MILLIMAN REPORT

Evaluating potential health benefits impacts from Cascade Care

Prepared for the Association of Washington Healthcare Plans

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Executive Summary

Milliman was engaged by the Association of Washington Healthcare Plans (AWHP) to model potential impacts from State Bill No. 1523, referred to in this report as Cascade Care. Our evaluation of Cascade Care in this report is based on the legislation as written on February 14, 2019. To the extent the legislation is modified, the contents of this report will need to be updated. Major provisions of the bill include:

- The Washington Health Benefit Exchange (WAHBE) will establish up to three standardized plans (a common benefit design would be used by each carrier offering a given plan) for each of the bronze, silver, and gold metallic levels.
- Beginning on January 1, 2021, carriers participating in WAHBE will be required to offer at least one standardized plan in the silver and gold tiers.
- Carriers offering standardized plans from 2021 through 2024 may continue to offer non-standardized plans (limited to three in each metallic tier beginning in 2023). Beginning on January 1, 2025, non-standardized plans may no longer be offered by carriers in WAHBE. However, carriers may offer non-standardized plans outside WAHBE.
- Starting in 2021, the Health Care Authority (HCA) will contract under a Request for Quotation (RFQ) process with one or more carriers to offer a class of standardized silver and gold qualified health plans (QHPs) on WAHBE. This report refers to these plans as "RFQ plans."
  - The plans' fee-for-service reimbursement rates for professional and facility reimbursement may not exceed Medicare rates for the same or similar covered services in the geographic region.
- WAHBE must implement a plan to offer premium assistance to persons with household income up to 500% of the federal poverty level (FPL). Under the Patient Protection and Affordable Care Act (ACA), premium subsidies currently made available through WAHBE are limited to income levels up to 400% FPL.

Overall reduction in WAHBE premium rates

Starting with their introduction in 2021, RFQ plans are estimated to be substantially less expensive than non-RFQ plans, all else equal. We estimate price reductions relative to current WAHBE offerings ranging from approximately 25% to 40%. However, changes in certain geographic areas and/or with certain carriers could be outside this range, as a result of current Medicare reimbursement relativities in provider contracts. Price reductions are caused by two primary factors: (1) reduced provider reimbursement levels, and (2) a favorable morbidity impact from migration of insureds from employer group markets (facilitated by integrated Health Reimbursement Arrangements (HRAs) funded by employers) and from the uninsured population. Figure 1 summarizes the premium rate changes by component. Note that a small incremental increase is estimated to result from re-calibrating the classification of a plan's benefit design to Medicare reimbursement levels (which will result in lower cost sharing for consumers).

FIGURE 1: SUMMARY OF RFQ PLAN PREMIUM ESTIMATES RELATIVE TO CY 2019 WAHBE PLAN OFFERINGS

	HIGH COST AREAS	LOW COST AREAS
PREMIUM CHANGE DUE TO IMPLEMENTING MEDICARE REIMBURSEMENT	-34% to -38%	-20% to -21%
PREMIUM CHANGE DUE TO COST SHARING DECREASE	2% to 4%	1% to 3%
PREMIUM CHANGE DUE TO FAVORABLE MORBIDITY SHIFT	-5% to -8%	-5% to -8%
TOTAL MODELED RATE IMPACT	-37% to -42%	-24% to -26%

Consumer premium affordability and reductions to the uninsured rate

While consumers who have income above 400% FPL will benefit directly from the lower premium rates associated with RFQ plans, many low income consumers qualifying for federal premium assistance will not see changes in out-of-pocket premium rates. For low income consumers, the federal government will retain premium rate savings through lower outlays for premium assistance provided through WAHBE. In considering the impact to the uninsured population, the greatest reductions to the uninsured rate are likely to occur from consumers with income above 400% FPL. However, this income cohort of the uninsured population is estimated to represent only 70,000 out of the approximately 410,000 persons in the state of Washington who are uninsured.

Provider reimbursement impact

Due the combination of mandated Medicare level reimbursement for RFQ plans and migration to these plans from other segments such as the employer group market and the uninsured, provider reimbursement revenue is estimated to decrease under Cascade Care. The magnitude of this decrease will depend on the amount of migration to RFQ plans and this migration, in turn, will vary by geographical area. Geographic variation in migration is due to several factors including the premium rate decreases in that area, provider participation in RFQ plans, and the resulting network adequacy. Provider revenue will increase slightly due to migration into RFQ plans from the currently uninsured population. We model three RFQ plan migration scenarios, with the net results shown below in Figure 2.

FIGURE 2: SUMMARY OF PROVIDER REIMBURSEMENT IMPACTS FROM RFQ MIGRATION SCENARIOS

RFQ MIGRATION SCENARIO	LOW	MEDIUM	HIGH
FROM INDIVIDUAL MARKET	178,000	201,000	223,000
FROM EMPLOYER GROUP	114,000	349,000	586,000
FROM UNINSURED	29,000	37,000	45,000
TOTAL RFQ MEMBERSHIP	321,000	587,000	854,000
PROVIDER MEDICAL REVENUE CHANGE ($ MILLIONS)	-$559	-$1,136	-$1,713
PROVIDER MEDICAL REVENUE CHANGE %	-1.4%	-2.9%	-4.4%
COST SHIFT TO RESIDUAL EMPLOYER GROUP MARKET (TO ACHIEVE PROVIDER BUDGET NEUTRALITY)	3.3%	7.2%	11.7%

Notes:
1. Values have been rounded.
2. Baseline medical revenue, reflective of all health benefits segments, is estimated at $38.6 billion. This amount was developed from enrollment and per capita medical revenue estimates as illustrated in Figure 7 of this report. The estimate was assessed for reasonableness relative to CMS Health Expenditures by State of Provider amounts for the State of Washington.

For each migration scenario, the following information is provided in Figure 2:

- *RFQ plan enrollment source*. Estimated enrollment in RFQ plans for persons previously in the individual, employer group, or uninsured market segment. For example, under the low migration scenario, we estimate RFQ plan enrollment of 178,000 from persons who would otherwise be in the individual market, 114,000 from the employer group market, and 29,000 previously uninsured individuals.
- *Total RFQ membership*. The sum of migration from the three market segments. For the low migration scenario, we estimate RFQ plan enrollment of 321,000. For perspective, we estimate 2019 individual market enrollment of 223,000 persons. To the extent migration from employer group coverage does occur, RFQ plan enrollment may be significantly greater than the current individual market.
- *Provider medical revenue change ($ millions)*.The estimated provider medical revenue change resulting from enrollment migration into RFQ plans and the estimated provider reimbursement relativities between the three

markets and the Medicare reimbursement requirements for the RFQ plans. For the low migration scenario, we estimate a provider medical revenue reduction of -$559 million. Note, we assume no effect on pharmacy or long-term supports and services (LTSS) as a result of Cascade Care.

- *Provider medical revenue change %*. The change in provider medical revenue, as a percent of baseline medical revenue ($38.6 billion, reflective of all health benefits segments). For the low migration scenario, we estimate aggregate provider medical revenue will decrease by -1.4%.
- *Cost shift to residual employer group market to achieve provider budget neutrality*. This percentage reflects the increase in provider reimbursement unit cost within the employer group market to completely offset the revenue change occurring from RFQ plan migration. For the low scenario, we estimate the residual employer group market will account for $16.9 billion in medical revenue after RFQ plan migration. If a 3.3% increase is applied to this amount, it negates the -$559 million reduction from RFQ plan migration. This provider response is referred to as "cost shifting". As fee schedules for public programs are set by payers (Medicare and Medicaid), we believe it is unlikely that cost shifting could occur for markets other than employer group. As discussed further in this report, cost shifting is one possible provider response to Cascade Care.

Health benefits market membership shifts

The introduction of lower premium RFQ plans is estimated to cause significant movement in the individual market away from non-RFQ plans. On a long-term basis, we estimate between 80% and 100% of the individual market will move to an RFQ plan, with the majority of this migration occurring immediately in 2021 when RFQ plans are first offered.

Migration of persons currently with employer group health benefits to RFQ plans is estimated to gradually occur over several years, beginning in 2021. Migration is contingent upon the following factors:

- Perceived provider network adequacy.
- Available benefit plans and comparable benefit richness to traditional employer group benefit offerings.
- Premium rates relative to traditional employer group benefits.
- Usage of non-taxable defined contribution accounts by employers to allow employees to purchase individual market health benefits (rather than enrolling in traditional employer group coverage).
  - Small employers are permitted to use a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).
  - Under proposed rules from the Trump administration, employers of any size may be allowed to use an Individual Integrated HRA (IIHRA) to satisfy the ACAs employer mandate.
  - For large employers (50 or more full-time employees), migration to RFQ plans is not expected without the availability of IIHRA as defined in the proposed rule.

Provider responses

Responses to Cascade Care by the provider community could vary depending on the provider's mix of payers (government, commercial etc.), geographic location and, most importantly, the degree of RFQ plan migration. Provider responses could range from:

- Not accepting patients with RFQ coverage
- Attempting to negotiate incremental increases in reimbursement from other payer contracts to make up revenue shortfalls (i.e., cost shifting).
- Changing payer mix away from lower paying market segments such as Medicaid and trying to increase the mix of patients with employer group health benefits.

Payers could also attempt to increase the volume of patients, improve their efficiency (including consolidating with other providers), do nothing and accept lower margins, or exit the market. It is also possible that providers will attempt a combination of these actions.

Provider responses to the RFQ plans could also affect carriers' abilities to contract adequate networks for RFQ plans. This could be particularly challenging in rural areas. The breadth of the provider networks will impact take-up rates of

RFQ plans, especially migration from the large employer group market. RFQ plans will also be subject to state network adequacy requirements.

Carrier responses

The likelihood of insurers electing to participate in Cascade Care may vary from current WAHBE participation. Traditional carriers might find meeting an 80% medical loss ratio challenging due to the lower prices on RFQ plans and the resulting higher fixed-costs as a percentage of premium. Strategically, not being chosen through the RFQ process to offer the RFQ plans could have a significant impact as it would likely mean large losses of membership in the individual market.

Provider-owned insurers and integrated delivery networks (IDNs) share these challenges as well. Additionally, consideration must be given to the reduced premium revenue from RFQ plans, the expected market share under Cascade Care's RFQ plans, and carrier's capabilities to reduce the costs of provider reimbursement for their clinicians and facilities.

Provider-owned plans and IDNs that obtain a disproportionately large share of RFQ plans relative to their employer group market business will see reduced premium revenue.

- If these entities are unable to reduce provider costs (such as salaries or capitations) or otherwise create efficiencies to offset the reduction in premium revenue, health system margins will be reduced by RFQ plans.
- These reduced margins will likely mean that costs will need to be shifted to, and absorbed by, the comparatively smaller employer group lines of business.
- The degree of cost shifting that occurs will depend on whether the provider-owned entity has excess capacity to fill.
- For IDNs with excess capacity, the reduction in premium revenue may be offset by additional patient volume. However, for IDNs already operating at capacity, cost shifting may be necessary to achieve revenue neutrality.

Finally, all carriers contracting to offer RFQ plans will have to demonstrate that underlying reimbursement is at levels equivalent to Medicare fee-for-service. This may be challenging for certain reimbursement structures, such as capitation, physician salaries, global capitation, and others that are common among integrated delivery systems. Carriers that find this requirement too burdensome or costly might elect to not offer RFQ plans and ultimately exit the individual market as their non-RFQ plan offerings will not be competitively priced.

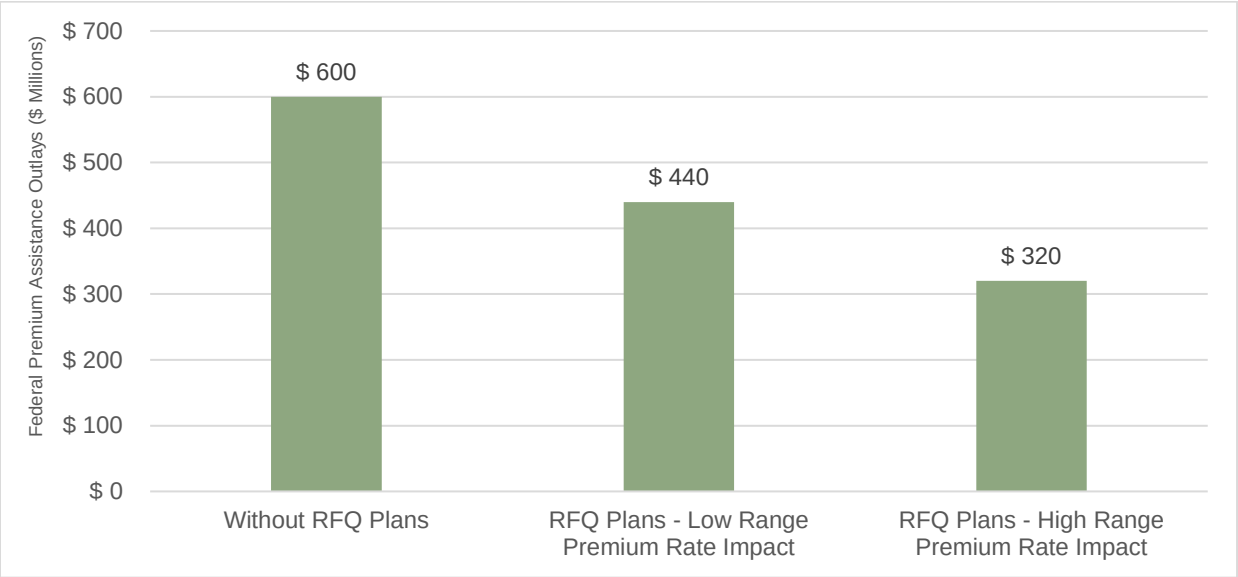
Consumer out-of-pocket premium savings and Section 1332 waiver

The implementation of RFQ plans under Cascade Care is estimated to result in significant premium rate reductions to the subsidy benchmark plans offered in WAHBE.

- These premium rate savings will be fully realized by consumers who do not currently qualify for subsidy assistance and partially by consumers who qualify for only limited premium assistance.
- The federal government will realize the entire amount of savings for low income consumers.
- A Section 1332 waiver is one potential policy option that would allow for the state's retention of annual federal premium assistance savings which are estimated to range from $160 million to $280 million (on a 2019 basis).
- These federal savings, if captured through a Section 1332 waiver, could be applied to extended premium assistance to the population with incomes between 401% FPL and 500% FPL or provide enhanced subsidies to lower-income populations (where the majority of the uninsured population exists).

Figure 3 summarizes federal premium assistance outlays estimated for 2019 based on current WAHBE offerings and as a result of the introduction of RFQ plans (low and high premium rate impact scenarios).

FIGURE 3: COMPARISON OF ESTIMATED FEDERAL PREMIUM ASSISTANCE OUTLAYS ($ MILLIONS), BASELINE AND RFQ PLAN PREMIUM SCENARIOS (CY 2019)



Initial conversations between CMS and the HCA regarding a section 1332 waiver submission based on Cascade Care may provide an understanding of whether or not federal approval would be possible.

Effects of plan standardization

Implementing standard plans will have little or no effect on overall costs. It is possible that certain low priced plans available currently are deriving some of their price advantage through oversimplifications in the federal actuarial value calculator. These plans designs might not be one of the standardized plan designs chosen and so, all else equal, prices for standardized plans would be higher than these plans.

Standardization, however, will make plan comparison simpler. It could also incent plans to further compete on features such as medical management and outcomes, customer service, and other product attributes. Standard plans may limit consumer choice and impact consumers' ability to select plans that fit their needs or preferences.

Conclusion

The introduction of significantly lower cost RFQ plans to WAHBE in 2021 will immediately change the competitive landscape of the individual health benefits market in Washington state. Insurers offering RFQ plans are likely to capture significant market share unless other plans offered in the market also contract with providers at Medicare reimbursement levels.

As a result of RFQ plans, the individual health benefits market may take a more pronounced position in providing health benefits to Washingtonians. The availability of lower cost health benefits coverage, potentially combined with tax-advantaged HRAs available to employers of all sizes, may result in slightly lower enrollment in the employer group market, but much greater enrollment in the individual market. From the health care providers' perspective, this may result in the Medicare reimbursement requirements under RFQ plans resulting in greater revenue reductions than anticipated based on current patient mixes by market.

Provider responses to revenue reductions are likely to vary by service type and market position. The provider response to lower provider reimbursement may include cost shifting to the employer group market segment. Policymakers should consider all downstream impacts to provider access, provider reimbursement rates for the employer group market, and potential provider market consolidation.

As Cascade Care is estimated to reduce federal expenditures for premium assistance offered through WAHBE, it does not maximize the material investment state of Washington providers would be making by accepting Medicare reimbursement for RFQ coverage. Additionally, while RFQ plans will improve premium affordability for high income consumers (income greater than 400% FPL), it does not improve affordability for low income consumers who represent the majority of the uninsured population. A Section 1332 waiver may be one policy option to retain and leverage the provider community's investment in Washington's healthcare delivery system.

Introduction

Milliman was engaged by the Association of Washington Healthcare Plans (AWHP) to model potential impacts from State Bill No. 1523, referred to in this report as "Cascade Care". Our evaluation of Cascade Care in this report is based on the legislation as written on February 14, 2019. To the extent the legislation is modified, the contents of this report will need to be updated. Major provisions of the bill include:

- The Washington Health Benefit Exchange (WAHBE) will establish up to three standardized plans for each of the bronze, silver, and gold metallic levels. A standardized plan requires each carrier offering the plan to utilize a common benefit design (deductible, co-insurance, co-pays, out-of-pocket maximum, and covered benefits).
- Beginning on January 1, 2021, carriers participating in WAHBE will be required to offer at least one standardized plan in the silver and gold tiers. To the extent a carrier offers a bronze plan, it must also offer a standardized bronze plan. Carriers must incorporate recommendations from the Robert Bree Collaborative and the Health Technology Assessment program into standardized plan offerings.
- Carriers offering standardized plans from 2021 through 2024 may continue to offer non-standardized plans (limited to three in each metallic tier beginning in 2023).
- Beginning on January 1, 2025, non-standardized plans may no longer be offered by carriers in WAHBE. However, carriers may offer non-standardized plans outside WAHBE.
- Starting in 2021, the Health Care Authority (HCA) will contract under an RFQ process with one or more carriers to offer silver and gold qualified health plans (QHPs) on WAHBE. This report will refer to these plans as "RFQ plans".
  - These silver and gold QHPs must be standardized designs as described above.
  - The plans' fee-for-service rates for professional and facility reimbursement may not exceed Medicare rates for the same or similar covered services in the geographic region.
  - Carriers must incorporate recommendations from the Robert Bree Collaborative and the Health Technology Assessment program into their RFQ plan offerings.
- WAHBE must conduct a study to offer premium assistance to persons with household incomes up to 500% of the federal poverty level (FPL). Under the ACA, premium subsidies currently made available through WAHBE are limited to income levels up to 400% FPL.

