WSHIP
WASHINGTON STATE
HEALTH INSURANCE POOL

2018 ANNUAL REPORT

Washington State Health Insurance Pool

Providing health benefits to Washington residents who were denied coverage or unable to obtain comprehensive coverage

WSHIP
WASHINGTON STATE
HEALTH INSURANCE POOL

P.O. Box 1088
Stanwood, WA 98292

May 2019

Honorable Jay Inslee, Washington State Governor
Honorable Mike Kreidler, Washington State Insurance Commissioner
Members of the Washington State Legislature
Members of Washington State's Congressional Delegation
Washington State Health Insurance Pool Member Plans
Washington State Health Insurance Pool Brokers and Agents
Interested Persons and Organizations

On behalf of the Board of Directors of the Washington State Health Insurance Pool (WSHIP), I am pleased to present this Annual Report for the calendar year 2018.

Total enrollment in WSHIP decreased 2.5% in 2018 with a year-end total of 1,418 enrollees. Of these, 321 were in WSHIP's non-Medicare program and 1,097 were in WSHIP's Medicare program. WSHIP's non-Medicare program is only available to persons enrolled in WSHIP prior to 2014 or who reside in a county where individual health plans are not offered. The non-Medicare program has been closed to new enrollment since 2014 because individual coverage has been available in all counties, and nearly 90% of individuals who had been enrolled in non-Medicare plans have transitioned to other coverage options. Our Medicare-eligible plan remains open to Medicare enrollees who are unable to obtain comprehensive supplemental coverage or a Medicare Advantage plan. Many of these enrollees are under age 65 and eligible for Medicare because they have End Stage Renal Disease (ESRD).

WSHIP's total claims costs increased 3.5% to $38.7 million in 2018. Assessments to Member Plans were $25.5 million in 2018 (an estimated $0.61 pmpm). WSHIP assessments for 2019 are currently projected to be $27.5 million. Cost saving measures implemented by WSHIP included the enhanced pricing for pharmacy benefits and discontinuation of WSHIP's indemnity plan.

The Board shares the concerns of many about affordability and access to individual coverage. These issues can be especially difficult for high risk individuals who have extremely high-cost and on-going treatment needs. As potential solutions are explored, WSHIP is committed to providing helpful input based on its expertise serving high risk individuals. We look forward to working with policy makers on these important issues. WSHIP's Executive Director, Sharon Becker, is available to answer questions or provide additional information. Please contact Sharon at (360) 671-2101 or sbecker@wship.org. I may be contacted at (206) 332-5460 or Kristen.Walter@Regence.com.

Sincerely,

Kristen Walter Wright, WSHIP Board Chair

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About WSHIP

As the State's high risk pool, WSHIP is a nonprofit health plan providing health benefits to Washington residents denied coverage because of their medical status or unable to obtain comprehensive coverage. WSHIP has offered benefit plans for individual coverage as well as Medicare supplemental coverage.

With the implementation of health care reforms in 2014, WSHIP's non-Medicare plans were closed to new enrollment and the majority of WSHIP's enrollment today is Medicare enrollees. Many of these Medicare enrollees are under age 65 and have End Stage Renal Disease (ESRD).

Created in 1987 by the Legislature, WSHIP is overseen by a Board of Directors that represents consumers, small employers, large employers, health care providers, agents, and member plans. The Insurance Commissioner or designee is an ex-officio, non-voting director.

By law, premiums are at least 10% higher than the average market rate for comparable coverage. Premiums currently cover about a third of claims costs; member plans pay the remaining costs.

EXECUTIVE SUMMARY

The Washington State Health Insurance Pool (WSHIP) has served as a safety net for individuals who have been denied health insurance coverage because of their medical status or are unable to obtain comprehensive coverage. Established by the Legislature in 1987, WSHIP has served two distinct populations: 1) uninsurable residents not eligible for Medicare or Medicaid, and 2) residents who are covered by Medicare but are unable to purchase a Medicare supplement or Medicare Advantage plan due to health reasons. With the implementation of the Affordable Care Act (ACA), insurance companies are now required to accept individuals with pre-existing conditions; however, the ACA did not change the marketplace rules for Medicare supplements or Medicare Advantage plans. As a result, eligibility for WSHIP's non-Medicare plans was changed in 2014 to limit enrollment to individuals enrolled in WSHIP prior to 2014 or who reside in a county where individual plans are not offered. No changes have been made to WSHIP's Medicare-eligible program.

In total, WSHIP provided coverage to 1,418 individuals as of December 31, 2018. This represents a decrease of 2.5% from 2017. Total claims costs were $38.7 million, an increase of 3.5% from 2017.

Non-Medicare: WSHIP's non-Medicare plans remained closed to new enrollment in 2018 since individual health plans were offered in all counties. 321 enrollees remained in these plans at year-end. Of those, 222 are individuals with HIV/AIDS who are sponsored by the Washington State Department of Health (DOH) Early Intervention Program (EIP).

Medicare: WSHIP's Medicare plans provided supplemental coverage to 1,097 enrollees.

Key Facts & Figures

Enrollment

▪ Total WSHIP enrollment as of 12/31/18:	**1,418**	(2.5% decrease from 2017)
Non-Medicare Plans:	321	(23% of total enrollment)
Medicare Plans:	1,097	(77% of total enrollment)

Total Revenue	$37.8 million	**Total Expenses**	$41.0 million
▪ Premiums	$12.2 million	▪ Medical Claims	$26.0 million
▪ Assessments	$25.5 million (est. $0.61 pmpm*)	▪ Rx Claims	$12.7 million
▪ Other	$0.1 million	▪ Administration	$ 2.3 million (5.6%)

* pmpm refers to those covered in the insured market in Washington on the basis of which carriers were assessed

Top Diagnoses and Drug Therapies

- Medical: Top diagnoses by medical claims were related to the treatment of kidney disease
- Pharmacy: 8 of the top 10 drugs by cost were for HIV/AIDS therapy

Cost Containment

- Provider Network Savings: $12.3 million
- Care Management Program Savings: $749,817
- Pharmacy Network and State Pharmaceutical Assistance Program Savings: $7.3 and $2.9 million

BACKGROUND

History and Purpose of the Pool

WSHIP is the high risk health insurance pool for the state of Washington. WSHIP was established under the Washington State Health Insurance Access Act of 1987 (RCW 48.41) which was substantially amended in 2000 after the state's individual health insurance market had collapsed in 1999 as a result of a combination of laws requiring guaranteed issue and community rating for applicants in the individual market.

As stated in the Act, its purpose and intent is: 1) to provide access to health insurance coverage to all residents of Washington who are denied health insurance, and 2) to provide a mechanism to ensure the availability of comprehensive health insurance to persons unable to obtain such insurance coverage on either an individual or group basis directly under any health plan. The mechanism established by the 2000 amendments was the use of a Standard Health Questionnaire for applicants in the individual health insurance market to identify (and allow rejection of) high risk applicants for coverage, and offer the alternative health insurance coverage by WSHIP.

The Act has been amended several times. In 2013, it was amended to address health care reforms that were implemented January 1, 2014 as part of the Affordable Care Act (ACA). Insurance companies are now required to accept individuals with pre-existing conditions; however, the ACA did not change the marketplace rules for Medicare supplements or Medicare Advantage plans. As a result, eligibility for WSHIP's non-Medicare plans was changed in 2014 to limit enrollment to individuals enrolled in WSHIP prior to 2014 or who reside in a county where individual plans are not offered. No changes were made to WSHIP's Medicare program. Other changes included the discontinuation of the Standard Health Questionnaire and a scheduled sunset date of December 31, 2017 for WSHIP's non-Medicare coverage.

In 2017, the statute was amended to extend the sunset of WSHIP's non-Medicare plans to December 31, 2022 and express the intent of the Legislature to further study the role of WSHIP in the future, as well as its funding mechanism.

In 2018, the statute was amended to provide premium reductions for WSHIP non-Medicare coverage in the event WSHIP was needed to cover bare counties in the plan year 2019. (There were no bare counties in 2019; therefore, this was not implemented.)

Key Historical Facts

Benefit Plans – The benefit plans created by statute in 1987 are comprehensive plans designed for a high risk population. In 2008, WSHIP added two higher deductible Preferred Provider (PPO) plans ($2,500 and $5,000) in response to affordability concerns by applicants. Two less comprehensive (and less expensive) plans were also offered, but interest in those plans was low and they were eventually closed due to lack of enrollment. WSHIP's indemnity plan (the "Standard Plan") was discontinued on December 31, 2017.

Access and Affordability – WSHIP has never implemented enrollment caps or wait lists. Premiums are based on the average market rate and not on actual claims expense. By law, WSHIP rates must be at least 10% higher than the Standard Risk Rate (SRR) – the average market rate for comparable coverage. Rates for all WSHIP PPO plans have been set at 110% of the SRR since 2007.

Lifetime Limits – WSHIP plans have not had lifetime limits since 2011. The Act's initial lifetime limit of $1 million was increased to $2 million in 2008 when the limit had been reached by one or more cases. In 2011, the lifetime limit was eliminated.

Surveys – What happened to individuals who were rejected from the individual market but did not enroll in WSHIP? – From 2002 until 2009, WSHIP periodically surveyed individuals who had applied and were rejected for individual coverage in the private market but chose not to enroll in WSHIP. Early surveys yielded information helpful to improve access to WSHIP such as simplifying the application process and adding lower-cost benefit plans. The last survey in 2009 indicated that 75% of respondents currently had health insurance coverage and 25% were uninsured. More than 50% of all respondents indicated they already had coverage at the time they applied and were rejected for individual coverage and many had the option to continue that coverage. Others found new coverage (e.g., through a spouse's employer).

BACKGROUND

Structure and Administration of the Pool

WSHIP is a nonprofit organization exempt from federal income tax under Section 501(c)(26) of the Internal Revenue Code. The Office of the Insurance Commissioner (OIC) has regulatory oversight of the Pool and approval authority for the Pool's Plan of Operations, benefit documents, and compliance with relevant statutes and regulations. Pool premiums and Member Plan assessments are not subject to approval by the OIC.

Board of Directors

Pool oversight is the responsibility of an eleven-member Board of Directors[1], ten of whom serve three-year terms. Six directors are appointed by the governor: they represent consumers (two positions), small employers (one), large employers (one), health care providers (one), and agents (one). Four directors are elected by Member Plans. The Insurance Commissioner or designee is an ex-officio, non-voting director.

