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1. **INSURANCE MARKETPLACES**

   a. **Introduction to the Marketplace**

Health Insurance Marketplaces (or exchanges) were created by the ACA to act as organized and competitive venues for individuals and families (and, in certain instances, small businesses) to purchase health insurance. The marketplace certifies and offers a choice of health plans in each state; some are operated by the state (or state-adjacent organizations), like Covered California, a small minority are run directly by the federal government on a centralized enrollment website (HealthCare.gov), and others operate a state-based marketplace facilitated federally through the HealthCare.gov portal.[1] Adjacent to the individual insurance market exists the small group insurance market, such as the Small Business Health Options Plan (SHOP) for employers with fewer than 50 employees.[2]

Formerly, owing to its intent to offer a large variety of more affordable plans, the ACA enforced an individual mandate, whereby any individual who did not receive insurance through an employer was required to purchase insurance in the marketplace; those who did not would be penalized, equivalent to what they would have otherwise paid for coverage. This was largely to ensure that healthy individuals would also purchase plans in the exchange, and thus prevent premiums from skyrocketing (were only sick/risky individuals to enroll, as would likely be the case without such a mandate). The Supreme Court considered the legality (and severability, were it not legal) of the individual mandate in National Federation of Independent Business v. Sebelius, split as to two different arguments for the legality Congress' enforcement of the individual mandate (under the Commerce Clause, which was not ultimately accepted, and under its taxing powers, which was), but eventually upholding the individual mandate from the constitutional perspective.[3] While it was upheld constitutionally by virtue of the fact that the penalty could be reasonably characterized as a tax, the Tax Cuts and Jobs Act of 2017 reduced the penalty to $0, effectively eliminating the individual mandate.[4] In response, California, Massachusetts, New Jersey, Rhode Island, and Washington DC have adopted individual mandates with tax penalties, in addition to Vermont, which has a mandate without penalty.[5]

   b. **Plans Types**

The ACA marketplace offers four main types of plans, categorized under metal tiers: Bronze, Silver, Gold, and Platinum. The ACA mandates that all plans,

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[1] https://www.kff.org/affordable-care-act/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[2] https://www.healthcare.gov/small-businesses/choose-and-enroll/shop-marketplace-overview/

[3] https://supreme.justia.com/cases/federal/us/567/519/

[4] https://www.congress.gov/crs-product/R48485

[5] https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/marketplace-basics/im-uninsured-am-i-required-to-get-health-insurance/

whether or not they are offered on an exchange, cover certain Essential Health Benefits (EHBs) over 10 categories, including but not limited to emergency services, hospitalization, maternity care, laboratory services, pediatric care, and behavioral health programs. Because premium subsidies (to be discussed below in further detail) cannot be applied to any portion of a plan's premium that goes towards non-essential benefits, the primary way in which the metal tiers distinguish themselves is through their cost sharing structure.

The 'lowest' tier plans, starting with Bronze, have the highest cost sharing at the point of service; with Bronze, the enrollee is expected to pay 40% of the cost (through co-pays and deductibles), whereas the insurer is expected to pay for 60%. This increases up to 10%/90% split of the actuarial value of the plan, or the proportion of anticipated covered medical spending that is to be paid by the plan. The higher a metal tier (and thus the higher the proportion of actuarial value paid by the insurer), the higher the premiums are, too.

Silver plans are unique in that they offer multiple gradations of actuarial values; this is due to how Cost Sharing Reductions (CSRs) are applied, as is to be discussed in section 2c. Thus, in addition to the standard Silver plan, with a 30/70 split, there are Silver 73, Silver 87, and Silver 94 plans that cover 73%, 87%, and 94% of actuarial value, respectively, for enrollees with certain income levels.

It is important to note that, in a perfect model, where costs are based on a uniform (or individual) pool, the overall values of the different metal tiers are equivalent—even though cost-sharing or actuarial values are structured differently, the increasing premiums should balance this out. If a particular metal tier plan were *actually* advantageous in terms of cost (for the same expected utilization), then an insurer would not offer this plan, and, if it were offered, all enrollees would select it. Rather, the difference is between *when* the payments happen. In essence, Platinum plan enrollees pay "in advance" through their higher premiums, and Bronze plan enrollees pay "as they go" with co-pays/co-insurance and deductibles.

In reality, this is not the case due to restrictions on what can be factored into premium calculations; this will be revisited in 2a., when discussing premium structures and subsidies, but since plans cannot effectively price discriminate, the expected costs for enrollees are aggregated and (mostly) evenly distributed, thus cross-subsidizing higher-utilization enrollments by raising costs for lower-risk ones. So, if a young, healthy person were to enroll in a Platinum plan, they are "paying in advance" for services they are not expected to utilize individually, but which aids with the expected costs for another, unhealthier/riskier person. This can drive those younger/healthier people out of the market entirely, as will be discussed later.

In addition to the four main metal tiers, there is also a minimum coverage option, often called a catastrophic plan, which covers little more than yearly primary-care visits and has an extremely high deductible, but charges very low

premiums as a result. This is primarily for young, healthy individuals who are not expected to utilize their insurance much anyway; these plans are currently restricted to enrollees under 30 years of age, or those with hardship exemptions. Hardship exemptions come in multiple forms, however affordability exemptions were previously an extremely narrow window due to the generosity of subsidies available while ARPA/IRA subsidy rates were in effect (as will be discussed below). Other hardship exemptions include homelessness/eviction, domestic violence, death of a family member, or ineligibility for Medicaid in a non-expanded state. Some policy proposals, like the Trump administration's new proposed rulemaking, suggest adding more flexibility to such catastrophic (and Bronze plans) with longer term periods of up to a decade, with revised cost-sharing structures.

c. **Medicaid Expansion**

In addition to establishing insurance exchanges, the ACA also expanded the eligibility requirements for Medicaid to nearly all adults up to 138% of the Federal Poverty Line (FPL). States receive enhanced federal matching rates (FMAP) for newly eligible enrollees, now at 90% since 2019[6]. National Federation of Independent Business v. Sebelius, the 2012 Supreme Court Case, upheld most provisions of the ACA but ruled that the Medicaid expansion clauses, as they stood, were coercive, and the expansion was made optional; currently, 40 states and DC have adopted the expansion, with many having automatic triggers that would end the expansion if federal funding were to be reduced.[7]

Prior to the passage of the ACA, eligibility was determined by both financial and categorical criteria; in addition to earning less than a certain percentage of FPL, members had to belong to a certain disadvantaged group (e.g. parents of dependents, disabled, elderly, or pregnant).[8] In the ten unexpanded states, this requirement persists, meaning some childless adults fall into a "coverage gap," whereby they are not eligible for Medicaid, but earn too little to qualify for subsidies in the ACA marketplace (explored below in 2a). An estimated 1.4 million adults fall into this gap, causing unexpanded states to have an uninsurance rate nearly twice as high as in expanded states (avg. 14.1% vs 7.6%)[9]

As an interesting note, Wisconsin is not expanded but provides Medicaid coverage to all adults up to 100% FPL, even those without children, effectively eliminating the coverage gap.[10]

Though anyone can buy a plan in the ACA marketplace, subsidies are not available for those eligible for Medicaid, meaning Medicaid functions as an

[6] https://www.congress.gov/crs-product/R43847#_Toc194592212

[7] https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/

[8] Institute for Medicaid Innovation, *Medicaid 101*.

[9] https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/

[10] https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/

adjacent coverage option to the plans in the exchange. To conceptualize it in parallel to the metal tier plans, Medicaid essentially functions as a tier above Platinum with a 0/100% split with a Cost Sharing Reduction (see 2c) that fully covers all expenses—a "Silver 100" plan which covers all actuarial value.

In expanded states, however, this parallel structure can cause inflated administrative costs. As low-income workers fluctuate around 138% of FPL in income, their eligibility switches between ACA subsidies and Medicaid; this churn costs an enormous amount of money each cycle, with the administrative cost of a single re-enrollment in Medicaid (not including the cost to ACA subsidy administration or disenrollment later) between $400 and $600.[11]

2. **COST STRUCTURES**
    a. **Premiums**

Premiums (the monthly payments made regardless of utilization in order to maintain coverage, as opposed to deductibles, which are a fixed amount that must be paid towards utilized care before insurance coverage kicks in) are strictly controlled on the ACA marketplace. They are determined by tobacco use, family size, geographic location, metal tier (as discussed above), and age, with older enrollees paying no more than three times their younger counterparts. Statutory regulations that prevent the consideration of pre-existing health conditions force the cross-subsidization of sick groups by healthy ones.

Because premium-setting is regulated in this way, ACA exchanges required mechanisms to incentivize insurers to compete based on the quality and efficiency of their plans, instead of trying to attract healthier patients who would require less spending. Formerly, these mechanisms included re-insurance programs (whereby the government re-insured, at an established rate, against particularly high cost claims above an "attachment" point) and risk corridors (which limited large profits, but guaranteed limited losses), however these were temporary programs. The risk corridors, in particular, caused much friction, as they were required to be budget-neutral, but in those initial years there were few insurers profitable above the risk corridor, and so the government transferred a mere fraction of what the risk corridor guaranteed to unprofitable companies; in Maine Community Health Options v. United States, the Supreme Court ruled that the government was required to pay over $12 billion to meet its unfulfilled risk corridor obligations.[12] Presently, however, there is only the risk adjustment payment mechanism remaining, as both re-insurance and risk corridors were created to end after 2016. Risk adjustment mechanisms are a budget neutral transfer between insurers, whereby funds from plans with lower-risk enrollees (as calculated by averaging individual risk scores within a plan) are transferred to those with higher-risk enrollees, with the amount being based on the baseline

[11] https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage

[12] https://www.supremecourt.gov/opinions/19pdf/18-1023_m64o.pdf

premium in a geographic area and the risk distribution. These transfers are a unique government function that helps stabilize premiums in a market and prevent, in part, a 'death spiral,' when plans with higher-risk enrollees must raise costs, driving out healthier individuals, thus increasing their risk yet again in an endless cycle. Importantly, though, this does not change the overall, aggregate burden on the system created by the exclusion of pre-existing conditions from consideration by insurers, which is ultimately paid by cross-subsidization from healthier individuals (as higher premiums).

Premiums are further inflated by the statutory definition of EHBs.[13] These EHBs, while important in defining a minimum standard of coverage for plans both on and off the ACA exchange, include a number of services that many willing participants in the exchange do not require, such as mental health services, substance cessation programs, chronic disease management, pediatric care, and maternity care. Because these services *must* be covered by all plans, as opposed to including them as an additional option, for an extra fee, on an as-needed basis, this enrollees who do not require such services to help pay (cross-subsidize) for those who do; while the morality of certain benefits (such as maternal care, even if the enrollee is a man, or pediatric care, even where the enrollee is childless) can be debated, these provisions empirically raise premiums across market.

b. Premium Subsidies (APTCs)

Subsidies towards these premiums, in the form of reimbursable tax credits (called Advance Premium Tax Credits, or APTCs) are widely available (formerly to anyone whose earnings made them ineligible for Medicaid, now capped at 400% of FPL). The size of these subsidies, further, is not a fixed amount; rather, it is calculated by subtracting the required individual contribution (which varies by income level) from the second least-expensive Silver plan offered in the recipient's geographic area (the benchmark plan). Thus, as premiums rise, so do subsidies. Formerly, the individual contribution ranged from 0% of income for the lowest earners to a cap of 8.5%, for which anyone at or above 400% FPL was eligible. These rates, set by the American Rescue Plan Act (ARPA) and extended by the Inflation Reduction Act (IRA), expired, and have reverted to pre-ARPA rates. Currently, required individual contributions range from 2.1% to 9.96%, with those earning above 400% FPL no longer eligible for any subsidies.[14]

Though the subsidy is benchmarked to a Silver plan, APTCs can be applied towards any metal tier plan. If the enrollee selects a higher tier plan, they must pay any difference in premium; if they select a lower tier plan (or the one cheaper

[13] In addition, the benchmark plan for calculating subsidy sizes is required to cover equivalent benefits to a "typical employer plan" (as determined by each state). While this often doesn't differ greatly, it should be noted that what is discussed in this paragraph also applies to the benchmark plan, thus inflating subsidies and the cost to taxpayers.

[14] https://www.healthinsurance.org/obamacare/will-you-receive-an-aca-premium-subsidy/#calculate; https://www.kff.org/affordable-care-act/explaining-health-care-reform-questions-about-health-insurance-subsidies/; https://www.congress.gov/crs-product/R48290.

Silver plan in their geographic region) they pay even less out of pocket, potentially making such a plan free; if this is the case, that the tax credit exceeds the cost of premiums, the remaining amount goes unused. APTCs, however, cannot be applied towards any portion of a plan that goes towards non-essential health benefits (such as dental or vision coverage).

Because they are intended to aid low-income individuals and families, APTCs are reimbursable (not against earned income) and can be claimed in advance, with up to 1/12 of the total amount paid directly to the insurer. If recipients choose to receive APTCs in advance, they must reconcile it with their actual (as opposed to estimated) income, receiving or repaying any difference; while the ARPA/IRA provisions were in effect, repayments were capped (at $375, $950, $1575 for individuals below 200%, 300%, and 400% of FPL, respectively), however, after their expiration, there are no limits on the amount of excess payments that must be returned.[15] This system has the potential for large amounts of fraud, though; in 2022, CMS estimated that it made $925 million in improper subsidy payments.[16]

c. Out-of-Pocket Costs and CSRs

Subsidies, in addition to APTCs, are available for out-of-pocket spending for eligible adults. These subsidies, known as Cost-Sharing Reductions (CSRs), reduce out-of-pocket spending by adding plans to the Silver tier (CSRs cannot be applied to any other metal tier of plan): Silver 73, Silver 87, and Silver 94 plans cover 73%, 87%, and 94% of actuarial value for enrollees below 250%, 200%, and 150% of FPL, respectively. These benefits are not paid to enrollees, as with the APTC, but are different structures of cost sharing (both by lowering deductibles and co-pay/co-insurance rates); as can be seen by comparing metal tiers, this essentially places Silver 87 plans above Gold, and Silver 94 plans above Platinum.

Further, CSR plans reduce out-of-pocket maximums to $3,050 for individuals below 200% FPL and $8,100 for those below 250%, as compared to $10,150 for individuals who do not qualify for CSRs, per CMS' 2026 PAPI parameters guidance; though the maximums for those below 200% FPL have not changed, this represents an approximately 10% increase over the 2025 year.[17]

d. Changing Subsidies

As mentioned above, subsidy rates set by ARPA and extended by IRA expired in 2025, leaving much debate about whether to extend these subsidies further, and by how much. These debates were the cause of our longest-ever government shutdown, the 43 days from October 1 to November 12, 2025. The most major talking point from the Democratic Party was the increase in costs

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[15] https://www.agentbrokerfaq.cms.gov/s/article/Are-there-limits-to-how-much-excess-advance-payments-of-the-premium-tax-credit-APTC-consumers-must-pay-back?s=SR&utm_campaign=hcgov_ab&utm_content=english&utm_medium=email&utm_source=govdelivery

[16] https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2024.pdf; https://www.washingtonpost.com/health/2025/06/17/affordable-care-act-obamacare-fraud/.

[17] https://www.cms.gov/files/document/2026-papi-parameters-guidance-2024-10-08.pdf

that a failure to extend the subsidies would cause. KFF estimated that the annual premium for the average subsidized household would more than double from $888 to $1,904, and similarly scary numbers estimating an increase in cost by up to 400% were thrown around as part of the debates. These numbers are not informative, however, on two levels.

Firstly, the ARPA/IRA rates were established such that *any* household was eligible for subsidies, with the required individual contribution capped at 8.5% (for those at or above 400% of FPL, and even more generous for those below). Because of this, the 'average' is dragged up significantly by medium to relatively high-income households who still take advantage of the subsidies: for those earning more than 400% FPL (currently $63,840), subsidies drop to $0, meaning their 'increased costs' are merely the cost of paying their own premiums. Since the required contribution for such individuals is 8.5%, these enrollees could earn as much as $183,388 in a state like Vermont, where a benchmark plan costs $1,299/mo, and still received subsidies under the ARPA/IRA rates—not the intended recipients of subsidies, nor folks who are exactly hard-pressed to pay their own premiums.[18] Nonetheless, their increased costs are factored into account.

Secondly, much of the debate centered around *relative* increases in cost, rather than discussing them in terms of absolute value. Thus, someone paying just $50 a month, who must pay $150 a month after the expiration of the enhanced subsidies, has a "200% increase" in cost, while only paying $100 more for their coverage. Someone earning, say, $16,000/year, would go from paying $0 in premiums to $336, a theoretically infinite increase (since it was entirely free before). Even more important than the fact that relative increases say very little at such low costs, even these projected costs are fictitious ones: if costs are as much a barrier as they are presented to be, then enrollees may select not to choose a Silver plan, to which subsidies are benchmarked, but a Bronze one instead, with even lower premiums. For a single, adult non-smoker at 180% FPL ($28,728 a year), their premiums would theoretically increase by $104, however a Bronze plan would cost $1 per month in the average US state.[19]

e. State-Level Variation

Currently, 10 states offer additional financial assistance for marketplace plans. Almost all of these states have expanded, extended, or altered their state-based subsidies for residents to help offset the increase in premiums in 2026. Pennsylvania, Georgia, Nebraska, Mississippi, Minnesota, Rhode Island, and Virginia have all considered in the past or are currently voting on additional

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[18] https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Average%20Benchmark%20Premium%22,%22sort%22:%22desc%22%7D

[19] https://www.kff.org/interactive/calculator-aca-enhanced-premium-tax-credit/#state=ca&zip=94618&income-type=percent&income=180&employer-coverage=0&people=1&alternate-plan-family=&adult-count=1&adults%5B0%5D%5Bage%5D=21&adults%5B0%5D%5Btobacco%5D=0&child-count=0

state-based subsidies. Though only state-run exchanges can process state-based subsidies, Nebraska and Mississippi, which use federally-facilitated exchanges, considered using tax returns to provide financial assistance to marketplace enrollees. Minnesota, New York, Oregon, and Washington DC, further offer Basic Health Programs (BHPs), which, although not direct financial assistance, create coverage options beyond the Medicaid expansion and under 200% FPL.[20] Wisconsin, while it does not offer additional assistance for plans purchased on the exchange, has rendered all adults earning under 100% FPL eligible for Medicaid, even though it is not an expanded state, thus eliminating its coverage gap.

These state-level subsidies are in fluctuation, particularly as federal-level subsidies fall for the 2026 year and various extension proposals are debated; the following subsections provide a very brief overview of the 10 states with current financial assistance for ACA marketplace plans, in addition to what is mandated by law.

i. California

Prior to 2026, California's additional financial assistance took the form of additional cost sharing reductions for recipients' deductibles, emergency facility fees, primary care and specialist visits, copayments, drug deductibles, and generic drug copayments.[21] In 2025 alone, California appropriated $165 million for these subsidies.[22] With the expiration of enhanced premium subsidies, California allocated $190 million for premium subsidies for those at or below 150% FPL.[23]

ii. Colorado

Similar to California, Colorado's state-based subsidy moved from an extra cost-sharing reduction to an extra premium subsidy, in effect for residents with income up to 400% FPL.[24] Their previous CSR system, beginning in 2023, increased Silver 94 plan eligibility from 150% to 200% FPL.[25] They also cover the additional fees required by federal statute to pay for non-Hyde abortion care.[26]

iii. Connecticut

Connecticut offers no-cost health plans to residents earning under 175% FPL through the Covered Connecticut Program.[27] For 2026, the state appropriated

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[20] https://www.healthinsurance.org/obamacare/affordable-care-acts-basic-health-program/

[21] https://www.coveredca.com/newsroom/news-releases/2023/07/20/covered-california-to-launch-state-enhanced-cost-sharing-reduction-program/

[22] https://www.coveredca.com/newsroom/news-releases/2024/07/24/2025-rates-and-plans/

[23] https://www.coveredca.com/newsroom/news-releases/2025/10/30/covered-californias-open-enrollment-2026-here-to-help-connect-californians-to-care-despite-uncertainty-around-federal-tax-credits/

[24] https://doi.colorado.gov/announcements/notice-of-adoption-amended-regulation-4-2-78-concerning-health-insurance

[25] Health Insurance Affordability Board Meeting Minutes: Friday, April 19th, 2024.

[26] https://doi.colorado.gov/sites/doi/files/documents/Bulletin%20B-4.148%20Abortion%20payments%20PY%202026%20update%20-%20adoption.pdf

[27] https://portal.ct.gov/dss/health-and-home-care/covered-connecticut-program?language=en_US

$70 million to offset drops in APTCs fully for those below 200% FPL, down to half coverage for those between 400%-500% FPL.[28]

iv. Maryland

Previously, Maryland only offered assistance to young adults, but has expanded its aid for 2026 to fully cover the loss of subsidies for residents below 200% FPL, and partially for those between 200% and 400%.[29]

v. Massachusetts

Massachusetts has extended its Connector Care program for 2026 to stabilize premiums for all residents under 400% FPL with a $250 million boost; those at 400%-500% FPL are also technically eligible for Connector Care, but such enrollees are statutorily required to receive federal subsidies that no longer exist, essentially rendering it unavailable.[30]

vi. New Jersey

New Jersey offers additional subsidies for residents with income up to 600% FPL; the exact reimbursement numbers are not transparently available for the 2026 year.[31]

vii. New Mexico

New Mexico plans to fully offset the reduction in federal premium subsidies for the 2026 year, including for residents earning more than 400% FPL. All residents below 400% FPL are eligible for cost sharing reductions that match Platinum-level actuarial values of 90% (known as "Turquoise" plans; the previous limit was 300% FPL).[32]

viii. New York

In 2025, New York began offering CSR options for residents earning up to 400% FPL, pregnant and postpartum women, and those with diabetes.[33] Though they are slated to continue through 2026, they may expire on July 1 due to funding insolvency.[34]

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[28] https://ctmirror.org/2025/12/11/lamont-aca-subsidies-surplus-funds-senate-vote/; https://agency.accesshealthct.com/deadline-to-enroll-in-health-and-dental-coverage-through-access-health-ct-has-been-extended-to-jan-31

[29] https://www.marylandhealthconnection.gov/maryland-premium-assistance/; https://www.marylandhbe.com/wp-content/uploads/2025/05/State-Based-Subsidy-Parameters-and-Regulations-Board-5.19.25.pdf

[30] https://www.mahealthconnector.org/connectorcare2024; https://betterhealthconnector.com/wp-content/uploads/Preliminary-Eligibility-2025-Presentation-090325.pdf; https://www.mahealthconnector.org/governor-healey-details-plan-to-protect-against-aca-cost-hikes

[31] https://www.nj.gov/getcoverednj/financialhelp/premiums/

[32] https://www.billtrack50.com/billdetail/1907376/17935; Addendum #1 to the New Mexico Health Insurance Marketplace Affordability Program Policy and Procedures Manual for the 2026 Plan Year; 2025 Plan Year Health Insurance Marketplace Affordability Program Policy and Procedures Manual;

[33] https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers#newyork

[34] https://info.nystateofhealth.ny.gov/sites/default/files/QHP%20%26%20EP%20Plan%20Line%20Up%20for%202026.pdf; https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20U%20-%20Cost%20Sharing%20Reduction%20Initiatives%202026.pdf

ix. Vermont

Both premium and cost-sharing subsidies are available to Vermont residents, with premium subsidies capping at 300% and CSRs at 250%.[35]

x. Washington

Washington offers premium subsidies for enrollees below 250% FPL through Cascade Care Savings, but only for Silver or Gold exchange plans; these subsidies are also available to (and increased for) undocumented immigrants.[36]

[35] https://legislature.vermont.gov/statutes/section/33/018/01812

[36] https://www.wahbexchange.org/content/dam/materials/communications/legislative/2025/WAHBE_Final_PY_2026_Cascade_Care_Savings_Maximum_Per_Member_Per_Month_Methodology.pdf