Milliman was requested by AWHP to model potential changes in health benefits coverage, provider reimbursement, and premium rates resulting from the implementation of Cascade Care. The modeling performed for this analysis reflects estimated impacts of Cascade Care on a 2019 basis to allow for direct comparisons to the current health benefits landscape. Our modeling does not consider future changes in Medicare reimbursement, health benefits payer mix, population or demographic changes, or indirect effects of Cascade Care on other public health benefits programs. Further, impacts from changes to the Washington state economy that may impact employment, eligibility for public health benefits programs, or federal premium assistance are outside the scope of this report.

1. State health benefits profile

In order to better evaluate potential impacts from Cascade Care, it is helpful to first establish a baseline for context and comparisons. This section of our report provides an overview of Washington's health benefits market landscape in 2019. Much of the information presented is used for further analysis, as well as to support assumptions and conclusions. We provide estimates of health benefits enrollment by market in 2019, as well as further enrollment analyses by age group and household income. Estimates for provider reimbursement (total non-prescription drug claims dollars) are developed by market segment. Finally, we provide an estimate of the 2019 federal premium assistance provided through WAHBE.

ENROLLMENT BY HEALTH BENEFITS MARKET

Figure 4 provides a summary of the estimated number of Washingtonians by health benefits coverage source in 2019. The estimates are developed from a combination of insurer financial information, publicly available reports on Medicaid and Medicare enrollment, the American Community Survey (ACS), and the Medical Expenditure Panel Survey (MEPS). Please see the methodology section of this report for further information.

FIGURE 4: STATE OF WASHINGTON, ESTIMATED 2019 HEALTH BENEFITS COVERAGE LANDSCAPE

MARKET	PERSONS	% OF POPULATION
Individual	223,000	3.0%
Small Group	283,000	3.7%
Large Group	1,132,000	15.0%
Self-Funded	2,457,000	32.5%
Employer Group Subtotal	**3,872,000**	**51.2%**
Medicaid	1,641,000	21.7%
Medicare	1,036,000	13.7%
Duals	201,000	2.7%
Other	172,000	2.3%
Uninsured	413,000	5.5%
Total	**7,558,000**	**100.0%**

Notes:
3. Values have been rounded to the nearest thousand.
4. Employer group subtotal includes small group, large group, and self-funded populations.
5. Medicaid enrollment includes CHIP.
6. "Other" coverage represents TRICARE, Veterans Health Administration (VHA), and other public healthcare programs.
7. "Duals" coverage reflects persons with both Medicaid and Medicare coverage.
8. Medicare values reflect traditional and Medicare Advantage enrollment.

As shown in Figure 4, the employer group market (small group, large group, and self-funded employers) is the source of health benefits for approximately 51% of Washington's population. However, we estimate only 3% of Washingtonians are purchasing coverage in the individual market in 2019. Enrollment in the individual market is estimated to have declined by nearly 80,000 persons since 2017. This may be attributable to a combination of factors, including:

- Significant premium rate increases that have adversely impacted persons not qualifying for federal premium assistance.[1]
- Improving economy and associated job growth that has resulted in greater access to employer group health benefits and less need for individual market health benefits.[2]

[1] See https://www.wahbexchange.org/wp-content/uploads/2019/01/WAHBE_HCW_012219_FINAL.pdf, slide 4 for annual individual market weighted rate change.

[2] Washington state Employment Security Department (December 2018). Monthly Employment Report. Retrieved March 4, 2019, from https://esd.wa.gov/labormarketinfo/monthly-employment-report

- The individual mandate penalty became $0 for 2019, potentially providing less incentive for some consumers to purchase health benefits.

Figure 5 provides estimated 2019 enrollment in each health benefits market by age group.

FIGURE 5: STATE OF WASHINGTON, ESTIMATED 2019 HEALTH BENEFITS MARKET ENROLLMENT BY AGE GROUP

MARKET	0 TO 17	18 TO 25	26 TO 34	35 TO 44	45 TO 54	55 TO 64	65+	TOTAL
INDIVIDUAL	22,000	17,000	35,000	36,000	43,000	67,000	3,000	223,000
EMPLOYER GROUP	779,000	475,000	618,000	690,000	673,000	607,000	30,000	3,872,000
MEDICAID	808,000	180,000	228,000	157,000	136,000	132,000	-	1,641,000
MEDICARE	5,000	2,000	5,000	7,000	15,000	50,000	952,000	1,036,000
DUALS	3,000	2,000	7,000	12,000	16,000	33,000	128,000	201,000
OTHER	46,000	28,000	31,000	21,000	20,000	25,000	1,000	172,000
UNINSURED	25,000	84,000	90,000	83,000	62,000	59,000	10,000	413,000
TOTAL	**1,688,000**	**788,000**	**1,014,000**	**1,006,000**	**965,000**	**973,000**	**1,124,000**	**7,558,000**

Notes:

1. Values have been rounded to the nearest thousand.
2. "Employer" coverage includes small group, large group, and self-funded populations.
3. Medicaid enrollment includes CHIP.
4. "Other" coverage represents Tricare, Veterans Health Administration (VHA), and other public healthcare programs.
5. "Duals" coverage reflects persons with both Medicaid and Medicare coverage.

For working age adults, 18 to 64 years old, employer coverage provides health benefits to approximately 65% of the population (3.1 million out of 4.7 million), while individual market coverage is only purchased by 4% of the population (198,000 out of 4.7 million). *In considering potential health benefits policy changes, policies that have a minor impact to the employer market may have a corresponding significant impact to the individual market.* For example, if 10% of the employer market shifted to individual market coverage due to Cascade Care, this would increase the size of the individual market from 223,000 to 610,000, a nearly 175% increase in market enrollment. More specifically, if there is systematic bias in terms of which 10% of the large employer group market (i.e., a less healthy 10%) moves over to the individual market, this could have a material effect on overall rates in the individual market due to increased morbidity. More discussion on the morbidity impact of moving populations can be found in Section 5 of this report below.

Comparing the individual and employer markets, it is noticeable that the age of consumers in the individual market is significantly older on average. Persons age 45 or older represent more than half of individual market consumers (113,000 out of 223,000), while in the employer group market, this age group represents approximately only one-third of enrollment (1.3 million out of 3.9 million). Age mix differences are a contributing factor to the individual market's higher estimated per capita claim cost relative to the employer group health benefits market (as shown in Figure 7 below).

Public programs represent a much greater share of health benefits coverage for children (Medicaid) and the elderly (Medicare). Nearly half of children residing in Washington are estimated to be enrolled in Medicaid (including the Children's Health benefits Program or CHIP).

We estimate a 2019 uninsured rate for the total Washington population of 5.5%. This estimate is not statistically different from the 5.3% estimate published in the 2017 National Health Interview Survey.[3] While Washington-specific estimates are not available, national uninsured rates for Medicaid expansion states have increased by 0.5% from 2017 to the third quarter of 2018 (the most recently available data published at the time of this report).[4] The uninsured rate is

[3] https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf, Table XVI.

[4] https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201902.pdf, Table XIII.

estimated to be greatest for the 18 to 25 year-old population (approximately 11%), while just over 6% for adults ages 45 to 64.

The uninsured population represents an important segment of the Washington market with regard to Cascade Care. Policymakers would like to see this segment reduced[5] and the lower premiums of RFQ plans could be an important tool in this effort. We estimate that the overall morbidity of the uninsured is favorable to the current individual and employer group markets and thus their entrance into the individual pool could lower rates for the RFQ plans (See Section 5 below for more discussion of the impact of morbidity on this analysis).

Figure 6 examines the estimated distribution of health benefits coverage by income level, measured as a percentage of the federal poverty level (FPL).

FIGURE 6: STATE OF WASHINGTON, ESTIMATED 2019 HEALTH BENEFITS ENROLLMENT BY INCOME LEVEL (AS PERCENTAGE OF THE FPL)

MARKET	<139%	139% TO 250%	251% TO 400%	401% TO 500%	500%+	TOTAL
INDIVIDUAL	10,000	77,000	43,000	38,000	56,000	223,000
EMPLOYER GROUP	114,000	472,000	871,000	546,000	1,869,000	3,872,000
MEDICAID	857,000	463,000	321,000	-	-	1,641,000
MEDICARE	171,000	227,000	245,000	114,000	280,000	1,036,000
DUALS	128,000	31,000	42,000	-	-	201,000
OTHER	25,000	43,000	42,000	23,000	39,000	172,000
UNINSURED	145,000	106,000	91,000	29,000	41,000	413,000
TOTAL	1,450,000	1,419,000	1,513,000	806,000	2,371,000	7,558,000

Notes:
1. Values have been rounded to the nearest thousand.
2. Employer' coverage includes small group, large group, and self-funded populations.
3. Medicaid enrollment includes CHIP.
4. 'Other' coverage represents Tricare, Veterans Administration (VA), and other public healthcare programs.
5. 'Duals' coverage reflects persons with both Medicaid and Medicare coverage.

Within the individual market, we estimate 94,000 persons (42%) have household income above 400% FPL and, therefore, do not qualify for federal premium assistance. Thirty-nine percent of individual market enrollees are estimated to have income at or below 250% FPL, allowing qualification for both federal premium assistance and cost sharing reductions through WAHBE (to the extent silver-level coverage is purchased). Note that the individual market cohort with income below 139% FPL is assumed to reflect lawfully present individuals who are eligible for federal premium assistance.

Relative to the individual market, the employer market is estimated to have a higher proportion of persons with household income above 400% FPL (62% vs. 42%) and significantly fewer persons with incomes below 250% FPL (15% vs. 39%). As discussed later in this report, large employers have continued to offer health benefits at high rates after the introduction of premium assistance through WAHBE beginning in 2014. While the ACA's employer mandate likely has some effect, this is also attributable to the significant proportion of employees who do not have access to federal premium assistance in WAHBE based on household income.

For each health benefits coverage segment in the state of Washington, Figure 7 provides detail on claims expenses as follows:

- Actuarial value (the percentage of claims expense paid by the insurer or claims administrator in the case of self-funded employer coverage) for the health benefits coverage for each market
- Per capita allowed claims (the cost of all covered services, including both insurer paid expenses and member cost sharing)

[5] University of Pennsylvania's "State Efforts to Close the Health Coverage Gap. Retrieved March 4, 2019 https://ldi.upenn.edu/brief/state-efforts-close-health-coverage-gap

- Proportion medical cost (the percentage of allowed claims attributable to medical costs (excluding pharmacy and long term services and supports or LTSS))
- Per capita allowed medical cost
- Aggregate medical cost, shown in billions of dollars

Note that costs for the uninsured population do not reflect uncompensated care delivered by providers and exclude any indirect payments for the delivery of uncompensated care. Based on national-level information, we have assumed approximately 80% of provider care to the uninsured population is uncompensated.[6]

The information provided in Figure 7 establishes a baseline view of 2019 provider revenue in Washington state. Projected revenue under Cascade Care enrollment scenarios will be compared to these baseline values later in this report.

FIGURE 7: STATE OF WASHINGTON, ESTIMATED 2019 HEALTH BENEFITS COVERAGE, ENROLLMENT AND CLAIMS EXPENSE

	PERSONS	ESTIMATED ACTUARIAL VALUE	PER CAPITA ALLOWED CLAIMS	PROPORTION MEDICAL COST	PER CAPITA ALLOWED MEDICAL COST	AGGREGATE MEDICAL COST ($ BILLIONS)
Individual	223,000	72%	$6,300	80%	5,050	$1.1
Small Group	283,000	77%	5,550	80%	4,450	1.3
Large Group	1,132,000	85%	5,575	80%	4,450	5.0
Self-Funded	2,457,000	90%	5,625	80%	4,500	11.1
Employer Group Subtotal	**3,872,000**	**88%**	**$5,600**	**80%**	**4,475**	**$17.4**
Medicaid	1,641,000	100%	5,375	85%	4,575	$7.5
Medicare	1,036,000	80%	10,550	80%	8,450	$8.8
Duals	201,000	94%	35,350	40%	14,150	$2.8
Other	172,000	90%	5,525	80%	4,425	$0.8
Uninsured	413,000	0%	825	80%	650	$0.3
Total	**7,558,000**		**$6,781**		**$5,109**	**$38.6**

Notes:

1. Values have been rounded.
2. Estimates for the individual, small group, and large group markets developed from 2017 medical loss ratio submissions trend to 2019 and WAHBE's 2019 open enrollment report presentation. Individual market claims expense estimated by 2019 premium estimates, an assumed market loss ratio of 80%, actuarial value estimates.
3. Estimates for public health benefits programs were estimated based on publicly available CMS data.
4. Percentage of claims by insurer estimates developed from CMS risk adjustment transfer reports and actuarial judgment. The estimate for the individual market includes cost sharing reduction plan design enhancements.
5. Medicaid per capita costs include supplemental payments and are net of pharmacy rebates

On a composite basis, we estimate approximately $39 billion in healthcare medical claims cost in 2019, with the individual market generating $1.1 billion or approximately 3% of the total. As shown in Figure 7, the per capita allowed claim costs for the individual market ($6,300) is higher than the employer group health benefits composite ($5,600). This difference is attributable to the following factors:

- As shown in Figure 4 above, the individual market is composed of a greater proportion of adults age 45 and over (51% of enrollees) and significantly fewer children (10% of enrollees) relative to the employer group market (34% of enrollees age 45 and over, and 20% of enrollees are children). As healthcare costs increase with age, the higher age mix in the individual market results in higher per capita claims expense.
- For a given age, we estimate that the average morbidity (illness burden) in the individual market is approximately 15% to 20% higher relative to the same age in the employer group health benefits market. This is likely driven by

[6] Kaiser Family Foundation (May 30, 2014). Uncompensated Care for the Uninsured in 2013: A Detailed Examination. Retrieved March 4, 2019, from https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/

the lower average household income[7] of the individual market and adverse selection among consumers (the greater likelihood that persons with greater healthcare needs will purchase coverage).

- All else equal, a non-biased, balanced cross-section of migration from the employer group market could improve overall rates in the individual markets. However, as we discuss in greater detail in later sections of this report, anti-selective behavior by large employers offering HRAs that result in the movement of sicker individuals could have a detrimental effect on individual morbidity and, therefore, overall premium rates.
- Offsetting age mix and morbidity to some degree, we estimate that current provider reimbursement in the individual market is less, on average, relative to employer group coverage. Narrow network strategies that contribute to lower provider reimbursement are employed by insurers operating in the individual market far more often than in the employer group health benefits market.
- The employer group market is estimated to have approximately $17 billion in aggregate allowed medical costs, reflecting nearly 45% of medical cost expenditures.

INDIVIDUAL MARKET DETAIL

This section provides additional information related to enrollment, premiums, federal premium assistance, and benefit design selections for Washington's individual market. Figure 8 provides a breakdown of 2019 enrollment, premium, and claims expense among the key segments of Washington's individual market. For WAHBE, additional detail is provided on persons purchasing coverage with an advanced premium tax credit (APTC) relative to those not receiving federal premium assistance (non-APTC).

FIGURE 8: STATE OF WASHINGTON, 2019 INDIVIDUAL HEALTH BENEFITS MARKET PROFILE

SEGMENT	PERSONS	ANNUAL PER CAPITA PREMIUM	AGGREGATE PREMIUM ($ MILLIONS)	ANNUAL PER CAPITA APTC	AGGREGATE APTC ($ MILLIONS)
WAHBE (EXCHANGE)	184,000	$6,600	$1,214.4	NA	NA
APTC	123,000	6,750	830.3	$4,775	$600.0
NON-APTC	61,000	6,300	384.3	NA	NA
OFF-EXCHANGE	33,000	6,300	207.9	NA	NA
GRANDFATHERED	6,000	4,825	29.0	NA	NA
TOTAL	**223,000**	**$6,500**	**$1,451.5**	**NA**	**$600.0**

Notes:

1. Person estimates have been rounded to the nearest thousand. With the exception of aggregate premium, other values have been rounded to the nearest multiple of 25.
2. Estimates developed from September 2018 effectuated enrollment reports released by WAHBE, WAHBE's 2019 open enrollment presentation, and insurer rate filings. Actual values are certain to vary from the estimates illustrated.

Individual market enrollment is estimated to decline in 2019 by approximately 19,000 persons (242,000 to 223,000). Based on effectuated enrollment (the number of people maintaining coverage through the year) patterns in 2018 and open enrollment selection differences between 2018 and 2019, we estimate average monthly WAHBE enrollment of 184,000 persons in 2019, accounting for 83% of individual market enrollment. [8] We have assumed enrollment declines from 2018 to 2019 in the off-exchange market will be similar to those observed in WAHBE. The grandfathered coverage estimate reflects enrollment from a single insurer.[9]

[7] http://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2017_SHS_Table_A-11.pdf
[8] WAHBE. Presentation by House Health Care and Wellness Committee, Slide 5. Retrieved March 4, 2019, from https://www.wahbexchange.org/wp-content/uploads/2019/01/WAHBE_HCW_012219_FINAL.pdf,
[9] Lifewise Health Plan of Washington, Request #346008, per the Office of the Insurance Commissioner, Washington state: Search Health Plan Rate Increases, at https://fortress.wa.gov/oic/consumertoolkitrt/Search.aspx,

Approximately 67% of consumers purchasing coverage through WAHBE receive federal premium assistance. For 2019, we estimate the average annual financial assistance received by APTC-eligible consumers is $4,775, resulting in $600 million in aggregate federal APTC expenditures. As individual market premiums have increased significantly in the last two years, this has resulted in greater levels of premium assistance being provided to Washingtonians.[10] From 2018 to 2019, we estimate that federal premium assistance expenditures increased by approximately $50 million. As we discuss later in this report, premium rates in the individual market are estimated to decrease significantly under Cascade Care. This will result in a corresponding decrease in federal premium assistance expenditures.

Figure 9 illustrates the estimated distribution of WAHBE enrollment by income and metallic level. Silver coverage is most popular for consumers with income at or below 250% FPL. Consumers in this income cohort are eligible for cost sharing assistance that is available only if a silver plan is purchased. At higher income levels, bronze coverage accounts for nearly half of exchange enrollment. Based on September 2018 data published by WAHBE, 94% of QHP enrollees with income between 139% and 400% FPL are receiving federal premium assistance.[11]

FIGURE 9: STATE OF WASHINGTON, ESTIMATED 2019 EXCHANGE ENROLLMENT BY METALLIC LEVEL

HOUSEHOLD INCOME	ENROLLMENT	%CATASTROPHIC	%BRONZE	%SILVER	%GOLD	%TOTAL
<250%	86,000	0.5%	18.4%	75.3%	5.8%	100.0%
251% to 400%	41,000	2.1%	46.5%	35.4%	15.9%	100.0%
>400%	56,000	2.1%	49.3%	28.8%	19.9%	100.0%
Total	**184,000**	**1.3%**	**34.2%**	**52.1%**	**12.4%**	**100.0%**

Note: Values have been rounded.

