employed person.[26] This means that the total number of people with ESI is approximately 1.96 times the number of employees directly enrolled in these plans. We made this adjustment to ensure that our analysis reflects only the employees themselves, rather than the broader group of individuals covered by ESI.

Table 10: Number of Small Group Employees Impacted by Reinsurance

Group	Number of Employees
Small group employees 2025	120,851
Small group employees 2026	121,447
Small group employees 2027	122,046
Small group employees 2028	122,648
Small group employees 2029	123,252

[26] Kaiser Family Foundation (KFF), "Health Policy 101: Employer-Sponsored Health Insurance," accessed August 10, 2024, https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-who-is-covered-by-employer-sponsored-health-insurance.

Effects on Small Group Wages and Employment

It is commonly believed that employer payments for health insurance premiums "ultimately come out of what would otherwise have been monetary wages for employees"[27] and that a reduction in health care premiums will lead to increased earnings. In addition, a reduction in premiums is assumed to encourage an increase in the number of employees and in the number of full-time rather than part-time workers.

The economic model used throughout this report assumes that a 10 percent reduction in premiums will lead to a 2.3 percent increase in wages, a 1.9 percent increase in the number of people who shift from part-time to full-time work, and a 1.6 percent increase in employment.[28] Table 11 illustrates the projected aggregate wage gains for both full-time and part-time insured employees from 2025 to 2029, based on a 10 percent decrease in premiums in 2025.

Table 11: Aggregate Wage Gains for 2025–2029 from a One-Time 10 Percent Decrease in Premiums in 2025 (Millions USD) in Small Group Market

% Decrease in Premiums	% Increase in Wages	Aggregate Wage Gains for Full Time Insured Employees	Aggregate Wage Gains for Part Time Insured Employees	Aggregate Wage Gains for Full Time & Part Time Insured Employees
10%	2.3%	$535.4	$308.2	$843.6

Economic research literature supports higher estimates for the impact on wages of changes in premiums. The most frequently accepted estimate is that 88 percent of premiums are offset by wage reductions.[29] In consideration of these higher estimates, this model includes a second scenario, which assumes that wages increase by 4 percent when premiums decrease by 10 percent (see Table 12).

Table 12: Aggregate Wage Gains for 2025–2029 (Millions USD) from a One-Time 10 Percent Decrease in Premiums in 2025 in Small Group Market, Assuming a Higher Wage Pass-Through

% Decrease in Premiums	% Increase in Wages	Aggregate Wage Gains for Full Time Insured Employees	Aggregate Wage Gains for Part Time Insured Employees	Aggregate Wage Gains for Full Time & Part Time Insured Employees
10%	4%	$931.1	$536.0	$1,467

[27] Pauly MV. *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance*. Ann Arbor: The University of Michigan Press.1997. p. 2.

[28] Baicker K, Chandra A. The Labor Market Effects of Rising Health Insurance Premiums. National Bureau of Economic Research. Working Paper 11160. February 2005. Available at: https://www.nber.org/papers/w11160. Baicker and Chandra estimate the impact on wages and employment of an increase in health care premiums. This model assumes that the relationship between health insurance premiums and labor market impacts will be of the same magnitude in either direction (i.e., whether the change in premiums is an increase or a decrease).

[29] Pauly MV. *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance*. Ann Arbor: The University of Michigan Press.1997. On page 2, Pauly references studies by economists John Gruber and Alan Krueger, which estimate the wage offset at 83 percent and 100 percent, respectively.

Transitioning Part-Time Roles to Full-Time Opportunities

Table 13 presents the projected aggregate earnings increase for part-time employees who convert to full-time status in 2025 to 2029, based on a 10 percent one-time decrease in premiums in 2025. The transition from part-time to full-time employment consists of changing the employee composition while holding wages constant.

Table 13: Aggregate Earnings Increase for Part-Time Employees Converted to Full-Time Employees for 2025–2029 (Millions USD)

% Decrease in Premiums	% of Employees Converted from Part Time to Full Time	# of Employees Converted to Full Time	Aggregate Wage Increase Due to Transition from Part Time to Full Time Employment
10%	1.9%	5,797	$187.6

Additional Employment

The evidence suggests that slowing the growth rate of health care costs would lower the unemployment rate by approximately one-quarter of a percentage point for a number of years while keeping inflation stable. [30] Table 14 shows the projected aggregate earnings increase for new full-time and part-time employees from 2025 to 2029 based on a 10 percent one-time decrease in premiums in 2025. This estimates new earnings from additional employment while holding wages constant.

Table 14: Aggregate Earnings Increase for New Full-Time and Part-Time Employees, 2025–2029 (Millions USD)

% Decrease in Premiums	% Increase in Employment	Aggregate Earnings Increase for New Full Time Employees	Aggregate Earnings Increase for New Part Time Employees	Aggregate Added Wages Due to New Full & Part Time Employees
10%	1.6%	$372.4	$214.4	$586.8

[30] Council of Economic Advisers. The Economic Case for Health Reform: Update. Executive Office of the President. December 14, 2009. Available at: https://obamawhitehouse.archives.gov/sites/default/files/microsites/091213-economic-case-health-care-reform.pdf.

Impact on Households

The model also estimates the extent to which the overall premium reduction would lower employees' share of premium payments.[31] The Kaiser Family Foundation (KFF) conducts an annual survey of employer-sponsored health insurance, with the latest results published in October 2023. [32] The results of this survey, other data sources used, and details about our methodology are described in Appendix B.

Table 15 details the reduction in employees' share of premiums over 2025−2029 for a 10 percent decrease in premiums. We also apply the multiplier effect to a reduction in employees' share of premiums because workers will have more disposable income. As their share of premium payments decreases, their increased disposable income leads to higher consumption, stimulating further economic activity. This growth in spending is an additional economic benefit of the increase in disposable income resulting from increased wages.

Table 15: Total Reduction in Employees' Share of Premiums, 2025−2029 (Millions USD)

Decrease in Premiums	Decrease in Employee Premium Contributions	Total Reduction in Premiums for Employees	Total Reduction in Premiums for Employees with Multiplier
10%	3%	$68.27	$124.1

Combined Labor and Household Effects, Taxes, and the Multiplier Effect

In addition to the labor market benefits described above, favorable ripple effects are likely because people who experience increased earnings begin to spend a larger portion of their income on goods and services—a phenomenon known as the multiplier effect. In calculating the multiplier effect, this model assumes that employees will save some of their new earnings. This analysis uses a savings rate of 4.3 percent—the average federal monthly savings rate in 2023 through April 2024.[33]

The model assumes a community multiplier developed by first estimating separate multipliers for each of several sectors of the local economy and then weighting each industry multiplier by the percentage of service recipients' income spent among these sectors. Researchers at California State University, Northridge, calculated this weighted average to be 1.9.[34]

[31] Some employers might lower deductibles in response to the reduction in premiums, but that response is considered unlikely and is omitted from the model.

[32] Claxton G, Rae M, Winger A, Wager E. Employer Health Benefits: 2023 Annual Survey. KFF. October 2023. Available at: https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf.

[33] US Bureau of Economic Analysis. Personal Saving Rate [PSAVERT]. FRED, Federal Reserve Bank of St. Louis. July 27, 2024. Available at: https://fred.stlouisfed.org/series/PSAVERT.

[34] Blake D, Coveney J. Family Source Network: Impact Study Results Year 6. California State University, Northridge, and CARE. 2016. Available at: https://scholarworks.calstate.edu/concern/publications/vq27zs92s.

Table 16 summarizes the total aggregate labor market impact for all affected employees in 2025−2029 if a one-time 10 percent decrease in premiums were to occur in 2025. The model does not assume continuous decreases in premiums over time, but rather that the one-time decrease in the first year would affect employee earnings and other variables that would carry over into future years. The data include the overall impact, the effect after taxes, and the total influence on the economy, including the multiplier effect.

Table 16: Total Impact of Labor Market and Household Effects for 2025−2029 (Millions USD)

% Decrease in Premiums	Total Impact of Labor Market Effects on Part Time & Full Time	Total Impact After Taxes	Total Impact Including Multiplier Effect
10%	$1,686	$1,306	$2,375

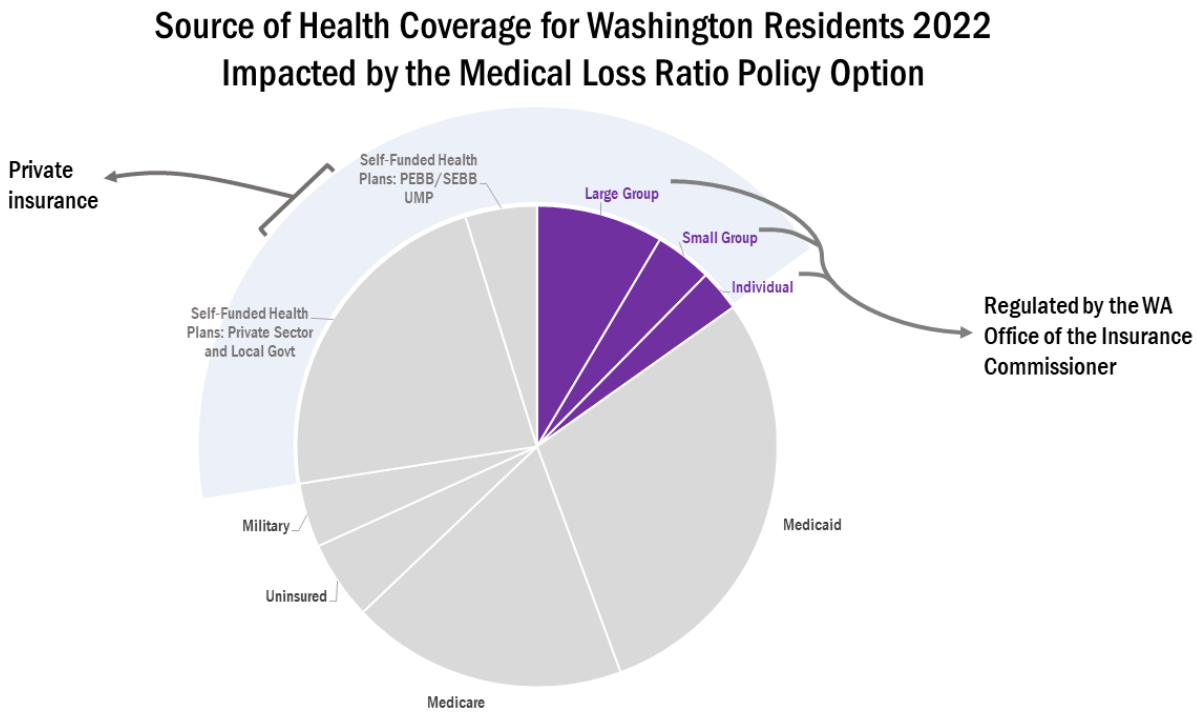
Additional Tax Revenue for Washington[35]

Washington has a 6.5 percent sales tax. In addition, individual municipalities have sales taxes of varying amounts. The model uses an average combined state and local tax rate of 8.86 percent.[36] Applying this tax rate to the total impact of the increase on take-home pay, including the multiplier resulting from a 10 percent reduction in health insurance premiums, provides an estimate of additional tax revenue of $210.4 million for Washington in 2025−2029.

[35] Washington does not have a state income tax. This report estimates increased state and local sales tax revenue that would be the result of adopting the policy options discussed.

[36] Tax Foundation. Washington Tax Rates, Collections, and Burdens. Available at: axfoundation.org/location/washington/#:~:text=Washington%20does%20not%20have%20a%20corporate%20income%20tax%20but%20does,on%20owner-occupied%20housing%20value.

INCREASE THE MEDICAL LOSS RATIO STANDARD



Background

The ACA requires fully insured commercial market health insurers to spend a minimum amount of the health insurance premium collected on medical care or quality improvement initiatives,[37] commonly referred to as the minimum medical loss ratio standard. In the individual and small group markets, this threshold is 80 percent or higher; in the large group market, it is 85 percent. Consequently, individual and small group insurers cannot allocate more than 20 percent of premiums collected to their profits and administrative expenses, such as staff salaries and marketing. Large group insurers cannot allocate more than 15 percent of premiums to profits and administrative costs. If expenses and profits exceed these thresholds, the difference must be returned to consumers as refunds or rebates.

[37] Self-funded plans are not subject to this requirement.

When the ACA was enacted, the MLR requirement was seen as a means of improving the value of individual and employer-based health insurance so consumers would get the most out of their premium contributions while also incentivizing efficient insurer operations and limiting profit potential. Beginning in plan year (PY) 2011, insurers nationwide were required to meet the MLR requirements or pay consumer rebates, with a few exceptions granted by CMS on a case-by-case basis. No state other than Massachusetts, which set its MLR at 88 percent for its merged individual and small group market, has adopted MLR requirements higher than the federal requirements. This section of the report estimates the impact of increasing the minimum MLR requirement in Washington to 88 percent in all three markets.

Health insurers report their MLR annually to CMS using the pooled experience in the most recent three calendar years. For 2022, the most recent reporting year, MLR was calculated using insurers' experience in 2020, 2021, and 2022. A credibility adjustment is applied to health insurers with small blocks of business or high average deductible amounts, which has the effect of raising their calculated MLR, making it easier for them to meet the threshold without paying rebates.[38]

In recent years, the number of health insurers in Washington paying rebates in the three health insurance markets, and the total amount of rebates paid, have declined substantially compared to the early years of ACA implementation. In the individual market, four health insurers paid rebates in 2020, three in 2021, and only one in 2022. In both the small group and large group markets, only one insurer paid MLR rebates in the last three years, despite the higher minimum MLR requirement for large groups. Tables 17−19 show the reported MLR and PMPM rebates for 2020−2022 in the three markets.[39]

[38] Issuers with fewer than 1,000 covered members over the three-year period are not required to comply with the MLR requirement. Issuers with up to 75,000 members benefit from the credibility adjustment, as do issuers with high average deductible amounts. A simplified formula to calculate the federal MLR is:

Federal MLR = [Incurred Claims +/- Risk Adjustment Transfer Amount + Quality Improvement Expenses] / [Earned Premium – Taxes and Fees] + Credibility Adjustment Factor.

[39] The 2020−2022 experience was affected by the COVID-19 pandemic and by the Medicaid redetermination enrollment migration. These challenges may have contributed to the MLR and rebate outcomes observed during this period. The directionality of the impact is mixed given the suppressed use of services, offset by the high cost of COVID treatment services.

Table 17: Individual Market 2020-2022 Historical MLR and Rebate Summary by Insurer

Company Name	2020 MLR	2020 Rebate Amount PMPM	2021 MLR	2021 Rebate Amount PMPM	2022 MLR	2022 Rebate Amount PMPM
Asuris Northwest Health	83.0%	$0.00	85.2%	$0.00	87.6%	$0.00
BridgeSpan Health Company	102.4%	$0.00	100.7%	$0.00	101.6%	$0.00
Community Health Network of Washington	0.0%	$0.00	0.0%	$0.00	93.7%	$0.00
Connecticut General Life Insurance Company	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
Coordinated Care Corporation Indiana	76.1%	$18.95	76.2%	$19.13	75.8%	$22.09
Health Alliance Northwest Health Plan	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
Health Net Health Plan of Oregon, Inc	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
Kaiser Foundation Health Plan of the Northwest	98.3%	$0.00	94.9%	$0.00	91.1%	$0.00
Kaiser Foundation Health Plan of Washington	88.5%	$0.00	91.6%	$0.00	96.9%	$0.00
LifeWise Health Plan of Washington	80.3%	$0.00	86.9%	$0.00	89.0%	$0.00
Molina Healthcare of Washington, Inc.	72.6%	$33.41	83.2%	$0.00	86.6%	$0.00

Company Name	2020 MLR	2020 Rebate Amount PMPM	2021 MLR	2021 Rebate Amount PMPM	2022 MLR	2022 Rebate Amount PMPM
PacificSource Health Plans	92.8%	$0.00	95.0%	$0.00	99.3%	$0.00
Premera Blue Cross	64.8%	$96.12	73.4%	$39.58	88.3%	$0.00
Providence Health Plan	0.0%	$0.00	0.0%	$0.00	95.3%	$0.00
Regence BlueCross BlueShield of Oregon	72.6%	$35.59	78.4%	$7.80	85.1%	$0.00
Regence BlueShield	129.3%	$0.00	95.8%	$0.00	93.7%	$0.00
State Farm Mutual Automobile Insurance Company	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
The Guardian Life Insurance Company of America	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
The United States Life Ins. Co. in the City of New York	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
UnitedHealthcare Insurance Company	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
UnitedHealthcare of Oregon, Inc.	0.0%	$0.00	90.0%	$0.00	85.1%	$0.00
UnitedHealthcare of Washington, Inc.	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
Average	80.7%	$17.13	84.9%	$6.24	89.0%	$3.02

Table 18: Small Group Market 2020–2022 Historical MLR

Company Name	2020 MLR	2020 Rebate Amount PMPM	2021 MLR	2021 Rebate Amount PMPM	2022 MLR	2022 MLR Rebate Amount PMPM
Aetna Life Insurance Company	79.3%	$3.38	78.0%	$11.88	84.9%	$0.00
Asuris Northwest Health	85.1%	$0.00	86.4%	$0.00	87.4%	$0.00
Health Alliance Northwest Health Plan	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
Kaiser Foundation Health Plan of the Northwest	106.2%	$0.00	100.0%	$0.00	92.4%	$0.00
Kaiser Foundation Health Plan of Washington	95.4%	$0.00	99.5%	$0.00	102.2%	$0.00
Kaiser Foundation Health Plan of Washington Options, Inc.	87.5%	$0.00	88.3%	$0.00	87.6%	$0.00
PacificSource Health Plans	0.0%	$0.00	0.0%	$0.00	92.4%	$0.00
Premera Blue Cross	81.5%	$0.00	84.1%	$0.00	84.6%	$0.00
Regence BlueCross BlueShield of Oregon	86.4%	$0.00	87.2%	$0.00	88.2%	$0.00
Regence BlueShield	83.5%	$0.00	84.4%	$0.00	84.8%	$0.00
UnitedHealthcare Insurance Company	86.4%	$0.00	86.5%	$0.00	85.2%	$0.00

Company Name	2020 MLR	2020 Rebate Amount PMPM	2021 MLR	2021 Rebate Amount PMPM	2022 MLR	2022 MLR Rebate Amount PMPM
UnitedHealthcare of Washington, Inc.	78.0%	$4.56	0.0%	$0.00	92.0%	$0.00
Health Net Health Plan of Oregon, Inc	104.3%	$0.00	0.0%	$0.00	0.0%	$0.00
Average	85.7%	$0.03	86.4%	$0.06	86.7%	$0.00

Table 19: Large Group Market 2020–2022 Historical MLR

Company Name	2020 MLR	2020 Rebate Amount PMPM	2021 MLR	2021 Rebate Amount PMPM	2022 MLR	2022 MLR Rebate Amount PMPM
Aetna Life Insurance Company	88.4%	$0.00	89.3%	$0.00	88.5%	$0.00
AMERICAN FIDELITY ASSURANCE COMPANY	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
Asuris Northwest Health	83.1%	$7.52	84.3%	$3.03	78.6%	$28.50
Cigna Health and Life Insurance Company	86.0%	$0.00	87.1%	$0.00	88.8%	$0.00
Health Net Health Plan of Oregon, Inc	106.1%	$0.00	104.0%	$0.00	103.1%	$0.00
Kaiser Foundation Health Plan of the Northwest	88.9%	$0.00	91.6%	$0.00	92.1%	$0.00

Company Name	2020 MLR	2020 Rebate Amount PMPM	2021 MLR	2021 Rebate Amount PMPM	2022 MLR	2022 MLR Rebate Amount PMPM
Kaiser Foundation Health Plan of Washington	87.8%	$0.00	89.5%	$0.00	91.1%	$0.00
Kaiser Foundation Health Plan of Washington Options, Inc.	89.4%	$0.00	89.7%	$0.00	90.0%	$0.00
LifeWise Assurance Company	92.9%	$0.00	90.2%	$0.00	91.9%	$0.00
PacificSource Health Plans	0.0%	$0.00	122.3%	$0.00	99.2%	$0.00
Premera Blue Cross	88.6%	$0.00	90.8%	$0.00	90.2%	$0.00
Providence Health Plan	94.8%	$0.00	95.7%	$0.00	94.2%	$0.00
Regence BlueCross BlueShield of Oregon	85.6%	$0.00	85.2%	$0.00	85.3%	$0.00
Regence BlueShield	85.2%	$0.00	85.7%	$0.00	86.2%	$0.00
UnitedHealthcare Insurance Company	88.0%	$0.00	90.0%	$0.00	89.0%	$0.00
UnitedHealthcare of Washington, Inc.	87.9%	$0.00	86.7%	$0.00	86.0%	$0.00
Health Alliance Northwest Health Plan	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
Average	87.9%	$0.09	89.4%	$0.03	89.5%	$0.29

As these results show, most health insurers in Washington already are reporting MLRs near, at, or higher than 88 percent. Therefore, increasing the minimum MLR requirement would affect only a limited subset of insurers and a limited number of people who purchase plans from those insurers. Members of plans in the small group market are more likely to reap these benefits than people enrolled in the individual and large group markets (see Table 20).

Table 20: 2022 MLR Metrics, Current versus Increased MLR Requirement

Market	Average MLR	# Insurers Below Current MLR	# Insurers Below 88% MLR	% Market Below 88%
Individual ACA	89.0%	1	5	39%
Small Group	86.7%	0	6	88%
Large Group (Fully Insured)	89.5%	1	4	24%

Actuarial Analysis of Increasing the Medical Loss Ratio

This report analyzes the impact of increasing the state minimum MLR standard to 88 percent in all markets from the current 80 percent in the individual and small group markets and 85 percent in the fully insured large group market, effective Plan Year 2025. The analysis quantifies potential changes in expected future health plan enrollment, premiums, and MLR rebates between a projected baseline in which the current MLR requirement remains unchanged and alternative projection scenarios that use 88 percent MLR (see Table 21).

Table 21: Impact of Increasing MLR Requirement, 2025–2029

Metric	Description
Estimated Annual Cost	N/A
Who Benefits?	Individual Market: 39% of the enrollees purchasing coverage from insurers with MLRs below 88% (2022) Small Group Market: 88% of the enrollees purchasing coverage from insurers with MLRs below 88% (2022) Large Group Fully Insured Market: 24% of the enrollees purchasing coverage from issuers with MLRs below 88% (2022)
Consumer Benefits	Individual Market: Up to 2.5% premium reduction and up to 0.5% increase in market enrollment Small Group Market: Up to 2.4% premium reduction and up to 1.0% increase in market enrollment Large Group Market: Up to 0.9% premium reduction and up to 0.3% increase in market enrollment
Washingtonians Impacted	Individual Market: 189,000 to 252,000* Small Group Market: 303,000 to 304,000* Large Group Fully Insured Market: 1.06 to 1.07 million* *Total market after the implementation of 88% MLR

This policy could affect people who purchase coverage in the three fully insured markets. This policy option has a broader reach than some of the alternatives analyzed in this report. This policy does not require state funding; rather, premium savings for consumers are achieved through a reduction in health insurers' administrative expenses.