Executive Director

An Executive Director oversees the day-to-day operations of the Pool augmented as necessary with consulting services. In 2018, WSHIP engaged the law firm Perkins Coie and the actuarial firm Leif Associates.

Third-Party Administrator & Contractors

WSHIP contracts with a third-party administrator – Benefit Management, LLC (BML) – to perform health plan enrollment, premium billing, claims processing, customer service, on-line information, accounting, reporting, and care management. BML works closely with WSHIP's other contractors who provide pharmacy benefit management, provider networks, and other services.

Pharmacy benefit management is provided by Express Scripts, Inc. These services include pharmacy network and pricing, drug claims processing and reporting, delivery-by-mail services, cost containment and quality programs, and customer service. Provider network services and claims pricing are provided by First Choice Health.

Member Plans

All Disability Carriers, Health Care Service Contractors, and Health Maintenance Organizations licensed under Title 48 RCW that sell health and/or stop-loss[*] coverage in Washington are Members of the Pool. Carriers that exclusively offer only life or dental products are not Members. Insured multiple-employer welfare associations are Members, but Employee Retirement Income Security Act (ERISA) groups are not. (Note: RCW 48.41. provides that the term "Member" shall be expanded to include ERISA groups at such time as permitted by federal law.) The State of Washington's self-insured Uniform Medical Plan (UMP) is also a Member. The UMP and Members that provide stop-loss insurance are assessed at a rate 1/10 of what other carriers pay per fully-insured covered life.

[1] A twelfth board position will be added at the time federal law permits states to regulate self-insured employer group plans.

[*] Stop-loss coverage is insurance that is purchased by self-insured entities for medical claim costs beyond a specified per-individual level.

Significant Activities

Bare County Preparedness Planning

Under current law, WSHIP is the safety net for individuals who reside in a "bare" county – a county that does not have any insurance carrier offering individual coverage. There have been no bare counties for individual coverage in Washington State since the 1990's; however, initial plan filings for 2019 raised significant concerns about the potential for bare counties. As such, WSHIP embarked on updating its preparedness planning to ensure the best approach and readiness to cover bare counties in the current landscape.

Key objectives included identifying opportunities to more closely align WSHIP coverage with current market offerings and consumer expectations if WSHIP bare county coverage is needed; ensure readiness of all WSHIP vendors; maintain fiscal responsibility; and work closely with the Office of Insurance Commissioner (OIC), Health Benefit Exchange (HBE), and other key participants in meeting these objectives. A bare county preparedness plan was approved by the Board in May of 2018. Fortunately, there were no bare counties in Washington State in 2019.

Discontinuation of WSHIP Indemnity Plan

During WSHIP's annual evaluation of benefit plans, the indemnity plan was identified as being out of sync with the market and was discontinued on December 31, 2017. Enrollees in that plan (approximately 30) were offered the option of changing to a WSHIP PPO plan in 2018 or a plan in the market.

Enhanced Pharmacy Pricing

WSHIP implemented new enhanced pricing with Express Scripts effective January 1, 2019.

Health Reform Communications

WSHIP continued its yearly communication activities to facilitate enrollees' understanding of new coverage options made possible by the Affordable Care Act (ACA) and the premium subsidies and shopping experience available through the Washington Healthplanfinder.

Enrollment & Services

Eligibility

Non-Medicare: Effective January 1, 2014, the only individuals eligible for non-Medicare WSHIP coverage are those who were enrolled in WSHIP prior to December 31, 2013 and individuals residing in a Washington State county where an individual plan (other than a catastrophic plan) is not offered during defined open enrollment or special enrollment periods. Enrollees must also not be eligible for Medicare or Medicaid. Individual coverage was available in all counties in 2018; therefore, WSHIP's non-Medicare plans were closed to new enrollment.

Medicare: There were no changes to eligibility for WSHIP's Medicare plans. Medicare-eligible state residents providing evidence of rejection or other adverse actions on a Medicare supplemental insurance policy are eligible for WSHIP's Medicare supplemental plan if they do not have a reasonable choice of Medicare Advantage plans. In 2018, there were 7 counties in Washington that offered a reasonable choice of Medicare Advantage plans. Medicare enrollees living in those counties were ineligible for WSHIP supplemental benefits unless their health care provider was not included as a member of at least one of the available HMO or PPO Medicare Advantage plans or they were ineligible for a Medicare Advantage plan because of End Stage Renal Disease (ESRD).

Enrollment

Total Number Enrolled

Enrollment in WSHIP decreased 2.5% in 2018, with a total of 1,418 individuals enrolled in the Pool at year-end. Enrollment of Washington State DOH Early Intervention Program (EIP) participants (serving low-income clients with HIV/AIDS) decreased 6% from 236 enrollees to 222 in 2018.

Age & Demographics

The average age of enrollees in the Pool increased from 56 to 57 years. Approximately 50% of all WSHIP enrollees were enrolled in Medicare due to disability. 65% of Medicare enrollees were under age 65.

WSHIP enrollees reside in all Washington State counties except Skamania and Columbia, with the majority of enrollees residing in King, Pierce, and Snohomish counties.

39% of WSHIP enrollees paid their premiums themselves. 61% of premiums were paid by a third party.

Tobacco Use

Approximately 17% of WSHIP enrollees report using tobacco.

Average Length of Enrollment

At year-end WSHIP enrollees had been covered by the Pool an average of 6.8 years. Of the total enrollment, 24% were covered by the Pool for more than 10 years; 28% between 5 and 10 years; and 18% for 2 to 5 years. Overall, 70% of enrollees have been covered by the Pool for 2 years or more.

Disenrollment

In 2018, 421 enrollees ended coverage for reasons such as acquisition of other insurance, failure to pay premium, loss of third-party sponsorship, relocation out of state, and death.

The average WSHIP enrollee is 57 years old and has been covered by the Pool for 6.8 years.

Benefit Plans

In 2018, WSHIP had four benefit plans: two plans for enrollees who are not enrolled in Medicare and two plans for those enrolled in Medicare.

Non-Medicare Plans (23% of enrollment)

- **PPO Plan** – $500, $1,000, $2,500 and $5,000 Deductibles (higher benefit level for network providers)

- **HSA Qualified Preferred Provider Plan** – a High Deductible Health Plan with a $3,000 combined medical/Rx deductible – can be used with a Health Savings Account (HSA) to pay for health care services with pre-tax dollars

Medicare Plans (77% of enrollment)

- **Basic** – $0 Deductible, supplements Medicare Parts A & B with no additional drug benefit

- **Basic Plus** (closed to new enrollment since December 31, 2008) – $0 Deductible, supplements Medicare Parts A, B, & D

Distribution by Age & Benefit Plan

At year-end, the largest non-Medicare enrollment was in the $500 deductible PPO plan and the largest Medicare enrollment was in the Basic Plan.

Non-Medicare PPO Plan				
Age	$500	$1,000	$2,500	$5,000
0-18	9	2	0	1
19-29	6	3	2	0
30-34	18	2	1	0
35-39	43	4	2	1
40-44	53	3	1	0
45-49	49	1	3	4
50-54	38	2	6	0
55-59	27	0	3	2
60-64	9	3	6	4
65-69	2	0	0	0
70-74	3	0	0	0
75-79	1	0	0	0
80-84	0	0	0	0
85+	0	0	0	0
Total	**258**	**20**	**24**	**12**

Non-Medicare HSA PPO Plan	
Age	$3,000
0-18	0
19-29	0
30-34	0
35-39	0
40-44	1
45-49	0
50-54	0
55-59	3
60-64	3
65-69	0
70-74	0
75-79	0
80-84	0
85+	0
Total	**7**

Total Non-Medicare Enrollment = 321

	Medicare Basic Plan	Medicare Basic Plus Plan
Age		
0-18	0	0
19-29	6	0
30-34	15	0
35-39	27	0
40-44	56	2
45-49	61	2
50-54	104	8
55-59	166	19
60-64	213	33
65-69	119	35
70-74	74	29
75-79	56	22
80-84	20	16
85+	13	1
Total	**930**	**167**

Total Medicare Enrollment = 1,097

Total Enrollment = 1,418

Care Management Programs

WSHIP's Care Management program provides a variety of important services to enrollees in our non-Medicare program. (WSHIP's Medicare program provides supplemental coverage only; primary coverage is managed by Medicare.) Services included in WSHIP's Care Management Program include Utilization Management, Case Management and Care Coaching specifically designed to meet the unique needs of WSHIP enrollees.

Utilization Management (UM)

WSHIP's utilization management program is comprehensive, integrated and collaborative. It provides the opportunity to identify psychosocial factors impacting medical utilization to ensure appropriate levels of care as well as optimal treatment plans. Medical necessity reviews include primary care physicians as well as psychiatrists and other specialists.

Utilization Management – 2018		
	WSHIP	**MedWatch Commercial Book of Business**
Inpatient Admissions/1,000 enrollees	247	36
Bed Days/1,000 enrollees	1,145	148
Average Length of Stay Days	4.6	4.1
UM Return on Investment (ROI)	$2:1	

Case Management

Case management brings traditional medical and behavioral health strategies and interventions together in a clinically integrated approach for enrollees with complex or chronic medical conditions. Case Managers help enrollees to understand their choices, navigate the healthcare system, use benefits wisely, and provide dedicated coordination on complex cases with the enrollee and their health care providers. The process includes identification, through utilization management, care coaching and claims analysis, of enrollees who would most benefit from case management. Participation is voluntary.

Case Management – 2018	
Number of cases	99
Average hours per case	12
Top Diagnoses Managed	Diseases of Genitourinary System Diseases of Nervous System Endocrine, Nutritional and Metabolic, Immunity Disorders
CM Return on Investment (ROI)	$6:1

Care Coaching

WSHIP offers a targeted population health management program for the chronically ill that improves clinical outcomes and lowers unnecessary utilization of services. It addresses the critical interplay between psychological, social and physical health. This program – Care Coaching – helps those with chronic medical conditions exacerbated by psychological factors (depression, anxiety, substance abuse, maladaptive behaviors, impaired social support, etc.).

