Universal Health Care Commission's
Finance Technical Advisory Committee meeting

March 13, 2025

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's
Finance Technical Advisory Committee (FTAC)

Agenda

Thursday, March 13, 2025
2:00 – 4:30 PM
Zoom meeting

FTAC members:		
☐ David DiGiuseppe, FTAC Liaison	☐ Esther Lucero	☐ Pam MacEwan
☐ Christine Eibner	☐ Ian Doyle	☐ Robert Murray
☐ Eddy Rauser	☐ Kai Yeung	☐ Roger Gantz

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome and call to order	1	David DiGiuseppe, FTAC Liaison to the Universal Health Care Commission (UHCC)
2:05 – 2:08 (3 min)	Roll call		Mary Franzen, HCA
2:08 – 2:10 (2 min)	Approval of 1/16/2025 Meeting Summary	2	David DiGiuseppe, FTAC Liaison to UHCC
2:10 – 2:25 (15 min)	Public comment	3	David DiGiuseppe, FTAC Liaison to UHCC
2:25 – 2:35 (10 min)	Universal Health Care Commission update	4	David DiGiuseppe, FTAC Liaison to UHCC
2:35 – 2:40 (5 min)	Workplan update	5	Mary Franzen, HCA
2:40 – 3:45 (65 min)	Milliman analysis findings and discussion	6	Peter Hallum, Milliman Mary Franzen, HCA
3:45 – 3:50 (5 min)	BREAK		
3:50 – 4:30 (50 min)	Cost containment memo discussion	7	Todd Bratton, HCA
4:30	Adjournment		David DiGiuseppe, FTAC Liaison to UHCC

Tab 2

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting summary

January 16, 2025

Hybrid meeting held on Zoom and in person at the Health Care Authority (HCA)
2-4:30 p.m.

Note: This meeting was recorded in its entirety. The recording and all materials provided to and considered by the Commission are available on the **FTAC webpage**. Additionally, votes made by the committee during this meeting are highlighted below in blue.

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero
Ian Doyle
Kai Yeung

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:04 p.m.

Agenda items

I. Welcoming remarks

Beginning with a land acknowledgement, MacEwan welcomed members of FTAC to the thirteenth meeting and provided an overview of the agenda.

MacEwan notified members that this would be her last meeting facilitating as the FTAC liaison to the Universal Health Care Commission (Commission) and that David DiGiuseppe will now be filling this role. MacEwan will

remain an FTAC member, while DiGiuseppe will assume responsibilities to facilitate FTAC meetings and the back-and-forth work with the Commission.

II. Meeting summary

Committee members voted by consensus to accept the November 2024 meeting summary.

III. Public comment

Peter Markus provided comment on behalf of Whole Washington. Markus thanked FTAC for their report and analysis of the Washington Health Trust bill and reminded members that their report committed to continued review. The latest version of the bill is Senate Bill 5233, which includes several updates. Markus requested that FTAC include review of this bill in the 2025 workplan, as the resulting analysis may inform Whole Washington's advocacy in the Legislature.

Cris Currie summarized written comments he submitted to the Commission, which outline how a state-based single-payer system may contain costs by reducing the incidence of unnecessary medical procedures. Currie advocated for a cost containment approach which includes mandatory global budgets, enhanced transparency to determine motivations behind unnecessary care, practitioner education and best practices, integrated data systems which aid in determining best practices, and a governance and enforcement structure free from industry bias. Currie urged FTAC to recommend that the Commission adopt the single-payer structure as a guiding principle to achieve cost containment most efficiently.

Aaron Katz summarized his written comments provided to FTAC and the Commission. Katz recommends that the Commission and FTAC revise the workplan and focus on the design of the governance structure first. Katz states that this is the most important step in designing a unified system that contains costs and assures equity and access for all.

Aruna Bhuta spoke in support of a state-based single payer system as a matter of cost containment and access to affordable care. Bhuta advocated for a state-administered single payer system to minimize administrative costs and thanked FTAC for their work.

IV. Progress update: 2025 workplan and Milliman analysis

Mary Franzen, Health Care Authority (HCA)

Mary Franzen presented the Commission's 2025 workplan, starting with the foundational legislative charge to prepare the state for a unified health care system and propose interim solutions. Franzen presented the milestone tracker document which includes the Commission's work products toward these goals.

The Commission's 2025 workplan focuses on benefits and services and cost containment design during the first half of the year. Provider reimbursement and participation design will be addressed in the second half of the year. The Commission's intent is to focus on universal design in the first half of the year and add transitional solutions back into the agendas in the second half of 2025. This will allow time for members to consider activities related to the legislative session.

Franzen provided a brief update on the Milliman benefit design cost analysis. FTAC liaisons have been meeting with Milliman actuaries throughout this process. The interim report will be shared with the Health Care Authority (HCA) in February, with a final report being available for FTAC in March.

V. Health Care Cost Transparency Board benchmark report update

Sheryll Namingit, HCA

Sheryll Namingit, Health Economics Research Manager at HCA, provided background on total health care spending data and the health care cost growth benchmark for Washington. Namingit briefly outlined the data and analytic initiatives that are the responsibility of the Health Care Cost Transparency Board (Cost Board). Setting an annual cost growth benchmark and measuring performance is one of several data and analytical responsibilities of the Cost Board.

The Cost Board's first data call occurred in 2022, collecting Washington state carrier and non-carrier data from 2017-2019. The most recent data call occurred in 2024 when the Cost Board collected 2020-2022 data. Namingit explained the Cost Boad's calculation for total health care expenditure (THCE). The calculation includes the sum of total medical expenses (TME) including claims and non-claims expenditures, non-claims and private insurance administrative costs, and other spending. TME is broken down by markets, particularly commercial, Medicare, and Medicaid. The analysis is also broken down by carrier, and an attribution calculation for large provider organization spending.

In 2021, the Cost Board set five years of cost growth targets from 2022-2026. The targets are based on economic indicators including nominal gross domestic product (GDP) as well as the nominal wage growth in Washington. The recent benchmark report and data compares performance against the 2022 target of 3.2%. In 2022 cost growth was 3.6%, slightly above the target of 3.2%. Excluding 2020, this was the slowest year of growth measured since 2018. Medicare was the only market to exceed the 2022 benchmark and spending on Veterans Affairs members also contributed to growth. A broader look at data from 2019-2022 shows growth driven by commercial and Medicare markets with prescription drugs, non-claims spending driven by Medicare capitation payments, and hospital outpatient services representing the top three categories of spending, respectively.

Incarcerated individuals incur a high per member per month (PMPM) cost, but the population is relatively small and amounts to 0.5 percent of total spending, Medicare spending accounts for nearly one third of all spending with a PMPM of $13,070 in 2022. Commercial market members accounted for 36.1 percent of spending, with a PMPM of $6400. Medicaid members represent 20.3 percent of spending at a PMPM rate of $5012.

Spending from 2019-2022 was reported by market, with the commercial market growing by 11.5 percent and Medicare growing by 7.7 percent during this time. Medicaid enrollment and total spending increased, but PMPM slightly decreased by 0.1 percent from 2019-2022. This was not the case in 2017 – 2019 when Medicaid growth ranged between 11.9 and13.8 percent. Washington's growth rate is similar to the median cost growth of other states participating in cost growth benchmark activities. The growth rate in commercial, Medicare, and Medicaid spending was also similar to other states. The final brief on the benchmark performance will be made public later this year.

In the Q&A FTAC members discussed the analysis, specifically regarding incarcerated populations, Veterans Affairs (VA) spending, and Medicare growth. They also discussed the Cost Board's opportunities to further identify cost drivers at the provider level. FTAC members expressed interest in continued updates on the Cost Board's work.

VI. Universal Health Care Commission update

Pam MacEwan, FTAC Liaison

MacEwan provided a brief update on the Commission's December 5th meeting.

MacEwan reported on the Commission's preview and discussion of proposed reference-based pricing bill for the public employee and school employee health plans (more information here). MacEwan shared FTAC's support for the proposal and following the presentation, the Commission voted to "support the principle of reference-based pricing, not only to contain costs, but to rebalance resources." The Commission also noted that the current proposed bills may change during the legislative process but agreed with supporting reference-based pricing as a strategy.

FTAC members discussed the potential of recommending that the Commission specifically endorse the reference-based pricing bill that has been introduced in the Legislature. Gary Cohen from Health Management Associates (HMA) affirmed that the Commission supports the reference-based pricing strategy and will be watching the progress in the Legislature. Cohen noted that the Commission may choose to take a stronger position in the future. FTAC members deliberated the appropriate level of recommendation back to the Commission. DiGiuseppe agreed to relay FTAC's endorsement of the bill at the February Commission meeting.

The Commission requested that FTAC continue to explore cost containment strategies such as out-of-network price caps and hospital global budgeting. The Commission also approved revisions to its 2025 workplan focusing on universal design during the first half of the year and continuing to consider transitional solutions in the second half of the year.

VII. Hospital global budgeting, presentation and Q&A

Robert Murray, FTAC member

Robert Murray presented an overview of hospital global budgeting (HGB), starting with his professional background, experience working in Maryland, and research into various models. Murray's presentation covered the general characteristics of HGB models, a simplified example of an HGB, past state approaches with HGB, policy objectives and incentives, advantages, disadvantages, modifications to address weaknesses, as well as governance and oversight considerations.

Murray shared his background and personal assertions regarding cost containment, including the risk that any expansion in services requires a well-regulated cost control system. Failure to develop effective models may hamper expansion efforts, which may have been the case in Vermont's single payer initiative. In Murray's estimation the Affordable Care Act may also be at risk due to a lack of substantive cost containment initiatives. States may be best situated to contain excess health care spending through rate setting. Murray advocates for a state-based rate setting model, as these types of price control measures

are common throughout developed nations. Murray further recommends that states utilize low intensity measures and simple models to avoid regulatory failures. The model Murray recommends is for states to start with price caps in state employee benefit plans, then consider out-of-network rate caps, as this will influence in-network pricing as well. Eventually states can more broadly contain costs through HGB.

Murray briefly described the prevalence of HGB approaches in Canada and European countries. France and Germany initially utilized fixed budgets and then opted for more flexible models. Murray advocates for flexible models which account for a provider's marginal costs. Several states have utilized HGB including Maryland's original flexible HGB model from 1976-1992 and the current Advancing All-Payer Health Equity Approaches and Development (Link: AHEAD) model advancing in several states in partnership with the United States Center for Medicare and Medicaid Services (CMS).

Murray outlined several general characteristics of HGB including mandated participation covering all hospitals and potentially other services. Murray stressed the importance of including all hospitals to avoid ineffectiveness and distortion between HGB and fee-for-service incentives and utilization across providers. Per Murray, a state-based HGB system would ideally be governed by a regulatory body, utilizing a public utility model. Services covered by HGB models generally include acute inpatient and outpatient hospital services, but states may opt to cover a variety of services such as post-acute care and home health services. HGB models are more comprehensive than rate caps but can remain simple and less complex than setting prices for individual services. Flexible aggregate budgets offer a simple, low-intensity regional rate setting model which focuses on one number and addresses both price and volume.

Murray described potential policy goals that might be achieved with HGB approaches, including constraining price and volume, removal or reduction of fee-for-service incentives for volume, and potential reduction in need for prior authorization. Other goals include investment in reducing unnecessary care, improvements to population health, predictability and stability for hospitals, and built-in incentives to constrain costs, which can improve hospital profitability. Hospitals that are struggling could be identified for increased funding and highly profitable hospitals could be identified for potential reductions. Through such a model, the system may achieve better payment equity, though Murray notes this will take time. The HGB model can be modified to support other value-based payment initiatives and quality incentive programs. HGB models do pose a risk of hospitals limiting care and therefore quality incentives are a potential mechanism for ensuring quality of care over time. Through the success of a simple and flexible HGB model, states may opt to undertake more complex population-based reimbursement approaches.

Murray provided a simplified example for HGB models with budgets increasing annually, considering inflationary measures and demographics. This model provides a strong incentive for hospitals to control operating costs and unnecessary volume increases. This strategy can increase profitability when successful, as Murry notes in Maryland's experience. If hospitals are incentivized to reinvest savings into population health and preventative care, this can help perpetuate the model.

Weaknesses of HGB models were also presented, including potential inequities if the model is not mandated, the risk of providers limiting care, increased wait times, and risk of shifting care out of hospitals to clinics, thereby collecting double payment. Fixed HGB are not responsive to volume shifts or changes in community needs and may pose significant financial risk. Both flexible and fixed HGB models face risks of regulatory capture and failure.

The requirements Murray listed for HGB models included state regulation of mandatory budget compliance and significant fining authority for non-compliance. The model should include a regulatory commission with broad power to collect data and the legal authority to set budgets. The regulatory commission should include governor appointed volunteers and be supported with professional staff. Murray noted that regulatory and rate setting commissions have been effective in the past and can help avoid regulatory capture or failure.

Murray recommended flexible HGB models to equally emphasize cost containment and hospital financial stability. Flexible global budgets models can provide revenue to cover marginal or variable costs of production and can also help cover fixed costs if volume declines. This may be a particular advantage for small and rural hospitals. This model is a middle ground between a fee-for-service model which may drive unnecessary care, and a fixed global budget model which risks excessive limits on care.

Murray provided a simplified example calculation of how a HGB model might address variable costs, based on an assumed 50 percent margin. A 1 percent increase in utilization would result in a 0.5 percent increase to the budget, to cover variable costs. A 1percent decrease in utilization would result in a 0.5 percent decrease to the budget and fixed costs remain funded. Hospitals would report data to the public commission monthly and adjust rates to remain in compliance with the approved HGB. Annually, the public commission would adjust the HGB depending on whether volume went up or down. This mandated model would include large fines for non-compliance, but the system can become nearly self-regulated with hospitals adjusting prices throughout the year to meet their approved HGB. Murray contends this model adds financial stability for hospitals and particularly small rural hospitals with limited population and volume of services.

The key steps to devising an HGB model include developing a rate base using historical volume and revenue data to set base year budgets, followed by defining which services are included. Next, there may be adjustments to the rate-base, such as funding for uncompensated care and case management. Whether choosing a fixed or flexible HGB, provider payment could remain consistent with all payers. The HGB model utilizes formula-based prospective budgeting which accounts for hospital input cost inflation and demographic changes. States could then choose to improve pricing and budget equity with tiered measures which limit high price updates and augment low priced hospital updates. Finally, Murray emphasized that the regulatory commission must exercise their legal authority to mandate compliance.

Murray's final observations on HGB models included their ability to redirect incentives toward improving hospital's operating cost efficiency, reducing levels of low value or unnecessary care and making investments to improve population health. Murray argued that the health care industry faces challenges which require rate regulation to improve market function. Avoiding complexity and providing the governance structure to avoid regulatory capture from the hospital industry is ultimately how Murray suggests these models will be successful.

Murray addressed questions from FTAC members following the presentation.

FTAC member Roger Gantz asked about the level of staffing required and Murray noted that a public commission could be staffed by as few as 20 professional staff. Though Maryland may employ twice as many staff for their rate setting commission, Murray contends that this is not necessary. Gantz was also

curious about payment methodologies and Murray reaffirmed that payment models should remain consistent with the status quo to avoid complexity.

FTAC member Christine Eibner inquired about risk related to hospitals refusing to provide some services that are deemed too costly. Murray noted that in some global systems with fixed models there may be issues with wait-times and other delays in care. Murray has not observed or heard about this phenomenon in the state-based models he has studied.

FTAC member Eddy Rauser asked what actions might be taken if hospitals were not able to meet their targets. Under a flexible HGB model, Murray reiterated the aim is to constrain cost and hospitals would need to adjust volume of unnecessary care and unit cost. The profit incentive would be enough to drive hospitals to make these adjustments, according to Murray, and it would be counterproductive for the state to bail them out. If the regulatory authority identified unique circumstances which threatened access, and required raising a hospital's budget temporarily, this could be built into the system.

FTAC Liaison DiGiuseppe inquired about various perspectives the Commission might need to consider if they were to make a recommendation on HGB. Murray suggested that payers and consumers will likely support this model, while hospitals will be more resistant to adoption. Murray expressed his knowledge of previous efforts in Washington to consider HGB models and that he had ideas on why the effort failed. He expressed his willingness to present his flexible HGB model to the Commission in the future.

VIII. Cost containment discussion and future direction

Todd Bratton, HCA and Gary Cohen, HMA

Todd Bratton from HCA presented a plan for helping FTAC develop cost containment recommendations to UHCC. Over the next several meetings, FTAC will review and draft recommendations on cost containment strategies and principles for universal design. Drafts and references will be sent to FTAC members for review between meetings.

Gary Cohen from HMA led a discussion on this process within context of the Commission's workplan. FTAC Liaison DiGiuseppe inquired whether FTAC's recommendations might include cost containment approaches for controlling trends moving forward or realizing cost reductions compared to the current system. DiGiuseppe noted the suggestions of the workgroup which preceded the Commission and the savings they estimated based on a unified fee schedule. DiGiuseppe noted that recommending an HGB model seems to be aligned with approaches for managing current costs. Based on Cohen's understanding and experience with the Commission, the workgroup's estimated savings come from administrative reduction and improved efficiency rather than reductions to the price of care.

Mary Franzen from HCA noted that due to meeting time constraints, staff will be able to send out drafts and incorporate FTAC member suggestions for discussion at the next meeting. FTAC member Pam MacEwan requested that staff incorporate the work that FTAC has already completed as the starting point for this effort.

FTAC member Gantz expressed interest in considering HGB models as one strategy, however noting that its application is best suited to hospital facilities and not necessarily the entire system. Gantz suspects reference-based pricing could apply to a broader set of services. Gantz also reiterated his understanding

of savings estimated by the workgroup, which include administrative savings associated with a single payer system, plus the system's ability to address trends. Gantz suggests FTAC continues to engage with the Health Care Cost Transparency Board and recommended that FTAC member Murray present on HGB. Gantz also recommended that FTAC encourage the Commission to more strongly support the reference based pricing legislation for the public employee and school employee plans.

Cohen inquired how reference-based pricing and HGB models might intertwine. FTAC member Murray estimates that an HGB model would reduce the need for price caps, as it addresses both volume and price. A regulatory commission would need to review whether the system is functioning as expected, and Murray notes that the HGB model does appear to reduce administrative costs in the studies he has reviewed.

FTAC member Christine Eibner expressed interest in more fully investigating which strategies make sense as transitional solutions or universal design. FTAC member MacEwan agreed that some of the strategies make more sense to include in universal design than others.

IX. Benefits and services prioritization model

Due to time constraints, FTAC was not able to spend time discussing prioritization of benefits and services. Mary Franzen, HCA, reminded FTAC the Milliman analysis will likely be presented at the March FTAC meeting. This report will inform benefits and services design work for the next several meetings.

Adjournment

Meeting adjourned at 4:31 p.m.

Next meeting

Thursday, March 13, 2025 from 2-4:30 p.m.
Meeting to be held on Zoom

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Universal Health Care Commission's

Finance Technical Advisory Committee

Written Comments

Received since January 2, 2025

Written comments submitted via e-mail:

Additional comments received at the January FTAC meeting:

- The recording of public comments begins here.

From: Aaron B Katz {he, him, his}
To: HCA Universal FTAC
Cc: HCA Universal HCC
Subject: Public comment submission to FTAC
Date: Wednesday, January 15, 2025 4:42:49 PM

Dear FTAC Members,

Some thoughts about your, and the Commission's, 2025 work plan.

First, it's good to see the work plan's priority given to design of a universal system. That focus has been long in coming.

I note that Slide 23 (also 25) shows the stepwise topics UHCC will take up in this system design work: Provider Participation and Financing at the end of Phase 1; Infrastructure and Enrollment in Phase 2; and then last, in Phase 3, Governance.

I'd like to suggest that Governance is the single most important feature of a unified system and the feature most related to its success in controlling future spending and assuring effective and efficient services. It's much more important, in my view, than the details of provider payment, for example, even though we ruminate (a lot!) on payment methods.

If you look at the histories of, for example, the German (and Japanese, since the latter was based on the former) social insurance model or Canada's single payer system or Britain's National Health Service, you'll see that the first and critical step in each case was determining what public body or process would be responsible for governing the new system and assuring affordability, access, and equity. Only later were decisions made about how to pay hospitals and doctors, etc.

I urge you to take up Governance much sooner in this year's work plan, as the success of the rest of the system's design rests upon it.

Thank you.

Cc. Universal Health Care Commission

Aaron

Aaron Katz, Principal Lecturer Emeritus
School of Public Health
University of Washington

Public comment to include in the packet for the March 13, 2025 FTAC meeting

To the Finance Technical Advisory Committee of the Universal Health Care Commission,

Health Care is a Human Right - Washington (HCHR-WA) is a coalition of 40 organizations including labor and many NGOs. "HUX" is a subcommittee of HCHR-WA which has been following and making public comments since the inception of UHCC and FTAC. We meet twice a month, once to review the packets and prepare comments, and then after to discuss the progress made at the meeting. HUX is composed of health care and public policy experts and concerned citizens who care very deeply about your work. Many of us have spent our careers working to expand access to health care. Because of the virtual nature of the meetings and the narrowly prescribed channels for input, we realize you might not be aware of the extent of our participation in your work.

We are concerned that governance is not prioritized early enough in your work plan. We have made several public comments stressing the importance of addressing governance as a foundational element from the outset. Without a universal healthcare model and a solid governance structure in place, it is premature to finalize decisions regarding eligibility, benefits, and services.

There are two universal healthcare bills, the Washington Health Security Trust (WHST) and the Washington Health Trust (WHT), that the UHCC and FTAC can use as models for governance. Many of our members are familiar with both bills. We are offering to present to the FTAC an overview of how governance is structured in the bills, as significant work has already been done in both that could help expedite the FTAC's governance tasks.

With this public comment, we are making that an offer. We request your reply. As we are uncertain how the FTAC agenda is developed, please let us know if there is a different channel we should use to make this offer.

Thank you,

Maureen (Mo) Brinck-Lund and Raleigh Watts
Health Care Advocates
Co-Chairs of HCHR-UHCC Subcommittee, "HUX"
http://healthcareisarightwa.org/

Tab 4

Washington State Health Care Authority

Universal Health Care Commission update

David DiGiuseppe, FTAC Liaison to the UHCC

Washington State Health Care Authority

February 13 Commission meeting

- Washington State Insurance Commissioner Patty Kuderer joined the meeting
  - She noted that establishing universal health care is not just “paramount,” but also inevitable
  - She hopes to attend future Commission meetings as her schedule allows
  - Commissioner Kuderer’s remarks begin here

Meeting materials here
Meeting recording here

February 13 UHCC public comment

- Clarification of eligibility
  - Concern re “completion”
  - Prior indication that Veterans not included
  - Many Veterans don’t use VA
    - Subsequent commentary in meeting that Veterans who don’t use VA services would be considered as Uninsured
- Timing of governance determination
  - Suggestions for governance: UHCWG; rural electric cooperatives
- Progress tracking
  - Discuss progress at beginning of each meeting (UHCC agenda satisfied this)
  - Add planned completion dates to each milestone

Reference-based pricing

- The Commission voted to support HB 1123/SB 5083
  - Introduces reference-based pricing for PEBB/SEBB plans
  - Referenced to Medicare rates
  - Exemptions for certain health care settings
  - Representative Joe Schmick abstained from this vote

Reference-based pricing

- Margaret Smith-Isa of the Oregon Health Authority shared Oregon's experience with reference-based pricing
  - Oregon exempts many small and rural hospitals from reference-based pricing
  - Savings over the first two years is estimated at more than $160M, with savings concentrated in outpatient services
  - Medicare rates are a broadly familiar and transparent benchmark, but may not be the best benchmark for services used infrequently by the Medicare population (e.g., maternity, neonatal care)
- *Are Medicare Fee Schedules Appropriate for Commercial Populations?* by Will Fox (*Health Affairs*)

Her presentation begins here.
Q & A from Commission members begins here.

Rural roundtable

- Discussion of the unique opportunities and challenges facing rural communities in Washington within the context of a universal health system
  - Brad Becker, Senior Director Payer Strategy, Mason Health and The Rural Collaborative
  - Shane McGuire, Chief Executive Officer, Columbia County Health System
  - Ashlen Strong, Vice President, Government Affairs
    Washington State Hospital Association

The roundtable discussion begins here.

Rural roundtable

- 37 of 45 rural hospitals are tax-supported hospital districts
- Interdependency across catchment areas: e.g., availability of specialty or post-acute care
- Cost pressures
  - Labor-related costs represent 83% of total cost: pay competitive wages attract labor from adjacent counties
  - Inconsistent volume (e.g., labor and delivery) and “open doors” exacerbate unit cost
  - Transportation services necessary for patients but not funded
  - Older facilities difficult to maintain; EHR systems expensive
  - Challenging to manage administrative processes across carriers; little leverage in contract negotiations

Next steps

- Letter of support to the Legislature for HB 1123/SB 5083
- Further exploration of cost containment
- Next UHCC meeting:
  - **2-5 pm, April 17, 2025**, in person and via Zoom
  - For more details visit the UHCC webpage

Questions/Comments?

Tab 5

Washington State Health Care Authority

Workplan update

Finance Technical Advisory Committee

March 2025

Universal Health Care Commission charge

As directed by the Legislature, the Commission must:

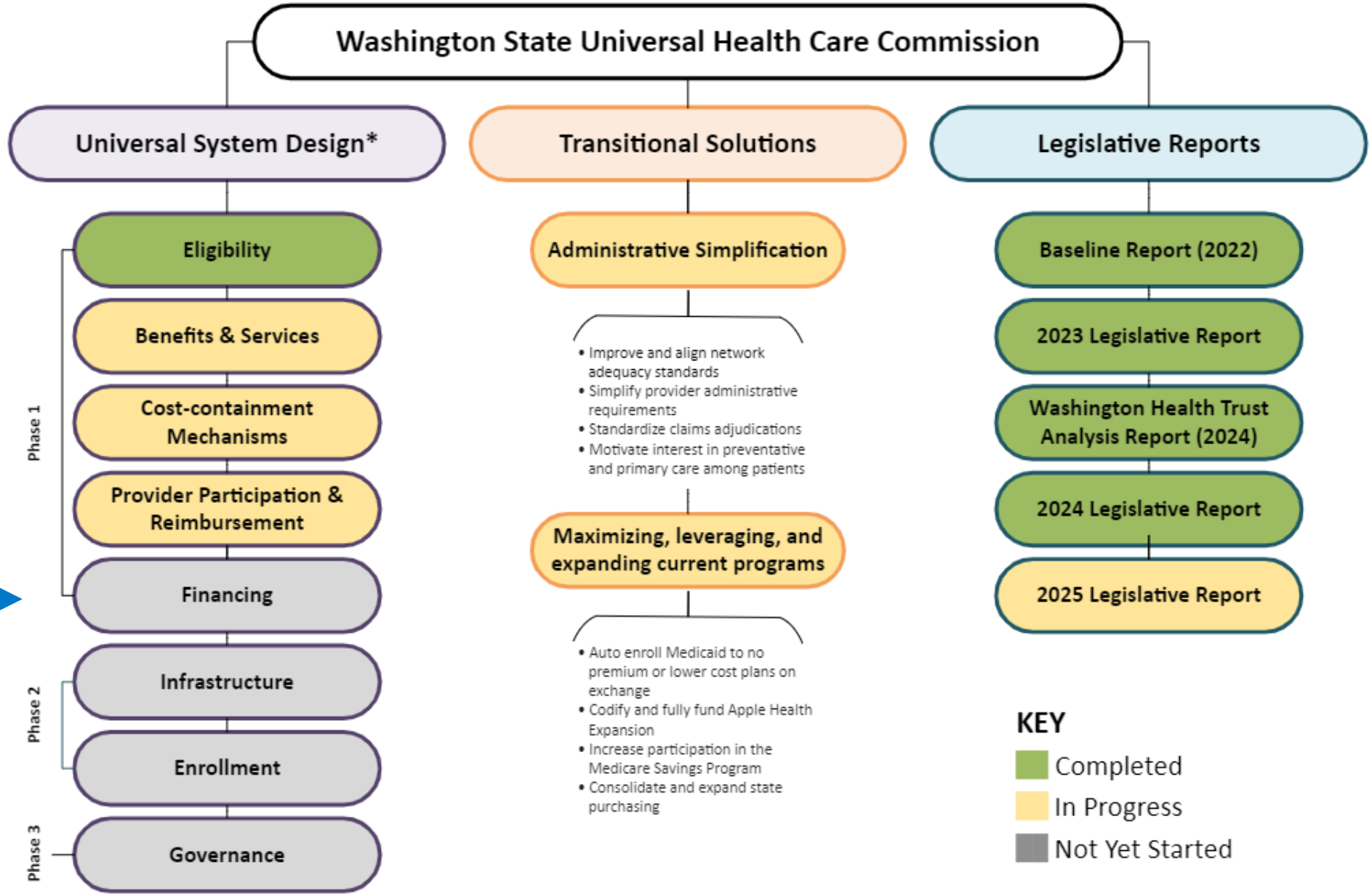
Transitional Solutions

"…create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available." (RCW 41.05.840)

Universal System Design

Milestone Tracker

Last updated: 11/21/2024



early 2026 →

**Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.*

Phase 1: Eligibility

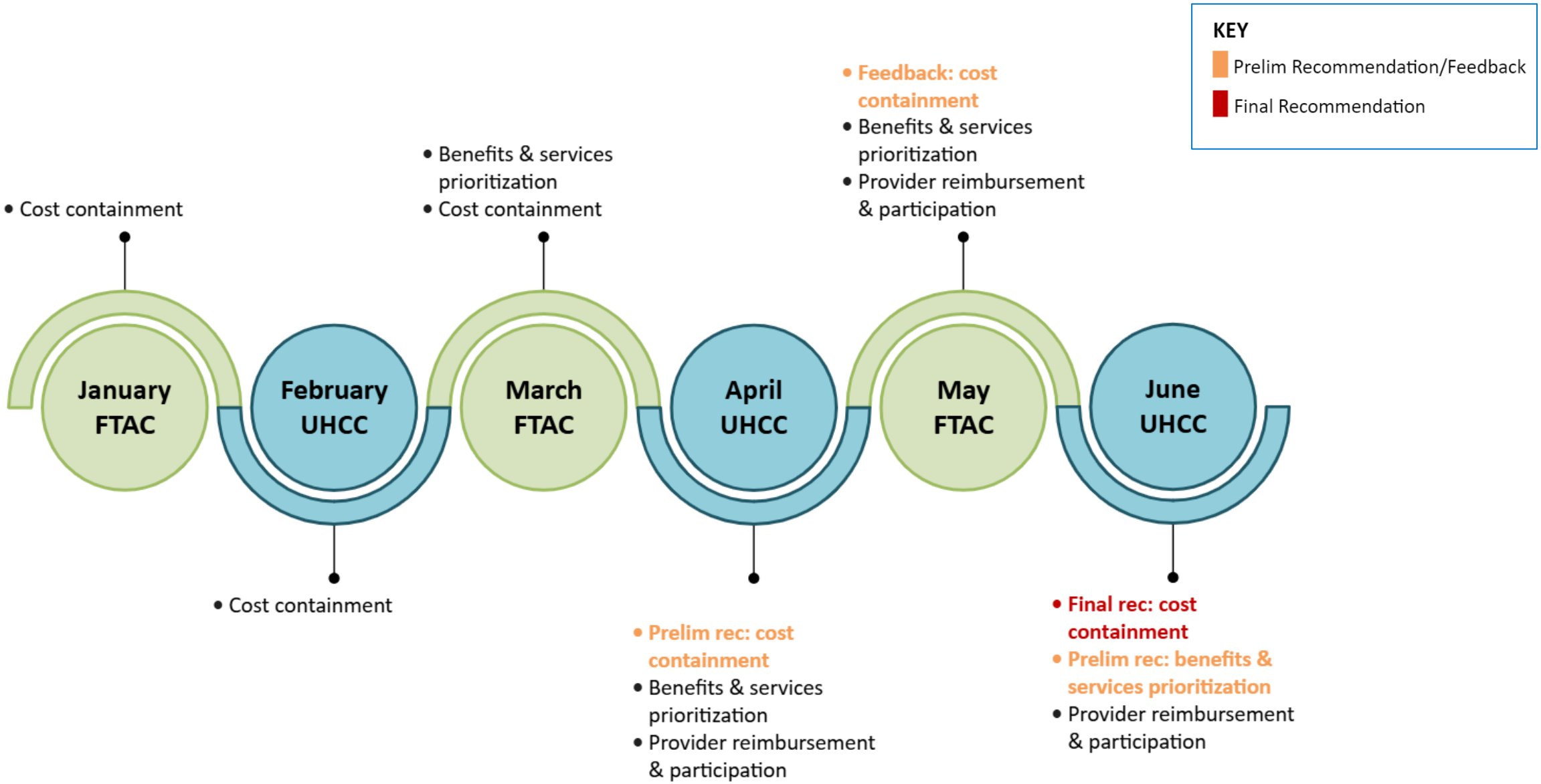
- FTAC helped the Commission identify the population that, as of now, has the greatest potential to be pooled into a unified system
- That population includes people currently covered by
  - Medicaid
  - Individual health plans
  - Fully-insured group health plans (small and large)
  - All PEBB/SEBB plans
  - Uninsured and underinsured people

Phase 1: Additional topics

- On today's agenda:
  - Milliman's cost modeling is a springboard for benefits & services
    - FTAC will have further discussion during the May meeting
  - Cost containment principles and memo to be discussed
    - Preliminary recommendation to UHCC
- Future agendas:
  - Provider participation and reimbursement
  - Financing

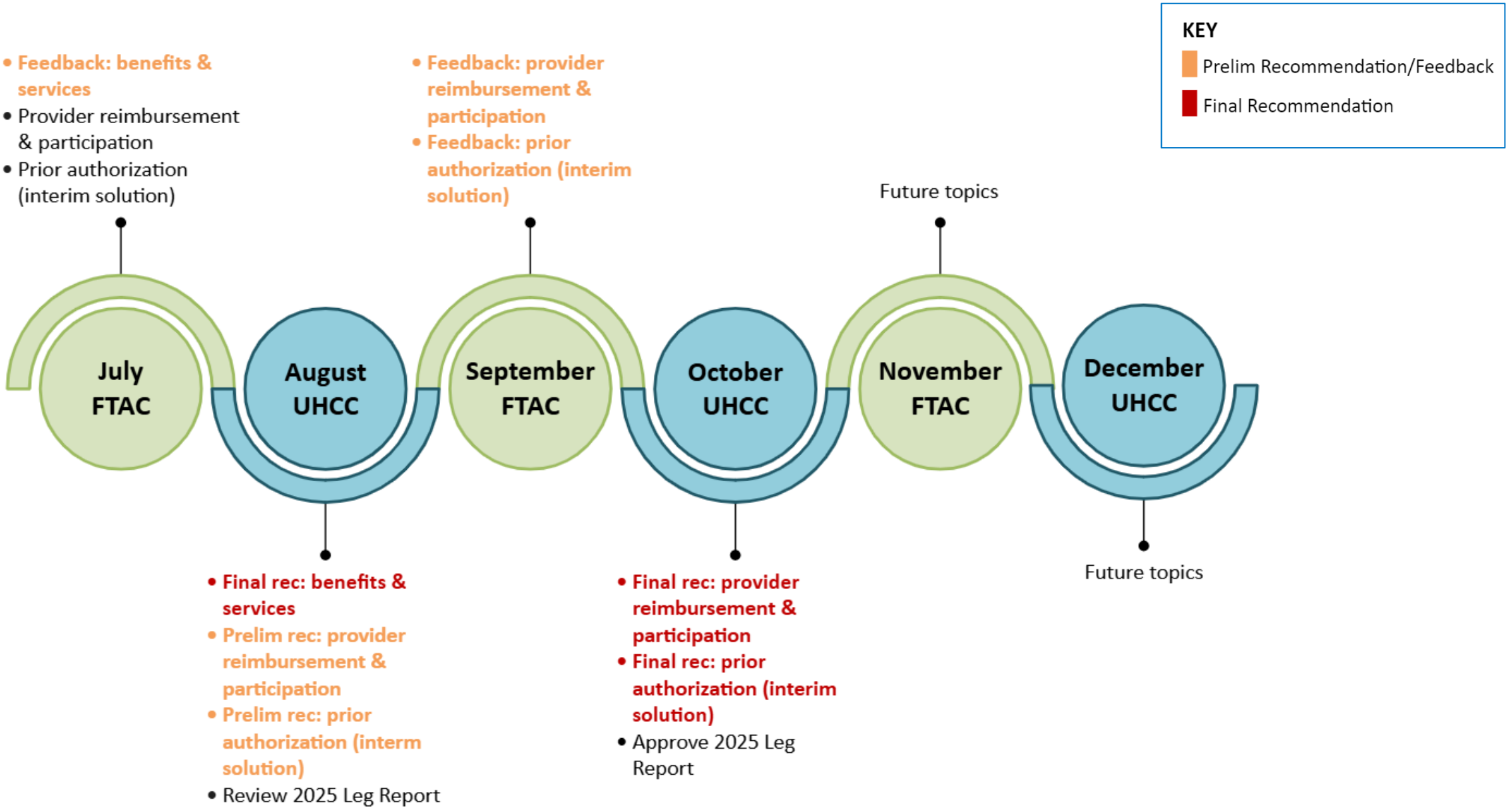
2025 Workplan

Last updated: February 2025



2025 Workplan

Last updated: February 2025



Tab 6

Washington State Health Care Authority

Milliman

Affordability Analysis Reporting

Finance Technical Advisory Committee: Universal Health Care System Design

Cost of care for select populations under existing benefit designs

Ben Diederich, FSA, MAAA
Principal and Consulting Actuary

Mark Franklin, ASA, MAAA
Associate Actuary

Peter Hallum, ASA, MAAA
Consulting Actuary

Menko Ypma, ASA, MAAA
Associate Actuary

March 13, 2025

Milliman

Background

- Purpose of this analysis
  - Model the cost impacts of providing selected benefit packages to an identified population
  - Results of this modeling are a starting point for discussion of benefits and services that could be included in a universal design
- The scenarios modeled ***are not*** proposals or recommendations that have been endorsed by FTAC or the Universal Health Care Commission

Milliman Affordability Analysis

Agenda (Table of contents)

- Disclaimer, background, and assumptions (2 slides)
- Results for the Identified Population (3 slides)
- Cost sharing and Identified Population (3 slides)
- Results for the alternative Identified Population (2 slides)
- Approach and methodology (4 slides)
- Sensitivity tests and further considerations (1 slide)
- Closing and questions

Please hold questions until the end of the presentation.

