Washington Section 1332 Waiver Application
Federal Questions and State Responses
December 2022

Below are Washington's responses to additional information as requested by the U.S. Department of Health and Human Services and the Department of the Treasury during the review of the waiver application.

Q1. Federal Question (6/29/22): **Could the state provide more information on why the state believes the waiver will reduce premium rates? More specifically, could the state provide their assumptions about the how the risk profile of new enrollees under the waiver differs from the current population, a detailed explanation of how they developed those assumptions, and how they reflected those projections in their projection model.**

A1. State Response (6/30/22): There are two distinct reasons for this belief. The first is that new enrollees tend to have lower claims cost relative to those currently in the market, likely because at a given price sicker individuals are more likely to enroll. For example, prior research has shown individuals that exit the market as a result of premium increases tend to have lower claims costs.[1] The same is true of individuals who newly enroll as a result of a change in the net price of enrolling (whether lower premiums or higher penalties for those that do not take up coverage).[2] Similarly, CBO assumes in its modeling[3] that individuals make utilitarian calculations comparing expected benefit (e.g., health costs without insurance) to cost of insurance (e.g., premiums) and therefore lowering premium costs should attract healthier individuals, ceteris paribus.

The second reason is that the key populations that will gain coverage under the waiver have lower expected claims costs than current enrollees. Specifically, there is considerable evidence that individuals without a federally recognized immigration status tend to be healthier and have lower claims costs on average than U.S. citizens and legal residents.[4,5] Similarly, individuals who are likely to newly enroll as part of the family glitch population are expected to decrease nongroup premiums when added to the nongroup, as they are expected to be healthier than current enrollees.[6]

Consequently, the combination of the targeted population and generally the impact of lowering net premiums are expected to improve the overall morbidity of the market.

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[1] https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4408001/

[3] https://www.cbo.gov/system/files/2019-12/55912-CBO-presentation.pdf

[4] https://www.rand.org/pubs/research_reports/RRA1964-1.html

[5] https://pubmed.ncbi.nlm.nih.gov/33306118/

[6] https://www.urban.org/sites/default/files/publication/104223/changing-the-family-glitch-would-make-health-coverage-more-affordable-for-many-families_1.pdf

Q2. Federal Question (6/29/22): **In the application it noted: "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." Could the state explain what the factor was in California and how this was applied in the Washington analysis? Is there a citation or source the California results that you can share.**

A2. State Response (6/30/22): To be clear, there was not a muting factor in California. Rather, the muting factor was developed for the Washington analysis to reflect expected lower take-up in the initial years given observed lower take-up in the initial year in California. The muting factor was used to adjust Wakely's normal take-up elasticities to reflect California's experience (i.e., take-up would be similar given similar reductions in net premiums to California's state subsidy program). For example, new enrollment was reduced 35%, in the first year of the program, relative to the predicted elasticity output, to best match the effect of the first year of California's state subsidy program. The muting factor was derived from data included in California Exchange's presentation titled "STATE SUBSIDY PROGRAM DESIGN FOR PLAN YEAR 2021, Covered California June 25, 2020 Board Meeting".[7]

Q3. Federal Question (7/15/22): **The state indicates in the actuarial analysis and their response to questions about their assumptions that they assume that the populations impacted by the waiver have lower than average claims costs. It does not appear that the state considered the fact that the pent-up demand for this population may offset some of the lower assumed claims cost. Could the state confirm if they considered this and how it was considered in the state's analysis?**

A3. State Response (7/19/22): The state did consider whether there would be pent-up demand among this population. We do not expect pent-up demand to significantly affect claims among those who newly enroll under the waiver, for two reasons. First, Washington state has a number of coverage options for those without a recognized immigration status, including the ability to purchase a commercial plan off-exchange and state-only Medicaid programs for children and pregnant people. Given that, we expect those among this population with higher acuity have generally already found a coverage option. Second, individuals without federally recognized immigration status tend to be healthier,[8] so they would be less likely to have unmet health needs to begin with. Given these factors, we expect those who would newly enroll in the individual market under the waiver would have lower acuity and resultingly improve the risk pool.