Given the uncertainty about how health insurers will react to the policy, HMA did not assess the feasibility of insurers adjusting their operating expenses and the implications on solvency and market participation. At present, insurers are not required to offer health plans in any Washington markets, except for a mandate that insurers offer individual health plans in the same counties where they offer PEBB or SEBB coverage.

If insurers face significant financial pressures in certain markets, they could stop offering plans and exit the market entirely. Absent other policy safeguards, insurers also could increase their MLRs by increasing their claims costs (e.g., by increasing provider reimbursement through risk sharing or increasing quality performance incentives), which would not lower premiums for members and could result in unintended outcomes.[40, 41, 42]

To quantify the impact of any given policy, two sets of projections for each market in 2025−2029 are needed: (1) a baseline projection assuming no policy change, and (2) projections with the policy in place.

Table 22 summarizes the baseline projection, including key metrics such as projected enrollment, average premium PMPM, average pricing loss ratio[43] as well as the average federal MLR (per federal definition and formula), and the average rebate PMPM in each of the three markets between 2025 and 2029. Historical experience[44] was used as the basis for the projections. In general, the projections are stable in the small and large group markets, and more varied in the individual market because of the impact of the anticipated expiration of additional ARPA premium subsidies in 2026.[45] Notably, in both individual and large group markets the projected average federal MLRs run close to 90 percent; however, the average small group market MLR is expected to be lower—just below 88 percent—in line with the historical patterns.

[40] Harrington SE. Medical Loss Ratio Regulation under the Affordable Care Act. *Inquiry*.2013;50:9–26. Available at: https://faculty.wharton.upenn.edu/wp-content/uploads/2018/04/inquiryjrnl_50.01.05.pdf.

[41] Hall MA, McCue MJ. How the ACA's Medical Loss Ratio Rule Protects Consumers and Insurers Against Ongoing Uncertainty. The Commonwealth Fund. July 2, 2019. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2019/jul/how-aca-medical-loss-ratio-rule-protects-consumers-insurers.

[42] Cicala S, Lieber EMJ, Marone V. Regulating Markets in US Health Insurance. American Economics Journal: Applied Economics. 2019;11(4):71−104. Available at: https://www.aeaweb.org/articles?id=10.1257/app.20180011. MLR provides incentive to increase claims cost.

[43] The pricing loss ratio is of total plan liability (claim costs and risk adjustment transfers) to the premium revenue.

[44] For the individual market, actual WAHBE enrollment and premiums (2019−2022) were used as the basis for developing the future projected market enrollment and premium. For the small and large group markets, actual enrollment and premiums (2019−2022) from MLR reporting data were used as the basis for developing the future projected market enrollment and premiums.

[45] The anticipated impact of expiration of the enhanced ARPA premium subsidies is enrollment attrition in the individual market, changing the demographic composition of the market and worsening the market morbidity.

Table 22: Baseline Projection (Current MLR Requirement 80% and 85%), 2025−2029

	Individual ACA	Small Group	Fully Insured Large Group
Projected Market Enrollment (Avg Lives)	188,000 to 251,000	301,000	1,062,000
Projected Average Premium (PMPM)	$629 to $847	$456 to $549	$580 to $679
Average Pricing Loss Ratio	86.2% to 86.3%	84.0%	86.4%
Average Federal MLR	89.5% to 90.5%	87.9%	89.8%
Average Rebate (PMPM)	$0.00 to $0.54	$0.00	$0.00

Given the large number of health insurers currently offering plans in Washington's fully insured markets, the uncertainty of individual insurers' reactions, and hence the range of potential outcomes, this report models two scenarios: 1) issuers maintain the status quo, and 2) insurers reduce premiums. In the status quo scenario, all current insurers would remain in the markets but are unable or unwilling to reduce their administrative expenses. As a result, in this scenario, they would pay out rebates over the 2025−2029 projection period if their MLR is below 88 percent. In the premium reduction scenario, the opposite insurer reaction is modeled. In this situation insurers are able and willing to comply with the higher minimum MLR requirement, thereby reducing their administrative expenses gradually over several years and passing along premium savings to members. The likely outcome will vary from both these projected scenarios, given the economic and regulatory uncertainty. However, the actual outcome should such a policy be enacted is generally expected to be a blend of these reactions and to fall within the range presented.

Table 23 summarizes the results for the status quo (scenario 1), including the range of changes in projected enrollment, average premium PMPM, average pricing loss ratio, average MLR, and average rebate PMPM in each of the three markets (individual, small group, and large group). The aggregate amount of rebates that would be paid out in each market ranges from $21 million to $33 million, and on a per member per month basis is $2.23 PMPM to $10.24 PMPM. No associated increase in market enrollment is projected to result from this policy outcome, given the insurer reaction modeled in this scenario.

Table 23: Status Quo (Scenario 1): Revised MLR Requirement Set at 88 Percent, 2025–2029

	Individual ACA	Small Group	Fully Insured Large Group
Projected Market Enrollment (Avg Lives)	188,000 to 251,000	301,000	1,062,000
Projected Average Premium (PMPM)	$629 to $847	$456 to $549	$580 to $679
Average Pricing Loss Ratio	86.2% to 86.3%	84.0%	86.4%
Average Federal MLR	89.5% to 90.5%	87.9%	89.8%
Average Rebate (PMPM)	$8.53 to $10.24	$6.11 to $7.29	$2.23 to $2.55
Market Enrollment Impact vs. Baseline %	0.0%	0.0%	0.0%
Average Premium Impact vs. Baseline %	0.0%	0.0%	0.0%
Change in Aggregate Rebate vs. Baseline (millions)	$21.3 to $25.6	$22.1 to $26.3	$28.4 to $32.5

Table 24 summarizes the projected results for a reduction in premiums (scenario 2). In this scenario, the decrease in the premiums for a subset of the health insurers would result in a modest 0.2 percent to 0.9 percent increase in enrollment over the five-year period. The aggregate amount of the combined effects of premium savings (a 0.5%−2.5% decrease) and changes in the rebates that would be paid out in each market range from $17 million to $51 million. Because the MLR reported in any given year reflects the combined experience from the past three years, it would take several years for an MLR to reach the required standard and result in zero rebates.

Table 24: Reduction in Premiums (Scenario 2): Revised MLR Requirement Set at 88 Percent, 2025–2029

	Individual ACA	Small Group	Fully Insured Large Group
Projected Market Enrollment (Avg Lives)	189,000 to 252,000	303,000 to 304,000	1,063,000 to 1,065,000
Projected Average Premium (PMPM)	$616 to $829	$451 to $535	$577 to $674
Average Pricing Loss Ratio	88.0% to 88.4%	85.0% to 86.1%	86.8% to 87.2%
Average Federal MLR	90.2% to 92.5%	88.2% to 89.8%	89.9% to 90.4%
Average Rebate PMPM	$0.00 to $5.13	$0.00 to $4.37	$0.00 to $1.44
Market Enrollment Impact vs. Baseline %	0.2% to 0.3%	0.4% to 0.9%	0.2% to 0.3%
Average Premium Impact vs. Baseline %	-2.5% to -2.0%	-2.4% to -1.1%	-0.9% to -0.5%
Change in Aggregate Premiums and Rebates vs. Baseline (millions)	$37.1 to $45.4	$17.2 to $28.8	$36.1 to $50.6

The goal of the policy is to lower premiums for members rather than having insurers make rebate payments to them. For example, the upper rebate amount in status quo scenario (1) for the small group market is $7.29 PMPM. The average premium reduction in lower premium scenario (2) is 2.4 percent, or $10.82 to $12.84 PMPM. Hence, policy enforcement through rate review would be an important component in achieving the desired outcomes.

Other Considerations

Medical Loss Ratio Variation by Market

The purpose of minimum MLR requirements is to ensure that health insurance rates are reasonable in relation to the benefits that the premium covers. Administrative expenses generally comprise fixed and variable components. The fixed component reflects operating expenses incurred independent of the number of people covered (staffing, compliance, etc.), whereas the variable expenses are generally per enrollee expenses. For example, claims processing, administrative expenses associated with member enrollment, and commissions paid to health insurance brokers and agents are examples of variable expenses.

Consequently, the fixed portion of these expenses becomes a smaller share of the premium as the number of enrollees increases and vice versa. This dynamic explains the higher MLR requirement that now applies to the large group market (85%) as compared with the individual and small group markets (80%). Consequently, it would be more difficult for the insurers that offer individual and small group market plans to meet the 88 percent MLR requirement than for those in the large group market. It is therefore anticipated that more disruption would occur in the individual and small group market if an increased minimum MLR policy is adopted.

Over the past decade, the individual market has experienced many shocks and changes, which have produced uncertainty and made it difficult to accurately set premiums for the individual market. Increasing MLR requirements is designed to reduce the margin of error issuers have in pricing. Consequently, the combination of uncertainty and higher MLR requirements may reduce the incentives for issuers to participate in the individual market.

Economic Impact of Increasing the Minimum Medical Loss Ratio in Group Markets

Changing Washington State's minimum MLR requirement from 80 and 85 percent to 88 percent can have notable labor market effects on the small and fully insured large group markets. In Scenario 1 (maintaining the status quo), discussed above, health insurers do not adjust premiums, but instead issue rebates to comply with the new MLR requirement. The resulting rebates would effectively reduce the net cost of insurance for employers and employees. This decrease in health care costs functions like a premium decrease, leading to increases in wages as employers redistribute the savings.

In Scenario 2, issuers adjust premiums downward to meet the 88 percent MLR without issuing rebates, and the direct reduction in premiums would lower health care costs for employers.

Wage Pass-Throughs

The actuarial analysis presented above suggests that premiums are expected to decrease by an average of approximately 1.14 percent annually in 2025 to 2029 if the MLR is increased to 88 percent for the small group and fully insured large group markets. These premium decreases will affect enrollees in each market who have insurance plans that are projected to have a loss ratio below the 88 percent threshold.

For our economic analysis, we started with the total number of individuals from the actuarial analysis. To refine our analysis, we adjusted these figures to focus specifically on the employees covered by their employers, excluding dependents and non-household members.

We based this adjustment on data from the Kaiser Family Foundation (KFF), which reported that in March 2023, 164.7 million people in the United States had employer-sponsored health insurance (ESI). Among these, 84.2 million were covered through their own employment, as opposed having coverage as a dependent of an employed person. This means that the total number of people with ESI is approximately 1.96 times the number of employees directly enrolled in these plans. We made this adjustment to ensure that our analysis reflects only the employees themselves, rather than the broader group of individuals covered by ESI.

Table 25 details the projected increase in wages for part-time and full-time insured employees over 2025−2029. Based on Baicker's and Chandra's estimates that a 10 percent reduction in health insurance premiums would result in a 2.3 percent increase in wages, we assume this proportionality also applies to premium decreases resulting from increases in minimum MLR requirements.[46] The literature supports higher estimates for the impact on wages of changes in premiums. The most frequently accepted estimate is that 88 percent of premiums are offset by wage reductions. In consideration of these higher estimates, this model includes a second scenario, which assumes that wages increase by 4 percent when premiums decrease by 10 percent.[47]

Table 25: Aggregate Wage Gains for 2025−2029 from Increasing the MLR (Millions USD)

% Increase in Wages for Each 10% Decrease in Premiums[48]	Aggregate Wage Gains for Full Time Insured Employees	Aggregate Wage Gains for Part Time Insured Employees	Aggregate Wage Gains for Full Time & Part Time Insured Employees
2.3%	$517.6	$101.5	$619.1
4%	$900.2	$176.5	$1,077

Transitioning Part-Time Roles to Full-Time Opportunities

Based on Baicker's and Chandra's estimates that a 10 percent reduction in health insurance premiums would result in 1.9 percent of part-time employees transitioning to full-time, we assume this proportionality also applies to premium decreases resulting from increases in the minimum MLR requirement. The effect of the decrease in premiums can be seen in Table 26 below.

Table 26: Projected Aggregate Earnings Increase for Part-Time Employees Converted to Full-Time Employees, 2025−2029 (Millions USD)

% of Employees for Each 10% Decrease in Premiums Converted from Part Time to Full Time	# of Employees Converted to Full Time	Aggregate Wage Increase Due to Transition from Part Time to Full Time Employment
1.9%	1,908	$61.77

[46] The Labor Market Effects of Rising Health Insurance Premiums. National Bureau of Economic Research. Working Paper 11160.

[47] Refer to the discussion in the reinsurance section for the bases of these two wage gain scenarios and assumptions in Appendix B.

[48] The actual decrease in premiums was calculated using the proportion of percentage increase in wages for each 10 percent reduction in premiums. The actual decrease in premium was calculated using this proportion with the data provided in the actuarial analysis (1.14%).

Additional Employment

Another potential impact of a health insurance premium reduction due to an increase in the minimum MLR requirement is an increase in employment. The effect of a cut in premiums on employment can be seen in Table 27 below.

Table 27: Projected Aggregate Earnings Increases for New Full-Time and Part-Time Employees, 2025−2029 (Millions USD)

% Increase in Employment for each 10% Decrease in Premiums	Aggregate Earnings Increase for New Full Time Employees	Aggregate Earnings Increase for New Part Time Employees	Aggregate Added Wages Due to New Full & Part Time Employees
1.6%	$360.1	$70.58	$430.7

Impact on Households

The model estimates the reduction in employees' share of health insurance premiums that would occur because of the increase in the minimum MLR requirement. Table 28 shows the results of that analysis.[49]

Table 28: Total Reduction in Employees' Share of Premiums in 2025−2029 (Millions USD)

Decrease in Employee Premium Contribution for each 10% Decrease in Premiums	Total Reduction in Premiums for Employees	Total Reduction in Premiums for Employees with Multiplier
3%	$44.28	$80.50

[49] Ibid, p. 28

Combined Labor and Household Effects, Taxes, and the Multiplier Effect

The combined labor effects of wage increases (lower wage pass-through scenario), part-time employees transitioning to full-time work, and additional employment can be seen in Table 29.

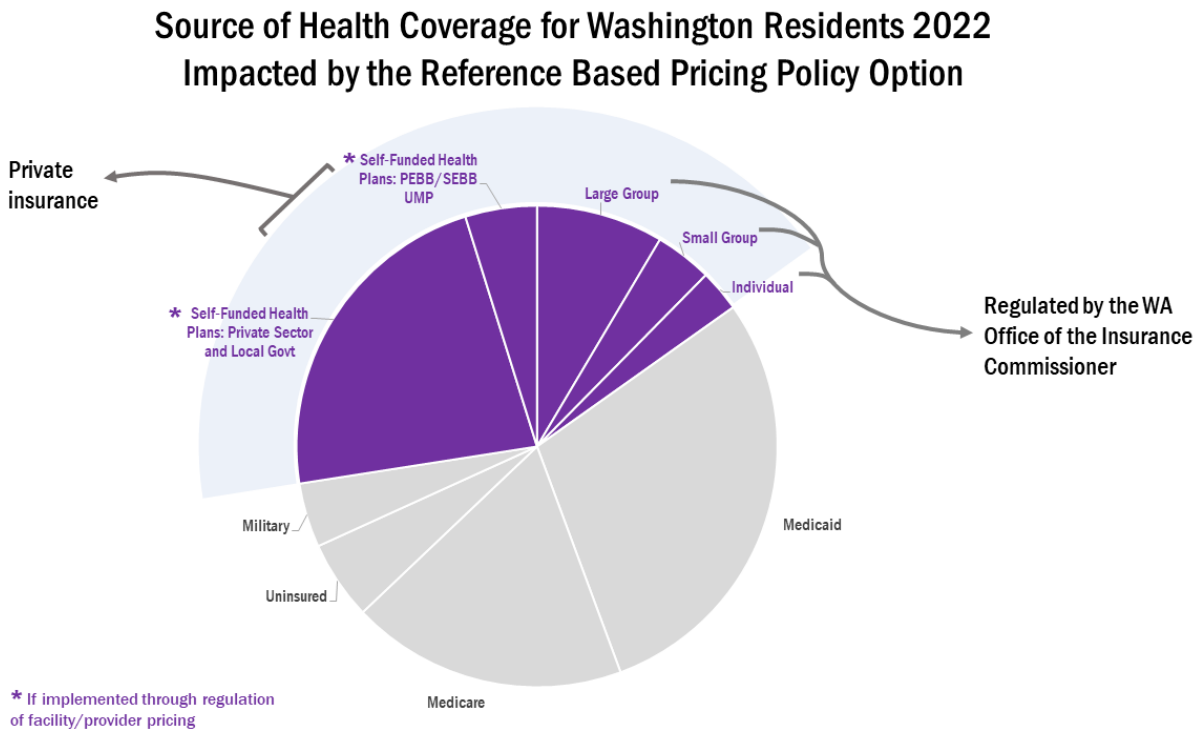
Table 29: Total Impact of Labor Market and Household Effects for 2025−2029 (Millions USD)

Total Impact of Labor Market Effects on Part Time & Full Time	Total Impact After Taxes	Total Impact Including Multiplier Effect
$1,156	$895.2	$1,628

Additional Tax Revenue for Washington

Washington has a 6.5 percent sales tax. In addition, individual counties, cities, and towns have their own sales taxes, with varying amounts. The Tax Foundation calculated that the average combined state and local tax rate in Washington is 8.86 percent. Therefore, the additional tax revenue from increasing the MLR requirement to 88 percent would be $144 million for the years 2025−2029.

USE REFERENCE-BASED PRICING



Background

Reference-based pricing ties the prices for a set of health care services such as hospital care to already defined and established pricing levels, such as Medicare reimbursement. Prices are usually set as a percentage above the reference rate. Reference-based pricing can be implemented in one of two ways. The first is to require that insurers establish standard reimbursement levels no higher than the reference-based price.[50] The second is to prohibit health care providers from charging prices higher than the reference-based price.

The first approach is more easily implemented and enforced because there are far fewer health insurers than health care providers. However, this strategy directly affects neither the prices self-funded employer health plans pay nor the premiums their employees pay due to federal preemption under the Employee Retirement Income Security Act of 1974 (ERISA). The second approach could have a much broader effect because it regulates providers rather than insurers.

[50] The CCS program uses this approach, which requires health insurers to pay no more than 160 percent of Medicare reimbursement rates to hospitals on an aggregate basis for all facility services.

Other states have limited experience with reference-based pricing. Two states have applied reference-based pricing to their public employee health plans. In Montana, prices paid by the plan were set at 220 percent to 225 percent of Medicare rates for inpatient services and 230 percent to 250 percent for outpatient services. An independent study estimated that the plan saved $47.8 million in fiscal years 2017−2019 because of this policy.[51]

Oregon passed a law in 2017 that requires health insurers and third-party administrators that contract with the state employee plan to cap payments for hospital facility services at 200 percent of Medicare rates for in-network and 185 percent of Medicare rates for out-of-network services. The hospital payment cap took effect in October 2019 for Oregon educators and in January 2020 for public employees. Only 24 of Oregon's 62 hospitals are subject to the policy. Exempt hospitals include rural or critical access hospitals (CAHs) and sole community hospitals that are located in counties with fewer than 70,000 people and receive at least 40 percent of their revenue from Medicare.

A study published in *Health Affairs* found that Oregon's hospital payment cap led to reductions in the prices paid by the state employee health plan for hospital facility services. Specifically, outpatient prices declined by 25 percent per procedure, and inpatient prices per admission in the first 27 months of the policy dropped by 3 percent. Price reductions were smaller in the inpatient setting because low-priced hospitals initially increased their prices to match the cap but were prohibited from doing so after the first year. The study estimated that these price reductions resulted in $107.5 million in savings for the state in the first 27 months of the policy, amounting to 4 percent of plan spending. All of the targeted hospitals remained in-network, and none of the evidence suggested that hospitals increased their prices for non-state employee commercial health plans to compensate for revenue losses.[52]

The reference-based pricing analysis in this report used 2022 commercial claims data from the Washington All-Payer Claims Database[53] (WA-APCD) to analyze and project health care costs under different pricing models.[54] The APCD claims data were repriced using Medicare fee schedules relevant to the date of service. The commercial allowed amounts paid,[55] which are the combined amount paid by the health insurer and the consumer through cost-sharing such as copayment or coinsurance, and the repriced Medicare amounts were projected forward to 2027. Separate trend factors were applied to commercial and Medicare amounts, with trend sources documented in Appendix A.

The data were aggregated by service category. The overall trend and comparison calculations were applied to the service categories. Table 30 identifies the service categories used in the analysis.

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[51] Schramm S, Aters Z. Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan. Optumas. April 6, 2021. Available at: www.nashp.org/wp-content/uploads/2021/04/MT-Eval-Analysis-Final-4-2-2021.pdf.

[52] Murray RC, Whaley CM, Fuse Brown EC, Ryan AM. How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan. The Milbank Memorial Fund. July 10, 2024. Available at: https://www.milbank.org/publications/how-payment-caps-can-reduce-hospital-prices-and-spending-lessons-from-the-oregon-state-employee-plan/#:~:text=The%20State%20of%20Oregon%20passed,out%2Dof%2Dnetwork%20prices.

[53] Washington State Health Care Authority. Washington State All Payer Claims Database (WA-APCD). Available at: https://www.hca.wa.gov/about-hca/data-and-reports/washington-state-all-payer-claims-database-wa-apcd.

[54] The APCD excludes significant amount claims paid by self-funded employer plans; therefore, this report does not model the impact of reference-based pricing on those plans.

[55] Centers for Medicare & Medicaid Services. No Surprises: Health Insurance Terms You Should Know. Available at: https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf.

Table 30: Service Categories Used in Reference-Based Pricing Analysis of WA-APCD

Inpatient Hospital (In Network Washington)	Outpatient Hospital (In Network Washington)	Professional (In Network Washington)	Ancillary (In Network Washington)
• Medical • Surgical • Maternity • MHSA (Mental Health & Substance Abuse)	• Observation • ER (Emergency Room) • Surgery • Pharmacy • MHSA • Preventive • All Other	• Urgent Care • Office Visits PCP (Primary care) • Office Visits Specialist • Physical Medicine • Preventive • MHSA • All Other	• All Ancillary Services

For each category of services, the total trended commercial allowed amounts and trended Medicare repriced amounts were summed. The ratio of these amounts equals the current percentage Medicare paid for these claims for the commercial population. Reference-based pricing (RBP) was set at a specific percentage of the Medicare fee schedule for each service category. For illustrative purposes, the report shows a reference price set at 160 percent of Medicare. This is the aggregate reference price that the legislature adopted for public option plans offered in the individual market, called Cascade Select plans. The estimated savings were calculated as the difference between the RBP commercial allowed amount and the trended commercial allowed amount.

The WA-APCD data have important limitations that affect this study's estimates. First, WA-APCD data excludes non-claims payments, such as capitation and risk-sharing payments. In contrast, other sources of commercial market payments data, most notably the unified rate review template (URRT), include those payments. This difference likely results in the WA-APCD producing payment levels that are generally lower than the URRT and other sources. Several states have APCDs that require carriers to report non-claims payments, providing policymakers in those states with a more complete picture of health care costs and spending in the commercial market. Secondly, based on HMA's analysis, it is possible that carriers are submitting claims with understated allowable amounts to the WA-APCD or not submitting claims at all.