Disclaimer and background

(2 slides)

Milliman Affordability Analysis

Disclaimer

This presentation, the report, and report brief were drafted by Milliman, on behalf of the Washington State Health Care Authority (HCA), and for the Finance Technical Advisory Committee (FTAC). FTAC supports the Universal Health Care Commission by providing technical guidance and options related to a potential universal health care system's design.

The results discussed in this presentation and the associated reports are not intended to determine or suggest any specific policy action or final program structure or design, and persons should consult qualified professionals before taking specific actions. The reports' authors are not advocating for the benefit structures, enrollment eligibility, provider reimbursement rates, or other elements of the underlying assumptions, and the authors have not examined the feasibility of the benefit designs. The reports' authors do not intend to benefit or create a legal duty to any third-party recipient of this work.

The modeled scenarios are intended to provide the spectrum of costs associated with select benefit and cost sharing structures (i.e., examples), but are not intended to represent a final benefit structure in a universal health care system. These results are not a projection of future cost of care.

Milliman Affordability Analysis

Background and assumptions

The reports' authors estimate the impact to historical cost of care for an Identified Population under select benefit scenarios. Key assumptions were either directed by FTAC, FTAC liaisons, and HCA; or confirmed by HCA and FTAC liaisons when developed by the authors.

Key assumptions include:

- Which populations would be included (e.g., the inclusion or exclusion of "other" fully insured group plans[1]) in the "Identified Population"
- What example benefit and cost sharing structures define the three scenarios presented in the report
- Assumed reimbursement rates for medical services and prescription drugs
- Reasonable ranges of variation from our assumptions and, where necessary, information from data sources (i.e., the sensitivity tests)
- Exclusion of administrative costs (i.e., only the cost of care is estimated)

The reports' authors did not project results into the future. These are cost of care estimates of the selected CY23 population enrolling in a plan with the benefit structures and related assumptions that define the three scenarios.

1. The Identified Population includes state government, local government, and religious organization plans but excludes other fully insured commercial group health plans. Alternative Identified Population results presented today also includes the "other" fully insured commercial group health plans.

Modeling results

(4 slides)

Milliman Affordability Analysis

Baseline Identified Population estimates - excludes “other” fully insured commercial health plans

Baseline CY23 metrics

The by-subpopulation baseline amounts are reported in the following table. These results are derived from research and estimates from benchmark populations and models. The baseline results reported below are compared to the modeled scenario results in the next slides.

Summary results (baseline or Identified Population)

Baseline / Scenario	Population	Patient Paid PMPM	Payer Paid PMPM[1]	Payer Paid per Year[1]
Total baseline (excl. other fully insured plans[2])	3,370,000	n/a	$403	$16.3 billion
State program costs	2,530,000	n/a	n/a	$13.6 billion
Medicaid	1,970,000	$0	$408	$9.6 billion
PEBB & SEBB	560,000	$78 (approx.)	$591	$4.0 billion
Other populations[2,3]	840,000	n/a	n/a	$2.7 billion

1. Payer refers to the organization providing medical insurance to the covered population. This is not the patient, who may be responsible for all or a portion of medical services. Paid is the cost paid for by the payer, not the patient. Includes dental costs for the Medicaid, PEBB, and SEBB populations, but are not included for other subpopulations, as those costs were not available.
2. Includes individual, uninsured and local government and religious organization group plans. Excludes other fully insured commercial health plans.
3. A portion of individual insurance premiums are paid for by the state via the Washington State Premium Assistance Program. These premium payments would cover some of the costs reported in this line. In the biennial 2024 - 2025 Washington State budget $100 million was funded to cover individual market premiums through the Washington State Premium Assistance Program.

Milliman Affordability Analysis

Scenario results - excludes “other” fully insured commercial health plans

Scenarios and benefits:

Scenario benefit details	Scenario 1 – Medicaid	Scenario 2 – PEBB Classic	Scenario 3 – Cascade Silver
Scenario Actuarial Value[1]	100% Actuarial Value (AV)	87% AV (100% AV for Medicaid)	68% AV (100% AV for Medicaid)

Summary results (*excludes* other fully insured commercial health plans)

Baseline costs include Medicaid, uninsured, individual, PEBB, SEBB, local government, and religious organization subpopulations.

Baseline / Scenario	Population	Allowed Cost	Patient Paid	Payer Paid[1]
Total baseline	3,370,000 (1,400,000 non-Medicaid)	**$18.0 billion**	**$1.7 billion**	**$16.3 billion**
		$444 PMPM (all persons)	n/a	$403 PMPM (all persons)
Sc. 1 – Medicaid-like benefits	3,370,000 (1,310,000 non-Medicaid)[3]	**$20.2 - $23.7 billion**	**$0.0 billion**	**$20.2 - $23.7 billion**
		$500 - $586 PMPM (all persons)	$0 PMPM (non-Medicaid)	$500 - $586 PMPM (all persons)
Sc. 2 – PEBB UMP Classic	3,370,000 (1,310,000 non-Medicaid)[3]	**$18.3 - $21.4 billion**	**$1.0 - $1.1 billion**	**$17.3 - $20.3 billion**
		$452 - $530 PMPM (all persons)	$64 - $72 PMPM (non-Medicaid)	$427 - $502 PMPM (all persons)
Sc. 3 – Cascade Select (HBE silver metal plan)	3,370,000 (1,310,000 non-Medicaid)[3]	**$17.6 - $20.6 billion**	**$2.3 - $2.5 billion**	**$15.2 - $18.1 billion**
		$434 - $510 PMPM (all persons)	$146 - $161 PMPM (non-Medicaid)	$377 - $447 PMPM (all persons)

1. Payer refers to the organization providing medical insurance to the covered population. This is not the patient, who may be responsible for all or a portion of medical services. Paid is the cost paid for by the payer, not the patient.
2. Range of estimates reported by scenario reflect reasonable variation from the starting assumptions. This is not a limit of possible outcomes should the assumptions not reflect plan designs or other underlying parameters of any eventual health care system.
3. The uninsured population with income less than 138% FPL is grouped with the Medicaid population in the scenario results.

Milliman Affordability Analysis

Scenario results - excludes “other” fully insured commercial health plans

Scenarios and benefits:

Scenario benefit details	Scenario 1 – Medicaid	Scenario 2 – PEBB Classic	Scenario 3 – Cascade Silver
Scenario Actuarial Value[1]	100% Actuarial Value (AV)	87% AV (100% AV for Medicaid)	68% AV (100% AV for Medicaid)

Summary results (*excludes* other fully insured commercial health plans)

Reduced cost sharing for patients increases payer paid costs. Covering the uninsured population increases total and payer paid costs further.

Baseline / Scenario	Population	Allowed Cost	Patient Paid	Payer Paid[1]
Total baseline	3,370,000 (1,400,000 non-Medicaid)	**$18.0 billion**	**$1.7 billion**	**$16.3 billion**
		$444 PMPM (all persons)	n/a	$403 PMPM (all persons)
Sc. 1 – Medicaid-like benefits	3,370,000 (1,310,000 non-Medicaid)[3]	**$20.2 - $23.7 billion**	**$0.0 billion**	**$20.2 - $23.7 billion**
		$500 - $586 PMPM (all persons)	$0 PMPM (non-Medicaid)	$500 - $586 PMPM (all persons)
Sc. 2 – PEBB UMP Classic	3,370,000 (1,310,000 non-Medicaid)[3]	**$18.3 - $21.4 billion**	**$1.0 - $1.1 billion**	**$17.3 - $20.3 billion**
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		$434 - $510 PMPM (all persons)	$146 - $161 PMPM (non-Medicaid)	$377 - $447 PMPM (all persons)

1. Payer refers to the organization providing medical insurance to the covered population. This is not the patient, who may be responsible for all or a portion of medical services. Paid is the cost paid for by the payer, not the patient.
2. Range of estimates reported by scenario reflect reasonable variation from the starting assumptions. This is not a limit of possible outcomes should the assumptions not reflect plan designs or other underlying parameters of any eventual health care system.
3. The uninsured population with income less than 138% FPL is grouped with the Medicaid population in the scenario results.

Milliman Affordability Analysis

Scenario results - excludes “other” fully insured commercial health plans

Scenarios and benefits:

Scenario benefit details	Scenario 1 – Medicaid	Scenario 2 – PEBB Classic	Scenario 3 – Cascade Silver
Scenario Actuarial Value[1]	100% Actuarial Value (AV)	87% AV (100% AV for Medicaid)	68% AV (100% AV for Medicaid)

Summary results (*excludes* other fully insured commercial health plans)

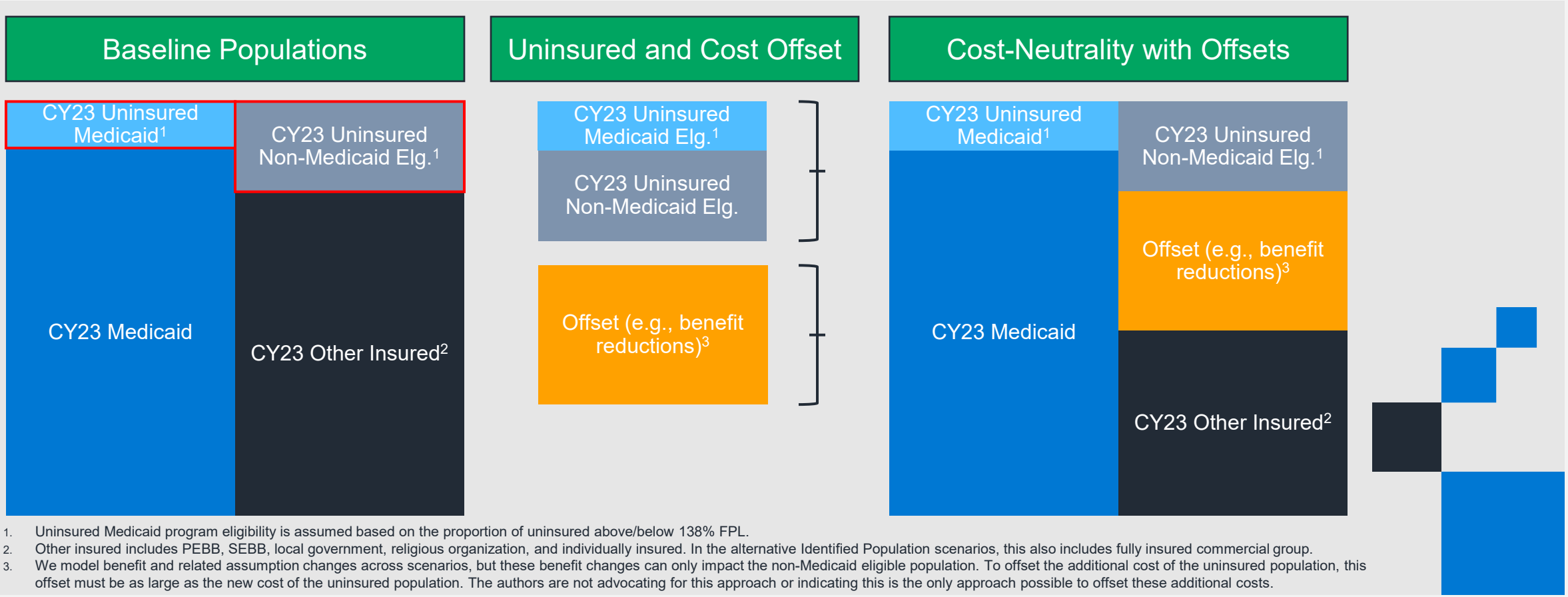
Plan costs decrease as patient costs increase, approximately offsetting the cost of the formerly uninsured in Scenario 3.

Baseline / Scenario	Population	Allowed Cost	Patient Paid	Payer Paid[1]
Total baseline	3,370,000 (1,400,000 non-Medicaid)	**$18.0 billion**	**$1.7 billion**	**$16.3 billion**
		$444 PMPM (all persons)	n/a	$403 PMPM (all persons)
Sc. 1 – Medicaid-like benefits	3,370,000 (1,310,000 non-Medicaid)[3]	**$20.2 - $23.7 billion**	**$0.0 billion**	**$20.2 - $23.7 billion**
		$500 - $586 PMPM (all persons)	$0 PMPM (non-Medicaid)	$500 - $586 PMPM (all persons)
Sc. 2 – PEBB UMP Classic	3,370,000 (1,310,000 non-Medicaid)[3]	**$18.3 - $21.4 billion**	**$1.0 - $1.1 billion**	**$17.3 - $20.3 billion**
		$452 - $530 PMPM (all persons)	$64 - $72 PMPM (non-Medicaid)	$427 - $502 PMPM (all persons)
Sc. 3 – Cascade Select (HBE silver metal plan)	3,370,000 (1,310,000 non-Medicaid)[3]	**$17.6 - $20.6 billion**	**$2.3 - $2.5 billion**	**$15.2 - $18.1 billion**
		$434 - $510 PMPM (all persons)	$146 - $161 PMPM (non-Medicaid)	$377 - $447 PMPM (all persons)

1. Payer refers to the organization providing medical insurance to the covered population. This is not the patient, who may be responsible for all or a portion of medical services. Paid is the cost paid for by the payer, not the patient.
2. Range of estimates reported by scenario reflect reasonable variation from the starting assumptions. This is not a limit of possible outcomes should the assumptions not reflect plan designs or other underlying parameters of any eventual health care system. It includes the impacts of varying reimbursement rates by +/-5% and utilization by +/-3%.
3. The uninsured population with income less than 138% FPL is grouped with the Medicaid population in the scenario results.

Milliman Affordability Analysis

Scenario results - explanation of results (not to scale)



1. Uninsured Medicaid program eligibility is assumed based on the proportion of uninsured above/below 138% FPL.
2. Other insured includes PEBB, SEBB, local government, religious organization, and individually insured. In the alternative Identified Population scenarios, this also includes fully insured commercial group.
3. We model benefit and related assumption changes across scenarios, but these benefit changes can only impact the non-Medicaid eligible population. To offset the additional cost of the uninsured population, this offset must be as large as the new cost of the uninsured population. The authors are not advocating for this approach or indicating this is the only approach possible to offset these additional costs.

Cost sharing and Identified Population

(3 slides)

Milliman Affordability Analysis

Populations and costs sharing

Scenarios and benefits:

Scenario benefit details	Scenario 1 – Medicaid	Scenario 2 – PEBB Classic	Scenario 3 – Cascade Silver
Scenario Actuarial Value[1]	100% Actuarial Value (AV)	87% AV (100% AV for Medicaid)	68% AV (100% AV for Medicaid)
Maximum Out-of-Pocket (individual)	$0	$2,000 medical $2,000 Rx (separate)	$8,500 (total)
Assumed medical management	Limited (FFS-like)	Moderate (PPO-like)	Moderate (PPO-like)

Additional benefit details:

- Medicaid benefits included in this presentation and the associated reports do not include LTSS
- PEBB UMP Classic and Cascade Silver benefits are broadly similar but have different cost sharing
- Cascade Silver benefits in the individual market include income-linked cost sharing reductions (CSRs); the estimates in this presentation and the associated reports exclude CSRs
- Dental services are included in all scenarios
  - Medicaid like for the Medicaid eligible population (and for all populations in Scenario 1)
  - PEBB like for the non-Medicaid population
- Some simplifications in modeling due to limited data (e.g., prescription drug formulary)

1. Inclusive of drugs, dental, and all other modeled benefits (e.g., excludes Medicaid LTSS). Reported AV excludes Medicaid eligible subpopulation unless otherwise noted.

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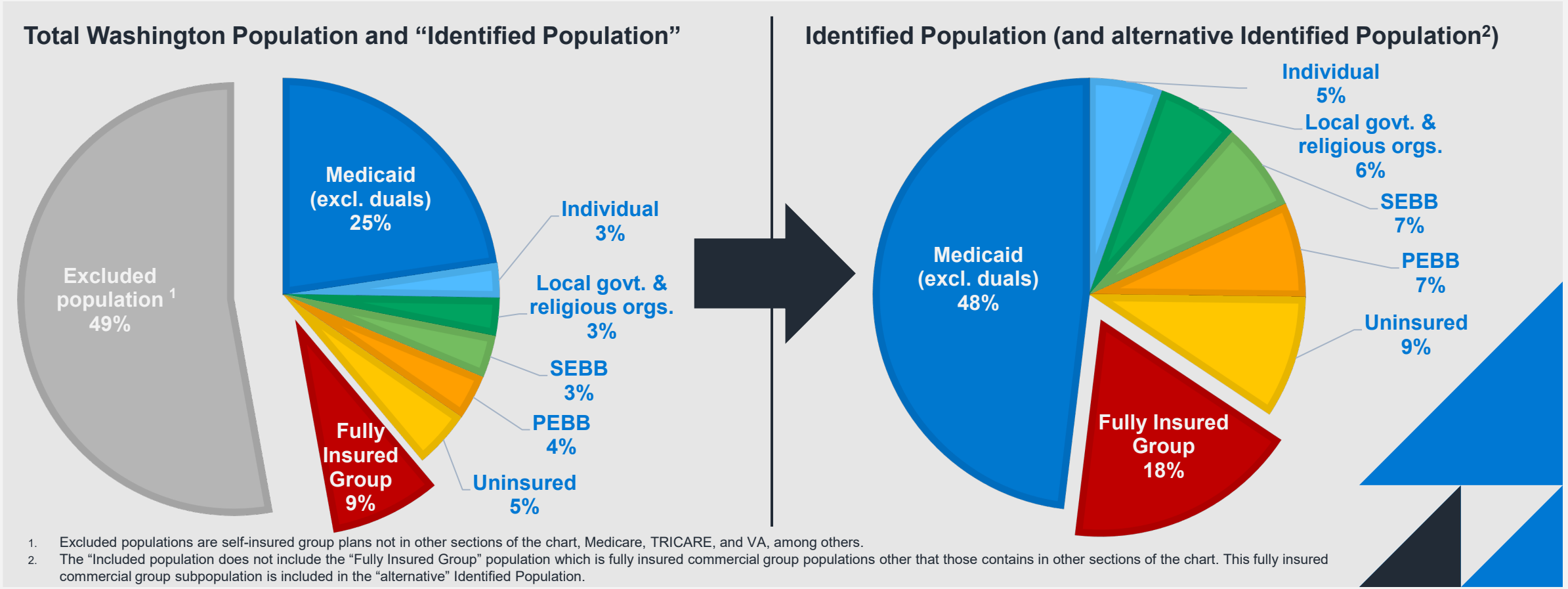
Populations included and excluded



1. Excluded populations are self-insured group plans not in other sections of the chart, Medicare, TRICARE, and VA, among others.
2. The "Included population does not include the "Fully Insured Group" population which is fully insured commercial group populations other that those contains in other sections of the chart. This fully insured commercial group subpopulation is included in the "alternative" Identified Population.

Milliman Affordability Analysis

Populations and costs sharing

This analysis includes the following scenarios (and associated sensitivity tests[1])

Enrollee Market Populations	Scenario 1 – Medicaid	Scenario 2 – PEBB Classic[2]	Scenario 3 – Cascade Silver
State & school district employees (PEBB & SEBB)	Medicaid-like (No Cost Sharing)	PEBB Classic (approx. 87% AV)	Silver Plan Benefits (approx. 70% AV)
Local governments and religious organizations	Medicaid-like (No Cost Sharing)	PEBB Classic (approx. 87% AV)	Silver Plan Benefits (approx. 70% AV)
Individual market (on & off HBE)	Medicaid-like (No Cost Sharing)	PEBB Classic (approx. 87% AV)	Silver Plan Benefits (approx. 70% AV)
Uninsured with income above 138% FPL[3]	Medicaid-like (No Cost Sharing)	PEBB Classic (approx. 87% AV)	Silver Plan Benefits (approx. 70% AV)
Uninsured with income below 138% FPL[3]	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)
Medicaid (excludes dual enrolled)	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)	Medicaid-like (No Cost Sharing)
Fully insured health plans[4]	EXCLUDED / Medicaid-like (No Cost Sharing)	EXCLUDED / PEBB Classic (approx. 87% AV)	EXCLUDED / Silver Plan Benefits (approx. 70% AV)
Self-insured health plans	EXCLUDED		
Federal Employees	EXCLUDED		
Veterans Admin & TRICARE	EXCLUDED		
Medicare	EXCLUDED		

1. For example, testing the impacts associated with increasing or decreasing assumed provider reimbursement rates by 5%.
2. PEBB Classic benefits are similar to SEBB Achieve 2.
3. Note that other Medicaid eligibility criteria exist, but were not used here to determine the estimate of Medicaid enrolled from the uninsured population.
4. Fully insured health plans, except state and local government and religious organization, are excluded from the baseline scenario results but included in the sensitivity test presented today.

Modeling results
(alternative Identified Population)

(2 slides)

Milliman Affordability Analysis

Baseline and alternative Identified Population estimates - includes “other” fully insured commercial health plans

Baseline CY23 metrics

The by-subpopulation baseline amounts are reported in the following table. These results are derived from research and estimates from benchmark populations and models. The baseline results reported below are compared to the modeled scenario results in the next slides.

Summary results (baseline and alternative Identified Population inclusive of fully insured)

Baseline / Scenario	Population	Patient Paid PMPM	Payer Paid PMPM[1]	Payer Paid per Year[1]
Total baseline (excl. other fully insured plans[2])	3,370,000	n/a	$403	$16.3 billion
State program costs	2,530,000	n/a	n/a	$13.6 billion
Medicaid	1,970,000	$0	$408	$9.6 billion
PEBB & SEBB	560,000	$78 (approx.)	$591	$4.0 billion
Other populations[2,3]	840,000	n/a	n/a	$2.7 billion
Total baseline (incl. fully insured health plans)	4,090,000	n/a	$407	$20.0 billion
Other fully insured commercial group plans[4]	720,000	$110 (approx.)	$425	$3.7 billion

1. Payer refers to the organization providing medical insurance to the covered population. This is not the patient, who may be responsible for all or a portion of medical services. Paid is the cost paid for by the payer, not the patient. Includes dental costs for the Medicaid, PEBB, and SEBB populations, but are not included for other subpopulations, as those costs were not available.
2. Includes individual, uninsured and local government and religious organization group plans. Excludes other fully insured commercial health plans.
3. A portion of individual insurance premiums are paid for by the state via the Washington State Premium Assistance Program. These premium payments would cover some of the costs reported in this line. In the biennial 2024 - 2025 Washington State budget $100 million was funded to cover individual market premiums through the Washington State Premium Assistance Program.
4. Additional enrollment relative over that included in the “other populations” row.

Milliman Affordability Analysis

Scenario results - includes “other” fully insured commercial health plans

Scenarios and benefits:

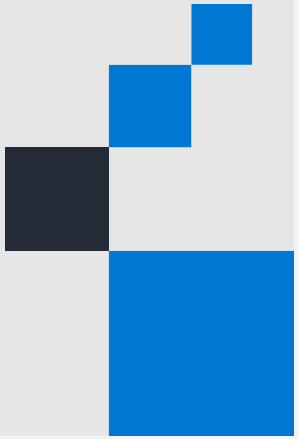
Scenario benefit details	Scenario 1 – Medicaid	Scenario 2 – PEBB Classic	Scenario 3 – Cascade Silver
Scenario Actuarial Value[1]	100% Actuarial Value (AV)	87% AV (100% AV for Medicaid)	68% AV (100% AV for Medicaid)

Summary results (*includes* other fully insured commercial health plans)

These results add approximately 720,000 additional individual enrolled in fully insured health plans. This increases both the baseline and the scenarios’ results.

Baseline / Scenario	Population	Allowed Cost	Patient Paid	Payer Paid[1]
Total baseline	4,090,000 (2,120,000 non-Medicaid)	**$22.6 billion**	**$2.6 billion**	**$20.0 billion**
		$460 PMPM (all persons)	n/a	$407 PMPM (all persons)
Sc. 1 – Medicaid-like benefits	4,090,000 (2,030,000 non-Medicaid)[3]	**$26.5 - $31.0 billion**	**$0.0 billion**	**$26.5 - $31.0 billion**
		$539 - $633 PMPM (all persons)	$0 PMPM (non-Medicaid)	$539 - $633 PMPM (all persons)
Sc. 2 – PEBB Classic	4,090,000 (2,030,000 non-Medicaid)	**$23.4 - $27.5 billion**	**$1.6 - $1.8 billion**	**$21.8 - $25.7 billion**
		$477 - $560 PMPM (all persons)	$65 - $73 PMPM (non-Medicaid)	$445 - $523 PMPM (all persons)
Sc. 3 – Cascade Select (HBE silver metal plan)	4,090,000 (2,030,000 non-Medicaid)	**$22.3 - $26.2 billion**	**$3.5 - $3.9 billion**	**$18.7 - $22.3 billion**
		$454 - $533 PMPM (all persons)	$145 - $160 PMPM (non-Medicaid)	$382 - $454 PMPM (all persons)

1. Payer refers to the organization providing medical insurance to the covered population. This is not the patient, who may be responsible for all or a portion of medical services. Paid is the cost paid for by the payer, not the patient.
2. Range of estimates reported by scenario reflect reasonable variation from the starting assumptions. This is not a limit of possible outcomes should the assumptions not reflect plan designs or other underlying parameters of any eventual health care system. It includes the impacts of varying reimbursement rates by +/-5% and utilization by +/-3%.
3. The uninsured population with income less than 138% FPL is grouped with the Medicaid population in the scenario results.



Approach and methodology

(4 slides)

Milliman Affordability Analysis

Data collection, reconciliation, modeling, and reporting approach

Data Collection

Collect data from:
1. FTAC, HCA, etc.
2. Public sources
3. Proprietary data

Develop assumptions:
1. Impacts of induced utilization
2. Baseline and estimated medical management
3. Payment-neutral reimbursement rates for medical services, prescription drugs, and dental.

Reconciliation

Where multiple data sources or assumptions overlap, the reports' authors attempt to reconcile them. Apparent discrepancies are often resolved via adjustments.

For example, OIC[1] reporting of and HCA data including Medicaid enrollment differed substantially due to the reporting period included.

Modeling

Reconciled data and assumptions were fed into Milliman models.

These models:
- Estimate impact of changing benefit structures and cost sharing for the included population, and
- Combine by-population estimates into a composite result

Reporting

The results summarized in this presentation are detailed in two papers:
- A short form briefing paper, and
- A detailed long form report, which includes detailed appendices of data sources, results, and assumptions.

Both reports are available as part of the FTAC meeting materials and are titled:

Finance Technical Advisory Committee: Universal Health Care System Design
Cost of care for select populations under existing benefit designs

The briefing paper includes the high-level results discussed in this presentation. The detailed report should be reviewed for a more complete understanding of the summary results and the variability of the estimates. The detailed report is also intended to provide sufficient information for the reader to recreate the results,[2] understand the data sources and evaluate the appropriateness of the authors' assumptions and methodology.

The contents of this presentation should not be interpreted as complete without the companion reports or the associated oral commentary

1. Washington State Office of the Insurance Commissioner
2. Note that some underlying data sources are not publicly available (e.g., information about historical PEBB and SEBB spending and reimbursement rates or other proprietary datasets). To the extent possible, the authors of the report have attempted to use publicly available information (with cross-referencing and validation using alternative or non-public data sources).

Milliman Affordability Analysis

Methodology steps

1. **Researched or estimated the following CY23 parameters for each subpopulation within the Identified Population (Medicare enrolled, uninsured, etc.)**

A. Enrollment	B. Cost of Care	C. Reimbursement Rates
Total average annual enrollment for each subpopulation.[1]	The historical costs of medical, prescription drug, dental, and other benefit costs for each subpopulation. This includes payment detail by payer[2] and patient obligation. Excludes administrative costs.	Estimated as a percent of Medicare for most medical services, average wholesale price for drugs, and relative to PEBB and SEBB rates for other non-Medicare covered services (e.g., dental).

1. Total average enrollment is calculated by counting the total member months within a year and dividing by 12. This is less than the count of total unique enrollees as some individuals will be enrolled for less than 12 months.
2. Payer refers to the organization providing medical insurance to the covered population. This is not the patient, who may be responsible for all or a portion of medical services. Paid is the cost paid for by the payer, not the patient.

Milliman Affordability Analysis

Methodology steps

2. Calculated a payment neutral reimbursement rate across all the Identified Population (by broad service category)

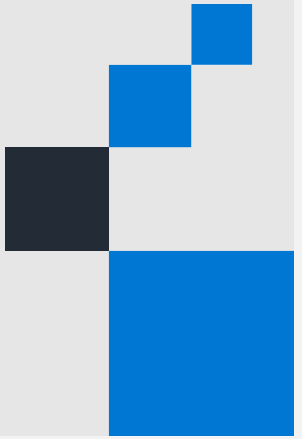
Subpopulation	Total Expenditures[1]	Estimated Percent of Medicare Allowed			Est. Pct. AWP[2]
		Inpatient Medical	Outpatient Medical	Professional and Ancillary	Prescription Drugs
Medicaid[3]	$9.1 billion	130%	77%	108%	24%
Uninsured	$0.7 billion	90%	85%	70%	52%
Individual	$1.6 billion	190%	220%	125%	39%
Local government and religious org.	$1.6 billion	224%	259%	147%	39%
PEBB	$2.3 billion	189%	232%	138%	39%
SEBB	$1.8 billion	189%	245%	151%	38%
Composite Reimbursement[4]	$17.0 billion	139%	126%	117%	31%

1. Estimated total expenditures from only included subpopulations. Actual calculation completed at a service category detail level. Table excludes expenditures for dental services.
2. Prescription drug estimated percent of Average Wholesale Price (AWP) is inclusive of savings due to drug rebates.
3. Medicaid reimbursement is inclusive of state-directed payments, GME, and other non-claim-based payments.
4. Composite reimbursement based on historical enrollment and utilization rates by major service category.

Milliman Affordability Analysis

Methodology steps

3. **Calculate by-scenario results at a detailed level modeling:**
    A. The selected benefit and cost sharing scenarios
        i. Medicaid benefits and cost sharing are held constant for the Medicaid enrolled and eligible populations
        ii. Other populations subject to the various scenario benefits and cost sharing
        iii. Dental is modeled as covered for all populations in all three scenarios
    B. Estimate ancillary impacts of scenarios (e.g., utilization impacts, medical management assumptions, population shifts, etc.)
4. **Calculate the composite results by combining the results of each subpopulation**
5. **Perform sensitivity tests of results by varying starting assumptions**



Sensitivity tests and further considerations

(1 slide)

Milliman Affordability Analysis

Sensitivity tests and further considerations

Sensitivity tests and other further considerations discussed in the reports

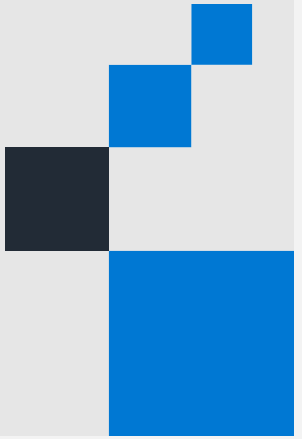
Sensitivity tests
1. Provider reimbursement rates
2. Prescription drug reimbursement rates
3. Alternative Identified Population[1]
4. Medicaid-eligible enrollment[2]
5. Medical management[2]
6. Other variation in utilization rates

Further considerations
Administrative costs are excluded
Practical reimbursement rates
Health insurance market externalities
Population changes, pent-up demand
Program funding
Limitations of data and modeling

Further considerations are not modeled

The impact of these further considerations has not been modeled. These represent an incomplete list of items that were raised during the modeling process but set aside as outside the scope of the analysis. Other important considerations exist, some of which will arise in possible next steps including planning, engagement with stakeholders, etc.

