Washington Section 1332 Waiver Application

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For Public Comment

Prepared by the Washington Health Benefit Exchange

810 Jefferson St SE Olympia, WA 98501

Phone: 360-668-7700

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Section I – Waiver Introduction and Summary

Washington is submitting this application for a Section 1332 waiver to the Department of the Treasury and the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (collectively, "the Departments") to expand state residents' access to Qualified Health Plans (QHP(s)), including stand-alone Qualified Dental Plans (QDP(s)), and state-funded QHP affordability programs. The waiver would be in effect for at least coverage years 2024-2028.

Washington is submitting this waiver to ensure that comprehensive coverage and more affordable choices are available to uninsured Washington residents. According to the most recent Census data, at least 22% of the currently uninsured population in Washington cannot purchase QHP coverage through the state-based marketplace (*Washington Healthplanfinder)* because of federal limitations placed on persons defined as "not lawfully present." This adversely impacts individual health outcomes and finances, the health care sector (increasing bad debt and uncompensated care), and Washington's economy. The waiver will provide access to federally non-subsidized QHP coverage options and state-funded affordability programs for Washington residents who cannot currently purchase coverage through *Washington Healthplanfinder*.

The Washington Health Benefit Exchange (the Exchange) administers and operates the online eligibility and enrollment portal *Washington Healthplanfinder.* The Exchange is currently implementing a state-based premium subsidy program (Cascade Care Savings) designed to enhance the affordability of coverage for low-income Washington residents, including those not eligible for federal advance premium tax credits (APTC). Based on state legislative requirements, these state subsidies are only available to residents that purchase a QHP through *Washington Healthplanfinder*. The Exchange will start making the state-funded premium subsidies available for the 2023 plan year. If the Departments approve this waiver request, those newly eligible to purchase a QHP will also be able to benefit from the state subsidy program starting in plan year 2024, because both those who are and are not APTC-eligible can benefit from the state subsidy program. State subsidies going to the newly eligible population under the waiver will be paid for using additional state funds and federal pass-through savings.

This waiver represents the next step in a series of policy innovations to make coverage more accessible and affordable for Washington residents. In 2019, the Washington State Legislature created two new plan offerings that were first available for plan year 2021. Cascade Plans feature a standardized set of benefit designs offered across the marketplace. Cascade Plans, on average, offer lower deductibles, provide more predictable cost-sharing, and offer more services before the deductible, compared to other QHP offerings. Cascade Select Plans pair the standardized benefits of Cascade Plans with a set of provider reimbursement limits and value goals in a model commonly referred to as a "public option." Cascade Select Plans are procured through the Washington Heath Care Authority, in partnership with the Exchange. Cascade Plans (standard) and Cascade Select Plans (public option), collectively called "Cascade Care Plans," are available through *Washington Healthplanfinder*. Currently, a third of all QHP enrollments are in Cascade Care Plans.

The Cascade Care Savings program will be available starting in plan year 2023 to Washington residents at or below 250% of the Federal Poverty Level (FPL) who purchase silver or gold Cascade Care Plans and meet other eligibility criteria defined in statute or Exchange policy. The Exchange will finalize the exact subsidy amount based on approved rates and pending Congressional action that could impact APTC levels. The current federal requirements that prevent a group of Washington residents from purchasing coverage on *Washington Healthplanfinder* due to immigration status also prevent them from accessing Cascade Care Savings. Through this waiver, this group of residents would also be able to access Cascade Care Savings in plan year 2024.

Washington proposes a waiver of Section 1312(f)(3) of the Patient Protection and Affordable Care Act (ACA), which bars persons considered "not lawfully present" from purchasing QHP coverage, including QDP coverage, through *Washington Healthplanfinder.* This waiver would allow newly QHP eligible applicants to have the same plan shopping and enrollment experience as those who are currently eligible. This includes accessing the online application, viewing and enrolling in available QHP plan options, viewing available Cascade Care Savings, and accessing decision support tools that help customers compare and select plans. The proposed waiver maximally leverages current information technology interfaces, operational procedures, and security and privacy safeguards. The waiver would, for the first time, allow newly eligible residents to enroll together with their currently QHP-eligible families in a single health plan.

This waiver is projected to improve the individual market risk pool and reduce the number of individuals and families who rely on less affordable or less comprehensive forms of coverage, or who remain uninsured and rely on costly emergency room services and charity care.

Washington is submitting this waiver pursuant to the authority provided in enacted Engrossed Second Substitute Senate Bill 5377 (2021-22), Engrossed Substitute Senate Bill 5092 (2021-22), and Engrossed Substitute Senate Bill 5693 (2021-22). To implement this waiver for the 2024 plan year, as directed by the Washington State Legislature, approval from federal Departments is requested by August 1, 2022 to allow sufficient time to: develop and test needed system updates (summer 2022 – summer 2023); engage with and learn from waiver-impacted communities to inform implementation efforts, including the development of outreach materials (summer 2022 – summer 2023); and train Exchange-certified Navigators and assisters on system and related updates (fall 2023), in advance of open-enrollment starting November 1, 2023 for coverage effective January 1, 2024.

Section II – Program Description

Cascade Care Savings

In 2021, the Washington State Legislature authorized the Exchange to administer a premium assistance program and cost-sharing reduction program, subject to the availability of appropriated funds. The state premium assistance program (Cascade Care Savings) was funded and takes effect for plan year 2023. The relevant policy bill provides the Exchange with implementation authority, and the relevant state budget bill defines the income eligibility limit and appropriated funding levels to be used by the Exchange when setting the assistance amounts. Together, the bills identify that Cascade Care Savings is available to Washington residents up to

250% FPL who purchase silver or gold Cascade Care Plans, apply for and accept all APTC they are eligible for, and meet other eligibility criteria defined in statute or Exchange policy.

Cascade Care Plans includes Cascade Plans (standard) and Cascade Select Plans (public option). All Cascade Care Plans have a standard benefit design that emphasizes lower deductibles and providing access to services before having to pay the deductible. Customers can make "apples to apples" comparisons across different insurance carriers because the benefits are the same. Cascade Select Plans are Washington's public option plans. These plans have the same standard benefit design, along with additional requirements, such as: incorporating community quality standards; value-based purchasing; and ensuring aggregate limits on provider reimbursements. These additional requirements help increase access to high-value care at a lower cost.

In plan year 2023, the Exchange intends to offer Cascade Care Savings to two distinct groups. The first includes individuals that receive APTC, purchase any silver or gold Cascade Care Plan (standard or public option plans), have a household income at or below 250% FPL, and meet other eligibility requirements.[1] The second group includes individuals who purchase any silver or gold Cascade Care Plan, have a household income at or below 250% FPL, meet other eligibility requirements, and who apply for but are not eligible to receive APTC.[2] If this waiver application is approved, the number of Washington residents in this second group will grow beginning in plan year 2024.

Washington Healthplanfinder is an integrated online portal that is used to determine eligibility for Washington Apple Health (Medicaid) programs, APTC, and QHP and QDP coverage. For purposes of determining income eligibility for Cascade Care Savings, the Exchange will leverage the same processes used to determine income eligibility for APTC. A condition of participation in the Cascade Care Savings program is that residents apply for and, if eligible, elect to receive the maximum amount of APTC.

If the Cascade Care Savings subsidy is greater than the monthly premium for the benchmark plan after the full APTC amount, the consumer is not eligible to receive the difference between the maximum subsidy amount and the after-APTC premium. Similar to APTC, this method helps ensure that, in any circumstance, the state subsidy amount will not be greater than the net premium for the benchmark plan (lowest cost silver Cascade Care Plan in the applicable county). More details regarding the subsidy policy can be found in Appendix B: Washington Health Benefit Exchange State Premium Assistance Policy.

Currently, enhanced federal subsidies are available through 2022 under the American Rescue Plan (ARP). For both groups described above who will be receiving Cascade Care Savings in 2023, the maximum projected state premium subsidy amount, per member per month (PMPM), is:

- $150 if ARP subsidies extended through plan year 2023

[1] This first group includes Washington residents in the "5-year bar" who can qualify for federally funded Washington Apple Health (Medicaid) coverage after they satisfy the federal five-year waiting period. In the meantime, these residents can qualify for APTC, QHP and QDP coverage.

[2] The second group includes Washington residents eligible for minimum essential coverage (MEC), except for those offered MEC through a federal or state medical assistance program, including Medicare and Washington Apple Health (Medicaid). See Appendix B: Washington Health Benefit Exchange Premium Assistance Program for more details.

- $75 if ARP subsidies expire at the end of plan year 2022 (current law)

These 2023 estimates exclude the waiver population, who will be eligible to purchase QHPs starting in plan year 2024 if the wavier application is approved. The maximum projected state premium amount is the same across both groups in 2023 but is projected to differ across groups starting in 2024.

The maximum projected state premium subsidy PMPM for 2024, assuming ARP subsidies expire (current law) is:

- $65 PMPM for those that receive APTC. This amount is not projected to change under the waiver.
- $195 for those that are not eligible for APTC (which would include the newly eligible waiver population), resulting in an average projected premium decrease of 46%.

Except as specified in Table 1, all included tables assume ARP subsidies expire at the end of 2022 (current law).

Table 1: Detailed Enrollment, State-Subsidy and Net Premium Projections, by APTC status, for Cascade Care Savings Enrollees in 2023, 2024 baseline (without waiver), and 2024 waiver (with approved 1332 waiver)

	2023 (With ARP)	2023 (No ARP)	2024 Baseline (With ARP	2024 Waiver (With ARP)	2024 Baseline (No ARP)	2024 Wavier (No ARP)
APTC Enrollment	85,900	67,700	86,300	86,300	64,000	64,000
Non-APTC Enrollment	3,300	2,000	4,000	6,500	3,600	6,200
APTC: State Subsidy PMPM	$150	$75	$140	$140	$65	$65
Non-APTC: State Subsidy PMPM	$150	$75	$185	$180	$195	$195
APTC: Average Subsidy Received	$33	$49	$33	$33	$43	$43
Non-APTC: Average Subsidy Received	$149	$74	$183	$184	$193	$194
APTC: Average Net Premium	$5	$46	$6	$6	$52	$52
Non-APTC: Average Net Premium	$301	$255	$262	$303	$255	$255

Note that members who are non-APTC eligible or APTC eligible but that do not qualify for the state subsidy program were excluded from the above calculations.

The Cascade Care Savings policy developed by the Exchange, including the method for determining the annual state subsidy amount – and the contingent budget amount appropriated by the Washington State Legislature – is structured to ensure that receipt of Cascade Care Savings among the newly eligible waiver population does not impact the amount of state

subsidies available for groups eligible in the baseline scenario. The Washington State Legislature recently passed their 2022 Supplemental Budget (pending the Washington Governor's signature), which includes $55 million in annual state funding for the Cascade Care Savings program.

The subsidy amount will be set, after establishing a 10% reserve to help account for enrollment uncertainty, to maximize assistance to the consumer while ensuring that any eligible consumer can receive the subsidy. However, if enrollment exceeds projections, the Exchange has the authority to cap enrollment in Cascade Care Savings to account for budget limits in the state appropriation. Of the total annual appropriation, $5 million is contingent on 1332 waiver approval and specifically allocated for those that do not receive APTC (which would include the newly eligible waiver population).

Under this waiver, all residents will utilize the eligibility and enrollment functionality of *Washington Healthplanfinder*. Included in this functionality will be the ability for family members to enroll in the same plan (provided they are all eligible for the plan). This will allow all mixed-status households to stay together in the same QHP, if desired (including 12% of currently enrolled QHP households). *Washington Healthplanfinder* will display all plans that an individual is eligible to purchase, along with any applicable subsidies, including APTC and Cascade Care Savings. While the waiver permits additional individuals to purchase plans on the marketplace, it does not extend eligibility for any federal subsidy to persons that are not currently eligible.

Expected Enrollment

Washington expects enrollment growth on the Exchange as a result of this waiver. Increased access to marketplace coverage as well as state-funded premium assistance for those newly eligible to purchase create the growth modeled for the waiver duration. The table below describes the estimated enrollment without the waiver (baseline) and with the waiver. Washington expects the waiver to result in total enrollment growth between 1.1 and 1.5% per year over the 5-year waiver period.

Table 2 - Enrollment Estimates 2024-2028 with Waiver

	2024	2025	2026	2027	2028
Baseline					
Total Individual Market Enrollment	241,600	244,500	249,500	254,200	259,200
Total Exchange Enrollment	215,200	218,500	223,800	228,800	234,200
APTC Only Enrollment	68,800	69,000	70,400	72,800	74,400
APTC and State Subsidy Enrollment	64,000	64,700	66,200	66,200	67,400
State Subsidy Only Enrollment	3,600	3,800	3,800	3,900	4,200
Not Eligible for Subsidies	78,800	81,000	83,400	85,800	88,200

	2024	2025	2026	2027	2028
Off-Exchange Enrollment	26,400	26,000	25,700	25,400	25,000
After Waiver					
Total Individual Market Enrollment	244,300	247,500	252,800	257,600	263,100
Total Exchange Enrollment	217,900	221,500	227,100	232,200	238,100
APTC Enrollment	132,800	133,700	136,600	139,000	141,800
APTC and State Subsidy Enrollment	64,000	64,700	66,200	66,200	67,400
State Subsidy Only Enrollment	6,200	6,800	7,100	7,400	8,100
Not Eligible for Subsidies	78,800	81,000	83,400	85,800	88,200
Off-Exchange Enrollment	26,400	26,000	25,700	25,400	25,000
Percent Change in Total Enrollment (relative to non-waiver)	1.1%	1.2%	1.3%	1.3%	1.5%

Expected Federal Savings and Pass-through Request

Table 3 - Effect of Waiver Relative to Baseline on Estimated Pass-Through Funding

Year	Federal Savings ($M)
2024	$1.71
2025	$1.95
2026	$2.11
2027	$2.25
2028	$2.56

Available federal pass-through funding resulting from the waiver will supplement the $5 million in Cascade Care Savings program contingent funds for those that do not receive APTC.

Section III – Authorizing Legislation

Washington is submitting this waiver pursuant to the authority provided in enacted Engrossed Second Substitute Senate Bill 5377, Engrossed Substitute Senate Bill 5092, and Engrossed Substitute Senate Bill 5693:

- In 2019, the Washington State Legislature created Cascade Care Plans – which include Cascade Plans (standard) and Cascade Select Plans (public option) – that were first available for plan year 2021.
- In 2021, the Washington State Legislature passed Engrossed Second Substitute Senate Bill 5377, which established state affordability programs tied to Cascade Care Plans. The Legislature funded a state premium assistance program (Cascade Care Savings) in the biennial operating budget (Engrossed Substitute Senate Bill 5092). In both vehicles the Exchange was authorized to develop a 1332 waiver.
- In 2022, the Legislature passed a supplemental operating budget (Engrossed Substitute Senate Bill 5693) that provided additional annual state premium assistance funding, contingent on 1332 waiver approval, and also provided funding to implement the1332 waiver for plan year 2024.

Table 4: Summary of Relevant State Legislation

Year Passed	Bill Number	Applicable Provisions

2019	E2SSB 5526
	(Policy Bill)
		• Established Washington State's Cascade Care Plans:
		  ○ Cascade Plan (standard)
		  ○ Cascade Select Plan (public option)
		• Required the Exchange to complete a state subsidy study and provide implementation recommendations to the Legislature by Dec. 2020

2021	E2SSB 5377 (Policy Bill)	• Established, subject to funding, state affordability programs (premium assistance and cost sharing reductions) for Exchange customers enrolling in a silver or gold Cascade Care Plan • Directed the Exchange to create an affordability program policy for funded initiatives, within parameters established by the budget • Provided authority to the Exchange to develop a 1332 waiver to receive federal funds, increase access to QHPs, and increase affordability or access to coverage
2021	ESSB 5092 (Biennial Operating Budget)	• Provided the Exchange with $50M annually for a state premium subsidy program starting in PY 2023, for those up to 250% FPL • Provided the Exchange with funding to implement the state premium subsidy program • Provided authority to the Exchange to develop a 1332 waiver to facilitate enrollment of Washington residents who do not qualify for non-emergency Medicaid or federal affordability programs into a state-funded program, no later than plan year 2024

2022	ESSB 5693 (Supplemental Operating Budget)	• Increased total annual appropriation for the state premium subsidy program to $55M, with $5M for non-federally subsidized enrollees contingent on 1332 waiver approval • Provided funding to the Exchange to support 1332 waiver implementation (community-led engagement/outreach and system updates)

On May 10, 2021, Washington enacted Engrossed Second Substitute Senate Bill 5377 (2021), effective on July 25, 2021. This legislation established, subject to funding, state affordability programs related to Cascade Care plans – including state funded premium assistance and cost sharing reductions. The legislation provided authority to the Exchange to develop a 1332 waiver application. The legislation includes the following provisions:

- Subject to the availability of amounts appropriated for this specific purpose, a premium assistance and cost-sharing reduction program is hereby established to be administered by the exchange.
- Premium assistance and cost-sharing reduction amounts must be established by the exchange within parameters established in the omnibus appropriations act.
- The Exchange, in close consultation with the authority and the office of the insurance commissioner, must explore all opportunities to apply to the secretary of health and human services under 42 U.S.C. Sec. 18052 for a waiver or other available federal flexibilities to:
    - Receive federal funds for the implementation of the premium assistance or cost-sharing reduction programs established under RCW 43.71.110;
    - Increase access to qualified health plans; and
    - Implement or expand other exchange programs that increase affordability of or access to health insurance coverage in Washington state.
- If, through the process described in subsection (1) of this section an opportunity to submit a waiver is identified, the exchange, in collaboration with the office of the insurance commissioner and the health care authority, may develop an application under this section to be submitted by the health care authority. If an application is submitted, the health care authority must notify the chairs and ranking minority members of the appropriate policy and fiscal committees of the legislature.
- Any application submitted under this section must meet all federal public notice and comment requirements under 42 U.S.C. Sec. 18052(a)(4)(B), including public hearings to ensure a meaningful level of public input.