These factors, independently or in combination, mean it is unlikely that the results of the unadjusted WA-APCD appropriately capture the entire claims costs associated with Washington's commercial market. Correspondingly, WA-APCD data yielded repriced payment levels (expressed as a percentage of Medicare) that were lower than the URRT and recent analyses by the RAND Corporation[56] and the Washington Health Alliance.[57]

Given these limitations and uncertainties, this study models three scenarios for the savings and impacts associated with RBP:

1. A baseline scenario using WA-APCD claims data with *no adjustments*
2. An illustrative scenario using WA-APCD claims data with a general adjustment based on the higher URRT payments data, which assumes that WA-APCD claims have *understated* allowable amounts
3. An illustrative scenario using WA-APCD claims data with a general adjustment based on the higher URRT payments data, which assumes that WA-APCD claims have *missing* allowable amounts

The below actuarial analysis portion of this section explains these data issues in greater detail.

Actuarial Analysis of Implementing Reference-Based Pricing

As noted above, this analysis reveals potential savings under various assumptions and scenarios. The results represent the current and projected 2027 allowed costs in Washington (statewide) for the subset of markets considered in the analysis, including large group fully insured, individual, small group, PEBB, and SEBB. The PEBB and SEBB estimates include all lines of business and are identified by plan type in the APCD. Additional self-funded data may have been submitted but are not separately identified. The analysis excludes out-of-network and out-of-state claims as well as pharmacy benefits to align with the RBP approach used in the Cascade Care Select public option. The exclusion of out-of-state and out-of-network claims reduces the volume of allowed dollars and savings amounts but does not have a significant impact on the results. The claims that were repriced to the Medicare fee schedule included facility and professional claims.[58]

[56] Whaley CM, Kerber R, Wang D, Kofner A, Briscombe B. Prices Paid to Hospitals by Private Health Plans. RAND Corporation. May 13, 2024. Available at: https://www.rand.org/pubs/research_reports/RRA1144-2.html.

[57] Washington Health Alliance. Washington's Uneven Hospital Landscape: How Price Levels Vary Statewide. May 2024. Available at: https://wahealthalliance.org/washingtons-uneven-hospital-landscape-how-price-levels-vary-statewide/.

[58] Several types of claims were not repriced using the Medicare fee schedule. A complete list of exclusions and corresponding allowed amounts for this group of claims can be found in the Appendix. In addition, some facilities were excluded from repricing. One of the larger facility categories that was not repriced is CAHs—smaller, rural hospitals that Medicare pays at "reasonable cost." These hospitals would continue to be reimbursed on a cost basis under this reference-based pricing model.

The unadjusted WA-APCD scenario, shown in Tables 31A through 31D, summarizes the results of average allowed amount in 2022 as well as projected average reimbursement in 2027 applied across all markets included in the analysis, shown in the total, and the subset of the total exclusively for PEBB and SEBB health plans. The analysis suggests that the current and projected average state reimbursements range from 170−172 percent of Medicare, with slightly lower reimbursement observed in the PEBB and SEBB markets at 160−165 percent of Medicare. Additional details of the baseline average reimbursement are available in the Appendix.

Table 31A: 2022 Incurred Claims in Washington's Commercial Markets, WA-APCD Unadjusted

Market	Current Allowed	Medicare Repriced	Current % of Medicare
Total	$5,519,857,063	$3,238,631,430	170%
PEBB/SEBB Subset	$1,901,253,161	$1,176,430,072	162%

Table 31B: Baseline Average Reimbursement in Washington's Commercial Markets by Service for 2022, WA-APCD Unadjusted

Service Category	Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Inpatient Hospital			
Surgical	$489,443,715	$242,705,559	202%
Maternity	$201,958,476	$114,076,555	177%
MHSA Substance Abuse	$2,137,757	$1,204,480	177%
Medical	$343,632,547	$232,771,179	148%
MHSA Mental Health	$16,898,477	$11,880,390	142%

Service Category	Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Outpatient Hospital			
ER	$337,847,110	$109,233,377	309%
Observations	$81,508,333	$30,538,504	267%
Surgery	$770,590,503	$331,780,498	232%
Preventive	$4,723,559	$2,118,692	223%
All Other	$407,783,216	$189,974,213	215%
MHSA	$4,421,349	$2,246,798	197%
Pharmacy	$38,909,064	$23,426,547	166%
Professional			
All Other	$1,458,732,772	$869,117,543	168%
Urgent Care	$46,104,951	$27,916,424	165%
Preventive	$191,935,907	$124,243,461	154%
Office Visits-PCP	$246,119,815	$165,214,762	149%
Office Visits-Specialist	$431,999,405	$300,978,995	144%
Physical Medicine	$154,312,228	$141,151,932	109%
MHSA	$210,368,349	$239,894,728	88%

Service Category	Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Ancillary			
All Ancillary Services	$80,429,531	$78,156,791	103%
Total (In-Network Washington)	$5,519,857,063	$3,238,631,430	170%

Table 31C: Baseline Average Reimbursement in Washington's Commercial Markets, 2027

Market	Current Allowed	Medicare Repriced	Current % of Medicare
Total	$6,755,275,932	$3,937,218,746	172%
PEBB/SEBB Subset	$2,326,779,402	$1,430,191,311	163%

Table 31D: Baseline Average Reimbursement in Washington's Commercial Markets by Service, 2027

Service Category	Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Inpatient Hospital			
Surgical	$598,987,856	$295,058,236	203%
MHSA Substance Abuse	$2,616,216	$1,464,291	179%
Maternity	$247,159,521	$138,683,379	178%
Medical	$420,542,171	$282,980,966	149%
MHSA Mental Health	$20,680,585	$14,443,044	143%

Service Category	Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Outpatient Hospital			
ER	$413,461,875	$132,795,507	311%
Observations	$99,751,003	$37,125,796	269%
Surgery	$943,059,108	$403,347,038	234%
Preventive	$5,780,755	$2,575,703	224%
All Other	$499,050,630	$230,952,502	216%
MHSA	$5,410,906	$2,731,443	198%
Pharmacy	$47,617,440	$28,479,758	167%
Professional			
All Other	$1,785,216,950	$1,056,590,093	169%
Urgent Care	$56,423,864	$33,938,122	166%
Preventive	$234,893,766	$151,043,333	156%
Office Visits PCP	$301,204,768	$200,852,326	150%
Office Visits Specialist	$528,686,731	$365,901,514	144%
Physical Medicine	$188,849,397	$171,599,036	110%
MHSA	$257,451,638	$291,641,096	88%

Service Category	Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Ancillary			
All Ancillary Services	$98,430,751	$95,015,561	104%
			172%

Tables 32 and 33 identify the estimated savings associated with implementing RBP at 160 percent of Medicare in two market subsets (all commercial markets and PEBB/SEBB). At present, 160 percent of Medicare is the allowed maximum aggregate reimbursement target for Cascade Care Select public option plans offered in the individual market.[59] Washington would have the flexibility to target a percent of Medicare for a particular category of service that is higher or lower than current reimbursement levels. For example, the state may wish to incentivize greater access to mental health, substance use disorder (SUD), or primary care services and therefore increase reimbursement rates above historical commercial reimbursement levels. Given the current average reimbursement of 172 percent, the resulting savings are modest, with additional variation in the PEBB and SEBB markets.

Table 32: Repricing at 160 Percent of Medicare

Service Category	160% RBP Allowed	Cost/ (Savings) $	Cost/(Savings) %
Inpatient Hospital (In-Network Washington)			
Surgical	$472,093,178	($126,894,677)	−21%
Substance Abuse	$2,342,866	($273,350)	−10%
Maternity	$221,893,407	($25,266,114)	−10%
Medical	$452,769,546	$32,227,375	8%
Mental Health	$23,108,870	$2,428,285	12%

[59] For CCS, a target reimbursement rate of 160 percent of Medicare rates is set for provider and facility services. Separate targets are set for CAHs, sole community hospitals, and primary care services. The reference price serves as a ceiling for the reimbursement rate that the insurer pays in the aggregate. Facilities and providers may be reimbursed at higher rates, and the reference price does not function as a ceiling for any individual facility or provider.

Service Category	160% RBP Allowed	Cost/ (Savings) $	Cost/(Savings) %
Outpatient Hospital (In-Network Washington)			
ER	$212,472,811	($200,989,065)	−49%
Observations	$59,401,274	($40,349,729)	−40%
Surgery	$645,355,261	($297,703,847)	−32%
Preventive	$4,121,125	($1,659,630)	−29%
All Other	$369,524,004	($129,526,626)	−26%
MHSA	$4,370,308	($1,040,598)	−19%
Pharmacy	$45,567,613	($2,049,827)	−4%
Professional (In-Network Washington)			
All Other	$1,690,544,149	($94,672,801)	−5%
Urgent Care	$54,300,995	($2,122,869)	−4%
Preventive	$241,669,333	$6,775,567	3%
Office Visits PCP	$321,363,722	$20,158,954	7%
Office Visits Specialist	$585,442,422	$56,755,691	11%
Physical Medicine	$274,558,458	$85,709,061	45%
MHSA	$466,625,754	$209,174,115	81%

Service Category	160% RBP Allowed	Cost/ (Savings) $	Cost/(Savings) %
Ancillary (In-Network Washington)			
All Ancillary Services	$152,024,898	$53,594,147	54%
Total (In-Network Washington)	$6,299,549,994	($455,725,938)	−7%

Table 33: Estimated 2027 Savings if RBP is Set at 160 Percent, WA-APCD Unadjusted

	RBP Allowed	Cost / (Savings) $	Cost / (Savings) %
PEBB/SEBB	$2,288,306,098	($38,473,304)	−2%

Limitations/Comparisons to Other Analyses of Washington Hospital Cost Data

As discussed above, the evidence suggests that the repricing estimates are subject to some uncertainty based on comparisons with other analyses and data sources. This analysis, which is based on calculations of claims costs using WA-APCD data, produced findings that differ from other published estimates of hospital claims costs in Washington. For example, the average cost as a percent of Medicare found in this analysis was substantially lower than average cost as a percent of Medicare estimated in a recent Washington Health Alliance study.[86] The methodology used in this analysis included hospital-specific adjustments (e.g., whether the facility is a teaching hospital) and accounted for regional differences in wage index, whereas the Washington Health Alliance analysis omitted these adjustments. The inclusion of these factors in this analysis would result in a lower percentage of Medicare estimate for claims.

The results of the analysis also differed from a recently published RAND analysis of Washington's WA-APCD data.[87] The average commercial reimbursement rate, as of percentage of Medicare, was higher in the RAND study than what was found in this analysis. The RAND methodology differs in several ways from the methodology used in this analysis, including the application of an adjustment factor that results in a higher percentage of Medicare estimate for inpatient claims. However, those differences may not entirely explain differences between this analysis and results in the RAND analysis.

This analysis also compared unadjusted WA-APCD allowed costs (individual and small group ACA markets only) to the URRT data—a compilation of rate filing information in the individual and small group markets. That comparison showed that allowed claims costs in the unadjusted WA-APCD were lower than in the URRT data. Discussions with Onpoint Health Data, WA-APCD's vendor, identified that, as noted previously, the WA-APCD excludes non-claims-based payments from the allowed amount, which leads to understating the total allowed amount compared with the URRT data. For example, the URRT data include capitation or risk-sharing payments and net payments from reinsurance arrangements or programs, whereas WA-APCD does not capture these payments. Estimating the magnitude of the difference between URRT and APCD data is challenging because the prevalence of non-claims payments varies by insurance market.

However, WA-APCD's exclusion of non-claims payments may not explain the full extent of the observed differences. The lower allowed claims cost observed in the unadjusted WA-APCD also may be the result of missing claims-based payments, leading to understated claims. If this discrepancy is occurring, then the percentages of Medicare identified in the above tables are likely lower than is appropriate, and the resulting shifts from the observed levels to the target rates underestimates the claims cost reduction. Hence, it is unlikely that the results of the unadjusted WA-APCD are appropriately capturing the entire claims costs associated with Washington's commercial market.

For illustrative purposes, assuming that similar levels of understatement observed in the individual and small group market exist throughout the commercial market (i.e., PEBB, SEBB, and large group) and applying adjustments (ranging from 1.12 to 1.84 based on high-level service categories) to all claims, the resulting alternative average percent of Medicare reimbursement currently being paid would be 209 percent. Details on the adjustment are described in Appendix A. As Tables 34A−34C show, the resulting savings would be substantially higher if the reference rate (160% of Medicare) is implemented, ranging from 19−23 percent by market, or from approximately $530 million to $1.91 billion. Comparing Tables 32 and 33 above, the difference in the resulting savings—approximately $1.4 billion—is significant.

Table 34A: Illustrative Average Reimbursement in Washington's Commercial Markets, 2027, with WA-APCD Adjustment for Understated Allowed Amounts

	Current Allowed	Medicare Repriced	Current % of Medicare
PEBB/SEBB	$2,818,285,706	$1,430,191,311	197%

Table 34B: Estimated Savings if RBP is Set at 160 Percent

	RBP Allowed	Cost / (Savings) $	Cost / (Savings) %
PEBB/SEBB	$2,288,306,098	($529,979,608)	−19%

Table 34C: Detailed Estimated Savings if RBP is Set at 160 Percent (Total)

Service Category	RBP Allowed	Cost/ (Savings) $	Cost/(Savings) %
Inpatient Hospital (In-Network Washington)			
Surgical	$472,093,178	($345,277,219)	−42%
MHSA Substance Abuse	$2,342,866	($1,227,186)	−34%
Maternity	$221,893,407	($115,376,997)	−34%
Medical	$452,769,546	($121,096,382)	−21%
MHSA Mental Health	$23,108,870	($5,111,565)	−18%
Outpatient Hospital (In-Network Washington)			
ER	$212,472,811	($304,316,585)	−59%
Observations	$59,401,274	($65,278,325)	−52%
Surgery	$645,355,261	($533,382,067)	−45%
Preventive	$4,121,125	($3,104,288)	−43%
All Other	$369,524,004	($254,243,479)	−41%
MHSA	$4,370,308	($2,392,828)	−35%
Pharmacy	$45,567,613	($13,949,816)	−23%

Service Category	RBP Allowed	Cost/ (Savings) $	Cost/(Savings) %
All Other	$1,690,544,149	($308,187,736)	−15%
			−14%
Preventive	$241,669,333	($21,318,121)	−8%
		($15,865,640)	−5%
Office Visits Specialist	$585,442,422	($6,476,127)	−1%
Physical Medicine	$274,558,458	$63,122,357	30%
MHSA	$466,625,754	$178,382,469	62%
Ancillary (In-Network Washington)			
All Ancillary Services	$152,024,898	($29,132,347)	−16%
Total (In-Network Washington)	$6,299,549,994	($1,913,103,140)	−23%

Another scenario was considered, in which the difference between WA-APCD and URRT total allowed amounts was driven by claims not submitted or captured in the WA-APCD. In this case, the overall percentages of Medicare and savings would remain the same as in the original analysis based on the assumption that the average reimbursement for the missing claims is the same as the claims reported in the WA-APCD.

Table 35: Illustrative Average Reimbursement in Washington's Commercial Markets, 2027, with WA-APCD Adjustment for Missing Allowed Amounts

	Current Allowed	Medicare Repriced	Current % of Medicare
PEBB/SEBB	$2,818,285,706	$1,723,387,530	164%

Table 36: Estimated Savings if RBP is Set at 160 Percent

	RBP Allowed	Cost / (Savings) $	Cost / (Savings) %
PEBB/SEBB	$2,757,420,048	($60,865,657)	−2%

This scenario produces additional savings of $132 million more than the scenario with the unadjusted WA-APCD allowed costs ($456 million). If missing claims are reimbursed at a higher level, savings would increase. It is possible that the discrepancy between the claims costs in the WA-APCD and as reported in the URRT is the result of a combination of both understated and missing claims, further complicating the savings estimate. Before a reference-based policy is finalized, HMA recommends further analysis of WA-APCD claims data to better understand the appropriate claim cost levels for the appropriate markets.

Economic Impact of Implementing Reference-Based Pricing

Wage Pass-Throughs

To estimate the effect of RBP savings on the Washington labor market, the model assumes a 2.3 percent wage increase for each 10 percent increase in savings.[60] HMA also modeled a 4 percent wage increase per 10 percent increase in savings to model the higher wage pass-through assumption. Table 37 describes the effect RBP would have on the labor market in 2027.

Table 37: Aggregate Wage Gains for 2027 from Implementing Reference Pricing (Millions USD)

% Increase in Wages for Each 10% Increase in Savings	Aggregate Wage Gains for Full Time Insured Employees	Aggregate Wage Gains for Part Time Insured Employees	Aggregate Wage Gains for Full Time & Part Time Insured Employees
2.3%	$44.7	$14.9	$60.0
4%	$77.7	$25.9	$103.5

Bureau of Labor Statistics plus authors' calculations

[60] These estimates are based on Baicker's and Chandra's working paper that estimated the impact of an increase in employment and wage on health insurance premiums. This model assumes that the relationship between health insurance premiums and the labor market will be of the magnitude in either direction; that is, whether the change in premiums is an increase or a decrease. (See p. 17, *supra*.)

Transitioning Part-Time Roles to Full-Time Opportunities

The analysis assumed a 10 percent increase in savings would translate to 1.9 percent of part-time employees transitioning to full-time. Table 38 shows the effect RBP would have on the labor market in 2027.

Table 38: Aggregate Earnings Increase for Part-Time Employees Converted to Full-Time Employees for 2027 (Millions USD)

% of Employees for Each 10% Increase in Savings Converted from Part Time to Full Time	Aggregate Wage Increase Due to Transition from Part Time to Full Time Employment
1.9%	$49.2

Additional Employment

The analysis assumed that a 10 percent increase in savings would translate to a 1.6 percent increase in employment. Table 39 outlines the effect RBP would have on the labor market for 2027.

Table 39: Aggregate Earnings Increase for New Full-Time and Part-Time Employees for 2027 (Millions USD)

% Increase in Employment for each 10% Increase in Savings	Aggregate Earnings Increase for New Full Time Employees	Aggregate Earnings Increase for New Part Time Employees	Aggregate Added Wages Due to New Full & Part Time Employees
1.6%	$31.1	$10.4	$41.4

Impact on Households

Table 40 details the reduction in employees' share of premiums for 2027, expressed in millions of USD.

Table 40: Total Reduction in Employee Share of Premiums for 2027 (Millions USD)

Decrease in Employee Premium Contribution for each 10% Increase in Savings	Total Reduction in Premiums for Employees	Total Reduction in Premiums for Employees with Multiplier
3%	$77.7	$141.2

Combined Labor and Household Effects, Taxes, and the Multiplier Effect

The combined labor effects of wage increases (lower wage pass-through scenario), part-time employees transitioning to full-time work, and additional employment can be seen in Table 41.

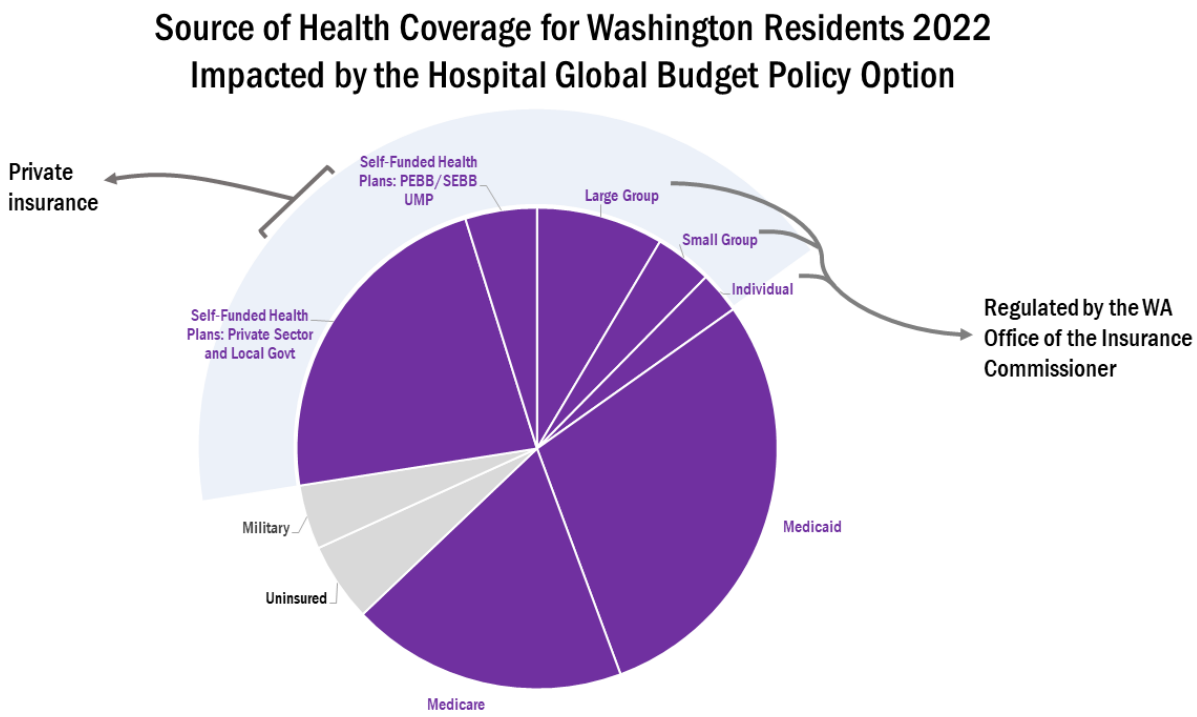
Table 41: Total Impact of Labor Market and Household Effects for 2027 (Millions USD)

Total Impact of Labor Market Effects on Part Time & Full Time Employment	Total Impact After Taxes	Total Impact, including Multiplier Effect
$227.8	$176.4	$320.80

Additional Tax Revenue for Washington

As noted previously, Washington's sales tax is set at 6.5 percent, and counties, towns, and cities have individual sales taxes of varying amounts. The Tax Foundation calculated that the average combined state and local tax rate in Washington is 8.86 percent. Therefore, the additional tax revenue from implementing reference-based pricing would be $24.9 million dollars for 2027.

HOSPITAL GLOBAL BUDGETING



Background

Under hospital global budgeting, hospitals receive a prospectively determined, fixed amount for all inpatient and outpatient services for a patient population in a given year. Hospital global budgets are designed to incentivize hospitals to shift away from pressures to increase revenues by increasing the volume of services they provide, as may occur in a fee-for-service reimbursement system, and instead adopt measures that control costs and increase efficiency. To properly incentivize hospitals and reduce potential cost shifting, global budgets should encompass as much hospital revenue as is appropriate.

To date, only Maryland has instituted a statewide hospital global budget. In 2014−2018, operating under a global budget established under a section 1115 demonstration waiver, Maryland's annual hospital revenue growth per capita was 1.92 percent, well below the original target of no more than 3.58 percent. Medicare savings were $1.4 billion during the waiver period, exceeding the original target of $330 million or more.

A CMS final evaluation report highlighted that total Medicare expenditures in Maryland "declined by 2.8% and hospital expenditures declined by 4.1% without shifting costs to other parts of the health care system. A 17.2% reduction in outpatient department service expenditures drove Medicare hospital savings."[61]

This report estimates the cost savings that could be achieved if Washington were to implement a hospital global budget policy in the years 2026−2029 similar to the one in effect in Maryland from 2014 to 2018. The following assumptions are included in the estimates:

- Hospital payment growth no greater than 2.8 percent each year on a per capita basis, consistent with the cost growth benchmark that the Washington Health Care Cost Transparency (HCCT) Board established.
- Mandatory participation for all acute care hospitals. CAHs, psychiatric hospitals, rehabilitation hospitals, and children's hospitals would be excluded from the program.

Based on Maryland's experience, hospital global budgeting should be paired with required care transformation activities (e.g., quality improvement and primary care investments). Consideration also should be given to the need to maintain access to higher cost/lower revenue services, such as obstetrics (OB), cancer care, and behavioral health (mental health and SUD services). Addressing these questions and considerations is paramount to developing a robust and effective hospital global budgeting (HGB) model that is tailored to Washington State's unique health care landscape.

This analysis projects the growth in hospital inpatient and outpatient payments from 2026 to 2029 under the natural trajectory absent any policy intervention based on Washington-adjusted trends from the CMS Office of the Actuary (OACT). These costs are inclusive of commercial, Medicare, and Medicaid coverage. The analysis compared these results with projected costs under an HGB. The difference is the savings resulting from implementation of the policy.[62]

[61] Centers for Medicare & Medicaid Services. Maryland All-Payer Model Final Evaluation Report (2014-2018). Available at: https://www.cms.gov/priorities/innovation/files/reports/md-allpayer-finalevalrpt-fg.pdf

[62] The primary data source for this analysis is the hospital cost report data as reported to the HCRIS. The data include hospital costs that reflect discrete services that were provided exclusive of supplemental Medicaid payments. As discussed in Appendix A, a key policy decision is whether to include or exclude these payments from hospital global budgeting.

Table 42: Summary of Hospital Spending[63]

	Net Patient Spending
2021 Hospital Spending Healthcare Cost Report Information System (HCRIS) Data Across All Hospitals Statewide	$27,084,000,000
2024 Trended Hospital Spending Across All Hospitals Statewide	$30,322,000,000

Estimated 2024 Distribution of Allowed Cost:	Net Patient Spending	% Of Total
Medicare	$10,649,000,000	35.1%
Medicaid	$6,319,000,000	20.8%
Commercial/other	$13,354,000,000	44.0%

Actuarial Analysis of Hospital Global Budgeting

The analysis reveals potential savings of 0 percent to 7.1 percent statewide savings under several scenarios. The results for Washington State are presented in aggregate, and for OIC geographic rating Areas 1 and 9. Rating Area 1 (King County) was chosen as representative of urban locations, whereas rating Area 9 (Asotin, Columbia, Garfield, Walla Walla, and Whitman counties) represents a rural region.

Tables 43 and 44 show the savings in facility reimbursement that would be achieved if the HCCT Board cost growth targets were met.[64] Two scenarios were modeled to illustrate variability in potential savings:

- **Optimistic Savings**: Assumes a natural trend (the rate at which facility reimbursement increases) 1 percent higher than the best estimate
- **Conservative Savings**: Assumes a natural trend 1 percent lower than the best estimate

[63] Underlying data source is hospital cost report data as reported to the HCRIS. See disclosures for more details. Costs by Medicare, Medicaid, and commercial insurers are not directly reported in HCRIS data, so the distribution is only an estimate. Net patient revenue includes all inpatient and outpatient revenue reported by the hospital and does not make exclusions for out-of-state patients or members in other rating areas.

[64] Theoretically, it is possible that hospital global budgeting could increase hospital spending.

Table 43: Percent Savings if Revenue Growth Target is Achieved

Statewide	Best Estimate	Optimistic	Conservative
2026 Savings	0.9%	1.9%	0.0%
2027 Savings	1.8%	3.7%	0.0%
2028 Savings	2.7%	5.4%	0.0%
2029 Savings	3.5%	7.1%	0.0%
Rating Area 1	**Best Estimate**	**Optimistic**	**Conservative**
2026 Savings	0.9%	1.9%	0.0%
2027 Savings	1.8%	3.7%	0.0%
2028 Savings	2.6%	5.4%	0.0%
2029 Savings	3.4%	7.0%	0.0%
Rating Area 9	**Best Estimate**	**Optimistic**	**Conservative**
2026 Savings	1.1%	1.8%	0.0%
2027 Savings	1.8%	4.1%	0.0%
2028 Savings	2.8%	5.4%	0.0%
2029 Savings	3.6%	7.2%	0.0%

Table 44: Savings if Revenue Growth Target is Achieved (Millions USD)

Statewide	Best Estimate	Optimistic	Conservative
2026 Savings	$265	$556	$0
2027 Savings	$549	$1,174	$0
2028 Savings	$839	$1,845	$0
2029 Savings	$1,139	$2,573	$0

Rating Area 1	Best Estimate	Optimistic	Conservative
2026 Savings	$112	$236	$0
2027 Savings	$231	$496	$0
2028 Savings	$348	$776	$0
2029 Savings	$472	$1,079	$0
Rating Area 9	**Best Estimate**	**Optimistic**	**Conservative**
2026 Savings	$3	$5	$0
2027 Savings	$5	$12	$0
2028 Savings	$8	$17	$0
2029 Savings	$11	$24	$0

As these tables illustrate, using simplified assumptions,[65] savings would be modest in the initial year of implementation, but would grow annually. By 2029, savings could total up to 7.1 percent of hospital spending, which would result in lower premiums and cost-sharing for residents. It may be advantageous from an operational perspective to phase in a target expenditure growth rate.

Economic Impact of Hospital Global Budgeting

The economic model provided in this report projects the potential annual savings Washington could realize by adopting an HGB model similar to the framework that Maryland implemented from 2014 to 2018. Maryland initiated an all-payer system for hospitals in the 1970s, under which Medicare, Medicaid, the public employee health benefit program, and commercial insurers all made nearly identical payments to hospitals on a cost-per-stay basis, which virtually eliminated differences in public and private payment rates. However, the volume of hospital services increased steadily as admissions and readmissions grew. In 2014−2018, Maryland switched to a global hospital budget and set a target of 3.58 percent per capita annual growth in hospital inpatient and outpatient revenue. The actual average annual growth in inpatient plus outpatient hospital revenue over the first five years of the Maryland HGB was 1.92 percent per capita.[66]

[65] Given the uncertainty of operational decisions and outstanding policy decisions (see Appendix), the estimates omit an adjustment for the monetary value of time. Final operational or policy decisions could affect the estimates included in this report. Wakely actuaries recommend updating this simplified analysis to include final operational and policy decisions when known.

[66] Maryland Health Services Cost Review Commission. Maryland's All-Payer Model Results. Available at: https://hscrc.maryland.gov/Documents/Maternal%20Task%20Force/HSCRC%20All%20Payer%20Model%20PY5%20Results.pdf.

Hospital Spending Reductions in Washington

State-by-state data from the CMS Office of the Actuary (OACT) showing trends in annual hospital spending for 2015−2020 was used for this analysis. The average annual growth in total hospital spending in Washington during this time was 3.11 percent per capita; the corresponding figure for the United States was 4.41 percent per capita. Total hospital spending in Washington was $26.523 billion in 2020.

This analysis begins with projected hospital spending through 2029 if no policy change occurs and compares that trend with a scenario in which HGB is implemented in January 2026. The analysis assumes that the 3.11 percent per capita long-term average annual growth in total hospital spending in Washington would continue without policy changes.[67]

Table 45 shows the projected amount of total hospital spending under this assumption and the growth in such costs if the average annual growth in total hospital expenditures is limited to 3 percent per capita in 2026 and to 2.8 percent per capita in 2027−2029.

Table 45: Projected Total Hospital Spending Growth in Washington 2026−2029 With and Without HGB (Millions USD)

Year	Hospital Spending with no Policy Changes	Per Capital Growth Limit	Total Hospital Spending Implementing Growth Limits	Annual Savings
2026	$32,870	3.00%	$31,845	$1,025
2027	$34,113	2.80%	$32,949	$1,164
2028	$35,403	2.80%	$34,092	$1,310
2029	$36,741	2.80%	$35,275	$1,466
2026-2029	$139,127	2.80%	$134,161	$4,966

Source: CMS OACT State (Residence) plus authors' projections, adjusted for population growth.

[67] Wakely, an HMA company, used a different number for the natural trajectory of growth based on the national health expenditure data published by CMS OACT because it was the only source that provided separate trends for Medicare, Medicaid, and commercial/other for the requested timeframe.

Wage Pass-Throughs

Table 46 shows the projected impact of HGB on the labor market in Washington from 2026 to 2029 and describes the projected increase in wages for part-time and full-time employees with insurance benefits over that period. Based on Baicker's and Chandra's estimates that a 10 percent reduction in health insurance premiums would yield a 2.3 percent increase in wages, the analysis assumes this proportionality also applies to an increase in savings resulting from implementation of HGBs. The economic research literature supports higher estimates for the impact of changes in premiums on wages. The most accepted estimate is that 88 percent of premiums are offset by wage reductions. To account for these higher estimates, this model includes a second scenario, which assumes that wages increase by 4 percent when premiums decrease by 10 percent.

Table 46: Aggregate Wage Gains for 2026−2029 from Implementation of Hospital Global Budget (Millions USD)

% Increase in Wages for Each 10% Decrease in Premiums	Aggregate Wage Gains for Full Time Insured Employees	Aggregate Wage Gains for Part Time Insured Employees	Aggregate Wage Gains for Full Time & Part Time Insured Employees
2.3%	$856.6	$285.5	$1,142
4%	$1,490	$496.6	$1,986

Transitioning Part-Time Roles to Full-Time Opportunities

The analysis assumed that a 10 percent increase in savings would result in 1.9 percent of part-time employees transitioning to full-time employment. Table 47 details the effect HGB would have on the labor market in 2026−2029.

Table 47: Aggregate Earnings Increase for Part-Time Employees Converted to Full-Time Employees for 2026−2029 (Millions USD)

% of Employees for Each 10% Increase in Savings Converted from Part Time to Full Time	Aggregate Wage Increase Due to Transition from Part Time to Full Time Employment
1.9%	$943.5

Additional Employment

The analysis assumed that a 10 percent increase in savings would translate into a 1.6 percent rise in employment. Table 48 details the effect HGB would have on the labor market in 2026−2029.

Table 48: Aggregate Earnings Increase for New Full-Time and Part-Time Employees, 2026–2029 (Millions USD)

% Increase in Employment for each 10% Increase in Savings	Aggregate Earnings Increase for New Full Time Employees	Aggregate Earnings Increase for New Part Time Employees	Aggregate Added Wages Due to New Full & Part Time Employees
1.6%	$595.9	$198.6	$794.5

Impact on Households

Table 49 details the reduction in employees' share of premiums from 2026 to 2029, expressed in millions of USD.

Table 49: Total Reduction in Employee Share of Premiums, 2026-2029 (Millions USD)

Decrease in Employee Premium Contribution for each 10% Increase in Savings	Total Reduction in Premiums for Employees	Total Reduction in Premiums for Employees with Multiplier
3%	$1,490	$2,709

Combined Labor and Household Effects, Taxes, and the Multiplier Effect

The combined labor effects of wage increases (lower wage pass-through scenario), part-time employees transitioning to full-time work, and additional employment are outlined in Table 50.

Table 50: Total Impact of Labor Market and Household Effects in 2026-2029 (Millions USD)

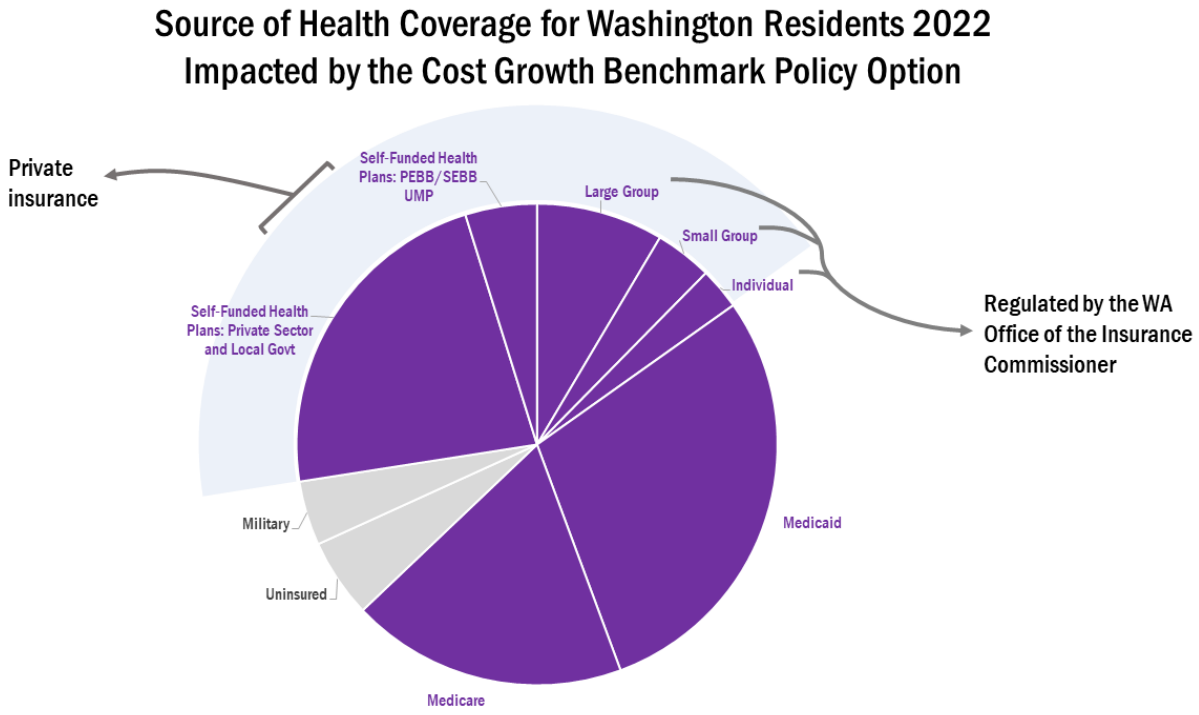
Total Impact of Labor Market Effects on Part Time & Full Time	Total Impact After Taxes	Total Impact Including Multiplier Effect
$4,370	$3,384	$6,154

Additional Tax Revenue for Washington

As noted previously, Washington State has a 6.5 percent sales tax, and local governments have sales taxes of varying amounts. The Tax Foundation calculated that the average combined state and local tax rate in Washington is 8.86 percent. Therefore, the additional tax revenue from implementing HGB would be $529.2 million in 2026–2029.

MEETING HEALTH CARE COST TRANSPARENCY BOARD COST GROWTH BENCHMARKS

Economic Impact of Meeting Health Care Cost Transparency Board Benchmarks on the Growth of Spending and the Economy



The Washington State HCCT Board has set health care cost growth benchmarks for the years 2022−2026 as follows:[68]

[68] Washington State Health Care Authority. Report to the Legislature. Health care Cost Transparency Board. Annual Report. August 1, 2022. p. 6. Available at: https://www.hca.wa.gov/assets/program/hcctb-annual-report-2022.pdf.

Table 51: Health Care Cost Growth Benchmarks for Washington State[69]

Year	Target
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

The cost growth benchmark measures annual health care cost growth and will allow policymakers to identify providers and insurers with costs that exceed the benchmark. Without any enforcement mechanism, the benchmark itself is not expected to lower health care expenditures or drive significant change in providers or health insurer practices. Based on current estimates of growth in health care costs absent any policy interventions, cost growth in Washington will exceed the benchmarks.

One policy intervention, in addition to the four proposed and modeled elsewhere in this report, would be to add enforcement authority to the benchmark statutes requiring providers and insurers to keep annual expenditure growth to levels at or below the state's cost growth targets by leveraging performance improvement plans, fines, or other penalties.[70]

The analysis in this report assumes that the five new policy initiatives explained above are implemented in 2025 or later. Based on the CMS OACT forecast for the average annual growth of US health care spending in 2022−2031, this analysis assumes that annual health spending will grow by 5.4 percent per year in 2025−2029. This projection outpaces the CMS forecast of 4.6 percent annual growth in the economy (gross domestic product).[71] The goal established by the HCCT Board's targets is to reduce growth in total health care spending from 5.4 percent per year to 3.0 percent in 2025 and 2.8 percent in 2026−2029.[72]

The economic model in this report estimates the impact of the slowdown in health care spending growth on the labor market, household budgets, and state taxes if the benchmarks that the HCCT Board set are met.

[69] Washington State Health Care Authority: HCCT Board. August 1, 2022. P. 6. Available at: https://www.hca.wa.gov/assets/program/hcctb-annual-report-2022.pdf.

[70] For example, California, Massachusetts, and Oregon have given enforcement authority to their cost boards. See WA OIC Preliminary Report at pp. 37-38. Available at: https://www.insurance.wa.gov/sites/default/files/documents/oic-prelim-report-1201123-final_2.pdf

[71] Centers for Medicare & Medicaid Service. CMS Office of the Actuary Releases 2022−2031 National Health Expenditure Projections. June 14, 2023. Available at: https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2022-2031-national-health-expenditure-projections.

[72] The HCCT Board has yet to publish the benchmark rate of growth for 2027. We assume it will remain at 2.8 percent.

Impact of Meeting the Benchmarks on the Growth of Total Spending and the Economy

Based on data from the CMS OACT, this analysis projects total health care spending in Washington at $71.277 billion in 2020.[73] Using CMS data and forecasts, without any policy changes to reduce the growth in health care spending, it would spike from $71.277 billion to approximately $114 billion in 2029. Table 52 outlines the projected savings in 2025−2029 if the cost growth benchmarks were met. Projected savings in total health care spending is multiplied by 0.75 to remove prescription drug costs because the policy options modeled in this report are not designed specifically to impact prescription drug pricing. The policies could affect prescription drug utilization if care patterns are modified in response to RBP or HGB. In addition, savings were multiplied by 0.9 to reflect the variable proportion of premiums plus the loss ratio.

Table 52: Impact of Meeting Spending Growth Benchmarks for 2025−2029 (Millions USD)

Year(s)	Spending Growth	Projected Savings
2025	3.00%	$1,420
2026	2.80%	$1,621
2027	2.80%	$1,708
2028	2.80%	$1,801
2029	2.80%	$1,898
2025-2029	2.84% (Avg)	$8,447

Wage Pass-Throughs

Table 53 shows the impact of the estimated savings in health care costs on earnings if the rate of health care spending growth decreases from 5.4 percent to 3.0 percent in 2025 and from 5.4 percent to 2.8 percent in 2026−2029.

The table details the projected increase in wages for part-time and full-time insured employees over the period 2025−2029. Based on Baicker's and Chandra's estimates that a 10 percent cut in health insurance premiums would result in a 2.3 percent wage hike, this analysis assumes this proportionality would apply to an increase in savings through implementation of hospital global budgets. Economic research literature supports higher estimates for the impact on wages of changes in premiums. The most frequently accepted estimate is that 88 percent of premiums are offset by wage reductions. Given these higher estimates, this model includes a second scenario that assumes wages increase by 4 percent when premiums decrease by 10 percent.

[73] Centers for Medicare & Medicaid Services. Projections of State Health Expenditures by State of Residence. Table 1 Total All Payers State Estimates by State of Residence (1991−2020) Personal Health Care (millions of dollars). Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.

Table 53: Aggregate Wage Gains for 2025-2029 from Impact of Benchmarks on Earnings (Millions USD)

% Increase in Wages for Each 10% Decrease in Premiums	Aggregate Wage Gains for Full Time Insured Employees	Aggregate Wage Gains for Part Time Insured Employees	Aggregate Wage Gains for Full Time & Part Time Insured Employees
2.3%	$1,457	$486	$1,942
4%	$2,534	$844.7	$3,379

Transitioning Part-Time Roles to Full-Time Opportunities

The analysis assumed that a 10 percent increase in savings would translate to 1.9 percent of the part-time workforce transitioning to full-time. Table 54 details the effect that cost growth benchmarks would have on the labor market in 2026−2029.

Table 54: Aggregate Earnings Increase for Part-Time Employees Converted to Full-Time Employees for 2025−2029 (Millions USD)

% of Employees for Each 10% Increase in Savings Converted from Part Time to Full Time	Aggregate Wage Increase Due to Transition from Part Time to Full Time Employment
1.9%	$1,605

Additional Employment

The analysis assumed a 10 percent increase in savings would translate to a 1.6 percent increase in employment. Table 55 shows the effect that cost growth benchmarks would have on the labor market for 2025−2029.

Table 55: Aggregate Earnings Increase for New Full-Time and Part-Time Employees for 2025−2029 (Millions USD)

% Increase in Employment for each 10% Increase in Savings	Aggregate Earnings Increase for New Full Time Employees	Aggregate Earnings Increase for New Part Time Employees	Aggregate Added Wages Due to New Full & Part Time Employees
1.6%	$1,014	$338	$1,352

Impact on Households

Table 56 shows the reduction in employees' share of premiums in 2025−2029 in millions of USD.

Table 56: Total Reduction in Employees' Share of Premiums for 2025-2029 (Millions USD)

Decrease in Employee Premium Contribution for each 10% Increase in Savings	Total Reduction in Premiums for Employees	Total Reduction in Premiums for Employees with Multiplier
3%	$2,534	$4,608

Combined Labor and Household Effects, Taxes, and the Multiplier Effect

The combined labor effects of wage increases (lower wage pass-through scenario), part-time employees transitioning to full-time work, and new jobs are shown in Table 57.

Table 57: Total Impact of Labor Market and Household Effects for 2025-2029 (Millions USD)

Total Impact of Labor Market Effects on Part Time & Full Time	Total Impact After Taxes	Total Impact Including Multiplier Effect
$7,433	$5,757	$10,468

Additional Tax Revenue for Washington

Washington's sales tax rate is 6.5 percent. In addition, local governments have sales taxes of varying amounts. The Tax Foundation calculated that the average combined state and local tax rate in Washington is 8.86 percent. Therefore, the additional tax revenue from implementing benchmarks would be $927.5 million dollars in 2025−2029.

Impact on Medicaid, PEBB, and SEBB Spending in Washington

The Financial Services Division of the Washington Health Care Authority (HCA) provided the data for Medicaid, PEBB, and SEBB spending in 2022–2023. HCA also provided projections for spending in state fiscal years (SFY) 2024 and 2025. The assumption of 5.4 percent as a baseline projection for growth in spending for SFY 2026 and SFY 2027 is based on projections from the CMS OACT. Table 58 shows the growth in annual Washington State health care spending if it remains at 3.2 percent in 2025 and 2.8 percent in 2026−2029 instead of the CMS forecast of 5.4 percent. Savings in total health care spending is multiplied by 0.75 to remove prescription drug costs because the policy options modeled in this report are not intended to specifically affect prescription drug pricing. The policies could affect prescription drug use if care patterns are modified in response to RBP or HGB. In addition, the savings were multiplied by 0.9 to reflect the variable proportion of premiums plus the loss ratio.

Table 58: Impact on Medicaid, PEBB, and SEBB Spending, 2025−2029

State Fiscal Year	Medicaid Spending	PEBB	SEBB	% Change from Previous Year	Savings per Year
Washington HCA Data					
2022	$5,366,579,934	$2,800,526,000	$1,937,015,000		
2023	$6,494,712,883	$2,798,386,000	$2,056,117,000		
Washington HCA State Estimates					
2024	$6,812,276,061	$2,935,227,075	$2,156,661,121	4.89%	
2025	$6,880,291,236	$2,964,872,869	$2,178,443,399	1.01%	
HMA Projections[74]					
2026	$7,251,826,963	$3,124,976,004	$2,296,079,342	5.4%	
2026	$7,072,939,391	$3,047,889,309	$2,239,439,814	2.8%	$211,014,311.69
2027	$7,643,425,619	$3,293,724,708	$2,420,067,627	5.4%	
2027	$7,270,981,694	$3,133,230,210	$2,302,144,129	2.8%	$439,331,796.93
2028	$8,056,170,602	$3,471,585,842	$2,550,751,278	5.40%	
2028	$7,474,569,181	$3,220,960,656	$2,366,604,164	2.80%	$686,052,262.33
2029	$8,491,203,815	$3,659,051,478	$2,688,491,848	5.40%	
2029	$7,683,857,118	$3,311,147,554	$2,432,869,081	2.80%	$952,339,536.21

Source: Washington HCA: 2022−2025; HMA estimates of alternative growth scenarios: 2026−2029.

[74] Based on data from CMS Office of the Actuary. Projections of average annual increases in total Medicaid spending through 2030. See CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures | CMS.

CONCLUSION

Rising health care costs are a persistent and growing challenge for Washington workers and businesses. In response, the Washington legislature directed the OIC and AGO to analyze policy approaches to improve health care affordability. OIC's preliminary report described Washington's health care system, provided an overview of policy options and presented an economic model to evaluate those policies. This final report examines five specific policy options that, if adopted, would improve affordability in different ways. The policy options include:

- Establishing a reinsurance program in the individual and small group markets
- Increasing the medical loss ratio standard
- Using reference-based pricing
- Adopting hospital global budgeting
- Meeting the HCCT Board's cost growth benchmarks

This final report uses actuarial and economic modeling to estimate the health care savings and economic impacts of these policies. The analysis shows that these policy options would meaningfully affect health care affordability to the benefit of individuals, families, employers, and state revenues. This report is designed to inform policymakers as they consider various approaches to improving health care affordability.

Each policy option analyzed targets a slightly different segment of the population, affects affordability differently, requires legal and regulatory changes, has various levels of administrative and operational complexity, and would disrupt the health care system in unique ways and to different degrees. The policy options analyzed include some uncertainty, as with any significant policy initiative. Though precedent has been set for the reinsurance and minimum MLR requirement policy options at a national level and in other states, there is less experience with RBP, HGB, and adherence to cost growth benchmarks, which makes drawing definitive conclusions about their effects challenging. Moreover, each policy option has its own set of operational issues and state administrative costs that are not fully accounted for in the savings estimates.

These differences among the policies affect the feasibility of adopting them and the length of time it would take to implement each program, as well as how predictable the outcomes would be and the risks of unintended negative consequences. This section of the report examines some of the factors for consideration in determining whether and how to adopt the policies analyzed.

Population Benefited

Different policy options benefit different groups of Washingtonians, with some policies affecting a much larger portion of the population than others. A reinsurance program and an increase in the minimum MLR requirement would benefit people who have health insurance through a fully insured employer-sponsored health plan as well as people who purchase their own health coverage on the individual market, whether on or off the Health Benefit Exchange. Reference-based pricing could be applied to a range of health care services and providers, potentially affecting all Washingtonians with commercial insurance.

Alternatively, reference-based pricing could be implemented in a more targeted way, such as by initially applying it to PEBB and SEBB plans similarly to the states of Montana and Oregon.[75] Hospital global budgeting would affect all Washingtonians.

Legal and Regulatory Requirements and Uncertainty

Adoption of each of these policies would require new legislation, new regulations, or both. As discussed below, policy decisions must be made regarding the design of each program. Legislative action and state agency implementation would require significant time and resources.

Several of the options could be enhanced with or would require CMS approval of a federal waiver. Some policies would involve obtaining a waiver under section 1332 of the ACA, and others would require both a 1332 waiver and a Medicaid waiver under section 1115 of the Social Security Act. These waivers would allow the state to gain access to federal funding or increase state flexibility. The process for obtaining these approvals is complex and lengthy, and there is no guarantee of success. Potential future federal policy changes are difficult to predict. For example, the expanded subsidies that were adopted in the ARPA are set to expire at the end of 2025 and may not be extended, which would affect the affordability of health insurance for many Washingtonians who now receive subsidies.

State Resources Needed

Adoption of each of these policies would require varying amounts of state funding. Each would require funding for operational costs to implement, operate, monitor and enforce the program, such as investment in IT systems, state personnel, and contractors. The reinsurance program requires state funding for outlays made to health insurers as reinsurance payments. These funds could be obtained through state general funds, an assessment on health insurers or covered lives, or a combination of the two.

Enforcement

For any of these policies to achieve the intended goal of reducing the cost of health care for Washington families, employers, and the state, ongoing monitoring and enforcement will be essential. The state should dedicate the necessary resources to ensure that the programs implemented can adapt to changing circumstances and that the agencies tasked with their enforcement have access to the data and other resources needed to make their potential a reality. Table 59 lists key considerations, both positive and negative, for determining whether and how to implement the policies discussed in this report.

[75] Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan and How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan.

Table 59: Key Advantages, Disadvantages, and Impacts

Option 1: Establish a reinsurance program in the individual and small group markets	
Key Takeaway: Lowers premiums in targeted markets but requires significant state funding	
State Cost Net of Pass-Through Funding: Individual Market: $42−$84 million Small Group Market: $147−$294 million	
Advantages	**Disadvantages**
Greater Impact on Middle-Income Consumers In the individual market, unsubsidized consumers would benefit from the lower premiums. In the small group market, the full benefit would be split between the small businesses and their employees. **Impact on Premiums and Enrollment** The program has been shown to reduce unsubsidized premiums and potentially increase enrollment. **Feasibility** Reinsurance programs have been implemented in 17 states. Administration of these programs is relatively simple. Though some states have outsourced administration of the program, others have performed almost all tasks in-house, mostly through staff actuaries.	**Limited Impact on Lowest Income Consumers** Because the largest portion of the lowest income consumers benefit from the federal APTC subsidies (if enrolled in the individual market), the reduction in market-wide premiums generally does not affect the final net premium these members pay. This policy also would have limited effects on the lowest-income workers who work for businesses that do not offer insurance benefits. **Market Disruption** Health insurers may be more conservative in their assessment of the impact of reinsurance on premiums than the state. To the extent insurers include a lower impact of reinsurance in their rate filings than estimated by the state, this could increase insurer profits or MLR rebates. The OIC must approve individual and small group rates, which could dampen the risk that health insurers would be overly conservative in their assessment of the impact. **Requires Funding** The program requires state funding. Implementing an additional assessment on issuers of fully insured employer plans is likely to be met with resistance and may induce market shifts (e.g., fully insured large groups may shift to self-funding). A 2018 proposal from the OIC that would have financed the state share through an assessment of covered lives would extended beyond fully insured health plans.

Option 2: Increase the medical loss ratio (MLR) standard

Key Takeaway: Provides slightly lower premiums to a subset of consumers in the market but results in only modest savings

State Cost: No direct costs, minimal operational costs

Advantages	Disadvantages
Low Operational Cost and Broad Market Applicability Implementation of this policy requires relatively little effort on the part of the state and would apply to all fully insured markets in the state. **No External Funding Needed** This policy does not require external state funding.	**Limited Impact on Low-Income Consumers** Because the policy would affect only a subset of health insurers, most consumers would not benefit from reduced premiums. Furthermore, lower-income households (i.e., those receiving premium tax credits) likely would see minimal benefit. **Low Impact on Premiums** The policy likely would result in modest reductions in premiums and/or increases in rebates paid to consumers. **Market Disruption and Unintended Consequences** There is significant uncertainty regarding health insurers' reactions to the policy. At present, insurers are not required to offer their products in any Washington health insurance market, other than the mandate that insurers participating in PEBB or SEBB offer individual health plans in the counties where they offer PEBB or SEBB coverage. As a result, if insurers face significant financial pressures in certain markets, they might stop offering plans or exit the market entirely. Absent other policy safeguards, insurers also could find a way to increase their MLRs by increasing provider reimbursement through risk-sharing payments, quality incentives, or other actions, which would not lower premiums for members and, therefore, would produce unintended outcomes.

Option 3: Use Reference Based Pricing

Key Takeaway: Could improve affordability for the greatest number of Washingtonians by addressing the underlying price of health care services, but may be operationally complex to implement

State Cost: No direct costs but substantial operational costs

Advantages	Disadvantages
Cost Savings Setting prices lower than they historically have been could reduce costs to insurers, employers, and consumers overall or could be designed to be cost-neutral. This policy directly affects the price of health care services. **Incentivize Key Services and Redistribute Health Care Spending** Setting prices for key services (e.g., primary care and behavioral health) higher than historical payment levels may increase access to these services and provider willingness to enter the profession. Primary care and behavioral health workforce shortages are a major challenge in Washington. **Increase Transparency** Extensive analysis is needed to implement RBP, which can produce transparent information on the exact costs associated with specific services.	**Operational Complexity** Creating, maintaining, and verifying an accurate benchmark is a significant operational undertaking. Additional policymaking may be necessary to determine how to apply RBP to services that do not have traditional Medicare prices. **Market Disruption** Given the scope of the potential impact, hospital financing could be significantly affected by the program. Consequently, understanding current hospital margins and potentially tailoring the budget appropriately for different types of hospitals may be needed. Consideration should be given to exempting sole community hospitals or CAHs.

Option 4: Hospital Global Budgeting

Key Takeaway: Has the potential to improve affordability for the greatest number of Washingtonians by controlling the growth in hospital payments, but at significant implementation costs

State Cost (millions USD): No direct costs but substantial operational costs

Advantages	Disadvantages
Potential for Large Impact HGB would have far-reaching effects because it would, by design, affect revenue from multiple payers (e.g., Medicare, Medicaid and commercial health insurers). The ability to alter overall trajectories of health care spending is high. This option would directly affect the rate of growth in hospital spending. **Incentivize Reinvestment in Services Providing Long-Term Benefits** The program can be created to incentivize spending on services with long-term health and equity benefits. For example, global budgets could be designed to incentivize greater spending in primary care or behavioral health.	**Operational Complexity** Given that hospital budgets are all-encompassing, significant state resources must be expended not only to make initial policy and operational decisions but to monitor, update, and adjust the program. **Market Disruption** Given the scope of the potential impact, hospital financing could be significantly affected. Consequently, understanding current hospital margins and appropriately tailoring the budget to different types of hospitals may be needed. Consideration should be given to exempting sole community or critical access hospitals. **Federal Approval** For hospital global budgets to apply to Medicaid and Medicare payments, a CMS waiver would be necessary. It would take significant time and effort to secure and maintain the necessary waivers from CMS, and approval cannot be guaranteed.

Option 5: Meeting the HCCT Board cost growth benchmarks

Key Takeaway: Directly lowers the growth in health care costs for the entire state, but without any enforcement mechanism, the benchmarks are unlikely to lower health care expenditures or drive significant changes in provider or insurer behavior. Providing authority to require performance improvement plans or impose fines and penalties for failure to meet the benchmarks could increase the likelihood that the benchmarks will be met.

Advantages	Disadvantages
Greatest Impact on Health Care Costs in the Entire State Because meeting the cost growth benchmarks would directly reduce the growth in health care costs, it would apply to all health care services in the state, regardless of recipient or provider. **Least Intrusive Mechanism** Least intrusive regulatory mechanism for targeting cost growth. Does not require providers or insurers to take any specific action, unlike capping reimbursement rates or medical loss ratio or setting global budgets for hospitals. **Most Flexible Approach** Allows providers and insurers to manage their own business strategies to achieve cost growth targets. **Public/Private Partnership** Provides opportunity for the HCCT Board and other state agencies to work with providers to identify strategies to achieve cost growth targets.	**Potentially Protects High-Cost Providers and Insurers** A focus on health care cost growth may allow providers and insurers with the highest costs to maintain those disparities. Discretion in enforcement may be needed to allow for greater increases in costs and investments for high-value providers and to allow for increased cost growth for services that currently are under-reimbursed. **Least Targeted Approach** Could incentivize providers and insurers to engage in perverse actions, such as decreasing access to and utilization of care, rather than reducing unit costs for certain services, which would lead to unintended adverse consequences. **Difficulty of Achieving Compliance** Experience in other states, such as Massachusetts, indicates that the ability to meet benchmarks, without additional policy interventions, wanes over time.

APPENDIX A: ACTUARIAL METHODOLOGY

Reinsurance

Reinsurance in the Individual ACA Market

For analysis of the individual market, Wakely analyzed the impact of implementing a state-based section 1332 reinsurance waiver program that targets a 10 percent reduction in market average premiums.

Baseline (Without Reinsurance) Projection, 2025−2029

We were able to start with the projected premium and enrollment for 2024−2027 from the Washington Health Benefit Exchange (WAHBE) premium and enrollment report exhibits as the baseline projection for the reinsurance analysis. Starting from the 2024 projections, the following steps were taken to estimate the impact of a state-based reinsurance program on Washington's non-group market for 2025−2029.

Enrollment, premiums, and advanced premium tax credit (APTC) amounts for 2025−2027 were taken from the WAHBE enrollment projection, with 2028 and 2029 estimates developed from 2027 (enrollment held constant, premiums trended at the 2026−2027 rate). Wakely arrived at the target loss ratios in the projection period by starting with the ratio reported in the most recent rate filings (2024). The variable portion of the administrative expenses were kept as a constant percentage of premium in 2024. The fixed portion of the administrative expenses was trended at 3.0 percent per year in both scenarios and was based on the long-term employment total compensation index in the Pacific region published by the US Bureau of Labor Statistics.

The incurred claims cost for each projection year was modeled by starting with the premium projection from the WAHBE enrollment projection and then backing out the fixed and variable administrative amounts as discussed in Appendix Table A2. This approach captured the impact of the large demographic changes anticipated in 2026 as a result of expiration of subsidies provided in the American Rescue Plan Act (ARPA). Wakely relied on the two baseline scenarios for 2025−2027 from the WAHBE enrollment projection. The assumptions for the base funding and enrollment scenario include:

- Effectuation rates consistent with past market experience
- Monthly member enrollment attrition consistent with 2023 market experience
- Enrollment attrition resulting from premium changes consistent with 2023 experience
- Special enrollment period (SEP) and Medicaid redetermination impact on enrollment consistent with 2023 and early 2024 market experience
- Uninsured take-up consistent with 2023 and early 2024 market experience
- Undocumented take-up with average dampening reflective of average enrollment hesitancy consistent with early 2024 market experience
- Lower morbidity by 27 percent among uninsured and undocumented populations taking up coverage as a result of lower net premiums

The assumptions that vary for the high enrollment and funding scenario are as follows:

- This scenario reflects generally higher estimates of market enrollment, driven by lower premium increases and low morbidity of those enrolling
- Higher effectuation rates relative to the base scenario
- Lower monthly member enrollment attrition relative to the base scenario
- Lower enrollment attrition due to higher premium changes relative to the base scenario
- Higher Medicaid redetermination impact on enrollment relative to the base scenario
- Higher Cascade Care Select (CCS) plan switching relative to the base scenario
- More take-up of uninsured people relative to the base scenario
- Higher take-up of undocumented Washingtonians with the dampening reflective of lower hesitancy to enroll relative to the base scenario
- 36 percent lower morbidity because of uninsured and undocumented populations taking up coverage
- Greater CCS funding and maximum per member per month subsidy amounts

With Reinsurance Projection, 2025−2029

The effects of the reinsurance program were then modeled relative to each baseline projection year to determine the impact on market enrollment, premiums, and APTCs. In addition to modeling a 10 percent premium reduction as a result of the reinsurance program, Wakely relied on the two baseline scenarios for 2025−2027 from the WAHBE enrollment projection. (WAHBE Projected 2024−2027 Premium and Enrollment Exhibits 2024-03-12_External.xlsx, WAHBE Projected 2024-2027 Premium and Enrollment Exhibits 2024-03-12.pdf).

The key factors in modeling the reinsurance impact included the change in the claims health insurers incur (i.e., net of reinsurance recoveries and reflecting lower market morbidity as a result of additional enrollment), the subsequent reduction in premiums (and the second lowest cost Silver plan [SLCSP] or benchmark premium), and the additional enrollment take-up by individuals who are ineligible for the federal APTC premium subsidies (i.e., unsubsidized populations). Note that the reduction in the incurred claims also affects the portion of premiums used to fund the variable administrative expenses such as premium taxes and other expenses that vary proportionally with the claim costs. No program assessment fee was assumed in these projections.

1. **Morbidity:** The estimated market-wide impact on morbidity because of uninsured, unsubsidized enrollees taking up coverage was estimated based on the National Bureau of Economic Research (NBER) study,[76] which estimated that new market entrants are estimated to have 27 percent lower morbidity than people already enrolled in the individual market. This assumption was varied in the base and high funding scenarios and was used to project the risk pool morbidity changes. The 2024−2027 projected premiums assume that any morbidity changes as a result of increased enrollment will be reflected in the lower premium rates during this time period. In reality, insurers may build in this impact more gradually over time.

2. **Impact on SLCSP:** The impact on SLCSP was assumed to be equal to the market average premium reduction or the target reduction amount (10%).

3. **Federal Savings:** The projected federal savings are calculated as the difference in the aggregate APTC amounts between the baseline (without reinsurance) and with reinsurance scenarios.

4. **Adjusted Federal Savings:** A key assumption included in calculating the total funding was an Advance Premium Tax Credits (APTC) to Premium Tax Credits (PTC) adjustment based on data released by CMS on the past adjustments made in other state programs. The actual value applied is based on tax return data that is unavailable publicly. The value of this assumption varies because of ARPA subsidies. For the 2025 projection, the PTC adjustment was set at the average of the 2023 adjustment values for states with reinsurance programs. For projection years 2026−2029, the PTC adjustment was set as the average of the 2019 adjustment values (pre-ARPA and pre-pandemic).

5. **State Funding:** This estimate was determined as the total amount required to fund the reinsurance program minus the federal pass-through savings.

When considering whether to adopt an affordability program such as reinsurance, it is important to weigh which populations will benefit from the program.

The main advantage of a reinsurance program is the ability to leverage federal funding to assist middle-income consumers in the individual market who do not receive a significant benefit through APTC subsidies. Lower-income, federally subsidized individuals are protected from premium increases because of the presence of the federal APTC subsidies, where the net premiums are indexed annually to income thresholds based on a percentage of the federal poverty level (FPL), but otherwise remain relatively flat. Reinsurance leads to lower premiums for health plan enrollees who are not benefiting from the APTC subsidies without reducing affordability for lower-income APTC-eligible people. ARPA subsidies are set to expire in 2025. The largest increases in net premiums (relative to the income level) will be felt by households with incomes between 139 percent and 250 percent FPL and those with incomes greater than 400 percent FPL. To date, the Washington legislators have chosen to apply additional state funding for subsidies through the CCS premium subsidy program.

[76] Hackmann MB, Kolstad JT, Kowalski AE. Adverse Selection and an Individual Mandate: When Theory Meets Practice. National Bureau of Economic Research Working Paper Series. June 2013. Available at: https://www.nber.org/system/files/working_papers/w19149/w19149.pdf.

Note that the introduction of the reinsurance program in the individual market is expected to neither significantly affect the CCS program nor yield savings for the CCS program because APTC subsidies are anchored in the second lowest cost Silver plan. A reduction in the second lowest cost Silver plan would result in a reduction in the APTC subsidy, keeping use of the CCS subsidy at a similar magnitude as without the reinsurance program.

Note that this analysis does not account for market migration as a result of reinsurance. No evidence to date suggests that other states that have implemented reinsurance programs in the individual market have experienced an intermarket migration (e.g., group employers stop offering coverage and force employees to seek coverage on individual exchanges).

Implementing reinsurance program is expensive and different mechanisms are in place to fund a reinsurance proposal that distribute costs beyond the general fund state spending. Table A1 summarizes the latest information from the Centers for Medicare & Medicaid Services (CMS) on the sources of state funds used to pay for reinsurance programs, focusing specifically on the states running claim-based reinsurance.[77] Most states rely on the general state funding and/or health insurer assessment. Several states assess individual mandate penalties, and other states assess fees on healthcare providers.

Table A1: State Funding Sources for Section 1332 Waivers for Claim-Based Reinsurance Waiver Programs

	General Fund	Issuer Assessment	Provider Fee		Notes and Other Funding Sources
Minnesota	X		X		A portion of past accumulations of the state's 2.0% provider tax, which applies to hospitals and other providers.
Oregon		X			Starting in Plan Year (PY) 2020, 2.0% state premium assessment on major medical premiums and stop loss insurance.
Maine		X			Assessment of $4 per member per month on fully-insured and self-funded commercial health insurance markets.
Maryland		X			In PY 2019, 2.75% premium assessment on health insurers. In PY 2020-2028, 1.0% assessment.
New Jersey	X			X	Revenue raised by shared responsibility payments per the state individual mandate, and if necessary, the state general fund.
Wisconsin	X				State general purpose revenue (GPR), which consists of general taxes, miscellaneous receipts, and revenues collected by the state.
Colorado	X	X	X		Fee on health insurers who would otherwise be subject to the now repealed federal health insurance provider fee under Section 9010 of the ACA. For PYs 2022 and 2023 only, a special assessment on hospitals. A portion of the state's health insurance premium tax revenue. Money from the state's general fund is available for section 1332 waiver administration.

[77] Data Brief on State Innovation Waivers: Section 1332 Waivers.

State	General Fund	Issuer Assessment	Provider Fee	Mandate Penalty	Notes and Other Funding Sources
Delaware		X			Assessment on carriers and entities that would otherwise be subject to the federal Health Insurance Providers Fee under Section 9010 of the ACA. The state assessment is 2.75% of premium annually in years that the health insurance providers fee is waived, and 1% of premium annually in years that the Health Insurance Providers Fee is assessed.
Montana		X			1.2% annual state assessment on major medical health insurance premiums.
North Dakota		X			A state assessment on insurers writing in the small and large group health insurance markets ($22M in PY 2020).
Rhode Island	X			X	Penalties collected from the state individual mandate. Rhode Island received a one-time state appropriation for the Health Insurance Market Integrity Fund to support operation and administration of the program.
Pennsylvania		X			A portion of a user fee that is 3.0% of premiums and assessed on issuers participating in the Pennsylvania health insurance exchange and other available state sources.
New Hampshire		X			A premium assessment of 0.6% of the previous year's second lowest cost silver plan without waiver rate across all licensed health insurance issuers in the state's individual and group health insurance markets with some exceptions.
Georgia	X				State general funds.
Virginia	X				State appropriations allotted in the Commonwealth health reinsurance program special fund.
Idaho	X	X			An annual premium tax allotment and one-time deposit of $25 million in 2022, and an assessment on the health insurance market on an as needed basis to achieve the state's target premium reduction.

Reinsurance in Small Group Market

For small group market analysis, Wakely analyzed the impact of implementing a state-funded reinsurance program that targets a 10 percent reduction in market average premiums.

Baseline (Without Reinsurance) Projection, 2025−2029

For small group market analysis, Wakely started with projected membership and premium from 2024 URRT public use data, and applied enrollment and premium trend assumptions based on historical trends. To reflect the inherent uncertainty in the baseline estimates, we developed three different scenarios based on differing levels of incurred claim cost and enrollment trends.

Base Scenario: The baseline scenario relied on the historical small group market experience from URRT submissions and CMS risk adjustment reports to evaluate the average incurred claim trend and market enrollment trends. The assumptions selected for the base scenario were 5.0 percent annual claim cost trend and 0.50 percent annual market enrollment trend.

Low: The assumptions selected for the low scenario assumed a lower annual claim cost trend and a lower annual market enrollment trend relative to the base scenario.

High: The assumptions selected for the high scenario assumed a higher annual claim cost trend and a higher annual market enrollment trend relative to the base scenario.

With Reinsurance Projection, 2025−2029

The effects of the reinsurance program were then modeled relative to each baseline projection year to determine the impact to the market enrollment and premiums. In addition to modeling 10 percent premium reduction as a result of implementing a reinsurance program, Wakely modeled three baseline scenarios for 2025−2029 described above.

The key factors in modeling the reinsurance impact included the change in the claims incurred by the health insurers (net of reinsurance recoveries), the subsequent reduction in premiums and additional enrollment take up by the small group employers. Note that the reduction in the incurred claims also affects the portion of premiums used to fund the variable administrative expenses such as premium taxes and other expenses that vary proportionally with the claim costs. No program assessment fee was assumed in these projections. The fixed portion of the administrative expenses was trended at 3.0 percent annually across all scenarios and was based on the long-term employment total compensation index in the Pacific region published by US Bureau of Labor Statistics.

Because of the impacts of employer choice on the small group market entry, as opposed to an individual making the enrollment decision based on their health status and needs, we did not assume any morbidity improvement from this incremental take-up by the employers.

Few states have implemented reinsurance programs in small group markets. An analogous program is a direct premium reduction that the State of New Mexico funds for the small group employer market, which yielded a 10 percent premium reduction in July 2022. Since the introduction of the program, no significant market size change has been observed that would indicate market migration.

Table A2: Summary of Key Assumptions by Scenario and Market

		Scenarios			
Assumption	**Market**	**Low**	**Best**	**High**	**Source / Note**
Incurred Claim Cost Annual Trend	Small Group	-0.8%	5.0%	11.1%	2024 URRT data for best scenario; vary for other scenarios.
Annual Enrollment Trend	Small Group	-1.5%	0.5%	3.0%	2019−2022 CMS Risk-Adjustment Reports.
Fixed Administrative Expense Annual Trend	Small Group	3.3%	3.3%	3.3%	US BLS Employment Cost Index (NAICS), 2013−2023. Total Compensation for Private Industry Employees in Pacific, All industries. Accessed on March 21, 2024, via https://www.bls.gov/regions/west/data/xg-tables/ro9xg04.htm.
Price Elasticity of Demand for Health Insurance	Small Group	-0.38	-0.38	-0.38	https://www.cbo.gov/system/files?file=2019-01/54915-New_Rules_for_AHPs_STPs.pdf
Number of Uninsured Working for Small Employers in WA	Small Group	118,000			Congressional Budget Office. How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans JANUARY 2019. https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf
Percent of Members in Self-funded plans	Small Group	20.0%	20.0%	20.0%	MEPS Data Washington 2022

		Scenarios			
Assumption	**Market**	**Low**	**Best**	**High**	**Source / Note**
Small Employer Acceptance	Small Group	63.3%	63.3%	63.3%	MEPS Data Washington 2022
Employee Acceptance	Small Group	81.0%	81.0%	81.0%	MEPS Data Washington 2022
Portion of Premium for Admin+ Taxes + Risk Load	Small Group	15.9%	15.9%	15.9%	2024 URRT Public Use File Data.
Portion of Total Administrative Expense That is Fixed	Both	50.0%	50.0%	50.0%	Assumption
Portion of Premium for Admin + Taxes + Risk Load	Individual		12.6%	12.6%	2024 URRT Public Use File Data.
Loss Ratio (Incurred Claim/Premium)	Individual	N/A	87.4%	87.4%	Varies by year, start with the 2025 value using URRT Admin amounts and adjusts from there based on fixed admin trend
Price Elasticity of Demand for Health Insurance	Individual	-0.40	-0.40	-0.40	https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea _issue_brief.pdf

		Scenarios			
Assumption	**Market**	**Low**	**Best**	**High**	**Source / Note**
PTC/APTC Adjustment - With ARPA	Individual	98.9%	98.9%	98.9%	Summary of 2019 pass-through components for states.xlsx
PTC/APTC Adjustment - Without ARPA	Individual	93.9%	93.9%	93.9%	1332 Key Components of 2021 Pass-through Feb. 2021.xlsx
Post Reinsurance Morbidity	Individual	0.73	0.73	0.73	https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea _issue_brief.pdf

Data Sources

Enrollment and experience figures, particularly in the small group market, rely on available data, including CMS's unified rate review template (URRT) public use dataset and risk-adjustment report values, which do not represent the most current experience with full run-out. Hence, we have relied on other sources for data and assumptions used in the report. URRT experience is lagged two years from the year of filing (ex: PY2024 URRTs contain PY2022 claims and enrollment). When an insurer exits the market, no information is available regarding its last two years of experience. URRT data do not represent final claims or risk-adjustment figures.

Our estimates also rely on the WAHBE enrollment projection report that estimates individual market enrollment and premium from 2024−2027.

List of All Files:

- WAHBE Projected 2024-2027 Premium and Enrollment Exhibits 2024-03-12_External.xlsx
- WAHBE Projected 2024-2027 Premium and Enrollment Exhibits 2024-03-12.pdf
- Summary Report on Permanent Risk-Adjustment Transfers for the 2019 Benefit Year
- Summary Report on Permanent Risk-Adjustment Transfers for the 2020 Benefit Year
- Summary Report on Permanent Risk-Adjustment Transfers for the 2021 Benefit Year
- Summary Report on Permanent Risk-Adjustment Transfers for the 2022 Benefit Year

URRT Public Use Data Files:

- Worksheet I, II and III Data for 2021 Single Risk Pool Filings
- Worksheet I, II and III Data for 2022 Single Risk Pool Filings
- Worksheet I, II and III Data for 2023 Single Risk Pool Filings
- Worksheet I, II and III Data for 2024 Single Risk Pool Filings

MLR public use files (PUFs) for premium year 2022. Downloaded from:

- Medical Loss Ratio Data and System Resources | CMS

Medical Loss Ratio

Alternate Minimum Loss Ratio in Individual Market

Wakely analyzed the impact on the individual market premiums and enrollment of adjusting the state medical loss ratio (MLR) standard from the current federal standard of 80 percent. To assess the impact of an adjusted MLR, Wakely modeled two scenarios of potential health insurer reactions—status quo and reductions in premiums. In both scenarios, Wakely did not assess the feasibility of insurers adjusting their operations and the implications on solvency and market participation.

Baseline Projection, 2025−2029

The baseline projection was developed to project the WA individual market under the existing MLR requirement of 80 percent. The basis of the analysis was the 2019−2022 reporting years CMS's MLR PUFs, along with premium and enrollment projections that Wakely developed for WAHBE in February 2024. Each Washington health insurer within the market was evaluated for credibility, and all calculations were performed at the insurer level before aggregating. From the 2019−2022 actual experience data, each component of the MLR calculation was projected for 2023−2029 using the following methodology.

- **Enrollment:** The actual and projected 2023−2027 enrollment was taken from the WAHBE premium and enrollment projections (see below). The projected enrollment for 2028−2029 was kept flat relative to 2027 levels.
- **Premium:** The actual and projected 2023−2029 premium was taken from the WAHBE premium and enrollment projections. The projected premium for 2028−2029 was based on 2026−2027 premium trend levels.
- **Incurred Claims:** Projected by trending the 2022 average incurred claims by insurer to each projection year. Wakely considered the annual historical claim trends by insurer. If an insurer's historical claim experience has been volatile from year to year, the market average annual claim trend (2019−2022) was used; otherwise, insurers' specific annual average claim cost trends were used in the projections.
- **Risk-Adjustment Transfer Amount:** The projected risk-adjustment transfer amount for each insurer was modeled as a percentage of the adjusted market average premium based on the most recent percentage as reported in 2021−2022 benefit years.
- **Taxes and Fees:** Projected as a percentage of insurer average premium consistent with the average percentage in 2019−2022 experience.
- **Health Care Quality Improvement Expenses**: Projected as a percentage of insurer average premium consistent with the average percentage in 2019−2022 experience.

Other components of the three-year average MLR calculation included:

- **Deductible Credibility Factor:** Average deductible was projected by trending issuer specific average deductible from 2019-2022 to the projection period.
- **Base Credibility Factor:** Three-year covered lives average was calculated from the enrollment projection described above, and the base credibility factor was calculated using the MLR requirement methodology.

Once all annual components were projected, Wakely followed the standard MLR formula outlined in the federal MLR calculator to calculate a projected MLR based on the three-year average plan experience. The plan specific projected results were then aggregated at a market level.

Alternate MLR Requirement Projection 2025−2029, Increased MLR Requirement from 80 Percent to 88 Percent

To assess the impact of a higher MLR requirement (88%), Wakely recalculated the rebates using the 88 percent minimum MLR requirement for the two scenarios modeled.

- **Scenario 1 — Status Quo**: Wakely assumed that insurers cannot adjust their premiums and expenses to meet the alternate MLR requirements and continue to price plans at current pricing loss ratios. In this scenario, premiums are not reduced and result in insurers incurring greater rebates.
- **Scenario 2 — Issuers Adjust Premiums**: Wakely assumed that insurers are able to adjust their premiums and expenses over time to meet the alternate MLR requirements. In this scenario, premiums are reduced and result in insurers incurring zero rebates by 2028. Neither the specific driver of the reduction nor their achievability of the reduction were assessed in this analysis. To adjust the pricing loss ratio upwards, an adjustment was applied to the insurers with a baseline MLR lower than the new standard (88%). The multiplicative adjustment was calculated to account for the relative size of insurers' claim costs, quality improvement expenses, and taxes and fees. Further, the adjusted pricing loss ratio was used to calculate the premium needed to reach the desired revised MLR. The resulting reduction in premiums was used to estimate an additional enrollment take-up by individuals who are ineligible for the federal APTC premium subsidies (unsubsidized populations).

Wakely relied on the base funding baseline scenario for 2025−2029 from the WAHBE enrollment projection. The assumptions for the base funding and enrollment scenario include:

- Effectuation rates consistent with past market experience.
- Monthly member enrollment attrition consistent with 2023 market experience.
- Enrollment attrition due to premium changes consistent with 2023 experience.
- SEP and Medicaid redetermination impact on enrollment consistent with 2023 and early 2024 market experience.
- Uninsured take-up consistent with 2023 and early 2024 market experience.
- Undocumented take-up with average dampening reflective of average enrollment hesitancy, consistent with early 2024 market experience.
- 27 percent lower morbidity among the uninsured and undocumented populations taking up coverage as a result of lower net premiums.
- Washington Apple Health (WAH) impact: We reflected the impact of a lower pool of undocumented uninsured people at <138 percent by reducing the starting number of 35,200 as follows:
- 9,500 individuals currently receiving some level of benefits who will be eligible for WAH program as of January 1, 2024 (35,200 – 9,500 = 25,700),
- Up to 4,300 new enrollees based on the Year 1 cap of eligible undocumented people as of July 1, 2024 (25,700 – 4,300 = 21,400).

    - Given the timing differences and our modeling year average impacts, we would take the average of these (25,700 and 21,400) to use in the take-up modeling, or 23,600.
- Deferred Action for Childhood Arrivals (DACA) impact: Based on information that the WAHBE provided on July 12, 2023, we increased the pool of qualified health plan (QHP)-eligible uninsured people with incomes at more than 138 percent FPL by 7,600, with income and age distribution also based on the information WAHBE shared. In additional, we reduced the starting Group 3-eligible 139−250 percent FPL undocumented cohort by (7,600 x % between 139−250% FPL), or 5,220.
- Note that no undocumented members are assumed to migrate from off-exchange to Group 3 in our modeling.

Figure A1: Alternate Minimum Loss Ratio in Individual Market Results

		Scenario 1 Status Quo: Issuers Do Not Adjust Premiums, Pay Non-Zero Rebates							
		2022	2023	2024	2025	2026	2027	2028	2029
Baseline 80% MLR	Projected Market Enrollment (Avg Lives)	244,000	241,000	274,000	251,000	188,000	208,000	208,000	208,000
	Projected Average Premium (PMPM)	$527	$568	$585	$629	$737	$763	$804	$847
	Average Pricing Loss Ratio	85.7%	85.6%	85.9%	86.2%	86.2%	86.2%	86.3%	86.3%
	Average Federal MLR	89.0%	90.8%	89.7%	89.5%	89.5%	89.5%	90.0%	90.5%
	Average Rebate (PMPM)	**$3.02**	**$3.41**	**$2.13**	**$0.54**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternate 88% MLR in 2025 2027	Projected Market Enrollment (Avg Lives)	244,000	241,000	274,000	251,000	188,000	208,000	208,000	208,000
	Projected Average Premium (PMPM)	$527	$568	$585	$629	$737	$763	$804	$847
	Average Pricing Loss Ratio	85.7%	85.6%	85.9%	86.2%	86.2%	86.2%	86.3%	86.3%
	Average Federal MLR	89.0%	90.8%	89.7%	89.5%	89.5%	89.5%	90.0%	90.5%
	Average Rebate (PMPM)	**$3.02**	**$3.41**	**$2.13**	**$8.99**	**$9.94**	**$10.24**	**$9.35**	**$8.53**
	Market Enrollment Impact vs. Baseline %				0.0%	0.0%	0.0%	0.0%	0.0%
	Average Premium Impact vs. Baseline %				0.0%	0.0%	0.0%	0.0%	0.0%
	Change in Aggregate Rebate vs. Baseline (millions)				$25.5	$22.4	$25.6	$23.3	$21.3

		Scenario 2 Issuers Adjust Premiums, Zero Rebates							
		2022	2023	2024	2025	2026	2027	2028	2029
Baseline 80% MLR	Projected Market Enrollment (Avg Lives)	244,000	241,000	274,000	251,000	188,000	208,000	208,000	208,000
	Projected Average Premium (PMPM)	$527	$568	$585	$629	$737	$763	$804	$847
	Average Pricing Loss Ratio	85.7%	85.6%	85.9%	86.2%	86.2%	86.2%	86.3%	86.3%
	Average Federal MLR	89.0%	90.8%	89.7%	89.5%	89.5%	89.5%	90.0%	90.5%
	Average Rebate (PMPM)	**$3.02**	**$3.41**	**$2.13**	**$0.54**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternate 88% MLR in 2025 2027	Projected Market Enrollment (Avg Lives)	244,000	241,000	274,000	252,000	189,000	209,000	208,000	208,000
	Projected Average Premium (PMPM)	$527	$568	$585	$616	$719	$744	$787	$829
	Average Pricing Loss Ratio	85.7%	85.6%	85.9%	88.0%	88.4%	88.4%	88.1%	88.1%
	Average Federal MLR	89.0%	90.8%	89.7%	90.2%	90.9%	91.6%	92.1%	92.5%
	Average Rebate PMPM	**$3.02**	**$3.41**	**$2.13**	**$5.13**	**$1.89**	**$0.00**	**$0.00**	**$0.00**
	Market Enrollment Impact vs. Baseline %				0.4%	0.5%	0.5%	0.0%	0.0%
	Average Premium Impact vs. Baseline %				-2.1%	-2.5%	-2.5%	-2.1%	-2.0%
	Change in Aggregate Premiums and Rebates vs. Baseline (millions)				$45.4	$37.1	$38.6	$41.2	$43.2

Alternate MLR in Small Group Market

Wakely analyzed the impact on the small group market premiums and enrollment of adjusting the state MLR standard from the current federal standard of 80 percent. To assess the effect of an adjusted minimum loss ratio, Wakely modeled two scenarios of potential health insurer reactions—status quo and reductions in premiums. Wakely did not assess the feasibility of insurers adjusting their operations and the implications on solvency and market participation.

Baseline Projection, 2025−2029

The baseline projection was developed to project the WA small group market under the existing MLR requirement of 80 percent. The basis of the analysis was the 2019−2022 reporting years MLR PUFs that CMS publishes. All calculations were performed at the insurer level before aggregating to the market level. From the 2019−2022 actual experience data, each component of the MLR calculation was projected for 2023−2029 using the following methodology:

- **Enrollment:** Projected based on the historical annual enrollment trends observed during 2019−2022.
- **Premium:** Projected to maintain issuers' historical most recent or the average pricing loss ratio observed during 2019−2022.
- **Incurred Claims:** Projected by trending the 2022 average incurred claims by insurer to each projection year. Wakely considered the annual historical claim trends by insurer. If an insurer's historical claim experience has been volatile from year to year, the market average annual claim trend (from 2019−2022) was used; otherwise, insurers' specific annual average claim cost trends were used in the projections.
- **Risk-Adjustment Transfer Amount**: The projected risk-adjustment transfer amount for each insurer was modeled as a percentage of the adjusted market average premium, based on the most recent percentage as reported in 2021−2022 benefit years.
- **Taxes and Fees**: Projected as a percentage of insurer average premium consistent with the average percentage in 2019−2022 experience.
- **Healthcare Quality Improvement Expenses:** Projected as a percentage of insurer average premium consistent with the average percentage in 2019−2022 experience.

Other components of the three-year average MLR calculation included:

- **Deductible Credibility Factor:** Average deductible was projected by trending insurer-specific average deductible from 2019−2022 to the projection period.
- **Base Credibility Factor:** Three-year covered lives average was calculated from the enrollment projection described above, and the base credibility factor was calculated using the MLR requirement methodology.

Once all annual components were projected, Wakely followed the standard MLR formula outlined in the federal MLR calculator to calculate a projected MLR based on the three-year average plan experience. The plan specific projected results were then aggregated at a market level.

Alternate MLR Requirement Projection 2025−2029, Increased MLR Requirement from 80 Percent to 88 Percent

To assess the impact of a higher MLR requirement (88%), Wakely recalculated the rebates using the 88 percent minimum MLR requirement for the two scenarios modeled.

- **Scenario 1 — Status Quo**: Wakely assumed that insurers cannot adjust their premiums and expenses to meet the alternate MLR requirements and continue to price plans at current pricing loss ratios. In this scenario, premiums are not reduced and result in greater rebates incurred by the issuers.
- **Scenario 2 — Issuers Adjust Premiums**: Wakely assumed that insurers are able to adjust their premiums and expenses over time to meet the alternate MLR requirements. In this scenario, premiums are reduced and result in insurers incurring zero rebates by 2028. Neither the specific driver of the reduction nor the achievability of the reduction were assessed in this analysis. To adjust the pricing loss ratio upward, an adjustment was applied to the insurers with a baseline MLR lower than the new standard (88%). The multiplicative adjustment was calculated to account for the relative size of insurers' claim costs, quality improvement expenses and taxes and fees. Further, the adjusted pricing loss ratio was used to calculate the premium needed to reach the desired revised MLR. The resulting reduction in premiums was used to estimate an additional enrollment take-up by small group employers.

Figure A2: Alternate MLR in Small Group Market Results

		Scenario 1 Status Quo: Issuers Do Not Adjust Premiums, Pay Non-Zero Rebates							
		2022	2023	2024	2025	2026	2027	2028	2029
Baseline 80% MLR	Projected Market Enrollment (Avg Lives)	301,000	301,000	301,000	301,000	301,000	301,000	301,000	301,000
	Projected Average Premium (PMPM)	$397	$417	$436	$456	$478	$500	$524	$549
	Average Pricing Loss Ratio	84.3%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%
	Average Federal MLR	86.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%
	Average Rebate (PMPM)	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternate 88% MLR in 2025 2027	Projected Market Enrollment (Avg Lives)	301,000	301,000	301,000	301,000	301,000	301,000	301,000	301,000
	Projected Average Premium (PMPM)	$397	$417	$436	$456	$478	$500	$524	$549
	Average Pricing Loss Ratio	84.3%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%
	Average Federal MLR	86.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%
	Average Rebate (PMPM)	**$0.00**	**$0.00**	**$0.00**	**$6.11**	**$6.39**	**$6.68**	**$6.98**	**$7.29**
	Market Enrollment Impact vs. Baseline %				0.0%	0.0%	0.0%	0.0%	0.0%
	Average Premium Impact vs. Baseline %				0.0%	0.0%	0.0%	0.0%	0.0%
	Change in Aggregate Rebate vs. Baseline (millions)				$22.1	$23.1	$24.1	$25.2	$26.3

		Scenario 2 Issuers Adjust Premiums, Zero Rebates							
		2022	2023	2024	2025	2026	2027	2028	2029
Baseline 80% MLR	Projected Market Enrollment (Avg Lives)	301,000	301,000	301,000	301,000	301,000	301,000	301,000	301,000
	Projected Average Premium (PMPM)	$397	$417	$436	$456	$478	$500	$524	$549
	Average Pricing Loss Ratio	84.3%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%
	Average Federal MLR	86.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%
	Average Rebate (PMPM)	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternate 88% MLR in 2025 2027	Projected Market Enrollment (Avg Lives)	301,000	301,000	301,000	303,000	304,000	304,000	304,000	304,000
	Projected Average Premium (PMPM)	$397	$417	$436	$451	$469	$491	$514	$535
	Average Pricing Loss Ratio	84.3%	84.0%	84.0%	85.0%	85.7%	85.7%	85.7%	86.1%
	Average Federal MLR	86.9%	87.9%	87.9%	88.2%	88.8%	89.4%	89.6%	89.8%
	Average Rebate PMPM	**$0.00**	**$0.00**	**$0.00**	**$4.37**	**$1.74**	**$0.00**	**$0.00**	**$0.00**
	Market Enrollment Impact vs. Baseline %				0.7%	1.0%	1.0%	1.0%	1.0%
	Average Premium Impact vs. Baseline %				-1.1%	-2.0%	-1.9%	-1.9%	-2.4%
	Change in Aggregate Premiums and Rebates vs. Baseline (millions)				$23.3	$23.3	$17.2	$18.1	$28.8

Alternate MLR in Large Group Market

Wakely analyzed the impact on the large group market premiums and enrollment of adjusting the state MLR standard from the current federal standard (85%). To assess the impact of an adjusted minimum loss ratio, Wakely modeled two scenarios of potential insurer reactions: Maintaining the status quo and reducing premiums. Wakely did not assess the feasibility of insurers adjusting their operations and the implications on solvency and market participation.

Baseline Projection, 2025−2029

The baseline projection was developed to project the WA small group market under the existing MLR requirement of 85 percent. The basis of the analysis was the 2019−2022 reporting years MLR PUFs from CMS. All calculations were performed at the insurer level before aggregating to the market level. From 2019−2022 actual experience data, each component of the MLR calculation was projected for 2023−2029 using the following methodology.

- **Enrollment:** Projected based on the historical annual enrollment trends observed in 2019−-2022.
- **Premium:** Projected to maintain an insurer historical trends either the most recent or the average pricing loss ratio observed during 2019-2022.
- **Incurred Claims:** Projected by trending the 2022 average incurred claims by insurer to each projection year. Wakely considered the annual historical claim trends by insurer. If an insurer's historical claim experience has been volatile from year to year, the market average annual claim trend (2019−2022) was used; otherwise, insurers' specific annual average claim cost trend were used in the projections.
- **Taxes and Fees:** Projected as a percentage of insurer average premium consistent with the average percentage in the 2019−2022 experience.
- **Healthcare Quality Improvement Expenses**: Projected as a percentage of insurer average premium consistent with the average percentage in 2019-2022 experience.

Other components of the three-year average MLR calculation included:

- **Deductible Credibility Factor**: Average deductible was projected by trending insurer-specific average deductible from 2019−2022 to the projection period.
- **Base Credibility Factor**: The three-year covered lives average was calculated from the enrollment projection described above, and the base credibility factor was calculated using the MLR requirement methodology.

Once all annual components were projected, Wakely followed the standard MLR formula outlined in the federal MLR calculator to arrive at a projected MLR based on the three-year average plan experience. The plan-specific projected results were then aggregated at the market level.

Alternate MLR Requirement Projection, 2025−2029, Increased MLR Requirement from 85 Percent to 88 Percent

To assess the impact of a higher MLR requirement (88%), Wakely recalculated the rebates using the 88 percent minimum MLR requirement for the two scenarios modeled.

- **Scenario 1 — Status Quo**: Wakely assumed that issuers cannot adjust their premiums and expenses to meet the alternate MLR requirements and continue to price plans at current pricing loss ratios. In this scenario, premiums are not reduced and result in greater rebates incurred by the insurers.
- **Scenario 2 — Insurers Adjust Premiums**: Wakely assumed that insurers are able to adjust their premiums and expenses over time to meet the alternate MLR requirements. In this scenario, premiums are reduced and result in insurers incurring zero rebates incurred by 2028. Neither the specific driver of the reduction nor the achievability of the reduction were assessed in this analysis. To adjust the pricing loss ratio upwards, an adjustment was applied to the insurers with a baseline MLR lower than the new standard (88%). The multiplicative adjustment was calculated to account for the relative size of insurers' claim costs, quality improvement expenses and taxes and fees. Further, the adjusted pricing loss ratio was used to calculate the premium needed to reach the desired revised MLR. The resulting reduction in premiums was used to estimate an additional enrollment take-up by large group employers.

Figure A3: Alternate MLR in Large Group Fully Insured Market Results

		Scenario 1 Status Quo: Issuers Do Not Adjust Premiums, Pay Non-Zero Rebates							
		2022	2023	2024	2025	2026	2027	2028	2029
Baseline 80% MLR	Projected Market Enrollment (Avg Lives)	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000
	Projected Average Premium (PMPM)	$515	$536	$557	$580	$603	$628	$653	$679
	Average Pricing Loss Ratio	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%
	Average Federal MLR	89.5%	90.1%	89.6%	89.8%	89.8%	89.8%	89.8%	89.8%
	Average Rebate (PMPM)	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternate 88% MLR in 2025 2027	Projected Market Enrollment (Avg Lives)	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000
	Projected Average Premium (PMPM)	$515	$536	$557	$580	$603	$628	$653	$679
	Average Pricing Loss Ratio	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%
	Average Federal MLR	89.5%	90.1%	89.6%	89.8%	89.8%	89.8%	89.8%	89.8%
	Average Rebate (PMPM)	**$0.29**	**$0.29**	**$0.21**	**$2.23**	**$2.31**	**$2.39**	**$2.46**	**$2.55**
	Market Enrollment Impact vs. Baseline %				0.0%	0.0%	0.0%	0.0%	0.0%
	Average Premium Impact vs. Baseline %				0.0%	0.0%	0.0%	0.0%	0.0%
	Change in Aggregate Rebate vs. Baseline (millions)				$28.4	$29.4	$30.5	$31.4	$32.5

		Scenario 2 Issuers Adjust Premiums, Zero Rebates							
		2022	2023	2024	2025	2026	2027	2028	2029
Baseline 80% MLR	Projected Market Enrollment (Avg Lives)	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000	1,062,000
	Projected Average Premium (PMPM)	$515	$536	$557	$580	$603	$628	$653	$679
	Average Pricing Loss Ratio	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%
	Average Federal MLR	89.5%	90.1%	89.6%	89.8%	89.8%	89.8%	89.8%	89.8%
	Average Rebate (PMPM)	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternate 88% MLR in 2025 2027	Projected Market Enrollment (Avg Lives)	1,062,000	1,062,000	1,062,000	1,063,000	1,065,000	1,064,000	1,064,000	1,065,000
	Projected Average Premium (PMPM)	$515	$536	$557	$577	$598	$624	$649	$674
	Average Pricing Loss Ratio	86.4%	86.4%	86.4%	86.8%	87.2%	87.0%	87.0%	87.1%
	Average Federal MLR	89.5%	90.1%	89.6%	89.9%	90.2%	90.4%	90.4%	90.4%
	Average Rebate PMPM	**$0.29**	**$0.29**	**$0.21**	**$1.44**	**$0.27**	**$0.00**	**$0.00**	**$0.00**
	Market Enrollment Impact vs. Baseline %				0.1%	0.3%	0.2%	0.2%	0.3%
	Average Premium Impact vs. Baseline %				-0.5%	-0.9%	-0.6%	-0.6%	-0.7%
	Change in Aggregate Premiums and Rebates vs. Baseline (millions)				$44.8	$50.6	$36.1	$36.9	$39.5

Figure A4: Assumptions

Assumption	Market	Value	Source / Note
Incurred Claim Cost Annual Average Market Trend	Individual	4.2%	2019-2022 MLR data
	Small Group	4.4%	2019-2022 MLR data
	Large Group	4.2%	2019-2022 MLR data
Price Elasticity of Demand for Health Insurance	Individual	-0.40	https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea _issue_brief.pdf
	Small and Large Group	-0.38	https://www.cbo.gov/system/files?file=2019-01/54915-New_Rules_for_AHPs_STPs.pdf
Annual Enrollment Trend	Individual		WAHBE Projected Enrollment
	Small and Large Group	0.0%	Based on historical trends in 2019-2022
% of Individual Market Enrollment Off Exchange	Individual	10.7%	WAHBE Projected Enrollment
Ratio of Premium Off Exchange / On Exchange	Individual	84.4%	Estimated using 2019-2022 actuals from WAHBE and CMS Risk adjustment reports
Issuers with reported MLR excluded from the analysis (those with minimal or zero enrollment in 2022)	Individual		Connecticut General Life Insurance Company
	Individual		Health Alliance Northwest Health Plan
	Individual		Health Net Health Plan of Oregon, Inc
	Individual		State Farm Mutual Automobile Insurance Company
	Individual		The Guardian Life Insurance Company of America
	Individual		The United States Life Ins. Co. in the City of New York
	Individual		UnitedHealthcare Insurance Company
	Individual		UnitedHealthcare of Washington, Inc.
	Small Group		Health Net Health Plan of Oregon, Inc
	Large Group		AMERICAN FIDELITY ASSURANCE COMPANY
	Large Group		Health Net Health Plan of Oregon, Inc

Reference-Based Pricing Model

This study used 2022 commercial claims data from the WA-APCD to analyze and project health care costs under different pricing models. The claims data were repriced using Medicare fee schedules relevant to the date of service. Specifically, the calendar year (CY) 2022 fee schedules were used for outpatient (OP) and professional services, and fiscal year (FY) 2022/2023 fee schedules were applied for inpatient (IP) services. Both the commercial allowed amounts and the repriced Medicare amounts were projected forward to 2027. Separate trend factors were applied for commercial and Medicare amounts. The data were aggregated by service category. For each category, the total trended commercial allowed amounts and trended Medicare repriced amounts were summed. The ratio of these sums provided the current percentage of Medicare for the commercial population. Reference-based pricing (RBP) was set at a specific percentage of the Medicare fee schedule for each service category. The RBP savings were calculated as the difference between the RBP commercial allowed amount and the current trended commercial allowed amount. Key data sources, assumptions, limitations, and other policy considerations that could affect the accuracy of the estimates are described below.

Data Source

The underlying data for this analysis were derived from the 2022 commercial claims data in the WA-APCD. This dataset includes medical claims incurred from January to December 2022 and paid through September 2023. The analysis excludes retail pharmacy claims but includes medically administered drugs. Specific data filters were applied as follows:

- For eligible members, the dataset was filtered to include only those with coverage class "medical" and line of business (LOB) "commercial"
- Primary claims only (claim status code -1, -2, 01, 19)
- Exclusion of denied claims
- Exclusion of orphan claims

Assumptions

The key assumptions included:

- Claims Run-Out
    - The 2022 incurred claims, paid through September 2023, were assumed to have sufficient run-out, and no additional completion factor was applied.
- Allowed Amount Definition
    - We defined allowed amount on a claim as the sum of paid amount, copay amount, coinsurance amount, and deductible amount.

- Trending to 2027
    - The commercial allowed amounts and Wakely Medicare Repricing Analysis Tool[78] Medicare Repriced Amounts from 2022 were trended forward to 2027. Trends were based on the national health expenditure (NHE) data from the CMS OACT. Because NHE estimates are national level estimates, we used data for CMS's OACT's historical hospital spending captured in the state residence data[79] to generate a dampening factor of 70 percent of national trend to align with Washington's historically lower growth rate. Separate trends were calculated for commercial insurance allowed amounts and Medicare repriced amounts.
- Geographical Determination
    - Member and provider ZIP codes were used to classify claims as in-state or out-of-state. Claims were identified as in-state if the CMS provider ID began with 50, indicating a Washington facility. For claims missing ZIP codes and/or provider IDs, an in-state assumption was applied. For provider location, we relied primarily on provider ZIP code. When provider ZIP code was not available for a claim, we used the member ZIP code. For provider identifier, we relied on the rendering provider. When the rendering provider was unavailable for a claim, we used the billing provider.
- Repriced Amounts
    - Repriced amounts were calculated gross of sequestration, meaning no adjustments were made to remove it. Additionally, no adjustments were made for changes in Medicare payments under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) or the Merit-based Incentive Payment System (MIPS) in our calculations.
- RBP Exclusions
    - RBP models excluded retail pharmacy benefits, aligning with the CCS public option RBP model. The model also excludes CAHs that are reimbursed at reasonable cost.
- In-Network Claims
    - We included any claims with network status of "unknown" or "other" with "in-network" claims.

[78] The Wakely Medicare Repricing Analysis Tool (WMRAT) is a reporting tool that provides claim line level detail and summaries of medical claims repriced to Medicare FFS rates. For details, see Wakely Medicare Repricing Analysis Tool (WMRAT) – Wakely.

[79] Centers for Medicare & Medicaid Services. Health Expenditures by State of Residence, 1991-2020. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.

Methodology

Commercial claims were repriced using Medicare fee schedules relevant to the date of service (CY 2022 fee schedules for outpatient and professional services and FY 2022/2023 for inpatient services).

- **Inpatient Repricing:** We identified inpatient claims in the dataset using the Wakely Grouper logic, which relies on bill type codes and revenue codes to determine which claims are for inpatient facility services. The CMS FY 2022 final rule and correction notice version of the Medicare inpatient prospective payment system (IPPS) fee schedule was used for this analysis of claims incurred January 1, 2022, through September 30, 2022. The CMS FY 2023 final rule and correction notice for the Medicare IPPS fee schedule were used in this analysis for claims incurred October 1, 2022, through December 31, 2022. Standard rates (inclusive of operating indirect medical expense amounts) were used for the repricing. The CMS FY 2022 final rule (for claims January through September 2022) and CMS FY 2023 final rule (for claims incurred October through December 2022) of the Medicare inpatient psychiatric facility prospective payment system (IPF PPS) fee schedule was used to reprice any claims identified as applying to services delivered at an inpatient psychiatric facility. IPF PPS differs from the IPPS and relies on variable rate per diem logic. All hospital-specific variables available in the provider specific files available from CMS are updated quarterly. Medicare reimburses inpatient hospital services using a PPS. This system assigns a facility a base rate composed of various components. We have calculated the base rates assuming standard pricing, as indicated, to reflect certain components (such as the indirect medical expense portion of the operating cost) are included in the rate. When a service is rendered in a facility, it is assigned a diagnosis-related group (DRG) code, which has a specific payment weight. Reimbursement is then calculated by multiplying the facility's base rate by the DRG payment weight. Additional calculations are made to determine if an outlier payment is needed and if a facility receives any pass-through per diems. Furthermore, when available, International Classification of Diseases (ICD-10) diagnosis and procedure codes are analyzed to identify if the claim has a new technology add-on payment (NTAP), a COVID-19 add-on payment, or a new COVID-19 treatment add-on payment (NCTAP).
- **Outpatient Repricing:** We identified outpatient claims in the dataset using the Wakely Grouper logic which relies on bill type codes and revenue codes to determine which claims are for services provided at an outpatient facility. We reprice outpatient claims with the first two digits of bill type equal to 13, 14, or 85 under the outpatient prospective payment system (OPPS). Claims with the first two digits of bill type equal to 83 are for services provided at an outpatient ambulatory surgery center (ASC). We included claims with the first two digits of bill type equal to 73 or 77 under the payment system for federally qualified health centers (FQHCs). The 2022 final rule for the OPPS, ASC, and FQHC Medicare fee schedules was used for this repricing analysis. Quarterly updates to Addenda A and B also were applied. Similarly, the 2022 Medicare physician fee schedule (MPFS) was used for the outpatient claims where MPFS applies in this analysis, including any quarterly updates.

Medicare reimburses outpatient facility claims using a PPS. This system primarily uses the procedure codes on a claim line that corresponds to an ambulatory payment classification (APC) and status indicator (SI). SI logic is applied on all services rendered during an encounter at the APC bundled rate, which reflects a discount and/or are packaged into the payment with the other services performed. Not all outpatient procedure codes are paid on an APC basis; rather, some claims are repriced using the resource-based relative value scale (RBRVS), which typically includes laboratory and pathology-related services. The APC reimbursement level is also facility-specific. ASC reimbursement is based on the core-based statistical area derived from the submitted ZIP code. In cases in which the ASC claim had no valid ASC NPI, the claim was still repriced using ASC rates and methodology using the ZIP code.

- **Professional Repricing:** We identified professional claims in the dataset using the Wakely Grouper logic, which relies on codes in the data (such as bill type, revenue, procedure, and POS codes) to determine which claims are for professional services. Professional claims include all health care professional care, including those delivered in a facility, an ASC, or a physician's office. The 2022 MPFS was used for this analysis. This includes any CMS quarterly updates to the professional fee schedules. Medicare reimburses professional claims using a prospective payment system. This system primarily uses the procedure codes and modifiers on a claim line. These claims are repriced using the RBRVS. Other fee schedules modeled include the clinical laboratory fee schedule; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); durable medical equipment parenteral and enteral nutrition (DMEPEN); anesthesia; ambulance; and Part B prescriptions.
- **Claims Not Amenable to Repricing under Medicare:** Data cannot be repriced under Medicare for a range of reasons. The supporting model documents a complete list of exclusions as well as corresponding allowed amounts. Claims not priced those for providers not paid under IPPS or with a NPI not mapping to a valid CMS certification number (CCN) or with a missing NPI. Additionally claims not repriced under IPPS, such as skilled nursing facility claims, inpatient rehab claims, and home health, were not repriced.

Data were aggregated to the service category level. For each category, the trended commercial allowed amounts and trended Medicare repriced amounts were summed. The ratio of the trended commercial allowed amount to the trended Medicare repriced amount was calculated to determine the current percentage of Medicare for the commercial population. RBP was modeled at a specified percentage (x%) of Medicare for each service category. The formula used was:

RBP Commercial Allowed = X% of Medicare x Trended Medicare Repriced Amount

Savings were calculated as the difference between the RBP commercial allowed amount and the current trended commercial allowed amount. RBP pricing was modeled at the aggregate service category level, meaning individual claims within a category might vary, but the overall calculation was not applied at the claim level.

Additional Detail Classifications for Baseline Average Reimbursement

Table A3: Baseline Average Reimbursement in Washington's Commercial Markets by Service, 2022, WA-APCD Unadjusted, Additional Detail

Service Category	Current Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Inpatient Hospital			
Surgical	$489,443,715	$242,705,559	202%
MHSA Substance Abuse	$2,137,757	$1,204,480	177%
Maternity	$201,958,476	$114,076,555	177%
Medical	$343,632,547	$232,771,179	148%
MHSA -Mental Health	$16,898,477	$11,880,390	142%
MHSA – Other	$0	$0	N/A
Skilled Nursing Facility (SNF)	$0	$0	N/A
Subtotal	$1,054,070,971	$602,638,164	175%

Service Category	Current Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Outpatient Hospital			
Emergency Room (ER)	$337,847,110	$109,233,377	309%
Radiology High-Tech	$54,515,617	$18,871,532	289%
Observations	$81,508,333	$30,538,504	267%
Radiology Other	$72,755,544	$29,205,896	249%
Cardiovascular	$67,263,722	$28,146,676	239%
Dialysis	$34,920	$14,760	237%
Surgery	$770,590,503	$331,780,498	232%
Therapy	$17,098,240	$7,379,463	232%
Preventive	$4,723,559	$2,118,692	223%
Miscellaneous	$18,551,122	$8,721,732	213%
Radiology Diagnostic	$78,045,416	$36,817,612	212%
MHSA	$4,421,349	$2,246,798	197%
Pharmacy	$38,909,064	$23,426,547	166%
Laboratory	$99,518,634	$60,816,543	164%
Subtotal	$1,645,783,133	$689,318,630	239%

Service Category	Current Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Professional			
OP Surgery Anesthesia	$64,688,233	$18,568,970	348%
IP Surgery Anesthesia	$32,275,866	$10,717,081	301%
IP Surgery	$40,307,799	$19,167,097	210%
ER Visits	$49,691,765	$23,653,832	210%
Radiology Office	$160,267,547	$76,593,426	209%
Cardiovascular	$23,936,290	$11,576,136	207%
IP Visits	$47,410,726	$23,559,808	201%
Radiology OP Hospital	$56,655,530	$28,932,340	196%
OP Surgery	$417,393,895	$222,435,939	188%
Radiology IP Hospital	$3,894,165	$2,084,518	187%
Allergy Testing	$4,398,481	$2,580,083	170%
IP Maternity	$52,378,319	$30,757,826	170%
Radiology Surgical Center	$304,359	$178,806	170%
Urgent Care	$46,104,951	$27,916,424	165%
Preventive	$191,935,907	$124,243,461	154%
Pathology Independent Lab	$135,817	$88,634	153%
Office Visits PCP	$246,119,815	$165,214,762	149%

Service Category	Current Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Professional Continued			
Pathology Office	$41,119,849	$28,531,451	144%
Hearing	$14,181,740	$9,860,055	144%
Office Visits Specialist	$431,999,405	$300,978,995	144%
Pathology IP Hospital	$2,500,745	$1,801,604	139%
Therapeutic Injections	$254,667,829	$192,664,751	132%
Pathology OP Hospital	$75,821,762	$57,442,096	132%
Allergy Immunotherapy	$6,458,230	$4,960,140	130%
Vision	$31,816,015	$25,067,714	127%
Miscellaneous	$38,482,354	$34,078,345	113%
Physical Medicine	$154,312,228	$141,151,932	109%
Chiro	$39,945,455	$43,816,893	91%
MHSA	$210,368,349	$239,894,728	88%
Subtotal	$2,739,573,427	$1,868,517,846	147%

Service Category	Current Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Ancillary			
Ambulance	$30,343,491	$10,959,933	277%
Home Health PDN	$1,023,922	$544,292	188%
Prosthetics	$12,866,400	$14,504,044	89%
DME	$30,949,950	$39,949,995	77%
Vision Hardware	$5,245,768	$12,198,527	43%
Hearing Aids Devices	$0	$0	N/A
Dental	$0	$0	N/A
Subtotal	$80,429,531	$78,156,791	103%
Total (In-Network Washington)	$5,519,857,063	$3,238,631,430	170%

Table A4: Baseline Average Reimbursement in Washington's Commercial Markets by Service, 2027, WA-APCD Unadjusted

Service Category	Trended Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Inpatient Hospital			
Surgical	$598,987,856	$295,058,236	203%
MHSA SUD	$2,616,216	$1,464,291	179%
Maternity	$247,159,521	$138,683,379	178%
Medical	$420,542,171	$282,980,966	149%
MHSA	$20,680,585	$14,443,044	143%
MHSA − Other	$0	$0	N/A
SNF	$0	$0	N/A
Subtotal	$1,289,986,349	$732,629,917	176%

Service Category	Trended Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Outpatient Hospital			
ER	$413,461,875	$132,795,507	311%
Radiology High-Tech	$66,716,951	$22,942,206	291%
Observations	$99,751,003	$37,125,796	269%
Radiology Other	$89,039,222	$35,505,739	251%
Cardiovascular	$82,318,256	$34,218,040	241%
Dialysis	$42,735	$17,943	238%
Surgery	$943,059,108	$403,347,038	234%
Therapy	$20,925,058	$8,971,246	233%
Preventive	$5,780,755	$2,575,703	224%
Miscellaneous	$22,703,115	$10,603,048	214%
Radiology Diagnostic	$95,513,039	$44,759,336	213%
MHSA	$5,410,906	$2,731,443	198%
Pharmacy	$47,617,440	$28,479,758	167%
Laboratory	$121,792,254	$73,934,944	165%
Subtotal	$2,014,131,718	$838,007,748	240%

Service Category	Trended Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Professional			
OP Surgery Anesthesia	$79,166,336	$22,574,380	351%
IP Surgery Anesthesia	$39,499,643	$13,028,803	303%
IP Surgery	$49,329,231	$23,301,526	212%
ER Visits	$60,813,456	$28,756,070	211%
Radiology Office	$196,137,598	$93,114,971	211%
Cardiovascular	$29,293,557	$14,073,160	208%
IP Visits	$58,021,890	$28,641,764	203%
Radiology OP Hospital	$69,335,806	$35,173,176	197%
OP Surgery	$510,812,309	$270,416,368	189%
Radiology IP Hospital	$4,765,732	$2,534,158	188%
Allergy Testing	$5,382,921	$3,136,618	172%
IP Maternity	$64,101,297	$37,392,427	171%
Radiology Surgical Center	$372,478	$217,376	171%
Urgent Care	$56,423,864	$33,938,122	166%
Preventive	$234,893,766	$151,043,333	156%
Pathology Independent Lab	$166,215	$107,753	154%
Office Visits PCP	$301,204,768	$200,852,326	150%

Service Category	Trended Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Professional Continued			
Pathology Office	$50,323,028	$34,685,812	145%
Hearing	$17,355,806	$11,986,913	145%
Office Visits Specialist	$528,686,731	$365,901,514	144%
Pathology IP Hospital	$3,060,446	$2,190,218	140%
Therapeutic Injections	$311,665,943	$234,223,402	133%
Pathology OP Hospital	$92,791,701	$69,832,613	133%
Allergy Immunotherapy	$7,903,670	$6,030,064	131%
Vision	$38,936,871	$30,474,932	128%
Miscellaneous	$47,095,227	$41,429,197	114%
Physical Medicine	$188,849,397	$171,599,036	110%
Chiro	$48,885,790	$53,268,393	92%
MHSA	$257,451,638	$291,641,096	88%
Subtotal	$3,352,727,114	$2,271,565,520	148%

Service Category	Trended Allowed	Medicare Repriced	Allowed as % of Medicare
In-Network (Washington)			
Ancillary			
Ambulance	$37,134,775	$13,324,039	279%
Home Health PDN	$1,253,090	$661,698	189%
Prosthetics	$15,746,075	$17,632,632	89%
DME	$37,876,968	$48,567,388	78%
Vision Hardware	$6,419,842	$14,829,804	43%
Hearing Aids Devices	$0	$0	N/A
Dental	$0	$0	N/A
Subtotal	$98,430,751	$95,015,561	104%
Total (In-Network Washington)	$6,755,275,932	$3,937,218,746	172%

Illustrative Example Using URRT Data

Adjustments were made to the allowed claim cost from the WA-APCD by service category in order to approximate allowed dollar totals from **URRT** 2022 data for the individual and small group ACA markets. In the first illustrative scenario where the claim allowed amount is assumed to be understated, the following adjustment factors were applied to the WA-APCD allowed amounts to estimate the complete level of allowed amounts by category of service.

Table A5: Service Category Adjustment

Category of Service	Adjustment Factor
Inpatient Hospital	1.36
Outpatient Hospital	1.25
Professional	1.12
Ancillary	1.84

These factors were calculated by comparing the combined individual and small group allowed cost PMPM as calculated from the URRT data with the combined individual and small group PMPM as calculated from the WA-APCD data. Given the lack of external data sources that could be used to validate other market segments (fully insured large group and self-funded Public Employees Benefits Board/School Employees Benefits Board [PEBB/SEBB]), similar levels of understatement were assumed to be present in the large group and PEBB/SEBB market segments.

For the second illustrative scenario, where we assumed that a subset of claims was missing from the WA-APCD and that the average reimbursement of those claims was similar to the WA-APCD-reported claims, the adjustment factors were applied to both the WA-APCD allowed amount and the Medicare repriced amount.

Key Policy Considerations

Beyond better understanding of the current target market reimbursement levels, there are a number of other key policy decisions that should be taken into consideration, which would affect the estimates included in the report, including:

- **Population Applicability**: Determining the target population for these pricing models is crucial. Considerations will have to be made for PEBB, SEBB, individual, small group, and large group markets. Expansion to self-insured plans must also be considered. The impact on each of these groups could vary significantly.
- **Operational Implementation**: Implementing RBP requires careful operational planning. Policymakers must consider how insurers and health care providers will transition to the new pricing model.
- **Legislative Requirements**: Introducing RBP may necessitate new legislation or amendments to existing laws. Policymakers should identify the specific legal requirements and legislative language that supports the smooth implementation of RBP, ensuring compliance with state and federal law.

- **Out-of-State Members and Providers**: Addressing the needs of out-of-state members and providers is essential. Policymakers must develop strategies for reimbursing these individuals and entities under the new model given differences in fee schedules and provider agreements across state lines.
- **Impact on Non-Medicare Reimbursed Providers**: RBP may significantly affect providers who do not typically receive Medicare reimbursements, such as cancer hospitals, children's hospitals, and some residential SUD facilities. Policymakers should assess the potential financial strain on these providers and consider alternative reimbursement strategies or exemptions to ensure their viability.
- **Impact on Utilization**: The shift to RBP could influence health care utilization patterns. Policymakers should evaluate how changes in reimbursement rates might affect provider behavior, patient access to care, and overall utilization of health care services. This includes assessing potential shifts in service delivery and patient outcomes.

Hospital Global Budgeting

Wakely created a simplified model to estimate the effects of hospital global budgeting (HGB) on hospital spending in Washington. Key methodological data and assumptions that were included in the estimates are described below, as well as additional information on the data, methods, limitations, and additional policy considerations that could affect the estimates.

Data Source

The analysis relies on hospital cost report data sourced from the HCRIS. These reports, submitted to CMS, provide detailed financial information at the hospital-specific level. The most recent available data are from the 2021 reporting period, with most reports indicating a status of "As Submitted." Earlier data may have a status of "Settled Without Audit" or "Settled With Audit."

Assumptions & Methodology

- **Data Utilization:** The following line items from the HCRIS data were used.
- Net Patient Revenue: G3-Line-3-Column-1: This is the net patient revenue which is arrived at by subtracting gross revenue (G3-Line-2-Column- 1) from less contractual allowance and discounts on patients' accounts (G3- Line-1-Column-1) on the statement of revenues and expenses (Worksheet G3). Net patient revenue includes all inpatient and outpatient revenue reported by the hospital and does not make exclusion for out-of-state patients or members in other counties. Net patient revenue includes inpatient and outpatient facility charges but excludes any professional charges occurring at facility-owned clinics or providers.

- Total Days (V + XVIII + XIX + Unknown): S3-Part1-Line-14-Column-8. This is total number of inpatient days for all classes of patients for each component as reported on the hospital and hospital health care complex statistical data and hospital wage index information (Worksheet S3). Include organ acquisition and HMO days in this column. This amount will not equal the sum of Title V, Title XVIII, Title XIX discharges (columns 5 through 7) when the provider renders services to patients who are not covered under Titles V, XVIII, or XIX.
- Days for Medicare FFS (S3-Part1-Line-14-Column-6), Medicare Advantage (S3-Part1-Line-2-Column-6), Medicaid FFS (S3-Part1-Line-14-Column-7), and managed Medicaid (S3-Part1-Line-2-Column-7)
- **Utilization Split Estimation:** The HCRIS data reports utilization split by Medicare, Medicaid, and other but does not split net patient revenue this way. We relied on inpatient bed days by LOB as a proxy for the distribution of allowed dollars. We assumed that the average per diem for commercial/other insurance is twice the Medicare and Medicaid per diem cost to calculate this high-level estimate. This distribution is an estimate only and should be considered with caution.
- **Default Trend Assumptions:** Default per enrollee and enrollment trends were sourced from NHE data published by the CMS OACT. Trends were adjusted to reflect the lower rate at which Washington trends compared with the nation as reported in the state health expenditures that the OACT published. Trends were applied separately for Medicare, Medicaid, and commercial/other.
- **Hospital Exclusions:** Certain hospitals were excluded from application of an HGB—specifically, CAHs, psychiatric hospitals, rehab hospitals, and children's hospitals. They were excluded at the OIC's request and to ensure consistency with the Maryland model.
- **Hospital Participation**: It was assumed that all hospitals in the selected area would participate in the program. If the program is voluntary, selection by hospitals is a risk and was not reflected in the estimates.
- **Calculation of Savings**: Savings are calculated by comparing inpatient and outpatient facility costs under an HGB capped at a growth rate of 2.8 percent with costs under the natural trajectory. The difference between the two represents the projected savings. Limiting cost growth to the Washington State cost growth benchmark of 2.8 percent to align with the HCCT Board. An additional scenario of 4 percent cap was used to illustrate the effects of a higher cap.

Limitations

Despite the robustness of the analysis, certain limitations exist and should be noted:

- **Assumptions Subject to Change**: The assumptions made in this analysis may not necessarily reflect the final policy decisions. Changes in policy parameters could lead to different outcomes than those presented here.

- **Hospital Participation Assumption:** The analysis assumes mandatory hospital participation in hospital global budgeting. Voluntary participation carries the risk of selective participation by hospitals, which would affect the projected savings. This has not been accounted for in these calculations.
- **Time Value of Money**: No adjustments have been made to account for the time value of money in the projections. This omission could affect the accuracy of the projected savings over time.
- **Supplemental and Directed Payments:** Supplemental and directed payments are not included in Medicare cost reporting metrics. The modeled results are net of these payments. The values of these supplemental exceed $750 million dollars[80], [81], [82] and represent a significant revenue source for hospitals.
- **Variability of Results:** The HGB model relies on many variables. Scenarios presented in the results are only a subset of potential outcomes and do not represent the maximum variability in outcomes.

These limitations underscore the need for ongoing refinement and validation of the analysis as policy decisions evolve. Further sensitivity analysis may be warranted to assess the potential impact of changes in assumptions on the findings. In particular, we recommend additional analysis after the following key policy considerations have been finalized.

Key Policy Considerations

An HGB or an all-payer model like Maryland's is complex and has many considerations that are not included in this model. Some of these considerations are policy decisions, and some are operational details that would require further analysis to be worked out in a design phase of implementing such a model.

- Mandatory versus Voluntary Participation
    - Determining whether hospital participation is mandatory or voluntary and addressing selection risk if participation is voluntary are crucial policy decisions.
- Inclusion of Specific Hospital Types
    - Deciding which hospital types should be included in HGBs or treated differently, such as CAHs, psychiatric hospitals, rehab hospitals, and children's hospitals requires careful consideration.
- Handling Service Leakage and Geographic Dynamics

[80] https://www.medicaid.gov/medicaid/managed-care/downloads/WA_Fee_IPH.OPH1_New_20240101-20241231.pdf

[81] https://www.medicaid.gov/medicaid/managed-care/downloads/WA_Fee_IPH.OPH1_New_20240101-20241231.pdf

[82] https://www.medicaid.gov/medicaid/managed-care/downloads/WA_Fee_IPH.OPH3_Renewal_20240101-20241231.pdf

    - Developing strategies to address service leakage between states or across counties and accounting for market dynamics and population shifts are essential for effective implementation.
        - Special attention should be given to border regions, where unique health care utilization patterns might emerge. For instance, children residing in Southwest Washington may be more likely to seek care at the children's hospital in Portland, OR, rather than at local facilities like Mary Bridge or Seattle Children's.
    - Reflecting market share changes between hospitals as well as hospital expanses or closures.
- Adjusting Hospital-Specific Global Budgets
    - Establishing mechanisms to adjust hospital-specific global budgets to account for changes in service mix, population demographics, market share, and hospital expansions or closures is critical.
    - Considering differentiated treatment for various hospital types, such as academic institutions and rural hospitals.
- Inclusion of Supplemental and Direct Payments
    - Whether to include supplemental and direct payments as part of HGB.
- Attribution Methodology and Financial Considerations
    - Determining whether attribution is needed and how it should be conducted.
- Operational Details
    - Considering the financial condition of hospitals.
    - Addressing operational details like reconciliation and rate-setting are vital components.
    - Handling professional services delivered at facility-owned clinics or at providers.
    - Policy decisions including whether savings would be redirected into other areas (e.g., primary care, health equity)
        - Baseline hospital spending includes inefficiencies in spending (e.g., wasteful care, admin costs). The goal of setting a cap on budget increases is to squeeze out the inefficiencies. The lesson learned from Maryland's first phase of HGB implementation is that the global budget should be paired with required care transformation activities (e.g., quality and primary care investments).
- Impact on Care Settings
    - Assessing the potential for hospitals to shift costs to other settings.
- Data Sources and Quality Improvement

- Exploring the availability of Washington-specific data sources for refining trend assumptions.

- Sustaining Critical Services
  - Adjustments may be needed to maintain access to higher cost/lower revenue services, such as obstetrics (OB), cancer, and behavioral health care. Addressing these questions and considerations is paramount for developing a robust and effective HGB model tailored to the unique health care landscape of Washington State.
- Legislative Changes
  - Determining what legislative changes would be required to make the HGBs feasible (e.g., very different landscape in WA than MD)

Disclosures and Limitations

Responsible Actuary. We, Ksenia Whittal, Oliver Smidt, and Darren Johnson, are the actuaries responsible for the actuarial analysis of reinsurance, MLR, reference-based pricing and hospital global budget cap as described in this communication. We are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. We meet the qualification standards of the American Academy of Actuaries to issue this analysis. Michael Cohen, Julie Steiner, Emily Janke, Matt Smith have made significant contributions to this analysis.

Purpose. The purpose of this analysis is to provide the estimated impacts of several policy options on Washington health care market consumers.

Intended Users. This information has been prepared for the sole use of the Washington Office of Insurance Commissioner (WA OIC). It is our understanding that these results will be provided to members of the stakeholder group for review. This analysis cannot be distributed to or relied on by any other third party without the prior written permission of Wakely and HMA. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and to notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent from WA OIC.

Data and Reliance. We have relied on others for data and assumptions used in the report. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. For some estimates, there are multiple sources of information, including public sources. In some cases, the different sources produce meaningfully different data/information. In this draft version of the model, we have reviewed the data for reasonableness, however, WA OIC should continue to review the various sources of information and subsequent versions may incorporate adjustments to better reflect the market in Washington.

Subsequent Events. Changes to federal or state law or regulation could impact the results. Additionally, changes to economic conditions could materially affect results. There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document and the supporting exhibits/files constitute the entirety of the actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis are in compliance with the appropriate actuarial standards of practice (ASOP) with no known deviations. In developing these standard plan designs and the resulting actuarial certification, Wakely followed applicable Actuarial Standards of Practice (ASOP) including:

- ASOP No. 23 Data Quality;
- ASOP No. 25 Credibility Procedures;
- ASOP No. 41 Actuarial Communications;
- ASOP No. 56 Modeling.

APPENDIX B: ECONOMIC METHODOLOGY

Research on the relationship between changes in employer health insurance premiums and wages, hours of work, and employment.

Baicker and Chandra[83] explored the impact of a 10 percent increase in health care premiums on wages, hours of work, and employment. HMA assumes that the relationship between health insurance premium changes and labor market outcomes will be of the same order of magnitude in either direction—that is, whether the change in premiums is an increase or a decrease. Baicker and Chandra also found that an increase in premiums increased the likelihood that a worker is employed only part-time instead of full-time by 1.9 percent. Further, they found that a 10 percent premium increase reduced the probability of being employed by 1.6 percent. Based on these findings, we project that a 10 percent drop in premiums in commercial markets in Washington will lead to a wage increase of 2.3 percent; a 1.9 percent increase in the number of people who shift from part-time to full-time work, and a 1.6 percent increase in employment.[84] This was an in-depth study prepared for the NBER.

We now turn to the analysis by Professor Mark Pauly, who presents the perspective of many economists in his book *Health Benefits at Work*. Pauly asserts that "the view held by almost all economists and policy analysts, some politicians, and some labor leaders is that employer payments for health insurance premiums ultimately come out of what would otherwise have been money wages for employees. The most frequently accepted point estimate at the moment, based on an estimate by Lewin-VHI, is that 88 percent of premiums are offset by money wage reductions, with the only stated reason for deviation from 100 percent being the tax subsidy to additional employer premium payments[85]."

Pauly references studies by economists John Gruber and Alan Krueger, which estimate the wage offset at 83 percent and 100 percent, respectively. Although we opted not to use such a high offset for wages, Pauly's findings and analysis influenced us to consider a higher wage offset as an additional scenario. Therefore, we included a second scenario where wages increase by 4 percent when premiums are assumed to decrease by 10 percent.

A recent study found that a $1 increase in the price of health insurance leads to a 52-cent increase in expenditures on health insurance. Approximately two-thirds of this increase is financed through reduced wages.[86]

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[83] The Labor Market Effects of Rising Health Insurance Premiums.

[84] Ibid.

[85] Pauly MV. *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance*. Ann Arbor: The University of Michigan Press.1997. p. 2.

[86] Goldman DP, Sood N, and Liebowitz A. The Reallocation of Compensation in Response to Health Insurance Premium Increases. Working Paper 9540. National Bureau of Economic Research. March 2023. Available at: https://www.nber.org/papers/w9540.

As noted previously, for our model, we relied on the Baicker's and Chandra's findings and also selected an alternative assumption about the wage pass-through that was in between their findings and the much higher estimates of this pass-through found in other studies cited. We thought that an assumption that almost all of the impact of changing premiums would pass through to employees' wages was unrealistic in today's economy. Yet, we thought an assumption above the levels found by Baicker and Chandra was appropriate as an alternative path. Thus, we selected a 40 percent response of wages to lower premiums as a realistic alternative to the 23 percent identified by Baicker and Chandra.

Assumptions and Limitations

The research on how wages, hours worked, and employment respond to changes in health insurance premiums focuses virtually exclusively on how increases in health insurance premiums lead to decreases in wages, hours worked, and employment. As noted above, in this study, the focus is on lower health insurance premiums that occur when the cost control policies studied are successful. For example, in this study we examine how much higher wages will be when the cost of health insurance is reduced.

Thus, a key assumption in our model is that there will be symmetry in the effects of premium changes. In other words, the magnitude of the increases in wages and other labor market variables in response to lower health insurance costs will be the same as the magnitude of the decreases in wages and other labor market variables in response to higher health insurance premiums.

A limitation of the study is that much of the research we found is dated. There was a lot of interest in the 1990s and 2000s around the issue of how sharply rising health insurance costs would impact the business community, and how they would respond to those increased costs. Many business organizations and a number of economists were actively exploring these impacts to remain competitive by finding ways to lower the growth in health insurance costs prior to the enactment of the ACA and other policy measures designed to produce value-based care.

Wage Pass-Throughs

Flow of Savings

The model illustrates how savings from reduced health care spending flow through to employees and employers. It also shows how lower health care premiums yield savings to households as their cost-sharing is reduced.

Breakdown of Full-Time vs Part-Time Employees

Below, we outline the assumptions used to determine the distribution of part-time versus full-time insured individuals based on insurance type.

Table B1: Assumptions About Distribution of Part-time v. Full-Time Insured

Type of Insurance	Full Time/Part Time Breakdown	Rationale
Large Group Insurance	(80% Full-Time, 20% Part-Time)	Larger employers typically offer more stable employment and benefits primarily to full-time employees due to the cost-effectiveness and regulatory requirements for providing benefits. It is commonly understood in employment studies that full-time positions are more likely to be accompanied by benefits like health insurance.
Individual Insurance	(25% Full-Time, 75% Part-Time)	Individual insurance markets primarily serve people who do not have employer-based coverage, including part-time employees, freelancers, and the self-employed. Individuals in these categories are more likely to seek individual coverage.
Small Group Insurance	(50% Full-Time, 50% Part-Time)	Small businesses vary widely in their structure and benefits offerings. Though some small businesses strive to offer full-time benefits to attract and retain talent, others rely more on part-time or flexible workforces. Given this variability, a balanced assumption reflects the diverse nature of small business employment.

Earnings Projections

- **Wage increases:** According to Baicker and Chandra, a $10 reduction in health insurance premiums leads to a $2.30 increase in wages.

Assuming a 10 percent drop in premiums in commercial markets, we projected the impact on employees and employers. Using the impact of such a premium reduction on wages found by Baicker and Chandra, we project wage increases of 2.3 percent. Based on average hourly earnings for employees in Washington, we calculated the hourly wage increase. Next, we translated this hourly rate increase into the expected annual earnings increase. We used U.S. Bureau of Labor Statistics (BLS) data on average hours worked by full-time and part-time employees. For full-time employees, we calculate the weekly wage increase by multiplying the hourly increase by the average weekly hours, and then annualize this figure using the estimated weeks worked per year. We follow a similar process for part-time employees.

To estimate the overall impact, we consider the proportion of full-time and part-time employees, using national averages provided by BLS. Based on BLS data, we assumed that part-time employees average 5.54 hours per day and work 27.7 weeks per year, whereas full-time employees average 8.42 hours per day and work 42.12 weeks per year. We then apply these proportions to the number of employees in Washington State. Finally, we calculate the aggregate annual wage increase for both full-time and part-time employees statewide.

- **Transition from part-time to full-time:** A 10 percent reduction in premiums is assumed to increase the proportion of part-time employees transitioning to full-time by 1.9 percent.
- **Increase in employment:** A 10 percent reduction in premiums is assumed to increase employment by 1.6 percent.

Net Earnings

The model combines these effects—wage increases, part-time to full-time transitions, and additional hiring—and accounts for payroll deductions (Social Security, Medicare, federal income tax) to estimate take-home pay. Washington State's lack of income tax is considered.

Multiplier Effect

- The model uses a multiplier of 1.9, based on a study by Daniel Blake and Julie Coveney from California State University, Northridge, to account for additional spending generated by increased earnings.
- Before calculating the multiplier effect, we accounted for the fact that employees will save some of the new earnings. We used a savings rate of 4.3 percent, which we chose because it is the average monthly savings rate for 2023 and up until April 2024. We did not use any numbers immediately before because those savings rates were still highly affected by COVID-19.

Additional Tax Revenue

- The model calculates the increase in sales tax revenue, considering both state and average local sales taxes, using data from the Tax Foundation.
- Washington does not have a state income tax but does have a sales tax of 6.5 percent. In addition, localities have sales taxes of varying amounts. The Tax Foundation calculated that the average combined state and local tax rate in Washington is 8.86 percent in 2023. We apply this tax rate to the total impact of the increase in take-home pay including the multiplier. This means that the state will collect tax revenues not only on the new spending by employees, but also on the new spending by stores, restaurants, and other businesses that receive additional revenue from these employees.

Impact on Households

Health Insurance Premiums

- The model presents data on health insurance premiums and the split between employer and employee contributions, based on the KFF annual survey.
- In 2023, the average premium for family coverage was $23,968, with employers paying $17,393 and employees $6,575. For single coverage, the average premium was $8,435, with employers paying $7,034 and employees $1,401.[87] From 2018 to 2023, employees' earnings increased by 27 percent, outpacing the 19 percent rise in their premium contributions. Overall inflation rose by 21 percent, and total health insurance premiums increased by 22 percent. Employee contributions to premiums averaged 19 percent over this period, higher for family coverage (29 percent) than single coverage (17 percent).

Coverage Distribution

- According to the Washington State Office of Financial Management, 55 percent of employees with private health insurance have single coverage and 45 percent have family coverage. These figures are used to project household savings from reduced insurance costs.[88]

Benchmarks

Spending Projections

Data from the Washington State Health Care Authority on Medicaid spending and PEBB/SEBB spending is extended through 2029.

Baseline Growth Rate

- The economic model uses a baseline growth rate of 5.4 percent for total health spending, based on the CMS OACT's forecast for annual growth in national health care spending through 2031.

Reduced Growth

- Growth rate meets the benchmarks set by the Washington State HCCT Board: 3.0 percent for 2025 and 2.8 percent for 2026, extending the 2.8 percent target through 2029.

[87] KFF. Employer Health Benefits: Summary of 2023 Findings. October 2023. Available at: https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey-Summary-of-Findings.pdf.

[88] Office of Financial Management Forecasting Division. Washington State Employer Sponsored Health Insurance.2010. Private Employer-Sponsored Health Insurance 2010, Washington State