1. The alternative results of this sensitivity test are those that are reported as the "includes fully insured plans" results in this presentation (i.e., the alternative Identified Population), and the reported ranges in results reflects the other sensitivity tests 1, 2, and 6.
2. The variance associated with sensitivity tests 4 and 5 are not included as part of the range of variation of the results included in this presentation.



Thank you

Complete report available at:
https://www.milliman.com/en/insight/universal-health-care-system-population-benefit-scenarios

Ben Diederich
ben.diederich@milliman.com

Mark Franklin
mark.franklin@milliman.com

Menko Ypma
menko.ypma@milliman.com

Peter Hallum
peter.hallum@milliman.com

MILLIMAN REPORT BRIEF

Finance Technical Advisory Committee: Universal Health Care System Design

Cost of care for select populations under existing benefit designs (brief)

Commissioned by Washington State Health Care Authority

Ben Diederich, FSA, MAAA
Mark Franklin, ASA, MAAA
Menko Ypma, ASA, MAAA
Peter Hallum, ASA, MAAA

Milliman

Estimating the cost of care for a potential universal health care system design in the state of Washington.

This report brief summarizes the results, methodology, limitations, and considerations found in the associated report also called, "Finance Technical Advisory Committee: Universal Health Care System Design," available at this link. This companion report provides additional and necessary detail, context, and considerations that should be reviewed for a more complete understanding of the summary results presented here.

The report and report brief were drafted by Milliman, on behalf of the Washington State Health Care Authority (HCA), and for the Finance Technical Advisory Committee (FTAC). FTAC supports the Universal Health Care Commission by providing technical guidance and options related to a potential universal health care system's design.

The report and report brief are not intended to determine or suggest any specific policy action or final program structure or design, and persons should consult qualified professionals before taking specific actions. We are not advocating for the benefit structures, enrollment eligibility, provider reimbursement rates, or other elements of the underlying assumptions, and we have not examined the feasibility of the benefit designs. Additionally, we do not intend to benefit or create a legal duty to any third-party recipient of this work.

Cost of care estimates

We have estimated the calendar year 2023 (CY23) cost of care for a potential population to be included in a universal health care system (hereafter referred to as the Identified Population). The costs are estimated under three benefit scenarios[1] and are compared to the estimated baseline cost of care[2] for the Identified Population. These estimates include the costs of medical services, prescription drugs, and dental care, but exclude the substantial administrative costs that would be associated with the management of the Identified Population. The term "payer" is used to refer to the health insurer (i.e., not the patient who may be responsible for a portion of the cost of care).

Per the FTAC, the following populations are included as the Identified Population (restricted to individuals not enrolled in Medicare who are less than 65 years of age):

- Medicaid enrolled (excluding duals);
- Persons covered by the state government's Public Employees Benefit Board (PEBB) or School Employees Benefit Board (SEBB) health plans;
- Persons covered by individual, local government, or religious organization health plans; and
- Uninsured persons.

In total, this is approximately 3.4 million individuals.

In addition to these groups, but presented as a separate sensitivity test, we estimated the cost of including persons enrolled in fully insured group health plans not included in the above list. This sensitivity test of an alternative Identified Population is found below.

At the direction of HCA and FTAC, we have modeled three benefit and cost sharing scenarios:

1. A Medicaid-like health plan (i.e., no patient cost sharing),
2. A PEBB Classic health plan-like structure, and
3. A Cascade Silver-like structure (i.e., essential health benefits with approximately 70% actuarial value / 30% patient pay on average).

The costs were modeled based on CY23 included populations, where provider reimbursement was estimated at rates that would be neutral for each of the inpatient, outpatient, and professional service categories, and in total. Medicaid long-term services and support (LTSS) were excluded.

[1] The three benefit scenarios are selected from existing plan designs in the health insurance market and do not represent plan designs that are ultimately intended for any future universal health care system. Instead, these several plan designs provide a wide spectrum of benefits and cost sharing to help the reader understand the interplay among benefits, cost sharing, and expected payer costs.

[2] The baseline cost of care is an estimate of CY23 costs for the Identified Population (or alternative Identified Population), inclusive of subpopulations of the Identified Population that are not presently paid for by the State (e.g., costs covered by individual plans). These are provided for comparison to the expected costs under the several benefit scenarios provided for a universal health care system.

Under the first scenario, all persons would be eligible for the Medicaid benefit. Under the second and third scenarios, CY23 Medicaid enrolled individuals would continue to have a Medicaid benefit, but all others would have the benefits in each scenario's description. Prescription drug and dental costs are estimated at current Medicaid costs for the Medicaid population and PEBB- and SEBB-like rates for the non-Medicaid population.

FIGURE 1: ESTIMATED CY23 PLAN PAID[A] – IDENTIFIED POPULATION

BASELINE/SCENARIO BENFITS AND COST SHARING	PAYER PAID PMPM[B,C]	TOTAL ANNUAL PAYER PAID
Total State program costs		$13.6 billion
Medicaid[D]	$408	$9.6 billion
PEBB[E]	$628	$2.2 billion
SEBB[E]	$551	$1.8 billion
Non-state program costs[F,G]		$2.7 billion
Total baseline costs		$16.3 billion
Sc. 1: Medicaid-like	$500 - $586	$20.2 - $23.7 billion
Sc. 2: PEBB-like	$427 - $502	$17.3 - $20.3 billion
Sc. 3: Cascade Silver-like	$377 - $447	$15.2 - $18.1 billion

(A) Totals include medical, pharmacy, and dental costs paid for by the plans (i.e., exclude patient paid cost of care), and exclude non-benefit expenses. Dental costs are not included in the non-state program cost baseline amount as those costs were not available for these populations.
(B) Per member per month
(C) Baseline payer paid amounts (e.g., Medicaid) are not directly comparable to the scenarios' ranges. The scenarios ranges are a composite of all baseline populations and individual subpopulations scenario results, like Medicaid, may have increased or decreased relative to the baseline.
(D) Costs are inclusive of both State and federal funding and based on CY23 reimbursement rates (i.e., exclude substantial payment rate changes since CY23).
(E) Note that these totals may include some coordination of benefit payments made by other payers which are not part of a state program.
(F) Includes local government, religious organization, and individual health plans and the uninsured.
(G) A portion of individual insurance premiums are paid for by the state via the Washington State Premium Assistance Program. These premium payments cover some of the costs reported in this line. In the biennial 2024 - 2025 Washington State budget $100 million was funded to cover individual market premiums through this program.

The results in Figure 1 are based on a total population of 3.4 million persons from the groups listed above.

Variability, limitations, and further considerations

FULLY INSURED GROUP HEALTH PLANS

Based on guidance from HCA, we understand all fully insured commercial group health plans may be included in an alternative Identified Population. In such a case, the Identified Population and associated baseline total costs increase, and so do the estimated costs of the several scenarios. Figure 2 reports the results of this larger alternative Identified Population of 4.1 million persons.

FIGURE 2: EST. CY23 PLAN PAID – ALTERNATIVE IDENTIFIED POP.[A]

BASELINE/SCENARIO BENFITS AND COST SHARING	PAYER PAID PMPM	TOTAL ANNUAL PAYER PAID
Total State program costs		$13.6 billion
Medicaid	$408	$9.6 billion
PEBB	$628	$2.2 billion
SEBB	$551	$1.8 billion
Non-State program costs[B]		$6.3 billion
Total baseline costs		$20.0 billion
Sc. 1: Medicaid-like	$539 - $633	$26.5 - $31.0 billion
Sc. 2: PEBB-like	$445 - $523	$21.8 - $25.7 billion
Sc. 3: Cascade Silver-like	$382 - $454	$18.7 - $22.3 billion

(A) See notes associated with Figure 1.
(B) Includes fully insured commercial, local government, religious organization, and individual health plans and the uninsured.

Because of the inclusion of the fully insured commercial group population, the payment neutral reimbursement rates for providers is higher in this sensitivity test than in the Figure 1 results reported above.

OTHER VARIABILITY AND ACCOMMODATIONS

Estimates of costs for the Identified Population have many sources of variability including, but not limited to:

- Errors or incomplete information in the data sources of population sizes and costs,
- Changes or inaccurate measurement of historical reimbursement rates,
- Changes in Medicaid eligibility status and enrollment rates,
- Administration and medical management practices, and
- Assumptions based on benchmark populations' health care utilization habits and their comparability to the actual Identified Population.[3]

We have attempted to account for these sources of variability in the ranges of results reported in the figures above. The specific sensitivity tests completed were:

- Increasing the uninsured population's estimated utilization and reimbursement rates by +25%,
- Varying medical service reimbursement rates by +/- 5%,
- Varying pharmacy discounted drug costs by +/- 5%,
- Testing lower rates of medical management (e.g., fee for service-like limited medical management),
- Modulating expected utilization rates by +/- 3%, and

[3] Because of limitations in the information available to us, we combined disparate data sources. We were not always able to reconcile differences between sources, and at times had to extrapolate using Milliman benchmark data. This approach results in some uncertainty in our estimates of actual baseline costs for the Identified Population. See the full report for more information regarding this limitation.

- Assuming higher and lower rates of Medicaid eligible enrollment (i.e., higher or lower rates of enrollment in the Identified Population of individuals eligible for zero cost sharing).

The ranges stated in Figures 1 and 2 do not include the full effects of all sensitivity tests simultaneously. While we believe the ranges cited are reasonable, results could fall outside those ranges should the assumptions be significantly more or less favorable than actual experience.

The results of these sensitivity tests and more detail about the methodology is available in the complete report.

VARIABILITY IN APPROACH AND ASSUMPTIONS

Because the estimates are subject to significant variability based on the starting assumptions and methodology employed, similar analyses performed by other qualified individuals may yield meaningfully different estimates.

FURTHER CONSIDERATIONS

Certain important considerations associated with the design and implementation of a potential universal health care system were outside of the scope of this analysis. While not addressed in this document, these items are discussed in limited detail in the complete report:

- Administrative costs and structure;
- Detailed reimbursement for medical services, drugs, and dental;
- Impacts external to the design that affect the health insurance and provider markets within Washington State;
- Pent-up demand in the Identified Population; and
- Changes of benefit designs relative to baseline population benefits (e.g., the improvement or erosion of benefits for individuals transferring from one of the coverage types in the baseline to those in the scenarios).

Other material considerations exist and may be discovered as the Identified Population and potential designs are further analyzed, developed, and feedback is received from stakeholders.

THIS IS NOT A PROJECTION

These estimates are limited in scope. Critically, the estimates do not constitute a projection; they are the estimated costs of the Identified Population in CY23. This means they do not include estimated cost and utilization trends, or the associated increase in variability for such projections. Moreover, large and known reimbursement changes have occurred since CY23, including substantial increases in Medicaid payments for some hospital providers. Because of these limitations, and others, the estimates are not representative of an expected cost in CY25, the time of publication of this report brief, or any other period after CY23.

Methodology and data sources

METHODOLOGY

We completed the following steps to develop the results included in this report brief and the associated report:

1. Collected data and base assumptions for each subpopulation of the Identified Population including:
   a. Enrollment statistics by subpopulation;
   b. CY23 cost of medical care, including cost of care by service category where possible, prescription drugs, and dental services;
   c. Estimates of reimbursement rates for care, including provider reimbursement rates, drug costs, etc.; and
   d. Other necessary information (e.g., details of benefit structures, implied medical management, etc.).
2. Calculated estimates of aggregate payment-neutral reimbursement rates across the Identified Population. These estimates represent reimbursement rates that, if applied consistently across the population, would result in the same aggregate provider revenue in the baseline, before scenario-specific adjustments.
3. Estimated the utilization and costs for each of the included subpopulations under each scenario and sensitivity test:
   a. For the Medicaid subpopulation, we estimate the impact of the shift from the current reimbursement rates to the estimated payment-neutral rates.[4]
   b. For the uninsured subpopulation, we divide it into the portion of the subpopulation presumed eligible for Medicaid in CY23 and the remainder of the subpopulation. We use these segmented subpopulation estimates to re-weight the final scenario and sensitivity test results.
   c. For each of the other included subpopulations (PEBB, SEBB, local government and religious organization plans, and individually insured), we separately modeled the impacts of the scenarios and sensitivity tests.
4. Create composite scenario and sensitivity test results by weighting the by-subpopulation results, as described in (3).

DATA SOURCES

We relied on many sources of CY23 reporting and assumptions including but not limited to the following:

- Data provided by HCA for the purposes of this report;

[4] Note that because the Medicaid benefit was used for the Medicaid enrolled population in all three scenarios, except for the addition of the uninsured and sensitivity testing of results, this represents all the changes included in modeling of the Medicaid enrolled subpopulation's costs.

- Data published by the National Association of Insurance Commissioners, US Department of Labor, Washington State Office of the Insurance Commissioner, KFF, Centers for Medicare & Medicaid Services (CMS), among others;
- Benchmark data, models, and prior analyses developed by Milliman; and
- Similar analyses performed by other states.

Caveats

This report brief represents an abbreviated version of the report cited above. The complete report provides additional and necessary detail, context, and considerations that should be reviewed for a fuller understanding of the results presented here.

We have developed certain models to estimate the values included in this report. The intent of the models was to estimate the cost of care of several benefit and cost sharing scenarios for the Identified Population on a CY23 basis. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

In preparation of the analysis, we relied upon the accuracy of data and information gathered from or provided to us by CMS, data partners, and other organizations as cited in the report. We have not audited this information, although we have reviewed it for reasonableness. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete.

We have also relied on the data and other information provided by HCA, UHCC, and FTAC for this analysis. We have performed a limited review of this information and checked for reasonableness and consistency. We have not found material defects discrepancies in the data or information used other than those described in the report, which also describes how those defects and discrepancies were addressed to enable this analysis to be performed. If there are other material defects in the data or other information, 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 this assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Peter Hallum, Ben Diederich, Mark Franklin, and Menko Ypma are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

Milliman is among the world's largest providers of actuarial, risk management, and technology solutions. Our consulting and advanced analytics capabilities encompass healthcare, property & casualty insurance, life insurance and financial services, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Ben Diederich
ben.diederich@milliman.com

Mark Franklin
mark.franklin@milliman.com

Menko Ypma
menko.ypma@milliman.com

Peter Hallum
peter.hallum@milliman.com

Finance Technical Advisory Committee meeting

We are currently on a short break

Washington State Health Care Authority

Tab 7

Washington State Health Care Authority

Cost Containment Memo

- GOAL 1: Discuss/Amend/Adopt Cost Containment Principles.
- GOAL 2: Discuss/Amend/Adopt Cost Containment Category Framework.
- GOAL 3: FTAC recommends specific strategies from each category to include in design of health system with unified financing.
  - Which strategies are transitional?
  - Which need further consideration?

Washington State Health Care Authority

Memo discussion – GOAL 1

- GOAL 1: Discuss/Amend/Adopt Cost Containment Principles

MOTION TO ADOPT?

Washington State Health Care Authority

Memo discussion – GOAL 2

- GOAL 2: Discuss/Amend/Adopt Cost Containment Category Framework

MOTION TO ADOPT?

Washington State Health Care Authority

Memo discussion – GOAL 3

- GOAL 3: Determine whether to label specific strategies in each category as recommended for any eventual health system with unified financing,
  - Which strategies are transitional?
  - Which need further consideration?

MOTION TO ADOPT?

Washington State Health Care Authority

Next Steps – Cost Containment Memo

- Further revisions?
- Further strategies to review?
- Send to Universal Health Care Commission

TO: **Finance and Technical Advisory (FTAC) members**
FR: **Health Care Authority staff**
RE: **Draft Cost Containment Memo update**

The draft memo has been revised with input from FTAC members. The general structure of the memo has not changed.

In preparation for the meeting on Thursday, March 13th your assistance is requested with the following.

- Please read the revised draft cost containment memo and note new edits or recommendations to the **principles** and to the **framework of 4 categories** proposed for selecting strategies. FTAC will modify and decide whether to approve these during the meeting.

- Please **code** each specific strategy as explained in the memo. This approach will be discussed and reviewed during the meeting. HCA staff will ask you to return your coded strategies by email after the meeting and FTAC reaches consensus on this process.

- **The next step** (May FTAC) for this draft will include determining whether FTAC wants to provide further key considerations or details regarding the results of FTAC's coded strategies.

To: **Universal Health Care Commission**
Fr: **Finance Technical Advisory Committee**
RE: **Cost Containment Principles and Framework Memo**

Background

As part of its charge from the Legislature (see RCW 41.05.845), the Universal Health Care Commission (Commission) must prepare Washington state for a universal health care system with unified financing. One essential component of designing such a system is *cost containment*, as specified in the legislative directive and identified in the Commission's workplan.

In December 2024, the Commission asked its Finance Technical Advisory Committee (FTAC) to participate in identifying and examining cost containment strategies that support sustainable, universal health care coverage. This memo includes suggested principles for managing costs in a universal health care system. It also provides a model for identifying mechanisms that address cost containment in the interim and/or eventual universal health care system.

Cost Containment Principles

Principle 1 – Adoption of a comprehensive cost containment strategy is an essential prerequisite to prepare Washington state for a universal health care system with unified financing.

Principle 2 – Adopt transitional cost containment and affordability strategies while state policymakers consider options a universal health care system.

Principle 3 – Adopt evidence-based strategies that do not create barriers to care or disrupt the provision of necessary and high-quality care.

Principle 4 – Address health care cost with respect to patient access, quality of care, affordability, price of services, volume of services, and the cost of administration.

Principle 5 – Identify and focus on primary drivers of health care spending and spending growth, including actions to limit excessive provider price growth, the provision of unnecessary health services, and administrative waste and inefficiency.

Principle 6 – Utilize a variety of targeted cost containment strategies with flexibility to modify those interventions over time to address unintended consequences and/or improve cost containment success over time.

Principle 7 – Align and coordinate cost containment strategies with the work of the Health Care Cost Transparency Board. Adopt transitional and long-term strategies which help Washington meet its health care cost growth benchmarks.

Principle 8 – Emphasize the goal of improving the overall equity of Washington's health delivery system, including addressing payment equity and systemic inequities, reducing disparities in care quality and access, and other equity goals. Review final decisions with use of the Health Care Authority's health equity toolkit.

Cost Containment Framework

FTAC has grouped potential cost containment mechanisms into four categories, as outlined below. This outline is based on FTAC members' awareness of, and research about, strategies used by other states and countries to contain health care costs and slow cost growth. This framework is not meant to be exhaustive or prescriptive. Rather, FTAC offers this framework as a toolbox for the Commission and FTAC to organize and recommend flexible, comprehensive, evidence based, cost containment approaches, whether they may be transitional strategies or mechanisms which are appropriate for any unified health care system.

The 4 categories are:

Category 1 – Utilization modifiers

Category 2 – Price and Spending Control Regulation

Category 3 – Administrative and Market Oversight

Category 4 – Program Modification and Investment

FTAC members: Please code the strategies listed below in preparation for the meeting on 3/13/25 according to the following table:

Include in any unified system	Add to toolbox	Transitional only	Exclude
CODE – A	**CODE - B**	**CODE - C**	**CODE - D**
This strategy should be included as a permanent part of any universal system.	This strategy should be added to a toolbox to use as appropriate in transitional solutions or a unified system.	This strategy may only work as an interim or transitional solution.	Do not include this strategy in universal design or transitional solutions.

Category 1 – Utilization modifiers

Examples

- **Modification of payment incentives implicit in Fee-for-Service (FFS).** The predominant FFS payment systems contain strong financial incentives for providers to increase utilization unnecessarily. Where possible, Washington should develop payment models that either remove or neutralize the incentives of FFS payment that could encourage overuse of services.
- **Utilization management.** Standardize, evaluate, and reduce prior authorization through independent expert review. Utilization management must carefully balance potentially overzealous prior authorization criteria with the need to ensure that unnecessary or inappropriate services are not approved.
- **Case management.** Health systems strive to identify high risk and rising risk members, connect them with community health workers, care coordinators, and case managers to help them navigate the system and avoid acute events.

Category 2 – Price and Spending Control Regulation

Examples

- **Cost growth limits.** Many states, including Washington, now set targets for total health care expenditure growth and monitor or enforce these targets.
- **Alternative payment models and value-based purchasing.** Payment models that incentivize quality of care and reduction of overutilization may result in overall health system savings.
- **Pharmaceutical and medical device price negotiation.**
  State and national health systems may use consolidated approaches for purchasing services, devices and prescription drugs.[1] Consolidated purchasing strategies can benefit any unified health system which manages pooled resources.

[1] Bulk Purchasing of Prescription Drugs (NCSL, 2023)

- **Rate setting.**
    - Reference based pricing. Through legislation and/or carrier contracts, many states have adopted strategies that set prices with reference to a benchmark price (often a percentage of Medicare rates).[2] Government regulated payment models can be designed to correct existing market failures in Washington's health care market by reducing extremely high prices, raising unreasonably low prices, and constraining excessive price growth over time. Regulated payment systems can also achieve other policy goals, such as improved pricing equity, improved access to care, and improved provider and payer accountability, while also increasing financial stability for providers.
    - Hospital global budgets. An analysis of universal health care proposals in the United States found global budgets to be the most frequently included cost containment strategy.[3] Many national systems around the world utilize global budgeting strategies for hospital services.[4] In the United States, Maryland has a hospital global budgeting model, while other states are considering phased total cost of care approaches such as the AHEAD model.[5] Global budgeting strategies may be effective at providing stability and controlling overall cost growth (constraining both excessive price and utilization increases) in any health system.
- **Competitive. Selective contracting with health carriers.** Selective contracting with carriers based on access and quality measures through competitive bidding process, as used in the public option and other procurement methods utilized by Washington state.
- **Site- neutral payment systems.** Strategies to pay equivalent rates for the same services, regardless of location type.[6]

Category 3 – Administrative and Market Oversight

Examples

- **Fraud, waste and abuse detection.** Some estimates place the cost of fraud, waste and abuse at around $100 million per day in the United States.[7] A universal system may allow for improvements and standardization of mechanisms to detect and prevent fraud, waste and abuse. Some specific strategies in this category may also belong to Category 1 as related to overutilization.
- **Technological improvements related to safety, efficacy, efficiency, etc.** Health systems may create clinical committees, such as Washington's Health Technology Clinical Committee, which makes "coverage determinations for selected health technologies based on the available scientific

[2] Overview of States' Hospitals Reference-Based Pricing to Medicare Initiatives (NASHP, 2023)
[3] What is Single Payer Health Care (Liu, 2017)
[4] International Profiles of Health Care Systems (Commonwealth Fund, 2017)
[5] CMS AHEAD Model (2024)
[6] KFF article on Medicare Site-Neutral Payment Reforms (2024)
[7] Fraud, Waste and Abuse (CHPW)

evidence."[8] Washington's example is not primarily intended to be a cost containment strategy, but the technology and pharmaceutical clinical review strategy is broadened in some health systems such as the United Kingdom's National Health Service program for prescription drug utilization oversight.[9] Additionally, standardization of data collection and electronic health systems may improv administrative efficiencies across the universal system.

- **Market competition oversight.** Market oversight strategies include policies that govern the actions of providers, carriers, consumers, and others. One example is the 2025 legislative proposal SB 5561 in Washington regarding provider ownership reporting requirements[10].
- **Caps on administrative expense and medical loss ratio limits.** Health systems may elect to place administrative spending caps within the system or carriers.
- **Common Measures.** Efforts to standardize administrative efficiency and health system evaluation may rely on development of common measures by which they may analyze quality of care and outcome data. Washington's example is available here.
- **Continuation of Health Care Cost Transparency Board activities.** In Washington, the Health Care Cost Transparency Board (Cost Board) evaluates total health care expenditures over time and sets cost growth targets. The Cost Board's efforts include identification of cost drivers.
- **Increasing consumer access to provider pricing.** Increased price transparency made available to consumers may encourage providers to lower prices, however ultimate price of care may include a complex summation of variables and decisions that complicate standardization including limited access to services. Whereas access exists for easily comparable, routine services, price transparency may encourage competition and suppress prices.
- **Administrative Services Organizations.** Organizations which may administer payment on behalf of the state without carrier or managed care participation. Connecticut uses these arrangements in its Medicaid program.[11]
- **Governance strategies.** Identify which governance entities have responsibility for policy recommendations and enforcement, and if additional structures are needed, for example, state-based rate setting commissions and the Medicaid and CHIP Payment and Access Commission.[12]

Category 4 – Program Modification and Investment

Examples

- **Benefit design.** The Commission will need to recommend which services are covered.

[8] Health Technology Clinical Committee | Washington State Health Care Authority
[9] NHS England » Medicines optimisation
[10] Draft Senate Bill 5561, (2025)
[11] Connecticut ASO information.
[12] (MACPAC)

- **Enrollment and Eligibility,** Strategies to determine new enrollment, determine eligibility, or provide wait lists with consideration to revenue constraints.
- **Cost sharing.** Cost sharing, including premiums, deductibles, copayments and fees, is a common mechanism used throughout health systems to varying degrees.
- **Primary care access.** Primary care availability and access can prevent acute events and the associated expense. The Health Care Cost Transparency Board (Cost Board) has set a goal and recommended policies and strategies for increasing primary care spending as a percentage of total health care spending from 4 percent to 12 percent.[13]
- **Behavioral health access.** Like primary care, behavioral health services may prevent acute events and associated expenses.
- **Public health infrastructure.** Like primary care, a robust public health system serves to prevent acute events and associated expenses. Many health systems integrate public health into the health care delivery system.

[13] See the recent presentation on primary care spend to the Cost Board (9/24, side 36-45)

Appendix

Updated post-meeting, March 31, 2025. Update includes previously omitted exhibits, II.4.a and II.4.b.

Washington State Health Care Authority

MILLIMAN REPORT

Finance Technical Advisory Committee: Universal Health Care System Design

Cost of care for select populations under existing benefit designs

Commissioned by Washington State Health Care Authority

March 28, 2025

Ben Diederich, FSA, MAAA
Mark Franklin, ASA, MAAA
Menko Ypma, ASA, MAAA
Peter Hallum, ASA, MAAA

Milliman

Table of Contents

Executive summary

The Washington State Health Care Authority (HCA)[1] engaged Milliman to perform an analysis of costs of several existing benefit plan designs when applied to a potential population to be included in a universal health care system (hereafter referred to as the Identified Population). This report is written for the use of HCA and the Finance Technical Advisory Committee (FTAC) in its role as an advisory body to the Universal Health Care Commission.

FTAC selected the following three benefit and cost sharing scenarios for analysis:

- Scenario 1: A Medicaid-like benefit and zero cost sharing structure;
- Scenario 2: A cost sharing structure modeled after the Public Employees Benefit Board (PEBB) "Classic" health insurance benefits and cost sharing;[2] and
- Scenario 3: Cascade Care Silver plan (i.e., individual market silver medal plan) standard benefits and cost sharing.

These scenarios are intended to provide the spectrum of costs associated with these structures, but are not intended to represent a final benefit structure in a universal health care system. We did not evaluate the feasibility of these options. Per the FTAC, the following populations are included as the Identified Population (restricted to individuals not enrolled in Medicare who are 0 through 65 years of age):

- Medicaid enrolled (excluding duals);
- Persons covered by the state government's PEBB or SEBB health plans;
- Persons covered by individual, local government, or religious organization health plans; and
- Uninsured persons.

The included subpopulations and CY23 enrollment counts are shown below in Table 1.

TABLE 1: BASELINE IDENTIFIED POPULATION AND ENROLLMENT

SUBPOPULATION	CY23 AVERAGE[A] MONTHLY ENROLLMENT	NOTES
Medicaid	1,970,000	Excludes Medicare-Medicaid dually eligible members
Uninsured	370,000	Includes individuals eligible for group coverage
Individual	220,000	On and off exchange individual enrollment
Local Government and Religious Organization Plan	240,000	Local government and religious organization plans
PEBB	290,000	State government, excludes Medicare covered persons
SEBB	270,000	State/local government education, excludes Medicare covered persons
Total Identified Population	3,370,000	

(A) Average monthly enrollment is calculated as the total observed member months divided by 12. Note that this is less than the actual number of distinct enrollees as some individuals will be enrolled for fewer than 12 months in a calendar year.

This report includes an analysis of medical, pharmacy, and ancillary service costs; together the allowed cost[3] of these services is referred to as total cost of care (TCOC).[4] The estimates in this report are based on the included CY23 Identified Population, CY23 utilization patterns, and CY23 payment rates. For reference and comparison, the composite historical utilization rates and cost measures for the Identified Population also are reported (and are referred to as "baseline" amounts). One key cost measure in this report is "payer paid." In this context, payer refers to a health insurer (i.e., payer does not refer to patients, who may be responsible for a portion, or all the cost associated

[1] Initialisms, acronyms, and terms with specific meaning in this report are defined in Appendix A.

[2] Note that these benefits and cost sharing are similar to those in School Employees Benefit Board's (SEBB's) "Achieve 2" plan.

[3] Allowed cost is the sum of health plan paid, member paid, and secondary payer paid (if applicable). For providers with contracts to provide services, it is usually the contracted payment rates for the rendered services.

[4] We have not analyzed non-benefit costs (e.g., costs for claim processing services, medical management, etc.), which may be substantial, particularly at the outset of any health plan.

with a given service), and payer paid refers to the portion of the cost of care paid for by the payer (i.e., excluding patient paid amounts).[5]

The following table includes a summary of the baseline payer paid amounts for programs in force in CY23 (restricted to the Identified Population), and the payer paid estimates for each of the three scenarios. These results should not be taken in isolation of the context provided by this report.

TABLE 2: ESTIMATED PER MEMBER PER MONTH (PMPM) AND TOTAL PLAN PAID[A] BY SCENARIO

BASELINE / SCENARIO BENEFITS AND COST SHARING	PAYER PAID PMPM[B]	TOTAL ANNUAL PAYER PAID[C]
Total current state program costs		$13.6 billion
Medicaid[D]	$408	$9.6 billion
PEBB[E]	$628	$2.2 billion
SEBB[E]	$551	$1.8 billion
Non-state program costs[F,G]		$2.7 billion
Total baseline costs		$16.3 billion
Scenario 1: Medicaid-like	$500 - $586	$20.2 - $23.7 billion
Scenario 2: PEBB-like	$427 - $502	$17.3 - $20.3 billion
Scenario 3: Cascade Silver-like	$377 - $447	$15.2 - $18.1 billion

(A) Totals include medical, pharmacy, and dental costs and exclude non-benefit expenses. Dental costs are not included in the non-state program cost baseline amount as those costs were not available for these populations.
(B) Baseline payer paid amounts (e.g., Medicaid) are not directly comparable to the scenarios' ranges. The scenarios ranges are a composite of all baseline populations and individual subpopulations scenario results, like Medicaid, may have increased or decreased relative to the baseline.
(C) Scenario results are based on the CY23 Identified Population of 3.4 million individuals.
(D) Includes Medicaid populations included in the Identified Population and select Medicaid services (e.g., excluding dual enrollment, long term services and supports (LTSS), etc.). Costs are inclusive of both state and federal funding.
(E) Note that these totals may include some coordination of benefit payments made by other payers which are not part of a state program.
(F) Includes local government, religious organization, and individual health plans and the uninsured.
(G) A portion of individual insurance premiums are paid for by the state via the Washington State Premium Assistance Program. These premium payments would cover some of the costs reported in this line. In the biennial 2024 - 2025 Washington State budget $100 million was funded to cover individual market premiums through the Washington State Premium Assistance Program, see [1].

The summary results in Table 2 are reported in more detail in the following sections, and Appendix C. Section II of Appendix C includes detailed scenario results, and Section III includes the CY23 baseline assumptions underpinning the estimates. Exhibit I in Appendix C contains a table of contents specific to the exhibits, including a brief description of each exhibit.

In each of the three scenarios, per FTAC's guidance:

- Individuals eligible for Medicaid benefits under eligibility requirements like those in force today would continue to have a Medicaid-like benefit and cost sharing structure.
- Income-linked cost sharing reductions are not modeled in any of the three scenarios (except for this Medicaid carveout).
- Dental services are covered in all scenarios, with a Medicaid-like benefit for the Medicaid subpopulation and a PEBB-like benefit for non-Medicaid subpopulations.

Reimbursement rates modeled in the scenarios also were directed by FTAC. Provider reimbursement rates are set at percent of Medicare fee-for-service (FFS) rates separately for inpatient, outpatient, and professional services at rates intended to approximate payment neutrality across the Identified Population. Prescription drug reimbursement rates are based on national average drug acquisition costs converted to discounts off average wholesale price (AWP). Dental reimbursement rates were set at PEBB and SEBB rates for the non-Medicaid population and Medicaid rates for the Medicaid population. All reimbursement rates were set using the payment rates observed in CY23.

[5] For example, a $500 service subject to a $50 copay has a $500 allowed cost amount, $50 patient paid amount, and $450 payer paid amount.

This report does not include consideration of funding or impacts on reimbursement from the federal government or other entities (e.g., the possible impacts to uncompensated care payments to hospitals in the Medicare program, the Federal Medicaid Assistance Percentage to the state, provider reimbursement rates for services rendered to persons outside of the Identified Population, etc.). While not studied in this report, these factors are important and could have a significant impact on actual costs. This topic, among others which were deemed outside the scope of this report, are noted and briefly discussed in the "Further considerations" section.

The level of medical management (i.e., utilization management, care coordination, and population health programs) can have a significant impact on program costs. We analyzed each scenario under assumed "moderate" medical management and "limited" medical management. Moderate medical management may be understood as preferred provider organization- (PPO-) like and limited as FFS-like. The level of provider reimbursement also has a significant impact on the estimated costs, and each scenario was modeled under a variety of reimbursement rate assumptions in the sensitivity tests. The results of these sensitivity tests of medical management assumptions, among other sensitivity tests, are discussed later in this report.

We believe the estimated ranges of the TCOC for each scenario to be reasonable, but the estimates are subject to significant variability based on the starting assumptions and the selected modeling approach. Similar analyses performed by other qualified individuals may yield meaningfully different estimates based on reasonable but different data sources, assumptions, and methods from those employed in this analysis and documented in this report.

Background

Senate Bill 5399, see [2], established the Universal Health Care Commission (UHCC) with direction to, “prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system…” The UHCC is now exploring the costs associated with a potential universal health care system’s design, with support from FTAC. HCA has engaged us to support FTAC's work by performing the following tasks:

- Estimate and compare the cost of care for a payer covering the Identified Population under three example benefit scenarios (based on already existing benefit plans within the health insurance market).
- Perform associated sensitivity tests (e.g., of impacts of adjusting reimbursement or medical management assumptions).
- Collaborate with HCA, FTAC, and designated FTAC liaisons to generate and refine assumptions associated with this analysis.
- Generate this report to document assumptions, methodology, and results associated with the tasks above.

