

Multiple Agency Fiscal Note Summary

Bill Number: 1392 HB	Title: Medicaid access program
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Estimated Cash Receipts

Agency Name	2025-27			2027-29			2029-31		
	GF-State	NGF-Outlook	Total	GF-State	NGF-Outlook	Total	GF-State	NGF-Outlook	Total
Office of State Treasurer	Non-zero but indeterminate cost and/or savings. Please see discussion.								
Washington State Health Care Authority	0	0	199,126,000	0	0	1,242,545,000	0	0	1,391,966,000
Washington State Health Care Authority	In addition to the estimate above, there are additional indeterminate costs and/or savings. Please see individual fiscal note.								
Office of Insurance Commissioner	0	0	0	0	0	13,116,588	0	0	13,116,588
Office of Insurance Commissioner	In addition to the estimate above, there are additional indeterminate costs and/or savings. Please see individual fiscal note.								
Total \$	0	0	199,126,000	0	0	1,255,661,588	0	0	1,405,082,588

Estimated Operating Expenditures

Agency Name	2025-27				2027-29				2029-31			
	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total	FTEs	GF-State	NGF-Outlook	Total
Office of State Treasurer	.0	0	0	0	.0	0	0	0	.0	0	0	0
Washington State Health Care Authority	3.6	35,991,000	35,991,000	118,519,000	5.9	0	0	1,112,089,000	5.9	0	0	1,326,322,000
Office of Insurance Commissioner	.3	0	0	116,049	.0	0	0	0	.0	0	0	0
Total \$	3.9	35,991,000	35,991,000	118,635,049	5.9	0	0	1,112,089,000	5.9	0	0	1,326,322,000

Estimated Capital Budget Expenditures

Agency Name	2025-27			2027-29			2029-31		
	FTEs	Bonds	Total	FTEs	Bonds	Total	FTEs	Bonds	Total
Office of State Treasurer	.0	0	0	.0	0	0	.0	0	0
Washington State Health Care Authority	.0	0	0	.0	0	0	.0	0	0
Office of Insurance Commissioner	.0	0	0	.0	0	0	.0	0	0
Total \$	0.0	0	0	0.0	0	0	0.0	0	0

Estimated Capital Budget Breakout

NONE

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Prepared by: Jason Brown, OFM	Phone: (360) 742-7277	Date Published: Final 2/12/2025
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Individual State Agency Fiscal Note

Bill Number: 1392 HB	Title: Medicaid access program	Agency: 090-Office of State Treasurer
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Part I: Estimates

No Fiscal Impact

Estimated Cash Receipts to:

Non-zero but indeterminate cost and/or savings. Please see discussion.

Estimated Operating Expenditures from:

NONE

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

- If fiscal impact is greater than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.
- If fiscal impact is less than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).
- Capital budget impact, complete Part IV.
- Requires new rule making, complete Part V.

Legislative Contact: Meghan Morris	Phone: 360-786-7119	Date: 01/17/2025
Agency Preparation: Dan Mason	Phone: (360) 902-8990	Date: 01/20/2025
Agency Approval: Dan Mason	Phone: (360) 902-8990	Date: 01/20/2025
OFM Review: Megan Tudor	Phone: (360) 890-1722	Date: 01/30/2025

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

HB 1392 creates the medicaid access program account and allows the account to retain its earnings from investments.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

Projected cash flows are currently unavailable; therefore, estimated earnings from investments are indeterminable.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

NONE

III. B - Expenditures by Object Or Purpose

NONE

III. C - Operating FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part I and Part IIIA.*

NONE

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

Individual State Agency Fiscal Note

Revised

Bill Number: 1392 HB	Title: Medicaid access program	Agency: 107-Washington State Health Care Authority
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Part I: Estimates

No Fiscal Impact

Estimated Cash Receipts to:

ACCOUNT	FY 2026	FY 2027	2025-27	2027-29	2029-31
General Fund-Federal 001-2	100,000	82,428,000	82,528,000	776,155,000	925,576,000
Medicaid Access Program-State NEW-1		116,598,000	116,598,000	466,390,000	466,390,000
Total \$	100,000	199,026,000	199,126,000	1,242,545,000	1,391,966,000

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

Estimated Operating Expenditures from:

	FY 2026	FY 2027	2025-27	2027-29	2029-31
FTE Staff Years	1.3	5.9	3.6	5.9	5.9
Account					
General Fund-State 001-1	111,000	35,880,000	35,991,000	0	0
General Fund-Federal 001-2	100,000	82,428,000	82,528,000	776,155,000	925,576,000
Medicaid Access Program-State NEW-1	0	0	0	335,934,000	400,746,000
Total \$	211,000	118,308,000	118,519,000	1,112,089,000	1,326,322,000

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

- If fiscal impact is greater than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.
- If fiscal impact is less than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).
- Capital budget impact, complete Part IV.
- Requires new rule making, complete Part V.

Legislative Contact: Meghan Morris	Phone: 360-786-7119	Date: 01/17/2025
Agency Preparation: Marcia Boyle	Phone: 360-725-0850	Date: 02/12/2025
Agency Approval: Catrina Lucero	Phone: 360-725-7192	Date: 02/12/2025
OFM Review: Jason Brown	Phone: (360) 742-7277	Date: 02/12/2025

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

See attached.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

HCA impacts identified above - see attached HCA FN for details.

HBE impacts indeterminate - see attached HBE FN for details.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

See attached.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2026	FY 2027	2025-27	2027-29	2029-31
001-1	General Fund	State	111,000	35,880,000	35,991,000	0	0
001-2	General Fund	Federal	100,000	82,428,000	82,528,000	776,155,000	925,576,000
NEW-1	Medicaid Access Program	State	0	0	0	335,934,000	400,746,000
Total \$			211,000	118,308,000	118,519,000	1,112,089,000	1,326,322,000

III. B - Expenditures by Object Or Purpose

	FY 2026	FY 2027	2025-27	2027-29	2029-31
FTE Staff Years	1.3	5.9	3.6	5.9	5.9
A-Salaries and Wages	127,000	559,000	686,000	1,118,000	1,118,000
B-Employee Benefits	37,000	166,000	203,000	332,000	332,000
C-Professional Service Contracts					
E-Goods and Other Services	9,000	809,000	818,000	1,198,000	1,198,000
G-Travel	2,000	12,000	14,000	24,000	24,000
J-Capital Outlays	1,000	6,000	7,000	12,000	12,000
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services		116,598,000	116,598,000	1,109,089,000	1,323,322,000
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements	35,000	158,000	193,000	316,000	316,000
9-					
Total \$	211,000	118,308,000	118,519,000	1,112,089,000	1,326,322,000

III. C - Operating FTE Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2026	FY 2027	2025-27	2027-29	2029-31
Fiscal Analyst 3	70,000	0.3	1.4	0.9	1.4	1.4
Fiscal Analyst 5	87,000		0.5	0.3	0.5	0.5
Occupational Nurse Consultant	140,000		0.5	0.3	0.5	0.5
WMS Band 2	127,000	1.0	3.5	2.3	3.5	3.5
Total FTEs		1.3	5.9	3.6	5.9	5.9

III. D - Expenditures By Program (optional)

Program	FY 2026	FY 2027	2025-27	2027-29	2029-31
HCA-Medicaid (200)	211,000	118,308,000	118,519,000	1,112,089,000	1,326,322,000
Total \$	211,000	118,308,000	118,519,000	1,112,089,000	1,326,322,000

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

See attached.