Care Coaching Activity	2018	Definition
Total Participant Interactions	276	Contact with participant or participant's provider
Nurse Activity	298	Education\coaching session or reviewing clinical information

Total Care Management Program Savings: $749,817

Customer Service & Website Activities

Telephone Activity

An average of 33 telephone inquiries per day was received by the Pool's Customer Service Representatives in 2018. The most common inquiries related to: 1) claims status, 2) enrollee eligibility/ID card, and 3) verifying benefits.

Website Activity

There was an average of 20 visits per day to the Pool's website (www.wship.org). The website offers useful information to applicants and enrollees as well as Board members, Member Plans, agents, providers, and others. Forms and documents may be viewed or downloaded from the site, enrollees may check the status of claims and submit inquiries, and Board activity and Pool operations reports are posted regularly to the site. The site also links to other important websites such as First Choice Health Network and Express Scripts.

Financial Information

Funding

Revenue to support WSHIP comes from the following sources:

1. Premiums

For 2018, rates for WSHIP's non-Medicare plans were set at 110% of the Standard Risk Rate (SRR). The Standard Risk Rate is the average premium charged for comparable coverage by the five largest Member Plans. The statute allows the rate for Preferred Provider Plans to be set between 110-125% of the SRR.

Rates for WSHIP's Medicare plans were set at 150% of the SRR for enrollees age 65 and over; and 110% of the SRR for enrollees under age 65. The statute allows the rates for these plans to be set between 110-150%.

Enrollees with prior continuous coverage and/or three years of WSHIP coverage also qualified for additional discounts so long as the rate they pay is not below 110% of the SRR.

The average percent of SRR paid by enrollees in 2018 was 110% for non-Medicare plans and 115% for Medicare plans.

In 2018, premiums totaled $12.2 million. Approximately 61% of all enrollees' premiums were paid by a third party.

The percent of total costs covered by premium was 32%.

2. Member Plan Assessments

Claims and operating expenses that exceed the total of premium income and interest income are paid by assessments on Member Plans. The WSHIP Board assesses each Member Plan according to the number of Washington State residents insured for health benefits by that carrier under its health insurance products. Assessments on the state's Uniform Medical Plan (UMP) and for enrollees covered under stop-loss policies are based on one-tenth of the Member Plans' enrollees.

In 2018, Member Plan assessments totaled $25.5 million (an estimated $0.61 pmpm).

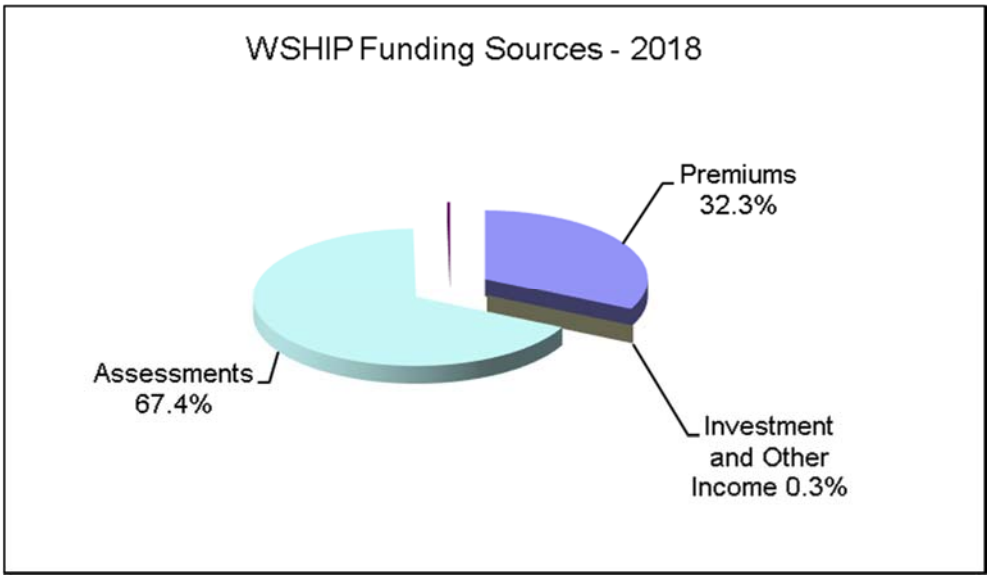
The percent of total costs covered by assessments was 67%.

3. Interest Income

Interest earned on funds held by WSHIP for future claim payments totaled $106,773.

4. Allocated Funds

Under RCW 48.41, the Pool has a general account with the state treasurer; however, it is not funded. The account can provide funds for WSHIP when the assessment on Member Plans exceeds a maximum per-member per-month (pmpm) level of $0.70 as specified in the law. These funds are accessible only if money has been allocated to the account by the Legislature. While WSHIP has exceeded this maximum in the past, no funds have been allocated to the account by the Legislature.



Claims Costs

Total Claims Costs

Total claims paid in 2018 were $38.7 million, an increase of 3.5% from 2017. 67% of claims were for medical claims and 33% for prescription drugs. The average cost per enrollee was $27,628 compared to $26,112 in 2017, an increase of 5.8%.

Total Claim Costs - 2018		
		Average cost per enrollee
Medical Claims	$26.0 million	$18,540
Pharmacy Claims	$12.7 million	$ 9,088
Total Claims	**$38.7 million**	**$27,628**

Non-Medicare vs. Medicare Claims Costs

Claims costs for enrollees in our non-Medicare program are significantly higher than claims costs for enrollees in our Medicare program. This is because WSHIP pays secondary to Medicare on claims for enrollees in our Medicare program (like a Medicare supplement).

The following chart shows the medical and pharmacy claims costs for each program.

Non-Medicare vs. Medicare Claim Costs - 2018		
	Non-Medicare	**Medicare**
Enrollment Count	321	1,097
Medical Claims	$16.2 million	$ 9.8 million
Pharmacy Claims	$11.8 million	$ 0.9 million
Total Claims	**$28.0 million**	**$10.7 million**
Loss Ratio	**350%**	**191%**
Claims Costs Per Member Per Month (PMPM)	**$7,047**	**$815**

Conditions Treated

Claims Costs by Major Diagnostic Category

The top diagnostic categories for total claims (medical and pharmacy) in 2018 were related to the treatment of HIV/AIDS and Kidney Disease. The following charts show the claims costs by diagnostic category for each program. Note: Enrollees were assigned a mutually exclusive diagnostic category based on the category which had the most allowed claims dollars.

Non-Medicare Claims By Diagnostic Category - 2018

Diagnosis Category	Number of Members	Percent of Members	% of Total Claims	% of Medical Claims	% of Rx Claims	Total Claims Paid PMPM
HIV/AIDS Related	228	65.1%	34.3%	9.2%	66.3%	$3,592
Kidney & Urinary Tract Disease	19	5.4%	24.1%	34.3%	11.0%	$30,858
Other	43	12.3%	8.4%	11.6%	4.3%	$4,997
Metabolic Disorders	3	0.9%	7.5%	11.6%	2.2%	$58,047
Coagulation Defects	3	0.9%	7.0%	12.4%	0.1%	$54,170
Cancer	9	2.6%	5.0%	5.5%	4.3%	$12,843
Spinal/Brain	6	1.7%	4.2%	7.5%	0.0%	$19,400
Arthritis and Joint Disorders	8	2.3%	3.7%	0.7%	7.5%	$10,716
Neurological	11	3.1%	2.4%	2.6%	2.0%	$5,570
Heart Related	4	1.1%	2.0%	3.2%	0.4%	$13,580
Diabetes	4	1.1%	0.8%	0.8%	0.7%	$4,595
Mental Disorders	9	2.6%	0.5%	0.6%	0.4%	$1,574
Hepatitis C	1	0.3%	0.3%	0.0%	0.6%	$6,640
No Claims Submitted	2	0.6%	0.0%	0.0%	0.0%	$0
TOTALS	**350**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**$6,964**

Notes: 350 unique members enrolled at some time during the calendar year 2018. Claims based on incurred date of service, paid through 1/31/19. Does not include IBNR. Enrollees assigned to a mutually exclusive diagnostic category based on the category which had the most allowed claims dollars.

Medicare Claims by Diagnostic Category - 2018

Diagnosis Category	Number of Members	Percent of Members	% of Total Claims	% of Medical Claims	% of Rx Claims	Total Claims Paid PMPM
Kidney and Urinary Tract Disease	763	57.7%	71.3%	78.7%	2.4%	$899
Other	173	13.1%	11.2%	6.8%	51.7%	$581
Heart Related	8	0.6%	3.3%	3.6%	0.4%	$4,518
Diabetes	57	4.3%	2.9%	2.4%	7.4%	$430
Metabolic Disorders	45	3.4%	2.6%	1.9%	8.7%	$492
Neurological	45	3.4%	2.5%	1.5%	11.6%	$479
Arthritis and Joint Disorders	51	3.9%	1.8%	1.9%	1.0%	$377
Cancer	43	3.3%	1.8%	1.6%	3.2%	$410
Spinal/Brain	15	1.1%	1.1%	0.4%	7.6%	$590
HIV/AIDS Related	24	1.8%	0.8%	0.5%	4.0%	$295
Mental Disorders	27	2.0%	0.8%	0.6%	2.2%	$248
Coagulation Defects	1	0.1%	0.0%	0.0%	0.0%	$0
Hepatitis C	1	0.1%	0.0%	0.0%	0.0%	$0
No Claims Submitted	70	5.3%	0.0%	0.0%	0.0%	$0
TOTALS	**1,323**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**$733**

Notes: 1,323 unique members enrolled at some time during the calendar year 2018. Claims based on incurred date of service, paid through 1/31/19. Does not include IBNR. Enrollees assigned to a mutually exclusive diagnostic category based on the category which had the most allowed claims dollars.

Pharmacy

Total Pharmacy Costs by Therapeutic Category

The ten indications identified below represented 89.8% of total pharmacy costs in 2018 led by those related to the treatment of HIV/AIDS.