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[7]
https://board.coveredca.com/meetings/2020/June%202020%20Meeting/PPT.Policy%20and%20Action.June%202020_6-24%20AT%202.25%20PM.pdf
[8] https://www.rand.org/pubs/research_reports/RRA1964-1.html

Q4. Federal Question (7/15/22): **The response notes that "similarly, individuals who are likely to newly enroll as part of the family glitch population are expected to decrease nongroup premiums when added to the nongroup, as they are expected to be healthier than current enrollees." Confirming that the state analysis did not consider the family glitch as a waiver effect. How is the family glitch population similar to the undocumented population in the state's example?**

A4. State Response (7/19/22): Confirming that the analysis did not consider impacts of the family glitch fix as resulting from the waiver, but as an independent impact on the market regardless of the waiver approval.

Like the undocumented population, those in the family glitch currently have access to coverage: in this case, both employer-sponsored coverage and also non-subsidized individual market coverage (both on and off-exchange). The vast majority of family glitch members have previous coverage and consequently would not have pent-up demand.[9] Those with higher acuity are especially likely to have obtained coverage. Thus those newly enrolling as a result of the family glitch regulation change will have lower acuity and improve morbidity in the individual market. Similarly, prior research has found that individuals without recognized immigration status tend to be less expensive than citizens.[10] Indeed, individuals gaining coverage through the family glitch fix are likely to be more expensive than the individuals without federally recognized immigration status. However, given the uncertainty, we conservatively assume that these populations would be equal to one another in terms of morbidity relative to the current population.

Q5. Federal Question (7/27/22): **For the modeling scenarios described in PDF pg. 83-85 of the application's actuarial analysis, please clarify the following on enrollment—In describing relative changes in enrollment (e.g., "2024 enrollment is slightly lower than 2023 enrollment…" and "a scenario of higher enrollment and lower premiums…"), are these descriptions in relation to the baseline without-waiver enrollment, or are these referring to expected take-up by uninsured individuals?**

A5. State Response (8/3/22): The descriptions are primarily in relation to the differences between the baseline (without waiver enrollment) scenarios.
   a. For each of the 8 different 2024 scenarios displayed – Wakely created a baseline, and then a with-waiver projection.
   b. Across scenarios, Wakely used different enrollment and morbidity assumption, resulting in varying premium levels to test a range of possible baseline and with-waiver situations.
      i. For each scenario explored, Wakely assigned a morbidity factor ["best" of .73 for scenarios 1,4,7,8; "high" of .85 for scenarios 2,5, and "low" of .64 for scenarios 3,6] to uninsured individuals entering the market.

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[9] https://www.urban.org/sites/default/files/publication/104223/changing-the-family-glitch-would-make-health-coverage-more-affordable-for-many-families_1.pdf
[10] https://www.rand.org/pubs/research_reports/RRA1964-1.html

ii. In selecting the range of morbidity assumptions (from 0.64 to 0.85), Wakely has relied on published research. Prior research has shown individuals that exit the market as a result of premium increases tend to have lower claims cost[1]. In research from Massachusetts' health reform, data showed that individuals who exited the market as a result of higher premiums tended to have claims cost that were approximately 73% of those enrollees that remained.[2] This research, cited by the Council of Economic Advisors[3], served as the morbidity assumption in the best enrollment scenarios of 0.73 morbidity of the newly insured enrollees.

iii. Research on Colorado's individual market had similar findings: premium increases cause an increase in annual medical expenditures of the insured population, albeit a stronger effect of premium increases and higher claims cost (in this case a $1 increase in premiums yielded a $0.85 to $0.95 increase in medical expenditures).[4] The lower bound of the range served as the morbidity assumption in the low enrollment scenarios of 0.85 morbidity of the newly insured enrollees.

iv. The upper bound of the morbidity was 0.64 in the model. This was based on Wakely's calculations of CBO's morbidity estimate of those exiting the market due to the repeal of the individual mandate.[5] In addition to providing subsidies, the state of Washington is expected to have significant outreach and a public campaign. This has the potential to mean that individuals will sign up for coverage not only for purely economic reasons but also changes in norms (which influenced some of the morbidity assumptions related to mandate induced coverage).

