OliverWyman

DC Health Benefit Exchange Authority

DISTRICT OF COLUMBIA BASIC HEALTH PLAN FEASIBILITY ANALYSIS

June 17, 2025

Tammy Tomczyk, FSA, MAAA, FCA | Peter Scharl, FSA, MAAA | Wency Zhao, ASA, MAAA

A business of Marsh McLennan

CONFIDENTIALITY

Our clients' industries are extremely competitive, and the maintenance of confidentiality with respect to our clients' plans and data is critical. Oliver Wyman rigorously applies internal confidentiality practices to protect the confidentiality of all client information.

Similarly, our industry is very competitive. We view our approaches and insights as proprietary and therefore look to our clients to protect our interests in our proposals, presentations, methodologies, and analytical techniques. Under no circumstances should this material be shared with any third party without the prior written consent of Oliver Wyman.

CONTENTS

1

PROJECT OVERVIEW AND DISCLAIMERS

PROJECT OVERVIEW AND DISCLAIMERS

High-Level Project Overview

- DC HBX requested Oliver Wyman to estimate potential CY 2026 funding amounts for a proposed Basic Health Plan (BHP)
- Potential BHP membership data provided by DHCF was utilized to estimate the number of members projected to move into the BHP and only members with an FPL > 138% and <= 200% were included in the analysis, as directed by DC HBX
- Costs estimates for the Medicaid benefits historically provided to the potential BHP population were provided by Mercer and are assumed to reflect reimbursement levels currently received by the MCOs for this population, and are assumed to be the same PMPM amount for all members
- BHP revenue was calculated based on the formulas and factors listed in the 2025 BHP final rule and was calculated for various age, FPL, household size, and BHP eligible family size combinations; the scenario that assumes CSR payments are funded by the federal government assumes BHP payments for CSRs consistent with the formula and factors outlined in the 2017-2018 BHP final rule

Disclaimers

- Any change to the underlying data, assumptions, factors, or formulas could have a meaningful impact on the provided results
- Any change to regulations that impact the funding calculation, relative to what was assumed, could have a meaningful impact on the results provided
- Alternate scenarios were provided and tested, however they do not represent the full range of possibilities for some assumptions; therefore, the range of estimates provided does not represent an absolute range of potential outcomes
- Information furnished by others is believed to be reliable but has not been independently verified
- The findings contained in this report contains predictions based on current data, historical trends, and current law; these predictions are subject to inherent risks and uncertainties
- This analysis represents aggregate BHP feasibility for DC as a whole and does not represent specific payments to carriers or other entities that may participate in the BHP

2

BHP FUNDING OVERVIEW

BHP FUNDING CALCULATION WITHOUT CSRs FUNDED BY THE FEDERAL GOVERNMENT

$$\left(SLCSP_{a,g,c} \times PHF \times PAF \times WF \right) - RPC_n \times IRF \times 95\%$$

SLCSP $_{a,g,c}$ = Second lowest cost silver plan premium based on the BHP eligible individual's age, geographic region, and coverage status (i.e., self only or applicable family coverage)

PHF = Population Health Factor (impact of the BHP population on the QHP premium rates)

PAF = Premium Adjustment Factor (accounts for the change in silver-level premium rates due to the discontinuance of CSR payments)

- In the first year of BHP implementation, if using prior year ACA premium rates, this factor is 1.00
- In subsequent years, if using ACA premium rates from a year when the BHP is not fully implemented, the factor is: 1.20 / (1 + CSR load underlying ACA rates used)
- When using ACA premium rates from a year when the BHP was fully implemented, this factor is 1.188

WF = Waiver Factor (accounts for the impact of a state's 1332 reinsurance waiver, where applicable)

RPC $_n$ = Required Premium Contribution per BHP eligible member (applicable percentage of household income that a PTC-eligible household must pay toward the coverage in the Exchange, divided by the number of BHP eligible members in the household that enroll in the BHP)

IRF = Income Reconciliation Factor (accounts for the difference between estimated PTC using household income at the initial application and as it would be reflected on individual federal income tax returns)

Assumptions Used:

PHF = 1.000

PAF = 1.188

WF = 1.000

IRF = 0.952

BHP FUNDING CALCULATION WITH CSRs FUNDED BY THE FEDERAL GOVERNMENT

$$\left(\left(SLCSP_{a,g,c} \times PHF\right) - RPC_n\right) \times IRF + \frac{SLCSP_{a,g,c} \times TRAF \times FRAC}{AV} \times IUF \times \Delta AV \times 95\%$$

