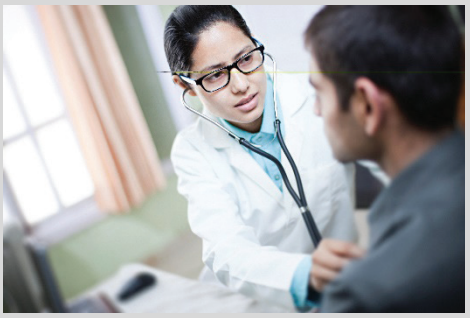
WSHIP
WASHINGTON STATE
HEALTH INSURANCE POOL

2016 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 2017

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. The report summarizes the Pool's operations and accomplishments for calendar year 2016.

Overall, WSHIP experienced a 6.3% decrease in enrollment during 2016. Total enrollment declined from 1,556 in 2015 to 1,458. At year-end, enrollment in WSHIP's non-Medicare plans totaled 421, and 1,037 were enrolled in a WSHIP Medicare plan. WSHIP's non-Medicare plans remained closed to new enrollment because individual plans were offered in all counties. Our Medicare-eligible plan remains open to 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 11.4% from $45.6 million to $40.4 million. Assessments to Member Plans were $31.4 million in 2016 (an estimated $0.85 pmpm). WSHIP assessments for 2017 are currently projected to be $29 million. The Board continues to implement new cost saving measures including enhanced pharmacy pricing for 2017. Most recently, the Board voted to discontinue WSHIP's indemnity plan option (the "Standard Plan") at the end of this year which is anticipated to provide additional reductions in WSHIP's costs. Premiums for all WSHIP Preferred Provider (PPO) plans were set at the lowest rate allowed by law – 110% of the average market rate for comparable coverage.

On April 25, 2017, Governor Inslee signed into law Second Substitute House Bill 1338 which extends the scheduled 2017 sunset of WSHIP's non-Medicare program to December 31, 2022 and expresses the intent of the Legislature to further study the role of WSHIP in the future, as well as its funding mechanism. This bill is consistent with the recommendations of the WSHIP Board, and we look forward to continuing our dialogue with policy makers on coverage issues for high risk individuals and the future of the Pool. WSHIP's Executive Director, Sharon Becker, is available to answer your questions or provide additional information. Please contact Sharon at (360) 671-2101 or by email at sbecker@wship.org. I may be contacted at (509) 264-1248 or by email at spkoos@hotmail.com.

Sincerely,

Shaun Koos

Shaun Koos, Chairman of the Board

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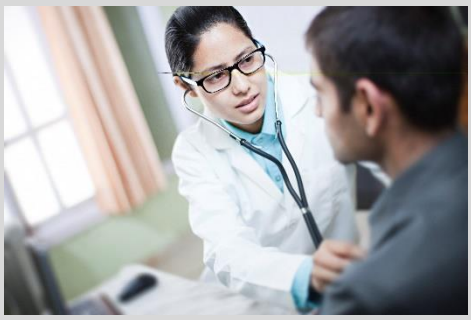

About WSHIP

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 fourth 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 who are 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. 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 rules for WSHIP's non-Medicare plans were changed in 2014 to limit enrollment to individuals enrolled in WSHIP prior to December 31, 2013 or individuals residing in a county where individual plans are not offered. No changes were made to WSHIP's Medicare-eligible program.

In total, WSHIP provided coverage to 1,458 individuals as of December 31, 2016. This represents an overall decrease of 6.3% from 2015. Total claims costs were $40.4 million, a decrease of 11.4% from 2015.

Non-Medicare: WSHIP's non-Medicare plans remained closed to new enrollment in 2016 since individual health plans were offered in all counties. 421 enrollees remained in these plans at year-end. Of those, 253 are individuals with HIV/AIDS who are sponsored by the Evergreen Health Insurance Program (EHIP).

Medicare: WSHIP's Medicare plans provided supplemental coverage to 1,037 enrollees.

Key Facts & Figures

Enrollment

▪ Total WSHIP enrollment as of 12/31/16:	**1,458**	(6.3% decrease from 2015)
Non-Medicare Plans:	421	(29% of total enrollment)
Medicare Plans:	1,037	(71% of total enrollment)

Total Revenue	$42.5 million	**Total Expenses**	$42.6 million
▪ Premiums	$11.1 million	▪ Medical Claims	$25.4 million
▪ Assessments	$31.4 million (est. $0.85 pmpm*)	▪ Rx Claims	$15.0 million
▪ Other	$0	▪ Administration	$ 2.2 million (5.2%)

* 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: $19.1 million
- Care Management Program Savings: $513,747
- Pharmacy Network and State Pharmacy Assistance Program Savings: $8.8 and $3 million

EXECUTIVE SUMMARY

Key Accomplishments

- Conducted follow-up dialogue with the Legislature on the findings of WSHIP's 2015 study entitled, "WSHIP After the ACA: A Study of High Risk Populations with Washington State Health Insurance Pool (WSHIP) Coverage and Barriers that Remain in Accessing Comprehensive Coverage Alternatives."

- Continued our communication plan to help enrollees understand the Affordable Care Act (ACA) and new coverage options.

- Audited our Pharmacy Benefits Manager.

- Negotiated improved pharmacy pricing effective January 1, 2017.

- Developed a new glucose monitoring care management program.

Future Considerations

WSHIP's policy agenda for 2017 focuses on the current challenges and uncertainties facing the individual market and the recommendations in the study that was requested by the Legislature in late 2015 concerning the populations that may need ongoing coverage through the Pool.

Specifically, the Board recommends:

1. Delaying the scheduled 2017 sunset of WSHIP's non-Medicare plans due to concerns that some enrollees may be left without coverage, and growing concerns about its impacts to the individual market (such as higher premiums), coverage availability, and potential federal changes to the Affordable Care Act.

2. Continuing WSHIP's Medicare Supplement coverage to Washington residents who are covered by Medicare and cannot obtain a Medicare Supplement or Medicare Advantage plan.

3. Maintaining the current or similar funding mechanism, and working with the Legislature to address ongoing funding of the Pool.

As of the date of this report, Second Substitute House Bill 1338 was passed by the Legislature which extends the scheduled sunset of WSHIP's non-Medicare plans to December 31, 2022 and expresses the intent of the Legislature to further study the role of WSHIP in the future, as well as its funding mechanism.

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 since 2000. In 2013, it was amended to address health care reforms that were implemented January 1, 2014 as part of the Affordable Care Act. These included changes to restrict eligibility for WSHIP non-Medicare plans, 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 again 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.

Key Historical Facts

Benefit Plans – The benefit plans created by statute in 1987 are comprehensive plans with relatively low deductibles and out-of-pocket maximums. 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.

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 2016 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 access, accounting, and reporting. BML works closely with WSHIP's other contractors who provide pharmacy, provider network, care management, 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. Care management services are provided by MedWatch. These services include utilization management, integrated case management, and disease management. Tobacco cessation services are provided by Optum.

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.

Significant Accomplishments

Legislative Study Follow-up

WSHIP continued its dialogue with legislators and others on the findings of WSHIP's 2015 study entitled, "WSHIP After the ACA: A Study of High Risk Populations with Washington State Health Insurance Pool (WSHIP) Coverage and Barriers that Remain in Accessing Comprehensive Coverage Alternatives." The study recommended that the sunset of WSHIP's non-Medicare program should be delayed, and WSHIP's Medicare program should remain open until additional options are available to address the barriers in accessing Medicare supplemental coverage.

Since the study, additional concerns were raised about discontinuing WSHIP's non-Medicare coverage at the end of 2017, largely due to increased challenges and uncertainties facing the individual market. These included the financial impact to the individual market, losing WSHIP as a safety net in the event there are counties in 2018 with no individual coverage options, and potential federal legislation related to the Affordable Care Act. The WSHIP Board unanimously recommended a delay in the sunset of WSHIP's non-Medicare program. (Second Substitute House Bill 1338 was passed by the Legislature in April 2017 which extends the sunset of WSHIP's non-Medicare plans to December 31, 2022 and expresses the intent of the Legislature to further study the role of WSHIP in the future, as well as its funding mechanism.)