Summary

Washington's individual market provides health benefits to persons without access to employer group or public program coverage. As Washington has a robust employer group market and public programs, the number of persons covered by the individual market is estimated to represent only 3% of state residents. However, market enrollment may increase materially in periods of higher unemployment (similar to expectations for Medicaid enrollment).[12]

Federal premium assistance is estimated to be responsible for more than half of WAHBE premium payment in 2019, with two-thirds of WAHBE enrollees receiving an advance premium tax credit (APTC). It is important to understand that for many consumers purchasing coverage in WAHBE, out-of-pocket premiums are capped at levels far below the full premium rate, with the APTC making up the difference. The estimated average annual APTC value of $4,775 per capita is estimated to cover more than 70% of premium for subsidy-eligible enrollees. Therefore, State of Washington initiatives such as Cascade Care that have the effect of reducing individual exchange rates, also have the indirect effect of reducing federal subsidies to the state as well. A Section 1332 waiver, discussed in detail later in this report, is one potential policy mechanism that may allow the state to retain federal premium assistance savings for reinvestment in Washington's health care delivery system.

Among the uninsured population of approximately 400,000, we estimate less than 20% have incomes above 400% FPL and, therefore, do not qualify for federal premium assistance. In evaluating the impact of Cascade Care on the state's uninsured rate, this higher income population would receive the direct benefits of lower market premium rates.

[10] WAHBE, Presentation by House Health Care and Wellness Committee, op cit., Slide 4.
[11] WAHBE, Presentation by House Health Care and Wellness Committee, ibid., Slide 17.
[12] Kaiser Family Foundation (December 2011). Medicaid and the Uninsured: Changes in Health benefits Coverage in the Great Recession, 2007-2010. Retrieved March 4, 2019, from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8264.pdf

2. Premium rate impact of Medicare reimbursement on RFQ plans

BACKGROUND AND ASSUMPTIONS

Cascade Care requires standardized plans in the bronze, silver and gold metal levels. Implementing standard plans is estimated to have little or no effect on overall costs but will make plan comparison simpler. Indirectly, it could incent carriers to further compete on other features such as medical management and outcomes, customer service, and member satisfaction. On the other hand, standard plans may limit consumer choice and their ability to select a plan that fits individual needs.

The more important feature of the requirement for standard plans is what this paper refers to as RFQ plans. Starting in 2021, Cascade Care requires the HCA to issue a request for quotation (RFQ) and contract with one or more carriers to establish a class of standardized plan designs that are priced consistent with underlying reimbursement no greater than Medicare fee-for-service (FFS) levels. Because Medicare reimbursement is generally 15% to 45% lower (depending on claims type, such as inpatient, physician, etc.) than existing reimbursement underlying WAHBE coverage (and approximately 30% to 70% lower than employer group coverage), it is estimated to result in reduced premium rates for RFQ plans relative to non-RFQ plans, as well as reduced cost sharing (such as deductibles, coinsurance and copays) for consumers buying RFQ plans.

We modeled the impact of Medicare reimbursement requirements on plan premiums and cost sharing for three 2019 plans available on WAHBE: the lowest-cost gold plan, the lowest-cost silver plan and the second-lowest-cost silver plan for King, Spokane and Thurston counties[13]. Enrollment from these counties accounted for nearly 50% of WAHBE enrollment in September 2018.[14] Benefit designs for these plans can be found in Appendix C.

Our modeling used the following process and assumptions:

- The Milliman Managed Care Rating Model (MCRM) was used to estimate underlying costs by inpatient, outpatient, and physician categories at both current estimated provider reimbursement levels and under Medicare reimbursement for each of the three plans.
- To estimate current reimbursement, we applied provider discount assumptions based on Milliman analysis of the in the IBM Marketscan® database, Milliman data trade contributors, and publicly available data sources. We also utilize survey information from Washington state carriers offering plans on WAHBE for King, Spokane and Thurston counties. For simplicity and to preserve confidentiality, we combined the carrier and claim type reimbursement information into a single overall reimbursement indicator for a low cost area scenario and a high cost area scenario.

  We estimate that provider reimbursement for non-prescription drug costs for plans available on WAHBE in 2019 ranges across Washington state from approximately 140% of Medicare (low-cost scenario) to 190% (high -cost scenario) of Medicare for facility and professional services on a composite basis, although relative reimbursement varies by claims type. Actual provider reimbursement within a geographic area or for an individual provider may be outside of this range; however, we believe this is a reasonable estimate of existing provider contracting levels. To the extent that provider reimbursement varies by geographic area, actual premium rate changes under Cascade Care could vary significantly by county.
- Demographic assumptions are based on WAHBE 2018 enrollment as of the September enrollment file.[15] The average assumed age is 48 years old.[16]
- We assume no change in prescription drug (Rx) costs for RFQ plans under Cascade Care.
- Finally, we assumed that administrative expenses, taxes, and profit built into WAHBE plans are on average approximately 17% of current premiums. We further assume that the fixed portion of these expenses is approximately $49 per member per month (PMPM) and variable expenses are 10% of premium[17].

[13] The lowest-cost Bronze plan modeled was only common to King and Thurston counties.

[14] https://www.wahbexchange.org/wp-content/uploads/2018/12/HBE_EN_181221_September_Enrollment_Report.xlsx

[15] https://www.wahbexchange.org/about-the-exchange/reports-data/enrollment-reports-data/

[16] Note that a per capita premium using a population distribution with an average age of 48 will not be consistent with WAHBE prices for a person 48 years old due to the non-linear nature of the ACA age curve.

[17] Assumptions are reasonable pricing assumptions that likely produce an 80% or greater medical loss ratio (MLR) and do not reflect any specific carrier or the actual experience in the Washington market.

- Under lower reimbursement levels, a given benefit design will cover a greater proportion of overall incurred health care expenses. For example, assume a hospitalization's cost was $10,000 under existing WAHBE provider contracting and $6,000 under Medicare reimbursement. If a policy had a $3,000 deductible, the plan design would cover 70% of costs under existing WAHBE provider reimbursement, compared to only 50% of the costs under Medicare reimbursement. We have assumed that the insurers offering RFQ plans will calibrate the federal actuarial value (AV) calculator to reflect Medicare reimbursement levels. In this simplified example, this would equate to the deductible being reduced from $3,000 to $1,800, resulting in the RFQ plan covering $4,200 or 70% of the cost.
- To reflect the above assumption regarding plan design actuarial value, the consumer cost sharing for each plan was adjusted so that the plan meets the federal minimum actuarial value[18] standards required by the ACA for WAHBE plans for the silver and gold metallic levels under Medicare reimbursement. Modeling of the necessary deductible changes to maintain the plan design's actuarial value was based on the Milliman's MCRM, as the federal AV calculator does not provide sufficient detail on non-pharmacy costs. Actual changes in deductibles for these plans could be different based on the use of the AV calculator in estimating the plan design adjustment.

RESULTS

The detailed results of our analysis for the three QHPs for a higher cost area are shown in Appendix A, with a summary shown in Figure 10. Corresponding analysis for the lower cost area scenario is shown in Appendix B and Figure 11.

FIGURE 10: IMPACT OF MEDICARE REIMBURSEMENT ON CY2019 PREMIUM RATES
LOW COST (140% OF MEDICARE) AREA SCENARIO

	MODELED PREMIUM-COMMERCIAL REIMBURSEMENT	MODELED PREMIUM-MEDICARE REIMBURSEMENT	INITIAL PREMIUM CHANGE	DEDUCTIBLE CHANGE[19]	DEDUCTIBLE CHANGE IMPACT	FINAL PRICE CHANGE
LOWEST-COST GOLD PLAN	$643.36	$488.32	-24.10%	($400)	3.1%	-21.1%
LOWEST-COST SILVER	$620.30	$483.64	-22.0%	($450)	1.0%	-21.0%
SECOND-LOWEST-COST SILVER	$626.14	$487.63	-22.1%	($500)	1.1%	-21.0%

FIGURE 11: IMPACT OF MEDICARE REIMBURSEMENT ON CY2019 PREMIUM RATES
HIGH COST (190% OF MEDICARE) AREA SCENARIO

	MODELED PRICE-COMMERCIAL REIMBURSEMENT	MODELED PRICE-MEDICARE REIMBURSEMENT	INITIAL PRICE CHANGE	DEDUCTIBLE CHANGE	DEDUCTIBLE CHANGE IMPACT	FINAL PRICE CHANGE
LOWEST-COST GOLD PLAN	$784.31	$482.36	-38.5%	($650)	4.4%	-34.1%
LOWEST-COST SILVER	$747.17	$480.97	-$0.36	($950)	1.8%	-33.9%
SECOND-LOWEST-COST SILVER	$754.79	$485.08	-$0.36	($950)	1.8%	-34.0%

[18] Actuarial value is defined as the estimated percentage of costs covered by the benefit plan. Higher actuarial value plans are more generous. The ACA requires bronze, silver, gold and platinum plans to meet 60%, 70%, 80% and 90% standards, with a de minimis range of -4/+ 2% for metallic tiers other than bronze (bronze plans have a de minimis range of -4/+5%.

[19] Starting deductibles were $1,500, $4,750, and $6,500 from top to bottom of the table in Figure 10.

Observations from the Figures 10 and 11 include:

- The overall impact on premium rates is dampened due to Medicare reimbursement not affecting pharmacy costs or fixed administrative expenses. We estimate pharmacy costs represents approximately 20% of incurred health care expenses for individual market coverage.
- The consumer cost sharing changes, as illustrated by the Deductible Change column needed to ensure compliance with actuarial value minimums will vary by the overall amount of reimbursement reduction (e.g., a $400 reduction in the high-cost scenario versus $650 in the low-cost scenario for the lowest-cost gold plan), as well as by plan design (e.g., under the high-cost scenario, a $650 reduction for the gold plan relative to a $950 reduction for the two silver plans).
- Consumer cost sharing changes are also contingent on modifications to underlying reimbursement assumptions in the federal AV calculator being allowed.
  - If modifications are not allowed, more of the savings for unsubsidized individuals would accrue through lower gross premium rates, rather than lower cost sharing. This will tend to benefit healthier consumers because they typically pay less in cost sharing.
  - Subsidized consumers would likely not benefit as their net premium is fixed as a percentage of income. Hence additional savings in gross premiums would, in absence of a Section 1332 waiver or other solution, accrue to the federal government in the form of lower premium subsidies. See Section 8 below for more discussion of Section 1332 waivers.

It is important to note that while our modeling is based on actual plan designs available on WAHBE for the lowest-cost gold and silver plans and the second-lowest-cost silver in King, Spokane and Thurston counties, the results shown are based on a composite demographic profile, as well as composite commercial reimbursement assumptions (high and low). The assumptions are intended to be applicable to any geographic region within Washington that has current WAHBE reimbursement levels near either 140% or 190% of Medicare FFS. The assumptions are not intended to represent any one single geographical area, any specific carrier in any of these regions or a premium rate for any specific age group. It is certain that the change in provider reimbursement for some providers as a result of Medicare reimbursement requirements for RFQ plans coverage will be outside of the aggregate assumed reimbursement reductions.

INDIVDIUAL MARKET MORBIDITY CHANGES

The premium changes shown above isolate the impact of Medicare reimbursement and do not include any potential morbidity impacts of migration from small and large group markets or from the uninsured. Employer group markets tend to be healthier than the individual market because employees have to maintain reasonable health status in order to work and because carriers typically enforce a minimum percentage of employees that must be enrolled in the plan. This helps ensure a balanced cross section of risk in each employer group.

By contrast, the individual market is the market of last resort and individual consumers may choose to enroll when they anticipate the need for services. The uninsured also tend to be healthier than the individual insured market, particularly at higher incomes because, for the reverse reason: they will choose to “self-insure” when they are healthy.

We estimate the effects of these dynamics for the employer group market and the uninsured population by normalizing composite per capita premium amounts derived from Figure 7 for differences in estimated provider reimbursement levels, thereby isolating differences in morbidity and age between markets. We then calculate the impact of migration from employer group markets and uninsured over to individual (using the migration scenarios described in Section 5 of this report). The results of this analysis are summarized in Figure 12.

FIGURE 12: CUMULATIVE MORBIDITY IMPACT OF EMPLOYER GROUP AND UNINSURED MIGRATION TO INDIVIDUAL SEGMENT

MIGRATION SCENARIO	BASELINE INDIVIDUAL MARKET	AFTER SMALL GROUP MIGRATION	AFTER LARGE GROUP MIGRATION	AFTER SELF-INSURED MIGRATION	AFTER UNINSURED MIGRATION
LOW	0.0%	-4.9%	-7.8%	-7.8%	-9.6%
MEDIUM	0.0%	-7.3%	-10.7%	-12.6%	-13.5%
HIGH	0.0%	-8.8%	-12.1%	-14.3%	-15.0%

Figure 12 illustrates that by adding members to the individual market from employer group markets and the uninsured population, the acuity of the individual market is reduced significantly in all scenarios relative to the baseline.

However these estimates should be dampened as we anticipate that there could be some anti-selective behavior on the part of large groups related to IIHRA offerings. It is conceivable, although against regulations, that employers would seek to make HRA offerings to certain classes of employees that are higher cost, thereby moving them out of the traditional employer group health plan and improving the employer's risk pool while worsening the individual pool. We estimate that anti-selective behavior could reduce the favorable impact shown above by approximately 50%.

Based on these considerations, we estimate that the individual market could see a range of improvement in overall morbidity and claims costs of between 5% and 8%. Unlike the impact of reimbursement changes, which would be immediate in 2021 for RFQ plans, the impact of morbidity improvements in the individual market would be over time, as actual migration takes place over several years.

Summary

Under Cascade Care, individual rates for RFQ plans could be reduced by 20% to 35% due to implementing Medicare reimbursement and an additional 5% to 8% due to favorable morbidity shifts from the employer group market and the uninsured. Total rate reductions could range from approximately 25% to 40% relative to rates in the market in the absence of Cascade Care. Note that the premium rate impact from the RFQ plans is likely to vary by geographic area based on existing relationships between individual market and Medicare provider reimbursement.

3. Impact to individual non-RFQ plans

As currently written, RFQ plans requiring Medicare reimbursement for facility and professional services would be introduced to WAHBE under the following timeline:

- 2021. RFQ plans are introduced, while still allowing non-RFQ plans to be offered by carriers that reflect either a standard or non-standard plan design.
- 2025. Only standardized plans may be offered in WAHBE. While RFQ plans must have a standardized plan design, non-RFQ plans with a standard plan design may also be offered.

While the above timeline proposes a stepwise approach for the introduction of RFQ plans and corresponding standardized plan design requirements, we believe it is likely that the market dynamics will render non-RFQ plans in the individual market (whether standardized or not) unviable for many carriers in 2021. This is attributable to the ACA's premium subsidy structure, which exposes all consumers in the market (regardless of subsidy eligibility and income levels) to the full premium differential between the plan selected and the benchmark silver plan.

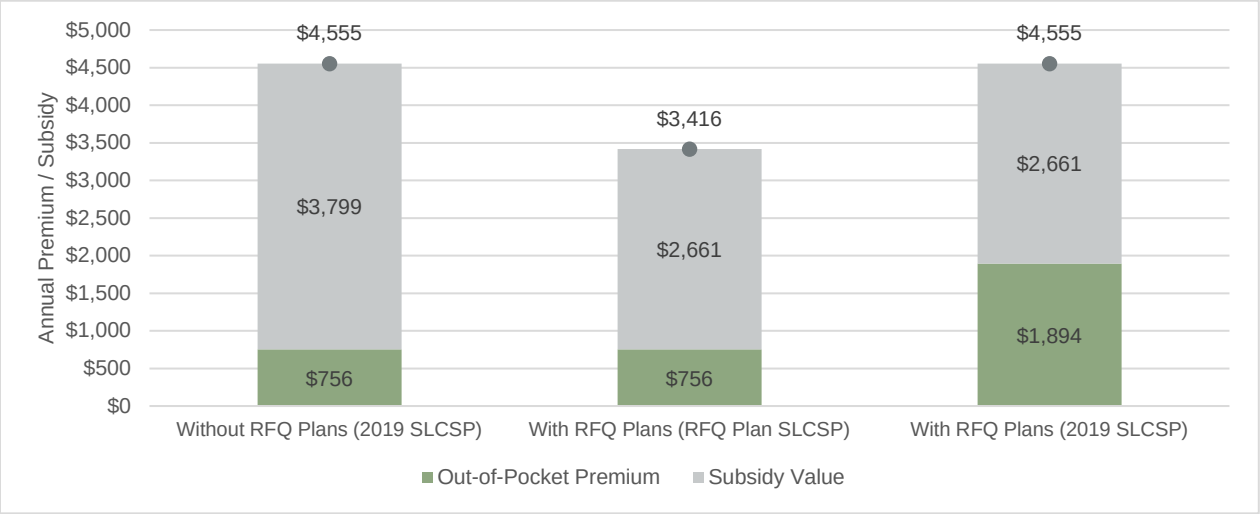
To illustrate these effects, Figures 13 to 16 illustrate the change in net premium for a single, 40-year-old in King County in 2019 at varying household income levels under three purchasing scenarios:

1. The actual 2019 second-lowest-cost silver plan (SLCSP) or subsidy benchmark premium offered by Coordinated Care with a monthly premium of $379.59 or a $4,555 annual premium is purchased.
2. The RFQ plan becomes the subsidy benchmark plan and is purchased by the consumer.
3. The same plan that was purchased in Scenario 1 (when it was the SLCSP) is purchased but it is offered alongside an RFQ plan that has become the SLCSP and, therefore, the subsidy benchmark plan.

For the Medicare reimbursement impact on gross premiums, we assume a premium rate decrease of 25%, which is at the low-end of our market premium rate change estimate for RFQ plans.