A copy of the Engrossed Second Substitute Senate Bill 5377 (2021) is included in Appendix A: Authorizing Legislation.

On May 18, 2021, Washington enacted Engrossed Substitute Senate Bill 5092 (2021), effective on May 18, 2021. The legislation provides the Exchange with $50 M annually beginning in plan year 2023 to provide a state premium assistance program, as established in E2SSB 5377 (2021). This legislation also directs the Exchange, in consultation with state agency partners, to explore coverage solutions specifically for Washington residents ineligible for non-emergency Medicaid

or federal affordability programs, and to facilitate enrollment into a state funded solution by plan year 2024. The legislation includes the following provisions:

- $50,000,000 of the health care affordability account-state appropriation is provided solely for the Exchange to administer a premium assistance program, beginning for plan year 2023, as established in Engrossed Second Substitute Senate Bill No. 5377 (standardized health plans), and this is the maximum amount the exchange may expend for this purpose. An individual is eligible for the premium assistance provided if the individual: (a) Has income up to 250 percent of the federal poverty level; and (b) meets other eligibility criteria as established in section 1 (4) (a) of Engrossed Second Substitute Senate Bill No. 5377 (standardized health plans).
- Within amounts appropriated in this section, the Exchange, in close consultation with the authority and the office of the insurance commissioner, shall explore opportunities to facilitate enrollment of Washington residents who do not qualify for non-emergency Medicaid or federal affordability programs in a state funded program no later than plan year 2024.
    - If an opportunity to apply to the secretary of health and human services under 42 U.S.C. Sec. 18052 for a waiver is identified or other federal flexibilities are available, the exchange, in collaboration with the office of the insurance commissioner and the authority may develop an application to be submitted by the authority. If an application is submitted, the authority must notify the chairs and ranking minority members of the appropriate policy and fiscal committees of the legislature.
    - Any application submitted under this subsection must meet all federal public notice and comment requirements under 42 U.S.C. Sec. 18052(a)(4)(B), including public hearings to ensure a meaningful level of public input.

A copy of the Engrossed Substitute Senate Bill 5092 (2021-22) is included in Appendix A: Authorizing Legislation.

On March 10, 2022, the Washington State Legislature passed Engrossed Substitute Senate Bill 5693, pending the Governor's signature at the time of this document release. This legislation increased the state appropriation for the state subsidy program, by adding $5M contingent on the 1332 waiver to the existing appropriation of $50M. Additional funding was also provided to support 1332 waiver implementation. The following additional provisions were added:

- $50,000 of the general fund—state appropriation for fiscal year 2022 and $2,891,000 of the general fund—state appropriation for fiscal year 2023 are provided solely for system updates and community-led engagement activities necessary to implement the waiver.
- $5,000,000 of the state health care affordability account— state appropriation is provided solely to provide premium assistance for customers ineligible for federal premium tax credits who meet the established eligibility criteria and is contingent upon approval of the applicable waiver.

A copy of the Engrossed Substitute Senate Bill 5693 (2021-22) is included in Appendix A: Authorizing Legislation.

Section IV – Provision(s) of the Law that the State Seeks to Waive

The state of Washington is seeking a waiver of Section 1312(f)(3) of the ACA (42 USC §18032 (f)(3)). This section prohibits persons that are not United States citizens, United States nationals, or aliens lawfully present in the United State from being deemed a qualified individual for the purpose of qualifying for coverage in a qualified health plan offered on the exchange. Washington is seeking a complete waiver of this subsection in order to deem any individual, regardless of immigration status, a qualified individual for the purpose of enrolling in a QHP, including QDPs, offered through *Washington Healthplanfinder*. Through this waiver, Washington intends that 45 CFR §155.305 (a)(1) would not be used as an eligibility requirement for enrollment in a QHP, including QDPs, through *Washington Healthplanfinder*. The other requirements of 45 CFR §155.305 (a) would apply to eligibility determinations.

Due to interactions between this waiver proposal and the premium tax credit, Washington is considering whether it is necessary to waive certain technical provisions under section 36B of the Internal Revenue Code to ensure that taxpayers and IRS can follow existing procedures. If it is determined that additional provisions are necessary to waive, there will be no impact on the program design or expected enrollment or costs that is in the current waiver application and analyses.

Section V – Compliance with Section 1332 Guardrails: Data, Analyses, and Certifications

The state of Washington conducted actuarial and economic analyses related to the changes that will occur after this section 1332 waiver application is approved and implemented beginning in plan year 2024. The actuarial and economic analyses and certifications that support the state's findings that all four of the section 1332 guardrails will be met, are included in Appendix C: Actuarial and Economic Analyses.

A. Comprehensiveness Requirement (Section 1332(b)(1)(A))

Comprehensiveness refers to the scope of benefits provided by the state plan as measured by the extent to which coverage meets essential health benefit (EHB) requirements as defined in section 1302(b) of the ACA and 45 CFR 156.110. Under the waiver, there will be no changes to the EHB and no diminution of benefits available to any Washington resident.

B. Affordability Requirement (Section 1332(b)(1)(B))

Affordability refers to the state residents' ability to pay out-of-pocket for their health care expenses relative to their income. Under the waiver, more Washington resident will have access to affordable coverage that they would without the waiver. Additionally, no Washington resident will experience less affordable coverage as a result of the waiver. The following chart provides

the expected premium cost reductions as a result of the waiver, given the availability of Cascade Care Savings:

Table 5 - Effect of Waiver Relative to Baseline on Premiums

Year	Change in Premiums
2024	-1.4%
2025	-1.5%
2026	-1.5%
2027	-1.5%
2028	-1.6%

The waiver will not have any impact on out-of-pocket costs for consumers. The waiver will not have any impact on the costs of coverage or the availability of tax credits for small group coverage.

C. Scope of Coverage Requirement (Section 1332(b)(1)(C))

The third guardrail specifies that meaningful health care coverage must be provided to a comparable number of state residents as Title I of the ACA would provide. This waiver will increase the number of Washington residents enrolled in coverage as compared to the baseline without the waiver. Washington does not expect a loss of coverage in any group as a result of the waiver. The following chart outlines the change in total enrollment in the individual market under the waiver over the course of the 5-year duration. The waiver is not expected to change enrollment in other types of coverage.

Table 6 - Effect of Waiver Relative to Baseline on Enrollment

Year	Change in Enrollment
2024	1.1%
2025	1.2%
2026	1.3%
2027	1.3%
2028	1.5%

D. Deficit Neutrality Requirement (Section 1332(b)(1)(D))

This proposed section 1332 waiver will not increase the deficit of the United States. The increased enrollment in the individual market as the result of the waiver represents persons that are not eligible for federal subsidies.

The costs to provide additional state-funded Cascade Care Savings resulting from increased uptake among the waiver population will be paid by state funding, and any eventual federal pass-through savings that may become available.

Because the section 1332 waiver is expected to increase overall individual market Exchange enrollment only for those ineligible for federal subsidies, the analysis does not predict an increase in PTC spending.

Washington's estimates show the amount of federal spending will be less than or equal to what the federal government would have paid during each year of the required 5-year budget period. Washington estimates that federal savings will be over $11 million over the course of the waiver.

Table 7 - Effect of Waiver Relative to Baseline on Estimated Pass-Through Funding

Year	Federal Savings ($M)
2024	$1.71
2025	$1.95
2026	$2.11
2027	$2.25
2028	$2.56

Section VI – Implementation Plan and Timeline

Following waiver approval, Washington will take the following steps to implement the section 1332 waiver:

Table 8 – 1332 Waiver Implementation Timeline

Expected Timing	1332 Waiver – Implementation and Years 0-2 Activity Timeline
August 2022	• WA receives approval of 1332 Waiver

Summer 2022	• The Exchange begins designing system changes • The Exchange begins community-led engagement activities to inform outreach strategy for 2024 Open Enrollment (OE)
September 2022	• Finalize modeling of Cascade Care Savings program per member per month subsidy (PMPMs) for plan year (PY) 2023
November 2022 - January 2023	• OE for Plan Year 2023 with Cascade Care Savings for non-waiver individuals.
June 2023	• Draft carrier rates available for PY 2024 • Initial modeling of Cascade Care Savings program PMPMs for PY 2024
July 2023	• State funds distributed for PY 2024 Cascade Care Savings program into affordability account ○ Includes newly eligible waiver population with approved 1332 Waiver in PY 2024
Summer 2023	• Finalize system updates and complete testing in advance of Fall open-enrollment activities, to support waiver implementation for Open Enrollment 2024
September 2023	• Final carrier rates for PY 2024 • Finalize modeling of Cascade Care Savings program PMPMs for PY 2024 • WA submits required annual 1332 Waiver and Baseline modeling
November 2023	• OE for PY 2024 begins ○ Waiver population able to purchase QHPs & QDPs and (if eligible) enroll in Cascade Care Savings program
January 2024	• QHP coverage begins for waiver population • OE 2024 ends January 15
April 2024	• State receives final pass-through for PY 2024 from Treasury/CMS
June 2024	• Draft carrier rates available for PY 2024 • Initial modeling of Cascade Care Savings program PMPMs for PY 2025 (includes any pass-through funds from PY 2024)

July 2024	• State funds distributed for PY 2025 into affordability account
September 2024	• Final carrier rates for PY 2025 • Finalize modeling of Cascade Care Savings program PMPMs for PY 2025s • WA submits required annual 1332 Waiver and Baseline modeling
November 2024	• OE for PY 2025 begins
January 2025	• OE 2025 ends January 15
April 2025	• State receives final pass-through for PY 2025 check from Treasury/CMS
June 2025	• Draft carrier rates available for PY 2024 • Initial modeling of Cascade Care Savings program PMPMs for PY 2026 (includes any pass-through funds from PY 2025)
July 2025	• State funds distributed for PY 2026 into affordability account
September 2025	• Final carrier rates for PY 2026 • Finalize modeling of Cascade Care Savings program PMPMs for PY 2026 • WA submits required annual 1332 Waiver and Baseline modeling
November 2025	• OE for PY 2026 begins

Section VII – Public Notice and Comment Process

On March 31, 2022, the state of Washington opened public comment for this section 1332 waiver application. Additional public comment information available on the Washington Health Benefit Exchange website: 1332 Waiver Information | Washington Health Benefit Exchange (wahbexchange.org).

[Additional details to be completed after public comment completed: March 31-May 2]

Tribal Consultation

[Additional details to be completed after Tribal Consultation on April 11, Dear Tribal Letter available on 1332 Waiver Information website]

Public Comment Hearings

[Additional details to be completed after public hearing meetings on April 12 and April 13; ppt; written comments; and summary of written and verbal comments to be included in Appendix]

Section VIII – Additional Information

A. Administrative Burden

The waiver would result in a minimal increase in administrative burden for the state of Washington. The Exchange will make the state-based technology changes needed to implement the waiver and assume the incremental increase in administration related to new enrollees including outreach, mailings, compliance, and customer service. Since the waiver is being administered by a state-based marketplace, and only increases enrollment for those persons not eligible for APTC, the only increase in federal administrative burden would be the calculation of pass-through funds and the receipt and review of mandatory reports. For consumers, the new ability to enroll in a health plan through *Washington Healthplanfinder,* a streamlined coverage path, will reduce the administrative burden for seeking coverage or care through other channels. The proposed changes from a 1332 waiver approval, allowing additional residents to purchase a QHP, will result in minimal additional administrative burden on issuers given no plan changes are necessary, and projected uptake should have limited impact on their total enrollment. There will be no administrative burden changes for the employer community.

B. PPACA Impacts

The waiver will have no impact on ACA provisions that are not being waived.

C. Out of State Services

This waiver represents an increase of access for persons seeking out-of-state services due to the increased number of Washington residents that enroll in QHP coverage, which provides coverage for out-of-state services.

D. Federal Administration and Operations

The state will provide the federal government with reports outlined in Section IX. Beyond reviewing reporting for compliance and annual calculation of any potential pass-through, there is no expected additional federal administrative burden or responsibilities.

E. Waste, Fraud, and Abuse

The approval of the 1332 waiver will not alter the Washington Health Benefit Exchange's typical waste, fraud, and abuse monitoring and mitigation. Given there is no impact on federal APTC as a result of the waiver, all monitoring and mitigation relates to state funds appropriated by the Washington State Legislature to the Exchange.

F. Health Equity Goal

With this 1332 waiver, the state seeks to provide all Washington families an opportunity to purchase QHP coverage together through *Washington Healthplanfinder*. This waiver aims to address health equity and reduce racial disparities by increasing coverage for underserved populations, and improve affordability for consumers in the individual market. Over 2 million of Washington's 6.5 million residents under 65 years old obtain health coverage through *Washington Healthplanfinder*. At the time a family first applies for coverage through the online portal, they do not know which health program they will be determined eligible for: Medicaid, CHIP, or QHP coverage. It is common in Washington for families to include members who qualify for different programs (over 10% of QHP enrolled families have at least one household member who is receiving Medicaid or CHIP) and members who have different immigration statuses (over 25% of QHP eligible households have at least one non-Citizen member).

The state provides an integrated eligibility and enrollment experience through *Washington Healthplanfinder* for families who qualify for different programs and seeks to do the same for mixed-status families and uninsured individuals who currently have no other health insurance coverage option. Data collected by the American Community Survey (ACS) and analyzed by the Washington Office of Financial Management estimates over 100,000 of the state's 465,000 uninsured state residents cannot currently access QHP coverage through *Washington Healthplanfinder* due to their immigration status – about 22% of the uninsured population in Washington. This rate is higher (29%) among the uninsured population under 250% FPL.[3] Immigrants are also overrepresented in low-wage jobs that are unlikely to offer employer-sponsored health coverage.

Table 9 – Uninsured Individuals in Washington State

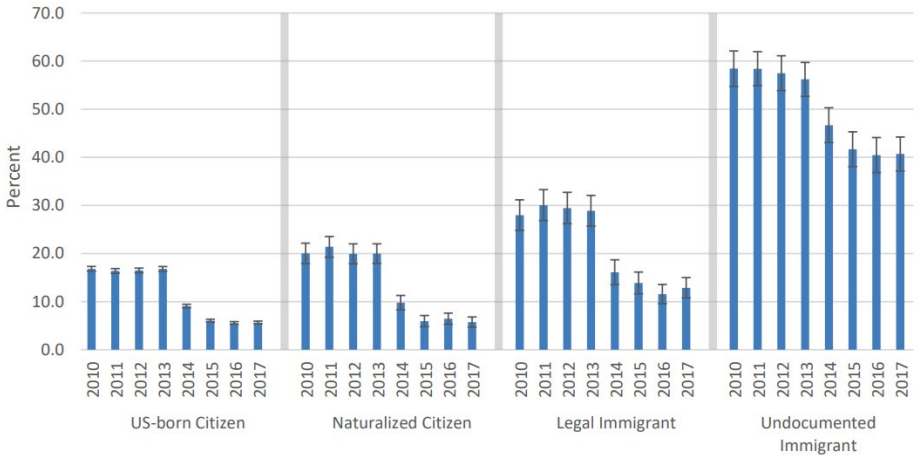
[3] Yen W. Washington State Health Services Research Project: Statewide Uninsured Rate Remained Unchanged from 2018 to 2019 (wa.gov); Research Brief. Washington State Office of Financial Management, Health Care Research Center; December 2020.

Family Income Level of Washington State's Uninsured Population, 2019										
	Family Income as Percent of Federal Poverty Level									
	Income unknown	**0-138%**	**139-150%**	**151-200%**	**201-250%**	**251-300%**	**301-400%**	**401-500%**	**501%+**	**Total**
Total (%)	14,745	105,668	15,349	61,888	58,899	46,993	71,074	34,926	55,671	**465,213**
	3.2%	22.7%	3.3%	13.3%	12.7%	10.1%	15.3%	7.5%	12.0%	
Undocumented (%)	1,319	32,399	3,543	13,964	18,722	10,652	13,760	5,474	5,426	**105,259**
	1.3%	30.8%	3.4%	13.3%	17.8%	10.1%	13.1%	5.2%	5.2%	

OFM Source: American Community Survey 2019 1-year PUMS with OFM adjustment for Medicaid enrollment

In Washington state's non-elderly adult population, approximately one in six (about 843,000) is a first-generation immigrant. When looking at the uninsured rate among U.S.-born citizens and individuals without a federally recognized status in Washington State, OFM found that 5-6% of U.S.-born citizens are uninsured, while nearly 41% of individuals who lack a federally recognized immigration status are uninsured. In 2017, individuals without a federally recognized status were 11 times as likely to be uninsured as U.S.-born citizens, when other population characteristics were held as equal.[4]

Table 10 – Percent Uninsured by Immigration Status, 2010-2017, Adults Aged 18-64, in Washington State



The uninsured rate in Washington also disproportionately impacts communities of color – the highest uninsured rates in Washington are among the Hispanic population (16.8%,

[4] Yen W. Health Coverage Disparities Associated with Immigration Status in Washington State's Non-elderly Adult Population: 2010-17. Washington State Health Services Research Project. Washington State Office of Financial Management; May 2019.

approximately four times higher than the uninsured rate of 4.5% for the non-Hispanic population), American Indians and Alaska Natives (11.2%) and Black residents (7.9%).[5]

Table 11 – Percent Uninsured by Race, 2013-2019, in Washington State

Without health insurance, it is unlikely that individuals and families, including children and young adults who are citizens, will receive the health care services they need to stay healthy.[6] Those without health insurance have more absences from work and delay preventive or chronic condition care which often results in poorer health outcomes, exacerbating health disparities.[7] Lack of health insurance can also lead to increased emergency room utilization, driving higher costs at the federal and state level for both providers (via uncompensated care) and families.