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised

Title: **Medicaid Access Program**

Part I: Estimates

No Fiscal Impact

Estimated Cash Receipts to:

ACCOUNT	REV SOURCE	FY-2026	FY-2027	FY-2028	FY-2029	FY-2030	FY-2031	2025-27	2027-29	2029-31
General Fund-Medicaid 001-C	0393	100,000	82,428,000	313,367,000	462,788,000	462,788,000	462,788,000	82,528,000	776,155,000	925,576,000
Medicaid Access Program-State MAP-1	0299		116,598,000	233,195,000	233,195,000	233,195,000	233,195,000	116,598,000	466,390,000	466,390,000
REVENUE - TOTAL \$		100,000	199,026,000	546,562,000	695,983,000	695,983,000	695,983,000	199,126,000	1,242,545,000	1,391,966,000

Estimated Operating Expenditures from:

STAFFING	FY-2026	FY-2027	FY-2028	FY-2029	FY-2030	FY-2031	2025-27	2027-29	2029-31
FTE STAFF YEARS - TOTAL	1.3	5.9	5.9	5.9	5.9	5.9	3.6	5.9	5.9
ACCOUNT	FY-2026	FY-2027	FY-2028	FY-2029	FY-2030	FY-2031	2025-27	2027-29	2029-31
General Fund-State 001-1	111,000	35,880,000	-	-	-	-	35,991,000	-	-
General Fund-Medicaid 001-C	100,000	82,428,000	313,367,000	462,788,000	462,788,000	462,788,000	82,528,000	776,155,000	925,576,000
Medicaid Access Program-State MAP-1	-	-	135,561,000	200,373,000	200,373,000	200,373,000	-	335,934,000	400,746,000
ACCOUNT - TOTAL \$		211,000	118,308,000	448,928,000	663,161,000	663,161,000	118,519,000	1,112,089,000	1,326,322,000

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

- If fiscal impact is greater than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.
- If fiscal impact is less than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).
- Capital budget impact, complete Part IV.
- Requires new rule making, complete Part V.

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised Title: **Medicaid Access Program**

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

This bill creates a Medicaid Access Program account with the state Treasurer. This account is funded with assessment fees collected from Managed Care Organizations (MCOs) and health carriers that will be used to fund the Medicaid professional services rate increase.

Section 2: The bill requires the Health Care Authority (HCA) to submit a state plan amendment (SPA) or waiver request to Centers for Medicare and Medicaid Services (CMS) by September 1, 2025, to collect an assessment fee for covered lives from MCOs. The assessment fee, collection, and disbursement of funds for this program will be conditioned upon final approval by CMS.

Section 3: All health carriers and MCOs will pay an assessment beginning January 1 of the year following the approval by CMS.

For health carriers, the first year covered lives assessment is set at \$0.50 per covered life. Subsequent assessments shall be made by HCA by May 15 each year. The covered lives assessment shall apply to the health carrier group plan lives followed by individual health plan lives, applicable to the first three million (3 million) member months (or 250,000 covered lives) within the group plan then individual plan.

For MCOs, the first plan year, HCA will assess a per member per month assessment of \$18 for MCOs. On or before May 15 of the first plan year and on or before May 15 of each subsequent year, HCA will determine the assessment rate necessary to fund the professional services rate increase. HCA will notify MCOs annually of the estimated assessment for the upcoming year. Payment collections are to be made no more frequently than quarterly.

Assessment fees are applied to the first 3,000,000 member months per MCOs. Payments from MCOs are due within 45 days of the payment schedule determined by HCA, with interest accrued on the amounts received after the 45-day period.

HCA will deposit the collected amounts from MCOs and interest with the state Treasurer designated for this purpose.

Section 5: Moneys in the account may be spent only after appropriation and used only for the administration and implementation of the Medicaid Access program as established in Section 6 of this bill. Payments from the account will be used to make payments to providers and MCOs. Additionally, disbursements will be made to MCOs to fund the nonfederal share of the increased capitation payments based on their projected assessment obligation.

Section 6: Beginning January 1 of the second plan year after the approval from CMS is granted, subject to available funds in the account, the fee-for-service (FFS) and managed care rates for professional services are to be increased to the corresponding Medicare rates as of December 31, 2024. Rates for subsequent years to be adjusted by the Medicare economic index (MEI). This section describes a wide range of services eligible for the rate increase. If funds are insufficient to fund the full rate increase, HCA may increase rates to a percentage of Medicare rates applied uniformly access service categories.

Section 7: This section states that the federal requirement for actuarially sound rates is not altered by this bill.

Section 8: HCA may adopt rules to carry out the requirements of this bill.

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised Title: **Medicaid Access Program**

Section 10 prohibits penalties or actions against HCA or its employees from health plan carriers assessed by HCA in the good faith operation of this program.

Section 18: This act expires if by January 1, 2027, CMS does not provide final approval of the SPA or waiver.

II. B - Cash Receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

The bill requires HCA and the Office of the Insurance Commissioner (OIC) to collect covered lives assessment from MCO and commercial health plans. The assessment is capped at 3,000,000 member months per plan. The revenue is determined by multiplying member months by \$18 (MCOs) and \$0.50 (commercial plans) for the initial year. HCA assumes that the assessment on Medicaid MCOs would be included as part of the non-benefit component of the MCO rates effective January 2027. MCOs will pay the assessment to HCA which will be deposited into a designated account with the state Treasurer. This revenue is intended to fund the rate increase for Apple Health professional services performed. It is unknown how the assessment rate may change over time. Below is the estimated revenue for HCA, assuming an \$18 per member per month assessment rate:

HCA Assessment Collection Estimate			
Fund Source	SFY27	SFY28	SFY29
GFF	\$ 81,618,379	\$ 163,236,758	\$ 163,236,758
GFS	\$ 34,979,305	\$ 69,958,611	\$ 69,958,611
Total:	\$ 116,597,684	\$ 233,195,368	\$ 233,195,368

Assumptions:

The total collected amount will change every year based on changes in the assessment fee that are driven by:

- Changes in the client caseload/enrollments.
- Recalculation of the assessment fee based on funding needs for the professional rate increase.
- Remaining fund balance available to pay the rates.