Top 10 Indications by Pharmacy Cost				
2018 Rank	Indication	Patients	Plan Cost	Plan Cost PMPM
1	HIV	257	$8,307,653	$484
2	URINARY DISORDERS	68	$1,183,509	$69
3	CANCER	15	$488,584	$28
4	HEREDITARY ANGIOEDEMA	1	$476,290	$28
5	PAIN/INFLAMMATION	255	$315,474	$18
6	INFLAMMATORY CONDITIONS	27	$309,089	$18
7	CYSTIC FIBROSIS	2	$257,327	$15
8	MULTIPLE SCLEROSIS	6	$202,593	$12
9	DIABETES	99	$180,204	$11
10	GROWTH DEFICIENCY	3	$122,875	$7

HIV/AIDS Drugs

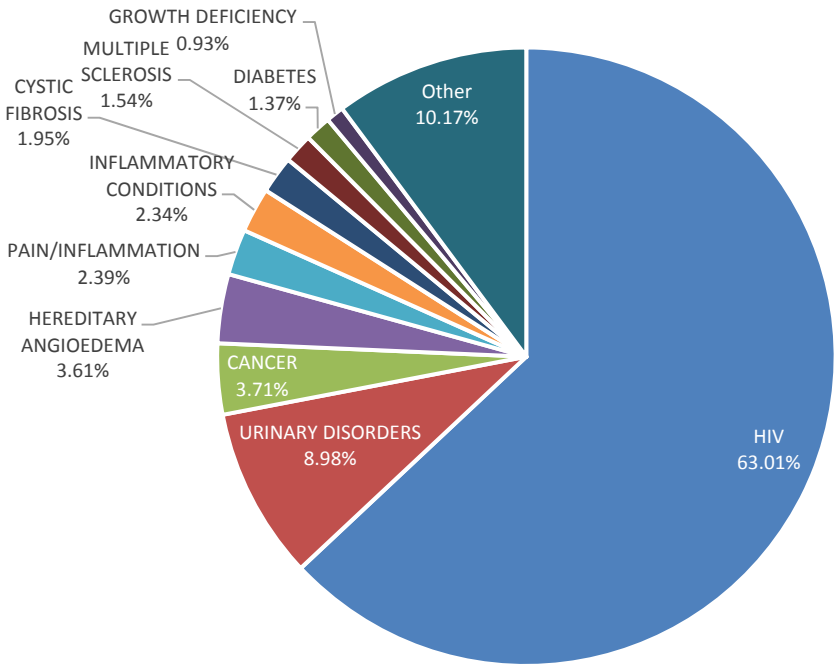
In 2018, 63% of the total pharmacy benefits paid were related to the treatment of HIV/AIDS. These drugs continue to dominate the Pool's top 25 drugs by cost. Enrollees with HIV/AIDS have pharmacy claims costs approximately 9 times higher than the average WSHIP enrollee.

Top 25 Drugs by Pharmacy Cost					
2018 Rank	Drug Name	Indication	Patients	Plan Cost	Plan Cost PMPM
1	TRUVADA	HIV	92	$1,169,707	$68
2	TIVICAY	HIV	74	$1,033,142	$60
3	GENVOYA	HIV	42	$1,016,227	$59
4	PROCYSBI	URINARY DISORDERS	2	$947,112	$55
5	ODEFSEY	HIV	28	$718,025	$42
6	CINRYZE	HEREDITARY ANGIOEDEMA	2	$713,196	$42
7	STRIBILD	HIV	27	$703,328	$41
8	TRIUMEQ	HIV	31	$661,277	$39
9	ATRIPLA	HIV	28	$573,817	$33
10	COMPLERA	HIV	16	$429,900	$25
11	PREZISTA	HIV	33	$411,783	$24
12	DESCOVY	HIV	36	$334,654	$20
13	ORKAMBI	CYSTIC FIBROSIS	2	$300,998	$18
14	ISENTRESS	HIV	27	$282,018	$16
15	ENBREL	INFLAMMATORY CONDITIONS	2	$198,822	$12
16	REYATAZ	HIV	18	$195,305	$11
17	FIRAZYR	HEREDITARY ANGIOEDEMA	1	$194,547	$11
18	BOSULIF	CANCER	1	$184,397	$11
19	COPAXONE	MULTIPLE SCLEROSIS	5	$174,528	$10
20	REVLIMID	CANCER	1	$131,697	$8
21	PREZCOBIX	HIV	10	$117,734	$7
22	CYSTARAN	OPHTHALMIC CONDITIONS	2	$109,431	$6
23	SENSIPAR	ENDOCRINE DISORDERS	15	$106,195	$6
24	INTELENCE	HIV	8	$105,441	$6
25	HUMIRA	INFLAMMATORY CONDITIONS	2	$102,462	$6

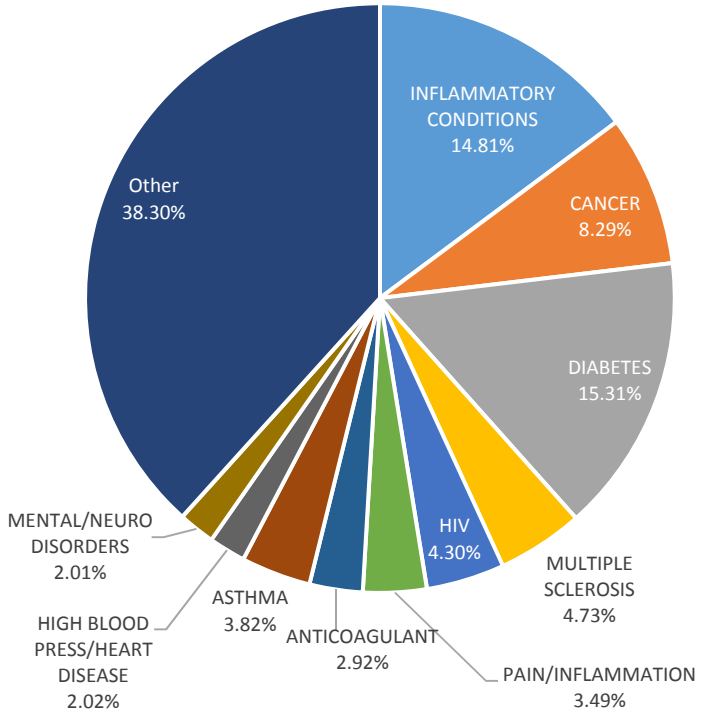
Pharmacy Costs – How WSHIP Compares to Others

WSHIP's prescription drug costs are higher than the commercial market due to the health conditions of WSHIP enrollees. The percentage of WSHIP enrollees with HIV/AIDS is also significantly higher. These enrollees have pharmacy costs approximately 9 times higher than the average WSHIP enrollee. Shown below is a comparison of WSHIP to Express Scripts' commercial business in 2018.

WSHIP



Express Scripts Commercial Business



Pharmacy Clinical Programs

WSHIP has coverage authorization programs, including step therapy, quantity management and prior authorization. The goal of these programs is to ensure WSHIP enrollees get the right drug at the right dose and at the right price for both traditional and specialty medications.

WSHIP also employs a comprehensive suite of utilization management rules for specialty medications, and utilizes the Personalized Medicine Program provided by Express Scripts. The Personalized Medicine Program offers the availability of specific tests which help prescribers to evaluate if the drug in question will be effective for an individual based on their individual genetic makeup.

State Pharmaceutical Assistance Program (SPAP)

WSHIP continues its status as a federally-qualified State Pharmaceutical Assistance Program (SPAP). WSHIP was approved by CMS to operate as an SPAP in late 2005 for its Basic Plus Plan that provides secondary prescription drug coverage to Medicare Part D. As an SPAP, WSHIP's secondary payments for Part D drugs count toward the enrollee's true-out-of-pocket (TrOOP) costs. This results in lower out-of-pocket costs for enrollees and lower pharmacy claim costs for WSHIP. In 2018, the total estimated SPAP savings to WSHIP was $2.9 million.

Cost Containment

WSHIP utilizes the First Choice Health Network for its provider network and claims pricing. In 2018, 98% of claim dollars were paid to network providers. Eligible charges were discounted an average of 43% as a result of network provider contracts. These negotiated provider discounts reduced the Pool's medical claims costs by $12.3 million.

Pharmacy cost savings were achieved through Express Script's pharmacy network. These discounts reduced the Pool's pharmacy costs by $7.3 million in 2018.

Administrative Expenses

Total administrative expenses for 2018 were $2.3 million or 5.6% of total expenses.

BOARD OF DIRECTORS & ADMINISTRATION

Board Members

Andrea (Andi) N. Bailey **RN**, appointed by the Governor in 2011, is a representative for small employers. She owns Alliance Nursing, a home health company that provides private duty nursing to medically fragile adults and children in the client's home or in one of Alliance Nursing's three Adult Family Homes. As a Gold Star mother (a mother who has lost a child while serving in the military), Andi serves as the Treasurer of Washington State Gold Star mothers. American Gold Star Mothers is a Veterans' Service Organization that provides service to veterans and active military. Andi belongs to two quilting guilds that provide education to quilters and are involved in making charity quilts and pillowcases for a variety of non-profit organizations.

Roger Bairstow, appointed by the Governor in 2015, is a representative for large employers. Roger currently is an executive at FirstFruits Farms LLC, helping the business balance its business-as-ministry agenda. He oversees its HR and Corporate Responsibility Department that supervises company-wide goals focused on business practices, employee outreach/services and corporate ethics. As part of his oversight, he also chairs the company's affordable housing operations. Roger is actively involved in his community through a number of non-profit organizations. He also currently serves as a Board member for the Association of Washington Business.

Bill Ely, appointed by the Governor in 2018, is a representative for Health Maintenance Organizations. Bill oversees actuarial functions for Kaiser Permanente Washington, Kaiser Permanente Northwest (Oregon) and Kaiser Permanente Hawaii. He previously was responsible for actuarial functions for individual and small group lines of business for Kaiser Permanente nationally. He has served on the Board of Directors for both Oregon's Temporary Reinsurance Program and the Oregon Medical Insurance Pool.

BOARD OF DIRECTORS & ADMINISTRATION

Kristy Hogue is a representative for Disability/Stop Loss Member Plans, elected in 2017. She is a Director of Network Management with UnitedHealthcare with a background in physician contracting. Kristy has been with United since 2010 and is currently responsible for provider network strategy in Washington and Alaska, with a focus on UnitedHealthcare's Community Plan. Kristy has a particular passion around rural and community-based healthcare, and she serves as a Tribal Liaison for UnitedHealthcare for American Indian/Alaska Native health within Washington. She holds a Bachelor of Arts with Distinction in Communication & Cultural Studies from the University of Washington.