Health Reform Communications

WSHIP continued its extensive communication plan 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.

Pharmacy Benefit Manager Audit

WSHIP conducted a full external audit of its Pharmacy Benefits Manager, in keeping with its usual practice to periodically audit its vendors.

Enhanced Pharmacy Pricing

WSHIP worked with Express Scripts on a new pricing program which includes improved rebate guarantees and additional discounts for Hepatitis C and oncology medications effective January 1, 2017.

New Glucose Monitoring Program

WSHIP worked with its care management provider, MedWatch, to make available a new glucose monitoring program to WSHIP non-Medicare enrollees in 2017. The program utilizes a cellular-enabled blood glucose meter that automatically triggers the transmission of data 24/7/365 to program staff who alert patients and the clinical team to critical readings and allow care coaches to work with the patient to get their glucose levels back in control.

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 2016; 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 2016 there were 12 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 6.3% in 2016, with a total of 1,458 individuals enrolled in the Pool at year-end. Enrollment of Evergreen Health Insurance Program (EHIP) participants (serving low-income clients with HIV/AIDS) decreased 4% from 264 enrollees to 253 in 2016.

Age & Demographics

The average age of enrollees in the Pool increased from 54 to 55 years. Approximately 48% of all WSHIP enrollees were enrolled in Medicare due to disability. 67% of Medicare enrollees were under age 65.

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

39% of WSHIP enrollees paid their premiums themselves compared to 44% in 2015. 61% of premiums were paid by a foundation or state agency compared to 56% in 2015.

Tobacco Use

Approximately 20% of WSHIP enrollees report using tobacco.

Average Length of Enrollment

At year-end WSHIP enrollees had been covered by the Pool an average of 6.5 years. Of the total enrollment, 25% were covered by the Pool for more than 10 years; 22% between 5 and 10 years; and 30% for 2 to 5 years. Overall, 77% of enrollees have been covered by the Pool for 2 years or more.

Disenrollment

In 2016, 406 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 55 years old and has been covered by the Pool for 6.5 years.

2016 HIGHLIGHTS

Enrollment & Services

Benefit Plans

In 2016 WSHIP had five benefit plans: three plans for enrollees who are not enrolled in Medicare and two plans for those enrolled in Medicare.

Non-Medicare Plans (29% of enrollment)

- **Standard Plan** – $500, $1,000, and $1,500 Deductibles (same benefit level for network and out-of-network providers)

- **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 (71% 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 enrollment in non-Medicare plans was in the $500 deductible PPO Plan (91% of whom had their premiums paid by third parties). The Basic Plan had 80% of Medicare enrollment. (The Basic Plus Plan has been closed to new enrollment since 2008.)

	Standard Plan		
Age	$500	$1,000	$1,500
0-18	4	0	0
19-29	4	0	2
30-34	1	0	1
35-39	3	0	0
40-44	4	0	0
45-49	1	1	1
50-54	6	2	2
55-59	0	0	0
60-64	1	1	1
65-69	0	0	1
70-74	2	0	0
75-79	0	0	0
80-84	0	0	0
85+	0	0	0
Total	26	4	8
Total STD Plan Enrollment = 38			

	PPO Plan			
Age	$500	$1,000	$2,500	$5,000
0-18	11	2	0	1
19-29	9	4	5	0
30-34	32	5	1	0
35-39	51	1	2	1
40-44	59	2	4	2
45-49	55	0	9	2
50-54	35	3	5	1
55-59	20	1	8	3
60-64	12	4	11	5
65-69	2	0	0	0
70-74	1	0	0	0
75-79	0	0	1	0
80-84	0	0	0	0
85+	0	0	0	0
Total	287	22	46	15
Total PPO Plan Enrollment = 383				

	HSA Qual PPO Plan
Age	$3,000
0-18	0
19-29	0
30-34	0
35-39	0
40-44	2
45-49	2
50-54	0
55-59	4
60-64	5
65-69	0
70-74	0
75-79	0
80-84	0
85+	0
Total	13

Total Non-Medicare Enrollment = 421

	Basic Plan	Basic Plus Plan
Age		
0-18	0	0
19-29	8	0
30-34	15	1
35-39	25	0
40-44	49	3
45-49	71	4
50-54	105	17
55-59	147	29
60-64	180	42
65-69	105	36
70-74	70	36
75-79	29	22
80-84	19	15
85+	6	3
Total	829	208
Total Medicare Enrollment = 1,037		

Total Enrollment = 1,458

Care Management Programs

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 – 2016	
Number of inpatient medical necessity reviews completed	72
Number of Bed Days	408
Percentage of inpatient days that did not meet medical necessity criteria	1.4%
Number of outpatient procedures or 23-hour stay reviews completed	3
Percentage of outpatient reviews that did not meet medical necessity criteria	0%
Reduction in inpatient utilization stays from previous year	45%
Inpatient Admissions/1,000 enrollees	159
Bed Days/1,000 enrollees	903
Average Length of Stay Days	5.67
Projected annual inpatient program savings	$98,688
Return on Investment (ROI) (savings per every dollar spent)	$8:1

Integrated Case Management (ICM)

WSHIP provides Medical and Behavioral Case Management in an integrated process. The process includes identification, through utilization management, care coaching and claims analysis, of enrollees who would most benefit from case management. Enrollees must consent to participate in the process. Care is coordinated and facilitated through comprehensive intake assessments and interactions between case managers, enrollees and their providers. Enrollee and provider education is initiated along with motivational techniques to promote compliance with individualized treatment plans and to ensure that the highest quality of care is delivered.

Integrated Case Management – 2016	
	Medical Case Management
Managed Medical Case Management	108
Behavioral Case Management	2
Average hours per case	9.38
WSHIP Membership with CM Activity	23.9%
Projected annual savings for medical and behavioral case management	$415,059
Return on Investment (ROI) (savings per every dollar spent)	$3:1

Total Care Management Program Savings: $513,747

Care Coaching

WSHIP offers a unique 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.).

- Tailored to WSHIP's unique populations, Care Coaching:
  - Reaches out to identified populations with creative engagement strategies
  - Provides a dedicated care coach with behavioral health expertise
  - Promotes greater self-management of member health conditions
  - Improves quality of life and clinical outcomes
  - Reduces overall health care costs for the enrollee and the health plan
- Enrollees are identified and targeted for outreach and engagement using proprietary techniques that include:
  - Predictive modeling using available data sources such as claims data
  - Behavioral health factors
  - Risk/cost influencers
  - Identification of enrollees with non-adherence issues resulting in better adherence to all aspects of their care plan
- Due to the clinical intensity of the enrollees remaining in WSHIP, there has been an increase in the level of care necessary to manage care. 26% of the enrollees are managed in Integrated Case Management versus the Care Coaching program.

2016 Care Coaching Activities

Care Coaching Activity	2016	Definition
Total Participant Interactions	323	Contact with participant or participant's provider
Nurse Activity	181	Education\coaching session or reviewing clinical information

New Program for 2017 – Glucose Monitoring

In 2017, a glucose monitoring program will be available to eligible enrollees. This program utilizes a cellular-enabled blood glucose meter that automatically triggers the transmission of data 24/7/365 to program staff who alert patients and the clinical team to critical readings and allow care coaches to work with the patient to get their glucose levels back in control.

Customer Service & Website Activities

Telephone Activity

An average of 37 telephone inquiries per day was received by the Pool's Customer Service Representatives in 2016. The most common inquiries related to: (1) claims status; (2) verifying benefits; and (3) enrollee eligibility/ID card.

