WSHIP
WASHINGTON STATE
HEALTH INSURANCE POOL

2023 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

1777 S Burlington Blvd, #449
Burlington, WA 98233

May 2023

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 2023.

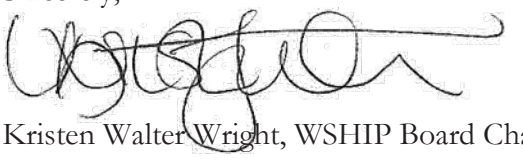
At year-end, there were a total of 694 enrollees in WSHIP. Of these, 158 enrollees were in WSHIP's non-Medicare program, and 536 enrollees were in WSHIP's Medicare program.

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 plans have been closed to new enrollment since 2014 because individual coverage has been available in all counties, and over 95% of individuals who had been enrolled in a non-Medicare plan prior to 2014 have left the Pool. 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 decreased 26% to $15.3 million in 2023. Assessments to Member Plans were $12 million in 2023 (an estimated $0.25 pmpm). WSHIP assessments for 2024 are currently projected to be $6 million.

We look forward to ongoing discussions with policy makers on the future of the Pool. WSHIP's Executive Director, Sharon Becker, is available to answer questions or provide additional information. Sharon can be reached at sbecker@wship.org. You may contact me at Kristen.Walter@Regence.com or Michael Dunlop at mjdunlop@cdchc.org who is succeeding me as Board Chair beginning June 1, 2024.

Sincerely,



Kristen Walter Wright, WSHIP Board Chair

TABLE OF CONTENTS

About WSHIP

As the State's high risk pool, WSHIP is a nonprofit health plan providing health benefits to Washington residents denied coverage or unable to obtain comprehensive coverage because of their medical status. 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 total funding.

EXECUTIVE SUMMARY

The Washington State Health Insurance Pool (WSHIP) has served as a safety net for individuals who have been denied health insurance coverage or are unable to obtain comprehensive coverage because of their medical status. 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 694 individuals as of December 31, 2023. This represents a decrease of 21% from the prior year. Total claims costs were $15.3 million, a decrease of 26% from the prior year.

Non-Medicare: WSHIP's non-Medicare plans remained closed to new enrollment in 2023 since individual health plans were offered in all counties. 158 enrollees were in these plans at year-end. Of those, 115 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 536 enrollees.

Key Facts & Figures

Enrollment

▪ Total WSHIP enrollment as of 12/31/23	694	(21% decrease from prior year)
Non-Medicare Plans:	158	(23% of total enrollment)
Medicare Plans:	536	(77% of total enrollment)

Total Revenue	$18.2 million	**Total Expenses**	$16.5 million
▪ Premiums	$5.7 million	▪ Medical Claims	$8.9 million
▪ Assessments	$12 million (est. $0.25 pmpm*)	▪ Rx Claims	$6.4 million
▪ Other	$492,637	▪ Administration	$1.2 million

* 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: 7 of the top 10 drugs by cost were for HIV/AIDS therapy

Cost Containment

- Provider Network Savings: $5.2 million
- Care Management Program Savings: $795,763
- Pharmacy Network and State Pharmaceutical Assistance Program Savings: $5.0 and $2.8 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; therefore, this was not implemented.)

In 2021, the statute was amended to remove the December 31, 2022 termination date of the non-Medicare plans.

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. In 2020 WSHIP added a new Medicare plan (the "Medical Supplement Plan").

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 for 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. The governor appoints six directors: 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 2023, WSHIP engaged the law firm Perkins Coie and the actuarial firm Leif Associates.

Third-Party Administrator & Contractors

WSHIP contracts with a third-party administrator – ValueHealth Benefit Administrators (VHBA), formerly named Benefit Management, LLC (BML) – to perform health plan enrollment, premium billing, claims processing, customer service, on-line information, accounting, reporting, and care management. VHBA 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.

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[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.

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 2023; 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 2023 there were 14 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.

Enrollment

Total Number Enrolled

Enrollment in WSHIP decreased 21% in 2023, with a total of 694 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 4% from 120 enrollees to 115 in 2023.

Age & Demographics

The average age of enrollees in the Pool was 60 years. Approximately 53% of all WSHIP enrollees were enrolled in Medicare due to disability. 53% of Medicare enrollees were under age 65.

55% of enrollees had their premiums paid by a third party.

Tobacco Use

Approximately 18% of WSHIP enrollees report using tobacco.

2023 HIGHLIGHTS

Enrollment & Services

Average Length of Enrollment

At year-end WSHIP enrollees had been covered by the Pool an average of 11 years. Of the total enrollment, 50% were covered by the Pool for more than 10 years; 22% between 5 and 10 years; and 24% for 2 to 5 years. Overall, 96% of enrollees have been covered by the Pool for 2 years or more.

Disenrollment

In 2023, 210 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 60 years old and has been covered by the Pool for 11 years.

Benefit Plans

In 2023 WSHIP had five benefit plans: two plans for enrollees who are not enrolled in Medicare and three 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** – 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)

- **Medical Supplement Plan** – Supplements Medicare Parts A & B with no additional drug benefit

- **Basic Plan** – (closed to new enrollment since 12/31/19) Supplements Medicare Parts A & B with no additional drug benefit

- **Basic Plus** – (closed to new enrollment since 12/31/08) Supplements Medicare Parts A, B & D

Distribution by Age & Benefit Plan

At year-end, the largest non-Medicare enrollment was in the $2,500 deductible PPO plan and the largest Medicare enrollment was in the Basic plan.

Non-Medicare PPO Plan					Non-Medicare HSA PPO Plan	
Age	$500	$1,000	$2,500	$5,000	Age	$3,000
0-18	2	0	0	0	0-18	0
19-29	6	1	0	0	19-29	0
30-34	0	0	2	0	30-34	0
35-39	3	0	5	0	35-39	0
40-44	2	3	21	1	40-44	0
45-49	1	1	27	0	45-49	1
50-54	2	0	26	1	50-54	0
55-59	2	1	21	0	55-59	0
60-64	1	0	12	2	60-64	1
65-69	1	0	8	0	65-69	0
70-74	0	0	2	0	70-74	0
75-79	0	0	2	0	75-79	0
80-84	0	0	0	0	80-84	0
85+	0	0	0	0	85+	0
Total	**20**	**6**	**126**	**4**	**Total**	**2**
Total Non-Medicare Enrollment = 158						

	Medicare Medical Supplement	Medicare Basic	Medicare Basic Plus
Age			
0-18	0	0	0
19-29	1	1	0
30-34	4	3	0
35-39	7	1	0
40-44	5	12	0
45-49	11	19	1
50-54	15	28	2
55-59	20	42	4
60-64	36	60	12
65-69	22	45	16
70-74	20	33	22
75-79	7	23	20
80-84	4	15	8
85+	4	5	8
Total	**156**	**287**	**93**
Total Medicare Enrollment = 536			

Total Enrollment = 694

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 – 2023		
	WSHIP	**MedWatch Commercial Book of Business**
Inpatient Admissions/1,000 enrollees	112	29
Bed Days/1,000 enrollees	379	126
Average Length of Stay Days	3.39	4.38
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 – 2023	
Number of cases	76
Average hours per case	5.7
Top Diagnoses Managed	Diseases of Genitourinary System Diseases of Endocrine, Nutritional and Metabolic, Immunity Disorders Diseases of the Circulatory System, Diseases of the Nervous System, and Sense Organs
CM Return on Investment (ROI)	$18:1

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.).