We understand this report will be used by HCA, FTAC, UHCC, and other individuals and organizations to help understand the spectrum of costs associated with varying benefit structures covering the Identified Population. This understanding may be used as a starting point for further refinement and analysis. This may include varying benefits, enrollment eligibility, provider reimbursement, or other elements that are assumptions that underlie the results to develop a program that meets the goals set out in the enabling legislation. Any such use of this report should be performed by persons with sufficient expertise and knowledge to accurately interpret and apply the results of this report. We are not responsible for the inappropriate application of these results. The use of the results included in this report or associated information for other purposes may not be appropriate.

This report was generated for FTAC and on behalf of HCA. It is not intended to determine or suggest any specific policy action or final program structure or design, and persons should consult qualified professionals before taking specific actions. Additionally, we are not advocating for or endorsing the benefit structures or their feasibility, enrollment eligibility, provider reimbursement rates, or other elements of the underlying assumptions. We do not intend to benefit or create a legal duty to any third-party recipient of this work.

Key considerations and limitations

To develop the estimates included in this report and its exhibits, we relied on information collected from various sources, direction from FTAC and HCA, and assumptions developed internally, among other resources. Because of this, the estimates are subject to considerations and limitations and understanding these limitations is an important part of understanding the estimates. Some key considerations and limitations are now discussed, and others are included as part of the sensitivity testing or as part of a discussion of further considerations outside of the scope of this analysis.

DATA SOURCES AND ASSUMPTIONS

Where possible, we have relied on publicly available information to underlie estimates and the development of assumptions. This information is catalogued in Appendix B, the bibliography of sources. In some cases, where limited or no public data is available, we have relied on information provided by HCA or on Milliman's internal data sources (e.g., Milliman's cost of care benchmarks and models). Due to these disparate sources and assumptions, the estimated costs associated with providing the benefits in each selected scenario are subject to a high degree of uncertainty. For example, the underlying data used to estimate reimbursement rates and service expenses for the various subpopulations did not always contain consistent estimates.

In addition, key guidance from FTAC was relied upon for the following details:

- Individuals eligible for Medicaid benefits in CY23 are modeled under a Medicaid-like benefit and cost sharing structure in all three scenarios and are carved out of the modeling of varying cost sharing.
- Except for the Medicaid carve-out in the prior bullet, income-linked cost sharing reductions are not modeled in any of the three scenarios.
- Medicaid program LTSS costs are excluded from this analysis.
- Dental services are modeled as covered in all scenarios with cost sharing arrangements which do not vary by scenario, other than the exclusion of all cost sharing under Scenario 1:
    - The Medicaid subpopulation is modeled as covered by a Medicaid-like benefit.
    - The non-Medicaid subpopulation is modeled as covered by a PEBB-like benefit.
- Reimbursement rates for all scenarios are intended to approximate payment neutrality across the Identified Population (when holding observed CY23 utilization constant).

REIMBURSEMENT RATES

The modeled reimbursement rates do not include prospective adjustments for known or possible changes to Medicare or other reimbursement rates between CY23 and any future time periods. This exclusion applies to known and large changes in reimbursement such as the increase in state-directed payments for Medicaid enrollees' inpatient services at the University of Washington Medical Center (among others).

Specific to prescription drugs, the modeling is simplified and does not consider possible differences in drug formularies or associated discount, rebate, and point-of-sale savings and costs. This is a significant source of variability in the estimates of drug costs.

MEDICAID ENROLLMENT AND FFCRA

The estimate of Medicaid enrollment was based on CY23 data provided by HCA. The Families First Coronavirus Response Act (FFCRA) of 2020 required states to continue coverage for the Medicaid enrolled through March of 2023, which is in the data period. This means, in CY24 and later periods, Medicaid enrollment may be overstated. Based on CY24 data provided by HCA, we observe Medicaid enrollment has declined by about 10 percent from CY23. These formerly Medicaid-covered individuals may or may not have moved from Medicaid to another subpopulation within the Identified Population (e.g., to the uninsured subpopulation which is included in the Identified Population or to a self-insured commercial group subpopulation that is not). We have included sensitivity tests of varying Medicaid enrollment to examine the possible impacts of this on the estimates.

SENSITIVITY TESTING AND FURTHER CONSIDERATIONS

The select sensitivity tests considered in the report, and the associated range of results, should not be understood as exhaustive; there are other un-tested sources of variability in this analysis, some of which are discussed but not tested in this report, and some of which are unknown.

THIS IS NOT A PROJECTION

Finally, we remind the reader this report and the associated results are not a projection. Cost of care for the CY23 Identified Population is repriced under several benefit and cost sharing scenarios, including impacts related to induced utilization (IU), reimbursement rate changes, and others. The report does not include trending of results forward to CY25 (or any other period). Ordinarily, a projection would also include adjustments accounting for, among other items, the following:

- Expected demographic and morbidity changes between the base period (i.e., CY23) and any projection period;
- Known or anticipated reimbursement rate changes to providers (e.g., changes in the Medicare, Medicaid, commercial, or individual fee schedules between CY23 and any projection period);
- Known or expected changes in service mix (e.g., explicit adjustments for the coming release of a new drug therapy);
- Changes to medical management practices based on administrative initiatives;
- Changes in expected enrollment counts; and
- Changes in cost-containment policies, health care coverage eligibility, or public health initiatives adopted by the legislature that may alter utilization patterns and cost.

Projecting the results into the future was deemed out-of-scope of this analysis.

Results by scenario

This section provides additional information about the results of our analysis, including both the range of reasonable estimates for the three scenarios and associated sensitivity tests. Table 3 summarizes key parameters of the three scenarios.

TABLE 3: ESTIMATED IDENTIFIED POPULATION COSTS BY SCENARIO

COST ESTIMATE OR COST SHARING ELEMENT	SC 1 – MEDICAID	SC 2 – PEBB	SC 3 – CASCADE CARE SILVER
Medical management[A]	FFS-like (limited)	PPO-like (moderate)	PPO-like (moderate)
PMPM medical and pharmacy allowed cost	$500 - $586	$452 - $530	$434 - $510
Actuarial value – All subpopulations – All Services[B,C]	100% - 100%	94% - 95%	87% - 88%
Actuarial value – non-Medicaid subpopulations – Medical and pharmacy	100%	90%	68%
Actuarial value – non-Medicaid subpopulations – Dental	100%	64%	64%
Maximum out-of-pocket costs	$0	$2,000 medical $2,000 Rx	$8,500 medical + Rx
Enrollee monthly costs	$0 - $0	$25 - $28	$57 - $63

(A) Medical management assumption information is found below in the "Medical management" subsection.

(B) Actuarial value (AV) represents an estimate of the average percent of allowed TCOC covered by the payer (i.e., one minus the percent of costs borne by the enrollee). Values are shown for the total population and for the non-Medicaid subpopulations separately. AV for the Medicaid subpopulation is 100 percent.

(C) Note that AV is sensitive to reimbursement rates. For example, for a plan with a deductible, if reimbursement rates are lowered, then a greater portion of the total allowed costs will be subject to the deductible and the AV will fall. This effect causes some varying estimates of AV within the report across the varying reimbursement scenarios or between the baseline and scenario results, despite modeled benefits being nominally the same.

More detailed results for these scenarios may be found in the exhibits in Section II of Appendix C. This includes service-line-level cost models that report estimated utilization, and costs, in Exhibits II.2.a, b, and c.

For comparison to the estimated costs for the Identified Population in each of the scenarios, this report includes the baseline costs for the Identified Population. This baseline includes the TCOC, patient paid, and payer paid amounts for the Identified Population under their existing CY23 coverage (e.g., Medicaid, uninsured, individual, commercial, or other plans). The CY23 baseline and assumptions underpinning the estimates are reported in the exhibits in Section III of Appendix C. This includes the development of a payment neutral reimbursement rate.

The following subsections discuss the results for each scenario in more detail. This includes both the best estimate results, sensitivity tests of the starting assumptions, and a discussion of interactions among specific scenarios and assumptions.

Key assumptions that underlie all three scenarios include:

- Reimbursement rates for medical services are set at "payment neutral" amounts.[6]
- Reimbursement rates for pharmacy are set at PEBB- and SEBB-like rates.[7]
- Dental services are covered under all three scenarios with Medicaid-like benefits and reimbursement rates for Medicaid enrollees and PEBB-like benefits and reimbursement rates for all other enrollees.
- The Identified Population underlying the results are those observed in CY23 (including their CY23 utilization patterns and overall morbidity).
- Individuals in the uninsured subpopulation in the CY23 baseline are incorporated into the Medicaid or individual enrollee subpopulations based on income level.[8]

[6] Payment neutral reimbursement is intended to mean provider payment rates that, in aggregate and across the Identified Population, result in the same total amount of dollars being paid to providers. These payment neutral amounts are calculated based on the baseline CY23 population and service mix. After layering on other impacts (e.g., changing utilization rates), the total payments to providers may increase or decrease in final scenario estimates and sensitivity tests.

[7] For pharmacy, this includes the estimated savings associated with manufacturer rebates.

[8] Note that this approach effectively assumes that the uninsured subpopulation will have utilization that is similar to the Medicaid or individual subpopulations into which they are merged. Discussions of possible group eligibility for some of the uninsured population and the expected utilization rates of this population are found later in this report.

- Limited or moderate medical management is assumed in the scenarios and sensitivity tests (e.g., prior authorization for service requirements, chronic disease management, etc.).
- In all three scenarios, Medicaid-like cost sharing for currently Medicaid-enrolled and Medicaid-eligible uninsured individuals.

The benefit and cost sharing structure for each of the scenarios is detailed in Appendix D. Note that Appendix D represents a summary of the major benefits and cost sharing for each modeled scenario; the actual health plans used as the basis for each scenario include additional benefits, limitations, or carveouts that are not shown. Appendix D also includes a description of how the benefits were incorporated into the pricing models.

SCENARIO 1 – MEDICAID COST SHARING

In Scenario 1, a Medicaid cost sharing and benefit structure is modeled (with the exclusion of LTSS). Medicaid cost sharing is negligible, so there is little incentive for consumers to select lower cost places of service[9] when seeking care, and limited ability for plan administration to encourage consumers to make such choices.[10] Because of this and related impacts of limited cost sharing, we have modeled limited medical management for this scenario as the starting assumption. This is a key difference between Scenario 1 and the other benefit scenarios discussed below. Other assumptions are largely consistent across the several scenarios.

While the currently Medicaid-enrolled subpopulation of the Identified Population does not see a change in cost sharing for the services analyzed, the size of this subpopulation has been increased to include the uninsured who are income-eligible for Medicaid.[11] The Medicaid cost sharing does represent a significant benefit enhancement for the other insured subpopulations. For the PEBB and SEBB enrolled, this is an increase in the AV of their plans from their baseline of about 88 percent to 100 percent. For the local government and religious organization plan subpopulation, this is an increase from about 80 percent[12] to 100 percent. For the subpopulation insured by individual plans, this is an increase from an average of approximately 82 percent[13] to 100 percent.

Note that the baseline AVs for the individual plan covered subpopulation and the local government and religious organization plan covered subpopulation include a variety of plan types, metal tier levels, and cost sharing reductions.

For the non-Medicaid eligible subpopulation, relative to baseline rates in Exhibit III.2 in Appendix C, utilization and allowed cost increased significantly for outpatient and professional services. This information is also summarized in Table 4. Comparing the “Per Member Per Month Allowed Cost” column[14] in the exhibits:

- Total allowed costs attributable to inpatient services decreased by 1 percent, related to the changes in modeling of the uninsured subpopulation between the baseline and this scenario.
- Costs for outpatient, professional, and ancillary services increased by 18 to 21 percent as shown in Table 4.
- Costs for specific professional and outpatient services including physical therapy, chiropractic services, and other outpatient rehabilitative therapies increased at greater rates. This is due to reduced limitations on those services under the modeled benefits relative to baseline.
- Costs of vision exams and glasses has increased as the non-PEBB, non-SEBB commercial subpopulations gain adult vision benefits modeled under this scenario.

[9] The term “place of service” refers to the physical setting of care, which can be variable for a given service. For example, some surgeries may take place in a hospital or in an ambulatory surgical center.

[10] See [3] for a survey of studies that show a relationship between modest cost sharing and deferred or avoided medical care.

[11] Estimates of Medicaid-eligible uninsured individuals were based on income estimates for the uninsured subpopulation and the 138 percent of FPL federal threshold. We did not make further adjustments for children or pregnant women who have broader income eligibility.

[12] Based on an analysis of Unified Rate Review Template (URRT) data from the state of Washington. This assumes that benefit richness is similar across local government, religious organization, and the excluded commercial group health plans in Washington State. See [4].

[13] Based on an analysis of URRT data from state of Washington. See [4].

[14] Note that the service level utilization and costs in the cost model do not include the full impact of IU due to cost sharing. The impact of the deductible and/or out-of-pocket maximum is reported only in the “Cost Sharing (Deductible/Coinsurance/OOP) Induced Utilization Adjustment Value (Net of Cost Sharing Subject to Deductible)” line item at the bottom of the exhibit.

While not included in the table, dental costs are also higher. The scenario modeling includes dental costs for the individual and local government and religious organization plan subpopulations, which may not have dental coverage in the baseline. This is true of all three scenarios.

TABLE 4: BASELINE VERSUS BEST ESTIMATE: SCENARIO 1 - MEDICAID

BROAD SERVICE CATEGORY	BASELINE	SC 1 – MEDICAID	RELATIVITY (SC 1 / BASELINE)
Total medical and pharmacy allowed PMPM[A,B]	$421	$507	1.20
Inpatient allowed PMPM	$109	$108	0.99
Outpatient allowed PMPM	$93	$110	1.18
Professional and ancillary allowed PMPM	$162	$197	1.21
Prescription drug allowed PMPM	$57	$73	1.28
Dental allowed PMPM	n/a	$35	n/a

(A) The "Total medical and pharmacy allowed PMPM" excludes dental costs which were not available for all the baseline Identified Population. Dental costs are modeled, included in the results of each scenario's costs, and reported elsewhere in the report.

(B) Total allowed includes a portion of the impact of additional adjustments (e.g., deductible- and MOOP-related impacts to IU) and therefore is not the sum of the broad service categories listed below it.

Overall, as can be seen in the total allowed cost fields in the cost model in Exhibit II.2.a and in Table 4, the cost of care has increased. Because unit prices were fixed at a payment-neutral rate, this implies that utilization rate shifts are, in total, increasing the cost of medical services (i.e., on a dollar-weighted basis, utilization has increased). These results are generally expected and follow from the following key assumptions:

- Reimbursement rates for services for the Medicaid enrolled subpopulation have increased relative to the baseline to the average rate across the Identified Population.
- Once uninsured individuals gain coverage, they are expected to have utilization rates like the Medicaid or individual insured subpopulations depending on their income level (i.e., representing a utilization and cost increase relative to their utilization and cost while uninsured).
- Increased benefit coverage or reduced limitations on covered benefits relative to the baseline for the non-Medicaid subpopulations.
- Relative to the baseline, less strict medical management for the non-Medicaid subpopulations increases the expected costs for individuals enrolled in commercial group, and individual plans.
- Lower cost sharing rates also reduce incentives for consumers to limit their consumption of services or select lower cost care options.[15]

In addition to the utilization-rate changes apparent in the allowed costs, the shift of cost sharing amounts from consumers to the payer represents a large increase in payer costs. In total this shift is approximately $1.7 billion. This estimate is based on the AV of the baseline scenario, 91 percent, compared to the modeled scenario and is calculated as $1.7 billion = (100% – 91%) × $18.0 billion.[16]

Exhibit II.3 of Appendix C and the "Sensitivity testing" section of this report contain the results of, and more information about, adjustments to starting assumptions. Some key takeaways from the sensitivity tests performed include the following:

- Increasing enrollment to include all fully insured commercial group plans (sensitivity test 3) results in a significant increase in total program spending.
- Results are sensitive to the reimbursement rate and utilization assumptions.

[15] This may include consumer choices such as those related to brand versus generic drugs, diagnostic imaging and elective procedure setting, or deferring medically needed care. Note that related drug formulary assumptions are discussed in the "Further considerations" section of this report.

[16] This approximation is subject to rounding and represents an underestimate of the additional cost due to the elimination of cost sharing (i.e., it accounts for neither the impact of IU nor the impact of medical management). This is the baseline allowed cost, not the baseline paid cost reported in Table 2.

- For Scenario 1, sensitivity test 5 does not include an alternative medical management assumption. This is due to the lack of cost sharing in Scenario 1 and the interrelationship between medical management and cost sharing. For the other scenarios, this impact of adjusting medical management assumptions was substantial.

Many of the sensitivity test results are relatively consistent across the several scenarios. One exception is sensitivity test 4, which modulates the proportion of the population enrolled in Medicaid. This exception stems from the fact that in Scenario 1, the commercial subpopulation of the Identified Population is modeled as more expensive than the Medicaid subpopulation, whereas in Scenario 2 they are about equal, and in Scenario 3 the commercial subpopulation is modeled as less expensive than the Medicaid subpopulation.

SCENARIO 2 – PEBB-LIKE HEALTH PLAN COST SHARING

In Scenario 2, the cost sharing and benefit structure similar to PEBB's "Classic" benefits is modeled, as detailed in Appendix D. The cost sharing structure of this scenario provides incentives for consumers to elect lower cost places of service when seeking care. Because of this, plan administrators have more financial leverage to steer consumers to services and sites of care which are lower cost or more medically appropriate.[17] We have, therefore, modeled moderate medical management for this scenario as the starting assumption. This level of medical management can be considered similar to a consumer's experience while enrolled in a PPO plan (e.g., possibly including a nurse line, limited chronic disease management, or some limited prior authorization requirements). This was modeled as consistent with the level of medical management in the baseline experience.

As in Scenario 1, the size of the "Medicaid enrolled" subpopulation has been increased to include the uninsured who are income-eligible for Medicaid. This combined subpopulation of the Identified Population has been modeled as having Medicaid-like benefits. For all other subpopulations, PEBB-like benefits are modeled. For the currently PEBB and SEBB enrolled, this is a stable AV of their plan from their baseline of about 88 percent. For the local government and religious organization plan subpopulation, this represents an AV increase from about 80 percent to 88 percent, and for the subpopulation insured by individual plans this represents an improvement from an average AV of about 82 percent to 88 percent.

For the non-Medicaid eligible subpopulation, relative to baseline rates in Exhibit III.2 in Appendix C, utilization and allowed costs increased significantly for outpatient and professional services. This information is summarized in Table 5. Comparing the "Per Member Per Month Allowed Cost" column in the exhibits:

- Total allowed costs attributable to inpatient services decreased by 1 percent, which is consistent with the results of Scenario 1.
- Costs of outpatient, professional, and ancillary services increased by 7 to 8 percent.
- Costs for specific professional and outpatient services including physical therapy, chiropractic services, and other outpatient rehabilitative therapies increased at greater rates. This is due to reduced limitations on those services under the modeled benefits relative to baseline.
- Costs of vision exams and glasses has increased as the non-PEBB, non-SEBB commercial subpopulations gain adult vision benefits modeled under this scenario.

[17] As this analysis is a precursor to UHCC making recommendations regarding benefit design, we were not provided with information about what sort of plan administration might be employed. It is possible that no medical management would be performed (e.g., the state may choose to administer a plan like an FFS program). If this is the case, then the medical management assumptions here are not appropriate.

TABLE 5: BASELINE VERSUS BEST ESTIMATE: SCENARIO 2 – PEBB-LIKE BENEFITS AND COST SHARING

BROAD SERVICE CATEGORY	BASELINE	SC 2 – PEBB	RELATIVITY (SC 2 / BASELINE)
Total medical and pharmacy allowed PMPM[A,B]	$421	$455	1.08
Inpatient allowed PMPM	$109	$108	0.99
Outpatient allowed PMPM	$93	$100	1.08
Professional and ancillary allowed PMPM	$162	$174	1.07
Prescription drug allowed PMPM	$57	$67	1.17
Dental allowed PMPM	n/a	$35	n/a

(A) The "Total medical and pharmacy allowed PMPM" excludes dental costs which were not available for all the baseline Identified Population. Dental costs are modeled, included in the results of each scenario's costs, and reported elsewhere in the report.

(B) Total allowed includes a portion of the impact of additional adjustments (e.g., deductible- and MOOP-related impacts to IU) and therefore is not the sum of the broad service categories listed below it.

As illustrated in Tables 4 and 5, the overall cost of care in Scenario 2 increased relative to the baseline, but by a smaller amount than in Scenario 1. Because unit prices were fixed at a payment-neutral rate, this result implies utilization rate shifts are, in total, increasing the cost of medical services (i.e., on a dollar-weighted basis, utilization has increased). These results are generally expected:

- Relative to the baseline, this scenario includes increased benefit coverage and reduced limitations on covered benefits for both the individual and the local government and religious organization plan subpopulations.
- Relative to the baseline, lower cost sharing rates for some of the non-Medicaid eligible subpopulations also reduces incentives for consumers to limit their consumption of services or select lower cost care options resulting in IU.
- Because medical management is assumed to be similar to the baseline, unlike Scenario 1, this assumption does not drive an increase in estimated allowed costs.
- Other key assumptions that drive differences from the baseline, are unchanged from Scenario 1.

In addition to the utilization rate changes increasing TCOC, the shift of cost sharing amounts from consumers to the payer represents an increase in payer costs. In total this is approximately $0.7 billion. This estimate is based on the AV of the baseline scenario, 91 percent, compared to the modeled scenario and is calculated as $0.7 billion = (95% – 91%) × $18.0 billion.[18]

In general, the results of the sensitivity tests are like those discussed in Scenario 1. Please refer to Exhibit II.3 of Appendix C and the associated section of this report for more information.

SCENARIO 3 – CASCADE CARE SILVER COST SHARING

In Scenario 3, the cost sharing and benefit structure modeled is based on Cascade Care's silver metal tier. These benefits and cost sharing parameters are detailed in Appendix D. The cost sharing structure in this scenario has higher patient pay obligations (i.e., lower AV) than those in scenarios 1 and 2 and, as in Scenario 2, plan administrators have financial leverage to steer consumers to lower cost or more medically appropriate sites of care or services. As in Scenario 2, a moderate level of medical management is the starting assumption.

As in scenarios 1 and 2, the size of the "Medicaid enrolled" subpopulation has been increased to include the uninsured who are income-eligible for Medicaid. This combined subpopulation of the Identified Population has been modeled as having Medicaid-like benefits. For all other subpopulations of the Identified Population, the Cascade Care silver metal tier-like benefits are modeled. For the currently PEBB and SEBB enrolled, this is a reduction in AV of their plan from their baseline of about 88 percent to 70 percent. For the local government and religious organization plan subpopulation, this represents an AV reduction from about 80 percent to 70 percent. For the subpopulation insured by individual plans, this represents an AV reduction from an average of about 82 percent to 70 percent.

[18] As previously noted, this approximation is subject to rounding and likely represents an underestimate of the additional cost due to the reduction of cost sharing (i.e., it does not account for the impact of IU). This is the baseline allowed cost, not the baseline paid cost reported in Table 2.

As illustrated in Table 6, relative to baseline PMPM costs in Exhibit III.2 in Appendix C, utilization and allowed costs for the non-Medicaid eligible subpopulations have increased significantly for outpatient and professional services. Comparing the "Per Member Per Month Allowed Cost" column in the exhibits:

- Like Scenario 2, costs of inpatient services decreased by 1 percent and the costs of outpatient, professional, and ancillary services increased by approximately 7 percent relative to the baseline.
- The costs of vision and chiropractic services is consistent with or reduced from the baseline.

TABLE 6: BASELINE VERSUS BEST ESTIMATE: SCENARIO 3 – CASCADE CARE SILVER-LIKE BENEFITS AND COST SHARING

BROAD SERVICE CATEGORY	BASELINE	SC 3 – CASCADE CARE SILVER	RELATIVITY (SC 3 / BASELINE)
Total medical and pharmacy allowed PMPM[A,B]	$421	$436	1.04
Inpatient allowed PMPM	$109	$108	0.99
Outpatient allowed PMPM	$93	$100	1.07
Professional and ancillary allowed PMPM	$162	$173	1.07
Prescription drug allowed PMPM	$57	$67	1.17
Dental allowed PMPM	n/a	$35	n/a

(A) The "Total medical and pharmacy allowed PMPM" excludes dental costs which were not available for all the baseline Identified Population. Dental costs are modeled, included in the results of each scenario's costs, and reported elsewhere in the report.

(B) Total allowed includes a portion of the impact of additional adjustments (e.g., deductible- and MOOP-related impacts to IU) and therefore is not the sum of the broad service categories listed below it.

Overall, as can be seen in Tables 4, 5, and 6, TCOC in Scenario 3 has decreased from scenarios 1 and 2. As before, unit prices were fixed at a payment-neutral rate, implying that utilization rate shifts are, in total, decreasing the cost of medical services (i.e., on a dollar-weighted basis, utilization has decreased). These results are generally expected and follow directly from the stricter medical management assumed in this scenario (relative to Scenario 1). Further, erosion of benefits for most individuals already with commercial cost sharing results in larger savings because of dampened utilization.[19] The same key assumptions that impact Scenario 2 also apply to Scenario 3.

In addition to the utilization-rate changes affecting TCOC, the shift of cost sharing amounts between the payer and consumers is again significant. In total, approximately $0.6 billion shifted from the payer to consumers. This estimate is based on the AV of the baseline scenario, 91 percent, relative to the AV of the modeled scenario and is calculated as ($0.6 billion) = (87% – 91%) × $18.0 billion.[20] This payer savings, in addition to the impacts discussed above, appears to approximately offset the cost of providing health care to the uninsured subpopulation.

As before, the results of the sensitivity tests are like those discussed in scenarios 1 and 2. Please refer to Exhibit II.3 of Appendix C and the associated section of this report for more information.

[19] Note that "dampened utilization" in this context is used as the opposite of IU. In other words, it is the reduction in utilization expected due to relatively higher patient cost sharing.

[20] As noted previously, this estimation is approximate and does not account for the impact of IU. This is the baseline allowed cost, not the baseline paid cost reported in Table 2.

Methodology, assumptions, and data sources

This section describes an outline of our approach, including an abbreviated description of each task. Following the outline, several subsections provide more detail related to some of the listed tasks. In general, we collected data and performed modeling separately for each of the subpopulations included in the Identified Population (combining the by-subpopulation results at the end of the analysis). These subpopulations are listed in Table 1.

We completed the following steps to develop the results included in this report and its appendices. Because of the complex and interrelated nature of these steps, each of the steps does not necessarily correspond to only one of the subsections following this outline; nevertheless, more complete descriptions can be found in the subsections.

1. Collect data and base assumptions for each of the Identified Population's subpopulations including (see exhibits in Subsection III.1 of Appendix C):
    a. Enrollment statistics by subpopulation (e.g., Medicaid, commercial group, PEBB, SEBB, etc.);
    b. CY23 cost of medical care, including cost of care by service category where possible, prescription drugs, and dental services;
    c. Estimates of reimbursement rates for care, including provider reimbursement rates, drug costs, etc.; and
    d. Other necessary information (e.g., details of benefit structures, implied medical management, etc.).
2. Calculate estimates of aggregate payment-neutral reimbursement rates for medical providers, prescription drugs, and dental care across the Identified Population. These estimates represent the single, flat reimbursement rates that, if applied consistently across the population, would result in the same aggregate revenue to providers (assuming the same service utilization as in the baseline). These payment-neutral reimbursement rates are calculated separately for each broad medical service category, prescription drugs, and dental services. (See the exhibits in Subsection III.3 of Appendix C.)
3. Estimate the utilization, allowed TCOC, patient pay, and AV for each of the included subpopulations under each scenario and sensitivity test:
    a. For the Medicaid subpopulation, we estimated the impact of the shift from the current reimbursement rates to the estimated payment-neutral rates.
    b. The uninsured subpopulation was divided into the portion presumed eligible for Medicaid in CY23 based on percent of federal poverty level (FPL) and the remainder of the subpopulation, which was assumed not eligible for Medicaid. For the non-Medicaid eligible portion of the subpopulation, we assume their profile is most like the individual plan enrolled subpopulation. These segmented subpopulation estimates are used to re-weight the final scenario and sensitivity test results.
    c. For each of the other Identified Population's subpopulations (PEBB, SEBB, local government and religious organization plans, and individually insured), the impacts of the scenarios' assumptions above were separately modeled, including payment-neutral reimbursement rates, changing benefits and cost sharing, medical management assumptions, etc.
4. Create composite scenario and sensitivity test results by weighting the by-subpopulation results, described in (3), by the Identified Population developed in numbered items (1.a) and (3.b).

More information related to the data and assumptions in item number (1) can be found in the following subsections, including the "Population estimation and blending across results," "Cost sharing and benefits," and, "Provider reimbursement," subsections. Similarly, the procedure to develop the payment neutral provider reimbursement rates used in the modeling, item number (2) above, is discussed in the subsection, "Provider reimbursement." The modeling of the scenarios' results (i.e., the combination of the data sources and assumptions described in item numbers (3) and (4)) is discussed in the "Benefit modeling results," subsection.

POPULATION ESTIMATION AND BLENDING ACROSS RESULTS

Table 7 shows each of the Identified Population's subpopulations, their CY23 average monthly enrollment, the starting CY23 medical costs, and the estimated CY23 reimbursement rates as a percentage of Medicare (for medical

services only). In addition to being the starting point for the estimates of utilization and medical costs, this information was used to determine starting reimbursement rates for the modeling and associated sensitivity test. Note this subsection discusses the population estimates in Table 7 and later subsections discuss other aspects of this table (i.e., the Medicare allowed and medical costs).

TABLE 7: SUBPOPULATION SEGMENTS AND HISTORICAL CY23 COUNTS, COSTS, AND REIMBURSEMENT RATES

SUBPOPULATION	SOURCE	CY23 AVERAGE MONTHLY ENROLLMENT	MEDICAL ALLOWED COSTS PMPM	ESTIMATED % OF MEDICARE ALLOWED[A]	PHARMACY COSTS PMPM	DENTAL COSTS PMPM
Medicaid enrolled	HCA Data	1,970,000	$345	107%	$42	$21
Uninsured population	HCA Presentation, KFF Report, and MEPS[B]	370,000	$135	80%	$13	n/a
Individual enrolled	HCA Presentation, and, URRT[C]	220,000	$465	161%	$122	n/a
Local government and religious organization enrolled	US Census, DOL, and SHCE[D]	240,000	$448	193%	$87	n/a
PEBB enrolled	HCA Data	290,000	$538	172%	$112	$56
SEBB enrolled	HCA Data	270,000	$475	183%	$91	$63
Total Identified Population		3,370,000	$364	125%	$57	n/a

(A) Includes only medical services covered by Medicare FFS. Excludes pharmacy and dental services.
(B) Uninsured subpopulation size is based on information published by HCA in the "Access to Coverage" presentation published by HCA, see [5]. Medical and pharmacy cost PMPMs are based on information from the Medical Expenditure Panel Survey (MEPS) Household Component.
(C) Population size is based on information also published in the HCA "Access to Coverage" presentation. Medical and pharmacy cost PMPMs are based on 2023 experience reported in the 2025 URRT published by the Centers for Medicare & Medicaid Services (CMS). See [4].
(D) Estimates are based on the 2023 Annual Survey of Public Employment & Payroll (ASPEP) from the US Census and 2023 WA employment by major occupation group information published by the Department of Labor. The medical costs estimate is based on information from the 2023 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibits (SHCEs), submitted by Washington health insurers. See [6].

Most data sources for enrollment estimates are listed above in Table 7 and its notes, and the enrollment counts we used were taken directly from those sources. Additional information about sources is included in the report's bibliography.

As noted above, we attempted to cross-reference data sources and note the following significant differences:

- Estimates of Medicaid enrollment varied by source. The HCA "Access to Coverage" presentation reports about 2.1 million Medicaid enrollees, whereas our analysis includes about 2.0 million average enrollees. Additionally, the Washington Office of the Insurance Commissioner (OIC) report, "WA OIC Preliminary Report on Health Care Affordability," see [7], includes an estimate of the percentage of Washington residents enrolled in the Medicaid program which is higher than what is used in this analysis. The apparent disconnect between sources is likely explained by differences in time periods and inclusion or exclusion of dually enrolled persons in the count. Our estimate of Medicaid enrolled was based on reporting from CY23 HCA data.
- Estimates of the uninsured population size varied by source. The "Access to Coverage" presentation, referenced above, reports about 370,000 uninsured persons (or about 4.7 percent of Washington residents). Information from the American Community Survey (ACS), see [8], suggests an uninsured rate of 6.3 percent[21] (when calculated using the ACS estimate of total Washington residents), and the report published by HMA on behalf of OIC, noted above, reported a rate of 5.3 percent. The OIC report also includes alternative estimates of other populations (e.g., the fully insured group population). Based on guidance from HCA, we relied on the estimates found in the HCA presentation which includes an adjustment by the Washington State Office of Financial Management to account for an apparent Medicaid undercount in the ACS data, see [9].
- Total Medicaid spending in Washington State is reported by KFF[22] at approximately $29.2 billion in CY23.[23] We were unable to reconcile the Medicaid spending from this analysis to the costs reported by KFF. Based on discussions with HCA, we have made no adjustments to the Medicaid costs included in the baseline for this

[21] Reporting of the uninsured rate as calculated by the ACS may differ between sources depending on the timeframe and selected subpopulation (e.g., whether restricting to individuals less than 65 years old).

[22] KFF is the organization formerly known as the "Kaiser Family Foundation."

[23] KFF data reporting CY23 Medicaid spending by state, see [10]. KFF data based on the CY23 Washington expenditure data, see [11].

report. A Universal Health Care Work Group report to the legislature also estimated the CY22 status quo expenditures for Medicaid (including CHIP) at $15.6 billion, see [12]. We were able to reconcile the difference between this amount and the approximately $9.6 billion included in this report as due to the exclusion of payments for LTSS services and payments attributable to dual-eligible enrollees.

- Estimates of the PEBB and SEBB enrollment varied by source. The "Access to Coverage" presentation, cited above, also included an estimate of enrollment for the PEBB plus SEBB subpopulation which is lower than the estimate used in this report. This lower estimate included only the self-insured subpopulation, and we ultimately relied on enrollment information received from HCA.
- The percentage of Medicare reimbursement estimate for the commercial group subpopulation used in this analysis differs materially from research published by RAND, see [13]. We understand these differences are likely driven by methodological differences between the two studies including data years studied.
- The percentage of Medicare reimbursement estimate for the Medicaid subpopulation used in this analysis is higher than the reimbursement level documented in Table 35 of the "Universal Health Care Work Group" report published by HCA. The Medicaid reimbursement level assumed in this analysis includes the loading of non-claim-based payments,[24] whereas the "Universal Health Care Work Group" report appears to exclude these amounts.

The following subsections specific to the commercial group and uninsured subpopulations include further detail where we used multiple data sources or otherwise had to compute or adjust portions of the estimates. They also discuss the blending of the results across the subpopulations.

Local government and religious organization plans

The local government and religious organization plan subpopulation is based on reported Washington State local government employee counts from the Annual Survey of Public Employment & Payroll (ASPEP) published by the United States Census Bureau, see [14]. Adjustments were made to the reported local government employee counts to avoid double counting with other subpopulations.