Website Activity

There was an average of 19 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 three sources:

1. Premiums

For 2016 the WSHIP Board continued to set the premium rate for all Preferred Provider Plans at 110% of the Standard Risk Rate (SRR) – 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.

Standard Plan premiums were set at 150% of the SRR, as were the rates for Medicare enrollees age 65 and over. Premiums for Medicare enrollees under age 65 continued to be set at 110% of the SRR. 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 2016 was 110% for Preferred Provider Plans, 133% for Standard Plans, and 115% for Medicare.

In 2016 premiums totaled $11.1 million.

The average monthly premium paid in 2016 for all enrollees was $629 compared to $604 in 2015. Non-Medicare enrollees paid an average monthly premium of $1,037; Medicare enrollees paid an average monthly premium of $398. (Note: These averages reflect the age and plan distribution of WSHIP's 2016 enrollment. For example, the average age for WSHIP's non-Medicare enrollment was 44 yrs. and most enrollees selected the lowest deductible PPO plan which has more expensive premiums than PPO plans with higher deductibles.)

61% of all enrollees' premiums were paid by a third party.

The percent of total costs covered by premium was 26%.

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 2016 Member Plan assessments totaled $31.4 million (an estimated $0.85 pmpm).

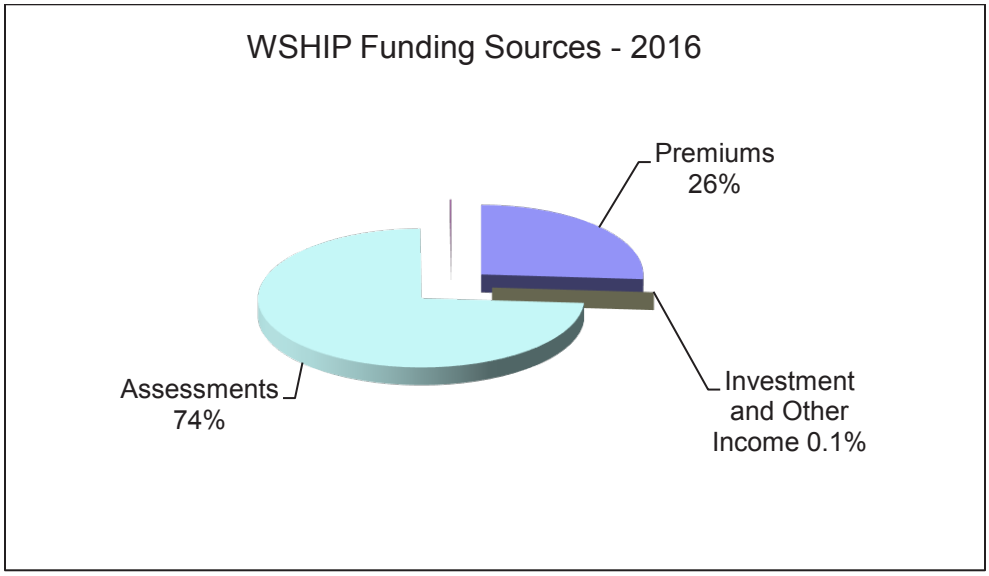
The percent of total costs covered by assessments was 74%.

3. Interest Income

Interest earned on funds held by WSHIP for future claim payments totaled $21,598.

Allocated Funds

Under RCW 48.41, the Pool has a general account with the state treasurer. The account can provide funds 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 threshold since 2004, no funds have been allocated to the account since it was established by the Legislature.



Claims Costs

Total Claims Costs

Total claims paid in 2016 were $40.4 million, a decrease of 11.4% from 2015. 63% of claims were for medical claims and 37% for prescription drugs. The average cost per enrollee was $27,528 compared to $28,529 in 2015, a decrease of 3.5%.

Total Claim Costs
01/01/2016 – 12/31/2016

		Average cost per enrollee
Medical Claims	$25.4 million	$17,280
Pharmacy Claims	$15.0 million	$10,248
Total Claims	**$40.4 million**	**$27,528**

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.

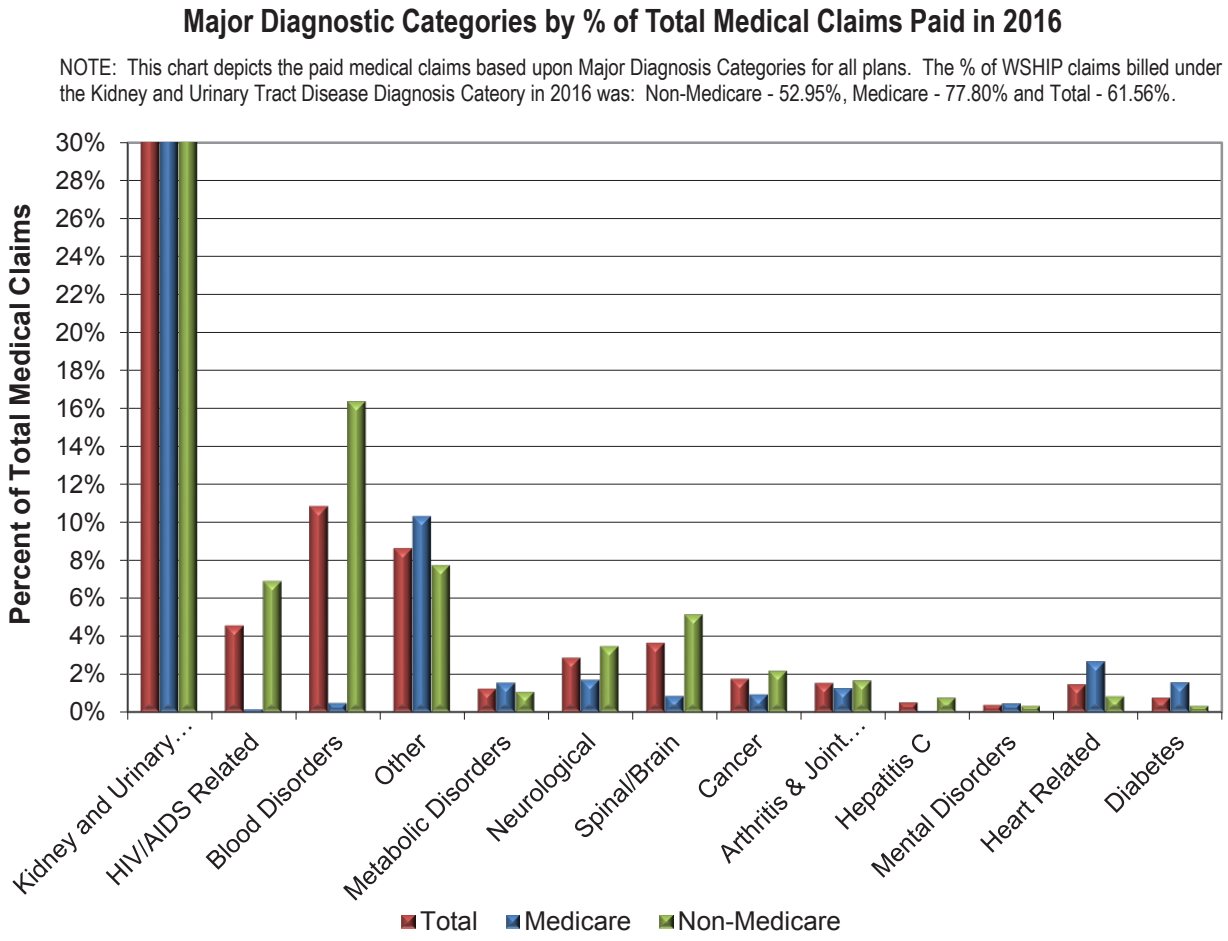
Non-Medicare vs. Medicare Claim Costs
01/01/2016 – 12/31/2016

	Non-Medicare	***Medicare***
Enrollment Count	421	1,037
Medical Claims	$16.0 million	$ 9.4 million
Pharmacy Claims	$13.9 million	$ 1.1 million
Total Claims	**$29.9 million**	**$10.5 million**
Loss Ratio	**570%**	**219%**
Claims Per Member Per Month (PMPM)	**$5,754**	**$846**

Conditions Treated

Medical Costs by Diagnostic Category

Over 61% of total medical benefits paid in 2016 were related to the treatment of kidney disease (and other diseases of the genitourinary system).