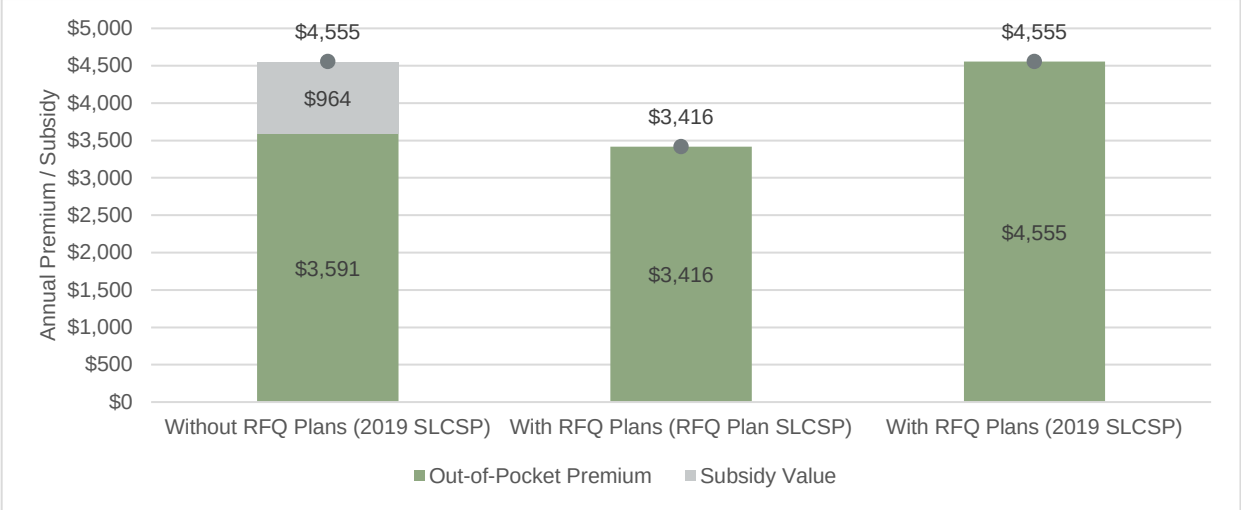
- **Consumer 1, Income 150% FPL**: For low income consumers (generally income below 250% FPL), the out-of-pocket cost or net premium for the subsidy benchmark plan will not change, as it will remain capped at the maximum percentage of household income. However, to the extent a consumer wanted to remain in a non-RFQ plan, that person would be required to pay the additional premium equal to the full differential between the RFQ plan and non-RFQ plan. Figure 13 illustrates out-of-pocket premiums for the three purchasing scenarios described above for a single 40 year old residing in King County with household income of 150% FPL.
  - The annual net premium for the subsidy benchmark plan is $756 under both scenarios 1 and 2. However, when a silver RFQ silver plan becomes the SLCSP, the federal government's subsidy decreases from $3,799 to $2,661, as the subsidy value is equal to the difference between the total premium and maximum the person must pay for the SLCSP ($756).
  - However, the cost to the consumer of the former subsidy benchmark plan under scenario 3 increases to $1,894, a 151% premium increase. To the extent the RFQ plan was 40% less expensive relative to the actual 2019 SLCSP, the out-of-pocket premium change in this scenario would be even greater, as the value of federal premium assistance would be reduced further. Given the price sensitivity of low income consumers, we estimate the non-RFQ plan in scenario 3 would attract very little market share. As shown in Figure 6 above, we estimate 40% of individual market consumers have income below 250% FPL and would likely shift to RFQ plan coverage immediately in 2021.

FIGURE 13: STATE OF WASHINGTON, KING COUNTY, SINGLE 40 YEAR-OLD, HOUSEHOLD INCOME 150% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF RFQ PLANS



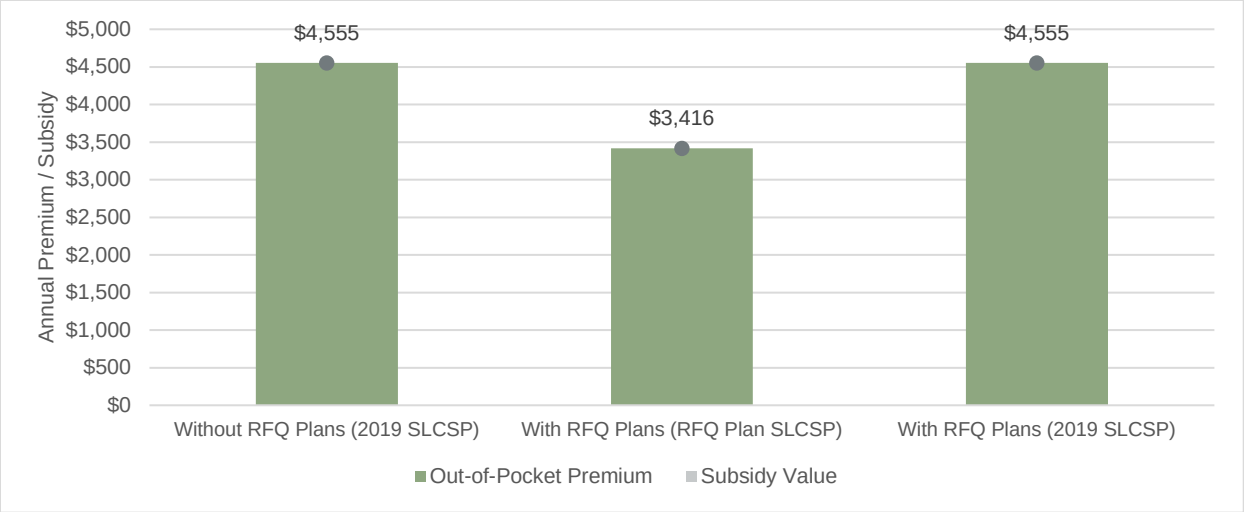
- **Consumer 2, 300% FPL:** We estimate for many middle income consumers (between 250% and 400% FPL), the cost of the subsidy benchmark plan will fall below the maximum annual premium cost under the ACA's subsidy schedule. These consumers will no longer be eligible for federal premium assistance but are estimated to still have lower net premiums for the subsidy benchmark plan. In Figure 14, a consumer with income at 300% FPL currently pays an annual net premium of $3,591 for the subsidy benchmark plan, receiving a premium subsidy value of $964 (reflecting a total premium of $4,555).
  - With the introduction of the RFQ plan, the annual premium for the subsidy benchmark plan drops from $4,555 to $3,416, below the consumer's out-of-pocket premium cap of $3,591.
  - To the extent the consumer wanted to remain in the non-RFQ plan, that person would be required to pay the full $4,555 premium, approximately a 27% net premium increase.

FIGURE 14: STATE OF WASHINGTON, KING COUNTY, SINGLE 40 YEAR-OLD, HOUSEHOLD INCOME 300% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF RFQ PLANS.



- **Consumer 3, 500% FPL:** For consumers with income above 400% FPL, the change in cost for the subsidy benchmark plan should equal to the premium rate difference between the RFQ and non-RFQ plans.

- **FIGURE 15: STATE OF WASHINGTON, KING COUNTY, SINGLE 40 YEAR-OLD, HOUSEHOLD INCOME 500% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF RFQ PLANS**



The price sensitivity of individual market consumers is supported by CMS research on consumer price sensitivity. CMS reported 64% of individuals selecting a marketplace plan chose the lowest or second-lowest-cost plan in a metallic tier in 2014, with this figure remaining at 47% for the 2015 coverage year.[20]

As discussed above, the premium rate differential between RFQ and non-RFQ plan options will likely vary across the state. Particularly in rural areas, existing provider reimbursement for WAHBE coverage may be comparable to employer group market reimbursement, creating significant premium differential between RFQ and non-RFQ plan options. In urban areas, where a narrow network strategy is more feasible, existing provider reimbursement for marketplace coverage may be significantly less than employer group health benefits, reducing the premium differential between the RFQ and non-RFQ plan options.

To the extent material network access differences exist between the RFQ plans offered through WAHBE and non-RFQ plans offered both inside and outside the exchange (with presumably broader provider access), it may be possible that a portion of the market will elect to remain enrolled in a non-RFQ plan. This may occur more frequently in urban areas where carriers have already developed narrow networks for plans offered through WAHBE.

Impact to out-of-pocket premium costs for bronze coverage

Based on discussions with AWHP, it is our interpretation that the Cascade Care legislation as currently written does not require an RFQ plan, with underlying Medicare reimbursement, for bronze-level coverage. Based on September 2018 WAHBE enrollment statistics, approximately 27% of enrollees with household income at or below 400% FPL purchased bronze coverage (with the vast majority receiving federal premium assistance).[21] For enrollees with income between 250% and 400% FPL, nearly 50% purchased bronze coverage in 2018.[22]

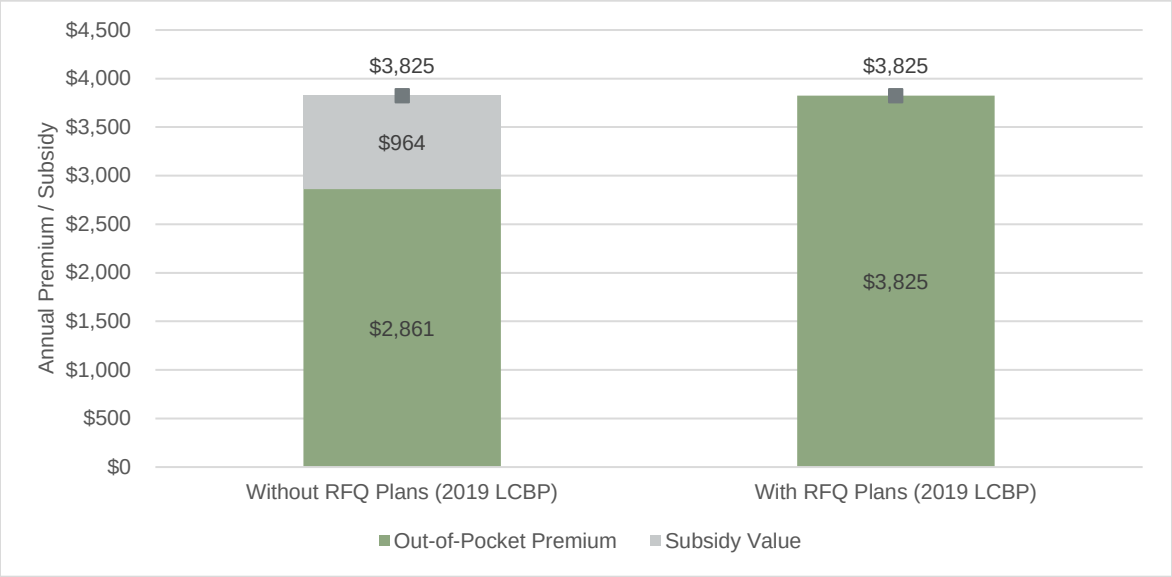
For consumers not qualifying for federal premium assistance, the premium cost of silver RFQ coverage may be less than for existing bronze-level coverage. The availability of coverage that is more affordable (with lower required cost sharing) should incent a portion of the uninsured population at higher income levels to purchase RFQ coverage.

However, the interaction between bronze and silver premium relativities and the ACA's subsidy structure may produce less favorable outcomes for a portion of the population currently qualifying for premium assistance and purchasing bronze-level coverage. If an RFQ plan (with underlying Medicare reimbursement) at the bronze-level is not made available to consumers and provider reimbursement for bronze non-RFQ plan coverage remains at status quo levels, then out-of-pocket premium costs for some subsidy eligible consumers could increase dramatically.

[20] HHS (October 30, 2015). Health Plan Choice and Premiums in the 2016 Health benefits Marketplace. Retrieved March 4, 2019, from https://aspe.hhs.gov/basic-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace
[21] WAHBE September 2018 Enrollment Report, op cit.
[22] WAHBE September 2018 Enrollment Report, ibid.

To illustrate this effect, Figure 16 provides a breakdown of out-of-pocket premium and federal premium assistance for a single 40-year-old in King County with income of 300% FPL purchasing the lowest-cost bronze plan (LCBP) offered in 2019 ($3,825 annual premium).

FIGURE 16: STATE OF WASHINGTON, KING COUNTY, SINGLE 40-YEAR-OLD, HOUSEHOLD INCOME 300% FPL, PREMIUM RATE IMPACT TO BRONZE COVERAGE FROM INTRODUCTION OF SILVER RFQ PLANS (ASSUMING NO BRONZE RFQ PLANS ARE OFFERED)



- In 2019, the individual would receive federal premium assistance of $964, resulting in a $2,861 annual out-of-pocket premium.
- With the introduction of the silver RFQ plan, it is assumed the subsidy value decreases to $0 (as the annual premium cost for the SLCSP decreases from $4,555 to $3,416).

As a result of the absence of federal premium assistance, the out-of-pocket premium cost to remain in the LCBP increases from $2,861 to $3,825. As the cost of bronze coverage exceeds the silver RFQ plan premium ($3,416), the consumer would likely migrate to silver coverage. However, given that the lowest-cost available plan increased from $2,861 to $3,416, it is also possible the consumer would forgo coverage due to the cost increase. This rate shock will either cause these consumers to simply drop coverage or they will switch to the silver RFQ plan. To the extent the first option is chosen, this could increase uninsured rates. An amendment to the Cascade Care legislation requiring a bronze RFQ plan to be offered would eliminate the out-of-pocket premium increases illustrated in the above scenario.

4. Employer group health benefits market dynamics

With potential premium rate decrease of 25% to 40% for RFQ plans on WAHBE as a result of Medicare reimbursement requirements and improved morbidity of the risk pool, premium rates for RFQ coverage be may lower relative to comparable benefit plans in the employer group health benefits market. The reduction in premium rates due to Medicare reimbursement requirements and morbidity improvements will more than offset the current estimated morbidity difference (15% to 20%) between individual and employer group health benefits markets. Therefore, at face value, RFQ plan premium rates may be less than employer group health benefits rates for comparable plan designs.

However, there are many other factors that employers may consider when assessing whether the lower cost RFQ plans available on WAHBE could be a viable alternative to traditional employer group health benefits. This section provides a summary of why offering employer group health benefits coverage is common place among large employers as well an examination of how the potentially lower cost of RFQ plans and changes in regulations governing HRAs may result in the RFQ plans being viewed by some employers as a superior alternative to offering traditional employer group health benefits.

REASONS EMPLOYERS OFFER HEALTH BENEFITS

Motivations to offer health benefits will vary by employer, particularly by size of firm (small group versus large group). However, generally, the following reasons have been broadly applicable since the introduction of employer-based health benefits coverage:

- **Attract and retain employees**. Health benefits are major part of an employer's compensation strategy. A survey conducted by America's Health Insurance Plans (AHIP) found 56% of workers view health benefits as a key factor in remaining at their current job.[23]
- **Employee population health**. A health benefits plan may be used by an employer to reduce employee absenteeism and increase productivity.[24]
- **Tax exclusion**. Employer group health benefits are excluded from state and federal income for employees and payroll taxes for both employer and employee.[25] Therefore, particularly for high wage-earners, employer group health benefits represent a very tax-efficient means of employee compensation.

Additional factors that are now considered after implementation of the ACA and federal premium assistance in the exchanges include:

- **Lack of eligibility for federal premium assistance**. As illustrated in Figure 6 above, approximately 62% of Washingtonians covered by an employer group health benefits plan have income above 400% FPL and, therefore, are not eligible for premium assistance. In the absence of eligibility for other types of coverage, it would be necessary to pay the full premium rate for individual market coverage with after-tax wages.
- **For employers in the large group market segment, ACA's employer mandate**. Under the ACA, an applicable large employer, defined as 50 or more full-time employees (and full-time equivalents), must offer minimum essential health benefits coverage or pay a penalty of approximately $2,300 per full-time employee in 2019 (the first 30 full-time employees are exempted).[26] Additionally, the employer mandate penalties are not tax-deductible.

[23] https://www.ahip.org/esi-survey/

[24] Lofland, J.H. & Frick, K.D. (January 2006). Effect of health benefits on workplace absenteeism in the U.S. workforce. *Journal of Occupational and Environmental Medicine*. Retrieved March 4, 2019, from https://journals.lww.com/joem/Abstract/2006/01000/Effect_of_Health_Insurance_on_Workplace.2.aspx

[25] IRS. Employee Benefits. Retrieved March 4, 2019, from https://www.irs.gov/businesses/small-businesses-self-employed/employee-benefits

[26] IRS. Employer Shared Responsibility Provisions. Retrieved March 4, 2019, from https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions

Based on Medical Expenditure Panel Survey (MEPS) data[27], nearly all large employers in the state of Washington (with 50 or more employees) offer health benefits. This observation has not changed with the introduction of WABHE and the availability of federal premium assistance beginning in 2014.

Small employers, however, offer traditional employer group coverage at far lower rates. MEPS data indicates that only 28% of Washington state private sector establishments with fewer than 50 employees offered health benefits in 2017.[28] Some small employers contribute to the cost of individual exchange coverage for their employees, even though up until the passage of the 21st Century Cures Act and the establishment of the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), this was against the law and subject to fines of up $36,500 per year per employee.[29]

FACTORS EMPLOYERS CONSIDER WHEN OFFERING SPECIFIC COVERAGE

In a study sponsored by the U.S. Department of Labor[30], the RAND Corporation found employers primarily select a health plan based on cost, defined by two measures:

- Provider discounts (including pharmacy costs)
- Administrative costs

These findings suggest that an employer may be open to alternatives to traditional employer group health benefits to the extent it results in cost savings to the organization. According to the Bureau of Labor Statistics, approximately 8% of 2018 compensation for civilian employees was related to health benefits.[31] Therefore, to the extent significantly more affordable options become available, it may allow an employer to materially reduce its employee benefit costs.

The RAND study also found that network adequacy was a major consideration for employers. To date, employers have been reluctant to offer narrow provider networks in employee health plan offerings. For example, the 2018 Kaiser Employer Health Benefits Survey indicated that only 6% of firms with 50 or more workers offered a narrow network plan.[32] The survey reported only 8% of employers had eliminated a hospital from their networks in the last year to achieve cost savings.[33]

A major contingency influencing employer take-up of RFQ plans, then is the extent to which adequate networks can be built by participating carriers, especially considering the significant reductions in reimbursement compared to current exchange market (WAHBE) reimbursement levels.

BENEFITS RICHNESS OF EMPLOYER PLANS RELATIVE TO WAHBE PLANS

Figure 17 illustrates the estimated distribution of employer group health benefits plan single or employee only offerings among private employers in the state of Washington during 2017.[34] Median values for the deductible and out-of-pocket maximum are $1,200 and $3,900, respectively.

[27] HHS. Medical Expenditure Panel Survey. Retrieved March 4, 2019, from https://meps.ahrq.gov/

[28] https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2017/tiia2.htm

[29] Ibid.