- Local government employees in the education sector were excluded to avoid double counting with the SEBB subpopulation.
- A portion of local government employees were excluded to reflect those that receive coverage through PEBB.
- We excluded a portion of reported part-time employees to avoid potential double counting with other subpopulations.

The percentage of part-time local government employees excluded from the estimate of this subpopulation is based on the implied percentage of part-time state government and local government education employees that receive health coverage through PEBB and SEBB. The PEBB and SEBB estimate is based on a comparison of information from ASPEP to actual active PEBB and SEBB enrollment. The final included local government employee counts were then adjusted to total health plan enrolled persons estimates based on an assumed average dependents per employee.

In addition to the subpopulation associated with local government plans, we added an estimate of the persons in plans offered by religious organizations based on employee counts by occupational group published by the United States Bureau of Labor Statistics, see [15].

Full details for the calculation of the estimated local government and religious organization plan subpopulation can be found in Exhibit III.1.b of Appendix C.

For the sensitivity test that includes the fully insured subpopulation, we relied on population counts from the "Access to Coverage" presentation. We compared these estimates to population counts reported in NAIC SHCEs and the ACS. Ultimately, after applying adjustments to the SHCE and ACS counts to avoid double counting with other subpopulations, we understand the various sources to be roughly aligned.

[24] Payments made outside of the claims system. For example, pass-through payments, certain state direct payments, or non-standard provider reimbursement arrangements under managed care.

Uninsured and Medicaid/not Medicaid eligible

Based on the information in the "Access to Coverage" presentation, we assumed the uninsured rate in Washington State to be 4.7 percent, or about 370,000 uninsured persons in CY23. From the underlying ACS data, we estimated 90,000 uninsured individuals, 24.5 percent of the total uninsured in the state, are eligible for Medicaid and the remaining 280,000 are not.

Our estimates of Medicaid-eligible uninsured individuals were based on income estimates for the uninsured subpopulation and the 138 percent of FPL household income threshold for Medicaid eligibility in the Expansion population. We did not make further adjustments for children or pregnant women who have broader income eligibility.[25] We assumed these special classes would already be enrolled in Medicaid due to their more frequent visits to providers and Washington State's Hospital Presumptive Eligibility program. Please note, because of limits on the number of undocumented residents who enroll in Medicaid-like coverage, some of the individuals with incomes of less than 138 percent FPL may still be ineligible under current rules. Moreover, depending on how the state determines eligibility for a universal health care system, uninsured individuals who are eligible for group coverage (e.g., from their employer) may or may not be ultimately included as covered.

For the purposes of estimating percent of Medicare reimbursement rates for the Identified Population, we used CY23 estimated base period uninsured persons, medical service costs, proportion of those costs which are paid to providers, and an estimate of the cost coverage for uninsured patients made by Medicaid allowed.[26] See Exhibit III.3.a of Appendix C for the estimate of Medicare allowed that resulted from these calculations. Please note, we have low confidence in the estimates of payment rates for the uninsured subpopulation. However, because of the relatively small size of this subpopulation in the Identified Population, the impact of modest errors in uninsured payment rates results in relatively small overall impacts to the estimates. See the sensitivity tests for more information.

To incorporate the uninsured subpopulation into the estimates of costs, the final modeled Medicaid subpopulation in each scenario and sensitivity test was increased by the 90,000 cited above, and the non-Medicaid subpopulation by 280,000 (i.e., those subject to cost sharing under scenarios 2 and 3). This effectively assumes the currently uninsured subpopulation will have utilization patterns like the subpopulations into which they are merged. We did not apply any age/gender or morbidity adjustments as part of this process.[27] The modeling does not further differentiate utilization rates or reimbursement rates between the Medicaid-eligible and not Medicaid-eligible uninsured subpopulations, though such an adjustment may be reasonable.[28] More information related to the blending of reimbursement rates may be found in the "Provider reimbursement" subsection of this document.

COST SHARING AND BENEFITS

Per FTAC, the following three benefit and cost sharing scenarios were modeled:

- Medicaid-like benefits and no cost sharing,
- PEBB Uniform Medical Plan (UMP) Classic benefits and cost sharing, and
- Cascade Select benefits (i.e., ACA individual silver metal tier plan essential health benefits).

The specific services and products covered and associated cost sharing amounts are included in Appendix D. This appendix also discusses the method by which the benefits and cost sharing were incorporated into the modeling.

Please note, dental benefits are not covered under all benefit scenarios based on the description above (e.g., the Cascade Select benefit does not include dental coverage by default). Despite this, at the request of FTAC, we have included dental coverage in each of the scenarios with the Medicaid subpopulation receiving a Medicaid-like benefit and the non-Medicaid receiving a PEBB-like benefit. No cost sharing for dental is modeled under Scenario 1 for any subpopulation.

[25] This includes coverage offered by Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP).

[26] Uninsured costs paid for by Medicaid were removed to avoid double counting those provider payments.

[27] We report the results of sensitivity testing of this approach (e.g., assuming lower utilization rates) later in the report.

[28] Note that because of Washington State's presumptive eligibility program, it may be reasonable to presume all (or much) of spending for the uninsured is associated with non-Medicaid eligible persons. Practically, without further adjustments, such an assumption has no impact on the results.

MEDICAL MANAGEMENT

As this analysis is a precursor to UHCC making recommendations regarding benefit design, we were not provided guidance related to the administration of a future health plan. With respect to medical management, the two following possible approaches were considered:

- An FFS-like administration that is limited or absent in terms of management of patients, prior authorization of covered services and drugs, management of persons after an acute care service, and management of persons with chronic disease. Referred to in this report as "limited" or "FFS-like" medical management.
- A PPO-like administration that includes some management of patients with chronic conditions or after acute care service, but no or limited prior authorization requirements for drugs or services. Referred to in this report as "moderate" or "PPO-like" medical management.

Medical management is a broad term which includes the shifting of services across places of service or provider types, reduction of non-necessary services (e.g., avoiding unnecessary readmissions via post-acute care), and management of chronic condition (e.g., by providing patients reminders to take medication). Plans exhibiting a higher degree of medical management may see increased utilization of lower-severity services like therapist visits, prescription drugs, and other management care. These plans may see both lower utilization rates and increased costs associated with the higher severity[29] acute services as the remaining medical services are attributable to the patients with the most resource intensive needs. In contrast, plans with more limited medical management will often see increased rates of emergency department, urgent care, and high-severity acute services. These plans may also have reduced utilization of maintenance drugs, as well as preventative and maintenance services.

The modeling of medical management is based on utilization patterns in Milliman's proprietary benchmark claims dataset, the Consolidated HCG Sources Database (CHSD). This includes nationwide experience from many organizations which have disparate medical management practices. The benchmarks range from 0 percent, which is a nationwide average PPO-like level of medical management, to 100 percent, which is a theoretical best-in-class highly managed population. When adjusting results for medical management, negative values are permissible and represent medical management that may be applicable to out-of-network care for a managed care organization or FFS-like (i.e., more limited than an average PPO). Please note, the cited percentages do not directly correspond to savings rates associated with medical management activities. For example, a 20 percent medical management assumption is not the same thing as a 20 percent reduction in medical service costs.

For the modeling in this report, a -20 percent medical management for the FFS-like administration and 20 percent medical management for the PPO-like administration was assumed. As noted above in the results, alternative medical management assumptions are included in the sensitivity tests.

The 20 percent starting medical management assumption for the non-Medicaid benefit scenarios followed directly from a review of historical experience. It was also used as the starting assumption at which the models were calibrated to the baseline. After model calibration, we discussed the possible impacts of changing medical management practices from the status quo (calibrated at 20 percent medical management) to an FFS-like system with the experts involved in the development of the medical management adjustments. Based on these discussions, and after reviewing impacts on a service-line level, we determined that a 40 percent reduction in medical management (i.e., from 20 percent to -20 percent) was reasonable. This assumption of -20 percent medical management in the FFS-like scenario is largely based on judgement and is a significant source of variation in our estimates.

Finally, we emphasize the difference between the related concepts of IU and medical management, with an example of each:

- IU is the change in habits of a patient due to cost sharing exclusive of intervention by plan administration. For example, a patient may elect to forego an expensive imaging procedure because they would be responsible for all or most of the cost of the service as a part of their plan's deductible.

[29] Note that the term "severe" or "higher severity" is used to differentiate among services that have greater costs or service intensity (e.g., inpatient hospital stays). It is not intended to diminish the medical needs associated with less resource intense alternatives (e.g., routine care or drugs).

- Medical management is the change in habits of a patient due to interaction with plan administration (which may include discussions of patient cost sharing). For example, a plan administrator may counsel (or require) a patient to receive imaging services at a freestanding imaging center rather than a hospital, thereby lowering the imaging service costs for both the patient and the plan.

The concepts, modeling, and practical execution or effects of cost sharing design, IU, and medical management are closely interrelated but not duplicative, and are all included in the modeling of this report's results. The impact of IU in each scenario is reported both as by-service line adjustments and at the bottom of the cost model exhibits, II.2.a, b, and c, in Appendix C.

PROVIDER REIMBURSEMENT

Starting with the information summarized in Table 7, we estimated the total reimbursement rate for CY23 services across the CY23 population. This calculation and detailed results are found in Exhibit III.1.a of Appendix C and are summarized in Exhibit III.3.a. As discussed above, this calculation was performed at an inpatient, outpatient, and professional service detail level for percent of Medicare reimbursement rates. In addition to the broad service category detail, this analysis was also performed at the following subpopulation level of detail:

- Medicaid enrolled subpopulation (exclusive of enrollees that are also eligible for Medicare, and exclusive of LTSS services),
- Estimates of cost coverage for services for the uninsured subpopulation (see the discussion in the subsection pertaining to the uninsured above),
- Individual plan enrolled subpopulation (inclusive of both health benefit exchange plans and off-exchange plans),
- Local government and religious organization plan enrolled subpopulation, and
- The PEBB and SEBB plans' enrolled subpopulations.

For the purposes of this analysis, we defined the fully loaded Medicare payment rates as the prospective payment rates, including, but not limited to, the following adjustments:

- Area-adjustments to payment rates,
- Disproportionate Share Hospital (DSH) payments,
- Indirect Medical Education (IME) payments,
- Uncompensated care payments (UCP), and
- Outlier payments.

This definition excludes pass through payments among other payments that may, in some settings, be included as a part of Medicare payment rates. Inpatient prospective payment system (IPPS) reimbursement was used as an approximated Medicare reimbursement for inpatient admissions at facilities that are paid through payment systems other than IPPS (e.g., children's hospitals, and psychiatric hospitals). Although this is the intended definition of Medicare payment rates, and we believe the various sources for this analysis to generally follow this definition, it was not always possible to confirm that there was full alignment. This should be considered as a possible significant source of uncertainty in the estimates of a "payment neutral" percent of Medicare FFS reimbursement rates. Partly in response to this, the report includes various reimbursement level sensitivity tests to provide a range of estimates that account for potential disconnects in the Medicare payment rate definition between data sources.

Prescription drug services are neither covered by nor priced at Medicare FFS payment rates, and no percent of Medicare amount was available for these services. Instead, we used estimated discounts off AWP,[30] reported rebates, and calibrated baseline results to confirm starting allowed amounts for each subpopulation agreed with the observed amounts. Observed prescription drug costs were collected from the following sources:

- Summarized HCA data sources for the Medicaid, PEBB, and SEBB subpopulations,
- URRT data for the individual subpopulation, and

[30]The discount rates were taken from those reported in Figure 2 of the Milliman whitepaper "NADAC-plus: An emerging paradigm in pharmacy pricing?" published in 2018, see [16].

- NAIC SHCE reported costs for the commercial group subpopulation.

Because the amounts reported in the NAIC SHCEs did not include detailed information by drug class (e.g., generic, brand, and specialty), Milliman's benchmark data was used to produce a more granular distribution of costs[31] for modeling purposes. Information about drug rebates—a significant source of cost savings for purchasers—was also taken from the sources cited above. Drug rebates were incorporated into the allowed costs that appear in the estimates.[32] Exhibit III.3.b has more detail of this calculation, but the variability of the underlying estimated discount rates is subject to significant uncertainty. In response to this uncertainty, the report includes sensitivity tests associated with variable rates of drug costs.

Dental care is also not covered by or priced at Medicare FFS rates. We compared historical paid dental care costs for the Medicaid, PEBB, and SEBB subpopulations. Based on this analysis, we have priced dental at PEBB and SEBB population-like costs for all the non-Medicaid subpopulations and at Medicaid costs for the Medicaid subpopulation. For the non-Medicaid subpopulations, we estimated the AV of the dental coverage at 64 percent and used this to estimate the total allowed amounts for dental care. For the individual and group subpopulations, the dental spend was modulated by the relativity of medical payments to PEBB and SEBB using the following formula (with the individual subpopulation used as an example).

$$\text{Estimated individual dental cost} = \text{Avg. PEBB \& SEBB dental PMPM} \times (\text{Individual medical PMPM} / \text{Avg. PEBB \& SEBB medical PMPM})$$

Dental rates are another source of uncertainty in the estimates. It is unclear whether the approach models a reimbursement neutral payment rate for services and whether individuals newly offered dental coverage under this program would have similar utilization rates to those currently enrolled in PEBB and SEBB. As dental coverage is often optional and available at additional costs to the enrollee, there is likely a degree of adverse selection in the observed dental utilization rates and cost of care.[33] It is also possible that there is pent-up demand for dental services among those who do not currently have coverage.

Together, these medical, pharmacy, and dental assumptions result in the estimated payment neutral reimbursement rates displayed below in Table 8.[34]

TABLE 8: CURRENT AND MODELED PROVIDER REIMBURSEMENT RATES

		PERCENT OF MEDICARE BY SERVICE CATEGORY			PERCENT OF AWP[A]
SUBPOPULATION	ESTIMATED TOTAL CY23 COST OF CARE[B]	INPATIENT MEDICAL	OUTPATIENT MEDICAL	PROFESSIONAL AND ANCILLARY	PRESCRIPTION DRUGS
Medicaid[C]	$9.1 billion	130%	77%	108%	24%
Uninsured	$0.7 billion	90%	85%	70%	52%
Individual	$1.6 billion	190%	220%	125%	39%
Local government and religious organization	$1.6 billion	224%	259%	147%	39%
PEBB	$2.3 billion	189%	232%	138%	39%
SEBB	$1.8 billion	189%	245%	151%	38%
Composite Reimbursement[D]	$17.0 billion	139%	126%	117%	31%

(A) Prescription drug estimated percent of AWP is inclusive of savings due to drug rebates. Medicare does not publish payment rates for prescription drugs and Medicare coverage is only available via private insurance under the Part D program.

[31] Compare the detail level of results in Exhibit III.1.a (inpatient, outpatient, professional, ancillary/other, prescription drug, and dental) to the increased detail included in Exhibit II.2.a.

[32] Note that because drug rebates are not usually included in the point-of-sale costs, our approach may result in slightly under-stated member cost sharing and over-stated paid amounts. We have tested the impacts of this simplifying modeling assumption and believe it to be small relative to other possible sources of error in the estimates.

[33] Adverse selection describes the propensity for individuals who expect to use these services to be more likely to enroll in dental plans.

[34] Note that dental is omitted in Table 8 as the approach does not directly generate a reportable payment rate relative to a standardized fee schedule or rate.

(B) Estimated total expenditures from only included subpopulations. Service-category specific estimated total expenditures are used to weight to composite rates on a by-service category detail level. Table excludes expenditures for dental services.
(C) Medicaid reimbursement is inclusive of state-directed payments, GME, and other non-claim based payments. See the discussion below for more information.
(D) Composite reimbursement based on historical enrollment and utilization rates. See exhibits III.1.a, III.3.a, and III.3.b for more information on the development of these reimbursement rates.

We emphasize that while the composite payment rates in Table 8 are used as the basis for this analysis, they are not appropriate "flat" percent of Medicare payment rates across Washington State. It is unlikely a flat percent of Medicare is an appropriate method of developing actual statewide reimbursement.

The following subsections discuss the source information used, and the development of the Medicaid, uninsured, individual, PEBB, SEBB, and commercial group reimbursement rates listed above. Significant limitations associated with the information used and the estimates derived also are discussed. In many cases, we collected several sources that provide estimates of reimbursement rates, reviewed the definition of "percent of Medicare" used in the underlying works, and reviewed the services included or excluded from the analyses. Because of reasonable differences in approach by the authors of the reports cited below, significant variations between sources can occur.

Medicaid reimbursement rates

Medicaid facility FFS reimbursement rates as a percent of Medicare were based on a Medicaid hospital payment benchmarking analysis performed by Milliman and commissioned by HCA.[35] The analysis relied on CY21 data and compared inpatient and outpatient Medicaid claim payments to Medicare and commercial reimbursement. Non-claim payments for access or medical services were added to the estimate of Medicaid reimbursement. This includes payments for graduate medical education (GME), safety net assessment fund (SNAF), and DSH payments, among other CY23 directed or pass-through amounts.[36] The full Medicaid payment amounts for inpatient and outpatient services, including FFS claim payments and non-claim payments, were then compared to Medicare reimbursement rates for the same services to generate the estimates.

The Medicaid FFS reimbursement rates as a percent of Medicare for professional and ancillary services is based on the Medicaid-to-Medicare fee index published in a study by Health Affairs (see [17]), additional comparisons of the Medicaid and Medicare fee schedules, and adjustments to incorporate Medicaid directed payments such as those made to Federally Qualified Health Centers.

PEBB and SEBB reimbursement rates

The CY23 allowed costs PMPM for medical, pharmacy, and dental services are based on claims data and other information provided by HCA. The Milliman's GlobalRVUs® and Medicare Repricer software was used to assign Medicare allowed amounts to the PEBB and SEBB claims data. These assigned Medicare allowed amounts, and the actual contracted allowed amounts were used to calculate the percent of Medicare reimbursement rates by service category. As described above, an alternate approach was used to estimate costs at a payment neutral level for pharmacy and dental services.

Uninsured reimbursement rates

Finding both historical service cost and reimbursement information to support the estimates for this subpopulation was more difficult than for other subpopulations of the Identified Population.

We relied on the following estimates:

- The estimated PMPM medical expenditures for the uninsured of $147.92 were calculated as ($1,350 annually ÷ 12 months) × 1.043 trend factor + $30.58 PMPM, with
  - CY22 costs of $1,350 per year based on MEPS-HC Data Tools – Medical Expenditure Panel Survey (MEPS) Household Component (HC) (see [18]), restricted to under 65, uninsured, and excluding dental costs. These expenditures are distributed across inpatient, outpatient, professional, ancillary, and prescription drug categories based on the costs by medical event reported by MEPS.

[35] This is part of the CMS Upper Payment Limit (UPL) demonstrations that must be submitted annually by state Medicaid agencies.

[36] Note that the estimates of payments are gross amounts (e.g., they do not remove the provider tax used to partially fund some of these payments).

  - CY22 to CY23 trends based on 2023Q3 Medicare Economic Index four-quarter moving average of 4.3 percent, see [19].
  - $30.58 PMPM, calculated as the estimated payments made through government funding to cover hospital uncompensated care costs. (See the following discussion regarding the development of the assumed reimbursement as a percentage of Medicare for details regarding this calculation.)
- The inpatient costs, reimbursement as a percentage of Medicare, and uncompensated care payments were estimated based on the following:
  - We assumed the subset of uninsured individuals with incomes less than 138 percent of FPL would have inpatient admission rates similar to the Medicaid subpopulation, and the remainder of the uninsured subpopulation would have admission rates similar to the individual subpopulation. Using these assumptions, we estimated an implied Medicare allowed amount for the uninsured subpopulation.
  - Based on reported hospital margins in Washington State for Medicare beneficiaries,[37] we estimated that the Medicare allowed cost PMPM represents 83.1 percent of facility incurred costs. The difference between the MEPS expenditures and implied hospital costs is the derived cost of uncompensated care.
  - Per a KFF analysis, see [21], we assumed 80 percent of these estimated costs are paid for via government uncompensated care payments. Based on the same KFF analysis, we assumed that 29 percent of these uncompensated care payments are made through the Medicaid program. These Medicaid uncompensated care payments are excluded from the estimate of reimbursement for uninsured patient services to avoid double-counting.
  - To calculate the total estimated payments for the uninsured subpopulation's inpatient services, the inpatient expenditures from MEPS[38] are added to the estimated non-Medicaid uncompensated care payments. The inpatient reimbursement as a percentage of Medicare is estimated as these medical payments divided by the previously calculated Medicare allowed cost PMPM.
- The outpatient reimbursement as a percentage of Medicare and outpatient uncompensated care payments were estimated based on the following:
  - Uncompensated care costs and reimbursement as a percentage of Medicare for emergency room visits are calculated using similar methodologies to, and assumptions as, the above estimate of inpatient admission costs.
  - Non-emergent outpatient medical costs are based on the reported expenditures from MEPS with no adjustment for uncompensated care.
  - The non-emergent outpatient reimbursement as a percentage of Medicare is calculated based on assumed utilization and reimbursement relativities between persons at different income levels as measured by FPL.
    - The income distribution of the uninsured subpopulation for this calculation is based on Washington State information reported by KFF, see [8].
    - The utilization and reimbursement relativities assume that uninsured individuals at higher income levels will both use more services and pay more for those services than uninsured individuals at lower income levels. These relativities are set based on actuarial judgment.
- The professional reimbursement as a percentage of Medicare is estimated using similar methodologies to, and assumptions as, non-emergent outpatient services.

Because of the variable nature of the estimates of uninsured medical costs and reimbursement rates, we performed several simple sensitivity tests of the assumptions above. These tests included the following:

- The uninsured utilization rate was increased by 25 percent with no changes to the assumed reimbursement level as a percentage of Medicare (i.e., also representing a 25 percent increase in the total allowed cost). This

[37] Milliman tracks reported hospital margins based on publicly available information in the CMS Hospital Cost Report Information System (HCRIS), see [20].

[38] These are the payments made by the uninsured patients themselves.

resulted in a 0.7 percent decrease in the baseline composite reimbursement level estimate across the Identified Population.[39]

- The assumed uninsured reimbursement rate as a percentage of Medicare was increased for all service types by 25 percent with no change to the allowed cost PMPM level (i.e., also representing a 25 percent decline in the assumed utilization rate). This resulted in a 1.7 percent increase in the baseline composite reimbursement level estimate across the Identified Population.

Based on the results of these and similar sensitivity tests, we concluded that due to the relatively small size of this subpopulation and low expenditures, deviation from the baseline assumptions within a reasonable range would have a small impact on the overall results.

Individual insurance reimbursement rates

The CY23 allowed cost PMPM for medical and pharmacy services is based on the 2025 Public Use File for Single Risk Pool Plans published by CMS, see [4]. Specifically, the experience period index rate PMPMs[40] from the Worksheet I URRT data were used to estimate the CY23 allowed cost PMPMs by service category.

The 2025 URRT data does not include CY23 experience for PacificSource Health Plans, which dropped out of the Washington individual market in 2025 and therefore did not submit URRTs. We reviewed CY22 experience in the 2024 URRT data to determine the potential impact of missing PacificSource Health Plans data. As of CY22, PacificSource Health Plans accounted for 1.6 percent of enrollment in the individual market, and the allowed cost PMPMs with and without PacificSource included were within 0.3 percent. Based on this review, we concluded the missing PacificSource Health Plans data in the CY23 experience data is not a material deficiency and used the 2025 URRT experience data without adjustment for the estimate of the individual market allowed cost PMPM by service category.

Reimbursement as a percentage of Medicare by major service category (inpatient, outpatient, professional) was estimated based on the relativity to the assumed commercial group reimbursement rate. To estimate the reimbursement relativity of the individual market to the commercial group market, we compared CY23 risk-normalized allowed cost PMPMs for the individual and small group enrolled from the published 2025 URRT data. The risk normalization was applied based on Washington State average Plan Liability Risk Scores (PLRS) published in the 2023 Risk Adjustment Summary Report, see [22]. The resulting difference between the risk-normalized allowed cost PMPMs for the individual and small group enrolled was assumed to represent reimbursement differences. This resulted in an 0.85 reimbursement relativity between the individual and group market.

The estimated factor of 0.85 was then applied to the assumed commercial group reimbursement level, which is based on analysis published by Milliman (see the “Commercial group reimbursement rates” subsection below). The calculated 0.85 relativity in risk-adjusted allowed cost PMPMs has been stable between CY19 and CY23.[41] Additionally, the calculated 0.85 reimbursement relativity is reasonably close to the result of an analysis performed by USC Schaeffer Center researchers, which estimated a 0.89 reimbursement relativity between ACA exchange plans and commercial group plans, see [23]. We acknowledge there are many other factors that are not captured in this simplified methodology to estimate the reimbursement relativity of the individual and group markets. Various reimbursement sensitivity tests to account for this uncertainty and to develop a range of reasonable estimates are included in this report.

The individual market’s reimbursement rate may change materially from CY23 to future years as enrollment in the Cascade Select program continues to change. The Cascade Select program is subject to legislative limits on provider reimbursement rates that may be lower than the individual market. Enrollment in the Cascade Select program grew from 17 percent of the individual exchange market in CY23 to 27 percent in CY24, based on the 2023 and 2024 fall enrollment reports published by the Washington State Health Benefit Exchange (HBE), see [24]. Together, this may

[39] This change is a result of the utilization weighting of the aggregate reimbursement rate. Because the uninsured population is assumed to have a relatively lower reimbursement rate, increasing the utilization rate for that subpopulation results in a lower utilization-weighted average reimbursement rate across the baseline (i.e., the decline of about 0.7 percent).

[40] The experience period for 2025 URRT submissions was calendar year 2023.

[41] Excluding 2020, the relativity from the same data sources ranged from 0.85 to 0.88 over that timeframe.

imply current or future average individual market provider reimbursement rates are lower than the rates modeled in this report.

Commercial group reimbursement rates

The estimated CY23 allowed cost PMPM for the commercial group subpopulation is based on paid PMPMs reported in the NAIC SHCEs and an assumed paid-to-allowed ratio based on Milliman research. The distribution of utilization and costs across detailed service categories (i.e., those appearing in Exhibit III.2 in Appendix C) is derived from the broad service category information in the NAIC SHCEs and the detailed distribution from Milliman's benchmark sources.

Reimbursement as a percentage of Medicare by major service category (inpatient, outpatient, professional) was estimated based on Washington State specific results from internal Milliman research. This same research underlies the results in Milliman's 2024 commercial reimbursement benchmarking analysis, see [25]. Based on a review of internal data sources, we determined the changes in the estimated percent of Medicare reimbursement levels in Washington State between CY23 and CY24 were modest, and thus the 2024 study's results are used without adjustment.

Calculation of composite reimbursement rates

Our calculation of a payment-neutral rate based on the information discussed in the preceding subsections may be found in Exhibit III.1.a in Appendix C. This exhibit shows the following results by subpopulation (Medicaid, uninsured, individual, etc.):

- Total enrollment and member months,
- CY23 PMPM costs by service category (i.e., total reimbursement by category, inclusive of supplemental payments where applicable),
- Estimated percent of Medicare by service category, and
- The implied total Medicare allowed cost PMPM for the same services.

The right of the exhibit reports the calculated aggregate totals which are used in the modeling as the "payment neutral" reimbursement rates as a percent of Medicare allowed. Note that, based on guidance from FTAC, we assumed there were no "out of network" or out-of-state providers that are paid at alternate reimbursement rates. The summary composite results in this exhibit are the same as those presented in more service category detail in Exhibit III.2 of Appendix C.

This approach has some exceptions. Glasses, contacts, hearing aids, and associated exams are not covered by the Medicare FFS benefit, and do not have a Medicare payment rate. Because of this, reimbursement rates for glasses, contacts, hearing aids, and associated exams are based on Milliman's benchmark utilization and unit costs, calibrated to baseline allowed costs. As discussed above, prescription drugs and dental services also were modeled using alternative methodologies.

BENEFIT MODELING RESULTS

The starting point of item number (3) in the outline at the start of this section, estimating the cost of care under the scenarios, is the detailed cost models of CY23 utilization and claim costs by subpopulation. This information is summarized in Exhibit III.2 of Appendix C.

The Medicaid source data relied on was actual CY23 encounters and claims made available by HCA for the purposes of this analysis, summarized at the cost model detail level. Additional Medicaid payments were not included in the encounter or claims data, including non-claims payments (e.g., subcapitation arrangements), state-directed payments (e.g., provider access payments), and pass through payments (e.g., SNAF). These amounts were adjusted to reflect only the portion of the Medicaid subpopulation of the Identified Population (e.g., excluding payments attributed to dual

eligible enrollees), and incorporated into the cost model according to their type. Additional payments, limited to those applicable to this analysis, were included based on information made available by HCA.[42]

For the PEBB and SEBB subpopulations, we used a combination of detailed cost models made available by HCA and Milliman's data sources and models.[43] To allow for modulation of reimbursement, benefits, and cost sharing, the Milliman models were calibrated to the PEBB and SEBB subpopulations on an allowed cost basis. The calibrated CY23 starting cost models provide detail at a service-line level, and the allowed cost calibration was performed at this level. Reimbursement rate adjustments were made at a less granular IP, OP, professional service, dental, and prescription drug level. Because of the nature of this calibration, utilization, paid, and patient pay amounts for specific service lines in the calibrated cost models may differ from actual PEBB and SEBB experience. Other modeling adjustments, including those made to estimate the cost under the scenarios' benefit structures, were made at a detailed service line level.

For the non-PEBB and non-SEBB commercial group and individual subpopulations, we used a combination of publicly reported information and Milliman's benchmarks and models. The Milliman models were calibrated to the non-PEBB and non-SEBB commercial group, and individual subpopulations to publicly reported CY23 allowed costs based on information from the NAIC SHCEs restricted to Washington State and URRT data published by CMS. We compared the information retrieved from these sources both between sources (where there was overlap) and to Milliman's benchmarks. Like the starting cost models for the Medicaid, PEBB, and SEBB subpopulations, the calibrated CY23 starting cost models provide detail at a service-line level, but the calibration and reimbursement rate adjustments were generally made at a less granular IP, OP, professional service, dental, and prescription drug level. As above, other modeling adjustments were made at a more detailed service line level.

As the Medicaid subpopulation's benefits and cost sharing are constant across all scenarios, to model the Medicaid subpopulation's costs, we used existing Medicaid summary cost models and modulated the reimbursement rates. Adjusting them upwards from the reimbursement rates found in the research to the payment neutral reimbursement rates across the Identified Population included in the modeling scenarios and sensitivity tests. For the other subpopulations, we used the MCRM, calibrated using the historical data, benefits, reimbursement rate, and other assumptions discussed above.

SERVICE CATEGORIES IN DETAILED EXHIBITS

Service categories and unit summaries (e.g., those in Exhibit III.2 in Appendix C) were assigned to Medicaid, PEBB, and SEBB claims data using the Milliman's HCG Grouper software. The HCG Grouper assigns each claim service line to an HCG service cost category based on the medical coding on the claim. In general, the following claims elements are used to assign service categories:

- **Inpatient:** Inpatient facility claims are identified based on the presence of room and board revenue codes and are categorized based on the diagnosis related group (DRG) present on the claim. When DRGs are unavailable, ICD diagnosis codes, ICD procedure codes, and revenue code information is used instead.
- **Outpatient:** Outpatient facility claims are identified based on the presence of revenue codes on the claim or based on the provider type (e.g., ambulatory surgical center). Outpatient claims are categorized primarily based on the revenue codes and Healthcare Common Procedure Coding System (HCPCS) or Common Procedure Terminology (CPT) codes on the claim.
- **Professional/other:** Professional/other claims are identified based on the lack of revenue codes or based on the provider type. Physician revenue code line items billed as part of a facility claim are categorized as professional/other. Professional/other claims are categorized primarily based on the HCPCS/CPT code, place of service, and provider type (e.g., home health provider) information.

[42] Including the CY2023 Apple Health Integrated Managed Care rate certification, the Apple Health Integrated Managed Care and Integrated Foster Care CY2022-23 Databook, the October 2023 MPA Medical Assistance Forecast Summary Report, and discussion with HCA.

[43] Including the Milliman Health Cost Guidelines (HCGs), the CHSD, and the Milliman Managed Care Rating Model (MCRM) to develop the baseline CY23 cost models.

The HCG Grouper categorization is continuously updated by Milliman and reflects the most current medical code sets. The HCG Grouper assigns the following traditional utilization metrics:

- **Admissions:** Count of unique admissions for a single patient at the same facility. Interim bills and same day readmissions are combined into a single admission.
- **Days:** Count of unique days of confinement for a single patient at a facility. Days are calculated based on the admission and discharge dates reported on the claim.
- **Visits:** Count of unique visits for a single patient with a single provider on a unique date of service.
- **Procedures:** Count of unique service lines for a single patient.

These categories are used in the estimation of the impacts of IU and medical management impacts.

Sensitivity testing

We performed sensitivity tests to estimate the impacts of adjusting the starting assumptions. Each of the sensitivity tests is discussed in this section, and the results of each sensitivity test may be found in Exhibit II.3 in Appendix C. The numbering of the following subsections, e.g., "1. Provider reimbursement rates," corresponds to the numbering within the results exhibit. Some of the results discussed here were previewed in the "Results by scenario" section or had their methodology addressed in the "Methodology, assumptions, and data sources" section.

1. PROVIDER REIMBURSEMENT RATES

The baseline scenario assumes a payment neutral composite reimbursement rate. A variety of sources contribute to the variability of the baseline assumption; these include:

- Changes in both Medicare reimbursement and the reimbursement rates of the included subpopulations over time;
- Inconsistent measures of "Medicare allowed" across data sources;
- Limitations in the methodology used to estimate Medicare allowed (e.g., in the approach using risk-adjusted allowed amounts used for the individual plan enrolled subpopulation);
- Data limitations, assumptions, and judgment used in the estimation of the uninsured subpopulation's reimbursement rates and total cost of care; and
- Lack of Medicare pricing for some services.

To estimate the potential impact of sources of variability, we adjusted the assumed reimbursement rate by plus and minus 5 percent.

At the request of FTAC, we have also included a sensitivity test where all services are subject to a fixed reimbursement rate of 160 percent of Medicare, intended to align with the maximum aggregate reimbursement rate for Cascade Select plans.[44]

Note that changes in the relative size of each subpopulation group also can impact the composite reimbursement rate. As such, other sensitivity tests which impact distribution across the subpopulations will also include the impact of changes to reimbursement rates.

2. PRESCRIPTION DRUG REIMBURSEMENT RATES

In an exercise similar to the estimates of medical services discussed in the first sensitivity test, we have estimated the impact of adjusting the assumed discount off AWP for prescription drugs. We have sensitivity tested an increase of the discounted drug cost by 5 percent (i.e., increased assumed price of prescription drugs), and a decrease of 5 percent.

Because the drug cost is often around one-fifth (or less) of the total cost of care, this sensitivity test has a smaller impact than the prior test on provider reimbursement rates.

3. FULLY INSURED GROUP PLANS

The baseline scenarios include enrollment from PEBB, SEBB, local government, and religious organization sponsored health plans. This sensitivity test adds to that selection all other fully insured commercial group plans, significantly increasing the size of the group subpopulation (and total Identified Population) modeled.