Non-Medicare vs. Medicare Costs by Diagnostic Category

The top diagnostic category for total claims (medical and pharmacy) for non-Medicare enrollees and Medicare enrollees was as follows:

Non-Medicare: HIV/AIDS

Medicare: Kidney and Urinary Tract Disease

Pharmacy

Pharmacy Costs by Therapeutic Category

The ten indications identified below represented 87.1% of total pharmacy costs in 2016 led by those related to the treatment of HIV/AIDS.

Top 10 Indications by Pharmacy Cost

2016 Rank	Indication	Patients	Plan Cost	Plan Cost PMPM
1	HIV	280	$8,241,932	$466.59
2	HEREDITARY ANGIOEDEMA	2	$1,841,551	$104.25
3	URINARY DISORDERS	77	$868,814	$49.19
4	INFLAMMATORY CONDITIONS	27	$482,643	$27.32
5	CANCER	35	$420,095	$23.78
6	MULTIPLE SCLEROSIS	12	$396,129	$22.43
7	PAIN/INFLAMMATION	320	$387,193	$21.92
8	HEPATITIS C	4	$337,583	$19.11
9	CYSTIC FIBROSIS	3	$287,219	$16.26
10	ENDOCRINE DISORDERS	33	$221,391	$12.53

HIV/AIDS Drugs

In 2016, 53.2% 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 over 4.5 times higher than the average WSHIP enrollee.

Top 25 Drugs by Cost

2016 Rank	Drug Name	Indication	Patients	Plan Cost	Plan Cost PMPM
1	TRUVADA*	HIV	127	$1,714,014	$97.03
2	CINRYZE*	HEREDITARY ANGIOEDEMA	2	$1,195,012	$67.65
3	ATRIPLA	HIV	56	$1,088,414	$61.62
4	TIVICAY	HIV	70	$875,959	$49.59
5	PROCYSBI*	URINARY DISORDERS	2	$837,209	$47.40
6	STRIBILD	HIV	33	$710,039	$40.20
7	COMPLERA	HIV	33	$699,096	$39.58
8	FIRAZYR*	HEREDITARY ANGIOEDEMA	1	$646,539	$36.60
9	PREZISTA	HIV	44	$563,148	$31.88
10	GENVOYA	HIV	29	$483,859	$27.39
11	REYATAZ	HIV	38	$378,424	$21.42
12	TRIUMEQ	HIV	20	$377,095	$21.35
13	ISENTRESS	HIV	35	$366,233	$20.73
14	ODEFSEY	HIV	21	$252,121	$14.27
15	COPAXONE*	MULTIPLE SCLEROSIS	5	$207,943	$11.77
16	SENSIPAR*	ENDOCRINE DISORDERS	23	$204,847	$11.60
17	HARVONI*	HEPATITIS C	2	$194,870	$11.03
18	ENBREL*	INFLAMMATORY CONDITIONS	3	$193,553	$10.96
19	RENVELA	KIDNEY DISEASE	21	$165,181	$9.35
20	NORVIR	HIV	78	$143,519	$8.12
21	VIEKIRA PAK*	HEPATITIS C	2	$141,715	$8.02
22	SIMPONI*	INFLAMMATORY CONDITIONS	1	$128,955	$7.30
23	OXYCONTIN	PAIN/INFLAMMATION	15	$124,487	$7.05
24	PULMOZYME*	CYSTIC FIBROSIS	3	$121,395	$6.87
25	IMATINIB MESYLATE*	CANCER	3	$119,770	$6.78

* Specialty Drugs

Pharmacy Trend

In 2016 pharmacy utilization increased for WSHIP non-Medicare plans and decreased for Medicare plans. Overall pharmacy costs remained flat year over year. The pharmacy cost per member per month (pmpm) for non-Medicare plans was $2,742, up 49.5%. The pmpm for Medicare plans was $107, down 10.2% primarily due to the decrease in overall enrollment.

Pharmacy Clinical Programs

WSHIP has coverage authorization programs, including step therapy, quantity management and prior authorization for 33 categories of drugs. 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's savings from use of pharmacy clinical programs in 2016 was $764,753, a 200% increase over the $254,715 saved in 2015.

WSHIP also employs a comprehensive suite of utilization management rules for specialty medications. These rules help to ensure that enrollees are utilizing clinically appropriate medications. Use of these rules also results in cost savings. These rules also apply to new specialty drugs that come to market.

WSHIP continues to utilize the Personalized Medicine Program provided by Express Scripts which was expanded in 2012 to include available tests related to therapy using certain HIV and oral oncology products. 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.

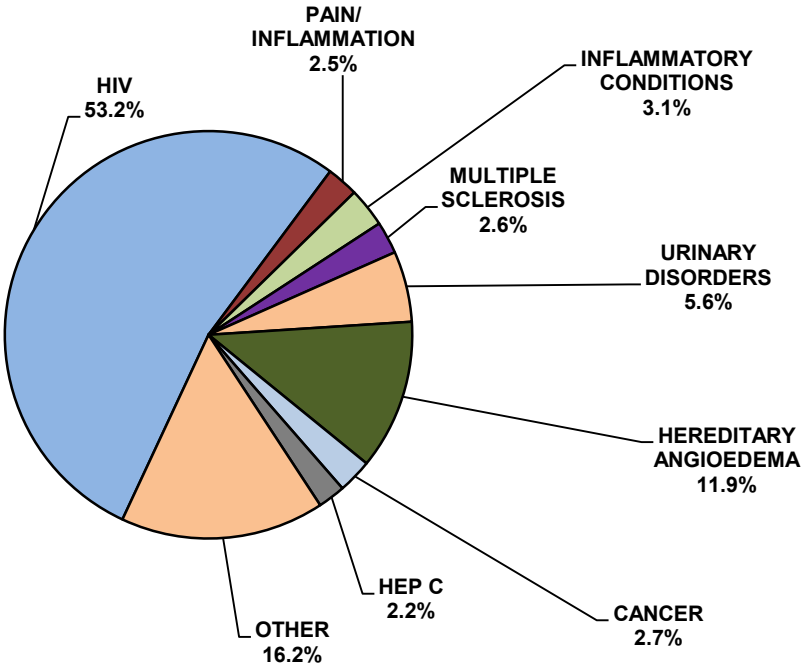
Pharmacy Costs – How WSHIP Compares to Other Risk Pools

WSHIP's enrollee contribution to the overall cost of drugs (2.5%) is significantly less than the average for Express Script's total state high risk pool business (16.9%).

WSHIP's percentage of pharmacy costs related to HIV/AIDS therapy is significantly higher than other state high risk pools and Express Script's commercial book of business.

The charts on the next page show a comparison of WSHIP to Express Script's peer high risk pool and commercial business.

2016 WSHIP



2016 WSHIP Comparison of Pharmacy Costs

2016	WSHIP	Risk Pool Peer	Commercial Division Peer
HIV	53.2%	16.6%	7.0%
PAIN / INFLAMMATION	2.5%	11.4%	10.1%
INFLAMMATORY CONDITIONS	3.1%	27.0%	25.1%
MULTIPLE SCLEROSIS	2.6%	6.3%	10.0%
URINARY DISORDERS	5.6%	0.5%	3.7%
HEREDITARY ANGIOEDEMA	11.9%	0.0%	0.4%
CANCER	2.7%	0.0%	15.1%
HEP C	2.2%	0.0%	4.2%
OTHER	16.2%	38.2%	24.4%

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. Enrollees are eligible for Part D catastrophic coverage once TrOOP has been satisfied. This results in lower out-of-pocket costs for enrollees and lower pharmacy claim costs for WSHIP.