$SLCSP_{a,g,c}$, PHF, RPC_n, IRF are all the same definition as the prior slide

TRAF = Tobacco Rating Adjustment Factor (impact of rated tobacco use on healthcare costs)

FRAC = Factor for Removing Administrative Costs (average proportion of the total premium that covers allowed health benefits)

AV = Actuarial Value (the percentage paid by a health plan of the total allowed costs of benefits; uses the metal AV of the standard silver plan)

IUF = Induced Utilization Factor (accounts for the increase in healthcare service utilization associated with a reduction in the level of cost sharing on CSR plans)

ΔAV = Change in Actuarial Value (accounts for the higher claims that would be covered under the CSR plans; the difference between the metal AV of the CSR plans and the standard silver plan (i.e., 0.940–0.700 for BHP members with household incomes at or below 150% FPL, or 0.870–0.700 for BHP members with household incomes above 150% FPL)

Note: We would expect the WF factor, implemented after the 2016–2017 (rule which is the source for the above formula), to be included on the lefthand side of the equation as shown on the previous slide, but it has no impact in the District, as there is no Section 1332 waiver in place (i.e., the WF factor would be 1.00)

Assumptions Used:

PHF = 1.000

IRF = 0.952

$TRAF$ = 1.000

$FRAC$ = 0.800

AV = 0.700

IUF = 1.120

ΔAV = 0.240 or 0.170

CERTAIN FACTORS IMPACT REVENUES AND COSTS DIFFERENTLY

Changes in the BHP Population's Income Distribution Impacts Revenue

Income impacts the corresponding PTCs provided to BHP enrollees had they enrolled in the Marketplace's SLCSP, and therefore, the amount of BHP revenue PMPM.

For Example: If the income distributions are higher than anticipated, generated BHP revenue PMPM will decrease.

Changes in the BHP Population's Age Distribution Impacts Both Revenue and Cost

QHP premiums (and therefore, corresponding PTCs) have a 3:1 age rating.

For Example: Younger enrollees would have lower ACA premium rates and therefore generate fewer PTCs, but also are likely to have lower claims cost.

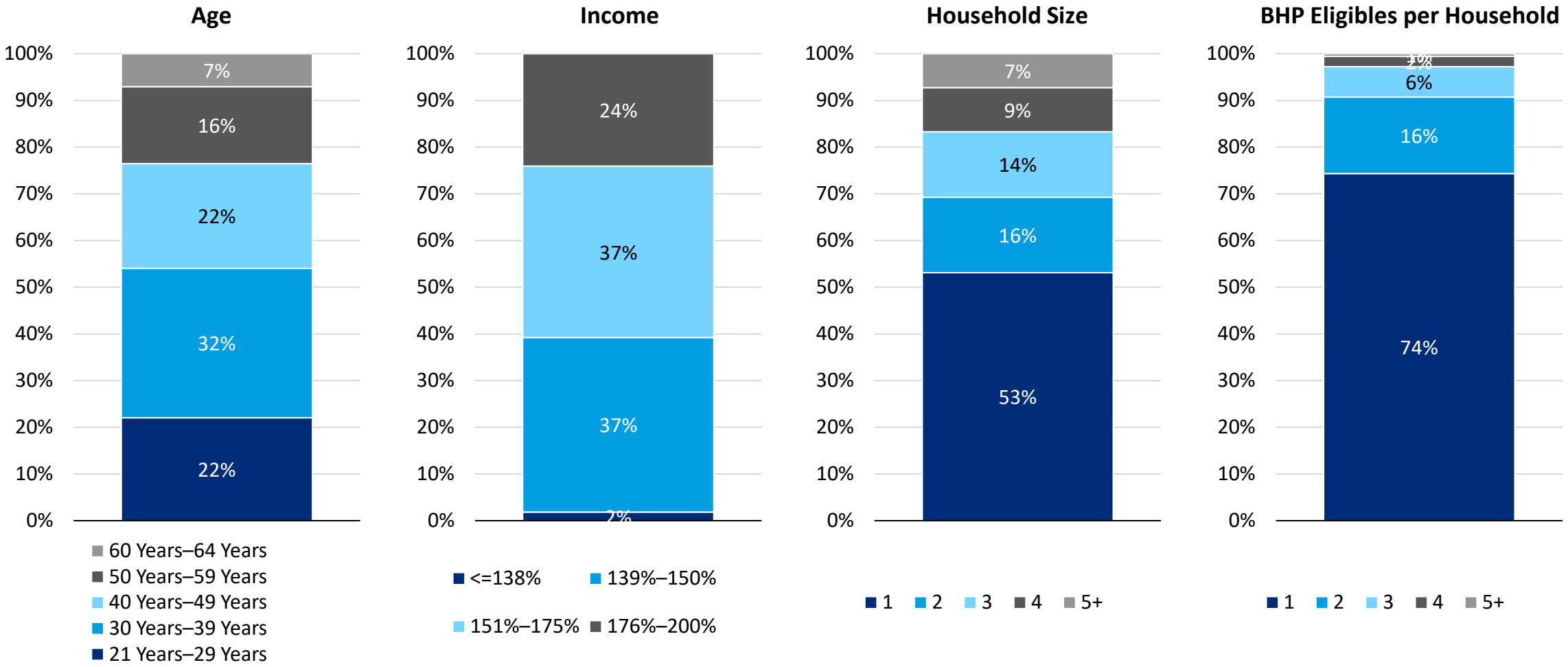
If the BHP population is older/younger than expected, both revenue and cost will be impacted.

Changes in the BHP Population's Morbidity Impacts Cost

Morbidity of the BHP populations will impact program cost.

For Example: If the morbidity of the BHP population is higher than expected, program cost will increase, however the State will not receive correspondingly higher BHP revenue.

MODELED BHP POPULATION CHARACTERISTICS



Observations: Membership data provided did not include any BHP eligible individuals ages 19 years–20 years, and very few households with incomes <=138% FPL (due to the Medicaid Expansion population remaining eligible for Medicaid)

3

KEY ASSUMPTIONS, CAVEATS, AND METHODOLOGY

KEY DATA SOURCES

Two main data sources were provided by DHCF to perform the calculations for this analysis

Membership Data

- The FPL percentage included for each individual was used as the primary source for income purposes as that was indicated to be more reliable than the household income amounts reported
- Only members with an FPL > 138% and <= 200% were included in the analysis
    - There are a few individuals identified with incomes <=138% FPL that are within families that have at least one member with FPL in the listed range; in these cases, all family members were assumed to be eligible for the BHP
- No gender information was provided; however, since premium and capitated rates do not vary by gender, this has no impact on the results of this analysis
- Members were assumed to remain at the same FPL level in 2026 as that which was provided in the data, when calculating their 2026 APTCs

Medicaid Claims Cost for the Applicable Population

- 2025 TANF Adult 19+ capitation rates PMPM were used as the starting point of the claim projection
- Maternity kick-payments were added to the capitation payment PMPM based on an analysis provided by Mercer
- Costs were also added for Medicaid covered benefits paid on a Fee-for-Service basis and an estimate of EHBs not covered by Medicaid, based on an analysis provided by Mercer to estimate these costs
    - Estimated Medicaid costs for benefits that are not considered EHBs in the ACA market were separately itemized
    - Estimated Medicaid costs for other pricing considerations (e.g., hospital reimbursement levels) and maternity costs were also itemized
- An annual claims trend of 4.5% was applied to the FY 2025 amounts noted above to project the FY 2026 and FY 2027 PMPM amounts; CY 2026 claims costs PMPM consist of 9 months at FY 2026 claims PMPM levels and 3 months at FY 2027 claims PMPM levels, as the fiscal year runs October through September
- In the baseline scenario, 100% of non-EHBs and the costs for other pricing considerations and maternity costs were excluded from the claim cost amount

KEY ASSUMPTIONS AND METHODOLOGY

The main assumptions and methodology used for the calculations are summarized below

BHP Revenue

- Calculated as 95% of the projected APTC payments, and 95% CSR payments if applicable, using the formulas outlined on slides 7 and 8
  - Membership was grouped into age ranges and the straight average of the age factors was used to determine the premium rate and therefore APTCs for all members within each age range
  - The BHP adjustment factors used (e.g., PHF, PAF, WF) are consistent with those in the 2025 BHP final rule
  - For the CSR calculation, the factors used (e.g., AV, IUF) are consistent with those in the 2017-2018 BHP final rule, which is the last year when CSRs were funded
- Initially filed 2026 ACA premium rates were used to estimate the second lowest cost silver premium rate
- The applicable percentage amounts by FPL were applied assuming the enhanced premium tax credits sunset after 2025

BHP Program Cost

- The projected cost of the BHP program was calculated as the difference between the projected 2026 BHP revenue from PTCs only and the projected 2026 claims cost
- BHP program enrollment was assumed to be consistent with the membership data received from DHCF (i.e., all members currently enrolled in Medicaid that would become eligible for the BHP were assumed to enroll in the BHP)
- Sensitivity testing was conducted by iterating on the values of three key assumptions: ACA premium rates, claims cost, and application of a population health factor

Other Key Assumptions

- Benefits provided in the BHP are equal to those provided in Medicaid that correspond with the capitation rates and other FFS costs used, plus EHBs not covered by Medicaid, less any non-EHBs currently covered by Medicaid, and less costs for other pricing considerations and maternity costs identified by Mercer
- No member cost sharing was assumed in the BHP, which is consistent with Medicaid cost sharing
- No member premium was assumed (this is a key assumption as the introduction of a member premium would lead to lower enrollment, adverse selection, and higher claims costs)
- No explicit morbidity adjustment was applied to ACA premium rates to account for adverse selection associated with the enhanced premium tax credits ending after 2025
- Individuals with incomes between 200-221% FPL will become eligible for APTCs in the Exchange
- No uninsured individuals eligible for the BHP were modeled to enroll
- MCOs will be able to negotiate provider contracts for the BHP at levels consistent with those currently in place for this population enrolled in Medicaid

MEDICAID CLAIM COST DETAILS

Mercer provided analysis of FY 2025 Medicaid capitation and FFS benefit costs to estimate total FY 2025 Medicaid claim costs for the BHP eligible population and to estimate areas for potential BHP program costs adjustments

FY 2025 Medicaid Total Claim Costs

Benefit	FY 2025 PMPM
FY 2025 Capitation Rate	$589.10
DME Hospital Payments	$8.88
Mother's Month of Delivery	$21.75
IMD FFS Stays	$1.13
Inpatient Transplants	$1.12
HIV Drugs	$53.85
Emergency Transportation	$13.65
Cell and Gene Therapies	$0.61
All FFS Behavioral Health Services	$100.46
Supportive Housing	$4.11
Health Homes	$1.29
Fertility Treatments (IVF)	$2.62
Non-Medical Considerations	$8.90
Total	**$807.47**

Areas for Potential Adjustment

- Mercer identified three potential areas which could lower the claim costs in the BHP: optional/non-EHBs, other pricing considerations, and maternity costs

Area	Benefit	FY 2025 PMPM
Optional/Non-EHBs	Capitation Benefits – Adult Dental	$17.29
Optional/Non-EHBs	Capitation Benefits – Vision/Hearing	$0.61
Optional/Non-EHBs	Capitation Benefits – All Other	$9.90
Optional/Non-EHBs	FFS BH Benefits	$92.54
Optional/Non-EHBs	Non-Medical Considerations	$5.71
Optional/Non-EHBs	**Total**	**$126.04**
Other Pricing Considerations	IP/OP MCO Hospital Contracting	$14.11
Other Pricing Considerations	HIV Formulary	$1.65
Other Pricing Considerations	Non-Medical Considerations	$0.75
Maternity Costs	Maternity Payment	$21.75
Maternity Costs	Maternity DME Hospital Payments	$2.58
Maternity Costs	Prenatal/Postpartum	$13.40
Maternity Costs	Non-Medical Considerations	$0.76
Other Pricing + Maternity	**Total**	**$55.00**

*Totals may not tie due to rounding

4

BASELINE MODELING RESULTS

THE BASELINE ASSUMPTIONS LEAD TO A PROJECTED PROGRAM SURPLUS IN 2026 OF $0.2M WITHOUT CSR FUNDING AND $11.4M WITH CSR FUNDING

Baseline Assumptions

Key Assumption	Baseline Value	Justification
Annual Claims Trend	4.5%	Provided by Mercer as the best estimate for the projected annual change in the projected BHP claim PMPM amount
Annual Premium Trend	6.1%	Estimated change in the SLCSP in DC from 2025 to 2026
Claim Cost Removal PMPM	$181	100% of non-EHBs, other pricing considerations, and maternity costs were all removed in the baseline scenario
Population Health Factor	1.000	No morbidity differential between the BHP population and the remaining ACA population was assumed in the baseline scenario

2026 Claims PMPM Projection

Time Period	Medicaid Claims PMPM
FY 2025	$626.43
Projected FY 2026	$654.62
Projected FY 2027	$684.07
Projected CY 2026*	**$661.98**