Hiu-wan Ko is a representative for Health Care Service Contractors, elected in 2018. Hiu-wan is Director of Actuarial Services at Premera Blue Cross. She manages a team that is responsible for premium rate-setting for individuals, small groups, large groups and senior insurance plans sold in Washington and Alaska. She began her actuarial career as a rating analyst at the Washington Office of the Insurance Commissioner (OIC) in 1995. She joined Premera in 1998 and has over twenty years of health care insurance experience related to the industry. Hiu-wan graduated from the University of Washington in 1995 with a Master's Degree in Statistics. She is a Fellow of the Society of Actuaries and has been a member of the American Academy of Actuaries since 2014.

Shaun Koos, appointed by the Governor in 2010, is a representative for providers. Shaun is currently retired, having been the Chief Operating Officer of Confluence Health in Wenatchee, Washington. He previously served as the Administrator of Wenatchee Valley Medical Center and was with the center since 1982. He graduated magna cum laude in economics from Carleton College and completed the MHA program at University of Washington. At the UW Shaun was Research Assistant for the AHA-sponsored "Hospital Response to Regulation Study." In 1999, he co-published "Prospects and Performance of Physician Practice Management Organizations" in Medical Care Research and Review. Shaun is affiliated with the Medical Group Management Association and the American Medical Group Association. Community activities have included board positions with the regional Workforce Development Council, YMCA, Red Cross, and the Chelan-Douglas Counties United Way. He is currently on the Executive Committee for Columbia Valley Community Health.

BOARD OF DIRECTORS & ADMINISTRATION

Lisa Matthews*,* appointed by the governor in 2011, is a representative for consumers. Lisa is a Licensed Clinical Psychotherapist with DaVita Dialysis Center in Yakima, Washington, where she has been serving End Stage Renal patients since 1997. The majority of her time is spent advocating for patients' health and insurance needs. She is an advocate with DaVita at the Federal and State level to help ensure continued quality of care for kidney patients. Lisa has a Bachelor of Arts degree in Sociology and Ethnic Studies from Central Washington University and a Masters in Social Work from Eastern Washington University. She subsequently obtained her Social Work Independent Clinical License in 2001. Lisa is a member of the National Association of Social Workers, Council of Nephrology Social Workers, and the Association of Certified Social Workers.

Alison Mondi, appointed by the Governor in 2015, is a representative for consumers. Alison is the Policy Analyst for Arcora Foundation. She has more than ten years' experience working in healthcare advocacy, including nearly three years in the HIV sector. Alison has worked closely on the implementation of the Affordable Care Act and facilitated the ACA Community Workgroup, a collaboration of healthcare advocates, public health entities, government agencies, carriers, and providers that focused on maximizing the benefits of the ACA for individuals living with chronic illnesses. She holds a B.A. in political science from Vassar College and resides in Seattle.

Molly Nollette joined the Board in 2018 as an ex-officio, non-voting board member representing the Insurance Commissioner. She was appointed as the Deputy Insurance Commissioner for Rates and Forms in 2013. Molly joined the Office of Insurance Commissioner in 2010 to work on grant projects funded by the then new Affordable Care Act. She managed grant projects focusing on consumer assistance, rate review, and agency IT modernization. Prior to joining the OIC, Molly was a senior manager at Starbucks Coffee Company, where she led a shared services team that supported a global department focused on employee and customer safety and security. Molly earned her Juris Doctor from Tulane University School of Law.

BOARD OF DIRECTORS & ADMINISTRATION

Mark Rose, appointed by the governor in 2011, is a representative for agents. Mark is an Equity Partner and the Director of Health Plan Compliance and Reform at The Partners Group. The Partners Group is a locally-owned independent financial services, risk management and employee benefit consulting firm. Mark has been a licensed health agent since 1999 and his past work experience includes a position with PacifiCare, a national health insurance company, as a Sr. Business Manager focusing on large employer issues. From 2007 to 2015, Mark was the Legislative Chair for the Washington Association of Health Underwriters. Mark is actively involved with several non-profit organizations and currently serves on the Board of Directors for Families Like Ours and the Program Committee and Advisory Board for Treehouse. These organizations provide financial and administrative support to pre- & post-adoptive families.

Kristen Walter Wright is a representative for all Member Plans, elected in 2013. She is Vice President of Actuarial Analysis for Regence, overseeing claims reserves adequacy, financial analysis, financial projections, and provider reimbursement analysis. Prior to joining Regence in 2005, Kristen served in actuarial roles with Symetra Financial, Milliman, and SAFECO Life Insurance Company. Kristen is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. Kristen earned her Bachelor's degree in Mathematics with an Actuarial Science concentration from Central Washington University.

BOARD OF DIRECTORS & ADMINISTRATION

Board Members Ending Their Terms in 2018

We extend our appreciation to the following Board members who served on the WSHIP Board in 2018:

AnnaLisa Gellermann joined the Board in 2017 as an ex-officio, non-voting board member representing the Insurance Commissioner. She is the Chief Deputy Commissioner and was most recently the Deputy Insurance Commissioner for Policy and Legislative Affairs. Prior to joining the OIC, AnnaLisa was an executive manager in Insurance Services at the Department of Labor and Industries. While at L&I, she held the position of Program Manager of the Self Insured Program, which regulated approximately 385 of the largest companies within Washington who self-insure their workers' compensation obligations. AnnaLisa began her service to the citizens of Washington as an Assistant Attorney General for the state and litigated cases before the Board of Industrial Insurance Appeals (BIIA) and state and federal court. AnnaLisa earned her Juris Doctor from Seattle University of Law.

Sheela Tallman was elected in 2014 as a representative for Health Care Service Contractors, and served on the board until early 2018. During her tenure on the Board, she was Senior Manager of Legislative Policy at Premera Blue Cross and served as Senior Legislative Affairs Executive for Premera in Alaska. Sheela was responsible for managing state legislative and public policy issues in Washington, Oregon, and Alaska and at the federal level. Before joining Premera in 2006, Sheela was a manager at Deloitte Consulting, based out of Houston, TX. She focused on public sector clients in the U.S. State and Federal Governments working on healthcare strategy and operations and technology integration projects. Sheela has a Bachelor of Science degree in Biology from Tufts University and has dual Master's degrees in Public Health and Public Affairs from Columbia University.

Barbie R. Wood was a representative for Health Maintenance Organizations, elected in 2017. During her tenure on the Board, she was Executive Director of Complex Care Management at Kaiser Permanente Washington, having programmatic oversight of Inpatient Care Management, Transition Management, Outpatient Case Management, Nurse Advice lines and external Emergency Department Management. Patient engagement in their healthcare choices and managing transitions of care have been a passion for her for several years. Barbie has been a national and local speaker on several Care Management topics over the last several years.

Board Committees

Executive Committee

Chair as of December 31, 2018: Kristen Walter Wright. The following Board members served on this committee in 2018: Roger Bairstow, Alison Mondi, Mark Rose and Sheela Tallman.

Governance Committee

Chair as of December 31, 2018: Shaun Koos. The following Board members served on this committee in 2018: AnnaLisa Gellermann, Lisa Matthews, Molly Nollette and Kristen Walter Wright.

Grievance Committee

Chair as of December 31, 2018: Alison Mondi. The following Board members served on this committee in 2018: Andi Bailey, Kristy Hogue, Sheela Tallman and Barbie Wood. Wendy Galloway from the Office of Insurance Commissioner (OIC) also served on this committee.

Planning Committee

Chair as of December 31, 2018: Lisa Matthews. The following Board members served on this committee in 2018: Bill Ely, AnnaLisa Gellermann, Kristy Hogue, Hiu-wan Ko and Shaun Koos.

Administration

Executive Director

Sharon Becker is WSHIP's Executive Director, and has been with the organization since 2006. She previously served as WSHIP's Deputy Executive Director. Sharon has over 29 years' experience in the health care industry, including health plan management and consulting. At Blue Cross of Washington and Alaska, Sharon managed provider contract administration, prescription drug programs and corporate projects. While in her own consulting firm and at Aon Consulting, she provided services to physician groups, hospitals, health plans and community organizations. Sharon received her Bachelor of Arts and Sciences in Health Education Planning from the University of Washington. Sharon serves on the Board of Directors for National Association of State Comprehensive Health Insurance Plans (NASCHIP).

Executive Assistant

Anita Wuellner is WSHIP's Executive Assistant and has been with WSHIP since 2009. Anita has over 10 years' experience in the healthcare industry and over 20 years' experience in the legal and banking industries. Anita earned an AA degree specializing in paralegal from Lansing Community College in Michigan and a degree from South Coast College of Court Reporting in California, and was a Certified Court Reporter for more than 10 years. While living on Misawa Air Base in Japan from 1993 to 1996, Anita taught English and Paralegal courses and performed court reporting services. She previously was co-owner and President of North County Outlook, a community newspaper in Marysville, Washington.