6. *Federal Question (7/27/22)*: For the modeling scenarios described in PDF pg. 83-85 of the application's actuarial analysis, please clarify the following on morbidity—For scenarios 1, 2, 3, please clarify which types of individuals are accounted for in the "morbidity of the uninsured (both QHP-eligible and Group 3)" and "morbidity of new enrollees"? Are these morbidity levels referring to people who are uninsured due to the Family Glitch, people who are uninsured due to ineligibility for QHP from immigration status, both of these groups, or other types of individuals?

State Response (8/3/22): For each scenario explored, Wakely assigned a morbidity factor [.73 for scenario 1; .85 for scenario 2, and .64 for scenario 3] to each uninsured individual entering the market (this includes both individuals uninsured due to the family glitch, or uninsured due to immigration status, or uninsured for any other reason and choosing to take up coverage in 2024).

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[1]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[2] https://www.nber.org/system/files/working_papers/w19149/w19149.pdf

[3]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[4] https://www.aeaweb.org/articles?id=10.1257/app.20170117

[5] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

Q6a. Federal Question (7/27/22): **Do the abovementioned morbidity levels assumed in scenarios 1-3 account for any morbidity impacts from Medicaid redeterminations?**

A6a. State Response (8/3/22): No. The morbidity factor for an uninsured person taking up coverage in 2024 is assumed to be the same for each scenario (is not population specific, see answer above).

Medicaid redeterminations/QHP enrollment associated with the PHE unwind is accounted for in model/scenarios in both the enrollment and premium estimates (model assumes unwind occurs during 2023 and assumed no market morbidity improvement from these members).

Q6b. Federal Question (7/27/22): **Given the morbidity assumptions with-waiver for scenarios 1-3, what are the assumptions about morbidity without the waiver? E.g., for scenario 1, the model assumes a morbidity of 0.73 with-waiver, what is the baseline morbidity?**

A6b. State Response (8/3/22): The projected <u>change</u> in premium/morbidity impact due to new members with waiver are below (and also updated in Table 3A):
- For scenario 1: -0.3%
- For scenario 2: -0.1%
- For scenario 3: -0.5%

For each scenario, the assigned a morbidity factor [.73 for scenario 1; .85 for scenario 2, and .64 for scenario 3] for each uninsured individual entering the market was applied in both the baseline and waiver calculations.

Q6c. Federal Question (7/27/22): **What does the analysis assume with-waiver and without-waiver about the morbidity for individuals who are uninsured due to the Family Glitch, and individuals who are uninsured due to immigration status?**

A6c. State Response (8/3/22): The analysis assumes that the morbidity for individuals who are uninsured due to the Family Glitch, and individuals who are uninsured due to immigration status would be the same relative to the current population.

For each scenario explored, Wakely assigned a morbidity factor [.73 for scenario 1; .85 for scenario 2, and .64 for scenario 3] to each uninsured individual entering the market (this includes both individuals uninsured due to the family glitch, or uninsured due to immigration status, or uninsured for any other reason and choosing to take up coverage in 2024).

Q6d. Federal Question (7/27/22): **For scenarios 4, 5, 6—which the analysis notes are parallel to scenarios 1, 2, 3 respectively but assume that ARP subsidies continue for 2024—are the morbidity assumptions about the uninsured/new enrollees the same as in scenarios 1-3? Considering if enrollees maintain their coverage due to the ARP's continuation, instead of dropping coverage in a non-ARP world as could happen in scenarios 1-3, would that change the morbidity assumptions for scenarios 4-6?**

A6d. State Response (8/3/22): Yes, the analysis assumes morbidity assumptions about the uninsured/new enrollees in scenarios 4-6 are the same as in scenarios 1-3.