*CY 2026 claims PMPM consists of 9 months of FY 2026 claims PMPM and 3 months of FY 2027 claims PMPM as the fiscal year runs October through September

2026 BHP Revenue PMPM Projection

Time Period	BHP Revenue PMPM
Projected CY 2026 – Without CSR Funding	**$662.70**
Projected CY 2026 – With CSR Funding	**$712.93**

2026 BHP Net Program Cost (in Millions)

	Federal Funding Amount	Capitated Claim Costs	BHP Net Cost*	CSR Funding Impact
Baseline Scenario – Without CSR Funding	$148.0	$147.8	**($0.2)**	
Baseline Scenario – With CSR Funding	$159.2	$147.8	**($11.4)**	**($11.2)**

* Excludes costs associated with administration of the BHP

5

SCENARIO TESTING

GIVEN THE LEVEL OF UNCERTAINTY AROUND OUR FEASIBILITY PROJECTIONS, SENSITIVITY TESTING WAS PERFORMED AROUND OUR BEST ESTIMATE ASSUMPTIONS

The impact of each scenario is shown independently; if scenarios are evaluated together, the sum of the results may not necessarily reflect our best estimate for the combined scenario

1	**ACA Premium Trend: 8.1%, 4.1%**	• Annual ACA premium trend of 6.1%, based on initially filed 2026 rates, was applied to the current 2025 SLCSP rates to project 2026 BHP revenue • Higher ACA premium trend leads to higher projected BHP revenue, yielding lower projected BHP program cost
2	**BHP Claims Trend: 6.5%, 2.5%**	• Annual claims trend of 4.5% was applied to the current FY2025 Medicaid capitation rates to project CY2026 BHP claim costs • Higher claims trend leads to higher projected claims cost, yielding higher projected BHP program cost • 6.5% claims trend results in projected claims of $678 PMPM • 2.5% claims trend results in projected claims of $646 PMPM
3	**Claim Adjustment: Remove Only 50% of non-EHBs, Remove Only non-EHBs, Remove All Potential Adjustments Except Hospital Contracting**	• Mercer identified three areas that could lower claim costs in the BHP: optional/non-EHBs, other pricing considerations, and maternity costs • The more claims removed, the lower the projected BHP program cost • Removing only 50% of non-EHBs results in projected claims of $787 PMPM • Removing only non-EHBs results in projected claims of $720 PMPM • Removing all potential adjustments identified by Mercer except hospital contracting results in projected claims of $677 PMPM
4	**Population Health Factor: 1.02**	• The population health factor (PHF) is used to adjust for morbidity changes in the ACA market • Higher PHF leads to higher projected BHP revenue, yielding lower projected BHP program cost
5	**Premium Adjustment Factor: 1.120, 1.150 (Applies only to the scenarios without CSRs funding)**	• The premium adjustment factor (PAF) is used to reflect the estimated impact to premiums due to the non funding of CSR payments and the current value in regulation is 1.188 • A lower PAF leads to lower projected BHP revenue, yielding higher projected BHP program cost • A PAF of 1.120 results in projected revenue of $619 PMPM and a total program cost of $9.5M • A PAF of 1.150 results in projected revenue of $638 PMPM and a total program cost of $5.3M

* The assumptions outside of the key assumption being tested in the scenarios are kept at the baseline values

IN SENSITIVITY TESTING OUR BEST ESTIMATE ASSUMPTIONS, THE EXPECTED NET COST TO DC FOR THE BHP RANGES FROM A $27.7 MILLION COST TO A $3.7 MILLION SURPLUS

The impact of each scenario is shown independently; if scenarios are evaluated together, the sum of the results may not reflect our best estimate for the combined scenario

DC BHP COST ESTIMATES – WITHOUT CSR FUNDING

	(in millions)	Federal BHP Funding Amount	BHP Claim (Capitation) Cost	BHP Net Cost**	BHP Cost Compared to Baseline***
	Baseline Scenario – Without CSR Funding	$148.0	$147.8	($0.2)	N/A
1*	ACA Premium Trend High: 8.1%	$151.2	$147.8	($3.4)	($3.2)
	ACA Premium Trend Low: 4.1%	$144.8	$147.8	$3.0	$3.2
2*	BHP Claims Trend High: 6.5%	$148.0	$151.4	$3.4	$3.6
	BHP Claims Trend Low: 2.5%	$148.0	$144.3	($3.7)	($3.5)
3*	Remove Only 50% of non-EHBs	$148.0	$175.7	$27.7	$27.9
	Remove Only non-EHBs	$148.0	$160.8	$12.8	$13.0
	Remove All Potential Adjustments Except Hospital Contracting	$148.0	$151.2	$3.2	$3.3
4*	Population Health Factor: 1.020	$151.4	$147.8	($3.5)	($3.4)
5	Premium Adjustment Factor: 1.120	$138.3	$147.8	$9.5	$9.7
	Premium Adjustment Factor: 1.150	$142.6	$147.8	$5.3	$5.4