Administrator
Benefit Management LLC (BML)
1-800-877-5187
www.wship.org

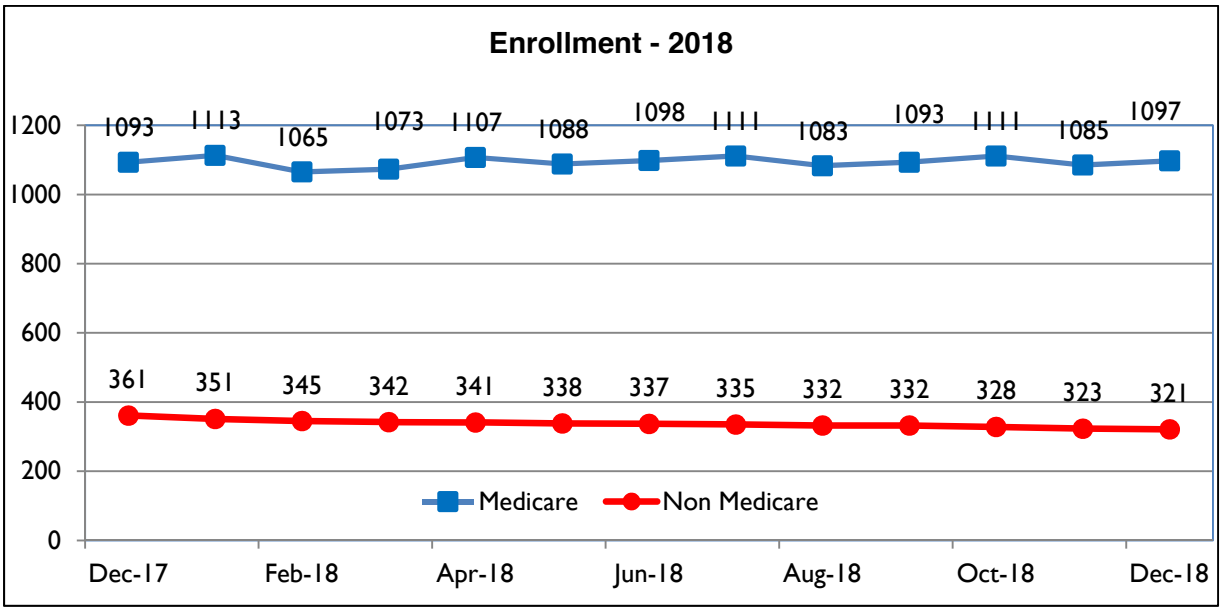
Preferred Provider Network
First Choice Health
1-800-231-6935
www.fchn.com

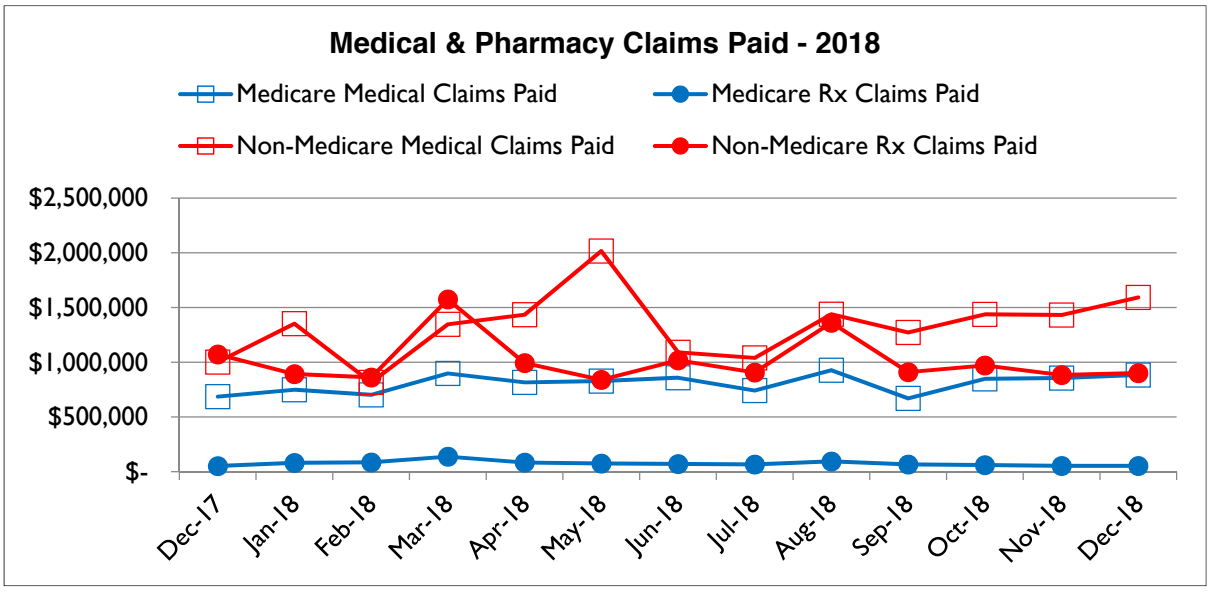
Pharmacy Benefits Manager
Express Scripts
1-800-859-8810
www.express-scripts.com

Care Management
MedWatch
1-800-549-7549
www.urmedwatch.com

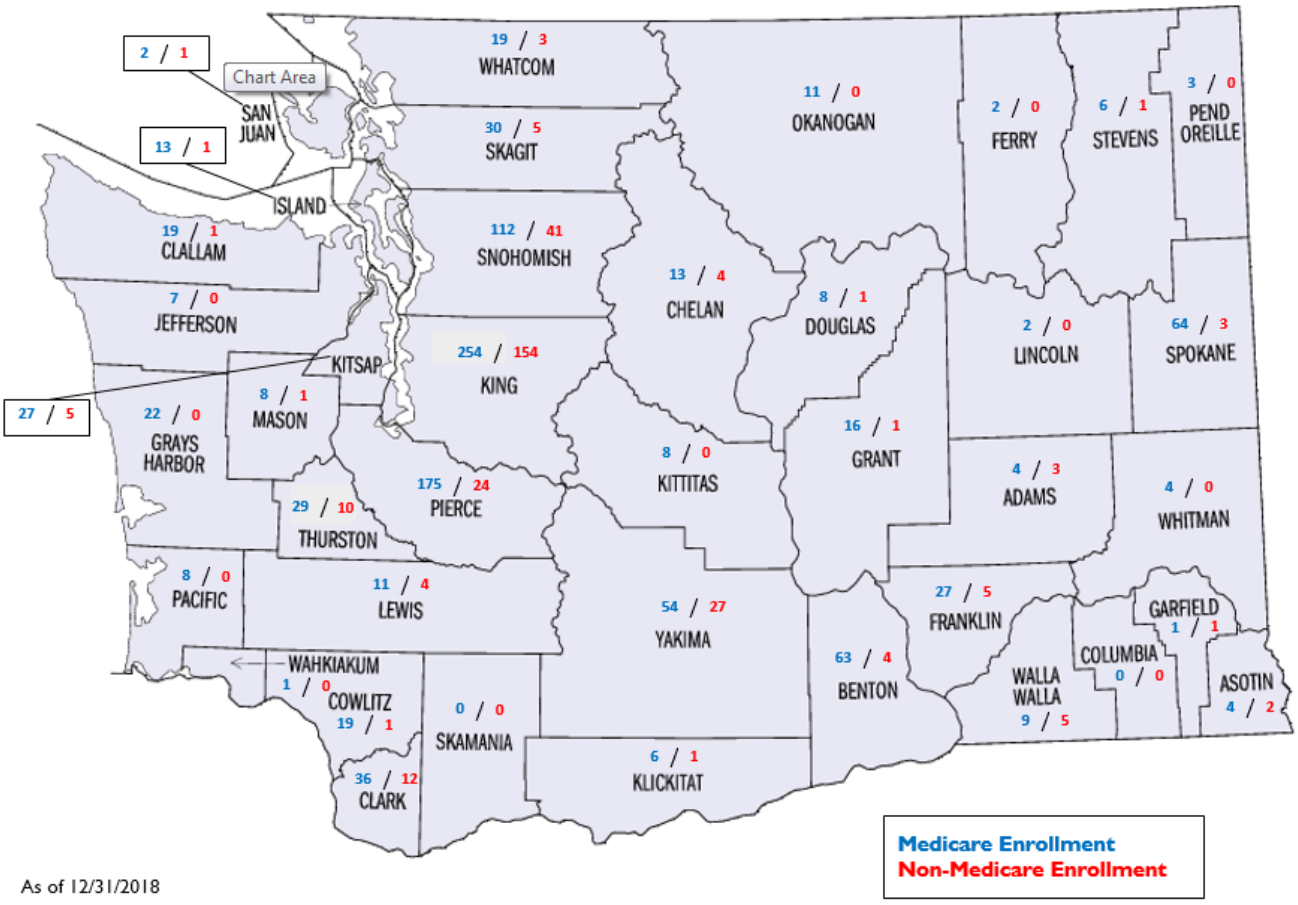
APPENDIX I - CHART A

Enrollment & Claims Summaries





Enrollment by County – 2018

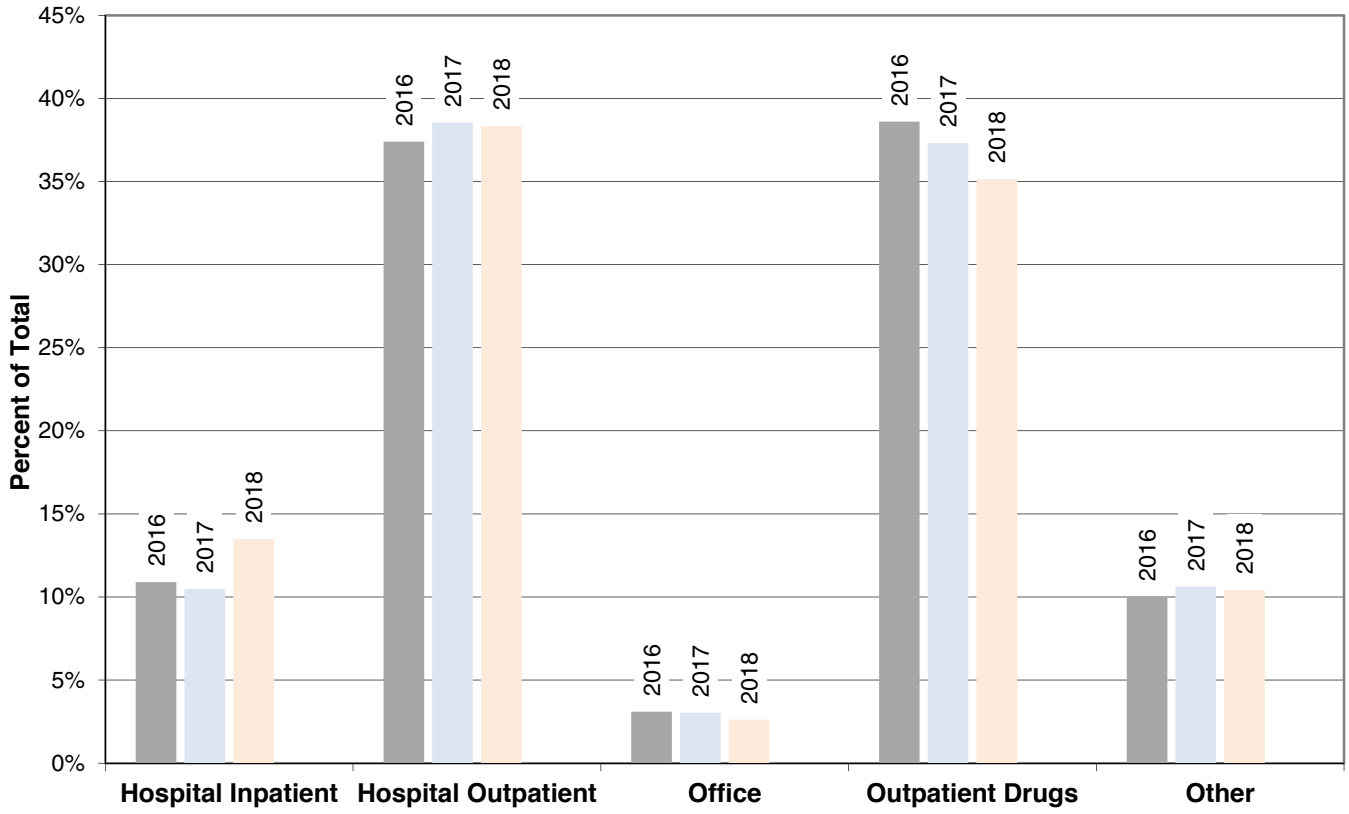


APPENDIX I – CHART C

Distribution of Claim Payments by Place of Service

Distribution of Claim Payments by Place of Service 2016–2018

This chart illustrates the total annual combined Medicare and Non-Medicare medical and pharmacy claims paid for each place of service as a percent of the total annual cost. "Other" is a total of services not within the defined labels below, such as Ambulance, Community Mental Health Center, Home Health / Hospice, and Substance Abuse Treatment Center.