Total Care Management Program Savings: $795,763

Customer Service & Website Activities

Telephone Activity

An average of 26 telephone inquiries per day was received by the Pool's Customer Service Representatives in 2023. The most common inquiries related to: 1) claims status and 2) verification of eligibility and benefits.

Website Activity

There was an average of 12 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 2023, 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 2023 was 110% for non-Medicare plans and 129% for Medicare plans.

In 2023, premiums totaled $5.7 million.

The percentage of total funding covered by premium was 31%.

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 2023, Member Plan assessments totaled $12 million (an estimated $0.25 pmpm).

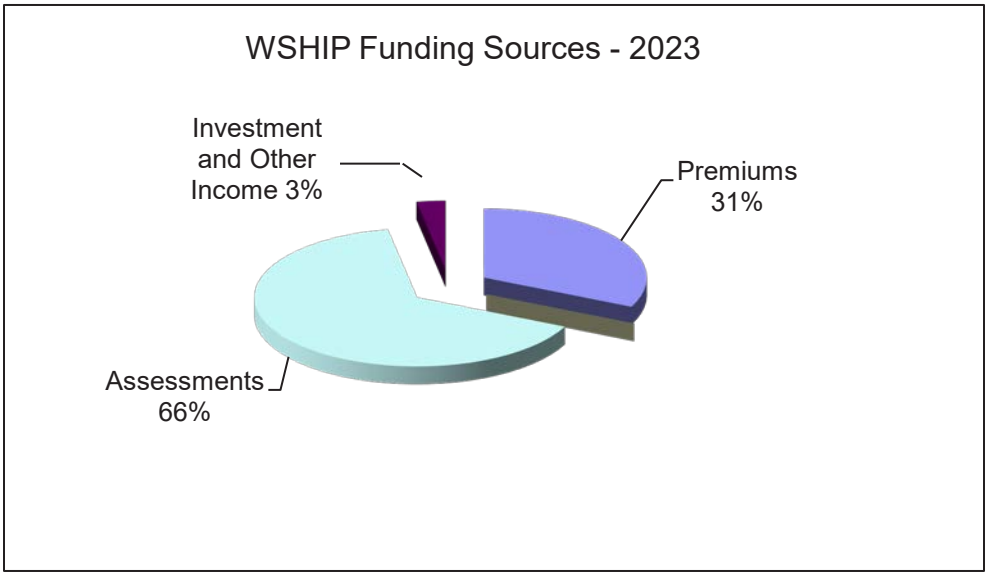
The percentage of total funding covered by assessments was 66%.

3. Interest Income

Interest earned on funds held by WSHIP for future claims payments totaled $492,637.

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 2023 were $15.3 million, a decrease of 26% from the prior year. 58% of claims were for medical claims and 42% for prescription drugs. The average cost per enrollee was $22,018.

Total Claim Costs - 2023		
		Average cost per enrollee
Medical Claims	$8.9 million	$12,783
Pharmacy Claims	$6.4 million	$9,235
Total Claims	**$15.3 million**	**$22,018**

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 - 2023		
	Non-Medicare	**Medicare**
Medical Claims	$4,426,199	$4,445,441
Pharmacy Claims	$5,917,173	$492,051
Total Claims	**$10,343,372**	**$4,937,492**
Loss Ratio	**517%**	**211%**
Claims Costs Per Member Per Month (PMPM)	**$5,424**	**$705**

Conditions Treated

Claims Costs by Major Diagnostic Category

The top diagnostic categories for total claims (medical and pharmacy) in 2023 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 – 2023

Diagnosis Category	Number of Members	Percent of Members	% of Total Claims	% of Medical Claims	% of Rx Claims	Total Claims Paid PMPM
HIV/AIDS Related	110	67.5%	42.0%	8.4%	64.4%	$3,503
Kidney and Urinary Tract Disease	11	6.7%	33.5%	59.4%	16.1%	$27,926
Cancer	4	2.5%	7.3%	11.2%	4.6%	$16,645
Neurological	7	4.3%	6.3%	11.0%	3.2%	$9,663
Other	12	7.4%	4.5%	3.9%	5.0%	$3,471
Metabolic Disorders	2	1.2%	4.0%	3.0%	4.7%	$18,420
Heart Related	4	2.5%	1.0%	1.6%	0.6%	$2,254
Arthritis and Joint Disorders	3	1.8%	0.9%	0.6%	1.1%	$2,841
Mental Disorders	2	1.2%	0.3%	0.3%	0.2%	$2,351
Spinal/Brain	1	0.6%	0.3%	0.6%	0.0%	$2,375
No Claims Submitted	7	4.3%	0.0%	0.0%	0.0%	$0
TOTALS	**163**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**$5,798**

Notes: 163 unique members enrolled at some time during the calendar year 2023. Claims based on incurred date of service, paid through 1/31/24. 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 – 2023

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	317	51.5%	63.3%	72.5%	0.5%	$754
Other	97	15.8%	16.3%	10.8%	54.1%	$599
Cancer	29	4.7%	5.2%	5.4%	3.8%	$708
Neurological	32	5.2%	3.1%	2.6%	6.5%	$354
Arthritis and Joint Disorders	10	1.6%	2.8%	1.0%	15.6%	$940
Heart Related	30	4.9%	2.7%	3.0%	0.0%	$335
HIV/AIDS Related	8	1.3%	2.2%	0.3%	14.8%	$904
Spinal/Brain	18	2.9%	1.6%	1.8%	0.5%	$315
Mental Disorders	10	1.6%	1.1%	0.8%	3.4%	$402
Diabetes	23	3.7%	1.0%	1.1%	0.8%	$160
Metabolic Disorders	4	0.7%	0.6%	0.7%	0.0%	$537
No Claims Submitted	37	6.0%	0.0%	0.0%	0.0%	$0
TOTALS	**615**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**$606**

Notes: 615 unique members enrolled at some time during the calendar year 2023. Claims based on incurred date of service, paid through 1/31/24. 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 93% of total pharmacy costs in 2023 led by those related to the treatment of HIV/AIDS.