For the commercial group subpopulation added in this sensitivity test, summing reported membership across carriers from the 2023 NAIC SHCEs results in an estimated 1.2 million enrollees. Alternatively, the "Access to Coverage" presentation published by HCA cited previously reports a total of about 945,000 enrollees. We relied on the HCA presentation and partially reconciled the differences between the sources by adjusting the NAIC SHCEs results for double counting of individuals with more than one commercial coverage or commercial and Medicare coverage. This results in an alternative Identified Population, inclusive of fully insured plans, of approximately 4.1 million.

[44] The Cascade Select or Public Option enabling legislation is ESSB 5526 (see [26]) and SB5377 (see [27]). Note that Cascade select does not have uniform reimbursement at 160 percent of Medicare but allows carriers to vary rates provided that overall reimbursement for medical services does not exceed that cap (and other requirements are met).

Lacking sufficient information in the data available to us to differentiate between the fully insured groups and the local government and religious organization sponsored plans, we did not adjust the commercial group subpopulation's starting utilization, costs, or reimbursement rates for the added enrollment in this sensitivity test. However, the aggregate results across all populations do change with the resulting re-weighting. In particular, the assumed payment neutral reimbursement rates increase from the baseline as shown in Table 9.

TABLE 9: ESTIMATED COMPOSITE PERCENT OF MEDICARE ALLOWED AND DRUG DISCOUNTS

SERVICE CATEGORY	BASELINE SCENARIOS	SENSITIVITY TEST 3
IP services	139%	148%
OP services	126%	147%
Professional services	117%	122%
Ancillary and other services	114%	119%
Total % Medicare allowed	125%	135%
Drug Discounts off AWP	52%	52%

These resulting increases in reimbursement rates significantly increased the estimated costs for the Identified Population. The baseline and modeling results for this alternate scenario are shown below in Table 10, including a range of results for this scenario based on the other sensitivity tests described in this section.

TABLE 10: ESTIMATED PER MEMBER PER MONTH (PMPM) AND TOTAL PLAN PAID[A] BY SCENARIO, ALTERNATIVE IDENTIFIED POPULATION

SCENARIO BENFITS AND COST SHARING	PAYER PAID PMPM[B]	TOTAL ANNUAL PAYER PAID[C]
Total current state program costs		$13.6 billion
Medicaid[D]	$408	$9.6 billion
PEBB[E]	$628	$2.2 billion
SEBB[E]	$551	$1.8 billion
Non-state program costs[F,G]		$6.3 billion
Total baseline costs		$20.0 billion
Scenario 1: Medicaid-like	$539 - $633	$26.5 - $31.0 billion
Scenario 2: PEBB- and SEBB-like	$445 - $523	$21.8 - $25.7 billion
Scenario 3: Cascade Silver-like	$382 - $454	$18.7 - $22.3 billion

(A) Totals include medical, pharmacy, and dental costs and exclude non-benefit expenses. Dental costs are not included in the non-state program cost baseline amount as those costs were not available for these populations.
(B) Baseline payer paid amounts (e.g., Medicaid) are not directly comparable to the scenarios' ranges. The scenarios ranges are a composite of all baseline populations and individual subpopulations scenario results, like Medicaid, may have increased or decreased relative to the baseline.
(C) Scenario results are based on the CY23 Identified Population, including fully insured health plans, of 4.1 million individuals.
(D) Includes Medicaid populations included in the Identified Population and select Medicaid services (e.g., excluding dual enrollment, LTSS, etc.). Costs are inclusive of both state and federal funding.
(E) Note that these totals may include some coordination of benefit payments made by other payers which are not part of a state program.
(F) Includes local government, religious organization, individual, fully insured group health plans, and the uninsured.
(G) A portion of individual insurance premiums are paid for by the state via the Washington State Premium Assistance Program. These premium payments would cover some of the costs reported in this line. In the biennial 2024 - 2025 Washington State budget $100 million was funded to cover individual market premiums through the Washington State Premium Assistance Program, see [1].

4. MEDICAID-ELIGIBLE ENROLLMENT

As noted, the ending of FFCRA's continuous coverage provision in CY23 may result in the base period data containing higher Medicaid enrollment rates than would be expected in a future period. Likely related to this, we observed emerging Medicaid enrollment in CY24 has declined by about 10 percent.

To estimate the impact of changes in Medicaid enrollment, for the reason cited above or others, we have assumed a 10 percent larger and 10 percent smaller Medicaid subpopulation. In these scenarios we have assumed that the total Identified Population is unchanged and a decrease (or increase) in Medicaid enrollment coincides with an increase

(or decrease) in enrollment in the non-PEBB and non-SEBB subpopulations within the Identified Population. We have not adjusted the aggregate reimbursement rate in either sensitivity test.

5. MEDICAL MANAGEMENT

As background, please see the "Medical management" subsection of the "Methodology, assumptions, and data sources" section above which describes the meaning of medical management in this report and the level of medical management assumed in the three scenarios. Because the structure and policies of medical management and its impacts on the population subject to management are variable, and because it is unclear what administrative structure may be developed, we have estimated the impact of an alternative rate of medical management on the results in Scenario 2 and Scenario 3. In both cases, the results of two medical management levels are included:

- A sensitivity test of limited or FFS-like medical management (i.e., more limited than the assumption in Scenarios 2 and 3), and
- Moderate or PPO-like medical management (i.e., the assumption in Scenarios 2 and 3).

Scenario 1 is based on a Medicaid FFS-like benefit structure with no cost sharing. Because of this, we have assumed that no or limited medical management is likely or possible, and therefore provided no alternative medical management sensitivity test results for this scenario.

6. OTHER VARIATION IN UTILIZATION RATES OR SELECTION

This sensitivity test provides the impacts of a 3 percent increase or decrease in CY23 utilization rates (across all services) and shows the impact of a modest change in utilization rates from the scenarios' estimates. This sensitivity test is intended to account for under- or over-reported utilization and medical costs in the base data. It also provides the reader with some additional context related to the variability inherent in the estimates.

Possible sources of variability in utilization rates and cost of care include (not all of which would be included within the narrow plus or minus 3 percent bounds provided):

- Undetected errors in the data underlying the analysis (as cited above);
- Unexpected impacts of selection;[45]
- Normal variation in demographics and morbidity;
- Changes in medical practices; and
- External forces, including pandemic or natural disaster.

This sensitivity test should not be understood as providing reasonable bounds for a future projection. It does not, for example, account for the impact or variability of utilization or cost trends over time.

SUMMARY OF SENSITIVITY TEST RESULTS

These tests are intended to examine the impacts of varying starting assumptions within reasonable ranges or based on direction from FTAC. They should not be interpreted as covering the entire spectrum of possible reasonable starting assumptions or possible final parameters of a health plan like those described above. For example, we have not tested the impacts of employing ACA-like cost sharing reductions (CSRs) to enrollees despite some of the enrollees in the Identified Population currently being eligible for CSRs.

[45] Selection includes the impacts associated with individuals or organizations changing their health insurance purchasing habits to enable or avoid participation in a universal health care system. Such individuals or groups may have a health status that is distinct from the population otherwise enrolling, thereby increasing or decreasing the utilization habits of the ultimately enrolled population. For example, an employer offering a self-insured group plan with a population that is expensive relative to the Identified Population may change their plan structure to enable its incorporation into a universal health care system. This would likely increase the utilization rates and cost of care of the Identified Population.

Further considerations

This section introduces some considerations that may impact the development of a future universal health care system with a design informed by one of those analyzed in this report. While we have not performed a detailed analysis of the following items, the reader is encouraged to carefully consider their possible implications. Future study of these items may be appropriate.

The items discussed here are not intended to be an exhaustive list of material considerations that are not elsewhere analyzed within this report. Instead, these are considerations that were raised throughout the development of the report but were deemed outside the scope of the analysis. Other material considerations exist and may be discovered as a prospective universal health care system is further analyzed, developed, and feedback is received from stakeholders.

This section has been organized into related subtopics, but the order of the sections should not be understood to correlate with the expected materiality of each consideration (or via any other metric).

ADMINISTRATIVE COSTS

Non-benefit program costs are not included in these estimates, but these program costs are a key consideration. Various approaches would be available to the state for the administration of a universal health care system. In general, non-benefit expenses associated with administration of services including claims processing, medical management, quality assurance or improvement, member communications, and other necessary activities may add significant additional costs beyond benefit expenses. Alternatively, an FFS-like administration may add more limited additional expenses beyond benefit costs.[46]

Note that it is not uncommon for the initial administrative startup costs of plans to be high relative to the cost of care. While this is often partially a result of relatively low enrollment in the first years of a new program, something which may not be the case for a universal health care system, other program costs also will be higher in year one. Drivers of increased costs, most of these additional early-year costs could apply to a universal health care system, include developing and adjusting plan design, outfitting claims processing and related systems for new use cases, and member engagement.

Finally, in our analysis we have assumed that a program would be administered by a single entity. If the state structured a universal health care system so multiple managed care organizations (MCOs) were paid capitation rates to manage portions of the population in a semi-competitive arrangement like Medicare Advantage or Medicaid Integrated Managed Care, then other significant considerations outside the scope of this paper should be analyzed. These considerations include risk adjustment of capitation rates (and associated diagnosis coding trends), differing medical management assumptions (including for the Medicaid eligible subpopulation), as well as administrative service costs for both the state and for the individual MCOs.

APPROPRIATENESS OF MODELED REIMBURSEMENT RATES

Our estimate of a payment-neutral percent of Medicare reimbursement rate does not include adjustments for known or possible changes in provider reimbursement rates between CY23 and CY25. For example, as discussed in the Section 438.6(c) Preprint (approval provided to HCA by CMS on March 21, 2024), see [29], the state will increase payments for inpatient and outpatient hospital services rendered by a hospital owned or operated by a state university by $433 million in CY24. There are also significant changes to state-directed payments in the Medicaid program, including but not limited to the replacement of the SNAF pass-through payments with the Hospital Safety Net Program (HSNP), payments for community behavioral health support services (CBHS), and minimum fee schedule increases for some physical and behavioral health services. In addition, changes to the Medicare fee schedule alone between 2023 and 2025 would necessitate a recalculation of the payment neutral reimbursement rate

[46] Commercial plans and administrative services organizations often see additional costs beyond benefit expense of between 10 and 20 percent. In contrast, Medicaid programs with limited managed care programs such as Alaska, Connecticut, and Montana (among others) have lower administrative costs, see [28] (Exhibits 16 and 17). Note that administrative costs attributable to managed care organizations are not broken out separately in Exhibit 16 in this report.

(e.g., if Medicare payments increase at a faster or slower rate than the average rates in the Identified Population, then the corresponding payment neutral percent of Medicare rate would fall or rise, respectively).

We have used reimbursement rates that are a flat percent of Medicare for each of the several broad service categories and used across the entire Identified Population. In practice, the development of reimbursement rates would require significantly more work. The following simplified example illustrates how a flat percent of Medicare applied across all providers may produce significant "winners and losers."

TABLE 11: EXAMPLE PROVIDER-LEVEL IMPACTS FOR FLAT PERCENT OF MEDICARE REIMBURSEMENT

	Example Provider 1	Example Provider 2	Composite (Across all providers)
Starting Percent of Medicare	140%	160%	150%
Flat Percent of Medicare	150%	150%	150%
Percent Change in Reimbursement	+ 10%	- 10%	0%

Different starting percent of Medicare rates may be related to a provider's patient mix. Based on the calculation of a payment neutral percent of Medicare rate (see Exhibit III.1.a in Appendix C), this would mean providers with a higher proportion of their patients enrolled in Medicaid in the current system may see a substantial payment increase, and providers with more patients enrolled in commercial group may see a substantial payment decrease. Medicare payment rates are tailored to specific providers or geographical areas, but even with these built-in adjustments in the Medicare payment system, using a flat percent of Medicare would result in actual payment rate changes of the sort illustrated in Table 11. Dramatic changes in provider reimbursement rates for a patient population as large as considered in this report may result in issues related to patient access to care.

We emphasize that Medicare allowed is not necessarily an appropriate basis for payment rates. While many payers mirror or use adjusted Medicare payments for portions of their own reimbursement structure, the following are examples of other key considerations:

- Medicare fee schedule rates may not always be appropriate for patients younger than 65 years old (e.g., a lack of granularity or inappropriate weights associated with neonatal care and maternity services).
- Some services are disallowed in certain settings (services which are often permitted outside of Medicare).
- Certain services rendered to patients younger than 65 years old are not applicable to a Medicare population (and have no associated fees under the Medicare payment system).
- Some payment polices are extremely complex (particularly with respect to the associated data requirements or settlement practices).

Relatedly, the estimate of a payment neutral percent of Medicare reimbursement rate includes some simplifying assumptions. For example, we have not adjusted the calculated percent of Medicare reimbursement rate to account for services not paid under Medicare or reported in such a manner that precise calculation of Medicare final payment rates are impossible.

The estimate of a payment-neutral percent of Medicare rate also does not account for the changes in utilization patterns of the modeled Identified Population. If utilization patterns shift (e.g., the uninsured subpopulation uses more services after gaining coverage, as might be reasonably expected), then the percent of Medicare used in this study will not result in the same total payments to providers.

Finally, note that many of the caveats discussed in this section in the context of the percent of Medicare payment rates for medical services carry over analogously to the modeled prescription drug payment rates and dental payment rates. In other words, no known changes to payment rates after CY23 are incorporated into the analysis, changes in utilization patterns are not accounted for in the development of the payment rates, and the payment rates modeled may not be appropriate for direct application in a universal health care system for some of the same reasons discussed above.

EXCLUDED GROUP PLANS

Self-insured Employee Retirement Income Security Act of 1974 (ERISA) covered plans' enrollees were not included in this analysis. Should enrollees in these plans be permitted to and elect to join in a plan offered under a universal health care system, this would result in deviation from the estimates. In particular, the population mix and morbidity profile of these enrollees may differ from those in the analysis presented above and thus impact the utilization rates and associated medical spend. This may also meaningfully impact the appropriateness of the estimates of payment neutral reimbursement rates for providers.

We have not considered the possible impacts to the commercial market as a whole. A few possible examples include:

- Carriers with group health plans covering populations that are not a part of the Identified Population may see pressure from providers to adjust reimbursement rates. Because it is unlikely that any combined reimbursement structure (i.e., combined across the Identified Population's formerly Medicaid, individual, uninsured, and local government and religious organization plan subpopulation) would leave all providers revenue neutral, providers may pressure carriers for adjustments to contractual rates.
- Depending on the pressure to adjust reimbursement rates, shifting enrollment from other blocks of business, or other unforeseen forces, insurance carriers with populations excluded from the Identified Population could choose to change their position in the remaining Washington health insurance market or withdraw entirely. Separate insurance plans offered by a given carrier (e.g., self-funded group, fully insured group, and individual market plans) have interrelations and interdependencies including administrative services, large claim pooling, provider relationships and reimbursement rates, among others. Disruption to one portion of a carrier's business may have impacts on other lines of business that are difficult to predict, even for each carrier themselves.
- Carriers' remaining plans outside of the Identified Population may be subject to pressure to adjust benefit and cost sharing structures to match the selected benefits in a universal health care system. This could, for example, make high-deductible health plans (HDHPs) less marketable and impact insurance premiums or availability for individuals currently enrolled in such plans. At present, almost 30 percent of group enrollment is in HDHPs, see [30]. Moreover, employers or insurers could adjust their offerings to push their enrollment (or more costly portions of their enrollment) into a universal health care system's coverage.

As noted above, these are provided as examples of possible externalities of a universal health care system on the broader commercial market and are not an exhaustive list of possible impacts. These examples are also not intended to be predictive but should be among the possible impacts considered as a universal health care system is designed and implemented.

CHANGES IN POPULATION AND ENROLLMENT

We have modeled the CY23 enrollment for each of the modeled subpopulations as summarized in Exhibit III.1.a of Appendix C. Actual enrollment in any of the modeled subpopulation segments in the future may differ significantly from the CY23 enrollment. Notably, the Medicaid subpopulation was not adjusted for the end of the COVID-19 continuous enrollment requirements, nor was it adjusted for the Apple Health Expansion program which started in July 2024, see [31]. That said, these specific changes may be partially captured by the modeling assumption that the uninsured subpopulation with income below 138 percent of FPL will be eligible for the Medicaid-like benefit and the associated sensitivity test, but other changes may not. Changes in the covered population directly impact the total cost of the program but can also impact aggregate reimbursement rates or the share of the total cost born by the payer vs. member cost sharing.

We have also assumed that the entire uninsured subpopulation will be included in a universal health care system (i.e., are included in the Identified Population). A portion of this subpopulation may be eligible for employer sponsored health coverage, including in both fully and self-insured plans. To the extent this group enrollment eligible subset is covered by some other mechanism (e.g., a state premium subsidy for their group coverage), the baseline and scenario results in this report may require adjustment.

EXCLUDED SERVICES

We have modeled the coverage reported in Appendix D. This excludes some services that may currently be covered by, or at least associated with, the existing health coverage of the modeled population. Moreover, these excluded

services may differ by subpopulation. The modeling of coverage also includes some simplifying assumptions which results in limitations in fidelity (e.g., we cannot precisely model the limitations of which hearing aid brands and models are or are not covered by the benefits). This is discussed in further detail in Appendix D.

Notably, the estimates exclude LTSS currently covered by Medicaid. This exclusion was directed by FTAC, is substantial, and the reader should include consideration of this service (possibly among others), when reviewing the estimates of the costs under the selected scenarios as they may not incorporate all expected or relevant program costs.

FUNDING (INCLUDING PAYMENTS BY OTHER PAYERS)

We have not included an analysis of funding sources as part of this report. That said, some related adjustments have been made where there were direct interactions with the modeling. For example, estimates of cost coverage and percent of Medicare for services provided to the uninsured subpopulation were adjusted to avoid double counting the portion of this funding provided via Medicaid payments. This sort of adjustment does not provide a deeper understanding of the impacts of a universal health care system on funding sources.

Some significant and possibly impacted funding sources include:

- DSH and UCP made by CMS as part of Medicare to cover the cost of services to the uninsured and Medicaid covered subpopulations. If most or all currently uninsured individuals in the state are covered by a universal health care system and Medicaid reimbursement is significantly increased, then it is possible Medicare DSH payments could be adjusted, directly or indirectly, as part of a waiver process with CMS.
- Medicaid funding may or may not cover expanded enrollment beyond the current 138 percent of FPL. While Washington, D.C., expanded Medicaid coverage to 215 percent of FPL, and at least one other state appears to have plans to request an expansion, see [32], it is not clear that an application would be approved. It is also unclear if or how increasing reimbursement rates as modeled in this report might interact with a CMS UPL.
- It is unclear how premium costs currently covered by the individual market's premium tax credit might be incorporated into a universal health care system. KFF estimates that in CY24 this represents over one billion dollars in federal government payments for individual market premiums in Washington State, see [33].
- Depending on other sources of funding, the tax revenue required to fund a universal health care system could be substantial. Moreover, as health insurance premiums in the commercial markets tend to be highly regressive (i.e., set at a fixed per member per month cost regardless of income), taxes tend to be structured progressively (i.e., are intended to generate more revenue from higher income or asset individuals and households). Depending on the tax source and the mix of funding sources in total, this could represent a significant shift in the cost burden of health care across households within the state.

This bulleted list represents a sample of possible funding considerations. Other current sources of funding of the cost of care for the Identified Population may change in structure or be eliminated as part of this program. Alternative sources of funding would need to be found to address any related shortfalls, and these alternative sources may represent significant shifts between the federal government and the state or between employers and taxpayers, as in some of the examples above.

OUT-OF-STATE ENROLLMENT AND UTILIZATION

Implicitly in the scenarios above, it is assumed that at least limited services for individuals traveling within the United States, but outside of Washington State, would be covered. It is also assumed that the enrollment and cost of care for services outside of Washington State is, in both the base data and in the estimates:

- Small relative to the total enrollment,
- Small in total dollars (relative to the Identified Population's costs in total), and
- For those services covered, not dissimilar in cost from the services already provided.

In other words, no adjustment was made for out-of-state enrollment and utilization rates. This means that:

- The costs and enrollment associated with individuals in the Identified Population, but receiving care out of state, were included in the estimates. These amounts are expected to be relatively small, and the corresponding cost of care like that for enrollees who live within Washington State.
- Currently Medicaid enrolled individuals would not substantially change their utilization patterns vis-à-vis receiving care in- or out-of-state.

Despite these simplifying assumptions, the reader is encouraged to consider if, under what circumstances, or how enrollment would be terminated for individuals moving outside of the state, and how claims would be adjudicated and paid for providers rendering services to enrollees who are treated outside of the state. Some individuals currently enrolled in PEBB, SEBB, commercial group, or individual plans may regularly travel out-of-state and already receive non-emergency care while out-of-state through their current coverage; this is unlike Medicaid coverage for out-of-state services,[47] which is restricted to emergency care. In other words, it is possible a restriction to coverage of only in-state services would significantly disrupt regular care for some of the enrolled population.

PENT-UP DEMAND

We have modeled IU in the estimates in this report. IU refers to the amount of additional care that is expected because of lower patient liability for care relative to current coverage (i.e., lower copays, coinsurance, deductibles, or out-of-pocket maximum). IU does not account for the impact of lowering patient liability such that previously unaffordable services become affordable or otherwise improving access to care. Some individuals may have currently deferred care and, when their patient liability is lowered or access is improved, they may choose to commence with the deferred care (possibly with additional costs due to worsening of an untreated condition).

As an example, the impact of deferred care was observed following the COVID-19 lockdowns, and appears to have rebounded, at least for select services, based on Milliman's internal data sources and external reporting, see [35]. Similarly, it is possible that the uninsured individuals receiving coverage or individuals enrolled in plans with relatively higher patient liability may have some level of deferred care that would result in an under-estimate of utilization rates in the baseline assumptions.[48]

Conversely, it is also possible these subpopulations have at least partially self-selected into the uninsured subpopulation or into health plans with higher cost sharing rates (i.e., lower AV), and they have correspondingly lower medical costs than the currently insured subpopulations. If this is the case, it could cause the assumption that, for example, the newly insured subpopulation will converge to the utilization rates of their paired Medicaid or non-Medicaid subpopulation to be an over-estimate of their utilization rates. We estimated the impact of dampening the utilization for the uninsured population by 30 percent relative to the modeled Medicaid and individual subpopulations as approximately a 5 percent decrease in the total allowed cost.

We have not explicitly modeled pent-up demand. Note that in sensitivity test 6, "6. Other variation in utilization rates or selection," the modulation of utilization rates, while not specifically designed to estimate the impact of pent-up demand, does illustrate the sensitivity of the estimates to utilization rate assumptions.

PHARMACY AND DENTAL MODELING AND REIMBURSEMENT

For both the pharmacy and dental modeling some key simplifying assumptions have been made in the modeling approach. These simplifying assumptions and the associated risks and variability are discussed in this section.

Pharmacy modeling and reimbursement

Because of the complexity of pharmacy reimbursement and more limited data available (e.g., manufacturer rebate amounts, formulary structure, etc.), the modeling assumptions are simplified:

- Discounts based on Milliman's benchmarks, calibrated to actual experience where possible, and estimated by
  - Generic drugs,
  - Brand drugs, and
  - Specialty drugs; and

[47] Note that coverage does extend to some border cities outside of Washington, see [34].

[48] I.e., interpreting both COVID-19 related limits on service availability and patient liability as barriers to care.

- Manufacturer rebates based on
  - Aggregated data reported in the NAIC SHCEs, and
  - Summary Medicaid, PEBB, and SEBB data provided by HCA.

These reimbursement rate assumptions have been applied in each scenario. We also calibrated the initial models to the historical utilization rates and allowed costs. Together, though, these assumptions have some key sources of variability. Some examples are discussed below, but the concept of a drug formulary must first be introduced.

Drug formularies are, in essence, a list of drugs covered by a plan and the classification of those drugs (e.g., into cost sharing tiers, by step-therapy requirements, or into therapeutic classes). Plans generally attempt to restrict member utilization to drugs included on the formulary and enforce any associated utilization management protocols.[49] The development of a drug formulary, associated rebates, and other related negotiated parameters is complex. Drugs are selected for a variety of reasons including ensuring coverage of therapies needed by members, minimizing costs to plans or enrollees, or minimizing administrative complexity or barriers to care. Sources of variability in the estimates of pharmacy care costs include the following:

- Formulary, discounts, and rebates are highly interrelated. A narrow formulary will tend to result in higher discounts and rebates but will restrict enrollee access to drug treatments (e.g., covering select drugs within classes or only generic or brand versions of drugs).
- Minimizing drug costs to the payer is not the same as minimizing point-of-sale drug costs for consumers. As a result of rebate mechanics, to minimize drug costs to the plan, drugs that have higher point-of-sale costs may sometimes be selected over drugs with lower point-of-sale costs.
- The formularies in the base period plans are not the same. For the purposes of this report, the possible impacts of formulary changes have not been modeled. Despite this, the changes may be significant and have significant impacts on costs.

With respect to the final bullet in this list, an example: If a highly sought-after and high-cost drug is not presently available to the Medicaid subpopulation but would be available in a universal health care system, a large increase in utilization for the drug may be experienced for the Medicaid subpopulation. In such an example, the estimates in this report may significantly under-estimate drug utilization rates and costs.

Dental modeling and reimbursement

As dental coverage in the commercial market is typically both optional and purchased separately from medical coverage, we have relied on estimates of plan spending on dental costs from the Medicaid, PEBB, and SEBB subpopulations, with the remaining subpopulations modeled relative to those costs. This approach introduces variability into the results, including but not limited to:

- Considerations around self-selection or pent-up demand may result in individuals in the commercial subpopulations having significantly different utilization rates for dental services than the PEBB or SEBB subpopulations.
- Reimbursement rates for dental services in the current market may differ significantly from those underlying the PEBB and SEBB costs used in the modeling.
- Dental benefits often have significant member cost sharing for non-preventative services, and there may be significant changes to member utilization rates if cost sharing for those benefits were to be reduced or eliminated.

[49] Despite this, plans will often permit exceptions to the formulary or utilization management policies. This can be an administratively complex process and represents policy adjustments that are exercised differently by different plans.

Caveats

This analysis has been prepared by Milliman for HCA and is intended for use by HCA, UHCC, and FTAC. This information is intended solely for educational purposes and presents information of a general nature. It is not intended to guide or determine any specific situation, and persons should consult qualified professionals before taking specific actions. We do not intend to benefit or create a legal duty to any third-party recipient of this work.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the cost of care for an Identified Population, under specified benefit and cost sharing scenarios, and on a CY23 basis. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

In preparation of the analysis, we relied upon the accuracy of data and information gathered from or provided by CMS, data partners, and other organizations as cited in the report and the bibliography found in Appendix B. We have not audited this information, although it has been reviewed for reasonableness. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete.

We have also relied on the data and other information provided by HCA, UHCC, FTAC, and the FTAC liaisons for this analysis. We have performed a limited review of this information and checked for reasonableness and consistency. We have not found material defects or discrepancies in the data and information used other than those described in this report, which also describes how those defects and discrepancies were addressed to enable this analysis to be performed. If there are other material defects in the data or other information, 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 this assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Peter Hallum, Ben Diederich, Mark Franklin, and Menko Ypma are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis in this report.

Appendix A: Glossary of terms

The following glossary of terms includes a definition of all acronyms and initialisms included in the text of this report and definitions of many terms of art or terms used with specific meaning within this report.

Actuarial value (AV)	The average percentage of covered medical costs (allowed cost) that a health plan will pay.
Administrative costs	Costs associated with the administration of a health plan that are not for paid claims or otherwise paid to providers. Includes items such as payroll for plan staff, claims processing, and customer support.
Allowed, allowed cost, or allowed amount	Total cost of a service after applying contractual reimbursement terms or discounts from billed charges.
Average monthly enrollment	This is the total member months of enrollment in a year divided by 12. Note that this is less than the actual count of distinct enrollees as some individuals will be enrolled for fewer than 12 months.
Average Wholesale Price (AWP)	Average price a retailer pays for purchasing a drug from a wholesaler. Does not include contractual discounts or rebates.
Cascade Care Silver plan or benefits	An exchange silver plan based on the essential health benefits, eligible for the premium tax credit, and with approximately 70 percent AV (subject to income-linked cost sharing reductions).
Centers for Medicare and Medicaid Services (CMS)	The national organization managing administration of the Medicare and Medicaid health systems. Some authority is delegated to the states, particularly for the Medicaid program.
Coinsurance	Member cost sharing that is paid as a percentage of the allowed cost.
Copay	Member cost sharing that is a fixed dollar amount.
Coverage limit or coverage maximum	The maximum amount the insurance plan will pay for covered services in a plan year.
Deductible	The amount a member must pay in a plan year before the insurance plan begins to pay.
Disproportionate-share hospital (DSH)	A hospital qualifying for an uncompensated care payment.
Effective coinsurance	Effective cost sharing if expressed as a coinsurance, e.g., a $20 copay on a service with a $200 average allowed unit cost is 10 percent effective coinsurance.
Employee Retirement Income Security Act of 1974 (ERISA)	The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. See: https://www.dol.gov/general/topic/retirement/erisa
Fee-for-service (FFS)	Medical coverage that does not include managed care enrollees (or includes only limited management). Enrollees are free to see any in-network providers for desired care (e.g., without requiring a referral to a specialist).

Finance Technical Advisory Committee (FTAC)	Supports the Universal Health Care Commission by providing guidance and options for the development of a universal health care system.
Health Benefit Exchange (HBE)	A marketplace for individual health care coverage. Manages the Washington Healthplanfinder and reports on services it administers.
Identified Population, and subpopulation	The term Identified Population is used to refer to all the individuals modeled as considered for coverage under the benefit and cost sharing scenarios. Subpopulation is used to refer to a subgroup of the Identified Population (e.g., those persons currently enrolled in individual plans, or a subset thereof).
Inpatient services (IP)	Facility claims associated with inpatient hospital stays, identified based on the presence of room and board revenue codes and are often categorized based on the diagnosis related group (DRG) present on the claim.
Managed care organization (MCO)	An organization, usually paid via a fixed regular amount, to manage the health care costs of a population (e.g., arranging a provider network, paying for services, assisting members with understanding and using their benefits, etc.).
Medical management	Efforts to contain unnecessary or wasteful health care spending via various types of care management including lower cost site selection, post-acute care follow-ups, drug reminders, step therapy regimes, nurse lines, etc.
Medicare reimbursement	The amount Medicare did or would have allowed for services. (Note that the specific definition depends on which additional payments are included or excluded in this calculation, as discussed in the report.)
National Association of Insurance Commissioners (NAIC)	A nationwide organization that enables collaboration between state insurance regulators. Provides a variety of support services, including some databases and standardization of reporting.
Office of the insurance commissioner (OIC)	The Washington State Office of the Insurance Commissioner regulates insurers operating within the state of Washington and publishes information related to that work.
Out-of-pocket maximum	The maximum amount a member will pay for covered services in a plan year, usually including payments for the deductible, coinsurance and copays.
Outpatient services (OP)	Facility claims for services performed in an outpatient setting, identified based on the presence of revenue codes on the claim or based on the provider type (e.g., ambulatory surgical center).
Paid, payer paid, paid costs, or paid dollars	Portion of the allowed cost that is paid by the insurance plan (e.g., the state in Medicaid FFS, or a health insurer in commercial group coverage).
Patient pay and cost sharing	Portion of the allowed cost that is paid by the patient, including deductibles, coinsurance, and copays.
Per member per month (PMPM)	Average payments associated with a single member in a single month of enrollment.
Percent of Medicare	Ratio of the actual allowed cost amount to Medicare reimbursement.
Population risk	The actual morbidity of a population; usually approximated by a risk score generated by risk adjustment software.

Preferred provider organization (PPO)	A health plan that contracts with medical providers to create a network of providers. Typically, has reduced cost sharing or services performed at providers inside the network.
Professional services (Prof)	Non-facility claims, including physician claims for services performed in an inpatient or outpatient setting, identified based on the lack of revenue codes or based on the provider type. Physician revenue code line items billed as part of a facility claim are categorized as professional/other.
Public Employees Benefit Board (PEBB)	Selects benefits and eligibility for health care options for State employees in Washington State.
Risk score and risk adjuster	Risk scores are measures of population morbidity or risk. These measures are population measures generated by risk adjustment software. Risk adjustment software ingests ICD-10-CM (diagnosis) codes, NDC (drug identification) codes, demographics, and other information to generate a risk score.
School Employees Benefit Board (SEBB)	Selects benefits and eligibility for health care options for school employees in Washington State.
Supplemental health care exhibit (SHCE)	A standardized report that contains information related to health plans' financials.
TRICARE	Health care program for active duty service members, active duty family members, National Guard and Reserve members and their family members, retirees and retiree family members, survivors, and certain former spouses worldwide.
Uncompensated Care Payments (UCP)	A payment made to hospitals for the purpose of partially covering costs associated with treating persons who do not pay for services.
Unified Rate Review Template (URRT)	A standardized template plans use to submit filing information to CMS. See: https://www.qhpcertification.cms.gov/s/Unified%20Rate%20Review
Universal Health Care Commission (UHCC)	Established by ESBB 5399 to aid in establishing a universal health care system for Washington residents
Washington State Health Care Authority (HCA)	A state agency that procures health care for various programs operating within the state, including PEBB, SEBB, and Medicaid. Also oversees various other health care-related activities and initiatives.

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Appendix C: Exhibits

Exhibit I
Table of Contents
FTAC - Universal Health Care Pricing Analysis
List of Exhibits, Titles, and Descriptions of Contents

Appendices

Appendix C
Exhibit II.1.a
FTAC - Universal Health Care Plan Pricing Analysis
Summary results - Identified Population (exclusive of fully insured commercial group plans)

	Scenario 1 - Medicaid	Scenario 2 - PEBB Classic	Scenario 3 - CC/Silver EHB
Payer paid cost of care (PMPM)			
Paid PMPM	$542	$464	$411
Medical and Pharmacy	$507	$437	$384
Dental	$35	$27	$27
Sensitivity testing range	$500 - $586	$427 - $502	$377 - $447
Patient paid cost of care (PMPM)			
Patient Pay PMPM	$0	$27	$60
Medical and Pharmacy	$0	$19	$52
Dental	$0	$8	$8
Sensitivity testing range	$0 - $0	$25 - $28	$57 - $63
Total cost of care (PMPM)			
Allowed PMPM	$542	$490	$471
Medical and Pharmacy	$507	$455	$436
Dental	$35	$35	$35
Sensitivity testing range	$500 - $586	$452 - $530	$434 - $510
Actuarial value by scenario (payer paid / total cost)			
Actuarial value	100%	95%	87%
Actuarial value (Non-Medicaid Populations, All Benefits)	100%	87%	68%
Actuarial value (Non-Medicaid Populations, Medical + Rx)	100%	90%	68%
Actuarial value (Non-Medicaid Populations, Dental)	100%	64%	64%
Sensitivity testing range[1]	100% - 100%	94% - 95%	87% - 88%
Estimated annual enrollment and total payer paid cost of care			
Identified Population scenario[2]	3,369,810	3,369,810	3,369,810
Annual payer paid cost of care (millions)	$20,204.5 - $23,708.0	$17,261.2 - $20,308.4	$15,246.3 - $18,079.5

Notes:

(1) Actuarial value of deductibles, out-of-pocket maximums, and copay is dependent on scenario assumptions and will vary between sensitivity tests.