[30] Mattke, S., Van Busum, K.R., & Martsolf, G. (2013). Final Report: Evaluation of Tools and Metrics to Support Employer Selection of Health Plans, Section 8.2. Retrieved March 4, 2019, from https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/evaluation-of-tools-and-metrics-to-support-employer-selection-of-health-plans.pdf

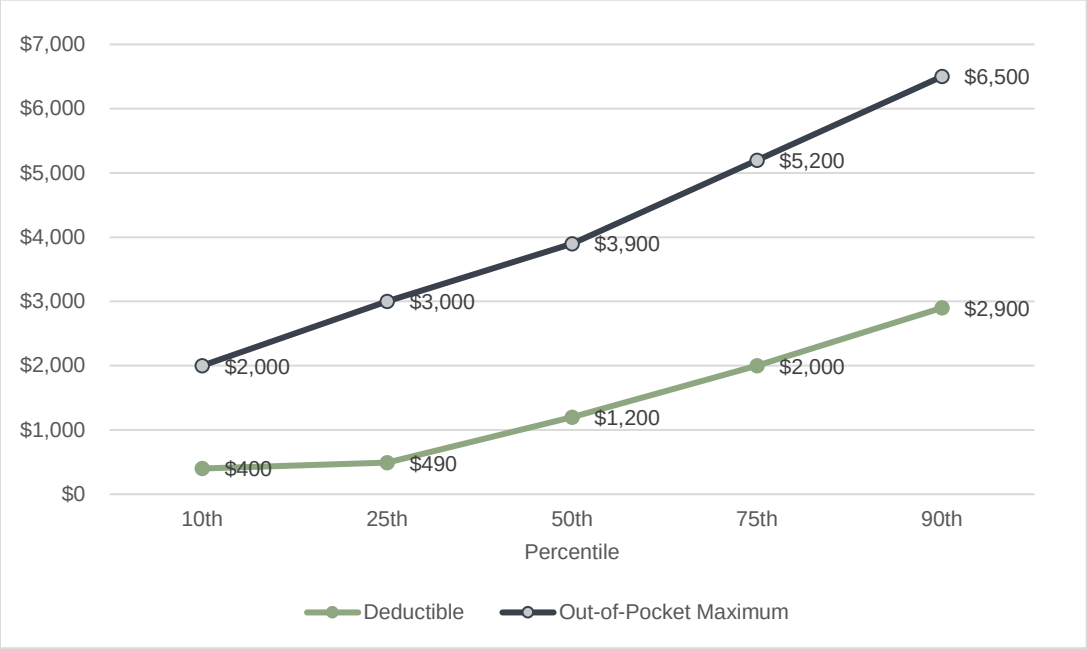
[31] Bureau of Labor Statistics (December 14, 2018). Employer costs for employee compensation news release text. Retrieved March 4, 2019, from https://www.bls.gov/news.release/ecec.nr0.htm

[32] Kaiser Family Foundation (October 3, 2018). 2018 Employer Health Benefits Survey, Figure 14.6. Retrieved March 4, 2019, from https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-section-14-employer-practices-and-health-plan-networks/, Figure 14.6

[33] Kaiser Family Foundation (October,3 2018) Ibid.

[34] Data sourced from the Medical Expenditure Panel Survey (MEPS). Deductible information is available: https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_10/2017/txf1.htm, out-of-pocket maximum information: https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_10/2017/txg1.htm.

FIGURE 17: CY 2017 DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM DISTRIBUTION FOR SINGLE HEALTH BENEFITS COVERAGE OFFERED BY EMPLOYERS, STATE OF WASHINGTON



Source: CY 2017 Medical Expenditure Panel Survey

For comparison purposes, bronze-level coverage offered in the WABHE generally has a single deductible of approximately $4,500 to $6,500 and a corresponding out-of-pocket maximum of approximately $7,000. Silver-level coverage deductibles (excluding cost sharing reduction plan variants) range from $2,000 to $7,000, with out-of-pocket maximum requirements typically in the range of $6,000 to $7,000.[35] While nearly half of exchange consumers with incomes above 250% FPL are purchasing bronze coverage, coverage offered by employers would typically be labeled as gold (80% actuarial value) or platinum (90% actuarial value) coverage.

EMPLOYER CONTRIBUTION STRATEGY

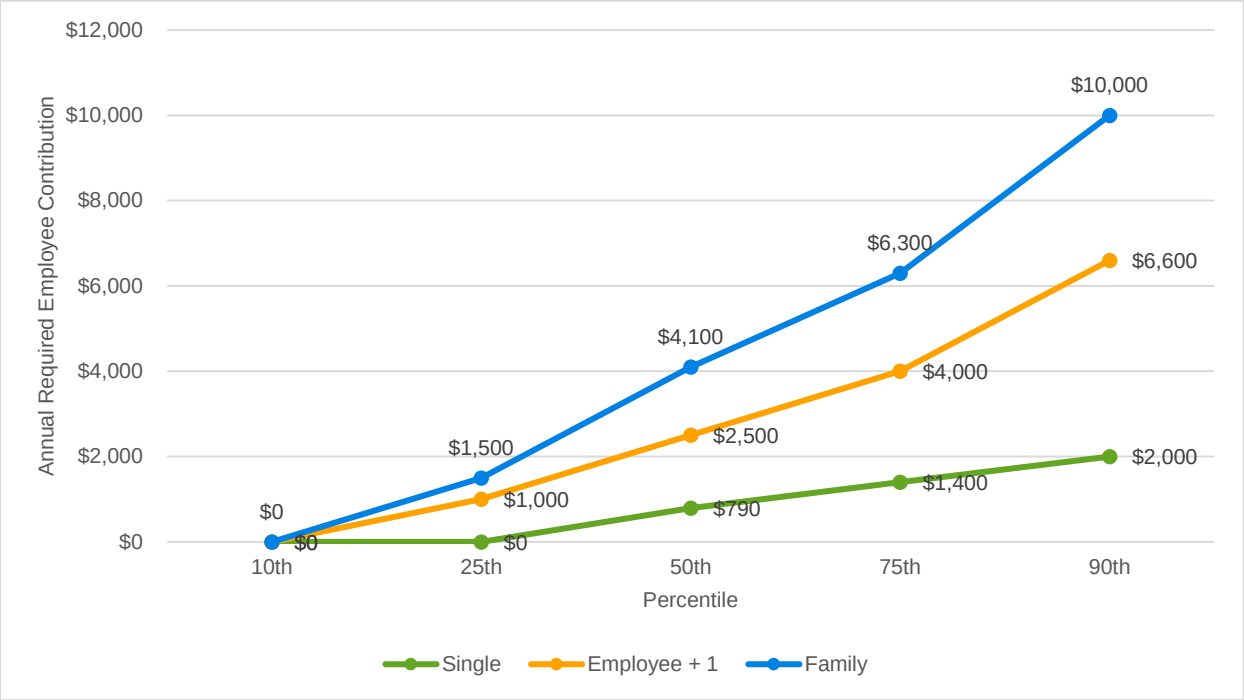
Figure 18 provides the distribution of required employee health benefits contributions by coverage tier for private Washington employers in 2017.[36] Employers typically heavily subsidize the cost of health benefits, particularly for single (also referred to as "employee only" coverage).

- In 2017, the annual median required contribution for single coverage was $790. The median single premium (reflecting both employer and employee costs) was $6,400.
- This implies that employers are contributing $5,610 annually or about $468 per member per month on average.
- For comparison relative to the ACA's subsidy structure, a single person with income slightly above 150% FPL would be required to pay $790 annually for the second-lowest-cost silver plan.
- Households at higher income levels pay significantly more. A single person with income at 300% FPL pays nearly $3,600 annually for the second-lowest-silver plan.

[35] For additional information, please see https://www.wahbexchange.org/wp-content/uploads/2019/01/WAHBE_HCW_012219_FINAL.pdf.

[36] CY 2017 MEPS data.

FIGURE 18: CY 2017 DISTRIBUTION OF REQUIRED EMPLOYEE CONTRIBUTIONS FOR EMPLOYER GROUP HEALTH BENEFITS BY COVERAGE TIER, STATE OF WASHINGTON



Source: CY 2017 Medical Expenditure Panel Survey

To the extent RFQ plans, with benefit designs similar to employer coverage, were priced materially lower relative to standard employer group coverage, the following outcome may occur:

- The employer converts existing subsidy costs associated with the provision of the traditional employer group health plan to a defined contribution approach, depositing money in each eligible employee's HRA.
- The employee, potentially pooling money from a spouse's HRA (and allowing the family to be insured through a single health benefits policy), purchases a RFQ plan offered through WAHBE.
- To the extent a price differential exists between the RFQ plan and traditional employer group coverage for similar benefit designs, the employee may be able to purchase a richer plan with the HRA funds.

Based on the above discussion, we conclude that employers may be satisfied with the plan designs offered by RFQ plans insofar as gold and silver plans were available. Some employers (approximately 30% based on Figure 17 might be looking for platinum coverage that would not be available. However, for the potential cost savings available under RFQ plans, even the employers currently offering platinum may consider switching to an HRA approach. The following section provides a detailed overview of HRAs and recent legislative and regulatory proposals surrounding their usage to purchase individual market health benefits coverage.

QSEHRA AND INTEGRATED INDIVIDUAL HRA AS ALTERNATIVES TO TRADITIONAL COVERAGE

Some employers have used health reimbursement arrangements (HRAs) as means to supplement employer group health benefits coverage for their employees.[37] The following are key aspects of traditional HRAs, prior to recent legislative and regulatory developments:[38]

[37] The 2018 Kaiser Family Foundation Employer Health Benefits Survey indicates 7% of employers (sponsoring an employer group health plan) offer a high-deductible health plan with an HRA. Please see https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-8-high-deductible-health-plans-with-savings-option/ for more information.

[38] More information about HRAs from the IRS is available at https://taxmap.irs.gov/taxmap/pubs/p969-003.htm

- An HRA must be funded solely by an employer
- Contributions made by an employer are excluded from an employee's gross income
- Reimbursements for qualified medical expenses from HRA funds are tax free to the employee
- An employer may elect to carry over unused funds in the HRA to the following year(s)
- There is no limit on the amount of money an employer can contribute to the accounts
- The HRA must be offered in conjunction with other employer-provided health benefits

As stated in the last bullet above, rules governing HRAs traditionally required HRAs to be offered in conjunction with a traditional employer group health plan. The U.S Department of Labor ruled that offering employees cash to specifically purchase individual policies would violate the group market reform provisions of the ACA because the arrangement would still be considered a group health plan and, therefore by default, have an annual limit which is prohibited. However, recent legislative and regulatory developments have modified the requirement for integrated group coverage for small employers, with regulatory changes pending for large employers. These changes create alternatives to traditional group coverage with equivalent tax benefits for both employer and employee, while also fulfilling the ACA's employer mandate for large employers.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

The 21st Century Cures Act (Cures Act), enacted on December 13, 2016, created the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).[39] A QSEHRA allows an eligible small employer to reimburse an employee's medical expenses, including premiums for individual health benefits policies, so long as certain requirements are met:

- As with any HRA, the arrangement is funded solely by an eligible employer (an employee cannot make voluntary salary reduction contributions toward a QSEHRA).
- The amount of payments and reimbursements in the benefit year cannot exceed $5,150 for single coverage or $10,450 for family coverage (2019 limits). Reimbursement limits are indexed each year.[40]
- The arrangement is generally provided on the same terms to all eligible employees of the eligible employer. Employers can vary contributions using the relevant ACA individual market age and family rating practices.
- The small employer must not offer a group health plan to any of its employees.
- The employee must be covered by minimum essential coverage (which would include individual coverage, but would not include coverage under a short-term limited duration insurance plan).

Additionally, QSEHRA amounts can be supplemented by APTCs under certain conditions:

- The employee's net premium for self-only coverage for the second-lowest-cost silver plan (SLCSP) after the self-only QSEHRA contribution must be below the APTC affordability threshold (9.86% of household income in 2019). The affordability threshold is indexed each year.
- For example, an employee with household income of $25,000 would not be eligible for an APTC to the extent that the post-QSEHRA out-of-pocket annual premium for the SLCSP was less than approximately $2,500.
- If individual market coverage is deemed unaffordable with the QSEHRA, then the enrollee can receive an APTC. The normal APTC amount calculated based on the employee's household income as a percentage of the federal poverty level is reduced by the funds available within the QSEHRA.

Individual Integrated Health Reimbursement Account (IIHRA)

In October 2018, the U.S. Departments of the Treasury, Health and Human Services (HHS), and Labor proposed new regulations to expand the usability of health reimbursement arrangements (HRAs). The proposed rule would require that several conditions be met for the Individual Integrated HRA to qualify[41]:

[39] IRS. Notice 2017-67: Qualified Small Employer Health Reimbursement Arrangements. Retrieved March 4, 2019, from https://www.irs.gov/pub/irs-drop/n-17-67.pdf

[40] IRS. Rev. Proc. 2018-57: Tax Forms and Instructions. Retrieved March 4, 2019, from https://www.irs.gov/pub/irs-drop/rp-18-57.pdf

[41] The full text of the proposed rule is available at https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans

- Individual employees (and their dependents) must be covered by an individual health benefits plan that meets minimum essential coverage requirements.
- Employees who are offered an IIHRA cannot be offered a traditional group health plan.
- Employees in the same "employee class[42]" are offered an HRA on the "same terms". Amounts can vary by employee age and family composition.
- Employees would have to be able to opt out of HRA coverage at least annually.
- Employees must substantiate coverage prior to receiving HRA reimbursements.

Unlike the QSEHRA, the employer can have a traditional group health plan along with an HRA offering, so long as no class of employees has access to both options at the same time. Therefore, employers could offer different reimbursement amounts or even different types of coverage to different classes of employees. Under the proposed rules, the following are examples of potential employer benefit offering scenarios:

- Full-time employees could be offered a traditional group plan and part-time employees an IIHRA.
- An IIHRA with one set of funding amounts could be offered to offices in one ACA rating area and with another set of funding amounts to offices in another ACA rating area.

Although these offerings to various classes cannot be discriminatory, it is possible that large employers could establish business classes such that certain higher cost individuals or groups of employees were offered HRAs, thereby removing them from employers' risk pools (and lowering their costs) and moving them into the individual market risk pool.

In general, IIHRAs offer employers more segmenting flexibility than QSEHRAs. However, variations in contributions for age and family size are more of a mixed bag. QSEHRAs can vary contributions according to the exact age and family size combination of each employee, but only according to ACA rate variations that apply, while IIHRAs can apply any non-discriminatory variation by family size, but can only account for the age of the employee. Additionally, IIHRAs do not have annual contribution maximums, unlike QSEHRAs.

Another key difference between IIHRAs and QSEHRAs relates to the determination of affordability. Affordability of a QSEHRA is determined relative to the second-lowest-cost silver plan, while affordability for an IIHRA would be evaluated against the lowest-cost silver plan instead. This difference can be significant in certain markets. Additionally, an individual who has access to a QSEHRA can still receive a supplementary APTC if coverage is unaffordable, while the employee must decline an IIHRA to be eligible for APTC. Concern about this distinction is reflected in recent comments submitted to CMS related to the HRA rule indicating industry concern about IIHRA making employees ineligible for premium tax credits.[43] However, we note the following in relation:

- While QSEHRA's do not disqualify employees from premium tax credits, they still must be evaluated for affordability and come with other limitations that IIHRA's do not have, such as annual contribution limits.

  Employees are not put in a materially worse place under the offering of an affordable IIHRA by a large employer than they would be under the offering an affordable, traditional group health plan. Under either circumstance, the employee is not eligible for premium tax credits.

Overall, these new regulatory developments, along with lower priced RFQ plans, have the potential to change the employer health benefit landscape in Washington state. By providing large employers (fully insured or self-funded) a legal and tax-efficient vehicle to make cash contributions toward individual market health benefits, it is possible that some employers will elect to forgo traditional group health benefit plan offerings, especially if RFQ plan coverage costs are less relative to traditional employer group coverage.

[42] Classes include full-time employees (EEs)s, part-time EEs, seasonal EEs, EEs covered by a collective bargaining agreement, EEs who have not satisfied a waiting period for coverage, EEs under age 25, non-resident aliens with no US-based income, and EEs whose primary site of employment is in the same rating area.

[43] As an example, see this comment from the DC Health Benefits Exchange available at https://www.regulations.gov/contentStreamer?documentId=IRS-2018-0028-0439&attachmentNumber=1&contentType=pdf (Retrieved February 28, 2019).

SUMMARY

Employer group health benefits is an important part of Washington state's health care landscape and most employees are satisfied with their coverage under traditional health plans.[44] However, because cost is the most important consideration for employers, they could view lower cost RFQ plans as a viable option provided they offer:

- A similar ability to attract and retain employees as current employer group health plans
- A contribution strategy that is similar to the current employer group health plan subsidy, funding an equivalent (or better) level of benefits
- Employees access to a similar level of benefits relative to the current employer group health plan available to them
- A tax-equivalent vehicle for funding costs (available for small employers; pending for large employers)
- Compliance with the ACA's employer mandate for large employers
- Adequate network breadth and provider access similar to the employees' current employer group health plan[45]

We summarize these consideration in Figure 19 and we discuss how these dynamics influence estimates of employer group take-up rates into RFQ plans in the next section.

FIGURE 19: SUMMARY OF EMPLOYER MOTIVATIONS TO MOVE TO INDIVDIUAL MARKET VIA HRA

	LARGE EMPLOYER	SMALL EMPLOYER	COMMENTS
ATTRACT AND RETAIN	+/-	+/-	Contingent upon public perception of RFQ plans, likely to vary significantly by employer
LOWER PRICE	+	+	Will vary by area
NETWORK ADEQUACY	+/-	+/-	Contingent on RFQ carrier's ability to contract
BENEFIT RICHNESS	+/-	+	No platinum-level benefits on WAHBE for some large employers
RATING RULES (3:1 AGE LIMITS)	-	NA	Age rating limits on WAHBE a disadvantage for large group younger employees
TAX BENEFITS	+	+	Both QSEHRA and IIHRA offer tax advantages
FULFILL EMPLOYER MANDATE	+	NA	Mandate does not apply to employers under 50 lives

[44] AHIP (February 6, 2018). The Value of Employer-Provided Coverage. Retrieved March 4, 2019, from https://www.ahip.org/esi-survey/

[45] Larger employers tend to value broad networks. See Kaiser Family Foundation (October 3, 2018). 2018 Employer Health Benefits Survey, Figure 14.6. at https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-section-14-employer-practices-and-health-plan-networks/.

5. RFQ plan take-up rates and impact to provider reimbursement

BACKGROUND

We modeled the potential impact of various RFQ plan take-up rates by commercial market segment (employer group and individual) to quantify the impact on the medical (non-pharmacy) revenues of Washington providers. The reduction in provider revenue is a result of persons shifting from higher provider reimbursement market segments (e.g., the employer group market) to the lower reimbursement RFQ plans, partially offset by reductions to uncompensated care from decreases to the uninsured population. Therefore, changes in provider revenue are directly correlated with RFQ plan take-up.

Based on these projected movements and the resulting provider revenue reduction, we calculated the "cost-shift" percentage, which represents the incremental provider reimbursement increase to the employer group market that would result in a complete offset to the revenue loss caused by shifts to Medicare reimbursement under the RFQ plans. Note, we believe it to be unlikely that cost shifting could occur in public health benefits programs (Medicare, Medicaid) due to the assumption that provider reimbursement is largely tied to Medicare or state Medicaid fee schedules.

We emphasize that while cost shifting to employer group market is one possible response by providers, there are other strategies that may be employed by them to compensate for revenue reductions. Moreover, market dynamics between payers and providers may only allow varying amounts of this cost shift to actually occur. Further discussion of provider responses to lower reimbursement under RFQ plans is provided later in this report.

RFQ PLAN TAKE-UP RATES

As each health benefits market segment has different demographic profiles, motivations, and purchasing habits, the markets dynamics that influence overall take up rates are discussed below.

Individuals

As discussed in Section 1 of this report, individual health benefits purchasers are primarily price-driven. Therefore, we assume that for comparable benefits and reasonable network access, consumers will readily switch to RFQ plans. Exchange consumers are likely acclimated to narrow networks in the current exchange market. To the extent that plans experience provider contracting difficulties under Cascade Care due to lower reimbursement, consumers may be more accepting of provider access limitations, particularly if there are significant premium cost differences between RFQ plans and non-RFQ plans.

We assume no changes to the ACA's premium subsidy structure. It is anticipated that RFQ plans will become the "subsidy benchmark plan" or second-lowest-cost silver plan (SLCSP), as well as the lowest-cost silver plan offered through WAHBE in each geographic area. As illustrated in Section 3 of this report, while subsidy-eligible consumers could continue to purchase non-RFQ plans through 2024, consumers will be exposed to the plan's full premium difference relative to the RFQ plan. Therefore, with the implementation of RFQ plans in 2021, significant RFQ plan take-up is anticipated from the individual market during the first year.

Fully insured small groups

Only an estimated 28% of Washington state private sector establishments with fewer than 50 employees are currently offer health benefits to their employees.[46] Small employer groups that currently either offer transitional small group plans or ACA compliant plans may have some incentive to move to RFQ plans due to lower price. Small employers, like individuals, are also price sensitive and since both a silver and gold level of benefits is available under Cascade Care's RFQ plans, small groups could receive a level of benefits comparable to their current plan and at potentially lower prices. Small employers may also be less averse to narrow networks, which are common on exchanges and could be a part of RFQ plans due to contracting challenges.

[46] https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2017/tiia2.htm

Given the past history of small employers contributing funds toward the cost of exchange coverage even when illegal, it is reasonable to assume that this practice will continue and expand with the introduction of QSEHRAs and, likely to a smaller degree, the IIHRA being proposed by the Trump administration (both would be available to small employers). These HRAs provide legal avenues for employers to establish alternative means of coverage for their employees on the individual market by making contributions both legal and tax-favored. Small employers *not* currently offering health benefits could now also use an HRA to re-enter the employee health benefits market and adopt defined-contribution approaches to health benefits offerings that are affordable for them. This may result in a reduction in Washington's uninsured population.

For these reasons, the RFQ plan take-up assumptions for small groups are less than for individuals but more than the for large group market. While employees of at least some of the employers not offering coverage are already purchasing coverage in the individual market, RFQ plan enrollment may occur from a portion of the approximately 70% of small employers that do not offer any coverage at all and are not captured in the small group enrollment numbers shown in Figure 4 above. We account for this potential enrollment by having slightly higher migration assumptions than we otherwise would.

The migration of fully-insured small groups to the individual market could have a favorable impact to RFQ plan rates given that the morbidity level in the small group market is estimated to be 15% to 20% lower relative to the individual market. If small employers with ACA-compliant coverage move employees into RFQ plans on WAHBE, they will most likely move their entire group. First, if a QSEHRA was used, the small employer cannot offer traditional group benefits to any employee. Second, there is little motivation to move only certain employees to RFQ plans (such as the less healthy) via an IIHRA because health status rating is not permitted in the ACA compliant small group market.

However, small employers that fund their current group health plan through self-funded or level-funded[47] arrangements might be motivated to offer an HRA to certain classes of employees to remove them from the group's risk pool, thereby directly reaping the benefits of improved overall medical costs. Self-funded small groups are considered in the self-insured market discussion below.

Large group fully insured and self-insured

Consistent with the previous section on employer group health benefits dynamics, we would generally assume no take-up from the large group employer market (either fully insured or self-insured) into RFQ plans in the absence of the IIHRA for the following reasons:

- Large employers appear to have greater motivation to provide traditional employer group coverage and employees are generally satisfied with that offering.
- The termination of a group health plan would lessen the perceived ability for many employers to attract and retain employee talent. Even if the IIHRA is made available to large employers, employee recruitment and retention will be a primary factor in maintaining traditional group coverage.
- Without a change in either law or regulation, making cash contributions for employees to purchase exchange products such as RFQ plans is a tax-inefficient employee compensation strategy.
- The absence of a traditional group health plan would run afoul of the ACA's employer mandate, generating non-deductible penalties for the employer.

However, if rules related to the IIHRA are finalized and these HRAs become available, large employers could opt to establish what amounts to a defined contribution approach to their health benefit plans. They could legally contribute to an employee's IIHRA to purchase a potentially lower cost RFQ plan on WAHBE. Moreover, if RFQ plans offer adequate networks and comparable benefits, there may less risk of employee dissatisfaction.

For these reasons, we project in all of our scenarios at least some take-up into RFQ plans by the large group segment and in both the medium and high scenarios for the self-insured segment, with take-up rates greater for the fully insured large group segment relative to the self-funded segment. Based on insurer financial data, the average fully insured large employer has approximately 110 insured employees, while self-funded groups have an average of more than

[47] Level-funded products are a form of self-funding for small groups. Small employers who purchase them are contained in the self-funded lines of Figures 4 and 12.

1,100 employees covered. Therefore, at the low end of the fully insured large group market, employer behavior under Cascade Care may have more parallels with small employers, if the IIHRA is available to subsidize the purchase of individual market coverage.

Note that while not inherently considered in our modeling, we would anticipate any employer migration to a defined contribution approach through an IIHRA would gradually occur over several years (5+ years).[48] Before terminating traditional employer group health benefits coverage, RFQ plans would need to have a favorable public perception in terms of provider access, ease of enrollment and premium payment, as well as benefit design choices.

Uninsured

The impact of Cascade Care on the uninsured population will most likely vary significantly by income level. In Section 1 of this report, we provided estimates of the uninsured population by income level. Approximately 60% of uninsured Washingtonians have income below 250% FPL, with the remaining 40% split almost evenly between the 251% to 400% FPL and 400%+ FPL cohorts. In assessing the potential reduction to the statewide uninsured rate from Cascade Care, consideration should be given to out-of-pocket premium rate impact to each income cohort and the relative size of the uninsured population within each income cohort. These effects are similar in nature to the out-of-pocket premium changes estimated for persons currently in the individual market with the same respective household income.

Household income below 250% FPL, premium rate savings retained by federal government

Lower income households purchasing health benefits coverage in WAHBE are currently receiving significant federal premium assistance. The value of the premium assistance caps out-of-pocket premium expenditures at a specified percentage of household income.

- We estimate that premium rates for RFQ plans will remain above the out-of-pocket premium limits, with out-of-pocket premiums for the vast majority of households at these lower income levels not changing.
- However, as previously discussed in Section 3 of this report, the federal government will accrue savings from a reduction in premium subsidy cost.
- This income cohort, as well as others, may benefit from lower required cost sharing, to the extent the classification of plan designs into metallic levels using the federal actuarial value calculator is permitted to be based on underlying Medicare reimbursement. However, we do not estimate this will have a material effect on insurance take-up rates.

Household income between 250% and 400% FPL, premium rate savings shared between consumers and federal government

Consumers at this higher income level are still eligible for federal premium assistance for coverage purchased through WAHBE. However, the value of premium assistance is significantly lower relative to lower income levels.

- To the extent RFQ plans reduce market premium rates by approximately 25% to 40%, some consumers in this income cohort will no longer receive premium assistance, as the cost of the second-lowest-cost silver plan may be below the limit specified by the ACA's premium subsidy formula.
- However, despite not being eligible for premium assistance for this reason, these consumers may have a lower out-of-pocket premium rates as the full premium rate of the RFQ plan may be less than the current subsidized premium for a non-RFQ plan.
- As the federal government will no longer be providing premium assistance or providing a lower subsidy amount per capita, it will share in the RFQ plan premium savings for consumers in this income cohort.
- For some consumers in this income cohort, particularly adults approaching age 65, the premium rate for the second-lowest-cost silver plan will still be high enough to trigger federal premium subsidy payments. The federal government will accrue the full savings from the RFQ plans for these consumers.

[48] A defined contribution reflects an employer contributing a set amount of money (e.g., percentage of salary) towards a health benefits benefit. The contribution is not tied directly towards the cost of the benefit.

The out-of-pocket premium rate changes for this income cohort will be mixed, with some consumers (particularly younger adults with higher incomes currently receiving limited premium subsidies) realizing direct premium rate savings from RFQ plans, while other consumers (older adults, particularly those with lower income) may not experience a reduction in out-of-pocket premium rates. While we estimate that lower out-of-pocket premium rates for some consumers in this income cohort will reduce the state's uninsured rate, the impact will be muted relative to the population with income above 400% FPL that is currently not eligible for premium assistance.

Household income above 400% FPL, premium rate savings retained by consumers

The impact to consumer premium rates as a result of the introduction of RFQ plans is most straightforward for the income cohort above 400% FPL. These consumers do not qualify for premium assistance under the ACA and will realize the full premium rate reduction from the introduction of the RFQ plans. Further premium rate reduction is likely for older adults in this income cohort to the extent premium subsidy eligibility is extended to 500% FPL.

Special considerations with bronze-level coverage

Cascade Care legislation as of the time of this report does not require an RFQ plan, with underlying Medicare reimbursement, for bronze-level coverage. Based on September 2018 WAHBE enrollment statistics, approximately 27% of enrollees with household income at or below 400% FPL purchased bronze coverage (with the vast majority receiving federal premium assistance).[49] For enrollees with income above 250% FPL, nearly 50% purchased bronze coverage in 2018.

This feature of the bill, whether intended or not, could create unique situations for uninsured individuals. For example, uninsured individuals who have income above 400% FPL, may need significant price decreases to purchase an RFQ plan given that they are not insured now and they likely will pay the full premium themselves because they are they're not eligible for subsidies. Our estimates of price decreases for RFQ plans from the use of Medicare reimbursement range from approximately 25% to 40% depending on region and plan. This may result in silver RFQ plans being less expensive than the non-RFQ bronze coverage, and with lower cost sharing requirements. This should incent a portion of the higher-income, unsubsidized uninsured to enter the individual market.

However, for subsidized consumers covered by a non-RFQ bronze plan in 2021, we have previously detailed in Section 3 the adverse interaction of the low RFQ silver premium and the ACA's subsidy structure, which results in the following effects:

- Reduction or elimination of federal subsidy payments
- Lower subsidy amount is applied to the non-RFQ plan bronze coverage (assumed to have the same premium rate under Cascade Care)
- Consumers' out-of-pocket premium for bronze coverage increases due to the subsidy value reduction

As this interaction increases the minimum out-of-pocket premium to enter the individual market, some consumers could choose to exit the market and become uninsured.

Thus, the impact of Cascade Care on the uninsured is most likely net favorable, with the greatest reductions in the uninsured population estimated to come from the population currently not eligible for premium assistance, offset by no material impact (and potentially unfavorable impacts to some purchasing bronze coverage) to lower income populations receiving premium assistance. Our scenarios reflect consideration of these dynamics.

IMPACT TO PROVIDER REIMBURSEMENT – RFQ MIGRATION SCENARIOS

Based on assumptions about general market dynamics resulting from Cascade Care described in the above discussion, we modeled three market shift scenarios, as shown in Figure 20. These percentages, applied to baseline enrollment estimates, represent the portion of each market segment that is estimated to transition to an RFQ plan under Cascade Care. These estimates reflect long-term (5+ years) migration impacts. While we believe the majority of migration to

[49] WAHBE September 2018 Enrollment Report, op cit.

RFQ plans in the individual market will occur in 2021, migration from the employer market (if it occurs) is more likely to happen gradually over the course of several years.

FIGURE 20: ASSUMPTIONS OF MIGRATION TO RFQ PLANS BY MARKET SEGMENT AND UNINSURED

SCENARIO	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	SELF-INSURED LARGE GROUP	UNINSURED
BASELINE ENROLLMENT	223,000	283,000	1,132,000	2,457,000	413,000
LOW SHIFT	80%	20%	5%	0%	7%
MEDIUM SHIFT	90%	40%	10%	5%	9%
HIGH SHIFT	100%	60%	15%	10%	11%

Figure 21 illustrates the baseline 2019 medical revenue (excluding prescription drugs and long-term services and supports (LTSS)) for each market segment, prior to any migration that is assumed to be caused by the introduction of RFQ plans under Cascade Care (the development of these estimates is provided in Figure 7 of this report). Additionally, we provided the estimated payment index for each market, which reflects the estimated relative provider reimbursement compared to the employer group markets (shown as a 1.0). For example, the payment index for the individual market is 77.2%, which indicates the estimated provider reimbursement in the market is approximately 23% less than the employer group markets. We exclude prescription drugs for all segments because these costs are not affected by Medicare fee-for-service reimbursement. We also estimate the portion of Medicaid and Medicare costs attributable to LTSS (nursing facility and waiver services) and exclude those costs as well.

Uninsured revenue is assumed to be the portion of revenue actually collected by providers directly from the patient.

FIGURE 21: WASHINGTON ESTIMATED 2019 PAYMENT INDEX, MEDICAL MEMBERSHIP AND ALLOWED CLAIMS DISTRIBUTIONS BY MARKET SEGMENT

MARKET SEGMENT	PERSONS	ASSUMED PAYMENT INDEX	ESTIMATED PROVIDER MEDICAL REVENUE ($ BILLIONS)	PERCENTAGE OF TOTAL MEDICAL REVENUE
INDIVIDUAL	223,000	77.2%	$1.1	2.8%
SMALL GROUP	283,000	100.0%	1.3	3.4%
LARGE GROUP	1,132,000	100.0%	5.0	12.9%
SELF-FUNDED	2,457,000	100.0%	11.1	28.7%
EMPLOYER SUBTOTAL	3,872,000	100.0%	$17.4	45.0%
MEDICAID	1,641,000	41.6%	$7.5	19.4%
MEDICARE	1,036,000	48.3%	$8.8	22.7%
DUALS	201,000	48.3%	$2.8	7.2%
OTHER	172,000	48.3%	$0.8	2.1%
UNINSURED	413,000	100.0%	$0.3	0.8%
TOTAL	7,558,000	71.4%	$38.6	100.0%

Based on the interaction of the market enrollment shifts illustrated in Figure 20 above and the estimated provider reimbursement levels in each market, we modeled the net change in provider revenue under Cascade Care for the three take-up scenarios. Additionally, we modeled the necessary cost shift (increase in provider reimbursement) to the residual employer group market to completely offset the provider revenue loss under Cascade Care. For example, if the provider revenue reduction was estimated at $300 million prior to cost shifting, we assumed the employer group market would absorb a $300 million provider revenue increase to result in provider revenue neutrality under Cascade Care.

As noted in Section 6, cost shifting is one of many possible provider responses to Cascade Care. The cost shift estimates reflected in the three scenarios reflect providers only cost shifting in response to Cascade Care. Therefore, cost shifting estimates illustrated in the three scenarios should be considered maximum estimates to employer group reimbursement. Particularly under the high take-up scenario, it is unlikely the employer market would be able to absorb the full cost increase and thus providers would need to take other actions to offset the reductions and may not be able to offset 100% of the reduction.

Low take-up scenario

Figure 22 illustrates the estimated RFQ plan enrollment and associated provider revenue impacts under the Low take-up scenario. Figure 22 provides the following information for the commercial (employer group and individual) markets and the uninsured population:

- **Baseline membership in each market:** The 2019 estimated enrollment by market, taken from Figure 4 above.
- **Percentage of market shifting to RFQ plans:** This reflects the estimated proportion of baseline enrollment in each market assumed to migrate to RFQ plans.
- **Market enrollment shifting to RFQ plans:** same as above percentage but using nominal values.
- **Cumulative RFQ plan membership:** Based on migration from each market, these values represent the cumulative RFQ membership. In Figure 22, under the 'Individual' column, enrollment of 178,400 is shown. This reflects 80% of the baseline enrollment of 223,000 enrollment shifting to RFQ plans. From the small group market, we assume 20% of the baseline enrollment of 283,000 or 57,000 will shift to RFQ plans. This enrollment is added to the individual market RFQ plan enrollment, resulting in a cumulative enrollment value of 235,000 for RFQ plans. The RFQ plan enrollment migration estimates continue from left to right in Figure 22. As the cumulative RFQ plan enrollment changes from 292,000 to 321,000 for the uninsured population, this indicates an assumption of 62,000 currently uninsured persons purchasing RFQ plans.
- **Cumulative total medical revenue impact:** Based on the market migration and estimated provider reimbursement relativities, this line item represents the cumulative aggregate provider medical revenue under Cascade Care. In a manner identical to the 'Cumulative RFQ membership' line item, the values represent the cumulative effect of RFQ plan migration by market. For example, we estimate a provider medical revenue reduction of $336 million from individual market migration and an additional $130 million reduction from the small group market, resulting in a cumulative reduction of $466 million. The cumulative provider revenue change before considering the uninsured population is -$596 million; however, we assume previously uninsured persons purchasing RFQ plans will increase provider medical revenue by $37 million, resulting in a final cumulative provider revenue loss of -$559 million.
- **Cumulative total medical revenue impact, % of total baseline revenue:** In addition to illustrating the provider revenue impact in millions of dollars, we also provide the provider revenue change as a percentage of the baseline medical revenue estimate of $38.6 billion. The cumulative $559 million net provider revenue reduction represents a 1.4% reduction in provider revenue relative to the aggregate baseline value.
- **Remaining employer group only medical revenue base ($ millions):** Based on the cumulative migration to RFQ plans across each market, this value represents the remaining residual provider revenue base derived from the employer group market. For the 'Individual' column, the value of $17.4 billion is equal to the baseline value illustrated in Figure 12. For the 'Small Group' column, the value is reduced to $17.1 billion, reflecting an estimated $300 million reduction in provider medical revenue resulting from small group migration to RFQ plans.
- **Remaining employer group only medical revenue base, % of total baseline revenue:** These values represent the estimated residual provider revenue derived from patients in the employer group market relative to the total

baseline medical revenue estimate of $38.6 billion. Based on cumulative RFQ plan migration across markets, provider's medical revenue derived from patients in the employer group market is estimated to be reduced to $16.9 billion, representing 43.6% of the baseline provider medical revenue.

- **Cost shift for budget neutrality:** Finally, we illustrate the increase in revenue associated with patients with employer group coverage that would completely offset the reduction in revenue resulting from RFQ plan migration. For example, in the 'Individual' market column, we show a cost shift of 1.9%. This is calculated based on applying a $336 million increase to the employer group medical revenue base of $17.4 billion. While not shown, the estimated premium rate increase for the employer group market resulting from the provider cost shift would be slightly less due to no assumed change in pharmacy costs or plan administrative expenses.

FIGURE 22: CUMULATIVE RFQ PLAN ENROLLMENT AND PROVIDER REVENUE IMPACTS – LOW RFQ PLAN MIGRATION SCENARIO

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$38.6 BILLION				
MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	223,000	283,000	1,132,000	2,457,000	413,000
PERCENTAGE OF MARKET SHIFTING TO RFQ PLANS	80%	20%	5%	0%	15%
MARKET ENROLLMENT SHIFTING TO RFQ PLANS	178,000	57,000	57,000	-	29,000
CUMULATIVE RFQ MEMBERSHIP	178,000	235,000	292,000	292,000	321,000
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$336	-$466	-$596	-$596	-$559
% OF TOTAL BASELINE REVENUE	-0.9%	-1.2%	-1.5%	-1.5%	-1.4%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$17,400	$17,100	$16,900	$16,900	$16,900
% OF TOTAL BASELINE REVENUE	45.0%	44.3%	43.6%	43.6%	43.6%
(C) = (A)/(B) COST SHIFT FOR PROVIDER REVENUE NEUTRALITY	1.9%	2.7%	3.5%	3.5%	3.3%

Medium take-up scenario

Figure 23 illustrates the estimated RFQ plan enrollment and associated provider revenue impacts under the medium-take-up scenario. Under this scenario, there are almost 600,000 members in RFQ plans with each employer group segment contributing approximately 100,000 each. Provider revenue declines by almost $1.2 billion from shifts to RFQ plans but is offset by approximately $48 million when additional uninsured enter the market. The net provider medical revenue loss of $1.1 billion is then shifted to the remaining employer group market revenue base of approximately $15.8 billion. Note that the employer group revenue base is now smaller relative to the Low scenario. The combination of the smaller residual employer group revenue base and larger provider revenue reduction from RFQ plan migration, creates a compounding effect on the cost shift percentage. Relative to the Low scenario, the final cumulative cost shift percentage to achieve provider revenue neutrality increases from 3.3% to 7.2%.

FIGURE 23: CUMULATIVE RFQ PLAN ENROLLMENT AND PROVIDER REVENUE IMPACTS – MEDIUM RFQ PLAN MIGRATION SCENARIO

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$38.6 BILLION				
MARKET	**Individual**	**Small Group**	**Fully Insured Large Group**	**Self-Insured Large Group**	**Uninsured**
BASELINE ENROLLMENT	223,000	283,000	1,132,000	2,457,000	413,000
PERCENTAGE OF MARKET SHIFTING TO RFQ PLANS	90%	40%	10%	5%	25%
MARKET ENROLLMENT SHIFTING TO RFQ PLANS	201,000	113,000	113,000	123,000	37,000
CUMULATIVE RFQ MEMBERSHIP	201,000	314,000	427,000	550,000	587,000
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$378	-$638	-$898	-$1,184	-$1,136
% OF TOTAL BASELINE REVENUE	-1.0%	-1.7%	-2.3%	-3.1%	-2.9%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILIONS)	$17,400	$16,900	$16,400	$15,800	$15,800
% OF TOTAL BASELINE REVENUE	45.0%	43.6%	42.3%	40.9%	40.9%
(C) = (A)/(B) COST SHIFT FOR REVENUE NEUTRALITY	2.2%	3.8%	5.5%	7.5%	7.2%

High take-up scenario

Figure 24 illustrates the estimated RFQ plan enrollment and associated provider revenue impacts under the medium-take-up scenario. Under this scenario, there are almost 900,000 persons in RFQ plans, resulting from the complete conversion of the individual market to RFQ plans, the small group and fully insured large group markets each experiencing RFQ plan migration of approximately 170,000 persons, and migration of approximately 250,000 persons from self-funded employer coverage. Provider revenue declines by nearly $1.7 billion from shifts to RFQ plans, but is offset by approximately $60 million from previously uninsured persons purchasing coverage. The net loss of ($1.7) billion in provider revenue is then shifted to the remaining employer group market revenue base of $14.7 billion.

FIGURE 24: CUMULATIVE RFQ ENROLLMENT AND PROVIDER REVENUE IMPACTS – HIGH MIGRATION PLAN SCENARIO

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$38.6 BILLION				
MARKET	**Individual**	**Small Group**	**Fully Insured Large Group**	**Self-Insured Large Group**	**Uninsured**
BASELINE ENROLLMENT	223,000	283,000	1,132,000	2,457,000	413,000
PERCENTAGE OF MARKET SHIFTING TO RFQ PLANS	100%	60%	15%	10%	11%
MARKET ENROLLMENT SHIFTING TO RFQ PLANS	223,000	170,000	170,000	246,000	45,000
CUMULATIVE RFQ MEMBERSHIP	223,000	393,000	563,000	808,000	854,000
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$420	-$809	-$1,200	-$1,772	-$1,713
% OF TOTAL BASELINE REVENUE	-1.1%	-2.1%	-3.1%	-4.6%	-4.4%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$17,400	$16,600	$15,800	$14,700	$14,700
% OF TOTAL BASELINE REVENUE	45.0%	43.0%	41.0%	38.2%	38.2%
(C) = (A)/(B) COST SHIFT FOR REVENUE NEUTRALITY	2.4%	4.9%	7.6%	12.1%	11.7%

Summary

Depending on network adequacy and the price, RFQ plans could see a wide variety of take up rates. The scenarios modeled are not intended to be more or less likely than any other but are used to illustrate potential ranges and impacts to provider revenue. However, it is reasonable to assume that a very large portion of the individual business will shift to RFQ plans under any set of circumstances and that any shifting by large employer segments depends almost entirely on the presence of a tax-favored vehicle that fulfills the employer mandate such as the IIHRA.

6. Response by providers

Depending on the number of enrollees covered by Cascade Care RFQ plans, providers will experience varying levels of reduced reimbursement. Providers' reactions will also vary accordingly. However, the most likely reactions may be:

Do not accept RFQ plan patients. The success of Cascade Care depends on the willingness of providers to accept lower reimbursement levels because consumers' coverage is less useful if they lack access to providers. Cascade Care's mandated Medicare-level reimbursement for the RFQ plans could discourage providers from contracting with a carrier that is seeking to build out its network for an RFQ plan offering. Depending on a particular provider's reimbursement mix from other payers, both RFQ plans and private, some may choose to contract and some may not.

While contracting at Medicare rates could be challenging for insurers in urban areas, it may be an even greater challenge in rural areas. In a 2019 10-state survey of marketplace administrators and insurers (including Washington state), the Urban Institute reported narrow networks (which typically include lower reimbursement) were difficult to establish in rural areas due to a limited number of providers and the resulting negotiating leverage retained by existing providers.[50] In addition, state network adequacy requirements still apply to RFQ plans, and an inability to negotiate contracts with a sufficient number of providers may prevent RFQ plans from being offered in rural and / or high cost areas.

The breadth and quality of the networks associated with Cascade Care's RFQ plans, based on the acceptance or lack of acceptance of Medicare reimbursement, will have other downstream impacts. As previously discussed in this report, an employer's strategy of terminating its traditional employer group health plan and funding IIHRAs for employees to purchase RFQ plans would likely be pre-conditioned upon there being reasonable provider access available through RFQ plan networks. To the extent provider access in RFQ plans is publicly perceived as limited, lower take-up rates for RFQ plans from persons currently enrolled in an employer group plan would be anticipated.

Shift costs to other markets when possible. In order to offset a reduction in exchange coverage reimbursement, a provider may attempt to negotiate higher reimbursement levels for other markets, particularly the employer group market. To the extent cost shifting occurs, higher underlying provider reimbursement rates will need to be absorbed in those markets, and all else equal, premiums will increase in the markets to which costs are shifted.

Change the payer mix. The provider may assess its mix of patients among employer group, exchange coverage (specifically RFQ plans), Medicaid, and Medicare. To the extent reimbursement associated with health benefits purchased through the exchange is reduced, the provider could elect to accept fewer Medicaid, Medicare, or RFQ patients (and additional employer group patients), offsetting the exchange reimbursement reduction. This option may not be possible in rural areas where provider access is limited. However, where it is possible to do this, this could cause access issues for vulnerable populations, such as low income and elderly under both Medicaid and Medicare programs.

Other responses by providers could include:

Increase efficiency. To the extent a provider can reduce underlying expenses associated with the delivery of healthcare services, the provider may be able to mitigate some of the margin decrease experienced from reduced reimbursement levels.

Increase volume. Particularly under fee-for-service reimbursement, a provider may elect to deliver more services per patient or add patients (if the provider currently has excess capacity). Adding patients could reduce visit times or otherwise compromise quality of care.

Accept lower reimbursement. To the extent a provider's underlying expenses are not reduced, lower reimbursement will result in lower margins for the provider.

Pursue consolidation with other providers. Small physician practices may join large medical groups to take advantage of typically higher negotiated commercial rates. Hospital mergers may occur to increase negotiating leverage, economies of scale, or population health management capabilities.

[50] Holahan, J., Blumberg, L.J., Wengle, E., & Elmendorf, C. (January 2019). What's Behind 2018 and 2019 Marketplace Insurer Participation and Pricing Decisions? Robert Wood Johnson Foundation. Retrieved February 14, 2019, from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2019/rwjf451264 (PDF download).

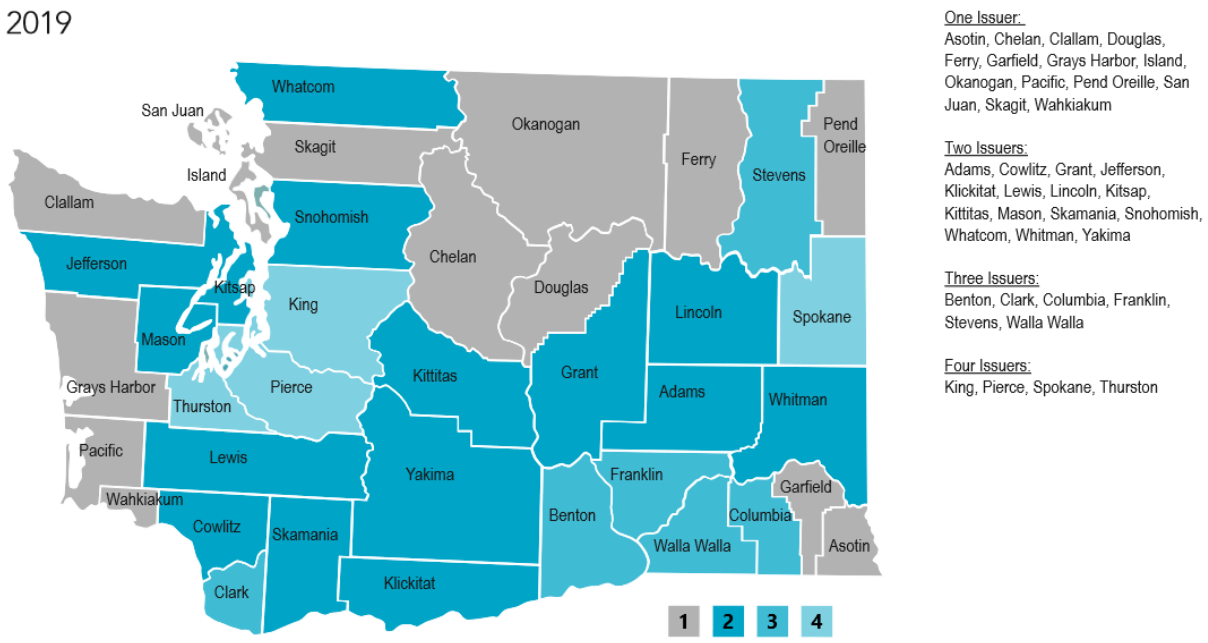
Exit market. A provider could exit the market (retire, move to a different state, etc.)

Additionally, it may be possible that a provider reacts to reduced reimbursement rates with a combination of behaviors. For example, healthcare delivery efficiency may be increased, and higher employer group reimbursements could be negotiated (cost shifting) while accepting slightly lower margins.

7. Carrier responses and provider reimbursement determination

Insurer participation and consumer choice under Cascade Care should be evaluated against current marketplace participation. Figure 25 illustrates the number of 2019 WAHBE issuers in each county. Across the state, seven separate insurers are offering coverage through WAHBE in 2019.[51] Weighted by September 2018 QHP enrollment in each county, the average Washington resident purchasing WAHBE coverage in 2019 had a choice of 3.1 insurance issuers. Nationally, 17% of marketplace enrollees in 2019 are estimated to have access to coverage from only a single insurer.[52] WAHBE compares favorably to this statistic, with only 9% of September 2018 QHP enrollees having a single insurer choice for the 2019 coverage year.

FIGURE 25: CY 2019 WAHBE INSURER PARTICIPATION BY COUNTY



Source: https://www.wahbexchange.org/wp-content/uploads/2018/09/HBE_PS_180913_2019-WAHBE-Certification-Request_Final.pdf

The likelihood of insurers electing to participate in Cascade Care may vary from current WAHBE participation. For insurers currently participating in both WAHBE and Washington Apple Health (Medicaid managed care),[53] existing established provider networks for both products may provide a competitive advantage to the extent they limit difficulties establishing a provider network for the RFQ plan options. These insurers may also be able to leverage essential community providers more heavily in developing provider networks.[54]

Traditional insurers could find meeting the minimum MLR of 80% more challenging due to the lower rates under RFQ plans and the related higher percentage of premium that fixed costs consume. For traditional carriers who are only in the individual market or who have relatively smaller blocks of non-individual business, not be chosen under the RFQ process to offer RFQ plans could cause a significant strategic shift in order to stay in business as their non-RFQ plans are unlikely to be competitive.

[51] WAHBE. Plans: 2019. Retrieved March 5, 2019, from https://www.wahbexchange.org/new-customers/coverage-basics/plans/#2019

[52] Kaiser Family Foundation (November 14, 2018). Insurer Participation on ACA Marketplaces, 2014-2019. Retrieved March 5, 2019, from https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/

[53] Washington Apple Health (January 2019). Apple Health Regional Service Areas. Retrieved February 14, 2019, from https://www.hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf.

[54] CMS (April 2017). Promoting Access in Medicaid and CHIP Managed Care, p. 99. Retrieved February 14, 2019, from https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf.

Provider-owned insurers and integrated delivery networks (IDNs) will share these challenges as well. However, for these types of plans, additional consideration must be given to reduced premium revenue from RFQ plans, the ability to reduce the costs of provider reimbursement for their clinicians and facilities, and the expected market share under Cascade Care's RFQ plans.

Provider-owned plans and IDNs that obtain a disproportionately large share of RFQ plans relative to their employer group market business will see reduced premium revenue. If they are unable to reduce provider costs (such as salaries or capitations) or otherwise create efficiencies to offset the reduction in premium revenue, system margins will be reduced by RFQ plans. These reduced margins will likely mean that costs will need to be shifted to, and absorbed by, the comparatively smaller employer group lines of business. The degree of cost shifting that occurs will depend on whether the provider-owned entity has excess capacity to fill. For IDNs with excess capacity, the reduction in premium revenue may be offset by additional patient volume. However, for IDNs already operating at capacity, cost shifting may be necessary to cover expenses.

Finally, all carriers contracting to offer RFQ plans will have to demonstrate that underlying reimbursement is at levels equivalent to Medicare fee-for-service. This may be challenging for certain reimbursement structures, such as capitation, physician salaries, global capitation, and others that are common among integrated delivery systems. Carriers that find this requirement too burdensome or costly might elect to not offer RFQ plans and ultimately exit the individual market as their non-RFQ plan offerings will not be competitively priced.

Determining Medicare fee-for-service reimbursement

The Cascade Care legislation requires insurers to reimburse professionals and facilities at Medicare fee-for-service (FFS) rates (or a rate equivalent to Medicare FFS) for their RFQ plans. While this may seem straightforward, there are a number of complicating factors to consider:

- **Physician reimbursement.** Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS implemented the Quality Payment Program (QPP). As part of the QPP, clinicians can participate in either the Merit-based Incentive Payment System and have reimbursement adjusted based on quality of care performance measures, or take part in Advanced Alternative Payment Models (APMs) and potentially earn incentive payments.[55]
- **Hospital Value-Based Purchasing.** Under the Hospital Value-Based Purchasing program, CMS also varies payments to inpatient hospitals based on quality and resource use measures.[56]
- **Existing value-based reimbursement methodologies.** It is likely that insurers currently participating in WAHBE have implemented value-based reimbursement methodologies (reimbursement other than strictly FFS payment). Guidance will be needed to determine how incentive or shared savings payments will be considered in the evaluation of the Medicare reimbursement requirement.
- **Dual Processing.** Carriers with alternative reimbursement structures may need to have a parallel process of gathering and inputting the required diagnosis and procedure codes for patients covered under an RFQ plan into an algorithm that simulates Medicare claims pricing and adjudication, including its fee schedules and rules.
- **Incorporating recommendations from the Robert Bree Collaborative.** Under Cascade Care, participating insurers are required to incorporate recommendations from the Dr. Robert Bree Collaborative (Bree Collaborative). The Bree Collaborative discusses healthcare topics that have high variation in care delivery and do not lead to improved care or patient health, and other patient safety issues.[57] In 2019, the Bree Collaborative is exploring a bundled payment model for maternity services.[58] Because recommendations made by the Bree Collaborative may not align with Medicare FFS reimbursement (such as a maternity bundled payment), insurers will need to have clear guidance on the extent to which they must implement suggestions from the Bree Collaborative and when it is permissible to deviate from Medicare reimbursement methodologies.

[55] CMS. 2019 Merit-based Incentive Payment System (MIPS) Participation and Eligibility Overview. Quality Payment Program. Retrieved February 14, 2019, from https://qpp-cm-prod-content.s3.amazonaws.com/uploads/349/2019%20MIPS%20Participation%20and%20Eligibility%20Fact%20Sheet.pdf (PDF download).
[56] CMS. Hospital Value-Based Purchasing. Retrieved February 14, 2019, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-.html.
[57] RBC (January 8, 2019). Maternity Bundled Payment Workgroup. Retrieved February 14, 2019, from http://www.breecollaborative.org/wp-content/uploads/Bree-Maternity-Bundle-Slides-19-0108.pdf.
[58] RBC (January 8, 2019), ibid.