*The assumptions outside of the key assumption being tested in scenarios 1-4 are kept at the baseline values

** Excludes costs associated with administration of the BHP

*** Positive values indicate additional cost from the baseline scenario, while negative values indicate additional surplus

IN SENSITIVITY TESTING OUR BEST ESTIMATE ASSUMPTIONS, THE EXPECTED NET COST TO DC FOR THE BHP RANGES FROM A $16.5 MILLION COST TO A $15.8 MILLION SURPLUS

The impact of each scenario is shown independently; if scenarios are evaluated together, the sum of the results may not reflect our best estimate for the combined scenario

DC BHP COST ESTIMATES – WITH CSR FUNDING

	(in millions)	Federal BHP Funding Amount	BHP Claim (Capitation) Cost	BHP Net Cost**	BHP Cost Compared to Baseline***	CSR Funding Impact****
	Baseline Scenario – With CSR Funding	$159.2	$147.8	($11.4)	N/A	($11.2)
1*	ACA Premium Trend High: 8.1%	$162.6	$147.8	($14.8)	($3.4)	($11.4)
	ACA Premium Trend Low: 4.1%	$155.8	$147.8	($8.0)	$3.4	($11.0)
2*	BHP Claims Trend High: 6.5%	$159.2	$151.4	($7.8)	$3.6	($11.2)
	BHP Claims Trend Low: 2.5%	$159.2	$144.3	($14.9)	($3.5)	($11.2)
3*	Remove Only 50% of non-EHBs	$159.2	$175.7	$16.5	$27.9	($11.2)
	Remove Only non-EHBs	$159.2	$160.8	$1.6	$13.0	($11.2)
	Remove All Potential Adjustments Except Hospital Contracting	$159.2	$151.2	($8.0)	$3.3	($11.2)
4*	Population Health Factor: 1.020	$163.6	$147.8	($15.8)	($4.4)	($12.2)

*The assumptions outside of the key assumption being tested in scenarios 1-4 are kept at the baseline values

** Excludes costs associated with administration of the BHP

*** Positive values indicate additional cost from the baseline scenario, while negative values indicate additional surplus

**** Positive values indicate additional cost from the same scenario without CSR funding, while negative values indicate additional surplus

QUALIFICATIONS, ASSUMPTIONS, AND LIMITING CONDITIONS

This report is for the exclusive use of the Oliver Wyman client named herein. This report is not intended for general circulation or publication, nor is it to be reproduced, quoted, or distributed for any purpose without the prior written permission of Oliver Wyman. There are no third-party beneficiaries with respect to this report, and Oliver Wyman does not accept any liability to any third party.

Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been independently verified, unless otherwise expressly indicated. Public information and industry and statistical data are from sources we deem to be reliable; however, we make no representation as to the accuracy or completeness of such information. The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. Oliver Wyman accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report. No obligation is assumed to revise this report to reflect changes, events, or conditions, which occur subsequent to the date hereof.

All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client. This report does not represent investment advice nor does it provide an opinion regarding the fairness of any transaction to any and all parties. In addition, this report does not represent legal, medical, accounting, safety, or other specialized advice. For any such advice, Oliver Wyman recommends seeking and obtaining advice from a qualified professional.

MERCER DISCLOSURES

Mercer's analysis relied upon enrollment, encounter claims, reimbursement level, benefit design, program descriptions, financial data, and information supplied by DHCF and its vendors. DHCF and its vendors are responsible for the validity and completeness of these supplied data and information. Mercer reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion, they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness or appropriateness the results.

The users of this report are cautioned against relying solely on the data contained herein. DHCF and Mercer provide no guarantee, either written or implied, that this report is 100% accurate or error free. Furthermore, projections outlined in this report are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially, wide range of variability from the estimate.

Mercer prepared these projections exclusively for the HBX, to estimate the benefit costs, to inform analyses for the BHP design. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by HBX and Mercer. HBX and Mercer are not responsible for the consequences of any unauthorized use.