[5] Yen W. Washington State Health Services Research Project: Statewide Uninsured Rate Remained Unchanged from 2018 to 2019 (wa.gov); Research Brief. Washington State Office of Financial Management, Health Care Research Center; December 2020.

[6] Healthy People 2020: Access to Health Services. 2018; Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services; Goldin J., Lurie I.Z., McCubbin J. Health Insurance and Mortality: Experimental Evidence from TaxPayer Outreach. NBER Working Paper Series. National Bureau of Economic Research (NBER); 2019.

[7] Institute of Medicine. America's Uninsured Crisis: Consequences for Health and Health Care. Washington, DC: The National Academics Press; 2009.

This waiver is expected to help stabilize the individual health insurance market in Washington, which already includes over 25,000 lawfully present QHP enrollees from across the state, because immigrants tend to be younger, healthier, or lower-than average utilizers of health care services when compared to the general insured population. As such, this waiver will also help improve affordability for consumers in the individual market.

To further support waiver implementation efforts, the Exchange will be leveraging funding provided by the Washington State Legislature for waiver related, community-led engagement activities starting in plan year 2023. The Exchange works with an extensive network of community-based Navigators, brokers and tribal assisters who provide outreach, language support and enrollment assistance. Leading up to plan year 2024, the Exchange will be learning from and working in partnership with impacted communities to inform waiver related messaging, outreach, materials development, and ongoing community engagement activities.

Section IX – Reporting Targets

Washington will submit all required quarterly, annual, and cumulative targets for the guardrail requirements in accordance with 31 CFR 33.108(f)(4)(vi) and 45 CFR 155.1308(f)(4)(vi).

The Exchange will assume responsibility for the reporting requirements, including the following:

- Quarterly reports (31 CFR 33.124(a) and 45 CFR 155.1324 (a)): To the extent required by the Departments, the Washington Health Benefit Exchange will submit quarterly reports, including reports of ongoing operational challenges, if any, and plans for, and results of, associated corrective actions.
- Annual reports (31 CFR 33.124(b) and 45 CFR 155.1324(b)): the Washington Health Benefit Exchange will submit annual reports documenting the following:
  (1) The current state and the progress of the section 1332 waiver to date.
  (2) Data on the state's compliance with the guardrails in ACA section 1332(b)(1)(A)-(D), 31 CFR 33.108(f)(3)(iv)(A)-(D), and 45 CFR 155.1308(f)(3)(iv)(A)-(D).
  (3) Premiums for the second lowest-cost silver plan under the section 1332 waiver and an estimate of the premium as it would have been without the waiver for a representative consumer in each rating area.
  (4) A summary of the annual public forum required by 31 CFR 33.120(c) and 45 CFR 155.1320(c) and a summary of actions taken in response to public input.

Community leaders in Washington have shared that distrust of the health care system and sharing information with the government, including on health coverage applications, is a barrier to accessing care. Required metrics will be submitted to the Departments at the aggregate level only; no individually identifiable information will be included or otherwise shared. Data will be reported to the Departments only to the extent necessary to satisfy federal requirements related to continuation of the waiver. Any creation, collection, use, and disclosure of waiver related data will adhere to protective federal and state privacy and security requirements that govern the use of Exchange data, and data minimization standards will be followed.

Section X – Administration

Name: Joan Altman, JD. MPH

Title: Director of Government Affairs and Strategic Partnerships, Washington Health Benefit Exchange

Telephone Number: 360-688-7774

Email address: joan.altman@wahbexchange.org

Appendix A: **Authorizing Legislation**

Included here is the entirety of the 2021 policy bill (E2SSB 5377), and the relevant components (Exchange budget sections) of the 2021 and 2022 budget bills (ESSB 5092 and ESSB 5693, respectively).

CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5377

67th Legislature
2021 Regular Session

Passed by the Senate April 19, 2021
Yeas 28 Nays 21

President of the Senate

Passed by the House April 8, 2021
Yeas 55 Nays 43

Speaker of the House of Representatives

Approved

Governor of the State of Washington

CERTIFICATE

I, Brad Hendrickson, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE SENATE BILL 5377** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

Secretary of State
State of Washington

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5377

AS AMENDED BY THE HOUSE

Passed Legislature - 2021 Regular Session

State of Washington 67th Legislature 2021 Regular Session

By Senate Ways & Means (originally sponsored by Senators Frockt, Keiser, Conway, Das, Dhingra, Hunt, Kuderer, Liias, Lovelett, Wilson, C., Nguyen, Pedersen, Saldaña, and Salomon)

READ FIRST TIME 02/22/21.

AN ACT Relating to increasing affordability of standardized plans on the individual market; amending RCW 41.05.410 and 43.71.095; adding new sections to chapter 43.71 RCW; adding a new section to chapter 48.43 RCW; and adding a new section to chapter 41.05 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 43.71 RCW to read as follows:

(1) Subject to the availability of amounts appropriated for this specific purpose, a premium assistance and cost-sharing reduction program is hereby established to be administered by the exchange.

(2) Premium assistance and cost-sharing reduction amounts must be established by the exchange within parameters established in the omnibus appropriations act.

(3) The exchange must establish, consistent with the omnibus appropriations act:

(a) Procedural requirements for eligibility and continued participation in any premium assistance program or cost-sharing program established under this section, including participant documentation requirements that are necessary to administer the program; and

(b) Procedural requirements for facilitating payments to carriers.

(4) Subject to the availability of amounts appropriated for this specific purpose, an individual is eligible for premium assistance and cost-sharing reductions under this section if the individual:

(a)(i) Is a resident of the state;

(ii) Has income that is up to an income threshold determined through appropriation or by the exchange if no income threshold is determined through appropriation;

(iii) Is enrolled in a silver or gold standard plan offered in the enrollee's county of residence;

(iv) Applies for and accepts all federal advance premium tax credits for which they may be eligible before receiving any state premium assistance;

(v) Applies for and accepts all federal cost-sharing reductions for which they may be eligible before receiving any state cost-sharing reductions;

(vi) Is ineligible for minimum essential coverage through medicare, a federal or state medical assistance program administered by the authority under chapter 74.09 RCW, or for premium assistance under RCW 43.71A.020; and

(vii) Meets any other eligibility criteria established by the exchange; or

(b) Meets alternate eligibility criteria as established in the omnibus appropriations act.

(5)(a) The exchange may disqualify an individual from receiving premium assistance or cost-sharing reductions under this section if the individual:

(i) No longer meets the eligibility criteria in subsection (4) of this section;

(ii) Fails, without good cause, to comply with any procedural or documentation requirements established by the exchange in accordance with subsection (3) of this section;

(iii) Fails, without good cause, to notify the exchange of a change of address in a timely manner;

(iv) Voluntarily withdraws from the program; or

(v) Performs an act, practice, or omission that constitutes fraud, and, as a result, an issuer rescinds the individual's policy for the qualified health plan.

(b) The exchange must develop a process for an individual to appeal a premium assistance or cost-sharing assistance eligibility determination from the exchange.

(6) Prior to establishing or altering premium assistance or cost-sharing reduction amounts, eligibility criteria, or procedural requirements under this section, the exchange must:

(a) Publish notice of the proposal on the exchange's website and provide electronic notice of the proposal to any person who has requested such notice. The notice must include an explanation of the proposal, the date, time, and location of the public hearing required in (b) of this subsection, and instructions and reasonable timelines to submit written comments on the proposal;

(b) Conduct at least one public hearing no sooner than 20 days after publishing the notice required in (a) of this subsection; and

(c) Publish notice of the finalized premium assistance or cost-sharing reduction amounts, eligibility criteria, or procedural requirements on the exchange's website and provide the notice electronically to any person who has requested it. The notice must include a detailed description of the finalized premium assistance or cost-sharing reduction amounts, eligibility criteria, or procedural requirements and a description and explanation of how they vary from the initial proposal.

(7) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Advance premium tax credit" means the premium assistance amount determined in accordance with the federal patient protection and affordable care act, P.L. 111-148, as amended by the federal health care and education reconciliation act of 2010, P.L. 111-152, or federal regulations or guidance issued under the affordable care act.

(b) "Income" means the modified adjusted gross income attributed to an individual for purposes of determining his or her eligibility for advance premium tax credits.

(c) "Standard plan" means a standardized health plan under RCW 43.71.095.

NEW SECTION. **Sec. 2.** A new section is added to chapter 43.71 RCW to read as follows:

(1) The exchange, in close consultation with the authority and the office of the insurance commissioner, must explore all

opportunities to apply to the secretary of health and human services under 42 U.S.C. Sec. 18052 for a waiver or other available federal flexibilities to:

(a) Receive federal funds for the implementation of the premium assistance or cost-sharing reduction programs established under section 1 of this act;

(b) Increase access to qualified health plans; and

(c) Implement or expand other exchange programs that increase affordability of or access to health insurance coverage in Washington state.

(2) If, through the process described in subsection (1) of this section an opportunity to submit a waiver is identified, the exchange, in collaboration with the office of the insurance commissioner and the health care authority, may develop an application under this section to be submitted by the health care authority. If an application is submitted, the health care authority must notify the chairs and ranking minority members of the appropriate policy and fiscal committees of the legislature.

(3) Any application submitted under this section must meet all federal public notice and comment requirements under 42 U.S.C. Sec. 18052(a)(4)(B), including public hearings to ensure a meaningful level of public input.

NEW SECTION. **Sec. 3.** A new section is added to chapter 43.71 RCW to read as follows:

(1) The state health care affordability account is created in the state treasury. Expenditures from the account may only be used for premium and cost-sharing assistance programs established in section 1 of this act.

(2) The following funds must be deposited in the account:

(a) Any grants, donations, or contributions of money collected for purposes of the premium assistance or cost-sharing reduction programs established in section 4 of this act;

(b) Any federal funds received by the health benefit exchange pursuant to section 2 of this act; and

(c) Any additional funding specifically appropriated to the account.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW to read as follows:

For qualified health plans offered on the exchange, a carrier shall:

(1) Accept payments for enrollee premiums or cost-sharing assistance under section 1 of this act or as part of a sponsorship program under RCW 43.71.030(4). Nothing in this subsection expands or restricts the types of sponsorship programs authorized under state and federal law;

(2) Clearly communicate premium assistance amounts to enrollees as part of the invoicing and payment process; and

(3) Accept and process enrollment and payment data transferred by the exchange in a timely manner.

NEW SECTION. **Sec. 5.** A new section is added to chapter 41.05 RCW to read as follows:

(1) If a public option plan is not available in each county in the state during plan year 2022 or later, the following requirements apply for all subsequent plan years:

(a) Upon an offer from a public option plan, a hospital licensed under chapter 70.41 RCW that receives payment for services provided to enrollees in the public employees' benefits program or school employees' benefits program, or through a medical assistance program under chapter 74.09 RCW, must contract with at least one public option plan to provide in-network services to enrollees of that plan. This subsection (1)(a) does not apply to a hospital owned and operated by a health maintenance organization licensed under chapter 48.46 RCW; and

(b) The authority shall contract, under RCW 41.05.410, with one or more health carriers to offer at least one standardized bronze, one standardized silver, and one standardized gold qualified health plan in every county in the state or in each county within a region of the state.

(2) Health carriers and hospitals may not condition negotiations or participation of a hospital licensed under chapter 70.41 RCW in any health plan offered by the health carrier on the hospital's negotiations or participation in a public option plan.

(3) By December 1st of the plan year during which enrollment in public option plans statewide is greater than 10,000 covered lives:

(a) The health benefit exchange, in consultation with the insurance commissioner and the authority, shall analyze public option plan rates paid to hospitals for in-network services and whether they

have impacted hospital financial sustainability. The analysis must include any impact on hospitals' operating margins during the years public option health plans have been offered in the state and the estimated impact on operating margins in future years if enrollment in public option plans increases. It must also examine the income levels of public option plan enrollees over time. The analysis may examine a sample of hospitals of various sizes and located in various counties. In conducting its analysis, the exchange must give substantial weight to any available reporting of health care provider and health system costs under RCW 70.390.050;

(b) The health care cost transparency board established under chapter 70.390 RCW shall analyze the effect that enrollment in public option plans has had on consumers, including an analysis of the benefits provided to, and premiums and cost-sharing amounts paid by, consumers enrolled in public option plans compared to other standardized and nonstandardized qualified health plans; and

(c) The health benefit exchange, in consultation with the insurance commissioner, the authority, and interested stakeholders, including, but not limited to, statewide associations representing hospitals, health insurers, and physicians, shall review the analyses completed under (a) and (b) of this subsection and develop recommendations to the legislature to address financial or other issues identified in the analyses.

(4) The authority may adopt program rules, in consultation with the office of the insurance commissioner, to ensure compliance with this section, including levying fines and taking other contract actions it deems necessary to enforce compliance with this section.

(5) For the purposes of this section, "public option plan" means a qualified health plan contracted by the authority under RCW 41.05.410.

Sec. 6. RCW 41.05.410 and 2019 c 364 s 3 are each amended to read as follows:

(1) The authority, in consultation with the health benefit exchange, must contract with one or more health carriers to offer qualified health plans on the Washington health benefit exchange for plan years beginning in 2021. A health carrier contracting with the authority under this section must offer at least one bronze, one silver, and one gold qualified health plan in a single county or in multiple counties. The goal of the procurement conducted under this

section is to have a choice of qualified health plans under this section offered in every county in the state. The authority may not execute a contract with an apparently successful bidder under this section until after the insurance commissioner has given final approval of the health carrier's rates and forms pertaining to the health plan to be offered under this section and certification of the health plan under RCW 43.71.065.

(2) A qualified health plan offered under this section must meet the following criteria:

(a) The qualified health plan must be a standardized health plan established under RCW 43.71.095;

(b) The qualified health plan must meet all requirements for qualified health plan certification under RCW 43.71.065 including, but not limited to, requirements relating to rate review and network adequacy;

(c) The qualified health plan must incorporate recommendations of the Robert Bree collaborative and the health technology assessment program;

(d) The qualified health plan may use an integrated delivery system or a managed care model that includes care coordination or care management to enrollees as appropriate;

(e) The qualified health plan must meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing. These requirements may include, but are not limited to, standards for population health management; high-value, proven care; health equity; primary care; care coordination and chronic disease management; wellness and prevention; prevention of wasteful and harmful care; and patient engagement;

(f) To reduce administrative burden and increase transparency, the qualified health plan's utilization review processes must:

(i) Be focused on care that has high variation, high cost, or low evidence of clinical effectiveness; and

(ii) Meet national accreditation standards;

(g)((~~(i)~~)) The total amount the qualified health plan reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed one hundred sixty percent of the total amount medicare would have reimbursed providers and facilities for the same or similar services in the statewide aggregate;

((~~(ii) Beginning in calendar year 2023, if the authority determines that selective contracting will result in actuarially sound premium rates that are no greater than the qualified health plan's previous plan year rates adjusted for inflation using the consumer price index, the director may, in consultation with the health benefit exchange, waive (g)(i) of this subsection as a requirement of the contracting process under this section;~~))

(h) For services provided by rural hospitals certified by the centers for medicare and medicaid services as critical access hospitals or sole community hospitals, the rates may not be less than one hundred one percent of allowable costs as defined by the United States centers for medicare and medicaid services for purposes of medicare cost reporting;

(i) Reimbursement for primary care services, as defined by the authority, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, may not be less than one hundred thirty-five percent of the amount that would have been reimbursed under the medicare program for the same or similar services; and

(j) The qualified health plan must comply with any requirements established by the authority to address amounts expended on pharmacy benefits including, but not limited to, increasing generic utilization and use of evidence-based formularies.

(3)(a) At the request of the authority for monitoring, enforcement, or program and quality improvement activities, a qualified health plan offered under this section must provide cost and quality of care information and data to the authority, and may not enter into an agreement with a provider or third party that would restrict the qualified health plan from providing this information or data.

(b) Pursuant to RCW 42.56.650, any cost or quality information or data submitted to the authority is exempt from public disclosure.

(4) Nothing in this section prohibits a health carrier offering qualified health plans under this section from offering other health plans in the individual market.

Sec. 7. RCW 43.71.095 and 2019 c 364 s 1 are each amended to read as follows:

(1) The exchange, in consultation with the commissioner, the authority, an independent actuary, and other stakeholders, must

establish up to three standardized health plans for each of the bronze, silver, and gold levels.

(a) The standardized health plans must be designed to reduce deductibles, make more services available before the deductible, provide predictable cost sharing, maximize subsidies, limit adverse premium impacts, reduce barriers to maintaining and improving health, and encourage choice based on value, while limiting increases in health plan premium rates.

(b) The exchange may update the standardized health plans annually.

(c) The exchange must provide a notice and public comment period before finalizing each year's standardized health plans.

(d) The exchange must provide written notice of the standardized health plans to licensed health carriers by January 31st before the year in which the health plans are to be offered on the exchange. The exchange may make modifications to the standardized plans after January 31st to comply with changes to state or federal law or regulations.

(2)(a) Beginning January 1, 2021, any health carrier offering a qualified health plan on the exchange must offer ((~~one~~)) the silver ((~~standardized health plan~~)) and ((~~one~~)) gold standardized health plans established under this section on the exchange in each county where the carrier offers a qualified health plan. If a health carrier offers a bronze health plan on the exchange, it must offer ((~~one~~)) the bronze standardized health plans established under this section on the exchange in each county where the carrier offers a qualified health plan.

(b)(i) ((~~A~~)) Until December 31, 2022, a health ((~~plan~~)) carrier offering a standardized health plan under this section may also offer nonstandardized health plans on the exchange. Beginning January 1, 2023, a health carrier offering a standardized health plan under this section may also offer up to two nonstandardized gold health plans, two nonstandardized bronze health plans, one nonstandardized silver health plan, one nonstandardized platinum health plan, and one nonstandardized catastrophic health plan in each county where the carrier offers a qualified health plan.