- **Prescription drugs.** We assume permissible reimbursement for prescription drugs and dental services would not be modified under the RFQ plans.

Policymakers will need to carefully consider guidance to insurers related to Medicare reimbursement requirements under Cascade Care and give due consideration to existing progress made by insurers and providers in moving away from traditional FFS reimbursement methodologies.

8. Section 1332 waivers

Section 1332 of the ACA permits a state to apply for a waiver to "pursue innovative strategies for providing their residents with access to high quality, affordable health benefits while retaining the basic protections of the ACA".[59] In a November 2018, CMS issued guidance describing several "waiver concepts", including state-specific premium assistance proposals.[60] In order for a waiver to be approved, the state's application must meet the following criteria, known as "guard rails":

- Health benefits coverage (coverage): The waiver must provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver.
- Health benefits affordability and comprehensiveness: The waiver would provide access to coverage that is affordable and comprehensive as would be accessible absent the waiver.
- Deficit neutrality: The waiver would not increase the federal deficit.

To the extent a waiver generates savings to the federal government, a state may receive federal pass-through funding based on the difference between federal expenditures with and without the waiver. As the Cascade legislation specifically states that a plan must be developed to implement and fund premium subsidies for individuals with income up to 500% FPL, a Section 1332 waiver may be one possible policy option to achieve this goal.

The Cascade Care legislation, which is estimated to reduce premium rates relative to the current 2019 plans by approximately 25% to 40%, will reduce premium rates for consumers not qualifying for premium assistance. Additionally, it will reduce federal premium assistance expenditures for the nearly 70% of the population purchasing WAHBE coverage with premium assistance. Figure 26 illustrates how pass-through funding under a Section 1332 waiver may be generated by Cascade Care based on current federal premium assistance being received by three households.

FIGURE 26: ILLUSTRATION OF POTENTIAL SECTION 1332 WAIVER PASS-THROUGH FUNDING GENERATED UNDER CASCADE CARE

	PREMIUM AND SUBSIDIES WITHOUT CASCADE CARE			PREMIUM AND SUBSIDIES WITH CASCADE CARE			CASCADE CARE IMPACT	
Household	Full Premium	Premium Subsidy	Net Premium	Full Premium	Premium Subsidy	Net Premium	Consumer Savings	Federal Government Savings
A	$500	$300	$200	$300	$100	$200	$0	$200
B	$500	$100	$400	$300	$0	$300	$100	$100
C	$500	$0	$500	$300	$0	$300	$200	$0

Household A. Consumers qualifying for premium assistance with value greater than the premium reduction resulting from the introduction of RFQ plans are unlikely to see a reduction in net premium cost (federal government retains 100% of premium savings, which becomes pass-through funding under the 1332 waiver). Consumers with household income under 250% FPL with be represented by Household A. As illustrated in Section 1, consumers in this income cohort are estimated to reflect nearly 40% of the population currently purchasing coverage in the individual market.

Household B. For consumers qualifying for limited premium assistance, such as Household B, premium savings will be shared by the consumers and the federal government. Household B does not qualify for premium assistance after the introduction of the RFQ plans, but experiences a $100 reduction in monthly net premiums (federal government retains 50% of premium savings, which become pass-through funding under the 1332 waiver). Consumers with household income between 250% and 400% FPL are most likely to be represented by Household B. As illustrated in

[59] https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html

[60] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf

Section 1, consumers in this income cohort are estimated to reflect approximately 20% of the population currently purchasing coverage in the individual market.

Household C. Higher income consumers who did not qualify for premium assistance prior to the implementation of the RFQ plans will realize the full premium savings from the reinsurance program (consumer retains 100% of premium savings, no pass-through funding available). Consumers with household income above 400% FPL are most likely to be represented by Household C. As illustrated in Section 1, consumers in this income cohort are estimated to reflect approximately 40% of the population currently purchasing coverage in the individual market.

By requiring Medicare reimbursement for private individual market coverage, the implementation of RFQ plans is estimated to reduce premium rates through what is, in essence, a provider assessment. This subsidy to the individual market will reduce premiums by reducing insurers' claims expenses and is very similar in effect to a state-based reinsurance program. As of March 2019, seven states have received federal approval to implement a state-based reinsurance program under a Section 1332 waiver.[61] A reinsurance program reduces an insurer's expenses *after* the direct provider payment is made. However, this legislation reduces an insurer's and consumers' claims expenses at the point of service.[62] As a result, this will also reduce consumer's claims expenses when services are subject to a deductible and/or coinsurance.

To the extent the state of Washington seeks a 1332 waiver for Cascade Care, approval may result in the return of federal pass-through savings to the state. Pass-through savings may be used to fund state premium assistance to the population with income between 401% and 500% FPL or provide a subsidy wrap to lower income populations. Figure 27 provides an estimate of federal premium assistance expenditure changes for the currently eligible population under Cascade Care, as well as the cost of state premium assistance for the population with income between 401% and 500% FPL. The assumptions underlying the low and high rate range scenarios reflect reductions to the premium rate of the second-lowest-cost silver plan (subsidy benchmark plan) by 20% and 35%, respectively. The values presented in Figure 27 are on a 2019 basis. Our modeling does not consider any impact from employer migration to RFQ plans (although to the extent an employee's RFQ plan premium is subsidized by an employer's HRA contribution, there may be little if any federal premium assistance provided). It should also be noted to the extent RFQ plans become the second-lowest-cost silver plan (or subsidy benchmark plan), federal premium assistance reductions will be realized regardless of RFQ plan market share.

FIGURE 27: STATE WASHINGTON, ESTIMATED 2019 IMPACT TO PREMIUM SUBSIDY EXPENDITURES RESULTING FROM CASCADE CARE

MARKET	ABSENT WAIVER	WITH WAIVER (LOW RANGE PREMIUM IMPACT)	WITH WAIVER (HIGH RANGE PREMIUM IMPACT)	WAIVER CHANGE LOW RANGE	WAIVER CHANGE HIGH RANGE
Currently Eligible APTC Enrollment	123,000	120,000	115,000	(3,000)	(8,000)
Currently Eligible APTC Expenditures ($ millions)	$ 600.0	$ 439.7	$ 320.0	($160.3)	($280.0)
Currently Eligible Per Capita APTC	$ 4,775	$ 3,675	$ 2,775	($1,100)	($2,000)
401% to 500% APTC Enrollment	-	30,000	23,000	30,000	23,000
401% to 500% APTC Expenditures ($ million)	$ 0.0	$ 49.8	$ 23.7	$ 49.8	$ 23.7
401% to 500% Per Capita APTC	$ 0	$ 1,650	$ 1,025	$1,650	$1,025
Total APTC Expenditures, Newly and Currently Eligible ($ million)	$ 600.0	$ 489.6	$ 343.7	($110.4)	($256.3)

Notes:

1. Values have been rounded.

[61] National Conference of State Legislatures. State Roles Using 1332 Health Waivers. Retrieved March 5, 2019, from http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx

[62] Note that, for provider-owned insurers, while the RFQ plans may reduce claims expenses on paper from the view of the insurance entity, participation as an RFQ plan does not reduce the actual cost to deliver healthcare services. Therefore, with respect to the parent company, offering an RFQ plan may result in an overall system net revenue reduction.

2. Subsidy value for the 401% to 500% FPL income cohorts caps out-of-pocket premium for the lowest-cost second-lowest-cost silver plan at the same percentage as the 300% to 400% FPL income cohort.

Figure 27 illustrates that federal premium subsidy savings on an annual basis are likely to be significant, even if premium assistance is extended to households with income up to 500% FPL. Annual premium subsidy savings are estimated in a range of approximately $110 million to $255 million (2019 basis). Without extending premium subsidies to this higher income cohort, premium subsidy savings range from approximately $160 million to $280 million (2019 basis).

Under October 2018 guidance, CMS indicated it will favorably view 1332 waiver applications that address some or all of the following five principles[63]:

- Provide increase to affordable private market coverage
- Encourage sustainable spending growth
- Foster state innovation
- Support and empower those in need
- Promote consumer driven healthcare in the state

Therefore, to the extent the state pursues a waiver for Cascade Care, the above principles should be considered in the waiver application.

Summary

The implementation of RFQ plans under Cascade Care is estimated to result in significant premium rate reductions to the subsidy benchmark plans offered in WAHBE. These premium rate savings will be fully realized by consumers who do not currently qualify for subsidy assistance and partially by consumers who qualify for only limited premium assistance. However, the federal government will realize the entire amount of savings for low income consumers. A 1332 waiver may be one policy option that would allow Washington's healthcare delivery system to retain annual federal premium assistance savings which are estimated to exceed $100 million on an annual basis (2019 basis). These federal savings, if captured through a Section 1332 waiver, could be applied to extended premium assistance to the population with income between 401% and 500% FPL or provide enhanced subsidies to lower income populations (where the majority of the uninsured population exists). Initial conversations between CMS and the HCA regarding a 1332 waiver submission based on Cascade Care may provide an understanding of whether or not federal approval would be possible.

[63] The full text of the CMS Guidance from October 24, 2018, is available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf

9. Data reliance and limitations

The services provided for this report were performed under the Consulting Services Agreement between Milliman Inc. (Milliman) and the Association of Washington Healthcare Plans dated January 17, 2019.

The information contained in this report has been prepared for the Association of Washington Healthcare Plans and its consultants and advisers to provide data and information related to the evaluation of potential health benefits market impacts from House Bill No. 1523 (Cascade Care) based on the legislative text submitted to the Washington House of Representatives on January 23, 2019, which is the most recent version at the time this report was authored. The data and information presented may not be appropriate for any other purpose. To the extent the legislation is updated or amended, changes may materially impact statements and conclusions made in this report.

It is our understanding that the information contained in this report will be released publicly once it is finalized. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for the Association of Washington Healthcare Plans by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the premium rates, insurance market population estimates, trend rates, and other assumptions.

Milliman has relied upon certain data and information that is publicly available from the Washington Health Benefit Exchange, Washington state Health Care Authority, Washington state Office of the Insurance Commissioner, and the Centers for Medicare and Medicaid Services (CMS). Additionally, we relied on statutory financial statement information downloaded from S&P Global Market Intelligence (formerly SNL Financial), AIS Health November 2018 State of Washington health benefits enrollment report, and proprietary insurer financial data related to provider reimbursement. Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data provided are not accurate, the estimates provided in this report would need to be modified to reflect revised information.

It should be noted there is significant uncertainty surrounding future enrollment and premiums in health benefits programs, particularly the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report, who are credentialed actuaries, are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

10. Methodologies

In preparing this report, we relied on data, information, and assumptions provided by certain health plans that offer coverage on WAHBE along with public data sources. Data sources utilized in our analysis include, but are not limited to, the following:

- Health plan financial information downloaded from S&P Global Market Intelligence
- Health insurer rate review information available at https://ratereview.healthcare.gov/
- Insurer rate filing information
- Medical Loss Ratio Reporting Form data, 2015 through 2017
- Historical Medical Expenditure Panel Survey data
- HHS Marketplace Open Enrollment reports
- Reports released by the federal government related to premium stabilization programs, APTC amounts, and effectuated marketplace coverage
- AIS Health Third Quarter 2018 Washington health benefits enrollment report
- WAHBE premium and enrollment information
- Bureau of Labor Statistics employment statistics
- Proprietary provider reimbursement levels for health benefits coverage offered through WAHBE provided by participating health insurers
- Medical Expenditure Panel Survey

We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

It should be noted there is significant uncertainty surrounding future enrollment and premiums in health benefits programs, particularly the individual market. Uncertainty arises from the inability to predict individual behavior, as well as the inability to predict the business decisions of carriers in the market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. *Federal pass-through funding will be based on actual premiums filed by insurers offering coverage in Washington's non-group market, final funding amounts may differ significantly from the high-level, preliminary estimates provided in this report.*

The actuarial analyses presented in this report solely reflect the estimated incremental impacts from HB 1523. Other state or federal policy changes may impact actual amounts presented in this report. This report does not constitute an actuarial certification for a 1332 waiver.

We specifically note that our projections of enrollment and premium rates in the individual market assume that federal funding of cost-sharing reduction (CSR) subsidies remains terminated, and that the individual mandate penalty remains $0. To the extent judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted by a significant degree.

Appendix A: Low-Cost Area Premium Impacts Detail

FIGURE 28: LOWEST-COST GOLD

	CURRENT COMMERCIAL REIMBURSEMENT LEVELS	MEDICARE REIMBURSEMENT LEVEL	CHANGE
TOTAL MEDICAL AND RX ALLOWED COSTS	$618.13	$475.89	-23.0%
TOTAL CONSUMER COST SHARING	$88.11	$85.40	-3.1%
TOTAL PLAN MEDICAL AND RX COSTS	$530.02	$390.49	-26.3%
FIXED ADMINISTRATIVE COSTS	$49.00	$49.00	0.0%
VARIABLE ADMINISTRATIVE COSTS	$64.34	$48.83	-24.1%
PREMIUM	$643.36	$488.32	-24.1%
IMPACT OF REQUIRED COST SHARING CHANGE		$19.52	-3.0%
FINAL PREMIUM CHANGE		$507.84	-21.1%

FIGURE 29: LOWEST-COST SILVER

	CURRENT COMMERCIAL REIMBURSEMENT LEVELS	MEDICARE REIMBURSEMENT LEVEL	CHANGE
TOTAL MEDICAL AND RX ALLOWED COSTS	$618.13	$475.89	-23.0%
TOTAL CONSUMER COST SHARING	$108.86	$89.61	-17.7%
TOTAL PLAN MEDICAL AND RX COSTS	$509.27	$386.27	-24.2%
FIXED ADMINISTRATIVE COSTS	$49.00	$49.00	0.0%
VARIABLE ADMINISTRATIVE COSTS	$62.03	$48.36	-22.0%
PREMIUM	$620.30	$483.64	-22.0%
IMPACT OF REQUIRED COST SHARING CHANGE		$6.45	-1.0%
FINAL PREMIUM CHANGE		$490.09	-21.0%

FIGURE 30: LOWEST-COSTSECOND-LOWEST-COST SILVER

	CURRENT COMMERCIAL REIMBURSEMENT LEVELS	MEDICARE REIMBURSEMENT LEVEL	CHANGE
TOTAL MEDICAL AND RX ALLOWED COSTS	$618.13	$475.89	-23.0%
TOTAL CONSUMER COST SHARING	$103.61	$86.02	-17.0%
TOTAL PLAN MEDICAL AND RX COSTS	$514.52	$389.87	-24.2%
FIXED ADMINISTRATIVE COSTS	$49.00	$49.00	0.0%
VARIABLE ADMINISTRATIVE COSTS	$62.61	$48.76	-22.1%
PREMIUM	$626.14	$487.63	-22.1%
IMPACT OF REQUIRED COST SHARING CHANGE		$6.95	-1.1%
FINAL PREMIUM CHANGE		$494.58	-21.0%

Appendix B: High-Cost Area Premium Impacts Detail

FIGURE 31: LOWEST-COST GOLD

	CURRENT COMMERCIAL REIMBURSEMENT LEVELS	MEDICARE REIMBURSEMENT LEVEL	CHANGE
TOTAL MEDICAL AND RX ALLOWED COSTS	$750.76	$475.89	-36.6%
TOTAL CONSUMER COST SHARING	$93.88	$88.26	-6.0%
TOTAL PLAN MEDICAL AND RX COSTS	$656.88	$387.63	-41.0%
FIXED ADMINISTRATIVE COSTS	$49.00	$49.00	0.0%
VARIABLE ADMINISTRATIVE COSTS	$78.43	$48.51	-38.1%
PREMIUM	$784.31	$485.15	-38.1%
IMPACT OF REQUIRED COST SHARING CHANGE		$31.94	-4.1%
FINAL PREMIUM CHANGE		$517.09	-34.1%

FIGURE 32: LOWEST-COST SILVER

	CURRENT COMMERCIAL REIMBURSEMENT LEVELS	MEDICARE REIMBURSEMENT LEVEL	CHANGE
TOTAL MEDICAL AND RX ALLOWED COSTS	$750.76	$475.89	-36.6%
TOTAL CONSUMER COST SHARING	$127.31	$92.02	-27.7%
TOTAL PLAN MEDICAL AND RX COSTS	$623.45	$383.87	-38.4%
FIXED ADMINISTRATIVE COSTS	$49.00	$49.00	0.0%
VARIABLE ADMINISTRATIVE COSTS	$74.72	$48.10	-35.6%
PREMIUM	$747.17	$480.97	-35.6%
IMPACT OF REQUIRED COST SHARING CHANGE		$12.58	-1.7%
FINAL PREMIUM CHANGE		$493.54	-33.9%

FIGURE 33: LOWEST-COSTSECOND-LOWEST-COST SILVER

	CURRENT COMMERCIAL REIMBURSEMENT LEVELS	MEDICARE REIMBURSEMENT LEVEL	CHANGE
TOTAL MEDICAL AND RX ALLOWED COSTS	$750.76	$475.89	-36.6%
TOTAL CONSUMER COST SHARING	$120.45	$88.32	-26.7%
TOTAL PLAN MEDICAL AND RX COSTS	$630.31	$387.57	-38.5%
FIXED ADMINISTRATIVE COSTS	$49.00	$49.00	0.0%
VARIABLE ADMINISTRATIVE COSTS	$75.48	$48.51	-35.7%
PREMIUM	$754.79	$485.08	-35.7%
IMPACT OF REQUIRED COST SHARING CHANGE		$13.30	-1.8%
FINAL PREMIUM CHANGE		$498.38	-34.0%

Appendix C – Benefit Plan Descriptions

	Core Bronze HSA - 19  Remove from Comparison ☐	Ambetter Balanced Care 2 (2019)  Remove from Comparison ☐
Out-of-Pocket Costs		
Services Covered Before Deductible	Preventive care services, pediatric eye exam and glasses	Preventive care services, primary care, specialist, and urgent care office visits, generic and preferred brand drugs are covered before you meet your deductible.
Annual Deductible	$4,750 Individual / $9,500 Family	$6,500 Individual / $13,000 Family
Annual Prescription Drug Deductible	Included in annual deductible	Included in annual deductible
Annual Out-of-Pocket Maximum	$6,550 Individual / $13,100 Family	$6,500 Individual / $13,000 Family
Preventive Services with $0 Co-pay	See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care- benefits/	See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care- benefits/
Primary Care Provider Required	Yes	Yes
Primary Care Visit to Treat an Illness or Injury	20% Coinsurance after deductible (applies after you have met deductible)	$30 Copay
Specialist Referrals Required	Yes	Yes
Specialist Visit	20% Coinsurance after deductible (applies after you have met deductible)	$60 Copay
Urgent Care Visit	20% Coinsurance after deductible (applies after you have met deductible)	$100 Copay

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