In 2016, the total estimated SPAP savings to WSHIP was $3 million. This amount is approximately $1 million less than last year primarily due to a decrease in Basic Plus Plan enrollment and a decrease in savings per enrollee.

Cost Containment

WSHIP utilizes the First Choice Health Network for its provider network and claims pricing. In 2016, 85% of claim dollars were paid to network providers. Eligible charges were discounted an average of 54% as a result of network provider contracts. These negotiated provider discounts reduced the Pool's medical claim costs by $19.1 million.

Pharmacy cost savings were achieved through Express Script's pharmacy network contract pricing. These discounts reduced the Pool's pharmacy costs by $8.8 million in 2016.

Administrative Expenses

Total administrative expenses for 2016 were $2.2 million or 5.2% of total expenses.

Future Considerations

The WSHIP Board annually identifies issues that are important to address with respect to the needs of WSHIP's stakeholders and operations. The Board includes representatives for consumers, providers, small and large employers, agents, health plans, and the Insurance Commissioner or designee.

WSHIP's 2017 Policy Agenda is summarized below:

1. **Delay 2017 Sunset of WSHIP Non-Medicare Plans**
   RCW 48.41 requires WSHIP to end its non-Medicare plans on December 31, 2017. The Board is concerned that some of the high risk enrollees in these plans may be left without coverage. Additionally, there are growing concerns about its impact to the individual market (such as higher premiums) given the market's current challenges. Continuing WSHIP coverage for these high cost enrollees will avoid further stress on the market and support market sustainability efforts consistent with the Pool's original intent.

2. **Continue WSHIP's Medicare Supplement Coverage**
   The Board recommends continuing WSHIP's role in providing supplemental coverage to Washington residents who are covered by Medicare and cannot obtain a Medicare Supplement or Medicare Advantage plan. Many of these enrollees are under age 65 and have End Stage Renal Disease (ESRD). They depend on WSHIP supplemental coverage for dialysis out-of-pocket costs and kidney transplant consideration.

3. **Maintain Current or Similar Funding Mechanism; Work With Legislature to Address Ongoing Funding of the Pool**
   To coincide with maintaining WSHIP's Medicare program and closed-enrollment non-Medicare program, the Board recommends keeping the current funding mechanism in place and working with the Legislature to address ongoing funding of the Pool.

NOTE: On April 25, 2017, Governor Inslee signed into law Second Substitute House Bill 1338 which extends the scheduled 2017 sunset of WSHIP's non-Medicare plans to December 31, 2022 and expresses the intent of the Legislature to further study the role of WSHIP in the future, as well as its funding mechanism.

BOARD OF DIRECTORS & ADMINISTRATION

Board Members

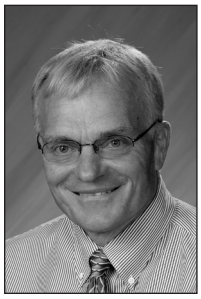
Andrea (Andi) N. Bailey **RN**, appointed by the Governor in 2011, is a representative for small employers. She owns Alliance Nursing, a home health company that provides private duty nursing to medically fragile adults and children in the client's home or in one of Alliance Nursing's three Adult Family Homes. Alliance Nursing (formerly Acute Care) has been in business since 1989 and currently has approximately 175 employees. Andi is currently a member of the Women Presidents Organization, where other women-owned companies help each other solve business issues. Andi is active in the Washington Medical Case Managers Association (WMCMA) and the Home Care Association of Washington. Both of these organizations work to solve issues in health care and provide education to support members. Alliance Nursing is a member of the Association of Washington Business to stay current with legislative and governmental issues and a means to support businesses in Washington State. Alliance Nursing is also a member of the Washington Policy Center. Andi is active in the Busy Bee and Stray Threads Quilt Guilds. As a Gold Star Mother, she serves as the Washington State Treasurer, which helps to provide support for veteran organizations and support to mothers who have lost their children while serving in the military.

Roger Bairstow, appointed by the Governor in 2015, is a representative for large employers. Roger currently serves as an Executive on Broetje Orchard's managing Board, 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, Snake River Housing Inc., C.A.S.A. LLC and Mano à Mano, a Washington State non-profit.

Jamie Clark is a representative for Disability/Stop Loss Member Plans, elected in 2013. She is the Director of Accountable Care Organization Programs for the West Region with UnitedHealthcare and has been with United since 2011. Prior to working for UnitedHealthcare, Jamie held positions with Evergreen Hospital Medical Center, a law firm, and worked in pharmaceutical sales. Jamie earned her Juris Doctor and Masters in Business Administration from Seattle University and a BA from the University of Washington.

BOARD OF DIRECTORS & ADMINISTRATION

AnnaLisa Gellermann joined the Board in 2016 as an ex-officio, non-voting board member representing the Insurance Commissioner. She is the Deputy Insurance Commissioner for Policy and Legislative Affairs and was most recently the Deputy Insurance Commissioner for Legal Affairs. Prior to joining the OIC, AnnaLisa was an executive manager in Insurance Services at the Department of Labor and Industries, heading the Integrated Claims Services Program (ICS), which included Legal Services, Return to Work Services, Policy, and Pension programs. 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.



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 in 1976 and completed the MHA program at University of Washington in 1982. 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 an active member of the Leavenworth Winter Sports Club and the Wenatchee Row and Paddle Club, and a former board member of USA Canoe/Kayak.

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.

BOARD OF DIRECTORS & ADMINISTRATION

Alison Mondi, appointed by the Governor in 2015, is a representative for consumers. Alison is the Policy Advocate & Analyst for the Washington Dental Service 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.

Scott Plack is a representative for Health Maintenance Organization (HMO) carriers, elected in 2010. Scott is Kaiser Permanente of Washington's Director of State Government Relations and has been at Kaiser Permanente (formerly Group Health Cooperative) since 1993. His responsibilities involve federal and state legislative strategy development and management of regulatory and legislative issues. Scott previously served in a policy capacity for two state legislatures: as Senior Analyst for the Washington State Senate Health and Long-Term Care Committee and as Director of the Subcommittee on Health Care for the Texas State Senate. Scott has a Bachelor of Arts degree from the University of Texas at Austin and a Master's Degree in Public Administration from the University of Washington. He serves on several boards.

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. The firm specializes in finding innovative solutions for employer groups and individuals through all aspects of insurance, compensation, and related risk management issues. 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. In addition to Mark's work and family commitments, he is actively involved with several non-profit organizations. Mark is currently on the Board of Directors for Families Like Ours and serves on the Program Committee and Advisory Board for Treehouse. These organizations provide financial and administrative support to pre- & post-adoptive families.

Sheela Tallman is a representative for Health Care Service Contractors, elected in 2014. She is Senior Manager of Legislative Policy at Premera Blue Cross and serves as Senior Legislative Affairs Executive for Premera in Alaska. Sheela is responsible for managing state legislative and public policy issues in Washington, Oregon, and Alaska and at the federal level. She develops positions on various legislative healthcare issues, testifies at hearings, and communicates with elected officials and key stakeholders. She is the current Board Chair of the Association of Washington Healthcare Plans and has been a board member since 2008. Before joining Premera in 2006, Sheela was a manager at Deloitte Consulting, based out of the Houston, TX office. She focused on public sector clients in the U.S. State and Federal Governments working on healthcare strategy and operations and technology integration projects. She has more than ten years' experience in healthcare policy. Sheela has a bachelor of science in Biology from Tufts University and has dual master's degrees in Public Health and Public Affairs from Columbia University.

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 2016

We extend our appreciation to the following Board member who served on the WSHIP Board in 2016:

Jason Siems joined the Board in 2013 as an ex-officio, non-voting board member representing the Insurance Commissioner. He was the Deputy Insurance Commissioner for Policy and Legislative Affairs. Prior to joining the OIC, Jason was the Legal Services Manager for the Washington State Health Care Authority. Prior to joining the Health Care Authority in 2006, Jason worked as a Deputy Attorney General for the state of Idaho, representing the five northern counties of Idaho. Jason also worked as a Deputy Public Defender in Coeur d'Alene, Idaho. Jason earned his Juris Doctorate degree from the University of Idaho and his B.A. from Brigham Young University.

BOARD OF DIRECTORS & ADMINISTRATION

Board Committees

Executive Committee

Chair as of December 31, 2016: Shaun Koos. The following Board members served on this committee in 2016: Lisa Matthews, Scott Plack and Mark Rose.

Board Governance Committee

Chair as of December 31, 2016: Kristen Walter Wright. The following Board members served on this committee in 2016: AnnaLisa Gellermann, Shaun Koos, Lisa Matthews and Jason Siems.

Grievance Committee

Chair as of December 31, 2016: Andi Bailey. The following Board members served on this committee in 2016: Alison Mondi, Wendy Galloway (OIC) and Sheela Tallman.

Planning Committee

Chair as of December 31, 2016: Jamie Clark. The following Board members served on this committee in 2016: Roger Bairstow, AnnaLisa Gellermann, Lisa Matthews, Alison Mondi, Mark Rose, Jason Siems and Sheela Tallman.

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 26 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 9 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

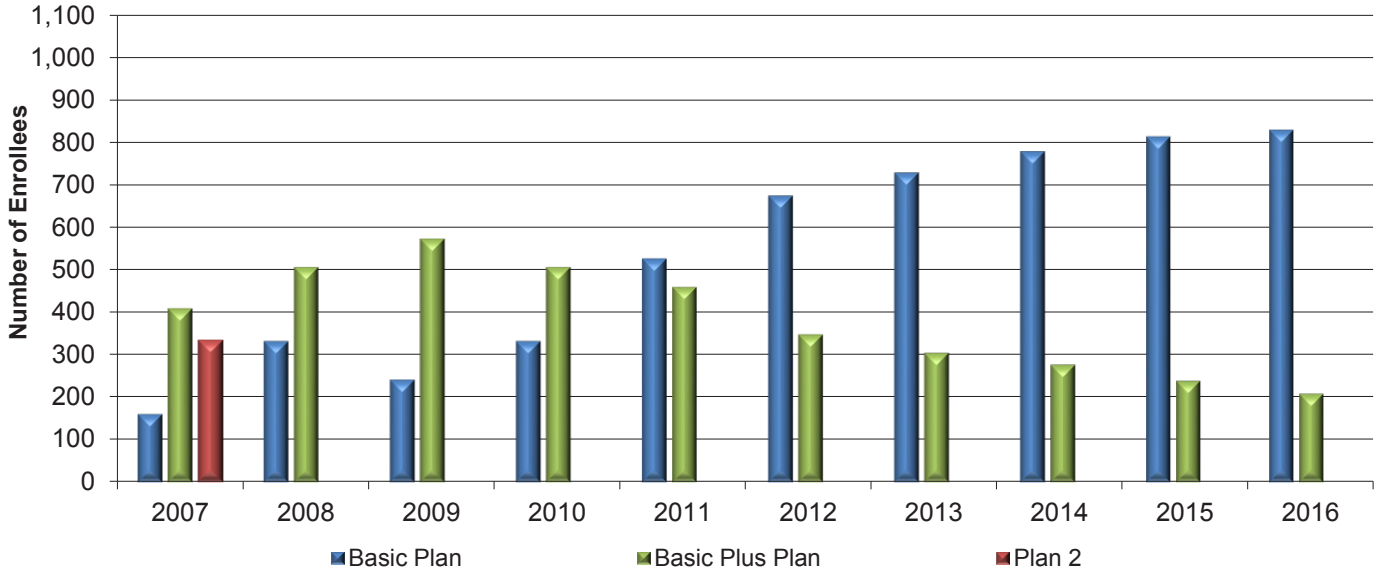
Care Management
MedWatch
1-800-549-7549
www.urmedwatch.com

APPENDIX I - CHART A

Non-Medicare & Medicare Policies in Force

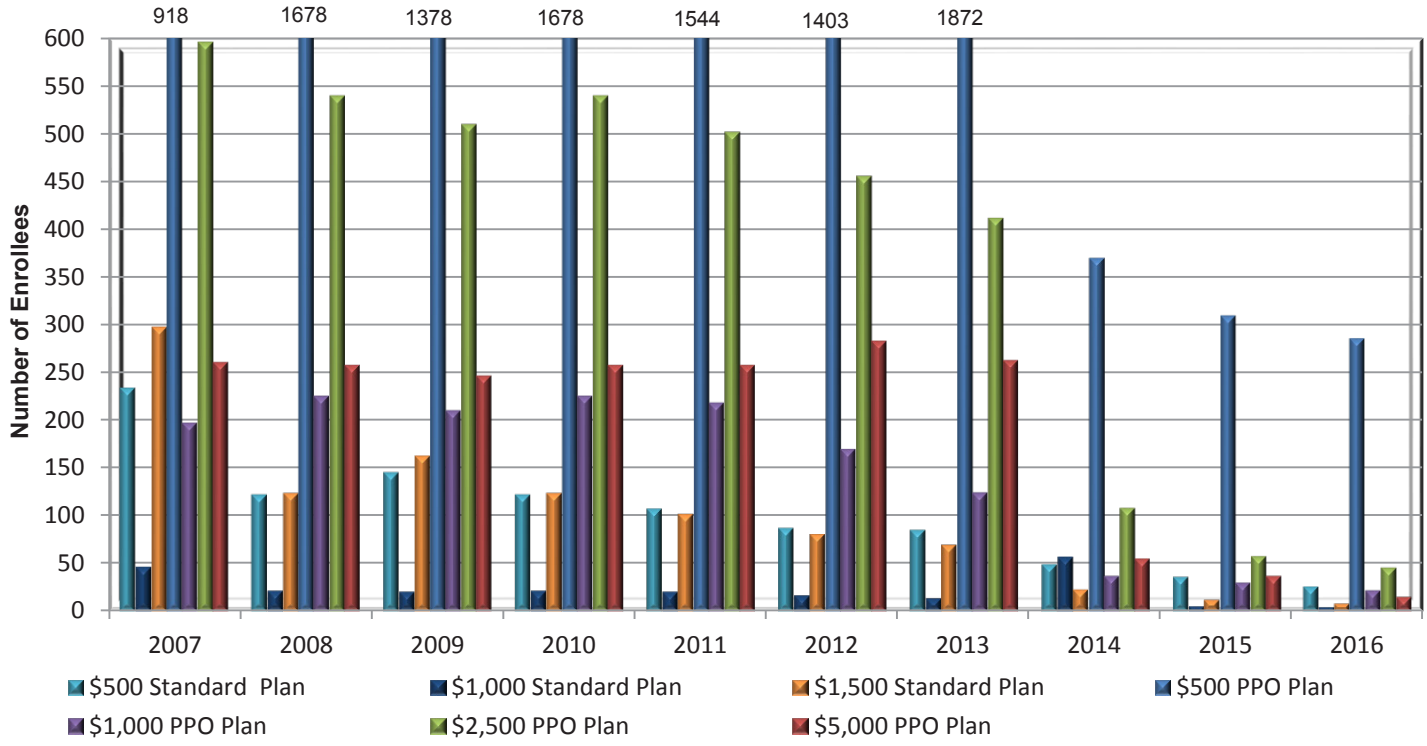
Medicare Policies in Force
2007 - 2016

NOTE: This chart depicts the change in enrollment by Medicare plans. Medicare Part D was introduced in 2006 causing a sharp decrease in WSHIP enrollment in Plan 2 as enrollees switched to either the Basic or Basic Plus plan options which were added in January of 2006. Effective January 2008, Plan 2 enrollees were required to switch to either Basic or Basic Plus plan options. Basic Plus was closed to new enrollment Dec. 31, 2008