(ii) The exchange, in consultation with the office of the insurance commissioner, shall analyze the impact to exchange consumers of offering only standard plans beginning in 2025 and submit a report to the appropriate committees of the legislature by

December 1, 2023. The report must include an analysis of how plan choice and affordability will be impacted for exchange consumers across the state, including an analysis of offering a bronze standardized high deductible health plan compatible with a health savings account, and a gold standardized health plan closer in actuarial value to the silver standardized health plan.

(iii) The actuarial value of nonstandardized silver health plans offered on the exchange may not be less than the actuarial value of the standardized silver health plan with the lowest actuarial value.

(c) A health carrier offering a standardized health plan on the exchange under this section must continue to meet all requirements for qualified health plan certification under RCW 43.71.065 including, but not limited to, requirements relating to rate review and network adequacy.

--- END ---

retirees to reestablish eligibility for enrollment in retiree benefits under the public employees' benefit board program. The authority shall submit the report to the appropriate committees of the legislature by January 1, 2022. At a minimum the report must include an estimate of the employer cost and a description of the assumptions used.

(6) $285,000 of the state health care authority administrative account—state appropriation is provided solely for a customer service scheduling tool, and is subject to the conditions, limitations, and review requirements of section 701 of this act.

NEW SECTION. **Sec. 213. FOR THE STATE HEALTH CARE AUTHORITY—SCHOOL EMPLOYEES' BENEFITS BOARD**

School Employees' Insurance Administrative Account—
State Appropriation. $25,771,000
TOTAL APPROPRIATION. $25,771,000

The appropriation in this section is subject to the following conditions and limitations: $15,000 of the school employees' insurance administrative account—state appropriation is provided solely for a customer service scheduling tool, and is subject to the conditions, limitations, and review requirements of section 701 of this act.

NEW SECTION. **Sec. 214. FOR THE STATE HEALTH CARE AUTHORITY—HEALTH BENEFIT EXCHANGE**

General Fund—State Appropriation (FY 2022). $4,831,000
General Fund—State Appropriation (FY 2023). $4,543,000
General Fund—Federal Appropriation. $83,017,000
Health Benefit Exchange Account—State Appropriation. . . $77,710,000
Health Care Affordability Account—State
Appropriation. $50,000,000
TOTAL APPROPRIATION. $220,101,000

The appropriations in this section are subject to the following conditions and limitations:

(1) The receipt and use of medicaid funds provided to the health benefit exchange from the health care authority are subject to compliance with state and federal regulations and policies governing

the Washington apple health programs, including timely and proper application, eligibility, and enrollment procedures.

(2)(a) By July 15th and January 15th of each year, the authority shall make a payment of one-half the general fund—state appropriation, one-half the health benefit exchange account—state appropriation, and one-half the health care affordability account—state appropriation to the exchange. By July 15, 2021, the authority shall make the payments of the general fund—federal appropriation (CRRSA) and the general fund—federal appropriation (ARPA) to the exchange.

(b) The exchange shall monitor actual to projected revenues and make necessary adjustments in expenditures or carrier assessments to ensure expenditures do not exceed actual revenues.

(c) Payments made from general fund—state appropriation and health benefit exchange account—state appropriation shall be available for expenditure for no longer than the period of the appropriation from which it was made. When the actual cost of materials and services have been fully determined, and in no event later than the lapsing of the appropriation, any unexpended balance of the payment shall be returned to the authority for credit to the fund or account from which it was made, and under no condition shall expenditures exceed actual revenue.

(3)(a) $146,000 of the general fund—state appropriation for fiscal year 2022 and $554,000 of the general fund—federal appropriation are provided solely for the exchange, in close consultation with the health and human services enterprise coalition (coalition), to develop a report on the next steps required for information technology solutions for an integrated health and human services eligibility solution. The report must include, but is not limited to a:

(i) Technical approach and architecture;

(ii) Roadmap and implementation plan for modernizing and integrating the information technology eligibility and enrollment system for including, but not limited to, medicaid, basic food, child care assistance, cash assistance, and other health and human service program benefits, beginning with classic medicaid; and

(iii) Discussion of how an integrated health and human services solution would:

(A) Comply with federal requirements;

(B) Maximize efficient use of staff time;

(C) Support accurate and secure client eligibility information;

(D) Improve the client enrollment experience; and

(E) Provide other notable coalition agency impacts.

(b) The exchange, in coordination with the coalition, must submit the report to the governor and appropriate committees of the legislature by January 15, 2022.

(4) $1,634,000 of the health benefit exchange account—state appropriation and $592,000 of the general fund—federal appropriation are provided solely for healthplanfinder enhancement activities. These amounts are subject to the conditions, limitations, and review provided in section 701 of this act.

(5) $1,324,000 of the health benefit exchange account—state appropriation and $2,740,000 of the general fund—federal appropriation are provided solely for the modernizing healthplanfinder project. These amounts are subject to the conditions, limitations, and review provided in section 701 of this act.

(6) $250,000 of the general fund—federal appropriation (CRRSA) and $150,000 of the general fund—federal appropriation (ARPA) are provided solely for pass-through funding to one or more lead navigator organizations to promote access to health services through outreach and insurance plan enrollment assistance for employees working in a licensed child care facility.

(7)(a) $25,171,000 of the general fund—federal appropriation (CRRSA) and $5,095,000 of the general fund—federal appropriation (ARPA) are provided solely for the exchange to implement a health care insurance premium assistance program for employees who work in licensed child care facilities. The general fund—federal appropriation (CRRSA) must be expended by September 30, 2022.

(b) An individual is eligible for the child care premium assistance program for the remainder of the plan year if the individual:

(i) Is an employee working in a licensed child care facility;

(ii) Enrolls in a silver standardized health plan under RCW 43.71.095;

(iii) Prior to January 1, 2023, has income that is less than 300 percent of the federal poverty level;

(iv) Applies for and accepts all federal advance premium tax credits for which he or she may be eligible before receiving any state premium assistance;

(v) Is ineligible for minimum essential coverage through medicare, a federal or state medical assistance program administered by the health care authority under chapter 74.09 RCW, or for premium assistance under RCW 43.71A.020; and

(vi) Meets other eligibility criteria as established by the exchange.

(c) Subject to the availability of amounts provided in this subsection, the exchange shall pay the premium cost for a qualified health plan for an individual who is eligible for the child care premium assistance program under (b) of this subsection.

(d) The exchange may disqualify a participant from the program if the participant:

(i) No longer meets the eligibility criteria in (b) of this subsection;

(ii) Fails, without good cause, to comply with procedural or documentation requirements established by the exchange in accordance with (e) of this subsection;

(iii) Fails, without good cause, to notify the exchange of a change of address in a timely manner;

(iv) Voluntarily withdraws from the program; or

(v) Performs an act, practice, or omission that constitutes fraud, and, as a result, an insurer rescinds the participant's policy for the qualified health plan.

(e) The exchange shall establish:

(i) Procedural requirements for eligibility and continued participation in any premium assistance program under this section, including participant documentation requirements that are necessary to administer the program; and

(ii) Procedural requirements for facilitating payments to and from carriers.

(f) The program must be implemented no later than November 1, 2021.

(g) No later than October 1, 2022, the exchange shall submit a report to the governor and appropriate committees of the legislature on the implementation of the child care premium assistance program including, but not limited to:

(i) The number of individuals participating in the program to date; and

(ii) The actual costs of the program to date, including agency administrative costs.

(8) $136,000 of the general fund—state appropriation for fiscal year 2022, $136,000 of the general fund—state appropriation for fiscal year 2023, $254,000 of the health benefit exchange account—state appropriation, and $274,000 of the general fund—federal appropriation are provided solely for pass through funding in the annual amount of $100,000 for the lead navigator organization in the four regions with the highest concentration of COFA citizens to:

(a) Support a staff position for someone from the COFA community to provide enrollment assistance to the COFA community beyond the scope of the current COFA program; and

(b) Support COFA community led outreach and enrollment activities that help COFA citizens obtain and access health and dental coverage.

(9) $142,000 of the general fund—state appropriation for fiscal year 2022 and $538,000 of the general fund—federal appropriation are provided solely for the implementation of Substitute Senate Bill No. 5068 (postpartum period/medicaid) and section 9812 of the American rescue plan act of 2021.

(10) $8,012,000 of the health benefit exchange account—state appropriation is provided solely to implement Engrossed Second Substitute Senate Bill No. 5377 (standardized health plans). If the bill is not enacted by June 30, 2021, the amount provided in this subsection shall lapse.

(11) $50,000,000 of the health care affordability account—state appropriation is provided solely for the exchange to administer a premium assistance program, beginning for plan year 2023, as established in Engrossed Second Substitute Senate Bill No. 5377 (standardized health plans), and this is the maximum amount the exchange may expend for this purpose. An individual is eligible for the premium assistance provided if the individual: (a) Has income up to 250 percent of the federal poverty level; and (b) meets other eligibility criteria as established in section 1(4)(a) of Engrossed Second Substitute Senate Bill No. 5377 (standardized health plans).

(12)(a) Within amounts appropriated in this section, the exchange, in close consultation with the authority and the office of the insurance commissioner, shall explore opportunities to facilitate

enrollment of Washington residents who do not qualify for non-emergency medicaid or federal affordability programs in a state-funded program no later than plan year 2024.

(b) If an opportunity to apply to the secretary of health and human services under 42 U.S.C. Sec. 18052 for a waiver is identified or other federal flexibilities are available, the exchange, in collaboration with the office of the insurance commissioner and the authority may develop an application to be submitted by the authority. If an application is submitted, the authority must notify the chairs and ranking minority members of the appropriate policy and fiscal committees of the legislature.

(c) Any application submitted under this subsection must meet all federal public notice and comment requirements under 42 U.S.C. Sec. 18052(a)(4)(B), including public hearings to ensure a meaningful level of public input.

NEW SECTION. **Sec. 215. FOR THE STATE HEALTH CARE AUTHORITY—COMMUNITY BEHAVIORAL HEALTH PROGRAM**

General Fund—State Appropriation (FY 2022). $667,948,000
General Fund—State Appropriation (FY 2023). $733,456,000
General Fund—Federal Appropriation. $2,593,457,000
General Fund—Private/Local Appropriation. $37,325,000
Criminal Justice Treatment Account—State
Appropriation. $21,988,000
Problem Gambling Account—State Appropriation. $1,963,000
Dedicated Marijuana Account—State Appropriation
(FY 2022). $28,493,000
Dedicated Marijuana Account—State Appropriation
(FY 2023). $28,493,000
Coronavirus State Fiscal Recovery Fund—Federal
Appropriation. $31,000,000
TOTAL APPROPRIATION. $4,144,123,000

The appropriations in this section are subject to the following conditions and limitations:

(1) For the purposes of this section, "behavioral health entities" means managed care organizations and behavioral health administrative services organizations.

(2) Within the amounts appropriated in this section, funding is provided for implementation of the settlement agreement under

FOR THE STATE HEALTH CARE AUTHORITY—SCHOOL EMPLOYEES' BENEFITS BOARD

School Employees' Insurance Administrative Account—

State Appropriation. . . . . ((~~$25,771,000~~))

$28,317,000

TOTAL APPROPRIATION. . . . . ((~~$25,771,000~~))

$28,317,000

The appropriation in this section is subject to the following conditions and limitations:

(1) $15,000 of the school employees' insurance administrative account—state appropriation is provided solely for a customer service scheduling tool, and is subject to the conditions, limitations, and review requirements of section 701 of this act.

(2) $250,000 of the school employees' insurance administrative account—state appropriation is provided solely for the study described in section 212(7) of this act.

Sec. 214. 2021 c 334 s 214 (uncodified) is amended to read as follows:

FOR THE STATE HEALTH CARE AUTHORITY—HEALTH BENEFIT EXCHANGE

General Fund—State Appropriation (FY 2022). . . . . ((~~$4,831,000~~))

$4,881,000

General Fund—State Appropriation (FY 2023). . . . . ((~~$4,543,000~~))

$9,547,000

General Fund—Federal Appropriation. . . . . ((~~$83,017,000~~))

$54,032,000

Health Benefit Exchange Account—State Appropriation. ((~~$77,710,000~~))

$80,860,000

State Health Care Affordability Account—State

Appropriation. . . . . ((~~$50,000,000~~))

$55,000,000

TOTAL APPROPRIATION. . . . . ((~~$220,101,000~~))

$204,320,000

The appropriations in this section are subject to the following conditions and limitations:

(1) The receipt and use of medicaid funds provided to the health benefit exchange from the health care authority are subject to compliance with state and federal regulations and policies governing

the Washington apple health programs, including timely and proper application, eligibility, and enrollment procedures.

(2)(a) By July 15th and January 15th of each year, the authority shall make a payment of one-half the general fund—state appropriation, one-half the health benefit exchange account—state appropriation, and one-half the health care affordability account—state appropriation to the exchange. By July 15, 2021, the authority shall make the payments of the general fund—federal appropriation (CRRSA) and the general fund—federal appropriation (ARPA) to the exchange.

(b) The exchange shall monitor actual to projected revenues and make necessary adjustments in expenditures or carrier assessments to ensure expenditures do not exceed actual revenues.

(c) Payments made from general fund—state appropriation and health benefit exchange account—state appropriation shall be available for expenditure for no longer than the period of the appropriation from which it was made. When the actual cost of materials and services have been fully determined, and in no event later than the lapsing of the appropriation, any unexpended balance of the payment shall be returned to the authority for credit to the fund or account from which it was made, and under no condition shall expenditures exceed actual revenue.

(3)(a) $146,000 of the general fund—state appropriation for fiscal year 2022 and $554,000 of the general fund—federal appropriation are provided solely for the exchange, in close consultation with the health and human services enterprise coalition (coalition), to develop a report on the next steps required for information technology solutions for an integrated health and human services eligibility solution. The report must include, but is not limited to a:

(i) Technical approach and architecture;

(ii) Roadmap and implementation plan for modernizing and integrating the information technology eligibility and enrollment system for including, but not limited to, medicaid, basic food, child care assistance, cash assistance, and other health and human service program benefits, beginning with classic medicaid; and

(iii) Discussion of how an integrated health and human services solution would:

(A) Comply with federal requirements;

(B) Maximize efficient use of staff time;

(C) Support accurate and secure client eligibility information;

(D) Improve the client enrollment experience; and

(E) Provide other notable coalition agency impacts.

(b) The exchange, in coordination with the coalition, must submit the report to the governor and appropriate committees of the legislature by January 15, 2022.

(4) $1,634,000 of the health benefit exchange account—state appropriation and $592,000 of the general fund—federal appropriation are provided solely for healthplanfinder enhancement activities. These amounts are subject to the conditions, limitations, and review provided in section 701 of this act.

(5) $1,324,000 of the health benefit exchange account—state appropriation and $2,740,000 of the general fund—federal appropriation are provided solely for the modernizing healthplanfinder project. These amounts are subject to the conditions, limitations, and review provided in section 701 of this act.

(6) $250,000 of the general fund—federal appropriation (CRRSA) and $150,000 of the general fund—federal appropriation (ARPA) are provided solely for pass-through funding to one or more lead navigator organizations to promote access to health services through outreach and insurance plan enrollment assistance for employees working in a licensed child care facility.

(7)(a) ((~~$25,171,000~~))$1,171,000 of the general fund—federal appropriation (CRRSA) and ((~~$5,095,000~~))$2,595,000 of the general fund—federal appropriation (ARPA) are provided solely for the exchange to implement a health care insurance premium assistance program for employees who work in licensed child care facilities. The general fund—federal appropriation (CRRSA) must be expended by September 30, 2022.

(b) An individual is eligible for the child care premium assistance program for the remainder of the plan year if the individual:

(i) Is an employee working in a licensed child care facility;

(ii) Enrolls in a silver standardized health plan under RCW 43.71.095;

(iii) Prior to January 1, ((~~2023~~))2024, has income that is less than 300 percent of the federal poverty level;

(iv) Applies for and accepts all federal advance premium tax credits for which he or she may be eligible before receiving any state premium assistance;

(v) Is ineligible for minimum essential coverage through medicare, a federal or state medical assistance program administered by the health care authority under chapter 74.09 RCW, or for premium assistance under RCW 43.71A.020; and

(vi) Meets other eligibility criteria as established by the exchange.

(c) Subject to the availability of amounts provided in this subsection, the exchange shall pay the premium cost for a qualified health plan for an individual who is eligible for the child care premium assistance program under (b) of this subsection.

(d) The exchange may disqualify a participant from the program if the participant:

(i) No longer meets the eligibility criteria in (b) of this subsection;

(ii) Fails, without good cause, to comply with procedural or documentation requirements established by the exchange in accordance with (e) of this subsection;

(iii) Fails, without good cause, to notify the exchange of a change of address in a timely manner;

(iv) Voluntarily withdraws from the program; or

(v) Performs an act, practice, or omission that constitutes fraud, and, as a result, an insurer rescinds the participant's policy for the qualified health plan.

(e) The exchange shall establish:

(i) Procedural requirements for eligibility and continued participation in any premium assistance program under this section, including participant documentation requirements that are necessary to administer the program; and

(ii) Procedural requirements for facilitating payments to and from carriers.

(f) The program must be implemented no later than November 1, 2021.

(g) No later than October 1, 2022, the exchange shall submit a report to the governor and appropriate committees of the legislature on the implementation of the child care premium assistance program including, but not limited to:

(i) The number of individuals participating in the program to date; and

(ii) The actual costs of the program to date, including agency administrative costs.

(h) Within the amounts provided in this subsection, the exchange may create an outreach program to help employees who work in licensed child care facilities enroll in the premium assistance program, beginning for plan year 2023, as established in chapter 246, Laws of 2021 (Engrossed Second Substitute Senate Bill No. 5377) (standardized health plans).

(i) The health care insurance premium assistance program for employees who work in licensed child care facilities is effective through plan year 2023.

(8) $136,000 of the general fund—state appropriation for fiscal year 2022, $136,000 of the general fund—state appropriation for fiscal year 2023, $254,000 of the health benefit exchange account—state appropriation, and $274,000 of the general fund—federal appropriation are provided solely for pass through funding in the annual amount of $100,000 for the lead navigator organization in the four regions with the highest concentration of COFA citizens to:

(a) Support a staff position for someone from the COFA community to provide enrollment assistance to the COFA community beyond the scope of the current COFA program; and

(b) Support COFA community led outreach and enrollment activities that help COFA citizens obtain and access health and dental coverage.

(9) $142,000 of the general fund—state appropriation for fiscal year 2022 and $538,000 of the general fund—federal appropriation are provided solely for the implementation of Substitute Senate Bill No. 5068 (postpartum period/medicaid) and section 9812 of the American rescue plan act of 2021.

(10) ((~~$8,012,000~~))$8,162,000 of the health benefit exchange account—state appropriation is provided solely to implement Engrossed Second Substitute Senate Bill No. 5377 (standardized health plans). ((~~If the bill is not enacted by June 30, 2021, the amount provided in this subsection shall lapse.~~))

(11) $50,000,000 of the state health care affordability account—state appropriation is provided solely for the exchange to administer a premium assistance program, beginning for plan year 2023, as established in Engrossed Second Substitute Senate Bill No. 5377

(standardized health plans), and this is the maximum amount the exchange may expend for this purpose. An individual is eligible for the premium assistance provided if the individual: (a) Has income up to 250 percent of the federal poverty level; and (b) meets other eligibility criteria as established in section 1(4)(a) of Engrossed Second Substitute Senate Bill No. 5377 (standardized health plans).

(12)(a) Within amounts appropriated in this section, the exchange, in close consultation with the authority and the office of the insurance commissioner, shall explore opportunities to facilitate enrollment of Washington residents who do not qualify for non-emergency medicaid or federal affordability programs in a state-funded program no later than plan year 2024.

(b) If an opportunity to apply to the secretary of health and human services under 42 U.S.C. Sec. 18052 for a waiver is identified or other federal flexibilities are available, the exchange, in collaboration with the office of the insurance commissioner and the authority may develop an application to be submitted by the authority. If an application is submitted, the authority must notify the chairs and ranking minority members of the appropriate policy and fiscal committees of the legislature.

(c) Any application submitted under this subsection must meet all federal public notice and comment requirements under 42 U.S.C. Sec. 18052(a)(4)(B), including public hearings to ensure a meaningful level of public input.

(d) $50,000 of the general fund—state appropriation for fiscal year 2022 and $2,891,000 of the general fund—state appropriation for fiscal year 2023 are provided solely for system updates and community-led engagement activities necessary to implement the waiver.

(13) $733,000 of the general fund—state appropriation for fiscal year 2023 is provided solely for system upgrades necessary for the anticipated expansion of medicaid equivalent health care coverage to uninsured adults with income up to 138 percent of the federal poverty level regardless of immigration status in collaboration with the health care authority.

(14) $1,000,000 of the general fund—state appropriation for fiscal year 2023 is provided solely for one-time activities to promote continuous coverage for individuals losing coverage through

Washington apple health at the end of the COVID-19 public health emergency.

(15) $20,000 of the general fund—state appropriation for fiscal year 2023 is provided solely for the exchange, in collaboration with the state board of community and technical colleges, the student achievement council, and the council of presidents, to provide educational resources and ongoing assister training to support the operations of a pilot program to help connect students, including those enrolled in state registered apprenticeship programs, with health care coverage.

(16) $5,000,000 of the state health care affordability account—state appropriation is provided solely to provide premium assistance for customers ineligible for federal premium tax credits who meet the eligibility criteria established in subsection (11)(a) of this section, and is contingent upon approval of the applicable waiver described in subsection (12)(b) of this section.

Sec. 215. 2021 c 334 s 215 (uncodified) is amended to read as follows:

FOR THE STATE HEALTH CARE AUTHORITY—COMMUNITY BEHAVIORAL HEALTH PROGRAM

General Fund—State Appropriation (FY 2022). . . . . ((~~$667,948,000~~)) $687,270,000

General Fund—State Appropriation (FY 2023). . . . . ((~~$733,456,000~~)) $914,234,000

General Fund—Federal Appropriation. . . . . ((~~$2,593,457,000~~)) $2,876,776,000

General Fund—Private/Local Appropriation. . . . . ((~~$37,325,000~~)) $37,675,000

Criminal Justice Treatment Account—State Appropriation. $21,988,000

Problem Gambling Account—State Appropriation. . . . . ((~~$1,963,000~~)) $2,113,000

Dedicated Marijuana Account—State Appropriation (FY 2022). $28,493,000

Dedicated Marijuana Account—State Appropriation (FY 2023). $28,493,000

Coronavirus State Fiscal Recovery Fund—Federal Appropriation. . . . . ((~~$31,000,000~~))

Appendix B: **Washington Health Benefit Exchange State Premium Assistance Policy**

The state premium assistance policy is in the process of being finalized. The version included below is the most recently available and is subject to change (does not yet reflect final state premium assistance policy).

The Exchange plans to release an updated draft for public comment in April, 2022 and will be available at: https://www.wahbexchange.org/about-the-exchange/what-is-the-exchange/cascade-care/cascade-care-2021-implementation/.

The final version of the state premium assistance policy will be included in the final waiver submission.

State Premium Assistance Policy – *DRAFT 2*

As of 1/21/2022

Section 1. State Premium Assistance Program

The 2021 Washington State Legislature enacted Engrossed Second Substitute Senate Bill 5377 which, among other provisions, directed the Exchange to establish a state premium assistance program for Washington residents. The Legislature included in Engrossed Substitute Senate Bill 5092 (Operating Budget)[1], $50 Million in state funding for the Exchange to implement the premium assistance program for plan year 2023, for individuals with income up to 250 percent of the federal poverty level.

The Legislature directed the Exchange to establish, consistent with the 2021 Operating Budget[2]:

1. Procedural requirements for eligibility and continued participation in any premium assistance program, including participant documentation requirements that are necessary to administer the program;
2. Procedural requirements for facilitating payments to health issuers;
3. Eligibility criteria, in addition to eligibility requirements established by RCW 43.71.110 and the Operating Budget; and
4. A process for an individual to appeal a premium assistance eligibility determination.

The requirements set forth in this Policy are established pursuant to and consistent with RCW 43.71.110 and the parameters established in the omnibus appropriations act and govern the Exchange's implementation and
administration of the Program.

Section 2. Policy Effective Dates

This Policy, governing the administration of the State Premium Assistance Program, is effective beginning in plan year 2023.

Section 3. Definitions

The definitions in this section apply throughout this Policy unless the context clearly requires otherwise.

1. "Advanced Premium Tax Credit" means the premium assistance amount determined in accordance with the federal patient protection and affordable care act, P.L. 111-148, as amended by the federal health care and education reconciliation act of 2010, P.L. 111-152, or federal regulations or guidance issued under the affordable care act.
2. "Cascade Care Plan" means any standardized qualified health plan (QHP) developed pursuantto RCW 43.71.095, sold on *Washington Healthplanfinder*, and marketed as either a Cascade or Cascade Select plan.
3. "Eligible Enrollee" means any individual that meets all premium assistance eligibility requirements established in section 4 of this policy.

[1] Engrossed Substitute Senate Bill 5092, Sec. 214(11)

[2] RCW 43.71.110

4. "Eligible Household" means a tax-filing household consisting of one or more individuals, all of whom are eligible enrollees.
5. "Enrollment Group" means a group of individuals enrolled in the same qualified health plan within the same insurance policy.
6. "Exchange" means the Washington health benefit exchange established in RCW 43.71.020.
7. "Federal Poverty Level" (FPL) means a measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine your eligibility for certain programs and benefits.
8. "Grace Period" means a period — either one month or three months — after an enrollee's monthly health insurance payment is due and a binding payment has been made. The grace period for health insurance is three months if an enrollee is subsidized by at least one of the following: 1) advance payments of the premium tax credit; or 2) state premium assistance. The grace period for health insurance is one month for unsubsidized enrollments.
9. "Income" has the same meaning as "household income" as defined in 26 U.S.C. § 36B(d)(2).

10. "Non-subsidized Enrollment" means an enrollment that does not receive APTC or state premium assistance.
11. "Operating Budget" means Engrossed Substitute Senate Bill 5092, passed by the Washington State legislature and signed by the Governor during the 2021 State Legislative Session.
12. "Parent Company" means a company that owns and controls other firms or companies, usually known as subsidiaries. Also known as a holding company.
13. "Policy" means the State Premium Assistance Program requirements and guidance set forth in this document.
14. "Premium assistance eligible plan" means a:
    - Silver or Gold Cascade Care plan; or
    - For American Indian and Alaska Natives eligible for a zero-dollar cost-sharing plan under 42 U.S.C. §18071(d)(1), any QHP.
15. "Presiding Officer" means an impartial person who is not involved in original eligibility decisions and who is appointed by the Washington health Benefit Exchange (Exchange) to conduct appeal proceedings for state premium assistance.
16. "State Premium Assistance Program" or "Program" means the premium assistance program established in RCW 43.71.110. This program is branded and known to consumers as Cascade Care Savings.
17. "Subsidized Enrollment" means an enrollment that receives APTC and/or state premium assistance.
18. "Qualified Health Plan" or "QHP" means a health plan that is certified by an exchange. To be certified in Washington, a health plan must be approved by OIC, satisfy the certification criteria specified in RCW 43.71.065, satisfy the minimum federal requirements of a QHP as outlined in 45 CFR parts §155 and §156, and be certified by the Exchange Board.
19. "Tax Filing Household" means a household consisting of one or more individuals for which those seeking enrollment meet eligibility requirements for State Premium Assistance.

Section 4. Eligibility

1. *Program Eligibility.* As required by RCW 43.71.110(4), consistent with the Operating Budget, and subject to Section 11(2) of this policy, an individual is an eligible enrollee if the individual:
    a. Is a resident of Washington State;
    b. Is QHP eligible
    c. Has an income at or below 250% of the Federal Poverty Level;
    d. Enrolls in a premium assistance eligible plan;
    e. Applies for and accepts all federal premium tax credits for which the individual's
    f. household is eligible, including consenting to the Exchange to verify the

g. individual's household federal tax information upon QHP renewal;
h. Is ineligible for minimum essential coverage through a federal or state medical assistance program, including Washington Apple Health and health coverage programs for Compact of Free Association (COFA) Islanders;
i. Is not enrolled in minimum essential coverage through Medicare.

2. *Multiple-Enrollment Eligibility.* For households with individuals enrolled in multiple enrollment groups, only those eligible individuals enrolled in a premium assistance eligible plan within the household will be eligible for state premium assistance.

3. *Insurance Affordability Programs*. To be eligible for state premium assistance, individuals must receive an eligibility determination for insurance affordability programs, including for:
   a. Washington Apple Health
   b. Advanced Premium Tax Credits
   c. Cost-sharing Reduction Subsidies

4. *Conditional Eligibility Verification.* The Exchange will verify data matching inconsistencies with existing Conditional Eligibility Verification processes. An individual may be requested to provide documents that verify application information not able to be confirmed via available electronic sources for:
   a. Citizenship/lawful presence status
   b. Incarceration
   c. Residency
   d. Eligibility for other MEC through a federal or state medical assistance program (Medicare, Washington Apple Health, health coverage programs for COFA Islanders)
   e. Income
   f. Tribal status

5. *Duration of Eligibility*. An eligible enrollee will remain eligible for the Program for the remainder of the plan year, until coverage is otherwise terminated, or until an eligible enrollee reports a change that no longer makes the individual eligible for the Program pursuant to the requirements of this section.

6. *Change Reporting*. Eligible enrollees are required to report changes in circumstances to their application, in accordance with federal guidelines (45 CFR §155.330).

7. *Program Disqualification*. Pursuant to RCW 43.71.110(5), an eligible enrollee may be disqualified from the Program by the Exchange if the eligible enrollee:
   a. No longer meets the eligibility criteria established in subsection 1 of this section.
   b. Fails, without good cause, to comply with procedural or documentation requirements established by the Exchange, including requirements for timely notification of changes impacting eligibility;

c. Voluntarily withdraws from the Program; or
d. Performs an act, practice, or omission that constitutes fraud, and, as a result, an issuer rescinds the individual's policy for the QHP.

8. *Income.* Income, for purposes of determining eligibility for the Premium Assistance program under subsection 1 of this section, shall be determined at the tax-filing household level.

9. *American Indian and Alaska Natives*. There are no requirements for American Indian and Alaska Natives to select a gold or silver Cascade Care plan in order to be eligible for state premium assistance.

Section 5. Premium Assistance Amount

1. *Calculation of premium assistance amounts.* Annual state premium assistance amounts for eligible households will be calculated as follows, subject to appropriated funding levels and parameters established in the omnibus appropriations act and alterations pursuant to Section 11(3) of this policy:
    a. A base fixed-dollar premium assistance amount will be calculated annually based on an actuarial analysis that includes considerations of annual program funding, uptake assumptions for the projected eligible enrollee population for that plan year, and qualified health plan rates.
    b. A household premium assistance amount will then be calculated by multiplying the base fixed-dollar assistance amount by the number of eligible enrollees in the eligible household .
    c. An eligible household's premium assistance amount calculated pursuant to subsection 1 of this section will be reduced so as not to exceed the lesser of:
        i. The household's net premiums after first applying all advance premium tax credits for which the household is eligible; or
        ii. The net premium all eligible enrollees in the household would pay if each eligible enrollee in the household were enrolled in the lowest cost Cascade Care silver plan in the household's county of residence.
    d. If there are multiple enrollment groups within an eligible household, the household's full premium assistance amount will be available to be applied across the enrollment groups' premiums.

2. *Coverage for non-EHB premiums.* The household premium assistance amount can be applied to the entire net premium including portions that are not attributable to essential health benefits.

3. *Application of advance premium tax credits.* If determined eligible for advance premium tax credits (APTCs), any APTCs for which an eligible household is eligible must be

applied to the household's premiums before application of any state premium assistance amounts.

4. *Opt-out.* Eligible enrollees who are awarded state premium assistance pursuant to this section may contact the Exchange call center to disenroll from the state premium assistance program.

Section 6. Notice and Appeals Rights

1. Individuals apply for state premium assistance with the same application form used to apply for Washington Apple Health, Qualified Health Plan coverage, and Advanced Payments of the Premium Tax Credit (APTC). Only if an applicant is determined eligible for Qualified Health Plan (QHP) coverage will there be a decision about eligibility for state premium assistance. Applicants may appeal the following state premium assistance eligibility decisions made by the Exchange to a Presiding Officer:
    a. Not eligible for state premium assistance.
    b. Eligible for state premium assistance, but the amount is wrong.

2. Appeals of eligibility for state premium assistance shall follow the Procedural Rules for Washington Health Benefit Exchange Appeals. The Procedural Rules implement the federal regulations in 45 CFR subpart F that govern appeals of Exchange determinations. The Exchange anticipates that most state premium assistance appeals will also be appeals of QHP/APTC eligibility determinations. This is because the eligibility criteria for QHP/APTC – residency, citizenship or lawful presence, not enrolled in Medicare or Medicaid minimum essential coverage, not incarcerated, and income requirements – mirrors the eligibility criteria for state premium assistance. The Exchange will update the Procedural Rules to include state premium assistance throughout and will add new provisions to govern second level appeals for state premium assistance (since QHP/APTC second level appeals are currently performed by HHS) and appeals of additional state premium assistance eligibility criteria (e.g. the requirement to enroll in a premium assistance eligible plan). These updates to the Procedural Rules will be available for review and comment.

Section 7. Exchange Responsibility As Administrator of State Premium Assistance Program

1. *Data Transmission.* The Exchange will transmit state premium assistance amounts to issuers through the Health Insurance Exchange (HIX) 820 format on a monthly basis for the duration of the premium assistance program.

2. *Payments.* The Exchange will make monthly payments to issuers on behalf of the state, for state premium assistance amounts awarded to eligible households enrolled in QHP coverage with that issuer.
    a. Monthly payments will be made in the aggregate for all premium assistance

amounts awarded to all eligible households receiving state premium assistance enrolled in QHP coverage with that issuer.

b. Monthly payments will include amounts owed to the issuer for the previous month net of any recoupments or discrepancies resulting from over- or under-payments from prior months of the plan year.

Section 8. Issuer Responsibility - Premium Assistance Payments

1. *Data Transmission.* Pursuant to RCW 48.43.795, issuers offering QHPs on the Exchange must accept and process enrollment and payment data transferred by the Exchange aspart of the Program.

2. *Payments.* Pursuant to RCW 48.43.795, issuers offering QHPs on the Exchange must accept payments for enrollee premiums as a condition of certification as a QHP offered on the Exchange.

3. *Plan Confirmation and Effectuation.* Issuers offering QHPs on the Exchange must complywith all requirements in the *2023 Guidance for Participation of Health Plans in the Washington Health Benefit Exchange* for confirming enrollments and effectuating coverage for eligible enrollees, including in the circumstance of an eligible enrollee or household with a zero-dollar monthly enrollee responsibility.

4. *Compliance with Exchange Premium Sponsorship Program Policy*. The Exchange is administering state premium assistance on behalf of Washington State. Issuers shall comply with all issuer requirements and responsibilities included in the *WAHBE PremiumSponsorship Program Policy*, including requirements related to premium refunds and Medical Loss Ratio (MLR) rebates. For purposes of issuers distributing MLR rebates on behalf of enrollees receiving state premium assistance, the pro rata portion of the MLR rebate based on the state premium assistance paid towards the enrollee's premium shall be distributed directly to the Exchange, on behalf of Washington State.

5. *Compliance with Enrollee Grace Period Requirements*. Issuers shall apply a three-month consecutive grace period for an enrollee, who when failing to timely pay premiums, is receiving state premium assistance. For enrollees receiving APTC, federal grace period rules supersede state grace period rules. For enrollees not receiving APTC, state grace period rules apply and align with federal grace period rules under 45 CFR 156.270, including the requirements for issuers to:
    - Notify the enrollee that they are delinquent on premium payment.
    - Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.
    - Continue to collect payments of the state premium assistance from the

Exchange on behalf of the enrollee during the three-month grace period.