(2) The alternate Identified Population scenario which includes fully insured commercial group plans corresponds to sensitivity test 3, as shown in "Exhibit II.3 - Sensitivity Tests." This alternate population is discussed in more detail in the "Sensitivity Testing" section of the report.

Appendix C
Exhibit II.1.b
FTAC - Universal Health Care Plan Pricing Analysis
Summary results - alternate Identified Population (inclusive of fully insured commercial group plans)

	Scenario 1 - Medicaid	Scenario 2 - PEBB Classic	Scenario 3 - CC/Silver EHB
Payer paid cost of care (PMPM)			
Paid PMPM	$585	$483	$417
Medical and Pharmacy	$544	$453	$387
Dental	$41	$31	$31
Sensitivity testing range	$539 - $633	$445 - $523	$382 - $454
Patient paid cost of care (PMPM)			
Patient Pay PMPM	$0	$34	$76
Medical and Pharmacy	$0	$24	$65
Dental	$0	$10	$10
Sensitivity testing range	$0 - $0	$32 - $36	$72 - $79
Total cost of care (PMPM)			
Allowed PMPM	$585	$518	$493
Medical and Pharmacy	$544	$477	$452
Dental	$41	$41	$41
Sensitivity testing range	$539 - $633	$477 - $560	$454 - $533
Actuarial value by scenario (payer paid / total cost)			
Actuarial value	100%	93%	85%
Actuarial value (Non-Medicaid Populations, All Benefits)	100%	87%	68%
Actuarial value (Non-Medicaid Populations, Medical + Rx)	100%	90%	69%
Actuarial value (Non-Medicaid Populations, Dental)	100%	64%	64%
Sensitivity testing range[1]	100% - 100%	93% - 94%	84% - 85%
Estimated annual enrollment and total payer paid cost of care			
Alternate Identified Population scenario[2]	4,087,723	4,087,723	4,087,723
Annual payer paid cost of care (millions)	$26,450.9 - $31,035.9	$21,809.7 - $25,671.5	$18,733.2 - $22,266.9

Notes:

(1) Actuarial value of deductibles, out-of-pocket maximums, and copay is dependent on scenario assumptions and will vary between sensitivity tests.

(2) The alternate Identified Population scenario which includes fully insured commercial group plans corresponds to sensitivity test 3, as shown in "Exhibit II.3 - Sensitivity Tests." This alternate population is discussed in more detail in the "Sensitivity Testing" section of the report.

Appendix C
Exhibit II.2.a
Detailed Pricing Cost Model
FTAC - Universal Health Care Plan Pricing Analysis
Scenario 1 - Medicaid-Like Benefit Structure
Best Estimate Scenario

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Average Allowed Reimbursement	(3) Per Member Per Month Allowed Cost	(4) Per Member Per Month Cost Sharing	(5) Net Per Member Per Month Payer Paid
Inpatient Facility (Excludes Professional in Facility if Billed Separately)							
Medical	22.9 admits	6.3	144.8 days	$3,407.67	$41.11	$0.00	$41.11
Surgical	8.9 admits	7.4	66.2 days	6,933.79	38.25	0.00	38.25
Psychiatric	26.4 admits	3.9	101.8 days	1,127.66	9.57	0.00	9.57
Substance Use Disorders	19.7 admits	2.3	46.2 days	867.60	3.34	0.00	3.34
Maternity	25.8 admits	2.1	55.1 days	2,276.63	10.46	0.00	10.46
Skilled Nursing Facility	9.2 admits	12.9	119.2 days	564.03	5.60	0.00	5.60
Inpatient Facility - Subtotal	112.9 admits	4.7	533.3 days		**$108.33**	**$0.00**	**$108.33**
Outpatient Facility (Excludes Professional in Facility if Billed Separately)							
Observation			8.4 visits	$2,160.54	$1.51	$0.00	$1.51
Emergency Department			255.5 visits	879.03	18.72	0.00	18.72
Surgery			118.7 visits	3,256.19	32.21	0.00	32.21
Radiology			718.9 visits	182.14	10.91	0.00	10.91
Pathology/Lab			444.4 visits	115.83	4.29	0.00	4.29
Pharmacy			214.3 visits	882.85	15.77	0.00	15.77
Cardiovascular			57.5 visits	425.40	2.04	0.00	2.04
PT/OT/ST			183.7 visits	187.46	2.87	0.00	2.87
Psychiatric			116.2 visits	196.99	1.91	0.00	1.91
Substance Use Disorders			97.1 visits	345.23	2.79	0.00	2.79
Preventive			153.7 visits	278.64	3.57	0.00	3.57
Other Outpatient Facility			543.1 visits	286.34	12.96	0.00	12.96
Outpatient Facility - Subtotal			2,911.5		**$109.54**	**$0.00**	**$109.54**
Professional							
Inpatient Surgery			109.1 proced	$338.74	$3.08	$0.00	$3.08
Maternity			58.9 proced	727.78	3.57	0.00	3.57
Outpatient Surgery			538.0 proced	263.32	11.81	0.00	11.81
Inpatient Visits			476.6 visits	152.33	6.05	0.00	6.05
Office/Home Visits - PCP			1,980.3 visits	139.30	22.99	0.00	22.99
Office/Home Visits - Specialist			922.0 visits	141.38	10.86	0.00	10.86
Urgent Care Visits			265.4 visits	142.19	3.15	0.00	3.15
Office Administered Drugs			291.1 proced	524.02	12.71	0.00	12.71
Allergy Testing & Immunotherapy			73.1 proced	70.79	0.43	0.00	0.43
Miscellaneous Medical			1,766.4 proced	44.25	6.51	0.00	6.51
Immunizations			630.6 proced	53.64	2.82	0.00	2.82
Well Baby Exams			82.0 visits	169.73	1.16	0.00	1.16
Physical Exams			371.0 visits	164.14	5.07	0.00	5.07
Other Preventive			1,189.9 proced	79.76	7.91	0.00	7.91
ED Visits and Observation Care			403.9 visits	155.38	5.23	0.00	5.23
Vision, Hearing, and Speech Exams			227.8 visits	82.54	1.57	0.00	1.57
Physical Therapy			1,653.3 visits	95.61	13.17	0.00	13.17
Cardiovascular			181.4 proced	61.10	0.92	0.00	0.92
Radiology			1,567.5 proced	53.29	6.96	0.00	6.96
Pathology/Lab			2,979.8 proced	40.97	10.17	0.00	10.17
Chiropractor			461.8 visits	61.76	2.38	0.00	2.38
Outpatient Psychiatric			5,460.6 visits	74.92	34.09	0.00	34.09
Outpatient Substance Use Disorders			1,643.5 visits	32.72	4.48	0.00	4.48
Professional - Total			23,334.1		**$177.10**	**$0.00**	**$177.10**
Other Medical							
Home Health Care			167.7 visits	$467.67	$6.53	$0.00	$6.53
Ambulance			68.5 cases	854.91	4.88	0.00	4.88
DME/Supplies/Prosthetics			519.2 proced	159.00	6.88	0.00	6.88
Other - Total			755.4		**$18.30**	**$0.00**	**$18.30**
Total Medical Benefits					**$413.28**	$0.00	**$413.28**
Prescription Drugs							
Prescription Drugs			10,438.5 scripts	$83.75	$72.85	$0.00	$72.85
Total Standard Benefits					**$486.13**	$0.00	**$486.13**
Additional Benefits							
Glasses/Contacts/Hearing Aids			121.0 cases	$124.91	$1.67	$0.00	$1.67
Dental					$34.96	$0.00	$34.96
Additional Benefits - Subtotal					$36.63	$0.00	$36.63
Total Benefit Cost					**$522.76**	$0.00	**$522.76**
Starting Net PMPM Claim Cost for Services Subj to Deductible							$213.11
Cost Sharing (Deductible/Coinsurance/OOP) Induced Utilization Adjustment Value (Net of Cost Sharing Subject to Deductible)							$19.39
Value of Deductible (Net of Cost Sharing Subject to Deductible)							0.00
Value of Out-of-Pocket Maximum (Including Deductible)							0.00
Value of Annual Maximum							0.00
Adjusted Net PMPM for Services Subject to Deductible							**$232.50**
PMPM for Services Not Subject to Deductible							**$309.65**
Total Medical Cost After Deductible and Cost Sharing					**$542.15**		**$542.15**

Notes

(1) Service line level costs and utilization not subject to the deductible do not include final adjustments for induced utilization. These impacts are shown in the rows below the "Total Benefit Cost".
Adjusted costs at the service line level can be estimated using the ratio of the final PMPM Allowed cost to the unadjusted PMPM claim cost.

(2) As certain development assumptions were only available at a high-level service category basis, service line level costs and utilization should be considered approximate.

Appendix C
Exhibit II.2.b
Detailed Pricing Cost Model
FTAC - Universal Health Care Plan Pricing Analysis
Scenario 2 - PEBB UMP Classic-like benefit structure
Best Estimate Scenario

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Average Allowed Reimbursement	(3) Per Member Per Month Allowed Cost	(4) Per Member Per Month Cost Sharing	(5) Net Per Member Per Month Payer Paid
Inpatient Facility (Excludes Professional in Facility if Billed Separately)							
Medical	22.9 admits	6.3	144.3 days	$3,409.28	$40.99	$0.23	$40.76
Surgical	9.0 admits	7.3	66.1 days	6,933.12	38.20	0.13	38.06
Psychiatric	26.3 admits	3.8	100.9 days	1,120.94	9.43	0.05	9.38
Substance Use Disorders	19.7 admits	2.3	45.7 days	849.96	3.24	0.03	3.21
Maternity	25.8 admits	2.2	55.4 days	2,287.72	10.57	0.17	10.39
Skilled Nursing Facility	9.2 admits	12.8	118.7 days	562.09	5.56	0.02	5.54
Inpatient Facility - Subtotal	112.9 admits	4.7	531.1 days		**$107.98**	**$0.63**	**$107.35**
Outpatient Facility (Excludes Professional in Facility if Billed Separately)							
Observation			8.0 visits	$2,079.56	$1.38	$0.18	$1.20
Emergency Department			229.2 visits	874.18	16.69	0.98	15.72
Surgery			106.9 visits	3,144.16	28.01	2.21	25.80
Radiology			700.3 visits	177.42	10.35	0.42	9.94
Pathology/Lab			403.9 visits	119.08	4.01	0.17	3.84
Pharmacy			209.1 visits	863.73	15.05	0.76	14.29
Cardiovascular			54.5 visits	419.02	1.90	0.13	1.77
PT/OT/ST			130.7 visits	200.24	2.18	0.13	2.05
Psychiatric			110.7 visits	194.98	1.80	0.05	1.74
Substance Use Disorders			93.7 visits	351.54	2.75	0.03	2.72
Preventive			151.4 visits	276.28	3.49	0.00	3.49
Other Outpatient Facility			530.8 visits	283.72	12.55	0.37	12.18
Outpatient Facility - Subtotal			2,729.1		**$100.16**	**$5.43**	**$94.74**
Professional							
Inpatient Surgery			106.9 proced	$335.31	$2.99	$0.18	$2.81
Maternity			57.1 proced	733.75	3.49	0.17	3.32
Outpatient Surgery			462.4 proced	270.87	10.44	0.87	9.57
Inpatient Visits			471.5 visits	152.43	5.99	0.15	5.84
Office/Home Visits - PCP			1,720.9 visits	140.23	20.11	1.15	18.96
Office/Home Visits - Specialist			821.7 visits	141.43	9.68	0.85	8.83
Urgent Care Visits			222.9 visits	143.92	2.67	0.17	2.51
Office Administered Drugs			275.7 proced	527.10	12.11	0.86	11.25
Allergy Testing & Immunotherapy			58.5 proced	67.94	0.33	0.04	0.29
Miscellaneous Medical			1,695.4 proced	42.79	6.05	0.27	5.78
Immunizations			738.6 proced	53.89	3.32	0.00	3.32
Well Baby Exams			82.2 visits	169.54	1.16	0.00	1.16
Physical Exams			382.0 visits	163.42	5.20	0.00	5.20
Other Preventive			1,227.2 proced	79.54	8.13	0.00	8.13
ED Visits and Observation Care			370.8 visits	154.87	4.79	0.15	4.64
Vision, Hearing, and Speech Exams			228.7 visits	83.07	1.58	0.17	1.42
Physical Therapy			961.2 visits	86.23	6.91	0.71	6.20
Cardiovascular			165.1 proced	61.48	0.85	0.07	0.77
Radiology			1,488.1 proced	52.30	6.49	0.52	5.96
Pathology/Lab			2,881.6 proced	41.18	9.89	0.65	9.24
Chiropractor			252.4 visits	61.29	1.29	0.30	0.99
Outpatient Psychiatric			4,878.4 visits	67.20	27.32	1.40	25.92
Outpatient Substance Use Disorders			1,636.2 visits	32.34	4.41	0.02	4.39
Professional - Total			21,185.7		**$155.19**	**$8.68**	**$146.51**
Other Medical							
Home Health Care			156.8 visits	$453.29	$5.92	$0.39	$5.53
Ambulance			67.0 cases	857.44	4.79	0.16	4.63
DME/Supplies/Prosthetics			490.1 proced	158.91	6.49	0.33	6.16
Other - Total			713.9		**$17.20**	**$0.88**	**$16.32**
Total Medical Benefits					**$380.53**	$15.61	**$364.92**
Prescription Drugs							
Prescription Drugs			9,330.6 scripts	$86.17	$67.00	$2.44	$64.56
Total Standard Benefits					**$447.53**	$18.05	**$429.48**
Additional Benefits							
Glasses/Contacts/Hearing Aids			118.2 cases	$122.58	$1.62	$0.03	$1.59
Dental					$34.96	$7.81	$27.15
Additional Benefits - Subtotal					$36.58	$7.83	$28.75
Total Benefit Cost					**$484.11**	$25.89	**$458.23**
Starting Net PMPM Claim Cost for Services Subj to Deductible							$147.11
Cost Sharing (Deductible/Coinsurance/OOP) Induced Utilization Adjustment Value (Net of Cost Sharing Subject to Deductible)							$5.57
Value of Deductible (Net of Cost Sharing Subject to Deductible)							(5.73)
Value of Out-of-Pocket Maximum (Including Deductible)							5.75
Value of Annual Maximum							0.00
Adjusted Net PMPM for Services Subject to Deductible							**$152.70**
PMPM for Services Not Subject to Deductible							**$311.12**
Total Medical Cost After Deductible and Cost Sharing					**$ 490.37**		**$463.82**

Notes

(1) Service line level costs and utilization not subject to the deductible do not include final adjustments for induced utilization. These impacts are shown in the rows below the "Total Benefit Cost".
Adjusted costs at the service line level can be estimated using the ratio of the final PMPM Allowed cost to the unadjusted PMPM claim cost.

(2) As certain development assumptions were only available at a high-level service category basis, service line level costs and utilization should be considered approximate.

Appendix C
Exhibit II.2.c
Detailed Pricing Cost Model
FTAC - Universal Health Care Plan Pricing Analysis
Scenario 3 - Cascade Care-like (silver EHB) benefit structure
Best Estimate Scenario

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Average Allowed Reimbursement	(3) Per Member Per Month Allowed Cost	(4) Per Member Per Month Cost Sharing	(5) Net Per Member Per Month Payer Paid
Inpatient Facility (Excludes Professional in Facility if Billed Separately)							
Medical	22.9 admits	6.3	144.3 days	$3,409.28	$40.99	$1.23	$39.77
Surgical	9.0 admits	7.3	66.1 days	6,933.12	38.20	0.71	37.48
Psychiatric	26.3 admits	3.8	100.9 days	1,120.94	9.43	0.29	9.14
Substance Use Disorders	19.7 admits	2.3	45.7 days	849.96	3.24	0.17	3.07
Maternity	25.8 admits	2.2	55.4 days	2,287.72	10.57	0.71	9.86
Skilled Nursing Facility	9.2 admits	12.8	118.7 days	562.09	5.56	0.10	5.45
Inpatient Facility - Subtotal	112.9 admits	4.7	531.1 days		**$107.98**	**$3.21**	**$104.78**
Outpatient Facility (Excludes Professional in Facility if Billed Separately)							
Observation			8.0 visits	$2,079.56	$1.38	$0.25	$1.14
Emergency Department			229.2 visits	874.18	16.69	3.83	12.86
Surgery			106.9 visits	3,144.16	28.01	2.03	25.98
Radiology			700.3 visits	177.42	10.35	0.65	9.71
Pathology/Lab			403.9 visits	119.08	4.01	0.54	3.46
Pharmacy			209.1 visits	863.73	15.05	1.52	13.53
Cardiovascular			54.5 visits	419.02	1.90	0.05	1.85
PT/OT/ST			98.6 visits	213.99	1.76	0.12	1.64
Psychiatric			110.7 visits	194.98	1.80	0.04	1.75
Substance Use Disorders			93.7 visits	351.54	2.75	0.03	2.71
Preventive			151.4 visits	276.28	3.49	0.00	3.49
Other Outpatient Facility			530.8 visits	283.72	12.55	0.74	11.81
Outpatient Facility - Subtotal			2,697.0		**$99.74**	**$9.81**	**$89.93**
Professional							
Inpatient Surgery			106.9 proced	$335.31	$2.99	$0.00	$2.99
Maternity			57.1 proced	733.75	3.49	0.00	3.49
Outpatient Surgery			462.4 proced	270.87	10.44	4.39	6.05
Inpatient Visits			471.5 visits	152.43	5.99	0.00	5.99
Office/Home Visits - PCP			1,720.9 visits	140.23	20.11	1.81	18.31
Office/Home Visits - Specialist			821.7 visits	141.43	9.68	2.67	7.01
Urgent Care Visits			222.9 visits	143.92	2.67	0.49	2.19
Office Administered Drugs			275.7 proced	527.10	12.11	0.33	11.78
Allergy Testing & Immunotherapy			58.5 proced	67.94	0.33	0.20	0.13
Miscellaneous Medical			1,695.4 proced	42.79	6.05	1.19	4.85
Immunizations			738.6 proced	53.89	3.32	0.00	3.32
Well Baby Exams			82.2 visits	169.54	1.16	0.00	1.16
Physical Exams			382.0 visits	163.42	5.20	0.00	5.20
Other Preventive			1,227.2 proced	79.54	8.13	0.00	8.13
ED Visits and Observation Care			370.8 visits	154.87	4.79	0.29	4.49
Vision, Hearing, and Speech Exams			152.4 visits	39.59	0.50	0.02	0.48
Physical Therapy			1,136.1 visits	89.68	8.49	1.89	6.60
Cardiovascular			165.1 proced	61.48	0.85	0.15	0.70
Radiology			1,488.1 proced	52.30	6.49	1.04	5.44
Pathology/Lab			2,881.6 proced	41.18	9.89	1.30	8.59
Chiropractor			156.4 visits	60.67	0.79	0.36	0.43
Outpatient Psychiatric			4,878.4 visits	67.20	27.32	4.31	23.00
Outpatient Substance Use Disorders			1,636.2 visits	32.34	4.41	0.06	4.35
Professional - Total			21,188.3		**$155.19**	**$20.50**	**$134.69**
Other Medical							
Home Health Care			156.8 visits	$453.29	$5.92	$0.11	$5.82
Ambulance			67.0 cases	857.44	4.79	0.41	4.38
DME/Supplies/Prosthetics			490.1 proced	158.91	6.49	0.67	5.82
Other - Total			713.9		**$17.20**	**$1.18**	**$16.02**
Total Medical Benefits					**$380.11**	$34.71	**$345.42**
Prescription Drugs							
Prescription Drugs			9,330.6 scripts	$86.17	$67.00	$6.70	$60.33
Total Standard Benefits					**$447.11**	$41.41	**$405.75**
Additional Benefits							
Glasses/Contacts/Hearing Aids			64.6 cases	$37.04	$0.63	$0.03	$0.60
Dental					$34.96	$7.81	$27.15
Additional Benefits - Subtotal					$35.59	$7.83	$27.75
Total Benefit Cost					**$482.70**	$49.24	**$433.50**
Starting Net PMPM Claim Cost for Services Subj to Deductible							$123.38
Cost Sharing (Deductible/Coinsurance/OOP) Induced Utilization Adjustment Value (Net of Cost Sharing Subject to Deductible)							($8.60)
Value of Deductible (Net of Cost Sharing Subject to Deductible)							(23.49)
Value of Out-of-Pocket Maximum (Including Deductible)							9.93
Value of Annual Maximum							0.00
Adjusted Net PMPM for Services Subject to Deductible							**$101.22**
PMPM for Services Not Subject to Deductible							**$310.12**
Total Medical Cost After Deductible and Cost Sharing					**$ 471.22**		**$411.35**

Notes

(1) Service line level costs and utilization not subject to the deductible do not include final adjustments for induced utilization. These impacts are shown in the rows below the "Total Benefit Cost".
Adjusted costs at the service line level can be estimated using the ratio of the final PMPM Allowed cost to the unadjusted PMPM claim cost.

(2) As certain development assumptions were only available at a high-level service category basis, service line level costs and utilization should be considered approximate.

Appendix C
Exhibit II.3
FTAC - Universal Health Care Plan Pricing Analysis
Sensitivity tests - summary results

	Scenario 1 - Medicaid		Scenario 2 - PEBB Classic		Scenario 3 - CC/Silver EHB	
Best estimate paid PMPM	**$542**		**$464**		**$411**	
1. Provider reimbursement rates *(Baseline assumption, 125% of Medicare FFS)*						
119% of Medicare FFS	-4.3%	$519	-4.4%	$444	-4.7%	$392
131% of Medicare FFS	4.3%	$565	4.4%	$484	4.7%	$431
160% of Medicare FFS	24.5%	$675	24.5%	$578	26.4%	$520
2. Prescription drug reimbursement rates[1] *(Baseline assumption, PEBB drug reimbursement)*						
5% lower discounted drug cost	-0.7%	$538	-0.7%	$460	-0.7%	$408
5% greater discounted drug cost	0.7%	$546	0.7%	$467	0.7%	$414
3. Fully insured commercial group plan enrollment (increased non-PEBB/SEBB group enrollment) *(Baseline assumption, no enrollment from fully insured commercial group plans)*						
Alternate Identified Population scenario[2]	7.9%	$585	4.2%	$483	1.4%	$417
4. Medicaid-eligible enrollment *(Baseline assumption, 61% of enrollees eligible for Medicaid)*						
10% lower Medicaid enrollment	2.1%	$554	-0.1%	$463	-2.1%	$403
10% higher Medicaid enrollment	-2.1%	$531	0.1%	$464	2.1%	$420
5. Medical management *Baseline assumption by scenario*	*FFS-like management*		*PPO-like management*		*PPO-like management*	
PPO-like medical management (more strict than FFS)			0.0%	$464	0.0%	$411
FFS-like medical management (less strict than PPO)	0.0%	$542	2.2%	$474	1.7%	$418
6. Other variation in utilization rates or selection *(Baseline assumption calibrated based on historical utilization rates)*						
Utilization assumed 3% lower than baseline	-3.0%	$526	-3.0%	$450	-3.1%	$399
Utilization assumed 3% greater than baseline	3.0%	$558	3.0%	$478	3.1%	$424
Reasonable range based on sensitivity tests						
Composite lower estimate from sensitivity tests	-7.8%	$500	-8.0%	$427	-8.3%	$377
Composite upper estimate from sensitivity tests[3]	8.1%	$586	8.3%	$502	8.7%	$447

Notes:

(1) We have not modeled the impact of changing prescription drug rebates or the mix of savings due to rebates and discounts. In general, increasing rebates at the expense of discounts will result in more savings to the payer and more cost to the consumer at the point of sale. This is because manufacturer rebates do not usually impact the point-of-sale cost of a drug.

(2) See 'Exhibit III.1.b - Group Enrollment' for the development of the estimated fully insured commercial group plan enrollment.

(3) Upper estimate excludes 160% of Medicare FFS reimbursement scenario, the fully insured commercial group enrollment scenario, variance in medical management, and variance in Medicaid enrollment.

Appendix C
Exhibit II.4.a
FTAC - Universal Health Care Plan Pricing Analysis
Summary results - Identified Population, by subpopulation (exclusive of fully insured commercial group plans)

	Medicaid	Uninsured[1]	Individual	Local Govt. & Religious Orgs.	PEBB	SEBB	Composite
CY23 Baseline[2]							
Enrollment[3,4,5,6]	1,966,170	373,704	224,057	243,980	289,725	272,173	3,369,810
Member Months	23,594,040	4,484,448	2,688,684	2,927,763	3,476,705	3,266,081	40,437,721
PMPM estimate ranges							
Plan paid cost of care (PMPM)	$408	$38	$471	$425	$628	$551	$403
Patient paid cost of care (PMPM)	$0	$110	$115	$110	$79	$78	$41
Total cost of care (PMPM)	$408	$148	$587	$535	$707	$628	$444
Total annual cost of care (millions)							
Plan paid cost of care (millions)	$9,633.6	$170.6	$1,266.5	$1,245.2	$2,182.8	$1,799.0	$16,297.8
Patient paid cost of care (millions)	$0.0	$492.7	$310.4	$321.6	$274.5	$253.2	$1,652.5
Total cost of care (millions)	$9,633.6	$663.3	$1,577.0	$1,566.8	$2,457.3	$2,052.2	$17,950.3
Scenario 1 - Medicaid							
Enrollment[3,4,5,6]	2,057,886		506,045	243,980	289,725	272,173	3,369,810
Member Months	24,694,627		6,072,545	2,927,763	3,476,705	3,266,081	40,437,721
PMPM estimate ranges[7]							
Plan paid cost of care (PMPM)	$433 - $508		$656 - $770	$528 - $620	$641 - $752	$539 - $632	$500 - $586
Patient paid cost of care (PMPM)	$0 - $0		$0 - $0	$0 - $0	$0 - $0	$0 - $0	$0 - $0
Total cost of care (PMPM)	$433 - $508		$656 - $770	$528 - $620	$641 - $752	$539 - $632	$500 - $586
Total annual cost of care (millions)							
Plan paid cost of care (millions)	$10,686 - $12,541		$3,985 - $4,675	$1,546 - $1,814	$2,227 - $2,613	$1,760 - $2,065	$20,205 - $23,708
Patient paid cost of care (millions)	$0 - $0		$0 - $0	$0 - $0	$0 - $0	$0 - $0	$0 - $0
Total cost of care (millions)	$10,686 - $12,541		$3,985 - $4,675	$1,546 - $1,814	$2,227 - $2,613	$1,760 - $2,065	$20,205 - $23,708
Scenario 2 - PEBB Classic							
Enrollment[3,4,5,6]	2,057,886		506,045	243,980	289,725	272,173	3,369,810
Member Months	24,694,627		6,072,545	2,927,763	3,476,705	3,266,081	40,437,721
PMPM estimate ranges[7]							
Plan paid cost of care (PMPM)	$433 - $508		$453 - $535	$362 - $428	$445 - $526	$372 - $440	$427 - $502
Patient paid cost of care (PMPM)	$0 - $0		$67 - $75	$58 - $65	$66 - $74	$64 - $71	$25 - $28
Total cost of care (PMPM)	$433 - $508		$520 - $610	$420 - $493	$512 - $601	$435 - $511	$452 - $530
Total annual cost of care (millions)							
Plan paid cost of care (millions)	$10,686 - $12,541		$2,753 - $3,250	$1,060 - $1,252	$1,549 - $1,830	$1,214 - $1,436	$17,261 - $20,308
Patient paid cost of care (millions)	$0 - $0		$404 - $454	$170 - $191	$231 - $258	$208 - $233	$1,013 - $1,136
Total cost of care (millions)	$10,686 - $12,541		$3,157 - $3,704	$1,230 - $1,443	$1,780 - $2,088	$1,421 - $1,668	$18,274 - $21,444
Scenario 3 - CC/Silver EHB							
Enrollment[3,4,5,6]	2,057,886		506,045	243,980	289,725	272,173	3,369,810
Member Months	24,694,627		6,072,545	2,927,763	3,476,705	3,266,081	40,437,721
PMPM estimate ranges[7]							
Plan paid cost of care (PMPM)	$433 - $508		$315 - $382	$249 - $302	$310 - $376	$258 - $314	$377 - $447
Patient paid cost of care (PMPM)	$0 - $0		$153 - $169	$130 - $144	$154 - $169	$140 - $155	$57 - $63
Total cost of care (PMPM)	$433 - $508		$468 - $551	$379 - $446	$463 - $545	$398 - $468	$434 - $510
Total annual cost of care (millions)							
Plan paid cost of care (millions)	$10,686 - $12,541		$1,914 - $2,321	$729 - $884	$1,076 - $1,309	$842 - $1,025	$15,246 - $18,080
Patient paid cost of care (millions)	$0 - $0		$930 - $1,026	$380 - $420	$535 - $587	$458 - $505	$2,304 - $2,538
Total cost of care (millions)	$10,686 - $12,541		$2,844 - $3,346	$1,109 - $1,305	$1,611 - $1,896	$1,300 - $1,530	$17,550 - $20,618

Notes:

(1) Uninsured baseline costs are net of charity care (hospital covered medical costs), and Medicaid uncompensated care payments. This avoids double-counting, but understates the reimbursement and actual resource requirements of services for services for this population.

(2) Baseline and scenarios are inclusive of dental costs for Medicaid, PEBB, and SEBB . For other subpopulations, baseline data for dental enrollment costs was unavailable. Scenarios include modeling of dental costs for all subpopulations.

(3) In the modeled scenarios the Uninsured subpopulation is distributed between the Medicaid and Individual subpopulations depending on whether income is above or below 138% FPL. Utilization rates and service mix were not adjusted when adding the uninsured population - the uninsured are assumed to have utilization patterns similar to the populations into which they are merged.

(4) Medicaid, PEBB, and SEBB enrollment based information from Milliman's contracted work with Washington State Health Care Authority.

(5) Individual plan enrollment based on information from the "Access to Coverage" presentation published by Washington State Health Care Authority.

(6) See 'Exhibit III.1.b' for the development of the estimated local government and religious organization plan covered population enrollment.

(7) The actuarial value of deductibles, out-of-pocket maximums, and copays is sensitive to reimbursement rates. As the reimbursement rates in the modeled scenarios differ from the baseline, the actuarial value for the same nominal benefit structure will differ between the modeled scenarios and the baseline.

Appendix C
Exhibit II.4.b
FTAC - Universal Health Care Plan Pricing Analysis
Summary results - alternative Identified Population, by subpopulation (inclusive of fully insured commercial group plans)

	Medicaid	Uninsured[1]	Individual	Local Govt. & Religious Orgs.	PEBB	SEBB	Composite
CY23 Baseline[2]							
Enrollment[3,4,5,6]	1,966,170	373,704	224,057	961,894	289,725	272,173	4,087,723
Member Months	23,594,040	4,484,448	2,688,684	11,542,723	3,476,705	3,266,081	49,052,681
PMPM estimate ranges							
Plan paid cost of care (PMPM)	$408	$38	$471	$425	$628	$551	$407
Patient paid cost of care (PMPM)	$0	$110	$115	$110	$79	$78	$53
Total cost of care (PMPM)	$408	$148	$587	$535	$707	$628	$460
Total annual cost of care (millions)							
Plan paid cost of care (millions)	$9,633.6	$170.6	$1,266.5	$4,909.2	$2,182.8	$1,799.0	$19,961.8
Patient paid cost of care (millions)	$0.0	$492.7	$310.4	$1,268.1	$274.5	$253.2	$2,599.0
Total cost of care (millions)	$9,633.6	$663.3	$1,577.0	$6,177.3	$2,457.3	$2,052.2	$22,560.8
Scenario 1 - Medicaid							
Enrollment[3,4,5,6]	2,057,886		506,045	961,894	289,725	272,173	4,087,723
Member Months	24,694,627		6,072,545	11,542,723	3,476,705	3,266,081	49,052,681
PMPM estimate ranges[7]							
Plan paid cost of care (PMPM)	$465 - $546		$696 - $817	$563 - $660	$681 - $799	$574 - $674	$539 - $633
Patient paid cost of care (PMPM)	$0 - $0		$0 - $0	$0 - $0	$0 - $0	$0 - $0	$0 - $0
Total cost of care (PMPM)	$465 - $546		$696 - $817	$563 - $660	$681 - $799	$574 - $674	$539 - $633
Total annual cost of care (millions)							
Plan paid cost of care (millions)	$11,479 - $13,472		$4,229 - $4,961	$6,499 - $7,624	$2,369 - $2,779	$1,875 - $2,200	$26,451 - $31,036
Patient paid cost of care (millions)	$0 - $0		$0 - $0	$0 - $0	$0 - $0	$0 - $0	$0 - $0
Total cost of care (millions)	$11,479 - $13,472		$4,229 - $4,961	$6,499 - $7,624	$2,369 - $2,779	$1,875 - $2,200	$26,451 - $31,036
Scenario 2 - PEBB Classic							
Enrollment[3,4,5,6]	2,057,886		506,045	961,894	289,725	272,173	4,087,723
Member Months	24,694,627		6,072,545	11,542,723	3,476,705	3,266,081	49,052,681
PMPM estimate ranges[7]							
Plan paid cost of care (PMPM)	$465 - $546		$482 - $569	$387 - $456	$474 - $560	$397 - $469	$445 - $523
Patient paid cost of care (PMPM)	$0 - $0		$70 - $78	$61 - $69	$70 - $78	$67 - $75	$32 - $36
Total cost of care (PMPM)	$465 - $546		$551 - $647	$448 - $525	$544 - $638	$463 - $544	$477 - $560
Total annual cost of care (millions)							
Plan paid cost of care (millions)	$11,479 - $13,472		$2,925 - $3,453	$4,461 - $5,268	$1,649 - $1,948	$1,295 - $1,532	$21,810 - $25,671
Patient paid cost of care (millions)	$0 - $0		$423 - $475	$705 - $793	$242 - $271	$218 - $245	$1,589 - $1,784
Total cost of care (millions)	$11,479 - $13,472		$3,348 - $3,928	$5,167 - $6,060	$1,892 - $2,219	$1,513 - $1,776	$23,398 - $27,455
Scenario 3 - CC/Silver EHB							
Enrollment[3,4,5,6]	2,057,886		506,045	961,894	289,725	272,173	4,087,723
Member Months	24,694,627		6,072,545	11,542,723	3,476,705	3,266,081	49,052,681
PMPM estimate ranges[7]							
Plan paid cost of care (PMPM)	$465 - $546		$340 - $411	$270 - $327	$335 - $406	$279 - $339	$382 - $454
Patient paid cost of care (PMPM)	$0 - $0		$158 - $174	$134 - $148	$159 - $174	$145 - $160	$72 - $79
Total cost of care (PMPM)	$465 - $546		$498 - $585	$404 - $476	$493 - $581	$425 - $499	$454 - $533
Total annual cost of care (millions)							
Plan paid cost of care (millions)	$11,479 - $13,472		$2,063 - $2,498	$3,116 - $3,775	$1,164 - $1,413	$912 - $1,109	$18,733 - $22,267
Patient paid cost of care (millions)	$0 - $0		$959 - $1,057	$1,551 - $1,714	$552 - $605	$474 - $523	$3,536 - $3,898
Total cost of care (millions)	$11,479 - $13,472		$3,022 - $3,555	$4,666 - $5,489	$1,715 - $2,018	$1,387 - $1,631	$22,269 - $26,165

Notes:

(1) Uninsured baseline costs are net of charity care (hospital covered medical costs), and Medicaid uncompensated care payments. This avoids double-counting, but understates the reimbursement and actual resource requirements of services for services for this population.