ACCOUNT	REV SOURCE	FY-2026	FY-2027	FY-2028	FY-2029	FY-2030	FY-2031	2025-27	2027-29	2029-31
General Fund-Medicaid 001-C	0393	100,000	82,428,000	313,367,000	462,788,000	462,788,000	462,788,000	82,528,000	776,155,000	925,576,000
Medicaid Access Program-State MAP-1	0299		116,598,000	233,195,000	233,195,000	233,195,000	233,195,000	116,598,000	466,390,000	466,390,000
REVENUE - TOTAL \$		100,000	199,026,000	546,562,000	695,983,000	695,983,000	695,983,000	199,126,000	1,242,545,000	1,391,966,000

II. C – Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

HCA requests the following:

\$211,000 (\$111,000 General Fund State (GFS)) in Fiscal Year (FY) 2026, \$118,308,000 (\$35,880,000 GFS) in FY 2027, \$448,928,000 in FY 2028, \$663,161,000 in FY 2029.

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised Title: **Medicaid Access Program**

All assumptions are based on CMS approval not being provided until sometime in calendar year 2026, resulting in Plan Year 1 starting January 1, 2027.

Agency Administrative Fiscal Impact

The bill creates a significant operational challenge and will require additional resources to implement. Workload impacts include:

- Manage the calculation of the assessment on an annual basis.
- Work with Milliman to ensure the funding for the professional services rate increase is incorporated into capitation rates. Inform decisions affecting actuarial work and facilitate the data transmission.
- Disburse funds for the professional services rate increase to FFS providers.
- Manage any reconciliations between HCA, MCOs and the fund account due to retroactive client disenrollments.
- Manage MCO contract language pertaining to the bill.
- Work with CMS on SPA/waiver and preprint submission.
- Coordinate with other areas of HCA on assigning appropriate quality metrics and developing evaluation plans for managed care state directed payments (SDP).
- Coordinate with the Office of Medicaid Systems and Data (OMSD) on any system changes.
- Coordinate with OFM and HCA on rule making process.
- Maintain FFS fee schedules.

Section 5 requires HCA to make payments to MCOs. If these payments meet the federal definition of a SDP, they would be subject to the associated CMS requirements. Data related impacts of those requirements include quality performance measures consultation, identification, modification, production and applied to the recipients of the payment. This would require new analytical work including:

- Consult on measure identification specific to the SDP.
- Review measure selection according to federal requirement.
- Guide statistical and technical measurement for approval through the agency's quality committee.
- Develop measure specification clarification/modification specific to SDP.
- Analytic data ongoing production of measure specific to SDP provider and enrollee population.
- Present of quarterly reporting on metric progress.
- Present annual evaluation of performance.
- Submit evaluation to CMS.
- Report out of evaluation of the Quality Strategy through External Quality Review Organization (EQRO) Technical Report.

For this administrative work, HCA requests:

- 1.0 FTE WMS2 Fiscal Information & Data Analyst (permanent)
 - Support development and submission of SPA/waiver due by September 1, 2025.
 - Respond to CMS questions on SPA/waiver.
 - Manage the development, implementation, and maintenance of the program on the managed care side.
 - Manage the evaluation and calculation of the assessment fee for MCOs and any reconciliation needed between HCA, MCOs and the fund account due to retroactive changes in client enrollment status.
 - Manage MCO contract work related to this bill and work with CMS on annual preprint submission and approval process for the rate increase.
 - Coordinate with other areas of HCA on appropriate quality metrics and evaluation plans for SDP process.
- 1.0 FTE WMS2 Fiscal Information & Data Analyst (permanent)
 - Manage the development, implementation, and maintenance of the program on the FFS side.
 - Ensure that eligible FFS providers are paid appropriately.

HCA Fiscal Note

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HCA Request #: 24-029Revised Title: **Medicaid Access Program**

- Coordinate with ProviderOne on system changes, maintain fee schedules and system rate sheets, in coordination with OFM and HCA's Rules and Publications work on WAC and SPA updates.
- 1.0 FTE WMS2 Data/Business Analyst (permanent)
 - On-going analytics, data monitoring and reporting within DATA division of HCA.
- 0.5 FTE Fiscal Analyst 5 (permanent)
 - Manage the collection of funds from the health plans on a quarterly basis.
- 0.5 FTE WMS2 Senior Data Analyst (permanent)
 - Consult on measurement production feasibility and alignment with Healthcare Effectiveness Data and Information Set (HEDIS), Medicaid Core Measures, and other key measure sets.
 - Advise on measure selection for CMS pre-print proposal.
 - Develop health care measure modifications and data source to fit the requirements of CMS and the SDP program.
 - Test selected measures and build process for ongoing metric production.
 - Ensure all federal validation requirements are adhered to.
 - Present results to stakeholders (Medicaid MCOs, provider groups, quality staff) on a quarterly basis.
- 0.5 FTE Occupational Nurse Consultant (permanent)
 - Facilitate the agency's federal compliance with quality monitoring for the SDP, collaborating with agency data teams to support compliance.
 - Review of available measures, using CMS guidance regarding prioritization of CMS Core Set measures and MCO contracted measures.
 - Verify alignment of MCO contracted measure expectations, SDP measures, and Medicaid Managed Care Quality Strategy. Facilitate revisions as required for alignment.
 - Facilitation of review and decision-making regarding selection of appropriate measures through recently established process, pulling this work into HCA's Quality Measurement Monitoring and Improvement (QMMI) framework.
 - Ongoing monitoring of interim performance with MCO communications (every 6 months or quarterly depending on the measure and typical measure production timelines).
 - Collaboration with fiscal's preparation of SDP Preprint.
 - Evaluation of the SDP measure performance, including submission of SDP Evaluation to CMS annually, in collaboration with FSD, and evaluation of Quality Strategy with submission to EQRO of results for annual publication.
 - EQRO contracting work and monitoring of impacted deliverables (Annual EQR Technical report at minimum).
- \$525,000 per year for Milliman contract. To evaluate the data as part of the annual rate setting process and calculate the assessment fee funding for inclusion into managed care rates. Milliman's work will also include SDP calculation and incorporation of this information into the rate certification package submitted to CMS
- \$210,000 one-time for ProviderOne system updates. To implement and manage necessary changes to ProviderOne to ensure that assessment fees are generated on valid enrollment records and the rates subsystem is supported to manage payment of higher rates based on eligible provider taxonomies.
- \$20,000 per year for External Quality Review Organization (EQRO) contract. For reporting of SDP evaluation results and impact on managed care quality as it relates to assessment of the Medicaid managed care quality strategy within the Annual EQR Technical Report as federally required.