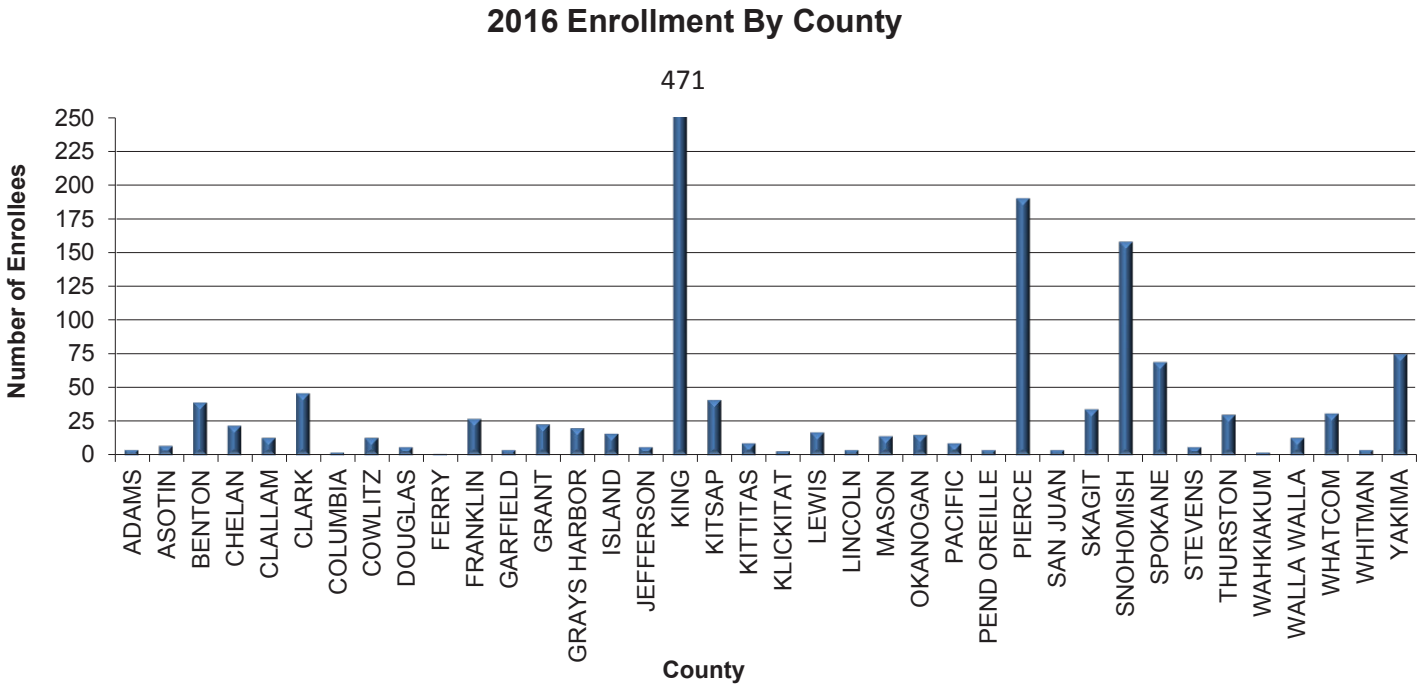
Non-Medicare Policies in Force
2007 - 2016

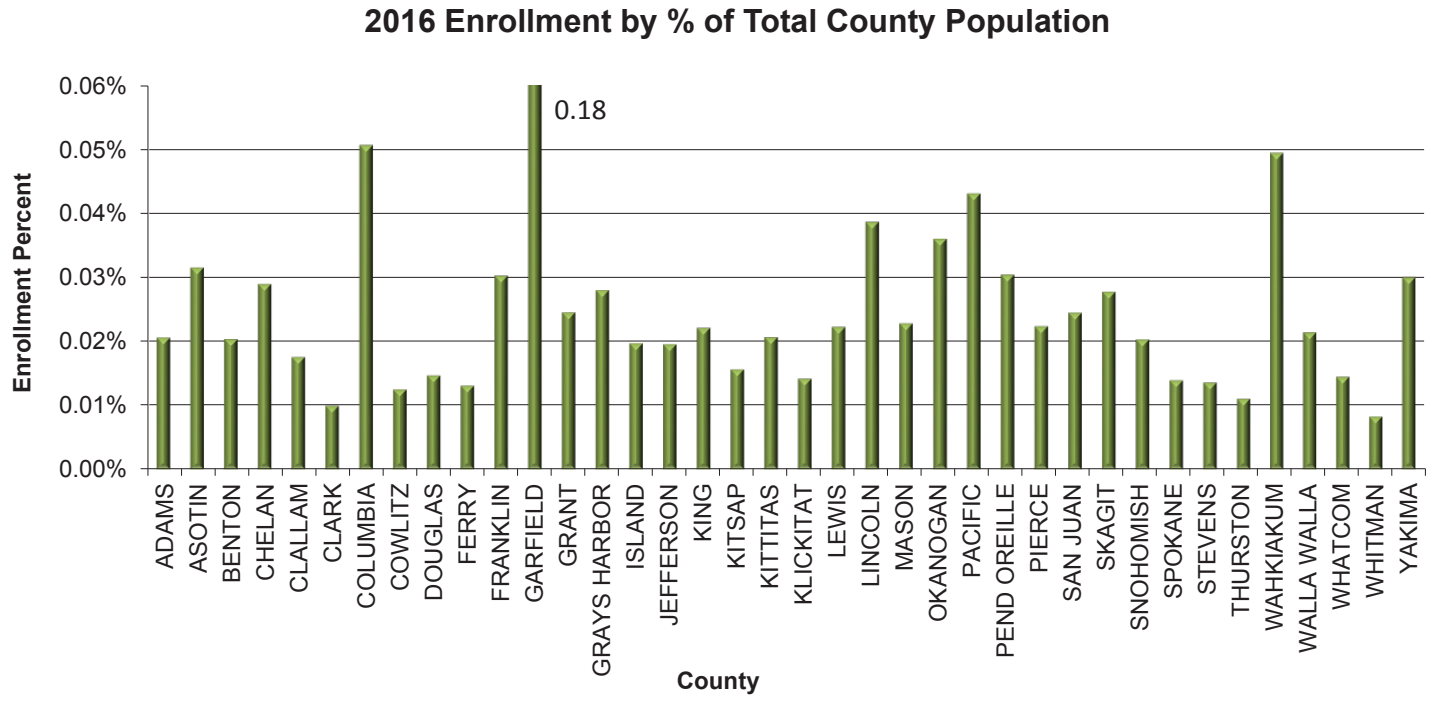
NOTE: This chart depicts the change in enrollment by plans. The HSA Qualified PPO Plan and Limited PPO Plans A and B were added in January of 2008 and are not included in this chart. Beginning in 2014, Non-Medicare plans are no longer open to new enrollment if individual plans are offered in all counties.



APPENDIX I – CHART B

Enrollment by County



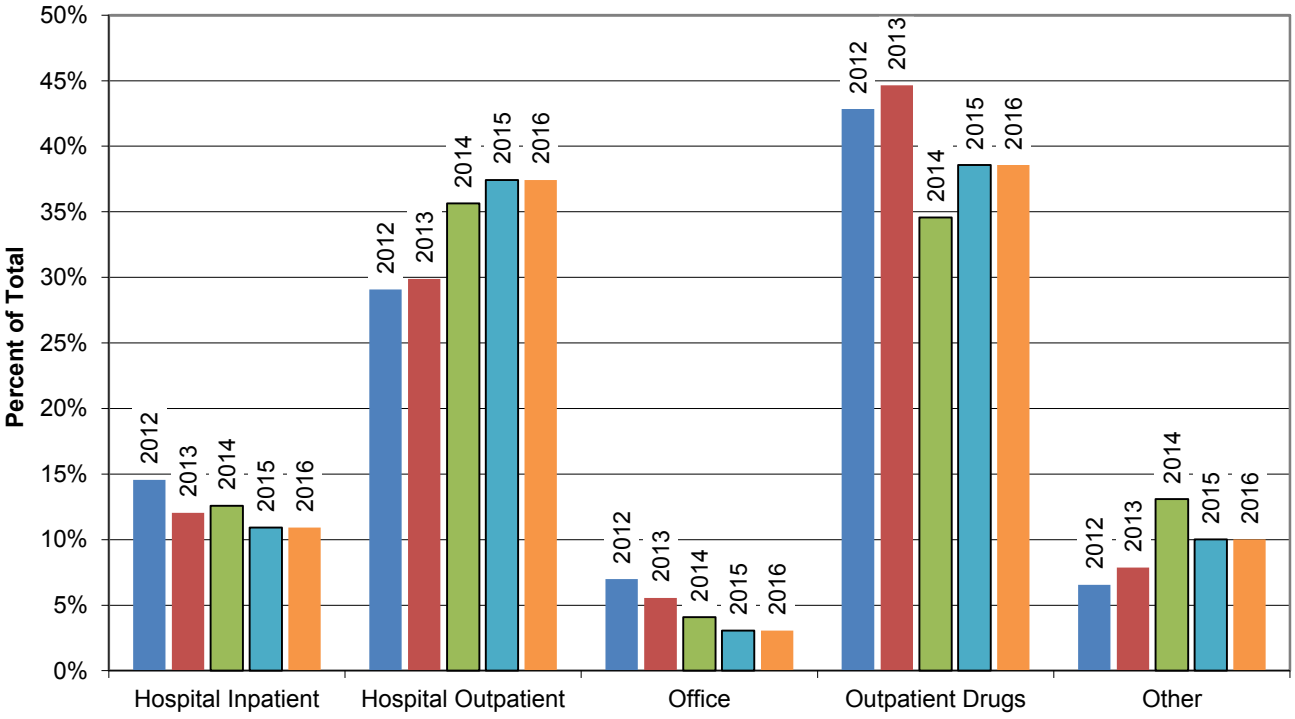


APPENDIX I – CHART C

Distribution of Claim Payments by Place of Service

Distribution of Claim Payments by Place of Service 2012 - 2016

NOTE: This chart depicts the annual paid medical and pharmacy claims cost 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,



WSHIP Enrollment & Financial Summary, 1988 – 2016; 2017 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 Proj	1486	$11,813,548	$11,819,292	$42,514,741	$1,895,117	$44,409,858	($32,590,566)
Total			$390,190,913	$1,103,105,858	$51,578,750	$1,154,684,608	($764,493,195)

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 – 2016; 2017 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 Proj	$29,000,000	$2,490	$662.49	26.6%	4.3%	($21,931.74)
Total	$792,144,953					

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.

APPENDIX II - FINANCIAL STATEMENTS

PetrowLeemhuis Vincent&Kane

Report of Independent Auditors

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, 2016 and 2015 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, whether due to fraud or material error.

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, 2016 and 2015, and the results of their 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.

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.

February 27, 2017

Washington State Health Insurance Pool

Balance Sheets

	December 31 2016	2015
Assets		
Cash and short term investments	**$ 12,629,342**	$ 13,186,859
Assessments receivable	**70,977**	3,221,579
Uncollected premiums	**11,777**	16,236
Federal grant receivable	**-**	141,641
Total assets	**$ 12,712,096**	$ 16,566,315
Liabilities and unassigned surplus		
Claims unpaid	**$ 4,953,000**	$ 5,286,000
Unpaid claims adjustment expenses	**305,000**	325,000
Premiums received in advance	**438,362**	1,179,342
Assessments payable	**797,770**	3,255,852
Abandoned claims reserve	**19,897**	83,081
General expenses due and accrued	**135,811**	249,117
Total liabilities	**6,649,840**	10,378,392
Unassigned surplus	**6,062,256**	6,187,923
Total liabilities and unassigned surplus	**$ 12,712,096**	$ 16,566,315

See accompanying notes and report of independent auditors.

Washington State Health Insurance Pool

Statements of Operations and Unassigned Surplus

	Years ended December 31	
	2016	**2015**
Operating revenues:		
Net premium income	**$ 11,080,165**	$ 11,602,968
	11,080,165	11,602,968
Operating expenses:		
Hospital and medical benefits	**40,393,344**	45,174,109
Claim adjustment expenses	**916,052**	1,005,730
General and administrative expenses	**1,298,195**	1,451,620
	42,607,591	47,631,459
Operating loss	**(31,527,426)**	(36,028,491)
Non-operating revenues:		
Investment and other income	**48,087**	2,150
	48,087	2,150
Loss before assessments	**(31,479,339)**	(36,026,341)
Assessments	**31,353,672**	33,999,828
Change in unassigned surplus	**(125,667)**	(2,026,513)
Unassigned surplus at beginning of year	**6,187,923**	8,214,436
Unassigned surplus at end of year	**$ 6,062,256**	$ 6,187,923

See accompanying notes and report of independent auditors.

Washington State Health Insurance Pool

Statements of Cash Flows

	Years ended December 31	
	2016	**2015**
Operating activities		
Premiums collected	**$ 10,319,292**	$ 12,345,832
Claims and claims adjustment expenses paid	**(41,143,628)**	(46,296,066)
General administrative expenses paid	**(1,969,101)**	(1,836,285)
Cash used by operating activities	**(32,793,437)**	(35,786,519)
Investing activities		
Investment and other income	**48,087**	2,150
Cash provided by investing activities	**48,087**	2,150
Financing activities		
Assessments collected	**32,046,192**	28,858,333
Federal grant proceeds	**141,641**	445,824
Cash provided by financing activities	**32,187,833**	29,304,157
Net decrease in cash and cash equivalents	**(557,517)**	(6,480,212)
Cash and short term investments at beginning of year	**13,186,859**	19,667,071
Cash and short term investments at end of year	**$ 12,629,342**	$ 13,186,859

See accompanying notes and report of independent auditors.

Washington State Health Insurance Pool
Notes to Financial Statements
December 31, 2016 and 2015

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. 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. Presently, assessments are made as funds are needed.

Basis of Presentation

The accompanying financial statements have been prepared, except as to form, 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. 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

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 as the Pool has the statutory authority to assess member plans 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, 2016 and 2015, none of the Pool's deposits are uninsured.

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 ("ASC") 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 2015, 2014 and 2013 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"). Such examinations could result in adjustments to the Pool's financial statements. The OIC's most recent examination covers the years 2008 through 2012, and was completed during 2014. No findings were noted that would require an adjustment to the financial statements.

2. Plan Administration Agreement

The Pool has outsourced its administrative services to Benefit Management Inc., a Kansas based third party administrator, under a service agreement effective through December 2017. 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 Inc. in 2016 and 2015 were $946,990 and $931,944, respectively, and are included in general and administrative expenses in the accompanying statements of operations and unassigned surplus.

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	
	2016	**2015**
Balances at January 1	**$ 5,611,000**	$ 6,262,000
Policy benefits incurred related to:		
Current year	**42,155,303**	46,351,770
Prior years (redundancy)	**(1,761,959)**	(1,177,661)
Total policy benefits incurred	**40,393,344**	45,174,109
Paid related to:		
Current year	**36,906,716**	40,752,759
Prior years	**3,839,628**	5,072,350
Total paid	**40,746,344**	45,825,109
Balances at December 31	**$ 5,258,000**	$ 5,611,000

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. 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, 2016 or 2015, nor were there any borrowings against this line during 2016 or 2015.

5. Subsequent Events

In accordance with ASC 855 *Subsequent Events* , the Pool has evaluated subsequent events through February 27, 2017, 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.