WSHIP Enrollment & Financial Summary, 1988–2018; 2019 Projected - Part 1

Year	Avg Enroll.[1]	Premiums	Total Revenues[2]	Claims	Administration	Total Costs	Income (Loss)
1988	394		$121,985	$856	$94,432	$95,288	$26,697
1989	1875		$2,064,594	$1,484,053	$282,796	$1,766,849	$297,745
1990	2793		$4,718,231	$7,186,956	$565,083	$7,752,039	($3,033,808)
1991	3343		$6,975,792	$9,502,008	$677,742	$10,179,750	($3,203,958)
1992	3930		$9,029,000	$15,899,000	$925,455	$16,824,455	($7,795,455)
1993	4387		$11,432,489	$18,946,873	$1,168,088	$20,114,961	($8,682,472)
1994*	1307		$6,705,787	$19,261,747	$1,172,972	$20,434,719	($13,728,932)
1995	862		$1,807,221	$8,422,077	$311,910	$8,733,987	($6,926,766)
1996	712		$1,491,985	$6,145,216	$353,677	$6,498,893	($5,006,908)
1997	766		$1,494,539	$6,309,514	$362,488	$6,672,002	($5,177,463)
1998**	808		$1,463,690	$6,302,588	$1,530,696	$7,833,284	($6,369,594)
1999#	1065		$1,951,282	$9,441,006	$694,650	$10,135,656	($8,184,374)
2000#	2333		$5,696,608	$13,318,529	$986,928	$14,305,457	($8,608,849)
2001	2104		$6,355,065	$23,540,322	$1,108,205	$24,648,527	($18,293,462)
2002	2333		$9,086,678	$31,646,688	$1,442,325	$33,089,013	($24,002,335)
2003†	2561		$12,829,025	$37,492,688	$1,746,160	$39,238,848	($26,409,823)
2004	2732		$14,249,945	$51,617,941	$2,075,926	$53,693,867	($39,443,922)
2005	2953	$17,483,874	$17,832,074	$51,137,955	$2,003,786	$53,141,741	($35,309,667)
2006	3103	$18,250,241	$21,804,262	$43,456,871	$2,388,435	$45,845,306	($24,041,044)
2007	3336	$18,617,550	$19,121,429	$57,357,281	$3,566,386	$60,923,667	($41,802,238)
2008	3345	$19,604,248	$21,503,568	$55,207,849	$3,567,380	$58,775,229	($37,271,661)
2009	3453	$24,408,153	$27,139,671	$67,609,809	$3,468,600	$71,078,409	($43,938,738)
2010	3768	$29,398,559	$31,522,303	$79,342,905	$2,938,775	$82,281,680	($50,759,377)
2011	3811	$31,036,298	$33,185,921	$93,010,033	$2,766,577	$95,776,610	($62,590,689)
2012	3675	$31,629,551	$33,144,683	$103,493,291	$3,018,110	$106,511,401	($73,366,718)
2013	3863	$36,594,592	$37,990,040	$108,940,514	$3,045,338	$111,985,852	($73,995,812)
2014***	1888	$13,806,921	$14,920,384	$48,949,094	$2,748,616	$51,697,710	($36,777,326)
2015	1600	$11,602,968	$11,605,118	$45,174,109	$2,457,850	$47,631,959	($36,026,341)
2016	1467	$11,080,165	$11,128,252	$40,393,344	$2,214,247	$42,607,591	($31,479,339)
2017	1459	$11,820,118	$11,884,626	$37,386,342	$2,118,887	$39,505,229	($27,620,603)
2018	1429	$12,211,368	$12,318,141	$38,725,315	$2,293,930	$41,019,245	($28,701,104)
2019 Proj	1407	$12,234,131	$12,248,739	$36,959,772	$1,943,910	$38,903,682	($26,654,943)
Total			$414,823,127	$1,173,662,546	$56,040,360	$1,229,702,906	($814,879,279)

NOTES:

[1] Enrollment 1988 – 2000 as of year-end; 2001 and following is average monthly enrollment.

[2] Total revenues include premiums, investment income, federal grants and carrier excess loss remittances.

* Enrollment declined sharply in 1994 following enactment of health insurance reforms.

** 1998 administration costs include one-time claims settlement of $1.05 million.

Enrollment climbed in 1999 and 2000 due to unavailability of individual insurance offerings

† $1,540,323 backlog processed in 2004, but included in 2003.

*** Enrollment decreased significantly due to enrollees transitioning to new options resulting from 2014 health care reforms.

APPENDIX I - CHART D

WSHIP Enrollment & Financial Summary

WSHIP Enrollment & Financial Summary, 1988–2018; 2019 Projected - Part 2

Year	Assessments	Costs pmpm[1]	Premium pmpm[2]	% Paid by Enrollees	Admin Ratio	Income (Loss) per enrollee
1988	$242,300	$20	$25.80	128.0%	99.1%	$67.76
1989	$1,419,656	$79	$91.76	116.9%	16.0%	$158.80
1990	$2,999,470	$231	$140.78	60.9%	7.3%	($1,086.22)
1991	$2,499,451	$254	$173.89	68.5%	6.7%	($958.41)
1992	$10,199,088	$357	$191.45	53.7%	5.5%	($1,983.58)
1993	$10,198,943	$382	$217.17	56.8%	5.8%	($1,979.14)
1994	$11,499,657	$1,303	$427.56	32.8%	5.7%	($10,504.16)
1995	$6,308,228	$844	$174.71	20.7%	3.6%	($8,035.69)
1996	$7,517,413	$761	$174.62	23.0%	5.4%	($7,032.17)
1997	$9,499,999	$726	$162.59	22.4%	5.4%	($6,759.09)
1998	$6,723,298	$808	$150.96	18.7%	19.5%	($7,883.16)
1999	$12,079,597	$793	$152.68	19.3%	6.9%	($7,684.86)
2000	$9,156,048	$511	$203.48	39.8%	6.9%	($3,690.03)
2001	$15,537,546	$976	$251.71	25.8%	4.5%	($8,694.61)
2002	$32,238,215	$1,182	$324.57	27.5%	4.4%	($9,627.95)
2003	$18,236,206	$1,277	$417.52	32.7%	4.5%	($10,312.31)
2004	$27,677,167	$1,638	$463.76	26.5%	3.9%	($14,437.75)
2005	$37,677,862	$1,500	$503.22	33.6%	3.8%	($11,957.22)
2006	$31,737,155	$1,231	$490.12	39.8%	5.2%	($7,747.68)
2007	$37,868,709	$1,522	$465.07	30.6%	5.9%	($12,530.65)
2008	$40,700,000	$1,464	$488.40	33.4%	6.1%	($11,142.50)
2009	$44,558,900	$1,715	$589.06	34.3%	4.9%	($12,724.80)
2010	$53,087,591	$1,820	$650.18	35.7%	3.6%	($13,471.17)
2011	$64,053,527	$2,094	$678.66	32.4%	2.9%	($16,423.69)
2012	$74,031,979	$2,415	$717.22	29.7%	2.8%	($19,963.73)
2013	$84,543,448	$2,416	$789.39	32.7%	2.7%	($19,154.19)
2014 **	$45,500,000	$2,282	$609.42	26.7%	5.3%	($19,479.52)
2015	$33,999,828	$2,481	$604.32	24.4%	5.2%	($22,516.46)
2016	$31,353,672	$2,420	$629.41	26.0%	5.2%	($21,458.31)
2017	$27,137,353	$2,256	$675.13	29.9%	5.4%	($18,931.19)
2018	$25,500,000	$2,392	$712.12	29.8%	5.6%	($20,084.75)
2019 Proj	$25,500,000	$2,304	$724.60	31.4%	5.0%	($18,944.52)
Total	$814,782,306					

NOTES:

[1] Enrollment 1988 – 2000 as of year-end; 2001 and following is average monthly enrollment.

[2] Premiums include investment income prior to 2005.

** 2014 Assessments includes a $20.8 million assessment for a state-mandated payment to the Washington Health Benefit Exchange.

Petrow Kane Leemhuis
Certified Public Accountants

Independent Auditors' Report

Board of Directors
Washington State Health Insurance Pool

Report on the Financial Statements
We have audited the accompanying financial statements of Washington State Health Insurance Pool (a nonprofit organization) which comprise the balance sheets as of December 31, 2018 and 2017 and the related statements of operations and unassigned surplus and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with the accounting practices prescribed or permitted by the Office of the Insurance Commissioner of the State of Washington (described in Note 1) and accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of the significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Washington State Health Insurance Pool as of December 31, 2018 and 2017, and the results of its operations and cash flows for the years then ended in accordance the accounting practices prescribed or permitted by the Office of the Insurance Commissioner of the State of Washington (described in Note 1) and accounting principles generally accepted in the United States of America.

Emphasis of Matter

Basis of Accounting
We draw attention to Note 1 of the financial statements, which describes the basis of accounting. The financial statements are prepared in accordance with accounting practices prescribed or permitted by the Office of the Insurance Commissioner of the State of Washington and accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to that matter.