Goods and services, travel, and equipment are calculated on actual program averages per FTE. Administrative costs are calculated at \$35,000/0.30 FTE per 1.0 FTE. This cost is included in Object T based on HCA's federally approved cost allocation plan. The FTE portion is included as a Fiscal Analyst 3.

Other impacts and challenges associated with implementation:

- **Rate setting methodology:** the bill directs HCA to increase Medicaid rates to the corresponding Medicare rates as of December 31, 2024, with annual adjustments based on the Medicare Economic index (MEI). This approach replaces the current RBRVS (Resource Based Relative Value Scale) methodology where annual rates are set in a budget

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised Title: **Medicaid Access Program**

neutral manner in order not to exceed the past utilization/expenditures, unless rates for targeted services are increased as directed by the Legislature. This change will require WAC and SPA updates.

- **Code misalignment:** not all services have a Medicare equivalent rate: e.g. some behavioral health services.
- **FQHC/RHC/Tribal/PAP impact:** the bill is silent whether the rate increase would apply to FQHC/RHC/Tribe/PAP providers. HCA's general practice is to exclude these providers from the rate increase for any encounter eligible services given that these services are already reimbursed based on cost.
- **Managed Care State directed payment:**
 - The rate increase described in section 6 will be operationalized via a state directed payment (SDP) through MCOs, where funding for the rate increase is included in managed care capitation rates. MCOs are directed via the contract to increase provider rates for impacted services to be at least the amount listed in FFS fee schedules. All SDPs require an annual evaluation plan that identifies measures that will be used to assess the effectiveness of the SDP in advancing goals and objectives of the Washington's Managed Care Quality Strategy. Evaluation plans require that selected measures demonstrate maintenance or improvement over baseline statistics.
 - The 2024 CMS Managed Care Final Rule aims to improve quality standards and strengthen fiscal and program integrity for SDPs. Given the rising demand for such rate increases, there is greater concern about their effectiveness in supporting care outcomes. To address this, the new regulations mandate increased oversight, leading to the implementation of quality initiatives designed to evaluate and improve these efforts for SDPs. Additionally, there are increased reporting requirements for larger state directed payments that exceed 1.5 percent of total capitation payments.
 - SDPs present both challenges and opportunities for providers. While they can incentivize improvements in access and quality of care, the final rule does establish a mechanism for CMS to withhold approval of an SDP if selected measures do not demonstrate progress.
- **Use of federal funding:** the MCO covered lives assessment would be included as part of the MCO capitation rate, a portion of which would be paid for with Federal funding. The revenue generated through the assessment would then be used to fund the professional services rate increase described in Section 6. There are federal rules around what is a permissible source for the non-federal share of Medicaid payments. It is unclear, without additional research, as to whether the current structure of the covered lives assessment and professional services rate increase in section 6 have any inconsistency with these federal rules HCA staff have reached out to CMS to request direction regarding this question on January 21, 2025. We have not heard back and do not anticipate to receive feedback in the near future due to the uncertainties at the federal level associated with the change in the administration.
- **MCO contracting relativity:** MCOs generally contract with providers at reimbursement rates that are higher than Medicaid FFS rates. For example, if the FFS rate is \$100 for a given service, MCOs may negotiate reimbursement rates with providers that are 5%-10% higher. It is expected that MCOs will maintain this relative difference even when Medicaid rates are increased to match Medicare levels, meaning they will then be paying rates above Medicare. However, the financial impact of this contracting gap is not accounted for in the estimates for the professional rate increase outlined in Section 6 of the bill.
- **MEI:** MEI is determined by CMS and is updated annually. For the initial year of this program, we are using the 2025 MEI rate of 3.5%. This rate is applied to projected years, although the actual MEI for those years will vary. Additionally, to estimate the fiscal impact, the MEI is being applied to services included in the modeling. Services already reimbursed at Medicare levels are excluded from modeling, meaning the fiscal impact does not account for any additional effect of applying the annual MEI to those excluded services.

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised

Title: **Medicaid Access Program**

Apple Health Service-Related Fiscal Impact

HCA expenditure will include two major factors:

- **Assessment Expenditures:** The assessment’s impact on the Medicaid MCO rates – per federal rule, HCA must include the impact of any taxes and fees in the non-benefit portion of the MCO rates. The table below summarizes the estimated impact.

HCA Assessment Collection Estimate			
Fund Source	SFY27	SFY28	SFY29
GFF	\$ 81,618,379	\$ 163,236,758	\$ 163,236,758
GFS	\$ 34,979,305	\$ 69,958,611	\$ 69,958,611
Total:	\$ 116,597,684	\$ 233,195,368	\$ 233,195,368

- **Professional services rate increase expenditures** - as required in Section 6 of the bill. The table below demonstrates the estimated fiscal impact of increasing current Medicaid rates to the level of 2024 Medicare rates. The amounts capture the CY2019 utilization for impacted services as that period represents a more stable time period (prior to PHE). Annual MEI is determined by CMS and changes every year. For CY2025 the MEI is 3.5% and it is applied to subsequent years in the absence of actual MEI. Another important assumption to note: MCOs generally contract with providers at reimbursement rates that are higher than Medicaid FFS rates. It is assumed that this contracting gap on the managed care side will be applied to higher (Medicare) rates. The contracting gap impact is not included in the below estimates.

Fund Source	SFY28 (6 months)	SFY29 (full year)
Fed	149,420,988	298,841,977
State	64,811,971	129,623,943
Total	214,232,960	428,465,919

Public Employee Benefits Board (PEBB) and School Employees Benefits Board (SEBB) Programs

No fiscal impact.

This bill creates a ‘covered lives assessment’ for fully insured health plan carriers to fund Medicaid’s professional services rate increases. The first year’s ‘covered lives assessment’ is \$0.50 per covered life. The subsequent ‘covered lives assessment’ shall be established by Health Care Authority (HCA) as outlined in House Bill 1392 Sections 3 and 6.

Fully insured carrier impacts

As drafted, the legislation impacts the PEBB and SEBB fully insured health plans governed under RCW 48.43 (Insurance Reform). The ‘covered lives assessment’ shall apply to the health carrier group plan lives followed by individual health plan lives, applicable to the first three million (3 million) member months (or 250,000 covered lives) within the group plan then individual plan. While each carrier’s total covered lives is unknown or how each carrier would apply the proportion of any assessment for the PEBB or SEBB plan membership, for purposes of this analysis we assume carriers could pass through the assessment costs on the total PEBB and SEBB lives. The most current health plan enrollment data indicates no fully insured

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised Title: **Medicaid Access Program**

carrier exceeds the 3,000,000 member months (250,000 covered lives) established cap for PEBB and SEBB individual health plan lives.

Two scenarios are illustrated below. Scenario 1 allows consolidation of lives for the assessment since HCA is a single purchaser of the identified health plan carrier. Scenario 2 does not consolidate lives and keeps the program separate. Since historical member months for PEBB and SEBB do not exceed 3,000,000 for any of its fully insured contracts, the assessment totals are the same for each scenario.

Scenario 1: Consolidation of lives as single purchaser – Year one increased liability

Kaiser Foundation Health Plan of Washington (KPWA)

Single Purchaser Health Plan: \$697,000 – \$841,000

Kaiser Foundation Health Plan of the Northwest (KPNW)

Single Purchaser Health Plan: \$62,000 – \$76,000

Premera

Single Purchaser Health Plan: \$315,000 – \$326,000

Scenario 2: PEBB and SEBB programs kept separate under single purchaser – Year one increased liability

Kaiser Foundation Health Plan of Washington (KPWA)

PEBB health plans only: \$292,000 – \$364,000

SEBB health plans only: \$405,000 – \$477,000

Kaiser Foundation Health Plan of the Northwest (KPNW)

PEBB health plans only: \$10,000 – \$21,000

SEBB health plans only: \$52,000 – \$55,000

Premera

SEBB health plans only: \$315,000 – \$326,000

Future impacts and increases in the assessment liability are indeterminate due to variables detailed in House Bill 1392 Sections 2, 3, and 6. However, the fully insured carrier liability associated with the ‘covered lives assessment’ does not impact state expenditures since the state expenditures for fully insured carriers is limited to the employer medical contribution (the state share of the monthly premium). The employer medical contribution is collectively bargained at 85% of the UMP Classic and Achieve 2 calculated rates. Monthly premium costs not covered by the employer medical contribution are the responsibility of the member. If enacted, fully insured carriers may add liability to their contract administration/operating costs, which may result in an increase in the employee paid share of the monthly premium for PEBB and SEBB populations. Year one impacts to the employee’s paid share of the monthly premium are expected to be minimal but future impacts may result in higher costs for employees.

United HealthCare (UHC) Balance and Complete plans, Kaiser Permanente NW Senior Advantage, and Kaiser Permanente WA Medicare Advantage are exempt from the ‘covered lives assessment’ impacts. As defined in House Bill 1392 Section1(5), Medicare advantage plans established under Medicare Part C or outpatient prescription drug plans established under Medicare Part D are not included. These plans meet the definition for exclusion.

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised

Title: **Medicaid Access Program**

Self-insured Uniform Medical Plan (UMP) impacts

As drafted, the legislation does not impact the state’s self-insured health plans governed under RCW 41.05 (State Health Care Authority). UMP is an employer-sponsored self-funded group health plan exempt from the assessment. There are no expected increases in state expenditures for the self-insured plan as a result of House Bill 1392.

Key Assumptions

- No changes to enrollment in fully insured and self-insured health plans.
- Health plan carriers may include costs associated with the ‘covered lives assessment’ to its known liabilities to calculate annual health care premiums.
- The above costs are assumed as a year one liability. Any subsequent liabilities associated with the ‘covered lives assessment’ is indeterminate based on variables outlined in Section 3 and 6 of House Bill 1392.
- The state plan, waiver, preprint, and/or any other documents the single state Medicaid agency requires to outline the program will seek approvals by CMS for the application of 3,000,000 member months cap and 36:1 ratio in House Bill 1392 Section 3 in its program design.
- Carriers may consolidate health plan contracts into one population if contract is with one purchaser.
- Collectively bargained employer medical contribution share remains at 85% of UMP Classic (PEBB) and Achieve 2 (SEBB) bid rates.
- Explicit Medical Subsidy retiree premium share remains at a maximum of \$183.
- Reporting of covered lives per plan year for assessment will be supported by current processes and staff.

Part III: Expenditure Detail

III. A - Operating Budget Expenditure

ACCOUNT	ACCOUNT TITLE	TYPE	FY-2026	FY-2027	FY-2028	FY-2029	FY-2030	FY-2031	2025-27	2027-29	2029-31
001-1	General Fund	State	111,000	35,880,000	-	-	-	-	35,991,000	-	-
001-C	General Fund	Medicaid	100,000	82,428,000	313,367,000	462,788,000	462,788,000	462,788,000	82,528,000	776,155,000	925,576,000
MAP-1	Medicaid Access Program	State	-	-	135,561,000	200,373,000	200,373,000	200,373,000	-	335,934,000	400,746,000
ACCOUNT - TOTAL \$			211,000	118,308,000	448,928,000	663,161,000	663,161,000	663,161,000	118,519,000	1,112,089,000	1,326,322,000

III. B - Expenditures by Object Or Purpose

OBJECT	OBJECT TITLE	FY-2026	FY-2027	FY-2028	FY-2029	FY-2030	FY-2031	2025-27	2027-29	2029-31
A	Salaries and Wages	127,000	559,000	559,000	559,000	559,000	559,000	686,000	1,118,000	1,118,000
B	Employee Benefits	37,000	166,000	166,000	166,000	166,000	166,000	203,000	332,000	332,000
E	Goods and Other Services	9,000	809,000	599,000	599,000	599,000	599,000	818,000	1,198,000	1,198,000
G	Travel	2,000	12,000	12,000	12,000	12,000	12,000	14,000	24,000	24,000
J	Capital Outlays	1,000	6,000	6,000	6,000	6,000	6,000	7,000	12,000	12,000
N	Grants, Benefits & Client Services	-	116,598,000	447,428,000	661,661,000	661,661,000	661,661,000	116,598,000	1,109,089,000	1,323,322,000
T	Intra-Agency Reimbursements	35,000	158,000	158,000	158,000	158,000	158,000	193,000	316,000	316,000
OBJECT - TOTAL \$		211,000	118,308,000	448,928,000	663,161,000	663,161,000	663,161,000	118,519,000	1,112,089,000	1,326,322,000

III. C - Operating FTE Detail: FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part I and Part IIIA.

FTE JOB TITLE	SALARY	FY-2026	FY-2027	FY-2028	FY-2029	FY-2030	FY-2031	2025-27	2027-29	2029-31
FISCAL ANALYST 3	70,000	0.3	1.4	1.4	1.4	1.4	1.4	0.8	1.4	1.4
FISCAL ANALYST 5	87,000	-	0.5	0.5	0.5	0.5	0.5	0.3	0.5	0.5
OCCUPATIONAL NURSE CONSULTANT	140,000	-	0.5	0.5	0.5	0.5	0.5	0.3	0.5	0.5
WMS BAND 02	127,000	1.0	3.5	3.5	3.5	3.5	3.5	2.3	3.5	3.5
FTE - TOTAL		1.3	5.9	5.9	5.9	5.9	5.9	3.6	5.9	5.9

HCA Fiscal Note

Bill Number: **HB 1392**

HCA Request #: 24-029Revised

Title: **Medicaid Access Program**

III. D - Expenditures By Program (optional)

Program No.	Program Title	FY-2026	FY-2027	FY-2028	FY-2029	FY-2030	FY-2031	2025-27	2027-29	2029-31
200	200 - HCA - MED	211,000	118,308,000	448,928,000	663,161,000	663,161,000	663,161,000	118,519,000	1,112,089,000	1,326,322,000
PROGRAM - TOTAL \$		211,000	118,308,000	448,928,000	663,161,000	663,161,000	663,161,000	118,519,000	1,112,089,000	1,326,322,000

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout: Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

HCA may adopt rules to carry out the requirements of Section 8 of this bill.

HBE Fiscal Note

Bill Number: 1392 HB

HBE Request #: 25-06-01

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

This bill directs the Health Care Authority (HCA) to submit any state plan amendments or waivers to the Centers for Medicare and Medicaid Services by September 1, 2025, that are necessary to establish the Medicaid Access Program.

Under the Medicaid Access Program, health carriers and Medicaid Managed Care Organizations (MCOs) are required to pay an annual covered lives assessment beginning January 1st of the plan year following the approval of Section 2(s)(a) of this bill.

- HCA is directed to Collect an \$18 assessment per member per month (pmpm) from MCOs \$0.50 assessment pmpm per covered life for health carriers.
- The assessments are applied to the first 3,000,000 member months of fully insured lives per MCO and per health carrier.
- For each health carrier, the assessment shall apply to member months of all group health plan lives first, followed by member months of individual health plans lives.
- The ratio of assessments from Medicaid MCO and health carriers must be set as 36:1.

Funds will go to raise Medicaid professional service payment rates up to corresponding Medicare rates to encourage providers to deliver services to Medicaid patients.

This bill also creates the Medicaid Access Program Account in the state treasury. All receipts from the assessments, interest, and penalties collected by HCA and the Insurance Commissioner under sections 3 and 4 of this act must be deposited into the account. Moneys in the account may be spent only after appropriation. Expenditures from the account may be used only for the administration and implementation of the Medicaid Access Program.

II. B - Cash Receipts Impact

Indeterminate. The assessment for health carriers applies to the first 3,000,000 member months per health carrier, with group health plan lives being charged the assessment before individual health plans, like those offered on the Exchange. It is unknown how this assessment would impact premiums for qualified health plans (QHP) offered on the exchange, and the number of exchange customers the assessment would apply to will likely differ by carrier so any premium impacts would be different by carrier. Any increase to premiums would be subject to the two percent premium tax the Exchange earns on QHP enrolled through *Washington Healthplanfinder* which would be deposited to the Health Benefit Exchange Account in the state treasury.

II. C - Expenditures

No fiscal impact. The Exchange does not anticipate any operational costs associated with the establishment of the Medicaid Access Program.

Part IV: Capital Budget Impact

None.

HBE Fiscal Note

Bill Number: 1392 HB

HBE Request #: 25-06-01

Part V: New Rule Making Required

None.

Individual State Agency Fiscal Note

Bill Number: 1392 HB	Title: Medicaid access program	Agency: 160-Office of Insurance Commissioner
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Part I: Estimates

No Fiscal Impact

Estimated Cash Receipts to:

ACCOUNT	FY 2026	FY 2027	2025-27	2027-29	2029-31
Medicaid Access Program Account-State NEW-1				13,116,588	13,116,588
Total \$				13,116,588	13,116,588

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

Estimated Operating Expenditures from:

	FY 2026	FY 2027	2025-27	2027-29	2029-31
FTE Staff Years	0.2	0.4	0.3	0.0	0.0
Account					
Insurance Commissioners Regulatory Account-State 138-1	38,785	77,264	116,049	0	0
Total \$	38,785	77,264	116,049	0	0

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

- If fiscal impact is greater than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.
- If fiscal impact is less than \$50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).
- Capital budget impact, complete Part IV.
- Requires new rule making, complete Part V.

Legislative Contact: Meghan Morris	Phone: 360-786-7119	Date: 01/17/2025
Agency Preparation: Jane Beyer	Phone: 360-725-7043	Date: 02/11/2025
Agency Approval: Stacey Warick	Phone: (360) 725-0000	Date: 02/11/2025
OFM Review: Jason Brown	Phone: (360) 742-7277	Date: 02/11/2025

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

Section 3(1)(a) requires all health carriers and Medicaid managed care organizations to pay an annual covered lives assessment beginning January 1st of the plan year following the final approval by CMS. For assessments due the first plan year, the OIC is required to assess a per member per month assessment of \$0.50 per covered life on health carriers.

Section 3(1)(b) requires that each year, on or before May 15th, HCA must determine the covered lives assessment for the calendar year.

Section 3(2)(b) limits the assessments to the first 3,000,000 member months of fully insured lives per health carrier. For each health carrier, the assessment shall apply to member months of all group health plan lives first, followed by member months of individual health plan lives.

Section 4(2) requires the OIC to assess a per member per month annual covered lives assessment on health carriers.

Section 4(3) requires the OIC to determine a payment schedule for receipt of assessments under this section in accordance with the Medicaid access program rules as established by the authority.

Section 4(4) requires that payments are due within 45 days of the payment schedule and requires the OIC to charge interest on amounts received after the 45-day period.

Section 4(5) requires the OIC to deposit the annual covered lives assessments and interest collected to the Medicaid Access Program Account.

Section 4(6) requires health carriers to submit any annual statements or other reports deemed necessary by the OIC for the HCA to calculate the assessment in a manner consistent with section 3 of this act.