(2) Baseline and scenarios are inclusive of dental costs for Medicaid, PEBB, and SEBB . For other subpopulations, baseline data for dental enrollment costs was unavailable. Scenarios include modeling of dental costs for all subpopulations.

(3) In the modeled scenarios the Uninsured subpopulation is distributed between the Medicaid and Individual subpopulations depending on whether income is above or below 138% FPL. Utilization rates and service mix were not adjusted when adding the uninsured population - the uninsured are assumed to have utilization patterns similar to the populations into which they are merged.

(4) Medicaid, PEBB, and SEBB enrollment based information from Milliman's contracted work with Washington State Health Care Authority.

(5) Individual plan enrollment based on information from the "Access to Coverage" presentation published by Washington State Health Care Authority.

(6) See 'Exhibit III.1.b' for the development of the estimated local government and religious organization plan covered population enrollment.

(7) The actuarial value of deductibles, out-of-pocket maximums, and copays is sensitive to reimbursement rates. As the reimbursement rates in the modeled scenarios differ from the baseline, the actuarial value for the same nominal benefit structure will differ between the modeled scenarios and the baseline.

Appendix C
Exhibit III.1.a
FTAC - Universal Health Care Pricing Analysis
Summary of starting assumptions and source information

	Medicaid	Uninsured	Individual	Local Govt. & Religious Orgs.	PEBB	SEBB	Composite
Population and enrollment							
2023 Washington Population[1]: 7,951,150							
% enrolled[2]	24.7%	4.7%	2.8%	3.1%	3.6%	3.4%	42.4%
Enrollment[3,4,5]	1,966,170	373,704	224,057	243,980	289,725	272,173	3,369,810
Member Months	23,594,040	4,484,448	2,688,684	2,927,763	3,476,705	3,266,081	40,437,721
Allowed costs							
Medical and Prescription Drug Allowed PMPM[6,7,8,9]	$386.83	$147.92	$586.52	$535.17	$650.52	$565.75	$421.47
Inpatient	$124.50	$60.94	$96.25	$93.40	$108.90	$87.88	$109.02
Outpatient	$64.55	$21.52	$161.81	$172.07	$186.35	$168.38	$92.89
Professional	$137.42	$44.15	$189.24	$163.77	$218.11	$196.11	$144.11
Ancillary/Other	$18.71	$8.43	$17.27	$18.65	$24.84	$22.33	$18.29
Prescription Drugs	$41.65	$12.86	$121.95	$87.27	$112.32	$91.05	$57.17
Dental Allowed PMPM[10]	$21.48	n/a	n/a	n/a	$56.28	$62.60	n/a
Percent of Medicare calculation for medical services[11]							
Inpatient	130%	90%	190%	224%	189%	189%	139%
Outpatient	77%	85%	220%	259%	232%	245%	126%
Professional	108%	70%	125%	147%	138%	151%	117%
Ancillary/Other	108%	70%	125%	147%	138%	151%	114%
Implied Medicare PMPM (Medical Only)	$323.40	$168.16	$289.33	$232.23	$313.68	$259.95	$291.36

Notes:

(1) Based on April 2023 population reported by the Washington State Office of Financial Management (OFM) (see [36]).

(2) Percentage of Washington State population uninsured based on information from the "Access to Coverage" presentation published by Washington State Health Care Authority (see [5]).

(3) Medicaid, PEBB, and SEBB enrollment based information from summary data provided by Washington State Health Care Authority.

(4) Individual plan enrollment based on information from the "Access to Coverage" presentation published by Washington State Health Care Authority (see [5]).

(5) See 'Exhibit III.1.b' for the development of the estimated local government and religious organization plan covered population enrollment.

(6) Medicaid Allowed PMPM based on information from Milliman's contracted work with Washington State Health Care Authority. Allowed PMPM includes fee-for-service claims, payments by managed care organizations (MCOs), and the following non-claim based payments: FQHC, SNAF, WISe, New Journeys, IDP, ODP, DCR, MCO reported amounts for non-claims payments, PAP, PSSP, CPE, airlift services, CLIP, DSH, and Rx rebates.

(7) Individual plan allowed PMPM based on URRT data (see [4]).

(8) Local government and religious organization allowed PMPM is based in paid amounts in the Supplemental Health Care Exhibit (SHCE) adjusted for an assumed paid to allowed ratio based on Milliman research (see [6]).

(9) PEBB and SEBB program allowed PMPMs are based on information from summary data provided by Washington State Health Care Authority.

(10) PEBB and SEBB dental allowed PMPM is based on paid amounts from summary data provided by Washington State Health Care Authority, and the estimated actuarial value of the dental benefit.

(11) See 'Exhibit III.3.a' for the detail related to percent of Medicare assumptions.

Appendix C
Exhibit III.1.b
FTAC - Universal Health Care Pricing Analysis
Estimation of group plan enrollment rates

	Subscribers	Members	
Local Government and Religious Organization Plan Only Scenario (Base Scenario)			
Non-education local government employees, full-time[1]	124,260	255,976	(A)
Non-education local government employees, part-time[1]	27,802	57,272	(B)
Assumed percentage part-time employees included in coverage[2]		33%	(C)
Local government employees enrolled in PEBB[3]	17,116	35,259	(D)
Religious organization employees[4]	2,090	4,305	(E)
Estimated local government and religious organization group population		243,980	(F) = (A) + (B)*(C) - (D) + (E)
Local Government and Religious Organization Plans + Other Fully Insured Commercial Group Scenario			
Fully-insured Large Group[5]		654,988	(G)
Fully-insured Small Group[5]		290,028	(H)
Fully-insured PEBB/SEBB[6]		222,797	(I)
Local government employees not enrolled in PEBB/SEBB		239,675	(J) = (F) - (E)
Estimated local government, religious org., and fully insured group population[7]		961,894	(K) = (G) + (H) - (I) + (J)

Notes:

(1) Based on subscriber counts reported in the 2023 Annual Survey of Public Employment & Payroll (ASPEP) Datasets and Tables (see [14]). Member counts are estimated using a members per subscriber assumption based on Milliman research. Limited to local government employees for government functions other than education.

(2) Based on the implied percentage of part-time state employees and local government education employees that receive coverage through PEBB and SEBB. This is calculated based on comparing the reported full-time and part-time employment from the ASPEP datasets to July 2023 PEBB and SEBB active enrollment reported in the Employee and Retiree Benefits (ERB) enrollment dashboard published by Washington State Health Care Authority (see [37]).

(3) PEBB employee counts based on information from Milliman's contracted work with Washington State Health Care Authority. Member counts are estimated using a members per subscriber assumption based on Milliman research.

(4) Based on subscriber counts reported in the May 2023 Washington State Occupational Employment and Wage Statistics (OES) published by the U.S. Bureau of Labor Statistics (see [15]). Subscriber counts for the following major occupational groups were included: 21-2011, 21-2021, 21-2099. Member counts are estimated using a members per subscriber assumption based on Milliman research.

(5) Fully insured enrollment counts based on information from the "Access to Coverage" presentation published by Washington State Health Care Authority (see [5]).

(6) Based on information from Milliman's contracted work with Washington State Health Care Authority.

(7) It is assumed that religious organization employees are included in the fully-insured populations ((G) and (H)).

Appendix C
Exhibit III.2
FTAC - Universal Health Care Pricing
Analysis Starting (baseline) cost model

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000		(2) Average Allowed Reimbursement	(3) Per Member Per Month Allowed Cost	(4) Per Member Per Month Cost Sharing	(5) Net Per Member Per Month Payer Paid
Inpatient Facility (Excludes Professional in Facility if Billed Separately)								
Medical	22.99 admits	6.20	143.0	days	$3,390.93	$40.40	$1.57	$38.83
Surgical	9.24 admits	7.15	66.3	days	7,094.23	39.17	0.90	38.27
Psychiatric	25.43 admits	3.86	98.5	days	1,107.51	9.09	0.45	8.65
Substance Use Disorders	18.90 admits	2.40	45.6	days	900.98	3.42	0.22	3.20
Maternity	26.81 admits	2.15	57.9	days	2,430.90	11.74	1.44	10.29
Skilled Nursing Facility	8.85 admits	12.85	114.1	days	541.18	5.15	0.12	5.03
Inpatient Facility - Subtotal	112.23 admits	34.62	525.3	days		**$108.96**	**$4.69**	**$104.27**
Outpatient Facility (Excludes Professional in Facility if Billed Separately)								
Observation			7.5	visits	$2,959.87	$1.84	$0.21	$1.63
Emergency Department			219.2	visits	791.92	14.46	1.89	12.58
Surgery			99.4	visits	3,687.18	30.55	2.36	28.19
Radiology			665.1	visits	157.85	8.75	0.61	8.14
Pathology/Lab			376.2	visits	108.81	3.41	0.29	3.12
Pharmacy			197.8	visits	830.16	13.68	1.40	12.29
Cardiovascular			51.0	visits	455.72	1.94	0.12	1.82
PT/OT/ST			99.0	visits	195.33	1.61	0.13	1.48
Psychiatric			105.7	visits	164.25	1.45	0.06	1.38
Substance Use Disorders			89.9	visits	240.85	1.80	0.03	1.77
Preventive			137.8	visits	319.87	3.67	0.00	3.67
Other Outpatient Facility			502.6	visits	230.62	9.66	0.68	8.98
Outpatient Facility - Subtotal			2,551.2			**$92.83**	**$7.78**	**$85.05**
Professional								
Inpatient Surgery			100.2	proced	$334.77	$2.80	$0.18	$2.61
Maternity			54.7	proced	720.73	3.28	0.23	3.06
Outpatient Surgery			426.2	proced	280.17	9.95	1.74	8.22
Inpatient Visits			465.0	visits	143.78	5.57	0.29	5.28
Office/Home Visits - PCP			1,607.7	visits	139.07	18.63	1.46	17.17
Office/Home Visits - Specialist			753.3	visits	145.03	9.10	1.32	7.78
Urgent Care Visits			211.7	visits	143.28	2.53	0.28	2.25
Office Administered Drugs			252.1	proced	530.96	11.15	0.88	10.27
Allergy Testing & Immunotherapy			54.2	proced	71.97	0.33	0.08	0.25
Miscellaneous Medical			1,607.8	proced	42.39	5.68	0.41	5.27
Immunizations			697.1	proced	56.15	3.26	0.11	3.16
Well Baby Exams			78.2	visits	164.14	1.07	0.01	1.06
Physical Exams			355.6	visits	162.82	4.83	0.18	4.65
Other Preventive			1,140.3	proced	79.20	7.53	0.22	7.30
ED Visits and Observation Care			352.7	visits	149.04	4.38	0.24	4.14
Vision, Hearing, and Speech Exams			162.2	visits	54.60	0.74	0.05	0.68
Physical Therapy			981.1	visits	90.97	7.44	1.40	6.03
Cardiovascular			150.4	proced	63.82	0.80	0.11	0.69
Radiology			1,394.7	proced	53.50	6.22	0.79	5.43
Pathology/Lab			2,624.3	proced	41.05	8.98	1.06	7.91
Chiropractor			176.2	visits	67.61	0.99	0.25	0.75
Outpatient Psychiatric			4,596.9	visits	64.93	24.87	2.33	22.55
Outpatient Substance Use Disorders			1,556.3	visits	30.09	3.90	0.03	3.87
Professional - Total			19,799.0			**$144.03**	**$13.66**	**$130.37**
Other Medical								
Home Health Care			158.5	visits	$456.50	$6.03	$0.66	$5.36
Ambulance			67.9	cases	841.33	4.76	0.27	4.49
DME/Supplies/Prosthetics			507.3	proced	156.18	6.60	0.85	5.75
Other - Total			733.6			**$17.39**	**$1.78**	**$15.61**
Total Medical Benefits						**$363.21**	$27.91	**$335.30**
Prescription Drugs								
Prescription Drugs			8,249.5	scripts	$83.11	$57.13	$3.91	$53.22
Total Standard Benefits						**$420.34**	$31.82	**$388.52**
Additional Benefits								
Glasses/Contacts/Hearing Aids			79.4	cases	$134.94	$0.89	$0.03	$0.87
Dental						$22.43	$3.54	$18.89
Additional Benefits - Subtotal						$23.32	$3.56	$19.76
Total Benefit Cost						**$443.66**	$35.38	**$408.28**
Starting Net PMPM Claim Cost for Services Subj to Deductible								$153.74
Cost Sharing (Deductible/Coinsurance/OOP) Induced Utilization Adjustment Value (Net of Cost Sharing Subject to Deductible)								$0.64
Value of Deductible (Net of Cost Sharing Subject to Deductible)								(11.59)
Value of Out-of-Pocket Maximum (Including Deductible)								5.70
Value of Annual Maximum								0.00
Adjusted Net PMPM for Services Subject to Deductible								**$148.49**
PMPM for Services Not Subject to Deductible								**$254.54**
Total Medical Cost After Deductible and Cost Sharing						**$443.90**		**$403.03**

Notes

(1) Service line level costs and utilization not subject to the deductible do not include final adjustments for induced utilization. These impacts are shown in the rows below the "Total Benefit Cost". Adjusted costs at the service line level can be estimated using the ratio of the final PMPM allowed cost to the unadjusted PMPM claim cost.

(2) As certain development assumptions were only available at a high-level service category basis, service line level costs and utilization should be considered approximate.

(3) Dental cost is included only for the Medicaid, PEBB, and SEBB subpopulations; individual, uninsured, local government, and religious organization subpopulations are assigned $0.

Appendix C
Exhibit III.3.a
FTAC - Universal Health Care Pricing Analysis
Estimated payment rate for medical services as a percent of Medicare

	Percent of Medicare	Sources and discussion
Medicaid medical services reimbursement rates		
Inpatient	130%	Medicaid facility reimbursement rates are based on a Medicaid hospital payment benchmarking analysis performed by Milliman commissioned
Outpatient	77%	by HCA, with adjustments for non-claim based payments.
Professional	108%	Medicaid professional and ancillary/other reimbursement rates are based on the Medicaid-to-Medicare fee index[1], with adjustments for
Ancillary/Other	108%	non-claim based payments.
Uninsured medical services reimbursement rates		
Inpatient	90%	Uninsured facility reimbursement rates are based on several assumptions including utilization levels relative to Medicaid, Medicare
Outpatient	85%	reimbursement cost coverage, payments made by state and federal government sources for uncompensated care, and actuarial judgement.
Professional	70%	Uninsured reimbursement rates for professional and ancillary/other services are based on assumed relativities to individual plan reimbursement
Ancillary/Other	70%	levels and actuarial judgement.
Individual plan medical services reimbursement rates		
Inpatient	190%	Individual reimbursement rates are based on a relativity to group reimbursement rates. This relativity is calculated based on a review of
Outpatient	220%	risk-adjusted Allowed PMPMs for the Washington state individual and small group markets sourced from URRT data[2].
Professional	125%	
Ancillary/Other	125%	
Group health plan medical services reimbursement rates		
Inpatient	224%	Group reimbursement rates are based on Milliman's commercial reimbursement benchmarking[3].
Outpatient	259%	
Professional	147%	
Ancillary/Other	147%	
PEBB plans' medical services reimbursement rates		
Inpatient	189%	PEBB reimbursement rates are calculated by Milliman through contracted work with HCA.
Outpatient	232%	
Professional	138%	
Ancillary/Other	138%	
SEBB plans' medical services reimbursement rates		
Inpatient	189%	SEBB reimbursement rates are calculated by Milliman through contracted work with HCA.
Outpatient	245%	
Professional	151%	
Ancillary/Other	151%	

Notes:

(1) Medicaid-to-Medicare fee index estimated at 69% based on the report (see [17]).

(2) Based on 2023 experience from the 2025 URRT data (see [4]), and state average Plan Liability Risk Scores from Appendix A of the 2023 Benefit Year Risk Adjustment Summary Report (see [22]).

(3) Based on the Washington State results from the Commercial Reimbursement Benchmarking analysis (see [25]).

Appendix C
Exhibit III.3.b
FTAC - Universal Health Care Pricing Analysis
Estimated payment rate for prescription drugs as percent of Average Wholesale Price (AWP)

	Medicaid	Uninsured	Individual	Local Govt. & Religious Orgs.	PEBB	SEBB
Estimated percent of AWP						
Point-of-sale allowed PMPM[1,2,3,4]	$91.15	$12.86	$159.70	$114.66	$149.92	$125.08
Estimated Discount off AWP[5]	51.7%	51.7%	51.7%	51.7%	51.7%	51.7%
Estimated AWP PMPM[6]	$176.30	$24.88	$308.90	$221.77	$289.97	$241.94
Rebates PMPM[7,8]	($49.50)	$0.00	($37.75)	($27.38)	($37.60)	($34.03)
Final allowed PMPM	$41.65	$12.86	$121.95	$87.27	$112.32	$91.05
Final allowed percent of AWP	23.6%	51.7%	39.5%	39.4%	38.7%	37.6%

Notes:

(1) Medicaid, PEBB, and SEBB point of sale allowed PMPMs are based on information from summary data provided by Washington State Health Care Authority.

(2) Estimated uninsured prescription drug cost based on information from the Medical Expenditure Panel Survey (MEPS) (see [18]).

(3) Individual plan estimated point-of-sale allowed PMPM is calculated based on pharmacy allowed cost information from URRT data adjusted for Rx rebates (see [4]).

(4) Local government and religious organization plans' estimated point-of-sale allowed PMPM is calculated based on the pharmacy paid amounts from the 2023 Supplemental Health Care Exhibit for small group and large group plans adjusted for the an assumed paid to allowed ratio based on Milliman research (see [6]).

(5) Average discount off of AWP is based on the information included in the Milliman White Paper 'NADAC-plus: An emerging paradigm in pharmacy pricing?" published in 2018 (see [16]). These discounts are blended across generic, brand, and specialty drugs using Milliman benchmark utilization rates.

(6) Estimated AWP PMPM is calculated based on the Point-of-sale allowed PMPM and the estimated discount off AWP.

(7) Medicaid, PEBB, and SEBB rebate amounts are based on information from summary data provided by Washington State Health Care Authority.

(8) Individual, local government, and religious organization plans' drug rebates are estimated based on values reported in 2023 Supplemental Health Care Exhibit (see [6]).

Appendix D: Summary of benefits by scenario

FTAC - Universal Health Care Pricing Analysis
Summary of benefits by scenario

Service Category	Description of Services	Medicaid Coverage[1]	PEBB (UMP Classic) Coverage	PEBB (UMP Classic) Copay[2,3,4]	Cascade Select Silver	Individual Copay (Silver)[2,5,6]	Modeling Notes[8]
Medical Deductible		None	Yes	Medical: $250/Member ($750 Max) Rx: $100/Member ($300 Max)	Yes	$2,500 Individual, $5,000 Family	PEBB and SEBB are modeled with an combined medical and Rx estimated effective deductible.
Maximum out-of-pocket Maximum (MOOP)		None	Yes	Medical: $2,000/Member ($4,000 Max) Rx: $2,000/Member ($4,000 Max)	Yes	$8,500 Individual, $17,000 Family	PEBB and SEBB are modeled with an combined medical and Rx estimated effective maximum out-of-pocket.
Alternative medicines		No	Acupuncture	$15 Copay	Yes-Acupuncture	$30 Copay	Acupuncture is not separately split-out in our modeling. PEBB and SEBB services implicitly modeled at 15% coinsurance.
Applied Behavioral Analysis (ABA)		Yes	Yes - Autism Diagnosis Only	15% Coinsurance	Yes	$30 Copay	Modeling does not include restriction on diagnosis.
Chiropractic/Spinal Manipulation		Yes[7]	24 visits/year	$15 Copay	10 visits/year	$30 Copay	
Dental	Routine exams, Cleaning, X-rays, Fluoride	Yes	Yes	None	Yes	None	Cascade Select dental modeled using PEBB benefit structure
	Fillings	Yes	Yes	20% Coinsurance	Yes	20% Coinsurance	
	Extractions	Yes	Yes	20% Coinsurance	Yes	20% Coinsurance	
	Periodontal (gum disease)	Yes	Yes	20% Coinsurance	Yes	20% Coinsurance	
	Root canal	Yes	Yes	20% Coinsurance	Yes	20% Coinsurance	
	Dentures/partials, Bridges	Dentures/partials Only	Yes	50% Coinsurance	Yes	50% Coinsurance	
	Oral surgery	Yes	Yes	20% Coinsurance	Yes	20% Coinsurance	
	Crowns	Stainless Steel Only	Yes	50% Coinsurance	Yes	50% Coinsurance	
	Orthodontics	Children Only - Medically Necessary	Yes	50% Coinsurance (Lifetime $1,750 Max)	Yes	50% Coinsurance (Lifetime $1,750 Max)	
Dental Services and Dental anesthesia as part of Medical Benefit		Yes	Yes	20% Coinsurance	Yes	30% Coinsurance	
Diagnosis and treatment of infertility, impotence, and sexual dysfunction		No	Yes-Initial diagnosis only	15% Coinsurance	Yes-Initial diagnosis only	30% Coinsurance	Modeling does not include restriction on first diagnosis.
Family planning/reproductive health	Prescription and OTC birth control, contraceptives and emergency contraceptives, HIV/AIDS screening	Yes	Yes	None	Yes	None	
General services and emergency care	Emergency services	Yes	Yes	$75 Copay	Yes	$800 Copay after deductible	
	Hospital inpatient and outpatient services	Yes	Yes	IP Facility: $200 Copay/Day, $600 Max/Year OP, Professional: 15% Coinsurance	Yes	Inpatient: $800/day Copay after deductible, 1-5 days Outpatient: $600 facility copay, $200 professional copay after deductible	PEBB/SEBB day limit modeled as per-admit rather than per-year.
	Urgent care	Yes	Yes	15% Coinsurance	Yes	$65 Copay	
Habilitative services	Occupational, physical, speech Therapies. Pulmonary and Cardiac rehabilitation	Yes	Yes, 60 day limit IP, 60 visit limit OP	IP Facility: $200 Copay/Day, $600 Max/Year OP, Professional: 15%	Yes, 30 day limit IP, 25 visit limit OP	Outpatient $40/visit Copay Inpatient $800/day Copay after deductible	
	Neurodevelopmental therapy	No	Yes		Yes		
Hearing	Hearing screening test	Yes	Yes - One/Year	$0	No	n/a	
	Hearing exams	Yes			No	n/a	
	Hearing Aids	Yes Bone-Anchored for Children Only	Yes	None up to $3,000/ear/ 3 calendar years Standard rate for battery, follow-up	Yes - Cochlear Only	30% Coinsurance	Hearing aids are not modeled as a distinct benefit. Baseline costs for this benefit were used for all benefit scenarios.[9]
Home Health services		Yes	Yes	15% Coinsurance	Yes	$30/day Copay	
Hospice services		Yes	Yes	None	Yes	$30/day Copay	
Labs and X-rays		Yes	Yes	15% Coinsurance	Yes	Lab outpatient and professional services: $40 Copay X-rays $65 Copay Complex imaging: 30% Coinsurance after deductible	
Marriage counseling and sex therapy		No	No	n/a	No	n/a	
Massage therapy		No	24 visits/year	$15 Copay	As Habilitative Service	As Habilitative Service	Massage therapy is not separately split-out in our modeling. PEBB and SEBB services implicitly modeled at 15% coinsurance.

Appendix D
FTAC - Universal Health Care Pricing Analysis
Summary of benefits by scenario

Service Category	Description of Services	Medicaid Coverage[1]	PEBB (UMP Classic) Coverage	PEBB (UMP Classic) Copay[2,3,4]	Cascade Select Silver	Individual Copay (Silver)[2,5,6]	Modeling Notes[8]
Maternity service	Routine prenatal care	Yes	Yes	IP Facility: $200 Copay/Day, $600 Max/Year OP, Professional: 15% Coinsurance	Yes	$30 Copay.	PEBB/SEBB day limit modeled as per-admit rather than per-year.
	Prenatal genetic counseling	Yes	Yes	As above	Yes	$40 Copay	Prenatal genetic counseling is not separately split-out in our modeling. Cascade Silver Select services implicitly modeled at $30 copay.
	Prenatal genetic testing	Yes	Yes	As above	Yes	$30 Copay.	
	Childbirth classes	Yes	Unclear	As above	No	n/a	
	Delivery	Yes	Yes	As above	Yes	$800/day after deductible	
	Comprehensive postpartum care for the birthing person	Yes	Yes	As above	Yes	$30 Copay.	
	Chest feeding-lactation consultation	Yes-12months	Yes	None	Yes	None	
	Breast pumps	Yes	Yes	None	Yes	None	
Medical equipment and supplies	Medically necessary medical equipment or supplies	Yes	Yes	15% Coinsurance	Yes	30% Coinsurance	
Medications for Opioid Disorder	Medications used to treat certain substance use disorders	Yes	No	n/a	No	n/a	
Mental health treatment	Intake evaluation, assessment, and screening	Yes	Yes	IP Facility: $200 Copay/Day, $600 Max/Year ($0 Professional) OP, Professional: 15% Coinsurance	Yes	$30 Copay	PEBB/SEBB day limit modeled as per-admit rather than per-year.
	Mental health treatment interventions, Medication Management	Yes	Yes	IP Facility: $200 Copay/Day, $600 Max/Year ($0 Professional) OP, Professional: 15% Coinsurance	Yes	Inpatient: $800/day Copay after deductible, 1-5 days Outpatient: $600 facility copay, $200 professional copay after deductible	
	Crisis services	Yes	No	n/a	No	n/a	
	Peer support	Yes	No	n/a	No	n/a	
	Care coordination and community integration	Yes	No	n/a	No	n/a	
Naturopathy		Yes	Yes	15% Coinsurance	No	PCP: $30 Copay Specialist: $65/visit Copay	
Non-medical equipment		No	No	n/a	No	n/a	
Nutrition	Parenteral nutrition supplies, Enteral nutrition supplies for tube-fed enrollees	Yes	No	n/a	Yes	$30 Copay	Not modeled as separate benefit.
	Medical nutrition therapy	Yes	12 Lifetime Visits	15% Coinsurance	Counseling	$30 Copay	
Prescription drugs	Covered as listed in Preferred Drug List. Includes a 90-day supply for maintenance medications.	Yes	Yes	Preventative: None Value Tier (Used to treat certain chronic conditions): 5% Coinsurance or $10 Copay, whichever is less / prescription, deductible does not apply Tier 1 (Low-cost generic prescription drugs) 10% Coinsurance or $25 Copay, whichever is less / prescription, deductible does not apply Tier 2 (Preferred brand drugs and high-cost generic drugs) 30% Coinsurance or $75 Copay, whichever is less, up to 30 day supply / prescription	Yes	Generic Drugs $25 per 30-day supply $67.50 per 90-day supply Preferred Brand Drugs $75 per 30-day supply $202.50 per 90-day supply Non-Preferred Brand Drugs $250 per 30-day supply after deductible Specialty Drugs $250 per 30-day supply after deductible	PEBB/SEBB benefits modeled as effective coinsurance. Specific formulary not modeled. Cascade Silver - preferred generics modeled as $5 copay due to model limitation.
Preventive services	Vaccines & Immunizations	Yes	Yes	None	Yes	None	
	Chronic disease management	Yes	Yes-Diabetes	None	Yes	None	
Problem gambling disorder treatment interventions	Assessment, Therapeutic individual, family and/or group services	No	No	n/a	No	n/a	Not modeled as separate benefit.
Skilled Nursing Facility		Yes	Yes	Facility: $200 Copay/Day, $600 Max/Year Professional: 15% Coinsurance	Yes	$800 Copay after deductible, 60 day /year limit	60 day/ year limit not modeled for Cascade Select Silver. PEBB/SEBB day limit modeled as per-admit rather than per-year.

Appendix D
FTAC - Universal Health Care Pricing Analysis
Summary of benefits by scenario

Service Category	Description of Services	Medicaid Coverage[1]	PEBB (UMP Classic) Coverage	PEBB (UMP Classic) Copay[2,3,4]	Cascade Select Silver	Individual Copay (Silver)[2,5,6]	Modeling Notes[8]
Specialty	Allergy services (antigen/allergy serum/allergy shots)	Yes	Skin testing	15% Coinsurance	Yes	$30 Copay	
	Ambulatory surgery center	Yes	Yes	15% Coinsurance	Yes	$600 Copay after deductible	
	Bariatric surgery	Yes	Yes	Facility: $200 Copay/Day, $600 Max/Year Professional: 15% Coinsurance	No	n/a	
	Chemotherapy	Yes	Yes	Facility: $200 Copay/Day, $600 Max/Year Professional: 15% Coinsurance	Yes	30% Coinsurance	
	Cosmetic surgery	Limited	Limited	Facility: $200 Copay/Day, $600 Max/Year Professional: 15% Coinsurance	Limited	30% Coinsurance after deductible	
	Diabetes comprehensive care	Yes	Yes	Facility: $200 Copay/Day, $600 Max/Year Professional: 15% Coinsurance	Yes	None	
	Diabetic education	Yes	Yes	None	Yes	None	
	Diabetic retinal screening	No	No	n/a	Yes	None	
	Diabetic supplies	Yes	Yes	As pharmacy	Yes	30% Coinsurance after	
	Dialysis	Yes	Yes	Facility: $200 Copay/Day, $600 Max/Year Professional: 15% Coinsurance	Yes	30% Coinsurance after deductible	
	Hepatitis C treatment	Yes	Yes	As pharmacy	Yes	As pharmacy	
	Organ transplants	Yes	Yes	Facility: $200 Copay/Day, $600 Max/Year Professional: 15% Coinsurance	Yes	Inpatient: $800/day Copay after deductible, 1-5 days Outpatient: $600 facility copay, $200 professional copay after deductible	
	Oxygen and respiratory services	Yes	Yes	15% Coinsurance	Yes	30% Coinsurance after deductible	
	Podiatry	Yes	Limited	15% Coinsurance	Limited	None	
	Smoking cessation	Yes	Yes	None	Yes	None	
	Gender affirming care/transhealth services	Yes	Yes	15% Coinsurance	Yes	As applicable for service type (e.g. PCP, Specialist)	
	Prostate/PSA cancer screening	Yes	Yes	15% Coinsurance	Yes	None	
	Colonoscopy	Yes	Yes	15% Coinsurance	Yes	None	
	Lung cancer screening	Yes	No	n/a	No	n/a	
	TB screening an following-up treatment	Yes	No	n/a	No	n/a	
Sterilization	FDA-approved female sterilization procedures, services and supplies	Yes	Yes	None	Yes	None	Not modeled as separate benefit.
SUD treatment services	Assessment	Yes	Yes	IP Facility: $200 Copay/Day, $600 Max/Year ($0 Professional) OP, Professional: 15% Coinsurance	Yes	Inpatient: $800/day Copay after deductible, 1-5 days Office visits $30/visit Other outpatient services: $30/visits	PEBB/SEBB day limit modeled as per-admit rather than per-year.
	Brief intervention and referral to treatment	Yes	Yes	As above	Yes	As above	
	Individual, family, and group therapy	Yes	Yes	As above	Yes	As above	
	Outpatient, residential, and inpatient	Yes	Yes	As above	Yes		
	Opiate substitution treatment services	Yes	Yes	As above	No	n/a	
	Case Management	Yes	Yes	As above	Yes		
	Peer support	Yes	No	n/a	No	n/a	
	Crisis services	Yes	No	n/a	No	n/a	
	Withdrawal management (detoxification)	Yes	Yes	As above	Yes		
Telehealth/Telemedicine	Telehealth services	Yes	Yes	As in-person by service	Yes	$30 Copay	
Transportation	Air ambulance services	Yes	Yes	20% Coinsurance	Yes	$375 Copay	
	Water ambulance	Yes	Yes	20% Coinsurance	No	n/a	
	Emergency and non-emergency ground ambulance services	Yes	Yes	20% Coinsurance	Yes	$375 Copay	
	Non-emergency medical transportation	Yes	No	n/a	No	n/a	
Vision	Eye exams	1/Two Years (Adults). 1/Year (Children)	1/Year	None	Pediatric Only	None	Medicaid modeled as 1/Two Years for all groups.
	Glasses	Coverage varies by plan	1/Two Years	$150 Allowance	Pediatric Only	None	PEBB modeled as $0 cost sharing (i.e., assuming total under allowance). Medicaid coverage modeled similar to PEBB.
	Contact lenses and fittings	Coverage varies by plan	1/Two Years	None	Pediatric Only	None	
	Treatment for medical conditions	Yes	Yes	15% Coinsurance	Pediatric Only	None	

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Service Category	Description of Services	Medicaid Coverage[1]	PEBB (UMP Classic) Coverage	PEBB (UMP Classic) Copay[2,3,4]	Cascade Select Silver	Individual Copay (Silver)[2,5,6]	Modeling Notes[8]
Weight reduction and control services	Weight-loss drugs, products, gym memberships, or equipment for the purpose of weight reduction	No	No	n/a	No- Covers obesity screening	n/a	Not modeled as separate benefit.
Women's Health	Mammograms, Pap smear, Pelvic Exam	Yes	Yes	None	Yes	None	Not modeled as separate benefit.
	Pregnancy termination-involuntary	Yes	Yes	None	Yes	None	
	Pregnancy termination-voluntary	Yes	Yes	None	Yes	None	

Notes:
(1) Medicaid has no member cost sharing for any covered acute care service.
(2) SEBB (UMP Achieve 2) benefits and cost sharing have only minor differences from to PEBB (UMP Classic) and are not shown.
(3) Copays and Coinsurance values are shown for in-network services at preferred providers only.
(4) Dental benefits provided separately, benefits below are for the PEBB Uniform Dental Plan
(5) Cascade Select Silver cost sharing does not reflect any cost sharing reductions that may be available to low-income enrollees
(6) Benefits shown in this exhibit do not include all available benefits, benefit limitations or exclusions.
(7) Chiropractic benefit available to members of some managed care plans, modeled as 24/year limit consistent with PEBB and SEBB benefits.
(8) While modeling of certain benefits is limited by the granularity of data sources and models, the costs for each subpopulation are calibrated based on actual costs and will implicitly account for small differences between the modeled benefits and actual benefits.
(9) We reviewed benefits and experience costs in the data available to us (where sufficient detail was included). The review supported the selected approach.

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority