PATTY KUDERER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

Phone: 360-725-7000
www.insurance.wa.gov

OFFICE OF
INSURANCE COMMISSIONER

June 30, 2025

Rep. Dan Bronoske, Chair, House Health Care and Wellness Committee
Sen. Annette Cleveland, Chair, Senate Health and Long-Term Care Committee
Rep. Timm Ormsby, Chair, House Appropriations Committee
Sen. June Robinson, Chair, Senate Ways and Means Committee
Washington State Legislature
Olympia, WA 98504

RE: Office of the Insurance Commissioner Report on Essential Worker Health Benefits

Dear Rep. Bronoske, Sen. Cleveland, Rep. Ormsby, Sen. Robinson and members of the House and Senate health care and fiscal committees:

Sec. 142(27) of SB 5950 directed the Office of the Insurance Commissioner (OIC) to conduct a feasibility analysis (hereafter, "report") of ways to enhance health coverage for essential workers. Specifically, the proviso directed OIC to focus on essential workers whose employers receive public funding to provide direct services to vulnerable populations, including but not limited to behavioral health, housing and homelessness, and childcare services. Sec. 204(48) of SB 5950 separately required the Department of Social and Health Services (DSHS) to submit to the Legislature an implementation plan for a health benefits program for nursing home workers. DSHS submitted its implementation plan on December 15, 2024 assessing a health benefit trust modeled on Oregon's multi-employer Essential Workers Healthcare Trust. OIC consulted with DSHS and considered how this type of health benefit trust could serve essential workers in non-nursing home settings.

The report found that **fully insured Association Health Plans (AHPs) and self-insured Multiple Employer Welfare Arrangements (MEWAs) are feasible options to improve health coverage for essential workers. These options could potentially provide richer benefits, lower out of pocket costs, and more affordable premiums for essential workers** compared to existing coverage options.[1] These options, depending on how they are structured, could require legislative action and funding.

[1] AHPs and MEWAs are options for employers and professional trade associations to join together to access health care coverage. AHPs are a type of MEWA. AHPs are considered large group health plans in Washington and are governed by both ERISA and Washington state law (WAC 284-43-8110). A comparable self-insured arrangement is called a self-funded MEWA. In this arrangement, the employer groups take on the insurance risk of paying the full liability for health care claims within a given period, although they often purchase reinsurance or stop-loss insurance. In a fully insured plan, the health insurance carrier takes on the insurance risk of paying the full liability for health care claims within a given period.

This report is divided into two main parts. The "market analysis" section presents research on current sources of coverage for essential workers, results of interviews with essential worker employer groups, and research on other states' approaches to covering these populations. Several groups of essential workers were surveyed, including those providing childcare, adult family home, behavioral health, hospital, and housing services. The "policy options" section of the report evaluates a list of policy approaches for improving health coverage for essential workers and selects two policy options for a feasibility analysis (fully insured AHPs and self-funded MEWAs). For these two policy options, the report estimates potential cost savings for essential workers and employers, as well as potential costs to the state in the form of state Medicaid funds.

OIC contracted with Risk and Regulatory Consulting, LLC to prepare the report. Their assumptions are based on current law as of the date of the report. Future changes to federal law, especially Medicaid financing mechanisms such as directed payments, could affect this report's results.

Key Findings from The Report

- Essential workers face significant challenges in accessing affordable health coverage.
- There is a diverse range of essential workers, with varying demographics, employment structures, and sources of health coverage (such as self-funded group health plans, Medicaid, and Health Benefit Exchange coverage).
- Many employer groups struggle to provide affordable health coverage to essential workers. They cited the complexity and expense of purchasing coverage, financial pressures, lack of access to data, challenges retaining workers, and other issues.
- OIC considered the following policy options: targeted Exchange subsidies, targeted Exchange outreach and marketing, increased Medicaid reimbursement to providers, creating a Basic Health Program, authorizing self-funded MEWAs and fully insured AHPs.
- After considering advantages and disadvantages of each option above, a feasibility analysis of fully insured AHPs and self-funded MEWAs was conducted. These plans would have a lower premium rate for employers and employees and lower enrollee cost-sharing than comparable coverage in the individual health insurance market. The report found that cost savings to workers and employers resulting from these options would vary depending on whether the state could access increased Medicaid reimbursement to health care providers. The report estimated the effects "with" and "without" increased Medicaid reimbursement to these providers.

Cost Saving Estimates for Essential Workers and their Employers

Below are tables showing the potential health care cost savings, per covered life, to essential workers and their employers that might result from establishing a fully insured AHP or self-insured MEWA.

Cost Savings of fully insured Association Health Plan or self-insured Multiple Employer Welfare Arrangement[2] ***Without* Increased Medicaid Reimbursement to Health Care Providers**
• Adult Family Home Workers: **1.0% to 12.7% cost reduction** • Childcare Workers**: 6.8% to 18.2% cost reduction**

Cost Savings of fully insured Association Health Plan or self-insured Multiple Employer Welfare Arrangement ***With* Increased Medicaid Reimbursement to Health Care Providers**
• Adult Family Home Workers: **39.2% to 42.3% cost reduction**[3]

[2] The analysis compares these options to individual health plans offered on the Exchange before any premium subsidies. The report anticipates that individuals who currently are under-insured in an employer plan, on Medicaid, or not insured would benefit from these options. The percentages represent the reduction in employer/employee costs per covered life. The full report explains the methodology and assumptions.

[3] Per 42 CFR § 447.272, Medicaid reimbursements to health care providers (also called supplemental payments) are not available to childcare workers, nor are these providers' services covered by Medicaid. The savings range for this group of essential workers is only provided for a scenario without increased Medicaid reimbursement to health care providers.

Estimated Costs to the State

The tables below show estimates of the total yearly cost to the state and federal government, by funding source, for AHP and MEWAs to cover adult family home workers and childcare workers. Increased Medicaid reimbursement represents new state funding. Dollars are in millions.[4]

Adult Family Home Workers	Distribution	2027 (M)	2028 (M)	2029 (M)
Employer/Employee	52.0%	$38.6	$60.2	$84.9
State (Medicaid – Premium Assistance)	1.8%	$1.4	$2.1	$3.0
State (Medicaid – Increased Reimbursement to Health Care Providers)	14.9%	$11.0	$17.2	$24.3
State (Medicaid Total)	16.7%	$12.4	$19.3	$27.3
Federal (Medicaid)	31.3%	$23.2	$36.2	$51.1
Total	**100%**	**$74.2**	**$115.7**	**$163.3**
Projected Subscribers		4,645	6,925	9,361
Projected Covered Lives		7,433	11,080	14,977

Childcare Workers	Distribution	2027 (M)	2028 (M)	2029 (M)
Employer/Employee	76.7%	$27.8	$43.2	$60.9
State (Medicaid – Premium Assistance)	2.3%	$0.8	$1.3	$1.8
Federal (Medicaid)	20.9%	$7.6	$11.8	$16.6
Total	**100%**	$36.2	$56.3	$79.4
Projected Subscribers		**2,422**	**3,601**	**4,863**
Projected Covered Lives		**3,876**	**5,761**	**7,780**

[4] The full report explains the methodology and assumptions behind these estimates.

The full report by Risk and Regulatory Consulting, LLC, is attached for your review.

We look forward to further discussion regarding this report. Please feel free to reach out with any questions.

Best,

Jane Beyer
Senior Health Policy Advisor

Nico Janssen
Senior Health Policy Analyst

Final Report

Essential Worker Health Benefits Feasibility Study

WASHINGTON STATE OFFICE OF INSURANCE COMMISSIONER

06/23/2025

Contents

1. Executive Summary

The Washington State Office of the Insurance Commissioner (OIC) commissioned Risk and Regulatory Consulting (RRC) to conduct a feasibility study on enhancing health benefits for essential workers. This study, mandated by the Legislature through ESSB 5950, explores options for improving health care coverage for essential workers whose employers receive significant public funding. These workers include those in behavioral health services, long-term services and supports, childcare, and housing and homelessness services.

The study involves extensive research and interested group interviews to identify barriers to accessing health care coverage and to develop potential solutions. Interested groups included organizations serving essential workers and state agencies. Feedback from other states also was obtained. The analysis was divided into two primary sections: Market Analysis and Policy Options.

This study considers the existing structure for Washington state Health Benefit Exchange (Exchange) plans made available by the Affordable Care Act and Medicaid eligibility and requirements as of May 19, 2025. We do not consider any potential future changes currently being considered by the federal government to either the Affordable Care Act or to Medicaid eligibility and requirements.

Key Findings

- Essential workers currently face significant challenges in accessing affordable health care coverage.
- There is a diverse range of essential worker populations, with varying demographics and employment structures. Essential workers currently receive health coverage through many different sources.
- Organizations representing essential workers and their employers highlighted issues such as data limitations, diversity within the essential worker population, affordability of health care coverage, the complexity and difficulty of purchasing health coverage, retaining employees, and unique challenges faced by essential workers.
- This feasibility analysis considers several policy options, including targeted subsidies for essential workers to purchase health plans on the Exchange, increasing Medicaid reimbursement to health care providers, authorizing a self-insured Multiple Employer Welfare Arrangement (MEWA), and formation of a fully insured association health plan.
- Based on a review of the policy options, we selected two main options for the feasibility analysis: **self-insured MEWAs** and **fully insured association health plans**[1].

[1] Association Health Plans (AHPs) and Multiple Employer Welfare Arrangements (MEWAs) are options for employers and professional trade associations to join together to access healthcare coverage. AHPs are a type of MEWA. They are regulated by state and federal law and allow qualified small employers to join together to buy coverage similar to large employers. AHPs are governed by both ERISA and Washington state law WAC 284-43-8110. In a self-insured plan, the employer groups take on the insurance risk of paying the full liability for healthcare claims within a given period. In a fully insured plan, the insurance carrier takes on the insurance risk of paying the full liability for healthcare claims within a given period.

Results of Feasibility Analysis

The feasibility analysis (discussed further in Section 4.2.2 of this report) evaluates the potential impact of implementing self-insured MEWAs and fully insured association health plans. Key metrics included total annual costs for coverage and employer/employee contribution requirements. The anticipated annual costs are allocated to each of the funding sources based on information from Oregon's Essential Worker Health Trust (EWHT) and the current distribution of Medicaid enrolled essential workers in each cohort in Washington state. The funding sources include the following:

- Employee and Employer Contributions
- Washington state Medicaid Funding, which includes the following sources:
    - Premium Assistance – Funding through which the employee is Medicaid-eligible and the Washington state Health Care Authority (HCA) is paying the employer sponsored insurance premium because it is cost-effective,
    - Medicaid Reimbursement Rates to Health Care Providers – Funding through increases in Medicaid reimbursement rates paid to providers that could be used to provide greater access to health coverage for employees. This could be through directed payments for managed care organizations (MCOs) or supplemental payments for fee-for-service (FFS) providers. This is the approach taken by Oregon.
- Federal Medicaid Funding, which is accessed through the Federal Medical Assistance Percentage (FMAP)

Below, we show our estimate of the difference between the proposed plan options and current plan options on the Exchange. We also show the potential cost to the state in the form of increased Medicaid reimbursement to health care providers (which are eligible to be matched with federal funds). The analysis found that these options could provide richer benefits, less member cost share, at more affordable premiums compared to existing employer-sponsored coverage and Exchange plans. The analysis compares these options to individual health plans offered on the Exchange. We anticipate that individuals who currently are under-insured in an employer plan, on Medicaid, or not insured would benefit from these options.

Cost savings as a result of forming the self-insured MEWA and/or fully insured association health plan options are expected to vary depending on whether Medicaid supplemental payments are accessed. The percentages below reflect the reduction in employer/employee costs per covered life compared to current Exchange plans.

<u>Without Increased Medicaid Reimbursement to Health Care Providers</u>

- Adult Family Home Workers: 1.0% to 12.7% reduction
- Childcare Workers: 6.8% to 18.2% reduction

<u>With Increased Medicaid Reimbursement to Health Care Providers</u>

- Adult Family Home Workers: 39.2% to 42.3% reduction

It is our understanding that per 42 CFR § 447.272[2], Medicaid supplemental payments are not applicable for childcare workers and Medicare provider reimbursement rates do not apply either, so the savings range for this group of essential workers is only provided for a scenario without increased Medicaid reimbursement to health care providers.

The tables below show our estimate of the total cost by year and cohort broken out by funding source separately for adult family home workers and for childcare workers. Increased Medicaid reimbursement to health care providers funded by the state shown in the first table below represent **new spending** by the Washington state general fund.

Adult Family Home Workers	**Distribution**	**2027 (M)**	**2028 (M)**	**2029 (M)**
Employer/Employee	52.0%	$38.6	$60.2	$84.9
State (Medicaid – Premium Assistance)	1.8%	$1.4	$2.1	$3.0
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Total	**100%**	$36.2	$56.3	$79.4
Projected Subscribers		**2,422**	**3,601**	**4,863**
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Implementing self-insured MEWAs and fully insured association health plan options appears feasible compared to currently available individual health plans sold on the Exchange prior to consumer premium subsidies[3]. These plans would have a lower premium rate for employers and employees and less member cost sharing, which could make health care more affordable and accessible for essential workers. These

[2] https://www.law.cornell.edu/cfr/text/42/447.272

[3] We note that benefits offered by a MEWA and AHP may not offer the same level of comprehensive coverage as an Exchange plan which is required to cover Essential Health Benefits. In the Oregon EWHT, plan options were selected for Kaiser HMO and Regence BCBS PPO. The Kaiser option was selected to allow for continuity of coverage for existing employees prior to creation of the EWHT.

plans would require legislative action and funding to establish and maintain them. In addition, securing increased Medicaid reimbursement to support these programs would likely require federal approval. This study recommends:

1. **Legislative Action**: Secure funding for implementation and make necessary regulatory changes.
    - There are two components related to funding that would require legislative action. If the state decides to pursue increased Medicaid funding through directed or supplemental payments, the first legislative action would be to enable the submission of a Medicaid supplemental payment application to secure state and federal funds. If the state decides to pursue additional Medicaid payments through increased reimbursement rates to providers, a State Plan Amendment may be needed. The second is securing general funds for seed funding which would likely be required to establish the self-funded MEWA. This would not be the case for a fully insured AHP unless the state wanted to provide stop loss support for the initial years of operation.
    - Regulatory changes would be required to authorize the self-insured MEWA option. Currently, Chapter 48.125 RCW effectively prevents any new self-insured MEWA from forming. It was enacted in 2004 in response to solvency concerns related to existing self-insured MEWAs. Regulatory changes would be needed to allow new self-insured MEWAs and to establish the necessary oversight of solvency and other consumer protection guardrails.
2. **Targeted Outreach**: Develop a comprehensive marketing and outreach campaign to educate essential workers about available health care options.
3. **Ongoing Evaluation**: Monitor and evaluate the effectiveness of implemented plans to ensure they meet the needs of essential workers on an ongoing basis.

This study provides an overview of the current landscape of health care coverage and discusses options for enhancing health benefits for essential workers in Washington state, aiming to improve access to affordable and comprehensive health care coverage for those who provide critical services to vulnerable populations. This study serves as the first step in evaluating various policy options. The estimates produced in this study are intended to serve as a feasibility analysis and are not intended to be used in setting premium or contribution rates. Actual cost and premium rates will almost certainly vary from the estimates provided due to the uncertainty inherent in these estimates.

2. Introduction

The Washington Office of the Insurance Commissioner (OIC) contracted with Risk and Regulatory Consulting (RRC) to prepare an Essential Worker Health Benefits Feasibility Analysis Study as directed by the Legislature in Sec. 142(27) of ESSB 5950[4]. The study was conducted in partnership with the Washington State Health Care Authority (HCA) and the Washington State Department of Social and Health Services (DSHS). The purpose of the study is to explore options to enhance health care coverage for essential workers whose employers receive significant public funding to provide direct services to vulnerable populations, such as behavioral health service providers, long term services and supports providers, childcare providers, and housing and homelessness service providers. We investigated the obstacles to enhanced health benefit coverage through research and interviews, explored policy alternatives, and developed potential policy options to reduce the barriers to accessing health care coverage for these essential workers. This report documents our analysis and is the result of the study.

The scope of essential workers discussed in this report are those described above and not the broader definition of essential workers, which include all workers whose job is considered necessary for the functioning of society.

During the 2024 legislative session, the Legislature also directed DSHS to develop a plan for a phase-in of an essential worker health benefits program for nursing facility employees and to evaluate the feasibility of such a program. DSHS completed their analysis and posted their report[5] in December 2024. We were directed to consider the options reviewed by DSHS and evaluate whether their proposal could be expanded or modified to include additional groups of essential workers in our study. DSHS considered three options: utilization of the existing SEIU 775 Multiemployer Health Benefits Trust, establishing a self-funded Multiple Employer Welfare Arrangement (MEWA) like the model used in Oregon[6], and establishing a fully insured association health plan. We considered these options in our analysis.

Our analysis is divided into two primary sections, Section 3. Market Analysis and Section 4. Policy Options. In Section 3, we summarize key themes related to access to health care coverage for essential workers and provide an overview of the current market. The purpose of this section is to report on current sources of health coverage, covered benefits, and costs of health care coverage for essential workers in Washington state, including but not limited to employer sponsored coverage, Medicaid, and individual health plans purchased through the Exchange. We also discuss the employer and employee shares of health care premiums, the value of the coverage provided, the scope of covered benefits, employee cost-sharing obligations and availability of coverage for dependents. This information comes from feedback collected from interested groups as well as independent research. There were three primary groups of interested groups consulted during this project: organizations and agencies that serve essential workers, Washington state

[4] https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5950-S.SL.pdf?q=20250412064304
[5] https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HBT%20report%20draft%20ALTSA_final_d48421e8-41f8-45be-bc0a-2a7303815b96.pdf
[6] https://essentialworkerhealth.org/about/about-the-trust/

agencies, and other states' agencies.

In Section 4, we present the policy options considered and the results of the feasibility analysis. The purpose of this section is to report on the structure and oversight of current programs or new policy options for a program or programs to enhance essential worker health benefits, including expanding or modifying a program to enhance health benefits for nursing home employees developed under section 204(48) of ESSB 5950, the use of fully insured health plan coverage, a self-funded multiemployer welfare arrangement, the Washington state Exchange, or another entity to offer health benefits comparable to the Gold or Platinum metal level under the Affordable Care Act, and meet defined health plan design, consumer protection and solvency requirements.

3. Market Analysis

In this section, we summarize key themes related to access to health care coverage for essential workers and provide an overview of the current market.

3.1 Overview and Key Themes

There were two primary sources of information utilized to inform this portion of the report: interested group interviews and publicly available population and demographic data. Based on feedback from the OIC, we contacted multiple entities and were able to interview the following organizations and agencies:

- Washington Childcare Centers Association (WCCA),
- Service Employees International Union Local 925 Family Childcare Providers (SEIU 925),
- Adult Family Home Council (AFHC),
- Washington Council for Behavioral Health (WCBH),
- Service Employees International Union Healthcare 1199NW (SEIU 1199),
- Washington State Health Care Authority (HCA),
- Department of Social and Health Services (DSHS),
- Northwest Health Law Advocates (NOHLA),
- Maine Department of Health and Human Services,
- Oregon State Division of Financial Regulation,
- North Carolina Department of Health and Human Service[7],
- Pennsylvania Captive for Rehabilitation and Community Providers Association, and
- Training Fund (SEIU 1199).

We also obtained feedback from the OIC and reached out to other states for feedback on their experience providing access to health care coverage for essential workers.

Throughout the interviews and research, five main themes were identified:

1. Data limitations:
    a. Interested groups were able to provide anecdotal information about their populations but very few had quantitative data to share regarding the demographics of essential workers and their access to health care coverage.

[7] This interview occurred after the Step 3 deliverable was provided to the OIC.

b. Publicly available data provides some demographic and health care coverage data but is not specific enough to drill down into the exact cohort of interest (essential workers whose employers receive significant public funding to provide direct services to vulnerable populations).

2. Diversity within the essential worker population related to employees/providers/reimbursements:
   a. Many essential worker industries are not demographically diverse in age or gender (for example childcare workers and adult family home providers reported being predominately female and childcare workers reported having younger staff compared to other professions).
   b. There are significant differences in the types of services essential workers provide, the ways they are reimbursed or paid for those services and how they compensate their essential workers.
   c. Some of these essential workers work independently as providers themselves (such as family home childcare providers and adult family home providers) and others work for large agencies or employers (such as a behavioral health agency or a large medical system).
   d. Some essential workers are members of unions, and some are not represented by a union.
   e. Some of the employers receive significant public funding through state or federal programs and Medicaid, but many employers of essential workers also receive payment from non-public funding, such as private payments. Given this mix of funding types, interested groups were concerned that policy options which varied by funding type could contribute to disparity across various types of providers and their essential workers by providing greater benefit to certain providers based on how they are funded.

3. Access and affordability of health care coverage:
   a. While there is a mix of health care coverage offered across the cohorts of essential workers, ranging from no health care coverage to employer sponsored coverage with no employee premium share, all interested groups cited the growing cost of health care coverage as a concern.
   b. Many of the employers in the health care space who receive Medicaid reimbursement reported those rates not being sufficient to cover the growing cost of health care.
   c. Affordable health care coverage (in terms of both employee premium and out-of-pocket costs), adequate provider networks, and access to dependent coverage were top issues.
   d. Employers cannot afford to provide a premium subsidy for essential worker employees that would be sufficient to make individual coverage affordable.
   e. No interested group interviewed covered any portion of premiums for dependent coverage.
   f. Employers may not have the knowledge or administrative resources to offer a Health Reimbursement Arrangement (HRA) to reimburse employees for monthly premiums and out-of-pocket costs for individually purchased health coverage.
   g. Essential workers likely cannot afford the premium share or absorb the out-of-pocket costs of high deductible plans.

h. Many essential workers have household income that exceeds Medicaid eligibility limits but is still too low for them to afford adequate private coverage for themselves or their dependents.

i. Essential workers may not be informed about individual public options for low-cost, low-deductible plans through the Washington Exchange.

4. Issues related to employer size:

   a. Employers with less than 50 full-time employees are not mandated to offer health coverage.

   b. An employer group may not meet the required minimum employee participation standard to offer a group health plan to its employees, because many essential workers are part-time or may have coverage through a parent or spouse.

   c. Small group health plan premiums are unaffordable for many small employers.

   d. Many of the health care providers receive Medicaid reimbursement, which is not seen as sufficient to cover the growing cost of health care coverage for their employees.

   e. Many essential workers may work part-time and at various jobs, making them ineligible for benefits even if their employer does offer benefits.

   f. The employee may not be represented by a union or advocacy organization that can collectively bargain for health care coverage.

   g. Washington state does not have a Small Business Health Options Program (SHOP) on the Exchange, and small group employers must purchase health coverage directly from an insurance company or through a broker. Due to their lack of negotiating power, small employers may find the high premiums and administrative costs unaffordable.

5. Unique challenges

   a. Interested groups noted competing pressure from increasing expenses of operating their organizations. For example, childcare center providers reported the rising cost of liability insurance, which is needed to keep these centers in business, puts additional pressure on their ability to offer health care coverage.

   b. Many essential workers who work in rural areas and have a health plan with a limited provider network may forgo care rather than miss work hours to obtain care.

   c. The demographics of the essential workers for different services are not equally distributed across age and gender (for example, childcare workers are mostly younger female); therefore, the group health coverage premiums could be higher than other groups' plans if the particular demographics result in higher health care costs compared to demographics of other plans' enrollees.

   d. Turnover in these essential worker roles is high due to limited wages and benefits as well as burnout (all of the essential workers are providing care for vulnerable populations).

   e. The need for health care for essential workers is high given the risks associated with their jobs.

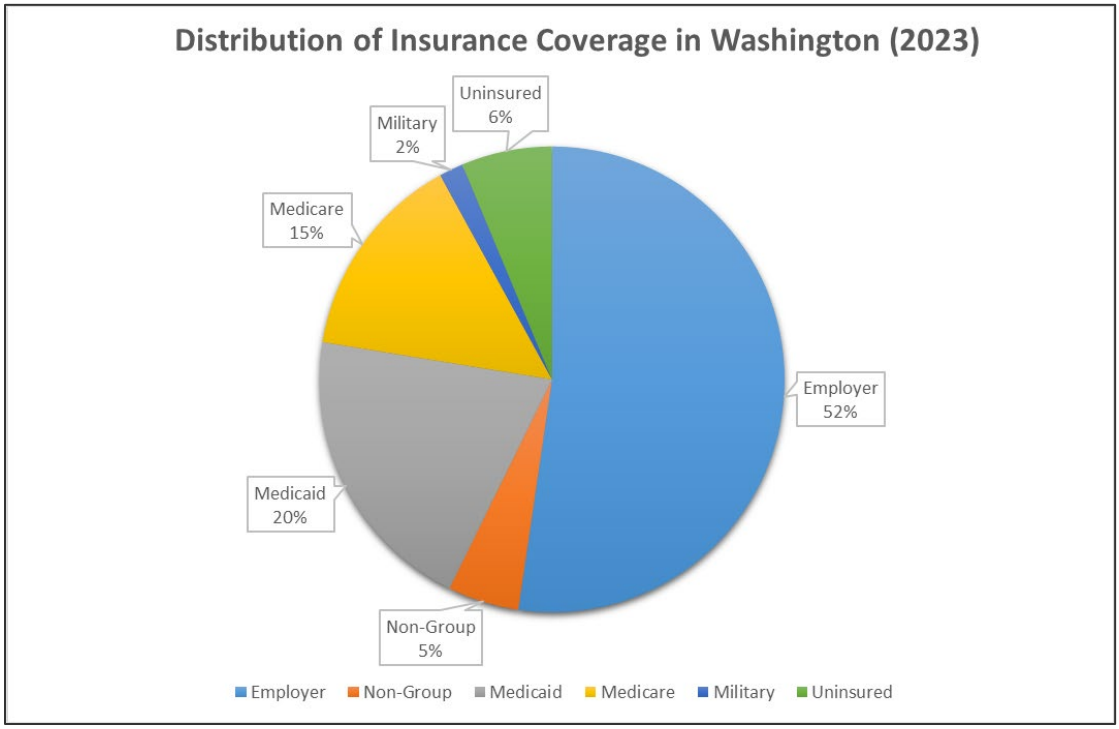
f. Adult family home providers face a unique challenge because passing Medicaid revenue through their personal accounts prevents them from qualifying for premium subsidies for themselves on the Washington Exchange.

g. Family home childcare providers also face a unique challenge. Providers (not staff) in their union (Service Employees International Union Local 925 Family Childcare Providers) are eligible for health benefits through a trust managed by a different union (Service Employees International Union Caregivers 775). To be eligible, a provider must care for at least one state subsidized child. However, the contract between the two unions has a cap of 1,000 childcare providers to participate in the health benefit trust. As of November 2024, there are 100 providers on a wait list for coverage, which can take several months, or longer.

3.2 Current Sources of Health Care Coverage

The initial stage in the study was to develop an understanding of the current coverage landscape in Washington state. This includes employer sponsored insurance (ESI), Medicaid, and individual health plans purchased through the Exchange. The different ways in which health care insurance is accessed by Washington state individuals and families, including essential workers, are discussed below. Chart 1 demonstrates the distribution of insurance coverage for the entire population of Washington state as of 2023.

CHART 1 – DISTRIBUTION OF INSURANCE COVERAGE IN WASHINGTON STATE



Source: Kaiser Family Foundation (KFF) estimates based on the 2008-2023 American Community Survey, 1-Year Estimates. Accessed 4/12/2025: https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

The majority, 52.3%, of individuals were covered in ESI plans, while 6.0% of individuals did not have coverage. In Oregon, 48.2% of individuals were covered in ESI plans and 5.4% were uninsured. Oregon had a larger portion of their population covered under Medicaid, 23.8%, compared to 20% for Washington state. On a nationwide basis, 48.6% of individuals are covered by ESI plans, 21.2% are covered by Medicaid, and 7.9% are uninsured. In this report, we do not address the Medicare and Military health care coverage options, as they generally do not apply to the essential worker population. We note that individual plans purchased through the Exchange would be included in the non-group category in the chart.

ESI plans can either be self-insured (the employer bears the risk of the claim costs) or fully insured (where the insurance carrier bears the risk of the claim costs). Group health care coverage also can be provided through associations, MEWAs, and Captives. Groups such as employer groups, trade associations, trusts, and other specified groups may join in some circumstances, to negotiate for health insurance coverage at more favorable terms than those they could receive when purchasing coverage for only their employees. Some of these coverage options are presently being used in Washington state.

Individuals who do not have access to affordable ESI plans or other group coverage may access individual coverage through a variety of options including:

> Apple Health – Washington state Medicaid coverage. Apple Health eligibility in Washington state depends on income, household size, health status, and other factors[8].
>
> Qualified Health Plans purchased on the Exchange – Federally qualified Affordable Care Act plans in multiple metal levels. All U.S. citizens who are Washington state residents are eligible for a plan, and, based on income, may receive federal advanced premium tax credit to assist with costs as well as cost-sharing reduction benefits. Additional subsidies are available through Cascade Care Savings, which is a state-funded premium subsidy program for individuals with income below 250% FPL. For those who qualify, plans are available for $0-$10 premiums.

3.3 Population Estimates

There was no direct way to measure the specific populations impacted by this study since most publicly available data sources do not go to the level of granularity needed for the study's definition of essential workers. We considered broader population statistics as well as information collected through our interviews. The Bureau of Labor Statistics (BLS) reports the estimated number of people employed in each occupation as well as salary statistics. Table 1 compiles the count of workers and median pay for certain occupations that include essential workers as defined in this study as of August 2024.

[8] https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/eligibility-overview

TABLE 1 – NUMBER OF WORKERS AND MEDIAN PAY BY OCCUPATION IN WASHINGTON STATE, AS OF AUGUST 2024

Washington State		
Occupation	**Count of Workers**	**Median Pay ($)**
Home Health and Personal Care Aides	78,990	42,350
Nursing Assistants	36,520	45,790
Medical Assistants	17,030	52,020
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	12,000	57,990
Preschool Teachers, Except Special Education	11,100	43,070
Child, Family, and School Social Workers	9,280	63,040
Social and Human Service Assistants	6,910	47,260
Licensed Practical and Licensed Vocational Nurses	6,080	76,160
Healthcare Social Workers	5,350	65,010
Childcare Workers	4,560	38,940
Rehabilitation Counselors	4,550	49,020
Social and Community Service Managers	3,230	90,640
Community and Social Service Specialists, All Other	3,190	57,910
Healthcare Support Workers, All Other	3,170	55,980
Mental Health and Substance Abuse Social Workers	2,790	59,700
Community Health Workers	2,030	52,520
Personal Care and Service Workers, All Other	1,330	44,100
Occupational Therapy Assistants	960	73,010
Psychiatric Technicians	960	48,760
Social Workers, All Other	710	92,780
Psychiatric Aides	260	48,890
Occupational Therapy Aides	40	50,380
Total	**211,040**	**49,210**

We expect that the information in Table 1 includes more than just the essential workers covered by this study because it is based solely on occupation not employer, but it is an approximation for the potential number of individuals impacted (about 200,000) and their median pay (approximately $50,000 across all groups). Some of these employees may currently have access to high quality and low cost care, while many others do not.

To further understand current access to health care coverage and the demographics of essential workers, we drew distributions of survey participants related to health insurance coverage and race/ethnicity from the American Community Survey (ACS). Chart 2 below shows the percentage of workers with health insurance coverage for a grouping of occupations in essential worker industries in both Washington state and nationwide, as of 2022. We note that only individuals who are currently employed are included in the values below.

CHART 2 – INSURANCE COVERAGE FOR GROUPED ESSENTIAL WORKER OCCUPATIONS

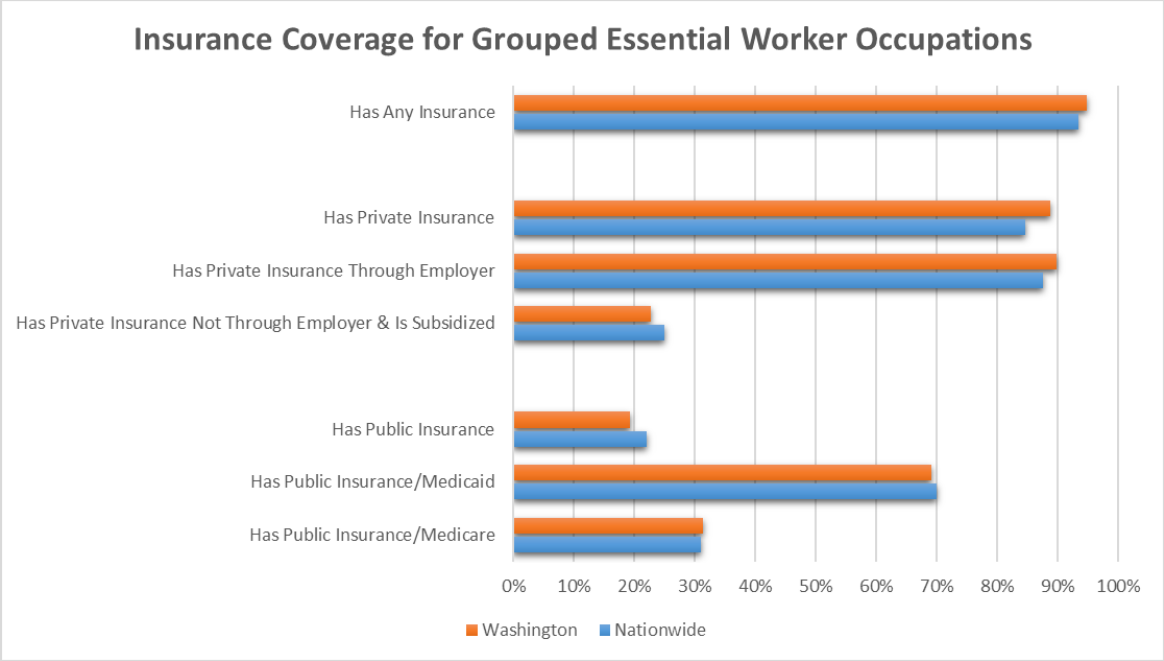


Chart Notes:

1. Essential worker occupations included in the distributions: "Childcare Workers", "Community and Social Service Specialists", "Counselors", "Licensed Practical and Licensed Vocational Nurses", "Medical Assistants and Other Healthcare Support", "Nursing, Psychiatric, and Home Health Aides", "Personal Care Aides", "Personal Care and Service Workers, All Other", "Physical Therapist Assistants and Aides", "Preschool and Kindergarten Teachers", "Registered Nurses", "Residential Advisors", "Social and Community Service Managers", "Social Workers", and "Therapists"
2. *Values reported for Private Insurance, Medicaid, and Medicare are not mutually exclusive as some survey respondents responded yes for multiple coverages (e.g., dual eligible Medicaid and Medicare individuals); thus, values will not add up to 100%.

94.8% of Washington state ACS survey respondents have insurance coverage, which is higher than the nationwide statistic of 93.4% of respondents. 88.7% of Washington state respondents have private insurance. Within this group, 89.7% have insurance through their employer and 22.7% have insurance through a source other than their employer that is subsidized (values do not sum to 100% as some respondents report multiple types of insurance). 19.2% of Washington state survey respondents have public insurance which is lower than the nationwide statistic of 22.0% respondents. Of those Washington state survey respondents with public insurance, the majority have Medicaid coverage (69.1%)

Despite having health insurance coverage, many Washington state residents cannot afford to access health care due to insurance plan provisions such as coverage limitations, limited provider networks, and significant cost sharing requirements. A survey of Washington state residents conducted in 2024 found that more than half did not get the medical care they needed in the prior year because of cost and many residents carry medical debt. Small group employers reported cost a primary driver of not offering health insurance coverage to employees with nearly one in three small group employers facing annual premium rate increases of 15% or more[9].

[9] https://fairhealthprices.org/wp-content/uploads/2024/08/Press-Release-2024-WA-Health-Care-Survey.pdf

Table 2 below contains health insurance coverage percentages by occupation for workers in essential worker occupations nationwide, as of 2022. Washington state-only data is not shown for each occupation due to a small sample size limiting credibility but is shown in the aggregate across the selected occupations. We observe that some occupations have health insurance coverage at greater levels than other occupations. For example, the distribution of those with health insurance coverage working as Home Health Aides is 90%, for Childcare Workers it is 88%, and for Registered Nurses it is 97%. We also note variance in the distribution of those with private insurance, Medicaid, or Medicare. Childcare Workers (27.4%), Home Health Aides (30.4%), and Personal Care Aides (37.9%) have the highest distribution of workers accessing health care coverage through Medicaid. Only individuals who are currently employed are included in the values below.

Table 2 – Insurance Coverage for Specific Essential Worker Occupations

Nationwide				
Has Insurance Coverage*	**Yes**	**Has Private Insurance**	**Has Medicaid**	**Has Medicare**
Childcare Workers	87.9%	72.2%	27.4%	8.5%
Community and Social Service Specialists	96.9%	87.4%	11.7%	7.1%
Counselors	95.7%	91.0%	8.4%	6.7%
Licensed Practical and Licensed Vocational Nurses	92.1%	86.8%	13.2%	6.7%
Medical Assistants and Other Healthcare Support	93.1%	86.2%	15.9%	3.3%
Nursing, Psychiatric, and Home Health Aides	89.5%	71.0%	30.4%	7.8%
Personal Care Aides	87.9%	60.8%	37.9%	15.4%
Personal Care and Service Workers	89.7%	76.7%	21.2%	9.4%
Physical Therapist Assistants and Aides	94.1%	91.3%	8.9%	2.2%
Preschool and Kindergarten Teachers	92.3%	85.5%	15.9%	4.0%
Registered Nurses	97.1%	95.7%	3.7%	5.0%
Residential Advisors	93.4%	83.8%	15.9%	3.5%
Social and Community Service Managers	97.1%	91.9%	6.8%	7.1%
Social Workers	96.2%	92.1%	8.4%	5.7%
Therapists	95.8%	89.4%	10.0%	6.7%
All Occupations Listed Above	**93.4%**	**84.6%**	**15.4%**	**6.8%**
All Occupations	**90.8%**	**87.8%**	**11.5%**	**6.8%**

Washington State				
Has Insurance Coverage*	**Yes**	**Has Private Insurance**	**Has Medicaid**	**Has Medicare**
All Occupations Listed Above	**94.0%**	**88.7%**	**13.3%**	**6.0%**
All Occupations	**93.0%**	**89.5%**	**10.8%**	**5.8%**

*Values reported for Private Insurance, Medicaid, and Medicare are not mutually exclusive as some survey respondents responded yes for multiple coverages (e.g., dual eligible Medicaid and Medicare individuals); thus, values will not add up to 100%.

In addition to insurance coverage, the ACS also collects information related to race and ethnicity. To further understand the demographic composition of the essential worker population, we reviewed the distribution[10] of essential workers by industry and for race and ethnicity nationwide, as of 2022. Washington state-only data is not shown for each occupation due to a small sample size limiting credibility. We observe that some occupations comprise more people of color (i.e., Asian/Asian Americans, Black/African Americans, and Hispanic/Latinos) than other occupations. For example, the distribution of people of color working as Home Health Aides is 59%, for Childcare Workers it is 44%, and for Registered Nurses it is 30%.

TABLE 3 – RACE AND ETHNICITY FOR SPECIFIC ESSENTIAL WORKER OCCUPATIONS

Nationwide					
Occupation	**Asian/ Asian American**	**Black/ African American**	**Hispanic/ Latino**	**White**	**Other**
Childcare Workers	4.1%	12.8%	27.5%	50.1%	5.5%
Community and Social Service Specialists	6.0%	18.6%	19.7%	49.8%	5.8%
Counselors	3.2%	17.0%	14.4%	60.2%	5.2%
Licensed Practical and Licensed Vocational Nurses	5.6%	16.0%	25.1%	48.5%	4.8%
Medical Assistants and Other Healthcare Support	5.5%	25.6%	14.2%	50.6%	4.1%
Nursing, Psychiatric, and Home Health Aides	6.3%	33.0%	19.8%	35.6%	5.4%
Personal Care Aides	9.5%	24.2%	22.9%	38.1%	5.3%
Personal Care and Service Workers	5.8%	11.6%	17.5%	59.5%	5.6%
Physical Therapist Assistants and Aides	9.8%	9.1%	13.6%	63.2%	4.3%
Preschool and Kindergarten Teachers	4.3%	13.3%	15.5%	62.7%	4.1%
Registered Nurses	9.3%	11.6%	9.0%	65.7%	4.5%
Residential Advisors	7.0%	22.7%	13.0%	50.1%	7.2%
Social and Community Service Managers	3.6%	15.6%	12.9%	62.3%	5.6%
Social Workers	3.5%	20.3%	17.1%	54.0%	5.1%
Therapists	4.0%	11.3%	13.9%	66.6%	4.3%
All Occupations Listed Above	**6.6%**	**18.3%**	**16.5%**	**53.7%**	**4.9%**
All Occupations Total Across All Industries	**6.5%**	**11.3%**	**18.6%**	**58.9%**	**4.7%**

[10] The ACS study contains separate questions on race and ethnicity. To combine them into a single race and ethnicity term, we define *race and ethnicity as the following:*

- *Asian/Asian American – survey participants responding to the race field as Chinese, Japanese, or Other Asian or Pacific Islander and the Hispanic Origin field as Not Hispanic*
- *Black/African American – survey participants responding to the race field as Black/African American and the Hispanic Origin field as Not Hispanic*
- *Hispanic/Latino – survey participants responding to the race field as Other Race, Two Major Races, Three or More Major Races, and the Hispanic Origin field as Mexican, Puerto Rican, Cuban or Other*
- *White – survey participants responding to the race field as white and the Hispanic Origin field as Not Hispanic*
- *Other – survey participants responding to the race field as other or American Indian or Alaska Native*

Washington State					
Occupation	**Asian/ Asian American**	**Black/ African American**	**Hispanic/ Latino**	**White**	**Other**
All Occupations Listed Above	**10.9%**	**8.5%**	**13.2%**	**59.3%**	**8.1%**
All Occupations Total Across All Industries	**11.8%**	**4.0%**	**13.1%**	**63.9%**	**7.3%**

We reviewed data from a 2020 study[11] of essential workers in Washington state, which aggregated 2014-2018 race and ethnicity distributions of Washington state workers by industry groupings from the ACS. The authors did not define what occupations made up these industry groupings or how they composed their race and ethnicity groupings. In order to identify any changes in demographics in more recent data, we summarized the 2022 data for similar industry and race and ethnicity groupings. We note that the distribution of people of color in childcare and social services increased from 31% (2014-2018) to 35% in 2022, while it remained at 28% between the two time periods for workers in health care. Table 4 summarizes this information.

TABLE 4 – RACE AND ETHNICITY BY INDUSTRY GROUPING

Race & Ethnicity	WA 2014-2018 Average (study definition of industry groups)	
	Childcare & Social Services	Health Care
Asian	9%	13%
Black	9%	7%
Hispanic	13%	8%
White	66%	70%
Other	3%	2%

Race & Ethnicity	WA 2022 (our definition of industry groups)	
	Childcare & Social Services	Health Care
Asian/Asian American	11%	10%
Black/African American	10%	8%
Hispanic/Latino	14%	10%
White	56%	64%
Other	9%	8%

We also reviewed a 2023 study[12] regarding the composition of the Washington state Long-Term Care workforce, also based on ACS data. The study included two analyses of direct care workers demonstrating the public assistance received by these workers and the parental status (i.e., number of dependents at home). Charts 3 and 4 show distributions for direct care workers in home care, residential care, and facilities. Chart 3 shows that nearly 50% of all direct care home care workers receive some form of public assistance, while Chart 4 shows that 30% of these workers have at least one dependent under age 18.

[11] Liz Olson, Washington state's essential workers deserve relief & real protections, July 20, 2020; *https://budgetandpolicy.org/schmudget/washington-states-essential-workers-deserve-relief-real-protections/*

[12] Donald Smith Jr, Dula, Christopher, Fite, Claire, et al; Washington Long-Term Care Workforce Initiative Legislative Report; Fall 2023; https://wtb.wa.gov/wp-content/uploads/2023/12/LTC-Workforce-Annual-Report-FINAL4-2023.pdf

CHART 3 – DIRECT CARE WORKERS RECEIVING PUBLIC ASSISTANCE IN WASHINGTON STATE, AS OF 2020

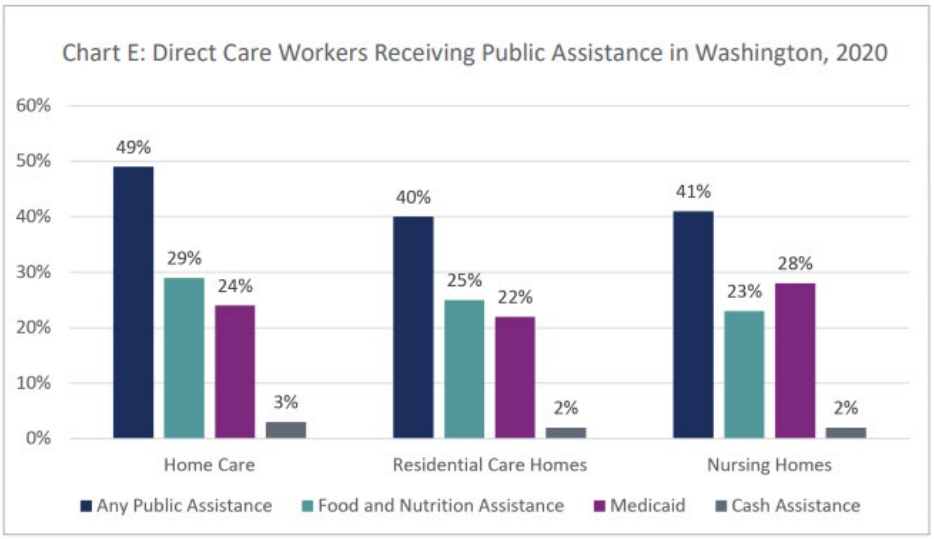
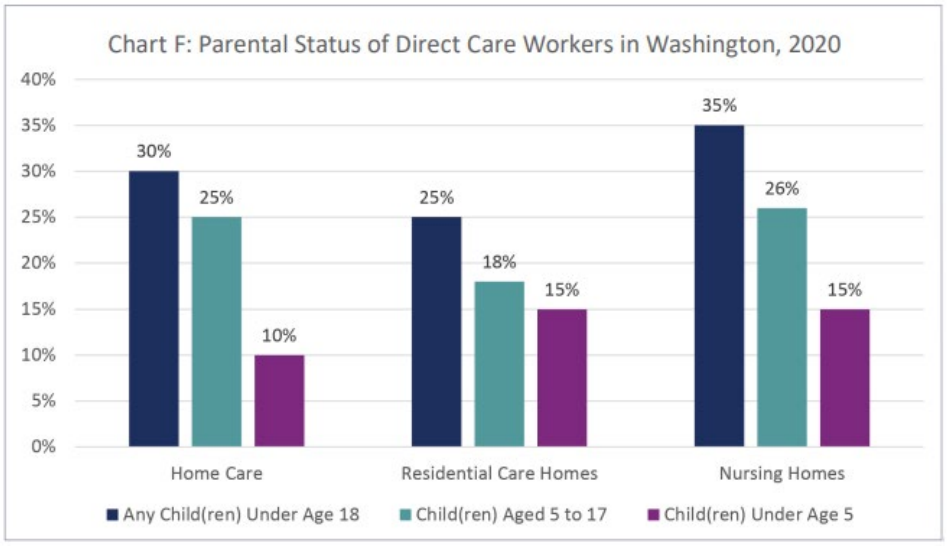


CHART 4 – PARENTAL STATUS OF DIRECT CARE WORKERS IN WASHINGTON STATE, AS OF 2020



3.4 Interested Groups

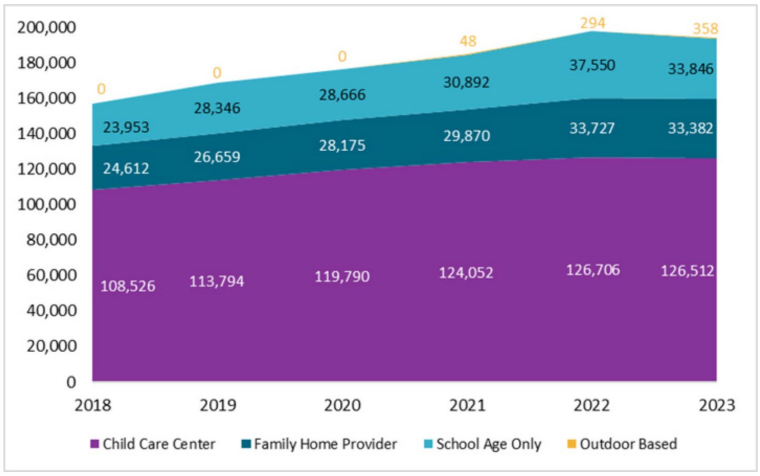
The following sections summarize key information we received through our meetings and supporting research for each interested group.

3.4.1 Childcare Center Essential Workers

According to the Washington State Department of Children, Youth & Families (DCYF) website, in 2023 Washington state had more than 5,700 licensed or certified childcare facilities, with a total licensed capacity of over 190,000 children. Licensed programs include childcare centers, family home childcare providers,

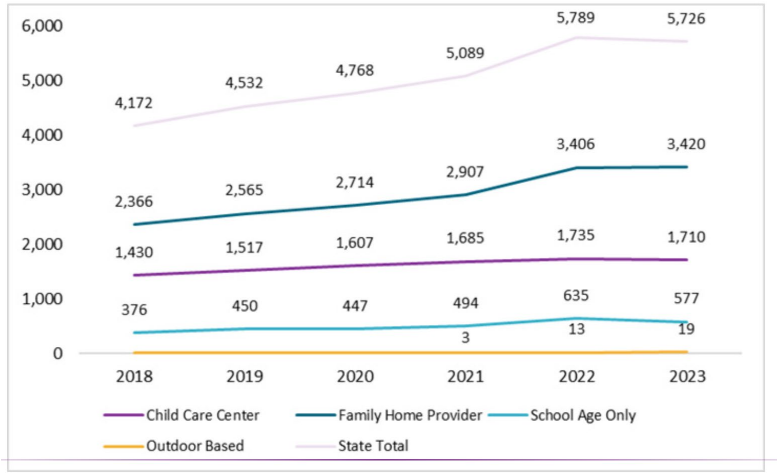
school-age care, and licensed outdoor-based programs. According to the DCYF charts below, childcare centers represent about 30% of childcare providers in 2023, and care for more than 65% of children.

CHART 5. LICENSED CAPACITY OF CHILDCARE PROVIDERS, BY TYPE, END OF STATE FISCAL YEARS 2018-2023



Source: Licensed Capacity | Washington State Department of Children, Youth, and Families

CHART 6. NUMBER OF LICENSED CHILDCARE PROVIDERS, BY TYPE, END OF STATE FISCAL YEARS 2018-2023



Source: Licensed Capacity | Washington State Department of Children, Youth, and Families

We spoke with five board members of the Washington Childcare Centers Association (WCCA). Each board member is also a childcare center owner in varying geographic areas of the state. Eligible individual families receive state subsidies for childcare. The percentage of subsidized vs. unsubsidized families varies by childcare center but for some centers up to 90% of the children's families receive subsidies for childcare. The following information was collected from our interview with the WCCA board members.

a) Workforce Characteristics

Childcare center staff typically fall into three key role categories, all of which are essential to the operation and quality of care in early learning settings:

- Assistant Teachers or Aides – These team members often work part-time and support classroom routines, supervision, and learning activities. Turnover in these roles can be high due to low wages, limited benefits, and fewer opportunities for advancement.
- Lead Teachers – Experienced early childhood educators who typically work full-time and take primary responsibility for curriculum planning, classroom management, and family engagement. While turnover is generally lower in these positions, the field as a whole continues to face retention challenges.
- Directors or Owner-Operators – In many centers, especially smaller or independently owned programs, directors not only manage all administrative and business operations—including staffing, licensing, enrollment, and budgeting—but also work directly in classrooms to maintain adult-to-child ratios and ensure high-quality care.

Availability of health benefits and access to health plans with low-cost sharing are primary concerns for essential childcare workers. The out-of-pocket costs associated with high-deductible plans are not affordable to most childcare workers. Some of the workers have access to health coverage through their spouse, receive benefits through individually purchased plans on the Washington state Exchange, or are dependents on a parent's plan (for workers under age 26). The turnover among childcare workers is high as they leave employment at childcare centers for higher wages and/or jobs with better benefits.

b) Current Health Coverage and Challenges

Childcare center owners want to offer health benefits to their workers and their dependents, but they face financial obstacles.

1. WCCA does not have collective bargaining rights for health care benefits for owners or employees of childcare centers. They expressed interest in accessing health coverage choices through a collective plan with another population that is more diverse, which would spread the risk from the unbalanced demographics of childcare center workers across among a broader demographic base, thus lowering health care premiums.
2. The rising cost and denial or cancellation of liability insurance, which is needed to keep these centers in business, puts additional pressure on their ability to offer health care coverage.
3. A portion of the large-scale childcare centers and multi-site businesses have the economies of scale and minimum number of employees needed to participate in small group health benefits, often with a lower deductible health plan. However, those that can afford to pay a portion of premium for their full-time workers are unable to afford extending coverage to part-time workers or dependents and find they must reduce coverage levels each year due to rising premiums.

4. Small childcare centers may not offer health benefits. Owners either cannot afford any amount of premium share or they do not meet the minimum employee participation requirements set by health insurers to offer small group benefits.

c) Public Funding Options

In response to the COVID-19 pandemic, the American Rescue Plan Act (ARPA) Childcare Stabilization program provided grant funds to help keep center-based and family childcare providers maintain financial stability, support, and grow the diverse early learning workforce to rebuild a stronger childcare system and expand access to affordable, high-quality childcare. The funding extended from Spring 2021 through Fall 2023[13].

WCCA members experienced several challenges with this one-time grant funding. Many childcare center workers did not qualify for premium subsidies from the grant funding since their household income was above the allowed limit. Additionally, some workers who did qualify did not enroll in the offered subsidized plan because it had an unaffordable, high deductible and the extension of Medicaid benefits was a better option for those workers.

d) Current Concerns Cited by Interested Group

WCCA is not interested in establishing their own health benefit trust. However, they feel that doing so would not yield affordable premiums due to their largely female worker population. Instead, WCCA believes having their center members accessing coverage choices through a collective plan with another association is ideal. First, their worker demographics would blend into a larger pool which would lower the average premium. Second, forming a larger pool with another association would provide more health care plan options, including low deductible plans. For childcare center employers, the ability to offer more than one health plan is ideal for workers who may want to and be able to pay more for richer benefit coverage. Next, being part of a larger pool could mean that center owners could lower their minimum eligibility requirement for health care coverage to 20+ hours per week for their essential workers. Finally, WCCA would like individual centers to have the option to participate in the association plan or provide their own small group benefits.

3.4.2 Family Home Childcare Provider Essential Workers

According to DCYF, family home care providers represent nearly 60% of childcare provider types in 2023, and care for more than 17% of children in care in the state.

[13] https://www.wahbexchange.org/content/dam/wahbe-assets/legislation/11.21.2023%20Washington%20Health%20Benefit%20Exchange%20Child%20Care%20Worker%20Report.pdf

A family home childcare business is a residential home that provides care for a maximum of 16 children. As part of our study, we spoke with Service Employees International Union Local 925 Family Childcare Providers (SEIU 925). The following information is from our interview.

a) Workforce Characteristics

There are 3,000+ family home childcare provider businesses in Washington state. The business owners are mostly female and women of color. In order to be a member of SEIU 925, the family home childcare provider must provide care to at least one child that is supported by state childcare subsidies. Most businesses are supported by at least one or two employees who are either part-time or full-time. Low wages and lack of benefits have been a barrier to fully staffing family childcare homes. Due to new state educational requirements effective August 2026, childcare providers in any role need to hold an early childhood education certificate following a minimum 12-credit program of study. Employee turnover in family home childcare settings may increase as workers move to jobs in other settings (such as school districts) that can offer higher wages commensurate with their education level.

b) Current Health Coverage and Challenges

Family home childcare provider business owners (license holders) are eligible for health benefits through a trust managed by SEIU 775. To be eligible, a license holder must care for at least one state subsidized child. If that child is no longer in their care, there is a 2-month look back for continued eligibility in the trust.

The contract between SEIU 925 and SEIU 775 allows up to 1,000 family home childcare providers (license holders) to participate in the health benefit trust. This is a contracted amount that has increased since 2009 when the contract first started. As of November 2024, there are 100 providers (license holders) on a wait list for coverage, which can take several months or longer.

Our contact at SEIU 925 stated that three years ago, the benefits changed to a high cost sharing plan with network limitations. They gave an example of an employee who had to drive more than 20 miles for care during business hours. Therefore, the coverage under the health benefit trust is still seen as limited in terms of access and affordability for childcare workers.

This contracted arrangement between these unions provides health care coverage for the childcare business owner but not their staff or dependents.

c) Public Funding Options

Other than the ARPA Childcare Stabilization program discussed above, there are no other health care coverage related subsidies or public funding available explicitly for family home childcare providers.

d) Current Concerns Cited by Interested Group

Family home childcare business owners and employees work with a vulnerable population. Family home care children needed more developmental support during COVID which has been magnified in the years

since COVID. Access to health care coverage would improve workers' health status and reduce work absences which would benefit the children they serve. Research has shown that early relational experiences have a significant impact on development and long-term outcomes. Safe, stable, consistent childcare relationships are a key component of early relational experiences[14]. SEIU 925 also highlighted the economic benefits of childcare since quality childcare enables parents to work.

3.4.3 Adult Family Home Essential Workers

An adult family home (AFH or home) in Washington state is a residential home licensed to care for up to six adult residents not related to the licensed operator of the AFH. The services provided include room, board, laundry, supervision, assistance with the activities of daily living, personal care, and social services. As part of our study, we spoke with the Adult Family Home Council (AFHC), a member organization of AFH operators in Washington state. AFHC provides advocacy, support, education, and marketing to its AFH members. The following information was collected during the interview.

There has been significant growth in this market since 2019-2020 when there were 3,000 unique adult family homes in the state. Today there are more than 5,000 unique adult family homes in Washington state, with more licenses issued each month. More than 20% of AFHs are associated with a multiple-home ownership group. However, generally operators do not view their AFH as a business and are not likely to track employee hours for data collection purposes. Alongside their family members, many operators invest considerable time caring for their residents and supplement the remaining hours with outside workers.

The number of resident beds per home generally ranges from two to six, although about 200 homes (or 4%) have expanded to 7 or 8 beds with special approval from DSHS. In total, this equates to a capacity of about 26,000 beds

AFHs can choose whether to accept Medicaid residents. The home operator enters a contract with the state and is paid a daily rate based on one of 17 different levels of resources required to care for each resident. About 90% of Washington's AFHs are contracted for Medicaid, while at any given time at least 75% of AFHs are actively receiving Medicaid funds.

a) Workforce Characteristics

There are roughly 20,000 adult family home employees in Washington. Each home employs on average 5 employees who are typically part-time and some of these employees work at multiple properties. A large portion of these essential workers are recent immigrants or first-generation Americans who might not be knowledgeable about accessing health coverage. AFH essential workers are very low paid employees who may change to jobs with higher wages and health benefits.

[14] https://burkefoundation.org/burke-portfolio/reports/early-relational-health-a-review-of-research-principles-and-perspectives/

The majority of home operators in Washington are women and/or minorities and are usually licensed home care aides, certified nursing assistants, or licensed practical nurses (LPNs). Some operators are registered nurses (RN) and physicians.

The AFHC recently surveyed operators to determine the demographics of those interested in health coverage. The small sample of 40 respondents indicated that homes who had two to four workers would be interested in affordable health care coverage. Of those employees interested, two thirds were women. The highest number of respondents were in the age category 55-60. Firm conclusions about the broader employee population cannot be drawn from this small sample of responses.

b) Current Health Coverage and Challenges

Affordability of basic health care is the largest health care issue faced by AFH operators. Access to mental health care is also of importance for operators and employees dealing with residents' illness and end of life care with no mental health support.

AFHs do not provide small group health coverage to their employees as it is unaffordable in the current small group market with such a small group size. Home operators are rarely willing or able to afford to contribute to employee access to individual coverage on the Washington state Exchange. Most home operators do not have health coverage for themselves and their families because passing their Medicaid reimbursement revenue through their personal accounts prevents them from qualifying for personal subsidies on the Washington state Exchange.

There is no assistance designed for the AFH operator to ease the financial burden of providing health coverage for their employees. Neither state nor federal funding is available specifically to private adult family home operators for health insurance premium assistance for their employees. Additionally, there is currently not an association for home operators to collectively access health coverage.

c) Public Funding Options

The AFHC collectively bargains for Medicaid reimbursement rates on behalf of any home operator accepting Medicaid. The bargaining does not extend to employees of the AFH. During the past decade, collective bargaining has increased Medicaid reimbursement rate by more than $100/day[1].

Health and welfare benefits are included in the scope of collective bargaining under Washington state law (see RCW 41.56.029). A health care benefit amount is embedded in the daily reimbursement rate. This amount is intended to be sufficient to cover silver plan coverage for the home operator who works at full capacity with all Medicaid residents. This daily rate portion does not extend to health coverage for AFH employees. AFHC would like to see the definition in the law of "adult family home provider" modified to include AFH employees as well as the operator to potentially broaden the health and welfare portion of the daily rate to benefit their staff. AFHC feels that Medicaid rates are not reimbursing at a realistic percentage of actual labor and administrative costs. Thus, these funds don't extend far enough for operators to use them to purchase health care coverage for their employees.

We note that adult family homes receive a federal tax incentive similar to what foster homes receive.

d) Current Concerns Cited by Interested Group

The AFHC is currently advocating to secure affordable health coverage for its operator members and extend coverage employees. Recently the AFHC surveyed its members to determine the cost of a meaningful health care subsidy. AFHC may also revisit the idea of forming association health plan for adult family home operators

Looking ahead, the AFHC has a newly filled Health Care Navigator position in their training network, and estimates that teaching operators about a new benefit or program would take 6 months and a well-organized campaign.

Ultimately, the AFHC would like to see the definition of "adult family home provider" in the law modified to include AFH employees as well as the operator to potentially broaden the health and welfare portion of the daily rate to benefit the staff.

3.4.4 Behavioral Health Agency Essential Workers

A behavioral health agency (BHA) is an organization licensed and credentialed by Washington state to provide community mental health services. These organizations are licensed as behavioral health agencies and then they are also credentialed to provide specific services, such as mental health outpatient, crisis services, inpatient, etc. Most BHAs are also dually licensed to provide outpatient substance use disorder treatment. As part of our study, we spoke with the Washington Council for Behavioral Health (WCBH), the professional association of licensed community BHAs across Washington state. The following information was gathered during the interview.

The WCBH has 42 member agencies that provide a full range of community behavioral health services in urban and rural areas across the state, including outpatient, residential and supportive housing, and voluntary and involuntary inpatient treatment. The agencies are primarily non-profit community-based organizations or county-based service entities. Collectively, they serve more than 100,000 very low-income individuals each year, primarily adults with serious mental illness and/or substance use disorder and children or youth with severe emotional disturbances.

These agencies are licensed by the Department of Health and have an active mental health contract with at least one managed care organization (MCO) in Washington state. The agencies primarily serve Medicaid enrollees with about 85%-95% of their revenue derived from Medicaid reimbursement, mostly through Medicaid MCOs and a lesser portion from county-based behavioral health administrative service organizations (ASOs).

a) Workforce Characteristics

Behavioral health agency essential workers include social workers, mental health counselors, substance abuse disorder professionals, marriage and family therapists, peer support specialists, nurses, and

prescribers, etc. This workforce is at an elevated risk of assault by the population it serves, which can include involuntary commitment or involvement in the criminal legal system. There is also risk related to exposure to any health conditions that can spread easily in residential or inpatient settings.

The workforce experiences turnover due to attrition to the private sector, government employers, hospital systems, and/or burnout in the behavioral health field. In order to obtain independent clinical licensure, workers must complete supervised clinical hours. Almost all BHAs have internship programs for graduate students, and all provide the required supervisory hours for a new graduate to earn their independent clinical license. Newly licensed workers often then leave publicly funded behavioral health positions for the private sector or professional roles with hospitals and government agencies. Some workers may leave the behavioral health industry altogether.

b) Current Health Coverage and Challenges

All WCBH agencies offer health coverage to their employees. The agency sizes vary; they access coverage through self-insurance or the small group market. Following up from our discussion, the WCBH shared the following information:

- All offer at least one health insurance plan. Some offer both a traditional plan and a high deductible health plan with a health savings account plan.
- 85% to 100% of the monthly premium for employees is paid by the employer. Some offer a "base plan" at no monthly premium cost to the employee with an option for the employee to upgrade to a richer health plan at their own expense.
- All offer an option to add dependents, but only at the expense of the employee. No agency that participated in our discussion covered premium costs for employees' dependents (this is a big driver for employees to leave for state or local government where dependent health insurance premiums are covered by the employer).
- No one has provided funding for employees to purchase health coverage through the Exchange.

c) Public Funding Options

Medicaid reimbursement has increased by 23% in recent years which has flowed through managed care organizations directly to behavioral health agencies. However, with at least 85%-95% of reimbursement to WCBH agencies coming from Medicaid, the impact of the increase is dampened by factors such as the geographic area of the provider, inflation, and Medicaid enrollment. WCBH members believe that Medicaid capitation rates do not adequately cover the cost of care delivered by providers or provide enough to alleviate the challenges for employers attempting to offer affordable health care coverage for their employees. Additionally, WCBH reported that Medicaid capitation rates were reduced in the most recent state operating budget, which may lead to additional challenges for BHAs to provide competitive compensation packages.

d) Current Concerns Cited by Interested Group

Premium rate increases are the most concerning issue for the WCBH member agencies. A primary complaint with member agencies is that it is difficult to budget for health care coverage premium increases that are unpredictable.

Additionally, agency members say Medicaid capitation rates do not adequately cover the cost of care delivered by the providers. This reimbursement issue has resulted in clinicians moving to more lucrative positions, including those in private practice, hospitals, government agencies, and telehealth.

3.4.5 Healthcare Service Employer Essential Workers

SEIU 1199 is a statewide union that includes registered nurses, licensed practical nurses, pharmacists, technicians, professionals, therapists, mental health workers, certified nursing aides, housekeeping and dietary staff, and other health care workers. As part of our study, we spoke with representatives from SEIU 1199, including their Legislative Director. Their bargaining unit represents a portion of the employees of an employer depending on how the union was formed at that workplace. Management and certain job classes could be excluded from the union. For example, the largest homelessness provider in the state has 1,000 employees but has represented union membership of about 700. Small behavioral providers may have as few as 90 represented members. The following information was gathered during the interview.

a) Workforce Characteristics

SEIU 1199 represents 33,000 members working in health care settings that are primarily hospitals and large clinic settings (such as Kaiser Permanente) but also include some federally qualified health centers, outpatient behavioral health settings, housing providers and wrap-around services providers (such as case management, counseling, family services, social work, housing assistance, and dietitian assistance).

The workforce is primarily comprised of women. It is a diverse workforce that varies by the geography and/or community that surrounds the location of the employer. The perspective of SEIU 1199's leadership is that these workers know the importance of maintaining their health.

b) Current Health Coverage and Challenges

Every employer in this union offers health insurance, but there may be relatively few plan options. Larger employers, such as hospitals and large clinics, are self-insured. Medium size employers buy fully funded group insurance in the small group market. The smallest employers struggle to find affordable group coverage. These are usually behavioral health, housing, and wrap-around service providers with less than 25 represented union members. One option for the smallest employers is to have their employees shop for individual coverage on the Washington state Exchange.

Employers vary in the percentage of employee health insurance premium that they pay[2]. Some employers pay the full premium for their employees but offer less rich coverage with higher employee cost-sharing. Other employers pay a larger share of premiums but offset that expense with lower wages.

c) Public Funding Options

For SEIU 1199, having reimbursement rates that are sufficient cover the rising cost of health care coverage is a key issue.

d) Current Concerns Cited by Interested Group

Dependent coverage is either not offered or not affordable for SEIU 1199 members.. As workers start families, many change jobs to work for employers that offer richer benefits and/or lower employee premium obligations.

SEIU 1199 has discussed potentially establishing a self-funded association or multiple employer welfare arrangement (MEWA) to provide health care to its members and their dependents. They noted having to meet applicable state or federal regulation of such arrangements; solvency concerns based on the size and risk of pooled members; and the potential selection bias of any enrolled dependents.

In terms of this project, SEIU 1199's most affected population is behavioral health and housing and homelessness services workers. These workers often have life experiences similar to their clients, are lower income and have greater behavioral and health care needs than other essential workers. This segment of essential workers is approximately 1,500 of the 33,000 union members.

3.4.6 Housing and Homelessness Service Providers

Homelessness prevention organizations were researched during the study as well, although no specific organizations were interviewed. In Washington state, the Department of Commerce is responsible for coordinating local, state, and federal efforts to combat homelessness. They oversee programs, administer grant funding, and create and distribute various statistics and studies on the homeless population in the state. According to the Department of Commerce's most recent Snapshot[15] reporting in July of 2023, there were 193,321 individuals in the state that were either homeless, or unstably housed. The State Funded Homeless Housing Report for 2024 reported that 16,003 households utilized either rapid rehousing, an emergency shelter, or transitional housing, and 15,631 received other types of outreach.

It is difficult to identify the total number of organizations that provide homelessness assistance. There are 84 homelessness prevention organizations in Washington state that combined employ 2,884 people[16]. There are 121 homeless housing programs, employing 1,312 individuals. It is possible these organizations may overlap, providing both homelessness prevention and housing programs. The organizations vary widely in

[15] https://app.box.com/s/xonalo6msygtcjt0hr7ci7qjg8lug7rc/file/1768769370756?sb=/details
[16] https://www.causeiq.com/directory/homeless-service-providers-list/washington-state/

the populations served, and the programs' underlying support. Some have a religious affiliation, and some serve youth, men, or women only. Often shelters have 24/7 staffing and mental health specialists on site, while some of the youth programs offer residential living within a host family structure. While interviews were not conducted, it can be assumed based on the populations served, and similarities in facility types, that the health care coverage obstacles found in key interested group interviews would also apply to this population. Employers may rely on local, state or federal funding, employees would likely have similar educational attainment, receive similar compensation and health care coverage options, and face the same risks based on the populations they serve.

3.5 Information from Other States

We reached out to or researched 18 other states (AZ, CA, CT, GA, ID, ME, MA, MN, NE, NV, NJ, NC, OR, PA, TN, VT, VA, and WV) regarding enhancing health care coverage for certain essential workers. Although some states did not respond to our inquiry, many of those who did respond stated that while they face the same issues regarding trying to enhance health care coverage for essential workers, they did not have any suggested policy options.

An overview of the interviews we conducted is provided below.

3.5.1 Maine Department of Health and Human Services

Maine's Department of Health and Human Services (DHHS) provides health and social services to approximately a third of the state's population, including children, families, older Mainers, and individuals with disabilities, mental illness, and substance use disorders. Our meeting included representatives from several DHHS departments including Healthcare Workforce Development; Workforce Office of Aging and Disability Services; Office of the Health Insurance Marketplace; and Direct Care Support Professional Advisory Council of the Long-Term Care Ombudsmen Program.

Similar to Washington state, Maine DHHS stated that premium affordability is a struggle when health care coverage is offered to essential workers in their state. Maine is reviewing affordability programs and enhanced subsidy programs for certain populations (like childcare) but has not yet implemented these programs or determined the funding mechanism.

Premium assistance offered through existing programs has helped many essential workers to afford coverage. However, many essential workers are unaware of available options. DHHS feels there is room for outreach and education about the access and financial aid assistance available to essential workers, such as through a Healthcare Navigator position.

DHHS also stated that in Maine the formation of self-funded multiple employer welfare arrangements (multiple employers who pool their resources to provide health and welfare benefits) is controversial due to the lack of regulatory oversight.

3.5.2 Oregon State Division of Financial Regulation

We met with the Department of Consumer Business Services within the Oregon State Division of Financial Regulation to learn about the Oregon Essential Worker Healthcare Trust. Oregon's long-term care employers and Service Employees International Union Local 503 Public Services and Care Providers (SEIU Local 503) joined together to provide affordable health care to some of Oregon's most essential workers through Oregon's Essential Worker Healthcare Trust[17]. The Oregon legislature appropriated money to support the trust through a specific regulatory account funded by premium taxes and unused general funds, rather than from the general budget of the state's Division of Financial Regulation. Setting up the trust involved some considerations so that the trust would be reviewed under the standard of groups allowed to self-fund (similar to the schools/municipalities that are allowed to self-fund according to the Oregon state code).

There are several key requirements for the trust including related to minimum enrollment, benefit standards, contributions and reserves are held in separate accounts and used for the exclusive benefit of the program, adequate reserves, adequate reinsurance, and sufficient administrative functions[18]. ORS 750.309 specifies that "the trust must possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $250,000 or an amount equal to 35 percent of incurred claims for the preceding 12-month period by the trust, whichever is greater. However, the required amount under this subsection may not be more than $500,000"[19] in addition to other provisions.

3.5.3 North Carolina (Various Agencies and Entities)

We met with officials from the NC Department of Health and Human Services Medicaid, Mental Health, and Aging divisions, the NC Coalition on Aging, and PHI (a national organization focused on promoting quality direct care jobs for those in the long-term services and supports sector)[20]. Through various initiatives, these individuals are attempting to create a more skilled and satisfied direct care workforce across long-term care settings. Their approach is to make improvements to job satisfaction on multiple fronts including developing standard competencies, uniform credentialing, paid training, improved compensation, and benefits, and overall support and recognition. While their definition of essential worker is more narrowly targeted to direct care workers in long-term care, many of the challenges are the same. However, the majority of the programs being implemented in NC are too new to determine their impacts.

While in general the group has found the same issues as our research, they also shared the following observations:

- Essential direct care workers are a broad category across multiple types of services which brings complexity when thinking about payment streams, oversight mechanisms, and agencies involved.

[17] https://essentialworkerhealth.org/
[18] https://oregon.public.law/statutes/ors_731.036
[19] https://oregon.public.law/statutes/ors_750.309
[20] https://www.phinational.org/about/

- Access to health care coverage is a challenge shared by workers across these occupational roles and settings, though it may be seen by some workers and their representatives as a lesser priority compared to inadequate wages, transportation challenges, etc.
- Workers want to make sure they have dependent care coverage, because there is value in having families on same health plan (rather than parents on one and Medicaid for children) as a recruitment mechanism and to keep workers in these essential work areas.
- During COVID there were rate increases provided for personal care services under NC's State Plan and Home and Community-Based Services (HCBS) waiver programs, along with other long-term care services. These rate increases were sustained through NC General Assembly appropriations in 2023.
- NC's Medicaid Section 1115 Demonstration waiver could be more fully leveraged to advance the state's direct care workforce training and compensation objectives
- PHI relayed that when New York created wage and benefit minimum requirements, home care agencies had difficulty with the new costs[21, 22].

3.5.4 Pennsylvania Captive for Rehabilitation and Community Providers Association

The Rehabilitation and Community Providers Association (RCPA) in Pennsylvania is one of the largest and most diverse state health and human services trade groups in the United States. RCPA has almost 400 provider member agencies and hospital systems (employers) across nine divisions of health and human services. Its employer group size varies from a few small employers with less than 50 employees to employers with up to 3,000 employees. RCPA provider members provide mental health, drug and alcohol, intellectual and developmental disabilities, children's, brain injury, medical rehabilitation, and physical disabilities and aging services, across all care settings and levels of care.

RCPA decided to offer a captive arrangement (a self-insurance mechanism) when many RCPA provider members became increasingly concerned about the sustainability of health insurance rate increases well beyond their budgets; the impact of high deductible plans on the employees; and having to stop offering dependent coverage due to cost. RCPA worked with a benefits consultant firm to establish a captive arrangement for its employer members through Pareto Health, the nation's largest and fastest growing captive insurance company that provides health insurance benefits. RCPA stated it did not encounter any regulatory hurdles in setting up this arrangement, which was established in Spring 2023. The one difficulty was finding a captive company that was willing to begin operations without a minimum participation standard.

[21] https://www.phinational.org/benefit-cliffs-and-plateaus-when-higher-wages-dont-always-result-in-higher-incomes/ https://www.phinational.org/benefit-cliffs-and-plateaus-when-higher-wages-dont-always-result-in-higher-incomes/

[22] https://www.phinational.org/resource/investing-in-the-home-care-workforce-a-brief-analysis-of-new-yorks-home-care-minimum-wage-increase/ https://www.phinational.org/resource/investing-in-the-home-care-workforce-a-brief-analysis-of-new-yorks-home-care-minimum-wage-increase/

RCPA's provider members who enter the captive arrangement take advantage of the opportunities to reduce costs outside of the fully insured market, specifically for the highest expense areas of inpatient and outpatient hospital services and prescription drugs. A captive arrangement allows the RCPA provider members to bypass the provider networks and pre-negotiated contracts of fully funded insurance arrangements. The mechanisms for savings for the RCPA captive center around:

- Direct Contracting – A direct agreement where the captive contracts directly with a provider to provide care to its members.
- Referenced-Based Pricing (RBP) – A structure that pays a set price for each health care service which is based on a benchmark reference point, such as Medicare reimbursement.
- Pass-Through Pharmacy Benefit Manager (PBM) – A pharmacy cost model that is fee based and ensures pharmacy rebates and discounts are passed through to the employers participating in the captive.

RCPA's experience has been that employer groups, especially small groups with less than 50 employees, are not immediately interested in the self-funding approach of a captive. Their member groups are interested in the cost savings but are hesitant to move into a captive due to a lack of understanding of the risk pooling and self-funding concepts. At the time of our interview, RCPA had enrolled one of its 360 employer members in the captive. They have been advised that once a small employer is introduced to the idea of a captive it can take on average three premium rate change cycles for some employers to become comfortable enough to enter a captive arrangement.

RCPA feels that captives are ideal for employer sizes of about 50 to several hundred employees and would work best for a large pool of employers with employee participants of a diverse risk pool. RCPA suggested the formation of a captive for small employers might necessitate a state mandate to reach the participation requirements needed for any captive manager and for partners like a third -party administrator, pharmacy benefits manager, etc. to be willing to take on this set of employers.

4. Policy Options

In this section, we present the policy options considered, the policy options selected for a feasibility analysis, and the results of that analysis.

This study considers the existing structure of individual health plans offered through the Washington state Health Benefit Exchange (HBE) authorized by the Affordable Care Act and Medicaid eligibility and requirements as of May 19, 2025. We do not consider any potential future changes currently under consideration by the federal government to either the Affordable Care Act or to Medicaid eligibility and other requirements.

4.1 Policy Options Considered

Based on the feedback collected through our interested group conversations, as well as research and discussion with other states and interested parties, we developed six potential policy options, which are summarized in Tables 5A-5F below. These policy options are designed to increase access to affordable health care coverage for essential workers. The policy options include a variety of approaches such as increasing enrollment in existing markets, increasing consumer premium subsidies, modifying existing reimbursement structures, and changes in regulatory oversight. The tables provide an overview of each policy option and list the key advantages and disadvantages related to each with respect to the type of coverage provided, access and affordability of the coverage, and funding of coverage.

As directed by the Legislature, we considered expanding or modifying a program to enhance health benefits for nursing home employees developed under section 204(48) of ESSB 5950 (2024). We reviewed the report from the study conducted by Department of Social and Health Services (DSHS) which included three options: use of the existing home care trust, establish a self-funded MEWA in the style of the Oregon model, or establish a fully insured association health plan in partnership with a related nursing home/long-term care association currently operating in Washington state. We include the second (a self-funded MEWA) and the third option (fully insured association health plan) in our feasibility analysis below.

TABLE 5A – TARGETED EXCHANGE SUBSIDIES

Offer enhanced premium subsidies and/or cost-share subsidies on the Exchange for essential workers. The program could include an eligibility requirement based on occupation or job type.

Advantages	Disadvantages
Leverages the existing Exchange and increases that risk pool. Structure for the program is already in place (Cascade Care Savings). A similar program (for childcare providers) has been used in the past. Provides access to the commercial market which generally has more provider participation than Medicaid markets. Would not require Federal funds. Exchange plans are required to cover Essential Health Benefits (EHBs).	May require community outreach and marketing to see an increase in enrollment. Requires funding which could come from state general funds or an alternative funding source, such as a covered lives assessment[23]. The fully insured small group market is currently struggling to maintain enrollment and affordable premiums. If a covered lives assessment is applied to all fully insured health plans, it would likely be passed through into premiums for fully insured plans. May be difficult to define which essential workers would be eligible. Does not reduce the underlying cost of health care and insurance coverage.

[23] House Bill 1392 was signed into law on 5/19/25 and implements a covered lives assessment https://app.leg.wa.gov/billsummary/?BillNumber=1392&Year=2025&Initiative=false

TABLE 5B – TARGETED EXCHANGE MARKETING/OUTREACH

Create a targeted marketing and outreach campaign for essential workers (through trade association, unions groups, employers) to educate them on their eligibility for existing Exchange plans, current subsidies (including Cascade Care Savings), and Cascade Care Select public option health plans.

Advantages	Disadvantages
Leverages the existing Exchange and expands that risk pool. Leverages existing subsidies (both state and federal). Encourages communication and information sharing between essential workers and state agencies, which can help to build trust and identify gaps in coverage. State-based outreach has been shown to increase Exchange enrollment for the uninsured . Government marketing has been shown to help expand the market. May be less costly to design and implement. Exchange plans are required to cover EHBs.	Requires funding which could come from state general funds or an alternative funding source, such as a covered lives assessment. The fully insured small group market is currently struggling to maintain enrollment and affordable premiums. If a covered lives assessment is applied to all fully insured health plans, it would likely be passed through into premiums for fully insured small group plans. Does not reduce the underlying cost of health care and insurance coverage.

TABLE 5C – INCREASING MEDICAID REIMBURSEMENT TO HEALTH CARE PROVIDERS

Increase Medicaid reimbursement to providers who employ essential workers and provide Medicaid-funded services so that the additional funds can be used for health care coverage.

Advantages	Disadvantages
Uses the existing mechanism of Medicaid reimbursement. Can use state directed payments to increase reimbursement. May attract essential workers who work for providers that receive Medicaid reimbursement.	Does not provide a solution for essential workers who do not work for providers that receive Medicaid reimbursement. Would require legislative action to guarantee that additional payments will be used to purchase health care coverage. Would also require state oversight to ensure additional payments meet their intended goal. Would require state Medicaid matching funds necessary to support increased Medicaid enrollment. Employers of essential workers who receive Medicaid reimbursement feel that current Medicaid reimbursement rates are not sufficient to cover costs and therefore it may take a significant increase in reimbursement to be sufficient to cover costs of health care coverage. Does not provide a mechanism to educate essential workers on available health care coverage options. Does not reduce the underlying cost of health care and insurance coverage. Medicaid has limited providers participating which creates access gaps that would not be addressed through this option.

TABLE 5D – CREATE A BASIC HEALTH PROGRAM

Create a Basic Health Program (BHP) that competes with Exchange plans.

Advantages	Disadvantages
Uses cost containment features to reduce the underlying cost of health care and insurance coverage.	Federal funding for BHPs is lower than the funding that would be received for enrollees on the Exchange. There are federal limitations as to how the program can be implemented. It could not be used solely for essential workers. Would carve out a population from the Exchange, which may result in reduced enrollment and/or higher cost on the Exchange market.

TABLE 5E – AUTHORIZING SELF-FUNDED MEWAs

Take legislative action to create the appropriate regulatory guardrails (similar to those used in Oregon) needed to oversee the financial solvency and consumer protection of a self-funded Multiple Employer Welfare Association (MEWA) plan.

Advantages	Disadvantages
Allows employers to increase their purchasing power to access more affordable health care coverage. Has the potential to reduce the underlying cost of health care and insurance coverage. Provides an opportunity for employers to offer affordable health care coverage which can be an important tool for retaining employees. Oregon has successfully implemented a similar program.	Seed funding is needed to establish reserves for a self-funded trust. Would likely require state or federal funding (could seek additional funding through a CMS 1115 waiver). State would need to provide regulatory oversight to ensure financial solvency and compliance with consumer protection requirements. This would create new costs to the agency conducting oversight (likely the OIC). This option could reduce enrollment in the fully insured group, which could impact premiums/risk profiles for other groups. Does not require coverage of EHBs.

TABLE 5F – FULLY INSURED ASSOCIATION HEALTH PLAN

Support the implementation of a fully insured AHP (would not require legislative action given that AHP's are considered large group health plans).

Advantages	Disadvantages
Allows employers to increase their purchasing power to access more affordable health care coverage. Has the potential to reduce the underlying cost of health care and insurance coverage. Provides an opportunity for employers to offer affordable health care coverage which can be an important tool for retaining employees.	Allows employers to increase their purchasing power to access more affordable health care coverage. Has the potential to reduce the underlying cost of health care and insurance coverage. Provides an opportunity for employers to offer affordable health care coverage which can be an important tool for retaining employees.

4.2 Policy Options Selected & Feasibility Results

We discussed the various options above with the OIC. Although enhanced subsidies on the Exchange were considered, the OIC ultimately decided to not pursue this option further given the challenges noted in Section 3.4.1.b and the limited take-up rate of the additional subsidies. After further considering the advantages and disadvantages of each option, the OIC recommended that we focus on the fifth (5E) and sixth (5F) policy options described above. Authorizing self-funded MEWAs would align with the directive by the Legislature to consider the work done by DSHS related to expanding coverage for nursing home workers. The OIC asked that we modify the option related to marketing/outreach to be applied to the MEWA and AHP options. Given the interplay between these three options, we considered them together as discussed in the feasibility analysis below.

We note that a trust, such as a Taft Hartley Trust or Voluntary Employees' Beneficiary Association, may be required to establish the above plan options. These are commonly used structures in setting up a self-insured MEWA or a fully insured AHP. It was outside of the scope of this study to analyze the precise governance structure of a MEWA or AHP.

4.2.1 Background from the Oregon Essential Worker Health Trust

We were directed to consider the experience of Oregon's Essential Worker Health Trust (EWHT). In our analysis, we refer to the EWHT's 2024 annual report[24]. Formation of the EWHT was authorized by passage of SB800[25] by the Oregon legislature in 2021 as a means to strengthen health care benefits for essential

[24] https://essentialworkerhealth.org/news-updates/2024-annual-report/
[25] https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB800/Enrolled

workers in the long-term care sector, which include nursing home workers, home care workers, and other direct care workers (nursing assistants, home health aides, and personal care aides). An important note is that the EWHT includes both a fully insured plan option and a self-insured plan option, which are similar in nature to the potential options for WA to consider. EWHT conducted focus groups to help inform which plans and benefits to offer. Based on feedback from the focus groups, they offer two benefit plans:

- Fully insured (risk-based) Kaiser HMO coverage that helped maintain existing coverage for subscribers who were satisfied with the care and seamless coordination offered by the Kaiser HMO care model.
- Self-funded Preferred Provider Organization (PPO) offering through Regence BlueCross BlueShield, which is available statewide.

The EWHT annual report highlights the need to support the direct care workforce, specifically those who provide long term care services, given that provider shortages can cause delays in care, increased readmission rates, and reduced quality of care, resulting in higher costs. The annual report notes EWHT provides affordable health care coverage through low premiums and low out-of-pocket costs. Significant improvements were observed for the EWHT compared to previous ESI options, including:

- 85% reduction in employee premiums, with no premiums for some of the lowest wage workers.
- 67% average reduction in employee deductible and out-of-pocket maximums, increasing access to care for low-wage workers.
- 90% of claim costs covered (the remaining 10% is covered by cost sharing amount covered by the employee), improved from prior ESI options covering 60% of claim costs.

The study also indicated increased participation in the health care coverage offered. Thirty-three percent of the workforce previously participated in ESI options and now over 65% participate in EWHT, likely due to the quality and affordability of the coverage offered by EWHT. Quality, affordable health care coverage is important for recruiting and retaining employees. One EWHT employer stated, "When interviewing new employees, I'll bring up the insurance that is available and what that offers before even talking about wages. I've been told that staff have accepted mainly because of the insurance alone. Back before [EWHT], we had some staff go and work for agencies for higher [pay] rates but then when they heard about the benefits that were available, they came back to work full-time here." The study found that 71% of employees enrolled in EWHT were still enrolled after one year and 62% were still enrolled after two years.

Like Washington state, Oregon's long term services and supports workforce is more diverse than the overall population. By expanding quality and affordable health care coverage, EWHT helps to reduce health disparities faced by women and people of color.

The information provided in the EWHT annual report informed our analysis. Below we discuss the methods, assumptions, results, and the conclusions for the selected options.

4.2.2 Analysis of the MEWA and AHP Plan Options

The MEWA and AHP plan options use the same general structure and funding mechanisms. Both the MEWA and AHP options are employer-sponsored coverage. They are funded through a combination of employer/employee contributions, state funds, and federal funds. One difference is that the fully insured plan option may not be available in all areas of the state (depending on the insurer selected and the plan option/s offered) whereas the self-insured option is more likely to be available in all areas of the state (again depending on the insurer selected and the plan option/s offered). Under either option, employers contribute to the trust or association health plan but do not directly bear the claim risk (the trust or association health plan bears the risk). Therefore, these options are potentially more viable for small employers. We note that unlike Exchange plans, these options do not guarantee coverage for EHBs. The benefit coverage considered in our analysis is based on the OR EWHT's comprehensive medical plan.

Our analysis focuses on the total cost of care across all sources of funding (employer, employee, state, and federal). For the purposes of this feasibility analysis, we did not differentiate between the fully insured and self-insured total cost of care. We believe this is a conservative assumption since we would anticipate that the self-insured costs could be lower than the fully insured costs due to more favorable administrative expenses (due to avoidance of insurer overhead and profit margins) and the absence of premium tax obligations. Some of these lower costs may be offset by other reporting and certification requirements for self-insured plans. The actual differential between the cost of care under a fully insured and self-insured option will depend on the insurer or third party administrator and plan designs selected.

Our feasibility analysis focuses on the **total annual combined employer/employee contribution** for health care coverage.

There were several simplifying assumptions made in the modeling. Directionally, each of these simplifying assumptions would serve to increase the feasibility of the options if included:

- The assumed percentage of essential workers currently eligible for Medicaid was based on employees only. Although our analysis uses a covered lives basis (i.e. includes dependents), we did not adjust the percentage to reflect that children are more likely than adults to be covered by Medicaid.
- We did not adjust fixed administrative costs to reflect the larger population size in the Washington state cohorts compared to the Oregon EWHT population.
- We did not reduce the self-insured costs below the fully insured costs to reflect potential savings.
- Medicaid enrollees may see providers that are part of a Managed Care Organization (MCO) or providers that are reimbursed on a fee-for-service basis. We did not distinguish between these provider types.

To model the potential health care premium costs and employer/employee contribution requirements, we developed two separate population models:

1. Employees in Adult Family Homes
2. Employees in Childcare and Preschool Settings

Our methodology for assessing the total annual cost and the annual employer/employee contribution requirements for the MEWA/AHP plan options uses relevant statistics for the WA populations supplemented by key metrics from OR's experience as needed. Our method for evaluating the two metrics noted above includes the following steps:

1. Population and Demographics: Using publicly available statistics and estimates provided through interested group interviews.

    a. We estimate the number of essential workers that would be eligible to participate and project that estimate forward to 2029. As discussed in the Section 3. Market Analysis, it is difficult to identify specific population and demographic information for the essential workers of interest. We use publicly available data[26] [27] to estimate the number of essential workers in the two cohorts above. We then apply a growth function to the historical data to project the number of workers for 2027 – 2029 as summarized in Table 6 below.

TABLE 6A – ESTIMATED NUMBER OF ESSENTIAL WORKERS BY COHORT 2027 – 2029

Number of Workers	2027	2028	2029
Adult Family Home Workers	13,273	13,850	14,401
Childcare Workers	6,921	7,201	7,481
Total	**20,194**	**21,051**	**21,882**

    b. We estimated the participation rates for these essential workers in the trust. Here, the participation rate means the number of employees who participate in their ESI. Based on our review of Oregon's EWHT experience, we assume the participation rates shown in Table 7.

TABLE 7 – ESTIMATED PARTICIPATION RATE FOR 2027 – 2029

	2027	2028	2029
Participation Rate	35%	50%	65%
Participating Workers (Number of Workers times Participation Rate)			
Adult Family Home Workers	4,645	6,925	9,361
Childcare Workers	2,422	3,601	4,863
Total Participating Workers	**7,067**	**10,526**	**14,224**

[26] Sources of employee counts for adult family home workers: https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/WA%20Adult%20Family%20Homes%20Payment%20Methodology%20Analysis.docx, https://www.wsna.org/news/2020/long-term-care-in-washington https://www.cornerstonehealthcaretraining.com/article/tips-for-managing-staff-adult-family-home, and https://conciergecareadvisors.com/5-reasons-adult-family-homes-in-seattle/

[27] Childcare workers https://dcyf.wa.gov/node/3296

We multiplied the assumed participation rate by the estimated number of workers to develop the estimated number of workers who would participate in the trust.

c. We then account for dependents also covered under the plan. We multiply the estimated participating workers by the subscriber to enrolled ratio observed in the EWHT, which was 1.6.

TABLE 8 – ESTIMATED NUMBER OF COVERED LIVES BY COHORT 2027 – 2029

Number of Workers	2027	2028	2029
Adult Family Home Workers	7,433	11,080	14,977
Childcare Workers	3,876	5,761	7,780
Total	**11,309**	**16,841**	**22,757**

d. We estimated key demographic factors for participating employees and dependents based on current information and assumed these factors would be constant during the projection period. The demographic assumptions that we made were average age and average family size. We assumed an average family size of 1.6 for all cohorts based on the experience of Oregon's EWHT. Table 9 shows the estimated average age of the workers, based on ACS data, and the average age of covered lives (including dependents), based on Oregon's EWHT experience.

TABLE 9 – ESTIMATED AVERAGE AGE OF WORKERS AND COVERED LIVES BY COHORT

Average Age	Workers	Covered Lives
Adult Family Home Workers	44	37
Childcare Workers	37	31

2. Health Care Cost: We used two main assumptions to estimate health care cost under the plan options

a. We reviewed the historical premium rates for Gold and Platinum plan options offered in Washington state for Affordable Care Act (ACA) individual and small group plans from 2021 through 2025[28]. We then trended this historical premium data using a growth function to project premium rates for the period 2026 through 2029. Ultimately, we only used Platinum rates in our analysis to reflect the richest benefit coverage. Again, we considered this to be a conservative assumption for feasibility testing since Gold plans would have a lower premium and therefore require less funding. Table 10A shows the estimated average market base rate (which is before any adjustments for age) per member per month (PMPM) for gold and platinum plans prior to adjusting for age rating. We used the federal age curve and the average ages from Table 8 to adjust these base rates separately for each adult family home workers and childcare, which are shown in Table 10B.

[28] https://www.cms.gov/marketplace/resources/data/rate-review-data

TABLE 10A – ESTIMATED AVERAGE BASE RATE PMPM FOR 2026 - 2029

Estimated Average Base Rate PMPM	2026	2027	2028	2029
Gold	$477.25	$504.18	$531.11	$558.04
Platinum	$563.11	$590.23	$617.34	$644.45

TABLE 10B – ESTIMATED AGE ADJUSTED PREMIUM PMPM FOR 2026 - 2029

Estimated Average Base Rate PMPM	2026	2027	2028	2029
Adult Family Home Workers				
Gold	$590.84	$624.18	$657.52	$690.85
Platinum	$697.14	$730.70	$764.26	$797.82
Childcare Workers				
Gold	$553.13	$584.35	$615.56	$646.77
Platinum	$652.65	$684.07	$715.49	$746.91

b. We developed a factor to adjust the ACA premiums to reflect expected health care costs under the MEWA and AHP plan options using the historical experience in Oregon using the following steps:

   i. Quantified the total cost of care for the Oregon EWHT on a per covered lives basis.

   ii. Identified the difference between the Oregon EWHT total premium requirements and Oregon small group market premiums.

   iii. Applied the Oregon pricing difference, which was 1.14, to the Washington state small group premium rates. This factor is driven by the demographic (beyond age) difference between the ACA market and the essential workers risk pool as well as other program differences.

3. Distribution by Funding Category for Total Health Care Cost: The health care costs estimated above would be funded by the employer/employee, Washington state, and the federal government. The Washington state portion includes funding where the employee is Medicaid eligible and Washington State Health Care Authority (HCA) is paying the employer sponsored insurance premium because it is cost-effective[29], funding through increases in Medicaid rates paid to providers that could be used to provide greater access to health coverage for employees, funding through Medicaid supplemental payments[30] (per CFR § 438.6) to providers as "directed payments", similar to the approach taken by

[29] Premium Payment Program | Washington State Health Care Authority – Private health insurance that qualifies for the Premium Payment Program includes: Employer sponsored insurance available through your job.

[30] https://www.macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf

Oregon. We estimate what portion would be funded by each payer using information from the Oregon EWHT and the current distribution of Medicaid enrolled essential workers in each cohort. For each cohort, we identified the percentage of workers enrolled in Medicaid.

For adult family home providers, we assume that 18.3% of these workers are eligible for Medicaid based on ACS data. We assume that these workers are all in the Medicaid expansion population, where the Federal government provides 90% of the Medicaid funding and Washington state would cover the remaining 10%; thus, we assume Washington state would contribute 1.8% of the premium and the federal government would contribute 16.5%. For childcare workers, we assume that 23.3% of these workers are eligible for Medicaid based on ACS data. Likewise, we assume that all childcare workers are in the Medicaid expansion population; thus, we assume Washington state would contribute 2.3% of the premium and the federal government would contribute 20.9%. We find our assumptions are supported by data from KFF, which shows that 23.9% of non-elderly people making less than 200% of the Federal Poverty Level (FPL) are covered by ESI[31].

For adult family home workers, since additional funding through increased Medicaid reimbursement may be available, we show results below both excluding and including increased Medicaid reimbursement to health care providers. We assume that the increased reimbursement amounts are subject to a 50% state contribution and a 50% federal contribution based on Washington state's Federal Medical Assistance Program (FMAP) matching rate. With increased Medicaid reimbursement to health care providers, we develop our assumption for the total state and federal contribution percentage based on the EWHT combined total, which is 58% for plan year 2024. We adjust this value for differences in the OR and WA FMAP match percentage, since OR has a match of 1.37 and WA has a match of 1.00. After adjustment, we assume the total state and federal contribution percentage is 48%. Of the 48%, we assume that 18.3% is for premium assistance for the Medicaid Expansion population and the remainder, 29.7% is for increased Medicaid reimbursement to health care providers, which is a 14.9% state contribution and 14.9% federal contribution.

Below Table 10A shows the distribution of the total cost of care by funding source for each cohort excluding any increased Medicaid reimbursement to health care providers, while Table 10B shows the

Supplemental payments are additional types of Medicaid payments that states can make to hospitals. They also include payments for nursing facility services and home health services provided by hospitals. These payments are typically made in lump sums for a fixed period of time and are intended to support various goals, such as covering the costs of services provided to Medicaid-enrolled patients, supporting specific types of hospitals, and improving health care quality and access. Supplemental payments are often used to supplement Medicaid base payment rates, which are usually below hospital costs. Section 1115 of the Social Security Act provides broad authority to the Secretary of the Department of Health and Human Services (HHS) to approve demonstrations that are likely to assist in promoting the objectives of the Medicaid program. This includes the authority to waive Medicaid requirements and to provide federal matching funds for costs that would not otherwise be matchable under the state plan, such as supplemental payments in managed care delivery systems.

[31] https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-who-is-covered-by-employer-sponsored-health-insurance

distribution of the total cost of care including the increased Medicaid reimbursement to health care providers.

TABLE 10A – DISTRIBUTION OF FUNDING EXCLUDING INCREASED MEDICAID REIMBURSEMENT TO HEALTH CARE PROVIDERS

Distribution of Funding by Source	Adult Family Home Workers	Childcare Workers
Employer/Employee Contribution	81.7%	76.7%
State Contribution (Medicaid)	1.8%	2.3%
Federal Contribution (Medicaid)	16.5%	20.9%

TABLE 10B – DISTRIBUTION OF FUNDING INCLUDING INCREASED MEDICAID REIMBURSEMENT TO HEALTH CARE PROVIDERS

Distribution of Funding by Source	Adult Family Home Workers	Childcare Workers
Employer/Employee Contribution	52.0%	N/A
State Contribution (Medicaid)	16.7%	N/A
Federal Contribution (Medicaid)	31.3%	N/A

Using the assumptions and methodology described above, we created an estimate of the per member per month (PMPM) total cost of care for each cohort. The results of the three models are provided below. Table 11 shows the estimated 2027 employer and employee cost per covered life under the status quo for each essential worker cohort. The actual results could be higher or lower than our estimates below. We did not make an assumption about the portion paid by the employer vs. the employee since that determination can vary for each employer and does not impact the overall cost reduction. The costs per covered life are then calculated without increased Medicaid reimbursement to health care providers and with increased Medicaid reimbursement to health care providers. Increased Medicaid reimbursement is only available for certain cohorts of essential workers, such as adult family home workers, and are paid for by both state and federal funding. Washington state would need to submit a request to the federal government (CMS) and be approved for the Medicaid direct or supplemental payments. Oregon used this approach in their EWHT. As a representation of affordability, we compared the total cost for the employer/employee under the MEWA/AHP plan to the current Exchange plans.

TABLE 11 – ESTIMATED 2027 MONTHLY EMPLOYER/EMPLOYEE COST PER COVERED LIFE

Employer/Employee Cost Per Covered Life Per Month	Adult Family Home Workers	Childcare Workers
Current Platinum Exchange Plan	$730.70	$684.07
Estimated 2027 Cost		
Under MEWA/AHP Plan **Excluding** Increased Medicaid Reimbursement to Health Care Providers	$680.04	$597.73
Under MEWA/AHP Plan **Including** Increased Medicaid Reimbursement to Health Care Providers	$432.71	N/A
% Difference from Current Platinum Exchange Plan		
Under MEWA/AHP Plan **Excluding** Increased Medicaid Reimbursement to Health Care Providers	-6.9%	-12.6%
Under MEWA/AHP Plan **Including** Increased Medicaid Reimbursement to Health Care Providers	-40.8%	N/A

Even without increased Medicaid reimbursement, the cost to the employer/employee for the MEWA/AHP plans are below the current Exchange plans prior to any additional federal and state premium subsidies. The differential ranges from 6.9% to 12.6% lower for MEWA/AHP plans assuming no increased Medicaid reimbursement and as high as 40.8% with increased Medicaid reimbursement for applicable cohorts.

Since the estimates above depend on our assumptions, which are subject to uncertainty, we conducted sensitivity testing of two key assumptions: the percentage of workers eligible for Medicaid and the differential in the premium rates between the MEWA/AHP plan compared to the current ACA market. We varied these assumptions to see what the impact to the resulting estimates would be if these assumptions were different than we expected. Based on our review of historical data and the Oregon EWHT, we varied each assumption +/-3% to test the impact on the results. The results of the sensitivity testing are shown in Table 12A below.

TABLE 12A – SENSITIVITY TESTING OF THE 2027 MONTHLY EMPLOYER/EMPLOYEE COST PER COVERED LIFE – LOW ESTIMATE

Employer/Employee Cost Per Covered Life Per Month	Adult Family Home Workers	Childcare Workers
Current Platinum Exchange Plan	$730.70	$684.07
Estimated 2027 Cost		
Under MEWA/AHP Plan **Excluding** Increased Medicaid Reimbursement to Health Care Providers	$723.57	$637.46
Under MEWA/AHP Plan **Including** Increased Medicaid Reimbursement to Health Care Providers	$444.11	N/A
% Difference from Current Platinum Exchange Plan		
Under MEWA/AHP Plan **Excluding** Increased Medicaid Reimbursement to Health Care Providers	-1.0%	-6.8%
Under MEWA/AHP Plan **Including** Increased Medicaid Reimbursement to Health Care Providers	-39.2%	N/A

TABLE 12B – SENSITIVITY TESTING OF THE 2027 MONTHLY EMPLOYER/EMPLOYEE COST PER COVERED LIFE – HIGH ESTIMATE

Employer/Employee Cost Per Covered Life Per Month	Adult Family Home Workers	Childcare Workers
Current Platinum Exchange Plan	$730.70	$684.07
Estimated 2027 Cost		
Under MEWA/AHP Plan **Excluding** Increased Medicaid Reimbursement to Health Care Providers	$637.82	$559.23
Under MEWA/AHP Plan **Including** Increased Medicaid Reimbursement to Health Care Providers	$421.31	n/a
% Difference from Current Platinum Exchange Plan		
Under MEWA/AHP Plan **Excluding** Increased Medicaid Reimbursement to Health Care Providers	-12.7%	-18.2%
Under MEWA/AHP Plan **Including** Increased Medicaid Reimbursement to Health Care Providers	-42.3%	N/A

Under the sensitivity testing, the cost to the employer/employee for the MEWA/AHP plans are still below the current platinum Exchange plans. The differential under the sensitivity testing ranges from 1.0% to 18.0% lower for MEWA/AHP plans assuming no increased Medicaid reimbursement and as high as 42.3% with increased Medicaid reimbursement for applicable cohorts. Note that this range represents our sensitivity results and is not intended to imply a maximum or minimum difference.

We estimated the total cost for 2027 through 2029 by cohort using population estimates (Table 6), expected participation rates (Table 7), and total cost per covered life (Table 11). The actual results could be higher or lower than our estimates below. We allocated the total cost by funding source (employee/employer, state, and federal) using information from the Oregon EWHT and current Medicaid eligibility in Washington state (Table 10). Tables 13 and 14 show the estimated total cost by year and cohort broken out by funding source. These scenarios assume that funding through increased Medicaid reimbursement is applied for and received.

TABLE 13 – DISTRIBUTION OF TOTAL COST BY FUNDING SOURCES FOR ADULT FAMILY HOME WORKERS FROM 2027-2029

Adult Family Home Workers	Distribution	2027 (M)	2028 (M)	2029 (M)
Employer/Employee	52.0%	$38.6	$60.2	$84.9
State (Medicaid – Premium Assistance)	1.8%	$1.4	$2.1	$3.0
State (Medicaid – Increased Reimbursement to Health Care Providers)	14.9%	$11.0	$17.2	$24.3
State (Medicaid Total)	16.7%	$12.4	$19.3	$27.3
Federal (Medicaid)	31.3%	$23.2	$36.2	$51.1
Total	**100%**	**$74.2**	**$115.7**	**$163.3**
Projected Subscribers		4,645	6,925	9,361
Projected Covered Lives		7,433	11,080	14,977

For the state portion reported in the table above, 14.9% would be additional state general fund spending required as state match through increased Medicaid reimbursement to health care providers, which equates to $11.0M in 2027, $17.2M in 2028, and $24.3M in 2029 based on our estimates. The remaining state amounts are assumed to be existing spending from the general fund that is redirected to ESI premium matching. In the table below, the state portion is also assumed to be fully funded from existing general fund spending.

TABLE 14 – DISTRIBUTION OF TOTAL COST BY FUNDING SOURCES FOR CHILDCARE WORKERS FROM 2027-2029

Childcare Workers	Distribution	2027 (M)	2028 (M)	2029 (M)
Employer/Employee	76.7%	$27.8	$43.2	$60.9
State (Medicaid – Premium Assistance)	2.3%	$0.8	$1.3	$1.8
Federal (Medicaid)	20.9%	$7.6	$11.8	$16.6
Total	**100%**	**$36.2**	**$56.3**	**$79.4**
Projected Subscribers		**2,422**	**3,601**	**4,863**
Projected Covered Lives		**3,876**	**5,761**	**7,780**

The results above indicate that implementing a MEWA/AHP plan option could result in more affordable and accessible health care coverage for essential workers in Washington state compared to existing Exchange plans. These options could provide richer benefit coverage than existing ESI and at more affordable premium rate than Exchange plans. Funding for these plan options comes from both state and federal funds related to existing Medicaid payments for ESI premium matching for Medicaid eligible employees. Legislature would need to take action to create the appropriate regulatory framework to allow self-insured MEWAs. An example is the 2021 bill[32] passed by the OR legislature authorizing the Essential Workforce Health Care Program. We note that fully insured AHPs are currently regulated as large group health plans; thus, no additional legislation would be required to create one.

Separate from the required Medicaid funding shown above, the Legislature would need to appropriate funding to implement these plan options (such as submitting the Medicaid supplemental payments application, seed funding to capitalize a self-funded MEWA, and marketing and outreach). When Oregon implemented the EWHT they made an investment from the General Fund to set up the program. Oregon funded $692,056 for two years plus an additional $514,278 for two additional years[33]. This amount could vary depending on the exact scope and structure of plans Washington state implements.

We note that enrollment in the MEWA/AHP plan options would likely grow if marketing and outreach efforts were included in the early stages of implementation, as well as in subsequent years. Additional enrollment would increase the size of the risk pool and reduce per capita administrative costs; however, it will also increase the required contributions from the state general fund, as shown in our projections above. The Oregon EWHT has a website with resources available to potential employers for enrolling in the trust. There are sections for enrollment, eligibility, benefits, FAQs, and other vital information, such as their annual report, which is discussed above.

[32] https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB800/Enrolled
[33] https://olis.oregonlegislature.gov/liz/2021R1/Downloads/CommitteeMeetingDocument/246196

5. Disclosures

I, Rebecca Sheppard, FSA, MAAA, am a consulting actuary from RRC, contracted by the Washington State Office of the Insurance Commissioner to conduct a feasibility study on enhancing health benefits for essential workers. I have met the basic education and experience prerequisites, and the continuing education requirements needed to meet the American Academy of Actuaries' Qualification Standards to issue Statements of Actuarial Opinion.

I, Andrew Larocque, ASA, MAAA, am a consulting actuary from RRC, contracted by the Washington State Office of the Insurance Commissioner to conduct a feasibility study on enhancing health benefits for essential workers. I have met the basic education and experience prerequisites, and the continuing education requirements needed to meet the American Academy of Actuaries' Qualification Standards to issue Statements of Actuarial Opinion.

Dave Heppen, FCAS, MAAA, partner and consulting actuary from RRC, reviewed this report.

We relied on publicly available information provide by federal and state agencies and feedback from interested groups. Although we reviewed the various data, analyses and information provided to us for reasonableness, we have not performed any audit or verification procedures. Unless otherwise stated in our report, we have assumed that the data, analyses, and information provided to us were complete and accurate.

The study was performed at a level of detail deemed professionally necessary to reasonably estimate the impact of the legislative change. There may be individual parameters or assumptions, which could be considered unreasonable by other actuaries, and which could have or would have been discovered by employing an exhaustive, detailed study of the underlying data, formulas, and assumptions. Such a study was beyond the scope of this study.

Projections of enrollment and premium rates for health insurance coverage is subject to certain assumptions about the future and to the occurrence or non-occurrence of future contingent events. Any estimate of enrollment and premium rates, as well as the associated program costs to Washington state, is therefore subject to uncertainty. Ultimate impact to enrollment, premium rates, and funding costs may vary in dollar amount, perhaps materially, from amounts estimated. We have utilized actuarial standards of practice as well as generally accepted actuarial procedures and methodologies in completing the tasks outlined in the scope section above. However, we do not guarantee that our conclusions, opinions, or estimates provided in this report are accurate in their expressed or implied predictions of future events. The results reached in this analysis are dependent on the assumptions used which are described in this report.

This actuarial report outlines the general scope and limitations of our analysis and provides an executive summary of our findings. This report is supplemented with work papers that relate to the underlying model used to estimate the impact of various policy options.

Actuarial Standard of Practice No. 56 *Modeling* requires actuaries to disclose the use of models in actuarial valuations. The intended purpose of the models we created are to estimate population, participation, premium rates, and contribution levels for self-funded and fully insured group health plans offered through a trust from 2027 to 2029 for essential workers in Washington state. To the best of our knowledge there are no material limitations of our models nor use of internally inconsistent assumptions.

This memorandum was prepared for the exclusive use of the Washington State Office of the Insurance Commissioner. Any other reader understands that this memorandum was provided exclusively for the Washington State Office of the Insurance Commissioner's sole benefit and use, and not for the benefit or use of the reader or any other third party. The reader acknowledges that this memorandum was prepared at the direction of the Washington State Office of the Insurance Commissioner and may not include all procedures or information deemed necessary for the purposes of the reader, and that certain findings and information may have been communicated to the Washington State Office of the Insurance Commissioner that are not reflected in this memorandum. The reader further acknowledges that RRC makes no representations as to the sufficiency, accuracy, completeness, or appropriateness of this memorandum for the reader's purposes. The reader agrees that it does not acquire any rights as a result of access to this memorandum that it would not otherwise have had and acknowledges that RRC does not assume any duties or obligations to the reader in connection with such access to this memorandum. The reader of this memorandum agrees to release, indemnify and hold harmless RRC and its affiliates and their respective partners, principals, officers, directors, employees, contractors and representatives from and against any and all claims, actions, liabilities, damages, losses, costs or expenses (including reasonable attorneys' fees) incurred or suffered by or asserted against RRC as a result of the Washington State Office of the Insurance Commissioner permitting the reader to access to the work or the reader's breach of the agreements herein. Any distribution of this memorandum must be in its entirety.

We are available to discuss the content of this report with the Washington State Office of the Insurance Commissioner.

6. Appendix A – Data Sources

We reviewed data from the following data sources.

A. American Community Survey

The ACS is a nationwide survey that collects and produces information about the US population every year. Information is also collected for each state. The most recent survey year currently available is 2022. The survey includes questions regarding social issues, economics, housing, and demographics. The following data fields are among those available in the ACS survey data.

- Sex
- Age
- Race and Ethnicity
- Income – Personal Income (i.e., per person or per household)
- Education Level – e.g., high school graduate, bachelor's degree, advanced degree
- Occupation/Industry
- Health Insurance – coverage and funding source (e.g., private, Medicaid, Medicare)
- Poverty Status – Income Level of Federal Poverty Threshold 1% to 500%
- Family Composition – Examples include marital status and number of dependents
- Governmental Assistance – Examples include Cash Assistance, Medicaid, Food and Nutrition Subsidy, Energy Subsidy

B. Other sources

In the course of our data collection procedures, we also reviewed data from the following sources: Medical Expenditure Panel Survey (MEPS), Current Population Survey (CPS), and the Annual Social and Economic Supplement (ASEC). We did not use data from these sources for the following reasons:

- The MEPS does not contain an occupation or a detailed level of industry classification that would help us narrow down health care utilization for the essential worker population. The finest level of detail that contains essential workers are the industry grouping "Education, Health and Social Services" and occupation grouping "Service Occupations."
- The CPS/ASEC contains similar information as the ACS (e.g., information on health insurance, occupation, and industry); however, the information is not available specific to WA, rather it is available on a nationwide basis.