Top 10 Indications by Pharmacy Cost				
2023 Rank	Indication	Patients	Plan Cost	Plan Cost PMPM
1	HIV	124	$4,322,254	$483.47
2	URINARY DISORDERS	43	$837,174	$93.64
3	CYSTIC FIBROSIS	2	$469,392	$52.50
4	CANCER	5	$294,473	$32.94
5	PAIN/INFLAMMATION	124	$150,979	$16.89
6	DIABETES	57	$135,503	$15.16
7	OPHTHALMIC CONDITIONS	17	$118,934	$13.30
8	INFLAMMATORY CONDITIONS	11	$103,490	$11.58
9	SEIZURES	36	$63,694	$7.12
10	ASTHMA	48	$53,462	$5.98

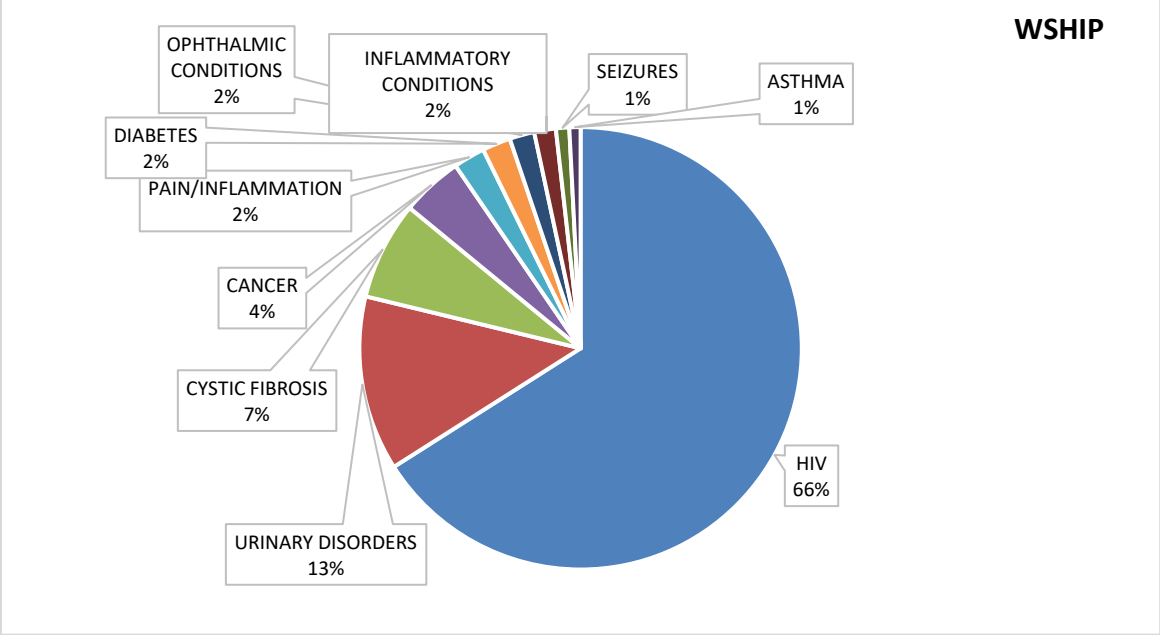
HIV/AIDS Drugs

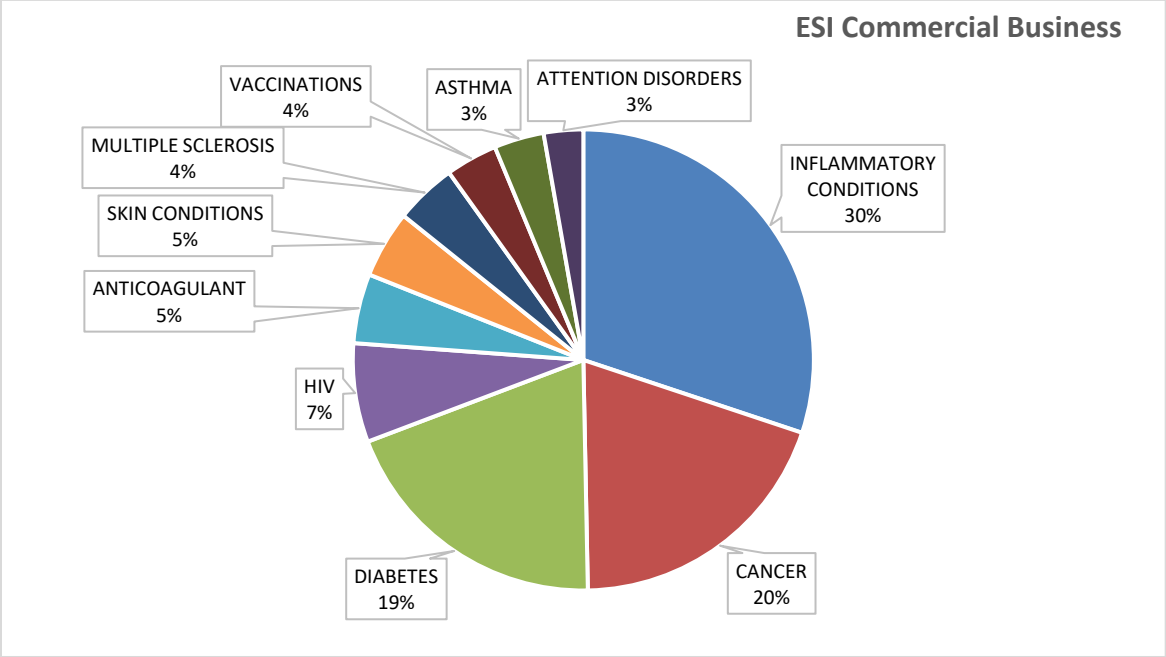
In 2023, 60.5% of the total pharmacy benefits paid were related to the treatment of HIV/AIDS. These drugs continue to dominate the Pool's top 25 drugs by cost. Enrollees with HIV/AIDS have pharmacy claims costs approximately 8.5 times higher than the average WSHIP enrollee.

Top 25 Drugs by Pharmacy Cost					
2023 Rank	Drug Name	Indication	Patients	Plan Cost	Plan Cost PMPM
1	BIKTARVY	HIV	40	$1,228,894	$137
2	PROCYSBI	URINARY DISORDERS	1	$811,252	$91
3	GENVOYA	HIV	16	$561,387	$63
4	TIVICAY	HIV	28	$499,892	$56
5	TRIKAFTA	CYSTIC FIBROSIS	2	$453,648	$51
6	DESCOVY	HIV	26	$445,345	$50
7	TRIUMEQ	HIV	11	$297,762	$33
8	JULUCA	HIV	11	$269,968	$30
9	ODEFSEY	HIV	6	$175,597	$20
10	POMALYST	CANCER	1	$168,364	$19
11	PREZCOBIX	HIV	7	$123,798	$14
12	BOSULIF	CANCER	1	$116,547	$13
13	CYSTARAN	OPHTHALMIC CONDITIONS	1	$116,060	$13
14	RUKOBIA	HIV	1	$93,850	$10
15	COMPLERA	HIV	3	$93,800	$10
16	XELJANZ XR	INFLAMMATORY CONDITIONS	2	$73,193	$8
17	PREZISTA	HIV	5	$62,736	$7
18	DOVATO	HIV	2	$59,077	$7
19	ISENTRESS	HIV	4	$58,219	$7
20	OXYCONTIN	PAIN/INFLAMMATION	4	$50,389	$6
21	SYMTUZA	HIV	1	$46,077	$5
22	PIFELTRO	HIV	3	$38,700	$4
23	STRIBILD	HIV	1	$30,426	$3
24	ERYTHROMYCIN ETHYLSUCCINATE	INFECTIONS	1	$27,858	$3
25	XOLAIR	ASTHMA	1	$27,049	$3

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. Shown below is a comparison of WSHIP to Express Scripts' commercial business in 2023.





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.

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 2023, the total estimated SPAP savings to WSHIP was $2.8 million.

Cost Containment

WSHIP utilizes the First Choice Health Network for its provider network and claims pricing. In 2023, 99% of claims dollars were paid to network providers. Eligible charges were discounted an average of 34% as a result of network provider contracts. These negotiated provider discounts reduced the Pool's medical claims costs by $5.2 million.

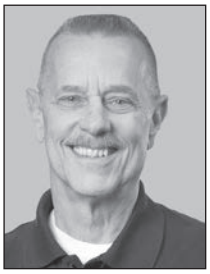
Pharmacy cost savings were achieved through Express Script's pharmacy network. These discounts reduced the Pool's pharmacy costs by $5 million in 2023.

Administrative Expenses

Total administrative expenses for 2023 were $1.2 million or 7% of total expenses.

Board Members

Todd Dixon joined the Board in May 2023 as an ex-officio, non-voting board member representing the Insurance Commissioner. Todd was appointed Deputy Commissioner for the Consumer Protection Division in 2019. He is responsible for effective and strategic management of: Consumer Advocacy, Producer Licensing and Oversight, and the State Health Insurance Benefits Advisors (SHIBA). Previously he spent over 5 years as the SHIBA Program Manager and 15 years in various leadership positions with the Washington State Employment Security Department. Todd is a nationally recognized speaker on topics like ethics, respectful workplace, managing conflict, power job interviewing, communicating with influence and performance contracting. He is an elected member of the national Statewide Health Insurance Assistance Program Steering Committee and leads the taskforce for congressional outreach and stakeholder communication. He graduated Magna Cum Laude from Heritage University with a B.A. Degree in Interdisciplinary Studies/Public Administration and was a recipient of the 2007 Governor's Leadership and Management Award. Todd was awarded a certificate of completion for the Promoting Racial Equity in the Workplace Program, May 2021, John F. Kennedy School of Government at Harvard University, Executive Education.



James Dixson, appointed by the Governor in 2022, is a representative for small employers. Jim is from Eastern Washington and is the owner of Friendly Computers Spokane which he established in 2010 to support business and retail customers in their computer needs. He is a 30-year retiree from the US Air Force where he led and managed teams of 900+ in multiple locations worldwide in the maintenance and operations of high performance aircraft and weapons systems in dynamic environments. After his military service, he spent several years in the heavy manufacturing industry until he began his current endeavor in the tech industry. Jim has an interest in providing a thoughtful small-business perspective on decisions affecting the high-risk pool and in assuring that excellent and affordable coverage is made available to those in the greatest need.

BOARD OF DIRECTORS & ADMINISTRATION

Michael Dunlop, appointed by the governor in 2021, is a representative for consumers. Michael is HIV Medical Case Manager at Country Doctor Community Health Centers which serves over 425 individuals diagnosed with HIV. Prior to Country Doctor, Michael was the Director of Healthcare Access at Lifelong. Lifelong delivers food, housing and health services to people living with chronic illnesses, including HIV and AIDS. He oversaw three programs serving People Living with HIV, including the Evergreen Health Insurance Program (EHIP), the Lifelong Dental Program (LDP) and the Program Referral and Enrollment (PRE) Department. As Manager of the EHIP Program, Michael was responsible for assisting over 2400 enrollees in securing and maintaining insurance and medical coverage on an annual basis. Michael has served the HIV community for over 30 years.

Rick Hourigan MD, appointed by the Governor in 2019, is a representative for providers. Rick is a board certified family physician. A Washington native, he graduated from Benedictine College with an undergraduate degree and then from the University of Kansas Medical School before returning to Central Washington where he practiced for nearly 30 years. He returned to school to earn an MHA from the University of Washington in 2012. Rick started working in the health insurance industry as medical director with Confluence Health, focusing on moving providers towards Value-Based Care. More recently, Rick is now working for Cigna Insurance as their Market Medical Executive for the Pacific Northwest where he continues to work with provider groups in improving quality and value for plan members.

Hiu-Wan Ko is a representative for Health Care Service Contractors, elected in 2023. She is vice president of Actuarial Services at Premera Blue Cross. In this role, she leads reserving, pricing, premium rate making, and all actuarial functions supporting the enterprise strategies and financial goals. Hiu-Wan started her actuarial career as a rating analyst at the Washington State Office of the Insurance Commissioner (OIC), where she reviewed premium rates for disability products including long-term care, disability income, and Medicare supplement. She holds over 27 years of experience working in the health insurance industry. She graduated from the University of Washington with a master's degree in statistics. She is a fellow of the Society of Actuaries (FSA) and has been a member of the American Academy of Actuaries since 2014.

BOARD OF DIRECTORS & ADMINISTRATION

Karen Lewis Smith is a representative for Health Maintenance Organizations, elected in 2022. Karen currently serves as Executive Director within the Kaiser Permanente National Medicare line of business with direct accountability for the Washington State region. In this role she has P&L accountability for ~100K lives, setting strategy, assuring compliance, member satisfaction and operational excellence on behalf of the same. Karen brings over 20 years of health care leadership experience. She has worked on both the Health Plan side as well as Care Delivery where she formally served as a Hospital Administrator with oversight for acute and post-acute care. Karen brings a depth and breadth of Health Plan experience including health plan contracting, network management, quality and member experience. Karen has a Bachelor from UCLA and a Master from the University of Washington.

Sheela Tallman is a representative for Disability/Stop Loss Member Plans, elected in 2020. She previously served on the Board from 2014-2018. She is Vice President of External Affairs for UnitedHealth Group overseeing state advocacy and public policy engagement in Washington, Oregon, and Alaska. Prior to joining UnitedHealth Group, she was Senior Manager of Legislative Policy and Senior Legislative Affairs Executive for Premera Blue Cross. She was also a Manager at Deloitte Consulting focused on public sector clients for federal and state governments working on healthcare strategy, operations, and technology integration projects. Sheela has a Bachelor of Science degree in Biology from Tufts University and has dual Masters' degrees in Public Health and Public Affairs from Columbia University.

Keith Wallace, appointed by the Governor in 2023, is a representative for agents. He is a dedicated sales representative with over 30 years of experience in the Medicare marketing and sales industry. He is an equity partner with PCF Insurance Services of the West. Keith attended Washington State University and Western Washington University majoring in history and education. He serves on the Washington State Office of Insurance Commissioner Producer Advisory Council. He serves as the National Membership Chair for the National Association of Benefits and Insurance Professionals (NABIP) and was the former President of the Domestic Violence Sexual Assault Services. He strongly believes that service is his product and that leadership is the byproduct of it.

BOARD OF DIRECTORS & ADMINISTRATION

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 Members Ending Their Terms in 2023

We extend our appreciation to the following Board members who served on the WSHIP Board in 2023:

Tracy Bos was a representative for Health Care Service Contractors, elected in 2021. She is Vice President and General Manager of Senior Markets for Premera Blue Cross and is responsible for the profit and loss of Premera's Medicare products, including Medicare Advantage and Medicare Supplement. Prior to joining Premera in 2013, Tracy worked at Safeco Insurance for 20 years in a variety of positions, concluding with Director, Innovation and Insights. She serves on the Advisory Board for Girls on the Run of Puget Sound where she previously held a variety of positions including Board President. She holds a Bachelor's degree in Economics from the University of Washington.

Halee Heath, appointed by the Governor in 2022, was a representative for consumers. She has worked for Davita Dialysis for more than 5 years. In 2021 she took on the role of insurance counselor in the western regions where she works directly with End State Renal patients. As an insurance counselor, her role is to advocate and encourage patients to take the lead on their insurance needs. This includes providing resources and educating patients on all insurance options available to them to assist with navigation through dialysis care. Previous to 2021, Halee worked directly with insurance companies to ensure the claims for Davita Dialysis patients were being processed and paid correctly. Halee graduated from Washington State University with a BA in Social Sciences with a focus in human development. She has a true passion to serve and work with the community.

BOARD OF DIRECTORS & ADMINISTRATION

Molly Nollette joined the Board in 2018 as an ex-officio, non-voting board member representing the Insurance Commissioner. She joined the Office of Insurance Commissioner in 2010 to work on the newly passed Affordable Care Act, and she was appointed to her current position as Deputy Commissioner for Rates, Forms, and Provider Networks in 2013. Molly and her team are responsible for ensuring that Health and Disability, Property and Casualty, and Life and Annuities insurance plans sold in Washington comply with state and federal law and regulations. As Deputy Commissioner she is active in advancing and implementing the Commissioner's policy and legislative agenda, including representing him at multiple national and state forums including the National Association of Insurance Commissioners and the Washington State Health Care Cost Transparency Board. Prior to joining the OIC, Molly worked 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 was awarded a B.A. from Reed College and J.D. from Tulane University School of Law.

Mark Rose, appointed by the governor in 2011, was a representative for agents. Mark is a Partner and Director of Sales Operations and Client Experience for The Partners Group, (TPG). TPG is a locally owned, independent financial services, risk management and employee benefit consulting firm with offices in Oregon, Washington and Idaho. 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 Senior Business Manager focusing on large employer issues. From 2007 to 2015, Mark was the State Legislative Chair for the National Association of Health Underwriters. Mark and his wife Lisa are actively involved in community service, volunteering at multiple organizations in their North Seattle Community.

BOARD OF DIRECTORS & ADMINISTRATION

Board Committees

Executive Committee

Chair as of December 31, 2023: Kristen Walter Wright. The following Board members also served on this committee in 2023: Michael Dunlop, Mark Rose and Sheela Tallman.

Governance Committee

Chair as of December 31, 2023: Michael Dunlop. The following Board members also served on this committee in 2023: Todd Dixon, Jim Dixson, Molly Nollette and Kristen Walter Wright.

Grievance Committee

Chair as of December 31, 2023: Sheela Tallman. The following Board members also served on this committee in 2023: Sarah Clark (OIC), Michael Dunlop, Mark Rose and Keith Wallace.

Planning Committee

Chair as of December 31, 2023: Karen Lewis Smith. The following Board members also served on this committee in 2023: Tracy Bos, Halee Heath, Richard Hourigan MD, Hiu-wan Ko and Keith Wallace.

Administration

Executive Director

Sharon Becker is WSHIP's Executive Director and has been with the organization since 2006. Sharon has over 33 years' experience in the health care industry, including health plan management and consulting. Prior to joining WSHIP, Sharon provided consulting services to physicians' groups, hospitals, and health plans. At Blue Cross of Washington and Alaska, Sharon managed provider contract administration, prescription drug programs and corporate projects. Sharon received her Bachelor of Arts and Sciences in Health Education Planning from the University of Washington. Sharon served on the Board of Directors for the 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 14 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 she 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
ValueHealth Benefit Administrators
(VHBA)
1-800-877-5187
www.wship.org

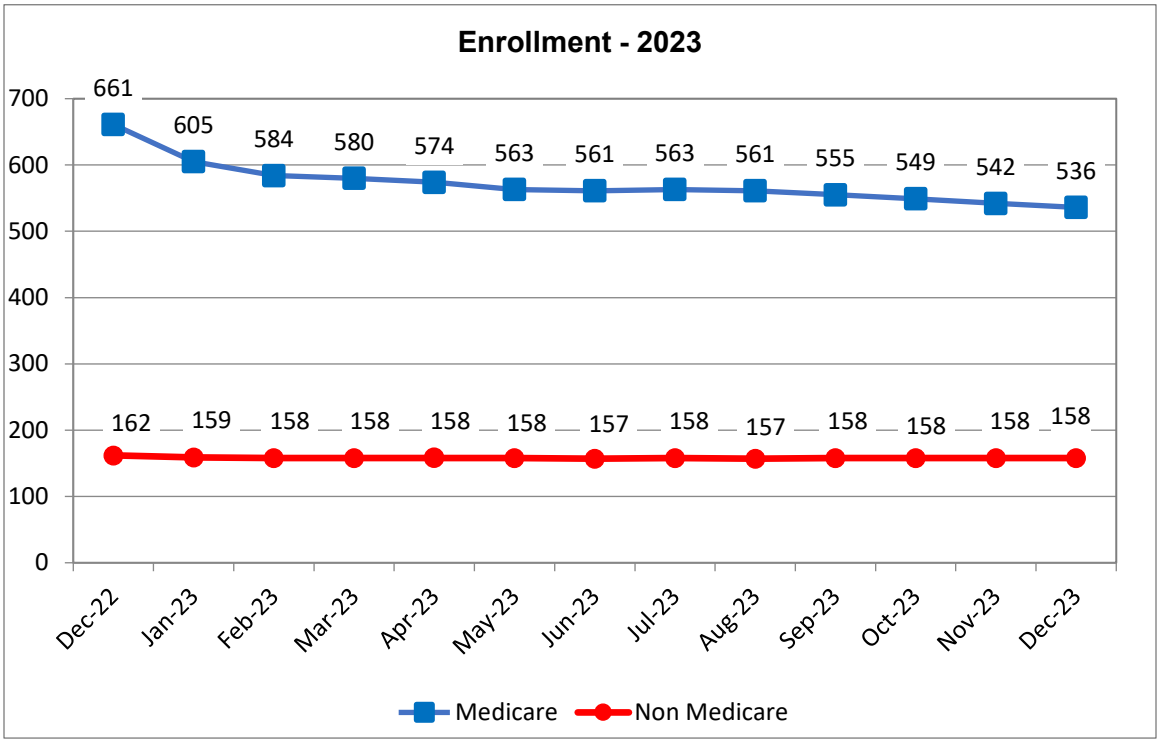
Preferred Provider Network
First Choice Health
1-800-231-6935
www.fchn.com

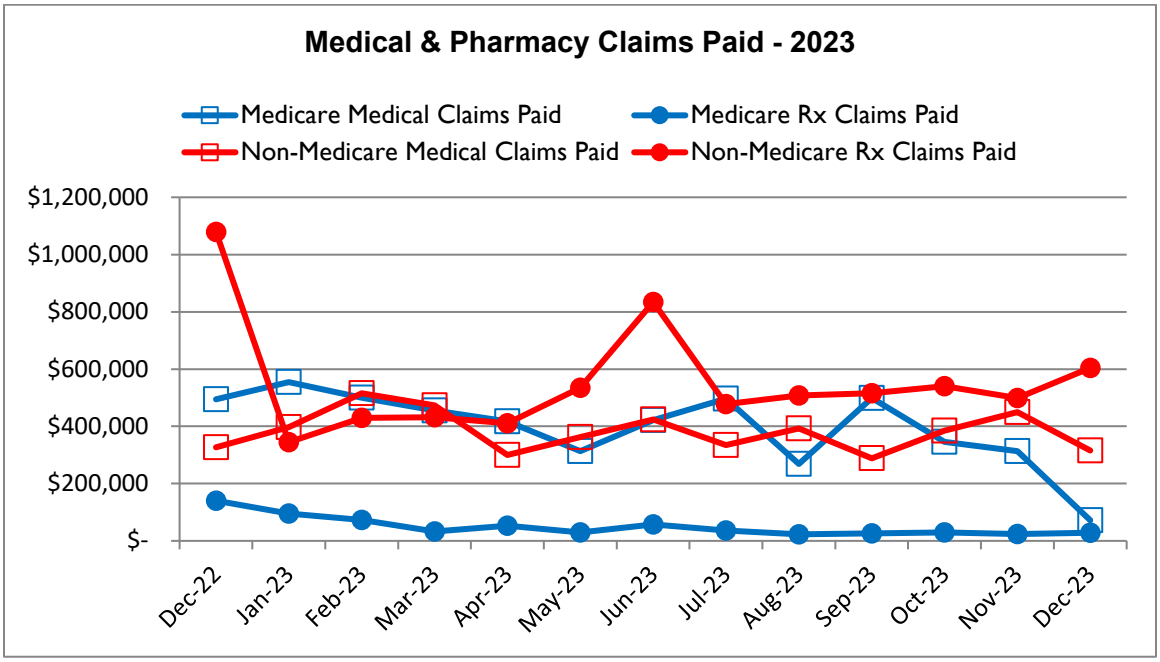
Pharmacy Benefits Manager
Express Scripts
1-800-859-8810
www.express-scripts.com

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

APPENDIX I - CHART A

Enrollment & Claims Summaries

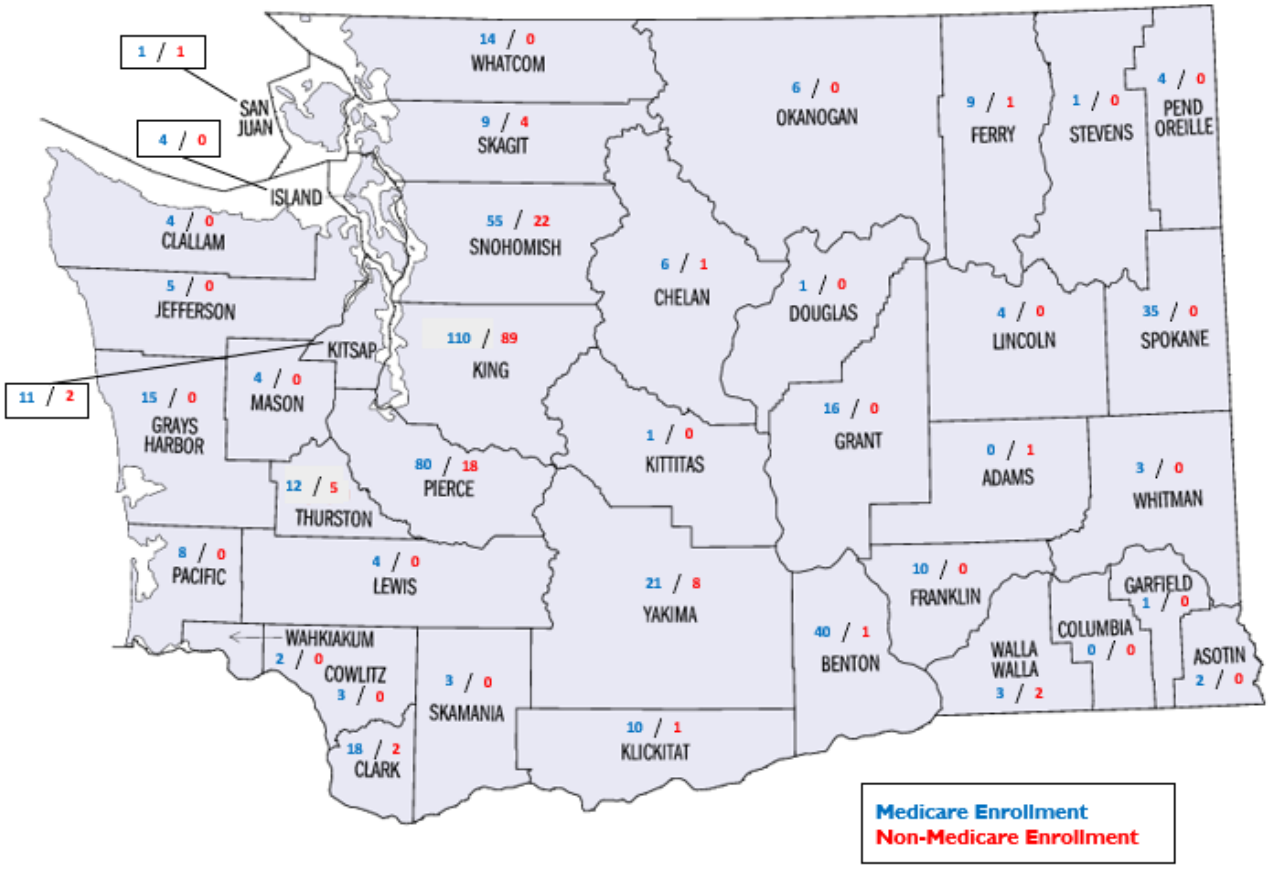




APPENDIX I – CHART B

Enrollment by County

Enrollment by County – 2023

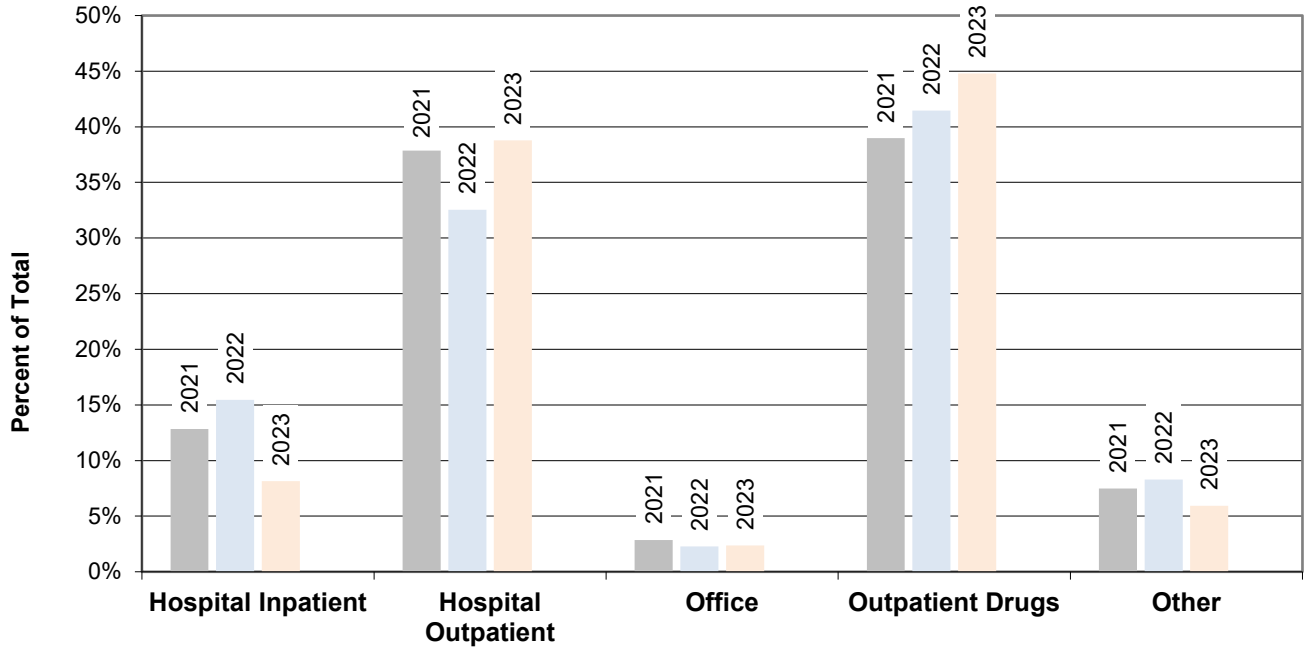


APPENDIX I – CHART C

Distribution of Claim Payments by Place of Service

Distribution of Claim Payments by Place of Service 2021–2023

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, 1988–2023; 2024 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	1405	$12,019,243	$12,155,085	$37,460,982	$1,924,105	$39,385,087	($27,230,002)
2020	1318	$8,174,887	$8,196,945	$27,924,914	$1,873,606	$29,798,520	($21,601,575)
2021	1197	$6,803,929	$6,806,973	$25,102,559	$1,710,645	$26,813,204	($20,009,275)
2022	882	$5,932,216	$6,075,786	$20,722,548	$1,152,625	$21,875,173	($15,799,387)
2023	742	$5,727,990	$6,220,627	$15,280,864	$1,249,675	$16,530,539	($10,309,912)
2024 proj	628	$4,805,056	$5,434,859	$13,999,828	$1,576,633	$15,576,461	($10,141,602)
Total			$447,464,663	$1,277,194,469	$63,583,739	$1,340,778,208	($893,316,089)

[1] Enrollment 1988-2000 as of year-end; 2001 and following 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 insurance reforms.
** 1998 administration costs include one-time claims settlement of $1.05 million.
*** Enrollment decreased in 2014 due to enrollees transitioning to the new Health Benefit Exchange.

APPENDIX I - CHART D

WSHIP Enrollment & Financial Summary

WSHIP Enrollment & Financial Summary, 1988–2023; 2024 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	$28,000,000	$2,336	$712.89	30.5%	4.8%	($19,380.78)
2020	$24,500,000	$1,884	$515.89	27.4%	6.3%	($16,406.40)
2021	$22,500,000	$1,867	$473.89	27.1%	6.8%	($15,181.54)
2022	$15,000,000	$1,952	$529.28	27.2%	5.5%	($17,913.14)
2023	$12,000,000	$1,857	$643.31	34.7%	7.6%	($13,894,76)
2024 proj	$6,000,000	$2,067	$637.61	30.8%	10.1%	($16,149.05)
Total	$920,782,306					

[1] Enrollment 1988-2000 as of year-end, 2001 and following average monthly enrollment.
[2] Premiums include investment income prior to 2005.
* 1998 administration costs include one-time claims settlement of $1.05 million.
** 2014 Assessments includes a $20.8 million assessment for a state mandated payment to the WA Health Benefit Exchange.

SIKICH®

WASHINGTON STATE HEALTH INSURANCE POOL

FINANCIAL STATEMENTS AND
INDEPENDENT AUDITOR'S REPORT

For the Years Ended December 31, 2023 and 2022

WASHINGTON STATE HEALTH INSURANCE POOL
TABLE OF CONTENTS

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INDEPENDENT AUDITOR'S REPORT

Board of Directors
Washington State Health Insurance Pool

Opinion

We have audited the accompanying financial statements of Washington State Health Insurance Pool (a nonprofit organization), which comprise the statements of financial position as of December 31, 2023 and 2022, and the related statements of activities and cash flows for the years then ended, and the related notes to the financial statements.

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, 2023 and 2022, and the changes in its net assets, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Washington State Health Insurance Pool and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America; and for 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.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Washington State Health Insurance Pool's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit 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 Washington State Health Insurance Pool's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Washington State Health Insurance Pool's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Sikich CPA LLC

Indianapolis, Indiana
May 8, 2024

FINANCIAL STATEMENTS

WASHINGTON STATE HEALTH INSURANCE POOL

STATEMENTS OF FINANCIAL POSITION

As of December 31, 2023 and 2022

	2023	2022
ASSETS		
ASSETS		
Cash and cash equivalents	$ 8,997,717	$ 9,138,244
Assessments receivable	3,585,569	2,643,527
Premiums receivable	183,341	71,841
Total assets	$ 12,766,627	$ 11,853,612
LIABILITIES AND NET ASSETS		
LIABILITIES		
Unpaid claims	2,704,000	3,237,000
Unpaid claims adjustment expenses	148,000	188,000
Assessments payable	95,202	105,249
Premiums received in advance	206,244	385,694
General expenses due and accrued	182,386	196,962
Total liabilities	3,335,832	4,112,905
NET ASSETS		
Without donor restrictions	9,430,795	7,740,707
TOTAL LIABILITIES AND NET ASSETS	$ 12,766,627	$ 11,853,612

See accompanying notes to financial statements.

WASHINGTON STATE HEALTH INSURANCE POOL

STATEMENTS OF ACTIVITIES

For the Years Ended December 31, 2023 and 2022

	2023	2022
REVENUES WITHOUT DONOR RESTRICTIONS		
Assessments	$ 12,000,000	$ 15,000,000
Net premium income	5,727,990	5,932,216
Interest income	492,637	143,570
	18,220,627	21,075,786
EXPENSES		
Program expenses:		
Hospital and medical benefits	14,914,776	20,212,007
Claim adjustment expenses	366,088	510,541
Total program expenses	15,280,864	20,722,548
Management and administrative expenses:		
Administrator fees	521,591	460,191
Personnel fees	431,631	412,829
Professional fees	210,045	160,573
Other expenses	86,408	119,032
Total management and general expenses	1,249,675	1,152,625
Total operating expenses	16,530,539	21,875,173
CHANGE IN NET ASSETS WITHOUT DONOR RESTRICTIONS	1,690,088	(799,387)
NET ASSETS, WITHOUT DONOR RESTRICTIONS, BEGINNING OF YEAR	7,740,707	8,540,094
NET ASSETS, WITHOUT DONOR RESTRICTIONS, END OF YEAR	$ 9,430,795	$ 7,740,707

See accompanying notes to financial statements.

WASHINGTON STATE HEALTH INSURANCE POOL

STATEMENTS OF CASH FLOWS

For the Years Ended December 31, 2023 and 2022

	2023	2022
CASH FLOWS FROM OPERATING ACTIVITIES		
Premiums collected	$ 5,434,036	$ 5,990,975
Claims and claims adjustment expenses paid	(15,558,994)	(23,061,007)
General and administrative expenses paid	(1,559,782)	(1,430,466)
Cash used by operating activities	(11,684,740)	(18,500,498)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest income	492,637	143,570
Cash provided by investing activities	492,635	143,570
CASH FLOWS FROM FINANCING ACTIVITIES		
Assessments collected	11,051,577	14,973,437
Cash provided by financing activities	11,051,577	14,973,437
CHANGE IN CASH AND CASH EQUIVALENTS	(140,526)	(3,383,491)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	9,138,244	12,521,735
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 8,997,717	$ 9,138,244

See accompanying notes to financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of 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 Accounting

The accompanying financial statements have been prepared in accordance with generally accepted accounting principles in the United States of America (USGAAP).

Use of Estimates

The preparation of financial statements in conformity with USGAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates.

Cash and Cash Equivalents

The Pool considers all highly liquid investments with an original maturity of three months or less to be cash equivalents.

Net Assets

Net assets, revenues and expenses, and gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

Without Donor Restrictions:

Net assets without donor restrictions represent funds which are fully available, at the discretion of management and the Board of Directors, for the Pool to utilize in any of its programs or supporting services. The funds can be either undesignated or Board designated for specific activities or programs and events. There were no net assets with board designations at December 31, 2023 and 2022, respectively.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Net Assets (Continued)

With Donor Restrictions:

Net assets with donor restrictions are comprised of funds which are restricted by donors for specific purposes. The restrictions are satisfied either by the passage of time or by actions of the Pool. Donor restrictions could also include resources with permanent donor-imposed restrictions, which require the assets to be maintained in perpetuity but permit the Pool to expend all or part of the income derived from the assets. There were no net assets with donor restrictions at December 31, 2023 and 2022, respectively.

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 recognized 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.

The unpaid claims and related expenses calculation methodology is consistent with that used in prior periods for all components. The Pool used the development method for medical and pharmacy claims as well as pharmacy invoices and pended claim information. The Pool also used actuarial judgment and projected per member per month incurred claims for the most recent incurred months. Additionally, the Pool considered large, pended claims of which they were aware.

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

Revenue Recognition

Net Premium Income

Premiums are earned pro rata over the period to which the premiums relate. Premiums received in advance represent amounts received in advance of the policy effective date. Premiums receivable represent monthly premiums due from policy holders. Premiums must be received by the Pool within 90 days of the due date or the policy holder is terminated from the pool. Delinquent premium payments are recognized as revenue upon collection and are not accrued. Based on information available, the Pool believes that no allowance for credit losses is required. However, actual write-offs may exceed the recorded allowance.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Revenue Recognition (Continued)

Assessments

Assessments of the insurer members are approved by the Board of Directors and are recognized as contribution revenue as there is no direct commensurate value received by the members for their contributions. 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. As the insurer members are required to pay the assessment by state statute, management has determined that no allowance for doubtful accounts is required. Assessments are not considered to have any donor restrictions as the money is used to fund operations of the Pool and are expected to be collected within the next year.

Concentration of Credit Risk

Deposits at the Pool's financial institutions are insured by the Federal Deposit Insurance Corporation up to $250,000. As of December 31, 2023 and 2022, the Pool had a balance in excess of the insured limit of approximately $8,914,000 and $9,225,000, respectively. The Pool has not experienced a loss due to uninsured balances and management believes it is not exposed to any significant credit risk on cash and cash equivalents.

Functional Expense Allocations

The costs of the supporting activities of the Pool have been summarized on a functional basis. All expenses are recorded directly to the corresponding function by account and therefore no allocations are necessary.

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) as other than a private foundation 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.

The Pool's 2022, 2021, and 2020 tax returns are subject to examination by the Internal Revenue Service.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Recent Accounting Guidance

In June 2016, the Financial Accounting Standards Board ("FASB") issued new guidance, Accounting Standards Update ("ASU") 2016-13 that created Topic 326, *Financial Instruments - Credit Losses*, in the Accounting Standards Codification ("ASC"). Topic 326 significantly changes how entities measure credit losses for most financial assets and certain other instruments that aren't measured at fair value through changes in net assets without donor restrictions. The most significant change in this standard is a shift from the incurred loss model to the expected loss model. Financial assets held by the Pool that are subject to the guidance in Topic 326 include premiums receivable.

The Pool adopted the standard as of January 1, 2023, utilizing the modified retrospective transition method. The adoption of this new accounting pronouncement did not have a material impact on the financial statements.

Subsequent Events

Subsequent events are events or transactions that occur after the balance sheet date but before financial statements are issued or are available to be issued. These events and transactions either provide additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing financial statements (that is, recognized subsequent events), or provide evidence about conditions that did not exist at the date of the balance sheet but arose after that date (that is, non-recognized subsequent events).

The Pool has evaluated subsequent events through May 8, 2024, which was the date that these financial statements were available for issuance and noted nothing additional to disclose.

2. 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:

	2023	2022
Balances at January 1	$ 3,425,000	$ 6,184,000
Policy benefits incurred related to:		
Current year	16,348,495	20,790,142
Prior years (redundancy)	(1,067,631)	(67,594)
Total policy benefits incurred	15,280,864	20,722,548
Paid related to:		
Current year	13,497,495	17,378,668
Prior years	2,356,369	6,102,880
Total paid	15,853,864	23,481,548
BALANCE AT DECEMBER 31	$ 2,852,000	$ 3,425,000

2. LIABILITY FOR UNPAID CLAIMS (Continued)

For the year ended December 31, 2023, prior year's liability for unpaid claims included no factors that were significant. 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.

The total liability for unpaid claims included incurred but not reported health claims (not including claim adjustment expenses of $148,000 and $188,000, respectively) of approximately $2,704,000 and $3,237,000 at December 31, 2023 and 2022, respectively. Substantially all of the IBNR balance at December 31, 2023 relates to the current year.

	Net Incurred Medical Costs For the Years Ended December 31	
Year	**2022**	**2023**
2022	$ 20,790,142	$ 19,496,405
2023		16,348,495
TOTAL		$ 35,844,900

	Net Cumulative Medical Payments For the Years Ended December 31	
Year	**2022**	**2023**
2022	$ (17,378,668)	$ (19,495,405)
2023		(13,497,495)
Total		(32,992,900)
Net remaining liabilities prior to 2022		-
TOTAL LIABILITY FOR UNPAID CLAIMS		$ 2,852,000

3. PLAN ADMINISTRATION AGREEMENT

The Pool has outsourced its administrative services to Benefit Management LLC (BML), a Kansas based third party administrator, under a service agreement effective through December 2023. 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 BML were $816,460 and $872,436 for the years ended December 31, 2023 and 2022, respectively. Included in fees paid to BML, $294,870 and $412,245 were considered to be claim adjustment expenses included in total claim adjustment expenses. Accordingly, at December 31, 2023 and 2022, $142,133 and $151,061 were due to BML and are recorded in general expenses due and accrued on the accompanying statements of financial position, respectively.

4. LIQUIDITY AND AVAILABILITY OF FINANCIAL ASSETS

The following reflects the Pool's financial assets for operating expenses within one year of the statements of financial position date:

	2023	2022
Cash and cash equivalents	$ 8,997,717	$ 9,138,244
Assessment receivable	3,585,569	2,643,527
Premiums receivable	183,341	71,841
TOTAL FINANCIAL ASSETS	$ 12,766,627	$ 11,853,612

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.

5. CONTINGENCY

The Pool is subject to an array of laws and regulations relating to the operations of the Pool. Under current laws and regulations, the Pool may be subject to litigation in the normal course of business. The management of the Pool believes that any liability that may result from any type of litigation is unlikely to have a material adverse effect on its financial condition as it has the authority to assess the insurer carriers for any such losses.