- In the event an enrollee exhausts the three-month grace period:
    - Return payments of the state premium assistance to the Exchange for the second and third months of the grace period; and
    - Terminate the enrollee's enrollment through the Exchange on the last day of the first month of the grace period.

Section 9. Special Enrollment Period –

1. *Special Enrollment Period*. Pursuant to the Exchange's Exceptional Circumstances SpecialEnrollment Period (SEP) Policy and authority granted to the Exchange under federal regulations (45 CFR § 155.420(d)(9)), households up to 250% FPL will be eligible for a monthly SEP.
    a. To be granted a SEP under this section, an individual must be a Washington state resident, meet all QHP eligibility requirements, and have an income at or below 250%of the federal poverty level.
    b. An individual granted this SEP must enroll in a Cascade Care Silver or Gold plan.
    c. An individual granted a SEP under this section may switch issuers, or change plans within the same issuer.
    d. An individual granted a SEP under this section that changes plans and remains enrolled with the same issuer, will not lose any cost accumulators accrued while in the previous plan.
        i. An individual granted a SEP under this section will be able to maintain all previous cost accumulators if they switch to a different issuer, if that issuer is under the same parent company as their previous issuer
    e. The Exchange will verify eligibility for this SEP. The issuer may not separately verify eligibility for this SEP.

2. *Effective date.* For a QHP selection by an individual under a special enrollment period under this section, coverage will be effective the first day ofthe month after plan selection.

Section 10. Premium Assistance Audit

1. The Exchange will annually contract with an independent CPA firm selected through a competitive procurement process to audit the financial statements of the Program.
2. The Exchange will distribute findings of the Program audit to the Exchange's Audit and Compliance Committee, the Exchange Board, organizations to whom the Exchange is required to submit a copy, and the legislature.

Section 11. Contingency for Low Funds

1. *Tracking Available Fund*. Beginning in January, 2023 and monthly thereafter, the Exchange will track total expected State Premium Assistance Program expenditures for the plan year. If, the Exchange determines that State Premium Assistance Program expenditures are at risk of exceeding available funds for the current plan year, newly eligible households not already receiving state premium assistance may not receive state premium assistance for the remainder of the plan year. Eligible households may qualify for state premium assistance in the subsequent plan years, subject to available funds.

2. *Impact to Premium Assistance Eligibility.* Individuals and households who would otherwise be eligible for state premium assistance pursuant to Section 4 of this policy but for a determination that State Premium Assistance Program expenditures are at risk of exceeding the available funding level may be determined ineligible for state premium assistance as determined by the Exchange. .

3. *Impact to Premium Assistance Recipients*. If it is determined at any time, based on projected premium assistance distribution through the Program, that premium assistance expenditures would be below available program funds, the monthly amount of premium assistance any eligible household or eligibleenrollee is currently receiving through the Program may be adjusted to increase recipients' state premium assistance amounts to best utilize available appropriations subject to parameters established consistent with RCW 43.71.110 and in the omnibus appropriations act.

Appendix C: **Actuarial and Economic Analyses**

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State of Washington

Section 1332 State Innovation Waiver

Actuarial and Economic Analysis

March 30, 2022

Prepared by:
Wakely Consulting Group, LLC

Ksenia Whittal, ASA, MAAA
Senior Consulting Actuary

Michael Cohen, PhD
Director

Julie Peper, FSA, MAAA
Principal

Alex Jarocki
Senior Analyst

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Introduction

The individual insurance market in the state of Washington ("Washington") has been relatively stable. The state wishes to further strengthen its individual market and provide greater access to health care coverage to its residents. In order to increase access to Qualified Health Plans (QHP), streamline coverage for families with mixed immigration status, and increase access to state affordability programs, Washington is submitting a Section 1332 State Innovation Waiver ("1332 waiver" or "waiver"). The Affordable Care Act (ACA) permits states to waive certain provisions of the ACA in order to increase access to affordable coverage. In order for the Secretaries of Health and Human Services (HHS) and Treasury to approve the waiver, the state must complete an application in which it demonstrates that it has met the regulatory requirements.

Pursuant to 45 CFR 155.1308(f)(4)(i)-(iii), in order for the Washington 1332 waiver to be approved, the state must demonstrate that the waiver satisfies the four "guardrails." The four guardrails are: coverage, affordability, comprehensiveness, and deficit neutrality.

The waiver, as proposed, would grant access to coverage through Washington's Exchange to residents lacking a federally recognized immigration status. Additionally, if the waiver is approved, some of these individuals would gain access to state-funded subsidies to support this coverage. Adding these consumers to the Marketplace is expected to reduce premiums. Federal savings resulting from the premium reduction will be passed through to the state to expand coverage subsidies to those who are currently not eligible for federal advanced premium tax credits (APTC), such as Washingtonians without a federally recognized status.

The goal of the waiver is to lower premiums and increase access and coverage among underserved and under-subsidized populations, specifically Washingtonians without a federally recognized status, while also improving the coordination of coverage in mixed-status families. We estimate that these individuals joining the individual market will result in downward pressure on premiums, given improvements in the overall morbidity of the individual market. If premiums are reduced (including the second lowest cost silver premium (SLCSP)), then Federal Government spending on premium tax credits (PTC) will also be reduced.

This report estimates the savings on aggregate PTC amounts. The waiver requests that Washington receive the amount of federal savings from PTC, net of other costs. By reducing premiums, and also by using pass-through funding to support affordability, the waiver seeks to improve access to affordable and comprehensive coverage.

Washington Health Benefit Exchange ("Exchange ") retained Wakely Consulting Group, LLC ("Wakely") to analyze the potential effects of the proposed 1332 waiver. This document has been prepared for the sole use of Washington. Wakely understands that

the report will be made public and used in the 1332 waiver process. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate. Other sections of the waiver contain the non-actuarial portions of the 1332 waiver requirement. Reliance on this report should include a review of the full report by individuals with appropriate qualifications.

Analysis Results

As described previously, the four guardrails for approval of a 1332 waiver application are requirements for: 1) Coverage; 2) Affordability; 3) Comprehensiveness; and 4) Deficit Neutrality.

Wakely's analysis estimated that the waiver meets each of the four guardrails in each of the five years of the waiver for our best estimates. The high-level guardrail results are shown in Table 1. Detailed results for all five years of the waiver are included in Appendix D. The analyses in this report utilized multiple data sources and methodologies. Further discussions on the data and methodology can be found in Appendix A.

Throughout this report, the estimates reflect the current law and thus assume that provisions of the American Rescue Plan (ARP), particularly the enhanced premium subsidies for individuals purchasing health coverage on the Exchange, are not in effect in 2023 and beyond, unless otherwise noted. Similarly, potential legislation or regulations that may have an impact on PTC amounts or eligibility are not included, unless otherwise noted. Below, and in Appendix A, we discuss the results of alternative scenarios to provide a range of possible outcomes due to the uncertainty of the assumptions included in this report, including several scenarios in which the enhanced premium subsidies available under ARP continue for the waiver period.

Table 1: High-Level Guardrail Results

Guardrail	Effect of Waiver
Coverage	Gains in coverage in each year of the waiver
Affordability	Improved affordability
Comprehensiveness	No change to EHBs (except insofar as increasing coverage increases the number of individuals with coverage providing EHBs).
Deficit Neutrality (5-year)	Federal savings in each year of the waiver and over the five-year waiver.

Coverage, Affordability, and Comprehensiveness

The waiver is expected to decrease net premiums in the individual market, especially for the waiver population. The reduction in net premiums is expected to increase overall coverage. Research from the Congressional Budget Office (CBO)[1] and the Council of Economic Advisors (CEA)[2] has noted that premium decreases result in enrollment increases. As the waiver results in decreased premiums, it is also expected to improve affordability for consumers. Finally, the increase in state premium subsidies would also increase coverage and improve affordability. The waiver would have no effect on the comprehensiveness of coverage (beyond increasing the number of people with comprehensive coverage). EHB requirements will not be affected by the waiver. The waiver is also expected to improve health equity by providing coverage to Washingtonians who have historically and systemically faced barriers to health, including people of color, immigrants, and Washingtonians with low incomes by specifically improving coverage, affordability, and ultimately access to health care services.

Deficit Impact

The following tables display the impact of the waiver on the individual market elements for each of the five years of the program. Based on the best estimate assumptions, the waiver will reduce premiums, increase individual enrollment, and have no negative effect on the federal deficit. Additional details regarding the 5-year estimates are shown in Appendix D.

Over the 5-year window, the waiver would provide savings to the Federal Government due to PTC savings. The details of the federal savings over the 5-year window are shown in Table 2.[3] Washington operates a state-based Exchange. Therefore, this waiver will not impact user fees for the Federally-Facilitated Exchange.

Table 2: Impact of Waiver on Premium, Enrollment, and Federal Deficit

	2024	2025	2026	2027	2028
Premiums	-1.4%	-1.5%	-1.5%	-1.5%	-1.6%
Individual Market Enrollment	1.1%	1.2%	1.3%	1.3%	1.5%
Federal Savings ($ millions)	$1.87	$2.14	$2.31	$2.46	$2.80

[1] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf
[2] https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf
[3] Insurers that utilize the Healthcare.gov platform are assessed a fee by the Federal government. This fee is calculated as percent of Exchange premium. Since Washington is a state-based Exchange, no Exchange fee offset was assumed.

Data and Methodology

Scenario Testing

Wakely performed scenario testing for 2024, which primarily involved changing assumptions about enrollment, premiums, and whether provisions under ARP continue beyond 2022. These assumptions were chosen for scenario testing, as they are significant drivers of the results of the analysis. For the remaining years of the waiver (2025-2028), only the best estimates were used and it was assumed provisions under ARP do not continue beyond 2022.

For 2024, six scenarios in total were produced, primarily driven by differences in enrollment assumptions and federal legislation (ARP/No ARP). Scenario 1 is the best uptake estimate, and assumed ARP not extending beyond 2022. Scenario 2 and Scenario 3 assumed ARP does not extend beyond 2022 and tested for scenarios in which enrollment and premium growth differed from the best estimate (Scenario 2 has lower enrollment while Scenario 3 has higher enrollment). Scenarios 4, 5, and 6 assumed that ARP enhanced premium subsidies are extended beyond 2022. Scenario 4 reflects our best estimate with ARP extended, while Scenario 5 assumes a lower uptake in enrollment in 2024 and beyond and Scenario 6 assumes higher enrollment take-up in 2024 and beyond than the best estimate (Scenario 4). In the higher enrollment scenarios, there are more PTCs in the baseline, which results in higher pass-through savings.

Further details regarding the scenario testing can be found in Appendix A and Appendix D. The high-level results of the scenario testing are shown in Table 3. Although a variety of alternative scenarios were tested, the basic conclusions did not change significantly from the best estimate scenarios.

Table 3: 2024 High-Level Results of Scenario Testing

Scenario	1	2	3	4	5	6
Description	No ARP - Best	No ARP - Lower Enrollment	No ARP - Higher Enrollment	ARP - Best	ARP - Lower Enrollment	ARP - Higher Enrollment
Premium / Morbidity Impact due to New Members	-1.4%	-0.9%	-1.6%	-1.4%	-0.8%	-1.4%
Estimated Net Federal Savings (millions)	$1.9	$1.0	$3.7	$2.3	$1.1	$4.8

Appendix A
Data and Methodology

2024 Baseline Enrollment and Premium Estimates

Data Collection

The Exchange provided Wakely with detailed, member-level, on-exchange enrollment information for customers enrolled as of January 2022. This data set contained detailed member level information such as premiums, APTC information, federal poverty level (FPL), county, metal level, age, and other enrollment specifications.

2024 Baseline Development

In order to calculate the impact of the program changes, Wakely developed a database to best estimate the environment in 2024 and beyond. Assumptions were developed based on Wakely internal modeling, 2022 Exchange experience to date, conversations with the Exchange, and public source information to project the 2022 enrollment data to the 2024 time period.

The baseline accounts for the introduction of a state-based partial premium subsidy for both the federally subsidized and federally non-subsidized, that supplements APTC for QHP-eligible individuals. This subsidy will be in place starting in 2023 and does not rely on any Federal funding. Wakely expects the state subsidy program will induce additional marketplace enrollment in 2023 and beyond, independent of the waiver.

The 2024 base data included member-level details as well as household-level details. Adjustments were made to the 2022 base data at a household level basis to generate an estimate of the 2024 baseline as described below.

Enrollment. To develop a 2024 enrollment estimate, for our best estimate, we assumed that the historical enrollment changes would continue, accounting for the impact on enrollment due to COVID-19 during 2020-2022.

On-Exchange: Historical enrollment increases were used as the basis for the assumed enrollment change from 2022 to 2024. We reviewed the annual enrollment change from 2017 to 2020 separately for federally subsidized and federally non-subsidized on-exchange customers and assumed the same average enrollment increase would continue from 2022 to 2024. We estimated an increase in subsidized enrollment on the exchange due to increased Medicaid redeterminations associated with unwinding from the Federal Public Health Emergency, from July 2022-July 2023.This was based on a study by the

Robert Wood Johnson Foundation.[4] We assumed that the enrollment would increase in 2023 by 5.1% and by 2025 revert to similar levels as 2021 as members roll into employer sponsored coverage or other forms of insurance. Except for the impact of Medicaid redetermination, we did not assume any significant changes to enrollment or plan offerings as a result of the ongoing COVID-19 pandemic. We are assuming that the January 2022 enrollment is representative of enrollment going forward.

Off-Exchange: Detailed enrollment information for off-exchange customers was not available. Wakely relied on an August 2021 off-exchange enrollment summary by plan, age, and gender. The 2021 off-exchange enrollment was then trended to 2022 based on the average reduction from 2017-2021 based on the same methodology. We reviewed more recent February 2022 off-exchange enrollment data for consistency with existing modeling. To estimate enrollment in 2024, it was assumed that the increase in federally non-subsidized on-exchange enrollment would be offset 1-to-1 by a decrease in off-exchange enrollment.

As noted above, the enrollment was allocated separately for federally subsidized on-exchange, federally non-subsidized on-exchange, and off-exchange. The resulting impact was an increase of 5.5% of federally subsidized enrollment on-exchange, a 2.4% decrease in the federally non-subsidized enrollment on-exchange, and a reduction of 6.2% of off-exchange customers from 2021 to 2022.

Gross Premiums (Before Federal Subsidies). The 2022 to 2024 premium change is assumed to follow with historical average increases. The overall annualized gross premium increase from 2022 to 2024 is estimated to be 0.9%.

APTC. The APTC per member per month (PMPM) amounts for 2022 were provided by the Exchange. To estimate the 2024 figures, Wakely increased the required contribution (i.e., net premium) 2% per year from 2022 to 2024 to account for the indexing of the contribution rate. We then inflated gross premiums for APTC customers (the 2022 APTC amounts plus net premiums) in 2024 by the average market premium increases, as described above. This new 2024 gross premium amount was then reduced by the 2024 net premium values (since APTC customers share of premiums is capped based on their respective household income) to calculate the 2024 APTC PMPM amounts. The resulting 2024 APTC and net premium amounts were reviewed for reasonability by FPL and metal level.

The tables below summarize the 2024 high level Washington market statistics based on the issuer data and adjustments as discussed above to project to the baseline. The 2024

[4] https://www.rwjf.org/en/library/research/2021/09/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency.html

estimates reflect the best estimate assumptions. Note that the decrease in APTC enrollment reflects the assumed ending of the Department of Health and Human Services' (HHS) public health emergency declaration (PHE) in 2022 and expiration of ARP at the end of 2022 as is current law.

Table 4: 2024 Baseline Average Enrollment Data / Estimates

Baseline Estimate	2024
Enrollment	
On-exchange – APTC	136,400
On-exchange – non-APTC	78,800
Off-exchange	26,400
Total	241,600
% Receiving APTC	56.5%

Table 5: 2024 Baseline Estimate of On-Exchange Enrollment by Age and FPL

FPL	17 and under	18-34	35-54	55 and over	Total
Below 139%	400	3,400	5,100	5,900	14,800
139-150%	0	4,300	4,900	4,400	13,600
151-200%	100	11,700	15,300	13,300	40,400
201-250%	100	8,000	11,400	10,400	29,900
251-300%	100	5,300	7,600	6,900	19,900
301-400%	3,100	6,000	9,700	9,800	28,600
401-500%	1,600	2,200	4,000	3,400	11,200
501-600%	800	1,100	2,100	2,100	6,100
Over 600%	1,400	1,900	3,900	3,800	11,000
Do Not Report	6,600	7,800	13,500	11,800	39,700
Total	**14,200**	**51,700**	**77,500**	**71,800**	**215,200**

Uninsured. In order to estimate take-up from the uninsured as a result of the subsidy program, we also needed to project a baseline estimate of the uninsured in 2024. The

number of uninsured individuals was estimated based on the average uninsured individuals reported through the American Community Survey (ACS) for 2019. We relied on information provided by the Washington State Office of Financial Management (OFM) for adjustments made to ACS data for members enrolled in Medicaid. The OFM data also provided estimates for the number of uninsured that are eligible for Medicaid, residents lacking a federally recognized immigration status, and those eligible for federal subsidies on-exchange. The number of uninsured individuals was assumed not to change materially from 2019 through 2021.[5] We further split the uninsured estimate into those that would be eligible for APTC and those that are not. In scenarios where it was assumed that ARP does not continue beyond 2022, all individuals above 400% FPL are not eligible for federal subsidies. For the remaining individuals under 400% FPL, we assumed 67% are eligible for APTC. This is based on a KFF study evaluating the distribution of uninsured that are ineligible for financial assistance due to an offer of employer coverage.[6]

This data was then projected to 2024. We assumed that in the absence of COVID-19, the uninsured rate and population would be steady from 2019-2024. In looking at the estimated uninsured rate as reported by the ACS from 2015-2019, the uninsured rate has remained relatively steady in Washington.

The regulatory environment, both at the federal and state level, impacts enrollment and premiums. The assumed regulatory environment in 2024 reflects the status quo, as follows:

- We assumed silver loading on-exchange would continue.
- No other proposed regulatory changes were included within the 2024 Baseline.
- We did not assume family glitch would be resolved by 2024 Baseline.
- We did model 2024 scenarios with ARP subsidies continuing and expiring at the end of 2022.

Based on the assumptions above, Wakely adjusted the 2022 member level detailed data to produce the detailed 2024 Baseline environment.

[5] This assumes no significant changes in coverage status due to Covid or overall economy.

[6] https://www.kff.org/health-reform/state-indicator/distribution-of-nonelderly-uninsured-individuals-who-are-ineligible-for-financial-assistance-due-to-income-offer-of-employer-coverage-or-citizenship-status/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Cascade Care Savings (State Premium Subsidy) Program

The state subsidy program, also referred to as Cascade Care Savings program, improves access for three distinct cohorts. First, those Washington residents who are eligible for APTC and have incomes up to 250% FPL (referred to as Group 1). The second cohort is Washington residents who are QHP eligible but do not receive APTC and have incomes up to 250% FPL (referred to as Group 2). The third cohort that will eligible for the state premium subsidy program, subject to waiver approval, is Washington residents without a federally recognized immigration status who are ineligible for APTC, currently ineligible for QHP coverage, and have incomes up to 250% FPL (referred to as Group 3).

Based on information from the Exchange, the baseline analysis assumes that each eligible group receives a fixed dollar amount per month (i.e. everyone in Group 1 gets a fixed PMPM amount and everyone in Group 2 gets a fixed PMPM amount). The waiver analysis assumes Group 3 members get the same fixed PMPM amount as those in Group 2. For all three groups this amount would be limited at the household level based on the number of billable customers. Therefore, households with more than three children would only receive a subsidy for a maximum of three children, consistent with how premiums are calculated.

After calculating the impact of the premium benefit at the household-level as described above, the results were then allocated back to the member-level in order to estimate the migration from off-exchange, and take-up among the currently uninsured in each cohort. Each member in the household was assigned an age rating factor and multiplier. The age rating factor was based on the federal age curve used to determine premiums for each member in Washington. Only the first three children under the age of 21 are billable. Therefore the multiplier is 1.0 for adults and the first three children under 21 in a household and 0.0 for additional children, reflecting that these customers do not contribute to the household premium. An individual factor for each member in the household is calculated as the product of the age factor and multiplier. The premium and APTC for the household was allocated to the individual level based on the proportion of the individual factor to the sum of factors for all customers in the household.

Migration of Off-Exchange Customers to On-Exchange

The proportion of off-exchange customers migrating to on-exchange, due to the baseline state subsidy program, was a function of the reduction in net premium due to the state-based premium subsidy program. This premium change calculation was done at the individual level, where off-exchange customers were “mapped” to currently enrolled individuals with similar characteristics. In instances where certain characteristics about the off-exchange customers were not known (e.g., age and FPL), we assumed their distribution would be similar to the on-exchange customers. In addition, we have assumed

that none of the customers migrating on-exchange from off-exchange would be eligible for federal subsidies, based on initial analysis showing a de minimis impact.

Once the premium reduction was estimated, we then applied an enrollment elasticity function based on the published research literature – "the cross-price elasticity for people currently insured in the nongroup market is –1.18."[7] Further, we included muting adjustments to account for some portion of off-exchange customers' lack of awareness of the newly available state premium subsidies (which would depend on the level of continued advertisement and member education provided by the state in 2024 after the launch of state subsidy program for 2023), a ramp up of take-up after 2024 (the first year the waiver would be effective), and the general level of inertia associated with changing a health insurance plan, among other reasons. This muting factor was developed based on initial take-up results in California with the introduction of the state's premium subsidy program. This factor was applied consistently to off-exchange customers and uninsured individuals and was varied in the low and high scenarios.

We estimate very little enrollment from individuals without federally recognized status migrating from off-exchange to on-exchange, based on the number of non-citizens enrolled in direct enrollment plans in Washington reflected in the 2020 CPS survey, adjusted to account for immigration status.. Therefore, the potential take-up from off-exchange Group 3 individuals was deemed immaterial.

For modeling purposes, we assumed that very few individuals without federally recognized status and with incomes above 250% FPL would be taking up coverage. This is a conservative estimate. It is expected that the Exchange will leverage their assister networks and undertake extensive outreach to all those who would newly qualify for QHP coverage if the waiver is approved, regardless of their household income. Previous literature has shown such efforts increase enrollment.[8] Consequently, the following discussion of uninsured take-up in the waiver scenarios may underestimate the coverage gains the waiver may have on Washington's individual market.

Uninsured Taking Up Coverage

The second source of the premium subsidy program enrollment increase is from currently uninsured individuals taking up enrollment on the exchange. The number of uninsured individuals reported by the census surveys includes members who are not eligible for federal subsidies as they are either (1) eligible for Medicaid or (2) are ineligible for subsidies due to their citizenship status. We reduced the number of potential subsidized

[7] https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf
[8] https://www.brookings.edu/opinions/comments-on-the-georgia-access-model/

uninsured individuals that may choose to take-up on the Exchange for those who would be ineligible for the above reasons as reported by the ACS survey.

For those enrollees currently ineligible for APTC we estimated a separate pool of uninsured that may choose to take-up coverage under the state-based subsidy program, to further refine the baseline. These individuals will continue to be ineligible for federal subsidies, notably. Most notably, this group includes "family glitch" households. These members are ineligible for federal subsidies due to an “affordable” offer of employer-sponsored coverage. Individuals that are ineligible for federal subsidies due to Medicaid eligibility will also not be eligible for the state program.

For the waiver subsidy analysis, the subsidies available for currently federally non-subsidized members (Group 2) would be extended to the Group 3 population. The number of Group 3 individuals was estimated based on information provided by the Kaiser Family Foundation, and corroborated with Washington specific information provided by the Exchange, generated by OFM. The same elasticity function as described above was used to estimate the number of individuals in Group 3 that may choose to take up coverage given the availability of the state premium subsidies. However the elasticity was muted to reflect that these individuals may be hesitant to sign up for coverage, particularly in the first couple years of the program.

We assumed that the uninsured people enrolling on the exchange would be similar to those currently enrolled on the exchange (in terms of what plans they would be purchasing). As described in the baseline methodology above, we assumed a portion of customers below 400% FPL would be eligible for federal subsidies. Similar to the off-exchange migration modeling, we mapped the uninsured individuals to those that are currently on-exchange based on similar characteristics (county, age group, income level). We modeled the proportion of uninsured people purchasing coverage on the exchange (for Groups 2 and 3) as a function of how much premiums were decreasing due to the state premium subsidy.

For Group 1 customers, the change in the premium amount the consumer pays (net premium) reflects the gross premium minus APTC and state premium subsidies. For Group 2 and 3 customers, the change in net premium was calculated relative to the existing gross premium. Once the net premium reduction was calculated, we then applied an enrollment elasticity function based on the published research literature to the pool of the uninsured individuals in Washington. The estimated elasticity was based on published research by the Congressional Budget Office.[9] This paper indicates that individuals with lower incomes are less likely to take-up coverage and that older individuals are more likely.

[9] https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/66xx/doc6620/08-24-healthinsurance.pdf

Therefore, we varied the elasticity rates applied by income and age of the uninsured, ensuring that the total aligned with the average elasticity published in the report (-0.57). As described above, a muting adjustment was included to account for potential lack of awareness about the waiver and resulting new coverage opportunity (if approved), initial hesitancy to sign up (influenced by the level of community-led engagement and outreach provided by the state), and overall ramp-up of the program over the 5-year waiver period. This factor was applied consistently to off-exchange customers and uninsured individuals and was varied in the low and high scenarios.

Table 6: 2024 Baseline Average Enrollment and Premium Data / Estimates[10]

Baseline	2024
Average Annual Enrollment	
Total Individual Enrollment	241,600
Exchange Enrollment	215,200
APTC Enrollment	132,800
Non-APTC Exchange Enrollment	82,400
Off-Exchange Enrollment	26,400
Total Non-APTC Enrollment	108,800
PMPM Amounts	
Exchange Premium PMPM	$536.87
Gross Premiums PMPM for APTC Members	$554.70
Net Premiums PMPM for APTC Members	$125.05
APTC PMPM	$409.06
Total Annual Dollars	
Total Exchange Gross Premiums (millions)	$1,392.0
Total APTC (millions)	$652.0

Waiver Estimates

To estimate the effects of the 1332 waiver, we modeled the estimated take-up among Group 3 using methods described above, with estimated state subsidy PMPM amounts. The process to determine the state subsidy PMPM amounts was iterative in order to ensure that the aggregate estimated funding amount for the waiver program did not exceed the amount of funding allocated by the state, plus any pass-through amounts

[10] Total premiums and APTC were rounded and the net premiums are calculated as gross premiums less APTC and state subsidy.

starting in 2025. The state subsidy PMPM amounts reduce net premiums, which in turn impacts the estimated number of individuals taking up coverage.

Table 7: Estimated Impact of Waiver

	2024 Baseline	2024 Waiver
Exchange Enrollment	215,200	217,900
APTC Enrollment	132,800	132,800
APTC PMPM	$409.06	$407.89
Total APTC ($M)	$652.0	$650.2

Table 8: Estimated 2024 and 2028 Average Enrollment and Premium - Impact of Waiver

After Waiver (Relative to Baseline)	2024	2028
Change in Premiums	-1.4%	-1.6%
Change in Total Individual Market Enrollment	1.1%	1.5%

For further details on the impact of additional subsidies that would result from approval of the waiver, please see Appendix D.

Based on the baseline and waiver estimates, Wakely calculated estimated Federal savings. To calculate the pass-through amounts, Wakely calculated the difference in APTC in the baseline scenario and waiver scenario. Wakely then multiplied the APTC savings amount by the ratio of total PTC subsidy after reconciliation to APTC based on Office of Tax Analyses Methodology for calculating Pass-Through Payments for 2021[11] (91.3%) to arrive at the PTC savings amount.[12] The pass-through funding in a given year was added to the Group 2/3 program funding in the following year starting with 2025, with

[11] https://www.cms.gov/files/document/key-components1332-pass-througharp-update.xlsx
[12] This aligns with the methodology for calculating the PTC as noted in the "Method for Calculation of Section 1332 Waiver 2019 Premium Tax Credit Pass-through Key Amounts" document located at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Treasury-Method-Calculation-1332-Pass-through-Amounts.pdf

2028 including pass-through amounts from both 2027 and 2028. The results of these assumptions, such as enrollment (both in total and in various distributions), changes to the SLCSP, and impact on the federal deficit are discussed in the Appendix D.

Alternative Scenarios

Wakely performed scenario testing for 2024, which primarily involved changing enrollment, premiums, and whether provisions under the ARP continued beyond 2022. These assumptions were chosen for scenario testing, as they are significant drivers of the results of the analysis. For the remaining years of the waiver (2025-2028), only the best estimates were produced.

For 2024, six scenarios in total were produced primarily by varying enrollment and federal legislation assumptions (ARP/No ARP). Scenario 1 is the best estimate scenario described above. Scenario 2 and Scenario 3 assumed ARP does not extend beyond 2022 and tested for scenarios in which enrollment and premium growth differed from the best estimate (Scenario 2 is low enrollment no ARP and Scenario 3 high enrollment no ARP). Scenarios 4, 5, and 6 assume that ARP enhanced premium subsidies are extended beyond 2022. Scenario 4 reflects our best estimate with the ARP extended, while Scenario 5 assumes a lower uptake in enrollment in 2024 and beyond and Scenario 6 assumes higher enrollment take-up in 2024 and beyond than the best estimate (Scenario 4). In the higher enrollment scenarios, there is more PTC in the baseline, which results in higher pass-through savings.

The following assumptions were made in each scenario modeled:

1. Scenario 1 (Best Estimate): 2024 enrollment is slightly lower than 2023 enrollment as it includes reduction in enrollment due the ending of ARP subsidies as well as reduced effects of increased enrollment due to Medicaid redetermination starting in July 2022. Enrollment and premium increases are in line with prior historical trends. Finally morbidity of the uninsured (both QHP eligible and Group 3) are assumed to be 0.73.

2. Scenario 2: This scenario conforms to a scenario of lower enrollment and higher premiums than Scenario 1. In particular, it assumes that ARP ends and enrollment is lower than Scenario 1 with resulting higher premium increases due to worse risk pool as well higher trend. Additionally, there are no enrollment changes due to Medicaid Redetermination/End of PHE. Finally, morbidity of new enrollees is higher than Scenario 1 (0.85).

3. Scenario 3: This scenario generally conforms to a scenario of higher enrollment and lower premiums than Scenario 1. In particular, it assumes that ARP ends but

enrollment is higher than Scenario 1 with resulting lower premium increases due to improved risk pool as well an overall lower premium trend. Additionally, enrollment changes due to Medicaid Redetermination/End of PHE remain high. Finally, morbidity of new enrollees is lower than Scenario 1 (0.64).

4. Scenarios 4, 5, 6 are similar to 1, 2, and 3, respectively. However, they assume that ARP subsidies continue for the duration of this analysis. All of assumptions, beyond ARP, conform to their parallel scenario.

For each of the scenarios, the same funding methodology was applied as was used in the baseline scenario with the exception of the assumptions noted above. Each scenario produced a decrease in the state average premiums PMPM in 2024 between -0.9% and -1.4%. In each scenario, the lower premiums resulted in more enrollees in the individual market. Finally, in each scenario, the combined lower premiums (including decreased APTC PMPMs) resulted in fewer Federal dollars being spent in 2024 as a result of the waiver program relative to the baseline. The detailed results of the scenario testing are shown in Table 9.

Scenario 1 is the best estimate scenario. This scenario was used for the 5-year economic analysis.

Table 9: Summary of Alternative Scenario Results for 2024

Scenario	1	2	3	4	5	6
Description	**No ARP - Best**	**No ARP - Low Enrollment**	**No ARP – High Enrollment**	**ARP - Best**	**ARP - Low Enrollment**	**ARP - High Enrollment**
Baseline						
Total Exchange Premium PMPM	$536.87	$631.74	$526.04	$542.01	$643.83	$529.62
APTC PMPM	$409.06	$516.20	$391.62	$452.37	$556.48	$438.45
Total Individual Enrollment	241,600	186,600	288,400	262,800	204,500	313,600
Exchange Enrollment	215,200	170,000	267,700	236,900	188,100	293,400
APTC Enrollment	132,800	114,900	163,400	170,600	141,100	211,400
Off-Exchange Enrollment	26,400	16,600	20,700	25,900	16,400	20,200
Total Gross Individual Premiums	$1,565.6	$1,421.4	$1,827.5	$1,697.1	$1,570.4	$1,984.2
Total APTC (millions)	$652.0	$711.8	$767.9	$926.2	$942.1	$1,112.2
Total State Subsidies	$41.1	$42.9	$40.6	$43.0	$33.6	$42.2
With Waiver						
Total Exchange Premium PMPM	$535.53	$630.68	$523.80	$540.77	$642.76	$527.56
APTC PMPM	$407.89	$515.49	$389.72	$451.24	$555.80	$436.54

Scenario	1	2	3	4	5	6
Description	**No ARP - Best**	**No ARP - Low Enrollment**	**No ARP – High Enrollment**	**ARP - Best**	**ARP - Low Enrollment**	**ARP - High Enrollment**
Total Individual Enrollment	244,300	188,400	292,400	265,300	206,200	317,500
Percent Change in Total Enrollment	1.1%	1.0%	1.4%	1.0%	0.8%	1.2%
Exchange Enrollment	217,900	171,800	271,700	239,400	189,800	297,300
APTC Enrollment	132,800	114,900	163,400	170,600	141,100	211,400
Off-Exchange Enrollment	26,400	16,600	20,700	25,900	16,400	20,200
Total Gross Individual Premiums	$1,578.8	$1,432.7	$1,844.9	$1,709.7	$1,581.3	$2,001.1
Total APTC (millions)	$650.2	$710.8	$764.1	$923.8	$940.9	$1,107.4
Total State Subsidies	$47.2	$48.7	$47.9	$48.5	$39.0	$49.0
Total Savings Waiver						
Estimated APTC Savings (millions)	$1.9	$1.0	$3.7	$2.3	$1.1	$4.8
Estimated PTC Adjustment	91.3%	91.3%	91.3%	91.3%	91.3%	91.3%
Estimated Pass Through Funding (millions)	$1.71	$0.90	$3.40	$2.12	$1.05	$4.41

Beyond 2024

For years beyond 2024, Wakely made the following assumptions specific to Scenario 1, where ARP does not extend past 2022:

1. Baseline premiums (both total individual and on-exchange) as well as Gross Premium Amounts for individuals with APTC were trended by 0.9%, based on Exchange enrollment projections as of January of 2022.
2. APTC Net Premiums were increased 2.0% annually after 2023 to account for indexing.
3. Enrollment was increased 5.5% based upon 2022 Open Enrollment data.
4. The federal poverty limits (FPL) were trended 2.0% to account for inflation indexing, based on historical average changes.
5. The muting adjustment used to reflect take-up of members eligible under the wavier was assumed to decrease over time after 2024 as program awareness increases in the state.

Table 10: Baseline Data and Detailed Results after Waiver by Year

	2024	2025	2026	2027	2028
Baseline					
Total Exchange Premium PMPM	$536.87	$541.10	$545.65	$550.51	$555.14
APTC PMPM	$409.06	$411.83	$414.19	$416.68	$418.91
Total Individual Enrollment	241,600	244,500	249,500	254,200	259,200
Exchange Enrollment	215,200	218,500	223,800	228,800	234,200
APTC Enrollment	132,800	133,700	136,600	139,000	141,800
Total Gross Individual Premiums	$1,565.6	$1,596.7	$1,642.8	$1,688.0	$1,735.9
Total APTC (millions)	$652.0	$660.7	$678.8	$695.1	$712.8
Total State Subsidies	$41.1	$42.2	$43.0	$40.5	$42.3
With Waiver					
Total Exchange Premium PMPM	$535.53	$539.58	$544.03	$548.82	$553.24
APTC PMPM	$407.89	$410.50	$412.78	$415.20	$417.27
Total Individual Enrollment	244,300	247,500	252,800	257,600	263,100
Percent Change in Exchange Enrollment	1.1%	1.2%	1.3%	1.3%	1.5%
Exchange Enrollment	217,900	221,500	227,100	232,200	238,100
APTC Enrollment	132,800	133,700	136,600	139,000	141,800
Total Gross Individual Premiums	$1,578.8	$1,611.9	$1,659.3	$1,705.7	$1,756.2
Total APTC (millions)	$650.2	$658.5	$676.5	$692.6	$710.0
Total State Subsidies	$47.2	$49.4	$50.5	$48.4	$51.6
Total Savings Waiver					
Estimated APTC Savings (millions)	$1.9	$2.1	$2.3	$2.5	$2.8
Estimated PTC Adjustment	91.3%	91.3%	91.3%	91.3%	91.3%
Estimated Pass Through Funding (millions)	$1.7	$2.0	$2.1	$2.2	$2.6

Table 11: Detailed Results after Waiver, by Year and Enrollment Cohort

	2024	2025	2026	2027	2028
Baseline					
Group 1 Enrollment	64,000	64,700	66,200	66,200	67,400
Group 2 Enrollment	3,600	3,800	3,800	3,900	4,200
APTC PMPM	$409	$412	$414	$417	$419
Group 1 Subsidy PMPM	$65	$65	$65	$60	$60
Group 2 Subsidy PMPM	$195	$200	$195	$190	$200
Group 1 Average Subsidy Utilization	$43	$43	$43	$40	$40
Group 2 Average Subsidy Utilization	$193	$198	$193	$188	$198
Group 1 Average Net Premium	$52	$53	$54	$59	$60
Group 2 Average Net Premium	$255	$253	$263	$273	$265
With Waiver					
Group 1 Enrollment	64,000	64,700	66,200	66,200	67,400
Group 2/3 Enrollment	6,200	6,800	7,100	7,400	8,100
APTC PMPM	$408	$410	$413	$415	$417
Group 1 Subsidy PMPM	$65	$65	$65	$60	$60
Group 2/3 Subsidy PMPM	$195	$200	$195	$190	$200
Group 1 Average Subsidy Utilization	$43	$43	$43	$40	$40
Group 2/3 Average Subsidy Utilization	$194	$198	$194	$189	$198
Group 1 Average Net Premium	$52	$53	$54	$58	$60
Group 2/3 Average Net Premium	$298	$299	$310	$321	$316

Appendix B
Waiver Program Parameters

Waiver and Additional Subsidies for Those Ineligible for Federal Premium Tax Credits

The waiver would allow individuals without a federally recognized status access to Washington's exchange. As part of that change in eligibility, these individuals who have incomes up to 250% FPL would gain access to the same level of state subsidies as other individuals that are ineligible for federal premium tax credits and meet state eligibility requirements (including FPL limit). To fund the additional enrollees as a result of an approved waiver, the state has allocated, contingent on waiver approval, an additional $5 M to its premium subsidy program.

For the baseline, the state, within amounts appropriated by the Legislature, has allocated $34.5 M to be used for premium subsidies for on-exchange enrollees who are eligible for APTC and have incomes up to 250% FPL (also referred to a Group 1) and $10.5 M for on-exchange enrollees who are ineligible for APTC and have incomes up to 250% FPL (also referred to as Group 2). Additionally, for both groups, state subsidies are available only for members enrolled in Silver or Gold Cascade and Cascade Select plans. In addition to the funding amounts listed above, $5 M (10% of the appropriated $50 M for the baseline) will be held in reserve to account for enrollment uncertainty. The state subsidy amounts are calculated before the benefit year on a PMPM basis, based on projected enrollment, appropriated funding levels, and allocated funding amounts for each Group.

For the waiver, a similar method to the baseline will be used to calculate the state subsidy before the benefit year, using the best enrollment estimate. In the waiver scenario, $34.5 M would be available to Group 1 and $15 M would be available for Groups 2 and 3. Any available federal pass-through funds will be allocated towards increasing the amount of subsidies for those ineligible for APTC (Groups 2 and 3). Given the uncertainty around enrollment, 10% of the total appropriation for the waiver ($5.5 M) will be held in reserve ($1 M for Group 1 and $4.5 M for Group 2 and 3, in case of higher-than-expected enrollment). Given the higher uncertainty in enrollment take-up, more of the reserve funding is allocated to Groups 2 and 3. Altogether, $55 M of state funding (plus any federal pass-through funds starting in 2025) would be available for the state subsidy program, contingent on an approved waiver.

Appendix C
Guardrail Requirements

Guardrail Impact for the Waiver's Individual Market Elements

Scope of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage to at least a comparable number of residents as would have been provided coverage without the waiver. Our analysis estimates that the waiver would provide for at least a comparable number of enrollees (and most likely a greater number of individuals) covered. This is due to premium reductions, to making more individuals eligible for QHP coverage, and to making more individuals eligible for subsidies.

In particular, we expect Washingtonians who have historically and systemically faced barriers to health coverage, including people of color, immigrants, and Washingtonians with low incomes, to benefit from the waiver. In Washington, the uninsured disproportionately consist of people of color, as shown in Table 12 below. Given the improved access to health insurance coverage, Wakely estimates that the waiver would increase health equity.

Table 12: Uninsured Population Characteristics

Total	White	Black	Hispanic	Asian/Pacific Islander	Native American	Multiple Races
479,800	221,300	23,100	172,900	36,600	9,400	16,500

**Data from Kaiser Family Foundation analysis of Current Population Survey Data*[13]

Affordability Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage, premiums, and cost-sharing protections that keep care at least as affordable to at least a comparable number of residents as would have been provided absent the waiver. Generally, we expect premiums to be lower than they otherwise would have been for each year of the waiver. As noted in Table 2, the waiver should reduce premiums on average 1.4% to 1.6% in each year of the waiver. Cost sharing for plans will remain similar. The waiver would also improve affordability by providing additional state subsidy funding for Washingtonians without a federally recognized immigration status, contingent on waiver approval. Because of these effects, our best estimate is that the waiver would provide for no change or possibly greater affordability for residents. Given the improved affordability of health insurance, Wakely also estimates that the waiver would increase health equity.

[13] https://www.kff.org/uninsured/state-indicator/distribution-uninsured-nonelderly-race-ethnicity/

Comprehensiveness of Coverage Requirement

In order for a 1332 waiver to be approved, the waiver must demonstrate that it will provide coverage that is at least as comprehensive as would be provided absent the waiver. This waiver will not result in any changes to the EHB benchmark or actuarial value requirements and, as such, will not have any impact on the comprehensiveness of coverage for residents. To the extent that additional individuals gain coverage, that will increase the number of Washington residents with comprehensive coverage.

Deficit Neutrality Requirement

PTC

Since PTCs are benchmarked to the SLCSP, the decrease in premiums (specifically the SLCSP) will result in lower per person PTC amounts in 2024. Increasing enrollment in the individual market is expected to reduce premiums due to improved morbidity. Due to the combination of a non-decreasing number of enrollees with APTC and a decrease in premiums, which is connected to PTC amounts, Wakely's best estimates analysis shows that the overall aggregate amount of PTCs will be lower each year over the 5-year period, as shown above in Table 10.

Offsets to PTC Savings

Exchange User Fee

Washington operates its own state-based exchange and therefore changes in premiums due to a 1332 waiver would not impact Federally-facilitated Exchange fees.

Other Federal Impacts

Wakely did not directly estimate the impact of the proposed waiver on the collections related to, small business tax credit or income taxes. It is unlikely that any of these would have a significant impact on the overall savings.[14]

Group Market

A detailed analysis of the group market was not completed. It is not expected that the waiver will have an impact on the large group, federal employee health benefits program, and other health programs in the state. In particular, we do not expect enrollment migration from the group market

[14] http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf

to the individual market as a result of the waiver. Prior research on the effects of the ACA showed no impact on Employer Sponsored Insurance.[15]

[15]https://dash.harvard.edu/bitstream/handle/1/28547756/Frean%20Gruber%20Sommers%20NEJM%20ACA%20Perspective%202016.pdf?sequence=1

Appendix D
5 Year Projections

Tables 13, 14, and 15 show various information as required under the CMS checklist.

In Table 13, the second lowest cost silver plan for each rating area is based on the 21-year old non-tobacco premium.

Table 13: Second Lowest Cost Silver Plan Premium PMPM, with and without Waiver, by Rating Area and Year

Rating Area	2024	2025	2026	2027	2028
Baseline					
Rating Area 1	$303	$306	$308	$311	$314
Rating Area 2	$323	$325	$328	$331	$334
Rating Area 3	$340	$342	$345	$349	$352
Rating Area 4	$283	$285	$287	$290	$293
Rating Area 5	$308	$310	$313	$316	$319
Rating Area 6	$299	$302	$304	$307	$310
Rating Area 7	$340	$343	$346	$349	$352
Rating Area 8	$324	$327	$330	$333	$336
Rating Area 9	$307	$310	$312	$315	$318
After Waiver					
Rating Area 1	$302	$305	$307	$310	$313
Rating Area 2	$322	$324	$327	$330	$333
Rating Area 3	$339	$341	$344	$347	$350
Rating Area 4	$282	$284	$286	$289	$291
Rating Area 5	$307	$309	$312	$315	$317
Rating Area 6	$298	$301	$303	$306	$309
Rating Area 7	$339	$342	$344	$347	$350
Rating Area 8	$323	$326	$328	$331	$334
Rating Area 9	$306	$309	$311	$314	$317

Table 14: Projected Enrollment by FPL, with and without Waiver, by Year

	2024	2025	2026	2027	2028
Baseline					
Total Individual Enrollment	215,200	218,500	223,800	228,800	234,200
<139% of FPL	14,800	15,100	15,700	16,200	16,800
139-150% of FPL	13,600	13,700	14,000	14,300	14,600
151-200% of FPL	40,400	40,900	41,800	42,500	43,400
201-250% of FPL	29,900	30,200	30,900	31,400	32,000
251-300% of FPL	19,800	19,900	20,300	20,700	21,200
301-400% of FPL	28,600	28,700	29,300	30,000	30,600
401-500% of FPL	11,300	11,600	11,900	12,200	12,500
501-600% of FPL	6,200	6,300	6,500	6,700	6,800
Over 600% of FPL	11,000	11,300	11,600	11,900	12,200
Did Not Report	39,700	40,700	41,800	42,900	44,000
After Wavier					
Total Individual Enrollment	217,900	221,500	227,100	232,200	238,100
<139% of FPL	15,600	16,100	16,700	17,300	18,000
139-150% of FPL	13,900	14,100	14,500	14,800	15,100
151-200% of FPL	41,200	41,700	42,700	43,500	44,600
201-250% of FPL	30,600	31,100	31,800	32,300	33,100
251-300% of FPL	19,800	19,900	20,300	20,700	21,200
301-400% of FPL	28,600	28,700	29,300	30,000	30,600
401-500% of FPL	11,300	11,600	11,900	12,200	12,500
501-600% of FPL	6,200	6,300	6,500	6,700	6,800
Over 600% of FPL	11,000	11,300	11,600	11,900	12,200
Did Not Report	39,700	40,700	41,800	42,900	44,000

Table 15: Projected Enrollment by Metal Level with and without Waiver, by Year

	2024	2025	2026	2027	2028
Baseline					
Total Individual Enrollment	215,200	218,500	223,800	228,800	234,200
Catastrophic	1,100	1,100	1,100	1,100	1,200
Bronze	84,600	85,800	87,900	90,500	92,700
Silver	101,800	103,300	105,800	107,400	109,900
Gold	27,800	28,300	29,000	29,700	30,400
Platinum	0	0	0	0	0
After Waiver					
Total Individual Enrollment	217,900	221,500	227,100	232,200	238,100
Catastrophic	1,100	1,100	1,100	1,100	1,200
Bronze	84,600	85,800	87,900	90,500	92,700
Silver	104,200	106,000	108,700	110,500	113,400
Gold	28,100	28,600	29,400	30,100	30,900
Platinum	0	0	0	0	0

Appendix E
Reliances

The following is a list of the data Wakely relied on for the analysis:

1. Member level on-exchange enrollment as of January 2022
2. The 2021 Open Enrollment Report PUF produced by HHS[16]
3. 2021 Final Marketplace Special Enrollment Period Report released by CMS[17]
4. Information from the state of Washington for on-exchange demographic and FPL data
5. National Health Expenditure Data from CMS[18]
6. CMS' Section 1332 Tentative Pass-Through Payments for 2021[19]
7. Method for Calculation of Section 1332 Waiver 2019 Premium Tax Credit Pass-through Key Amounts[20]
8. CBO Analysis on Impact of Repeal of the Mandate[21]
9. CBO's Health Insurance Simulation Model: A Technical Description[22]
10. CBO Modeling of the impact of ARP[23]
11. CBO's Price Sensitivity of Demand for Nongroup Health Insurance[24]
12. CEA's Understanding Recent Developments In The Individual Health Insurance Market[25]
13. Matthew Fiedler's comment letter Re: Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule[26]

[16] https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot
[17] https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf
[18] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
[19] https://www.cms.gov/files/document/key-components1332-pass-throughharp-update.xlsx
[20] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Treasury-Method-Calculation-1332-Pass-through-Amounts.pdf
[21] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf
[22] https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf
[23] https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf
[24] https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/66xx/doc6620/08-24-healthinsurance.pdf
[25] https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf
[26] https://www.brookings.edu/wp-content/uploads/2021/08/Fiedler-SEPCommentLetter-FINAL.pdf

14. Health Insurance Demand and the Generosity of Benefits: Fixed Effects Estimates of the Price Elasticity[27]

15. National Bureau of Economic Research's Inertia, Market Power, and Adverse Selection in Health Insurance: Evidence from the ACA Exchanges[28]

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Washington for reasonability.

The following are additional reliances and caveats that could have an impact on results:

1. Data Limitations. Wakely received member level detailed on-exchange enrollment data as of January 2022, and summarized off-exchange enrollment as of August 2021, and February 2022. We reviewed the data for reasonability, but we did not audit the data. To the extent that the data is not correct, the results of this analysis will be impacted.

2. Political Uncertainty. There is significant policy uncertainty. Future federal actions in regards to American Rescue Plan, premium subsidies, silver-loading, prescription drugs, and other policy changes could significantly change premiums and enrollment in 2023 or future years. In particular, extension of the American Rescue Plan enhanced subsidies or other changes to premium subsidies or CSR funding could impact pass-through, enrollment, or premiums. State political reactions to changes in the individual market could alter the results.

3. Family Glitch. It is possible that a change in regulation could change eligibility for premium tax credits for those in the family glitch. Such a change would increase the number of individuals receiving state subsidies in Group 1 and decrease that number in Group 2.

4. Enrollment Uncertainty. Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also have uncertainty. All of these uncertainties result in limitations in providing point estimates on impacts of a 1332 waiver.

5. Premium Uncertainty. Given that several recent changes to statutory and regulatory rules of the individual market (e.g., American Rescue Plan) have not reached steady state in their effects on the individual market, there is uncertainty in how insurers may respond in their 2023 premiums. Furthermore, issuer response to the standard plan requirements and their pricing of non-standard plans is uncertain. These uncertainties result in limitations in providing point estimates on the impacts of a 1332 waiver.

[27] https://ideas.repec.org/a/bpj/fhecpo/v12y2009i2n3.html
[28] https://www.nber.org/system/files/working_papers/w29097/w29097.pdf

6. COVID-19. There remains significant uncertainty as to the effects the COVID pandemic will have on enrollment, premiums, health care utilization, the economy, and other factors.

7. Public Health Emergency Related Uncertainty. The ending of the Public Health Emergency could result in a number of individuals transitioning from Medicaid to the exchange market.

8. Pass-Through Uncertainty. Ultimately, the Department of Health and Human Services and the Department of Treasury model the pass-through amounts. The extent to which the exact assumptions and micro-simulation modeling differs from Wakely's models, differences in the pass-through amounts are possible.

9. State-Based Premium Subsidy Structure. If the parameters (type of subsidy, level of subsidy, and eligibility requirements) of the premium subsidies offered differ from the assumptions used in this analysis, Wakely's analysis would need to be adjusted to match actual programs. Changes to assumed parameters may impact the results.

Appendix F
Disclosures and Limitations

Responsible Actuary. Julie Peper and Ksenia Whittal are the actuaries responsible for this communication. They are both Members of the American Academy of Actuaries. Julie and Ksenia are Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen, Danielle Hilson, and Alex Jarocki contributed significantly to the analysis and contents of this report.

Intended Users. This information has been prepared for the sole use of the management of Washington. Wakely understands that the report will be made public and used in the 1332 waiver process. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. The extent to which the enrollment experience for 2022 is different than expected results could be affected. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Washington will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuary is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to the State of Washington.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the ‘Data and Methodology’ and ‘Reliances and Caveats’ sections identifies the key data and assumptions.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans or federal subsidy levels may have a material impact on the results included in this report. In addition, many of the assumptions are based on the initial 2022 experiences. Change in emerging 2022 enrollment and experience could impact the results.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

ASOP No. 56, Modeling

Appendix D: **Public Notice and Comment Process**

Materials related to public comment will be included in full in the final 1332 waiver application, following 30-day state public comment period.