Adoption of New Reporting Standard
As discussed in Note 2 to the financial statements, Washington State Health Insurance Pool has adopted the provisions of Auditing Standards Update 2016-14 *Presentation of Financial Statements of Not-for-Profit Entities.* The new standard affects the presentation of certain items in the financial statements, requires the disclosure of functional expenses and requires qualitative and quantitative disclosures in the notes to the financial statements regarding the Pool's ability to meet future cash flow needs. Our opinion is not modified with respect to this matter.

Petrow Kane Leemhuis

March 1, 2019

Washington State Health Insurance Pool

Balance Sheets

	December 31 2018	2017
Assets		
Cash and short term investments	**$ 4,023,437**	$ 5,683,892
Assessments receivable	**6,462,515**	6,131,528
Uncollected premiums	**18,915**	12,668
Prepaid expenses	**-**	15,055
Total assets	**$ 10,504,867**	$ 11,843,143
Liabilities and unassigned surplus		
Unpaid claims	**$ 5,157,000**	$ 4,390,000
Unpaid claims adjustment expenses	**285,000**	295,000
Premiums received in advance	**1,568,197**	222,822
Assessments payable	**990,915**	1,238,834
Abandoned claims reserve	**-**	2,084
General expenses due and accrued	**125,853**	115,397
Total liabilities	**8,126,965**	6,264,137
Unassigned surplus	**2,377,902**	5,579,006
Total liabilities and unassigned surplus	**$ 10,504,867**	$ 11,843,143

See accompanying notes and independent auditors' report.

Washington State Health Insurance Pool

Statements of Operations and Unassigned Surplus

	Years ended December 31	
	2018	**2017**
Operating revenues:		
Net premium income	**$ 12,211,368**	$ 11,820,118
	12,211,368	11,820,118
Operating expenses:		
Hospital and medical benefits	**38,725,315**	37,386,342
Claim adjustment expenses	**884,631**	860,794
General and administrative expenses	**1,409,299**	1,258,093
	41,019,245	39,505,229
Operating loss	**(28,807,877)**	(27,685,111)
Non-operating revenues:		
Investment and other income	**106,773**	64,508
	106,773	64,508
Loss before assessments	**(28,701,104)**	(27,620,603)
Assessments	**25,500,000**	27,137,353
Change in unassigned surplus	**(3,201,104)**	(483,250)
Unassigned surplus at beginning of year	**5,579,006**	6,062,256
Unassigned surplus at end of year	**$ 2,377,902**	$ 5,579,006

See accompanying notes and independent auditors' report.

Washington State Health Insurance Pool

Statements of Cash Flows

	Years ended December 31	
	2018	**2017**
Operating activities		
Premiums collected	**$ 13,550,496**	$ 11,603,191
Claims and claims adjustment expenses paid	**(38,376,343)**	(38,313,151)
General administrative expenses paid	**(1,862,474)**	(1,817,864)
Cash used by operating activities	**(26,688,321)**	(28,527,824)
Investing activities		
Investment and other income	**106,772**	64,508
Cash provided by investing activities	**106,772**	64,508
Financing activities		
Assessments collected	**24,921,094**	21,517,866
Cash provided by financing activities	**24,921,094**	21,517,866
Net decrease in cash and cash equivalents	**(1,660,455)**	(6,945,450)
Cash and short term investments at beginning of year	**5,683,892**	12,629,342
Cash and short term investments at end of year	**$ 4,023,437**	$ 5,683,892

See accompanying notes and independent auditors' report.

1. Organization and Significant Accounting Policies

Organization

Washington State Health Insurance Pool (the Pool), a nonprofit unincorporated entity, was established by the State of Washington to make health care coverage available for eligible persons in Washington who have been rejected for individual coverage by licensed insurance carriers.

Basis of Presentation

The accompanying financial statements have been prepared on the basis of accounting practices prescribed or permitted by the Office of the Insurance Commissioner of the State of Washington. Such practices may vary from accounting principles generally accepted in the United States of America (GAAP). However, the effect of such variances is not considered to be material and the financial statements are also considered to be in conformity with GAAP.

Use of Estimates

Preparation of financial statements requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Estimates in the accompanying financial statements include amounts recorded for the liabilities for unpaid claims and related expenses. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported and disclosed herein.

Cash and Cash Equivalents

All investments with a remaining maturity of three months or less at the date of acquisition are considered cash equivalents. Short-term investments are recorded at cost, which approximates market.

Assessments

The Pool has the authority, under state law, to assess insurance companies writing health premiums in the State of Washington for all losses of the Pool. Assessments of the insurer members are approved by the Board of Directors and are recognized as a contribution to unassigned surplus. Assessments are made periodically and are based on projected cash flow needs. Assessments receivable represents outstanding balances assessed to insurance companies but not yet collected, and assessments payable represents amounts overpaid by insurance companies and are to be refunded.

1. Organization and Significant Accounting Policies (continued)

Unpaid Claims and Related Expenses

The liabilities for unpaid claims and related expenses are estimated based on historical claim development, including the effects of six-month pre-existing condition exclusion. Considerable variability is inherent in such estimates. However, management believes that liabilities for unpaid claims and related expenses are adequate. The estimates are continually reviewed and updated as experience develops or new information becomes known; such adjustments are reflected in current operations.

Premium deficiencies are not recognized since the Pool has the authority to assess member carriers for operating losses.

Revenue Recognition

Premiums are earned pro rata over the periods to which the premiums relate. Premiums received in advance represent amounts received in advance of the policy effective date.

Concentration of Credit Risk

Deposits at the Pool's financial institutions are insured by the Federal Deposit Insurance Corporation up to $250,000. The Pool has not experienced a loss due to uninsured balances, and at December 31, 2018 and 2017, cash balances were fully insured.

Income Taxes

The Internal Revenue Service has determined that the Pool qualifies as a tax-exempt organization under Section 501(c)(26) of the Internal Revenue Code (IRC) and is, therefore, not subject to tax under present income tax law. The Pool is required to operate in conformity with the IRC to maintain its qualification. The Pool is also exempt from State of Washington taxes.

In consideration of Accounting Standards Codification 740-10-25 *Income Taxes* , the Pool has not taken any uncertain tax positions that should be recognized in the accompanying financial statements. The Pool's 2017, 2016 and 2015 tax returns are subject to examination by the Internal Revenue Service.

Regulatory Examination

The Pool's financial statements are subject to examination by the Office of the Insurance Commissioner of the State of Washington (OIC). The OIC's most recent examination covers three years through 2017, and was completed during 2018. No findings were noted that required an adjustment to the financial statements.

2. New Accounting Guidance

In August 2016, the Financial Accounting Standards Board issued Auditing Standards Update (ASU) 2016-14 *Presentation of Financial Statement of Not-for-Profit Entities.* The new standard replaces the existing three classes of net assets with two classes; net assets with donor restrictions and net assets without donor restrictions. The standard also gives not-for-profit entities the option of presenting the statement of cash flows using the direct method, and requires all not-for-profits to present operating expenses by both nature and function. Additional requirements include improved disclosures related to board-designated net assets, under-water endowments, cost allocation methods, management and general activities and quantitative and qualitative disclosures related to liquidity and a not-for-profit's ability to meet future cash flow needs from one year of the statement of financial position date. The Pool adopted ASU 2016-14 for the year ended December 31, 2018. However, as noted above, the Pool's financial statements are presented on the basis of accounting practices prescribed or permitted by the Office of the Insurance Commissioner of the State of Washington. As such, the provisions of the new standard are not applicable to the Pool's basic financial statements, but are applicable to certain footnote disclosures included herein.

3. Liability for Unpaid Claims

The following table provides a reconciliation of the beginning and ending balances of the liability for unpaid claims and unpaid claims adjustment expenses:

	Years ended December 31	
	2018	**2017**
Balances at January 1	**$ 4,685,000**	$ 5,258,000
Policy benefits incurred related to:		
Current year	**39,679,863**	38,795,571
Prior years (redundancy)	**(954,548)**	(1,409,229)
Total policy benefits incurred	**38,725,315**	37,386,342
Paid related to:		
Current year	**34,239,863**	34,110,571
Prior years	**3,728,452**	3,848,771
Total paid	**37,968,315**	37,959,342
Balances at December 31	**$ 5,442,000**	$ 4,685,000

Policy benefits incurred related to prior years varies from previously estimated liabilities as the claims are ultimately settled. The changes in amounts incurred related to prior years are the result of changes in morbidity experience, health care utilization and claim payment patterns.

4. Plan Administration Agreement

The Pool has outsourced its administrative services to Benefit Management LLC, a Kansas based third party administrator, under a service agreement effective through December 2020. In accordance with the agreement, the Pool is charged a monthly per-member-per-month fee based on the number of active members, and variable fees for certain services. Total fees paid to Benefit Management LLC in 2018 and 2017 were $955,996 and $910,507, respectively, and are included in general and administrative expenses in the accompanying statements of operations and unassigned surplus.

5. Line of Credit

The Pool has a secured revolving line of credit agreement with KeyBank National Association, which provides for borrowing up to a maximum of $5 million. There were no outstanding balances at December 31, 2018 or 2017, nor were there any borrowings against this line during 2018 or 2017.

6. Functional Classification of Expenses

Functional classification of expenses for the Pool for the years ended December 31 consisted of the following:

	2018	2017
Program (claims)	**$ 38,725,315**	$ 37,386,342
Management and adminstrative	**2,293,930**	2,118,887
Total operating expenses	**$ 41,019,245**	$ 39,505,229

7. Analysis of Cash Flow

The Pool has $10,504,867 of financial assets available within one year of the balance sheet date to meet cash needs for general expenditures consisting of cash of $4,023,437, assessments receivable of $6,462,515, and premium receivable of $18,915. All of the Pool's financial assets are to be used to pay claims and operating expenses. When at any time claims and operating expenses are projected to exceed premium revenue, the Pool has the statutory authority to assess the insurance carriers writing business in the State of Washington for cash flow to cover the losses.

8. Subsequent Events

In accordance with ASC 855 *Subsequent Events* , the Pool has evaluated subsequent events through March 1, 2019, the date these financial statements were available to be issued. There were no material subsequent events that required recognition or additional disclosure in these financial statements.