Section 9 authorizes the OIC to adopt rules necessary to carry out section 4 of this act.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

Assumptions:

- First assessment collection is based on CY2026 member months.
- Beginning in calendar year 2027, Health Care Authority (HCA) will provide the Office of Insurance Commissioner (OIC) with the amount needed to fund the professional services rate increases.
- Collection of assessments occurs annually and will be due by July 15.

Section 3(1)(a) requires all health carriers to pay an annual covered lives assessment beginning January 1st of the plan year following the final approval by CMS. For assessments due the first plan year, the OIC is required to assess a per member per month assessment of \$0.50 per covered life on health carriers. Based on October 2024 data for the fully insured commercial market, and limiting the assessment to 3 million member months per carrier, there were 1,093,049 persons covered under a fully insured individual or group health plan in CY2024. Assuming, for purposes of this fiscal note, that \$0.50 per covered life will be assessed and that the number of covered lives for CY2026 will remain the same as CY2024, estimated revenue of \$6,558,294 (1,093,049 covered lives x \$0.50 x 12 member months) will be collected in the first year. The number of covered lives will be captured from health carriers via the CY2026 insurance premium tax return, which is due in March 2027. OIC will then calculate and bill health carriers for the first plan year with a due date of July 2027.

Section 3(1)(b) requires that each year, on or before May 15th, HCA must determine the covered lives assessment for the calendar year. Section 3(2)(b) limits the assessments to the first 3,000,000 member months of fully insured lives per health carrier. For each health carrier, the assessment shall apply to member months of all group health plan lives first, followed by member months of individual health plan lives. The HCA is unable to provide the amount needed to fund the professional services rate increases for CY2027 and beyond at this time. For purposes of this fiscal note, the OIC assumes the same assessment as the first plan year.

Section 4(4) requires that payments are due within 45 days of the payment schedule and requires the OIC to charge interest on amounts received after the 45-day period. For purposes of this fiscal note, the OIC assumes that all payments will be received within 45 days of the due date.

Section 4(5) requires the OIC to deposit the annual covered lives assessments and interest collected to the Medicaid Access Program Account.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

Sections 3 and 4 will require changes to IT systems to include a combination of system configuration changes and software programming enhancements. The Office of Insurance Commissioner’s IT staff will implement these changes in-house to ensure that the system changes align with existing IT infrastructure and technical approaches that the OIC uses in its other online payment and filing portal and back-office systems. The cost estimate for the system changes and new software development is assumed to be a one-time cost in FY2027 and estimated at 659 hours utilizing nine IT staff. The cost estimate is based on the similar work performed to implement the Health Care Benefit Manager renewal and billing processes, which the agency completed in 2022/2023.

Section 9 authorizes the OIC to adopt rules necessary to carry out section 4 of this act. ‘Normal’ rulemaking’, in FY2026 will be required to address questions such as the mechanism to calculate the 3 million member month threshold for assessments.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Account	Account Title	Type	FY 2026	FY 2027	2025-27	2027-29	2029-31
138-1	Insurance Commissioners Regulatory Account	State	38,785	77,264	116,049	0	0
Total \$			38,785	77,264	116,049	0	0

III. B - Expenditures by Object Or Purpose

	FY 2026	FY 2027	2025-27	2027-29	2029-31
FTE Staff Years	0.2	0.4	0.3		
A-Salaries and Wages	24,035	47,736	71,771		
B-Employee Benefits	6,993	14,075	21,068		
C-Professional Service Contracts					
E-Goods and Other Services	7,757	15,453	23,210		
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total \$	38,785	77,264	116,049	0	0

III. C - Operating FTE Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2026	FY 2027	2025-27	2027-29	2029-31
Functional Program Analyst 4	86,712	0.1		0.0		
IT Applications Developer - Journey	94,728		0.1	0.1		
IT Applications Developer - Senior	124,068		0.1	0.1		
IT Architecture - Senior	147,204		0.0	0.0		
IT Business Analyst - Senior	130,272		0.0	0.0		
IT Data Management - Senior	121,116		0.0	0.0		
IT Quality Assurance - Journey	109,848		0.1	0.1		
Senior Policy Analyst	131,328	0.2		0.1		
Total FTEs		0.2	0.4	0.3		0.0

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

Section 9 authorizes the OIC to adopt rules necessary to carry out section 4 of this act. 'Normal' rulemaking', in FY2026 will be required to address questions such as the mechanism to calculate the 3 million member month threshold for assessments.



Multiple Agency Ten-Year Analysis Summary

Bill Number 1392 HB	Title Medicaid access program
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This ten-year analysis is limited to the estimated cash receipts associated with the proposed tax or fee increases.

Estimated Cash Receipts

	Fiscal Year 2026	Fiscal Year 2027	Fiscal Year 2028	Fiscal Year 2029	Fiscal Year 2030	Fiscal Year 2031	Fiscal Year 2032	Fiscal Year 2033	Fiscal Year 2034	Fiscal Year 2035	2026-35 TOTAL
Office of State Treasurer	0	0	0	0	0	0	0	0	0	0	0
Washington State Health Care Authority Partially Indeterminate Impact	0	116,598,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	1,982,158,000
Office of Insurance Commissioner Partially Indeterminate Impact	0	0	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	52,466,352
Total	0	116,598,000	239,753,294	239,753,294	239,753,294	239,753,294	239,753,294	239,753,294	239,753,294	239,753,294	2,034,624,352



Ten-Year Analysis

Bill Number 1392 HB	Title Medicaid access program	Agency 090 Office of State Treasurer
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This ten-year analysis is limited to agency estimated cash receipts associated with the proposed tax or fee increases. The Office of Financial Management ten-year projection can be found at <http://www.ofm.wa.gov/tax/default.asp>.

Estimates

No Cash Receipts

 Partially Indeterminate Cash Receipts

 Indeterminate Cash Receipts

Name of Tax or Fee	Acct Code												
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Agency Preparation: Dan Mason	Phone: (360) 902-8990	Date: 1/20/2025 10:23:33 an
Agency Approval: Dan Mason	Phone: (360) 902-8990	Date: 1/20/2025 10:23:33 an
OFM Review:	Phone:	Date:



Ten-Year Analysis

Bill Number 1392 HB	Title Medicaid access program	Agency 107 Washington State Health Care Authority
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This ten-year analysis is limited to agency estimated cash receipts associated with the proposed tax or fee increases. The Office of Financial Management ten-year projection can be found at <http://www.ofm.wa.gov/tax/default.asp>.

Estimates

No Cash Receipts
 Partially Indeterminate Cash Receipts
 Indeterminate Cash Receipts

Estimated Cash Receipts

Name of Tax or Fee	Acct Code	Fiscal Year 2026	Fiscal Year 2027	Fiscal Year 2028	Fiscal Year 2029	Fiscal Year 2030	Fiscal Year 2031	Fiscal Year 2032	Fiscal Year 2033	Fiscal Year 2034	Fiscal Year 2035	2026-35 TOTAL
Covered Lives Assessment	NEW		116,598,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	1,982,158,000
Total			116,598,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	233,195,000	1,982,158,000
Biennial Totals			116,598,000	466,390,000	466,390,000	466,390,000	466,390,000	466,390,000	466,390,000	466,390,000	466,390,000	1,982,158,000

Narrative Explanation (Required for Indeterminate Cash Receipts)

Section 3: All health carriers and Managed Care Organizations (MCOs) will pay an assessment beginning January 1 of the year following the approval by Centers for Medicare and Medicaid Services (CMS).

For health carriers, the first year covered lives assessment is set at \$0.50 per covered life. Subsequent assessments shall be made by the Health Care Authority (HCA) by May 15 each year. The covered lives assessment shall apply to the health carrier group plan lives followed by individual health plan lives, applicable to the first three million (3 million) member months (or 250,000 covered lives) within the group plan then individual plan.

For MCOs, the first plan year, HCA will assess a per member per month assessment of \$18 for MCOs. On or before May 15 of the first plan year and on or before May 15 of each subsequent year, HCA will determine the assessment rate necessary to fund the professional services rate increase. HCA will notify MCOs annually of the estimated assessment for the upcoming year. Payment collections are to be made no more frequently than quarterly.

Assessment fees are applied to the first 3,000,000 member months per MCOs. Payments from MCOs are due within 45 days of the payment schedule determined by HCA with interest accrued on the amounts received after the 45-day period.

Assumptions are based on CMS approval not being provided until sometime in calendar year 2026, resulting in Plan Year 1 starting January 1, 2027.



Ten-Year Analysis

Bill Number	Title	Agency
1392 HB	Medicaid access program	107 Washington State Health Care Authority

This ten-year analysis is limited to agency estimated cash receipts associated with the proposed tax or fee increases. The Office of Financial Management ten-year projection can be found at <http://www.ofm.wa.gov/tax/default.asp>.

Narrative Explanation (Required for Indeterminate Cash Receipts)

HCA Impact:

The bill requires HCA and the Office of the Insurance Commissioner (OIC) to collect covered lives assessment from MCO and commercial health plans. The assessment capped at 3,000,000 member months per plan. The revenue is determined by multiplying member months by \$18 (MCOs) and \$0.50 (commercial plans) for the initial year. HCA assumes that the assessment on Medicaid MCOs would be included as part of the non-benefit component of the MCO rates effective January 2027. MCOs will pay assessment to HCA which will be deposited into a designated account with the state Treasurer. This revenue is intended to fund the rate increase for Apple Health professional services performed. It is unknown how the assessment rate may change over time.

Assumptions:

The total collected amount will change every year based on changes in the assessment fee that are driven by:

- Changes in the client caseload/enrollments.
- Recalculation of the assessment fee based on funding needs for the professional rate increase.
- Remaining fund balance available to pay the rates.

HBE Impacts:

Indeterminate. The assessment for health carriers applies to the first 3,000,000 member months per health carrier, with group health plan lives being charged the assessment before individual health plans, like those offered on the Exchange. It is unknown how this assessment would impact premiums for qualified health plans (QHP) offered on the exchange, and the number of exchange customers the assessment would apply to will likely differ by carrier so any premium impacts would be different by carrier. Any increase to premiums would be subject to the two percent premium tax the Exchange earns on QHP enrolled through Washington Healthplanfinder which would be deposited to the Health Benefit Exchange Account in the state treasury.

Agency Preparation: Marcia Boyle	Phone: 360-725-0850	Date: 2/12/2025 11:06:55 am
Agency Approval: Catrina Lucero	Phone: 360-725-7192	Date: 2/12/2025 11:06:55 am
OFM Review:	Phone:	Date:



Ten-Year Analysis

Bill Number 1392 HB	Title Medicaid access program	Agency 160 Office of Insurance Commissioner
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This ten-year analysis is limited to agency estimated cash receipts associated with the proposed tax or fee increases. The Office of Financial Management ten-year projection can be found at <http://www.ofm.wa.gov/tax/default.asp>.

Estimates

No Cash Receipts
 Partially Indeterminate Cash Receipts
 Indeterminate Cash Receipts

Estimated Cash Receipts

Name of Tax or Fee	Acct Code	Fiscal Year 2026	Fiscal Year 2027	Fiscal Year 2028	Fiscal Year 2029	Fiscal Year 2030	Fiscal Year 2031	Fiscal Year 2032	Fiscal Year 2033	Fiscal Year 2034	Fiscal Year 2035	2026-35 TOTAL
Covered Lives Assessment	NEW			6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	52,466,352
Total				6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	6,558,294	52,466,352
Biennial Totals				13,116,588		13,116,588		13,116,588		13,116,588		52,466,352

Narrative Explanation (Required for Indeterminate Cash Receipts)

Section 3(1)(a) requires all health carriers to pay an annual covered lives assessment beginning January 1st of the plan year following the final approval by CMS. For assessments due the first plan year, the OIC is required to access a per member per month assessment of \$0.50 per covered life on health carriers. Based on October 2024 data for the fully insured commercial market, and limiting the assessment to 3 million member months per carrier, there were 1,093,049 persons covered under a fully insured individual or group health plan in CY2024. Assuming, for purposes of this fiscal note, that \$0.50 per covered life will be assessed and that the number of covered lives for CY2026 will remain the same as CY2024, estimated revenue of \$6,558,294 (1,093,049 covered lives x \$0.50 x 12 member months) will be collected in the first year. The number of covered lives will be captured from health carriers via the CY2026 insurance premium tax return, which is due in March 2027. OIC will then calculate and health carriers for the first plan year with a due date of July 2027.

Section 3(1)(b) requires that each year, on or before May 15th, HCA must determine the covered lives assessment for the calendar year. Section 3(2)(b) limits the assessments to the first 3,000,000 member months of fully insured lives per health carrier. For each health carrier, the assessment shall apply to member months of all group health plan lives first, followed by member months of individual health plan lives. The HCA is unable to provide the amount needed to fund the professional service rate increases for CY2027 and beyond at this time. For purposes of this fiscal note, the OIC assumes the same assessment as the first plan year.



Ten-Year Analysis

Bill Number 1392 HB	Title Medicaid access program	Agency 160 Office of Insurance Commissioner
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Agency Preparation: Jane Beyer	Phone: 360-725-7043	Date: 2/11/2025 2:54:46 pm
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