No, it does not change the morbidity assumptions. The model accounts for impacts of ARP's continuation in projected enrollment and premium impacts (in the with ARP scenarios).

Q6e. Federal Question (7/27/22): **For 2024 to 2033, under a with-waiver scenario, the state's estimated impact on premium reduction of about 1.41.5% for the entire risk pool appears somewhat ambitious when considering the projected increase in individual market enrollment is about 1.1-1.4%. It seems questionable that morbidity of the newly enrolled population will be low enough to impact premiums for the entire risk pool by this amount. Could the state please specify and consider revising the expected morbidity of the market with- and without-waiver, and note the assumptions used to reach those conclusions regarding premium impact and enrollment?**

A6e. State Response (8/3/22): In further discussing the estimated premium impacts of the WA's proposed 1332 waiver with Wakely, it was discovered that the actuarial outputs in the application regarding impact of waiver on premiums reflect the combined impact of <u>both</u> the waiver and state subsidy on individual market morbidity – with the majority of the projected premium impact due to the state subsidy (-1.1% in 2024) and only a small amount attributable to the 1332 waiver (-0.3% in 2024). WA's application has been updated accordingly (topline updates reflected below). The submitted pass-through amounts correctly reflect the change in morbidity only attributable to the 1332 waiver, so those were not adjusted as a result of this update.

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

	2024	2025	2026	2027	2028
Premiums	-0.3%~~1.4%~~	-0.3%~~1.6%~~	-0.3%~~1.6%~~	-0.3% ~~1.6%~~	-0.3%~~1.6%~~
Individual Market Enrollment	1.1%	1.3%	1.3%	1.3%	1.4%
Federal PTC Savings ($ millions)	$1.7	$2.0	$2.2	$2.4	$2.6
	2029	2030	2031	2032	2033
Premiums	-0.3%~~1.6%~~	-0.3%~~1.6%~~	-0.4%~~1.6%~~	-0.4% ~~1.6%~~	-0.4%~~1.5%~~
Individual Market Enrollment	1.4%	1.4%	1.4%	1.4%	1.4%
Federal PTC Savings ($ millions)	$2.7	$2.8	$3.1	$3.3	$3.4

*Q7. Federal Question (7/27/22)***: How does the state expect issuers will price for the waiver and what feedback has the state received from issuers on this point?**

A7. State Response (8/3/22): We are pleased that during the state public comment period, letters of strong support for the waiver were submitted by America's Health Insurance Plans (AHIP), the Association of Washington Health Care Plans (AWHP) (representing 13 companies – including all of the Exchange issuers - offering health insurance coverage to over 7 million Washington residents), and five Exchange issuers in their individual capacity. The unanimous support articulated in submitted comments stems from a shared expectation that the waiver will, as noted by AHWP "increase coverage among the uninsured, improve the sustainability and affordability of the individual market, and draw down additional federal funding to support the state's premium assistance program." More specifically, as was noted by the Community Health Plan of Washington during public comment, and echoed in individual discussions with issuers and state regulators, it is expected that, "[e]xtending affordable coverage to this population benefits the broader population by improving the health of the communities, improving the risk pool, and lowering premiums." With regard to overall costs, AWHP and numerous others have also documented their expectation that the waiver will, "reduce the amount of uncompensated care in Washington by allowing those without a coverage pathway to enroll in a QHP" and "have a positive impact on Washington's economy and health care sector by reducing uncompensated care, including charity care and medical debt." These comments are a strong indication that issuers will take the waiver population into consideration when pricing, in a manner that improves affordability.

Q8. Federal Question: **Please provide additional context on how the RAND study findings were utilized in the state's actuarial analysis.[11]**

A8. State Response: A recent (2022) RAND study, funded by the Robert Wood Johnson Foundation and focusing on potential policy implementations in Connecticut was used to assist the modeling effort for Washington's recently submitted Section 1332 Waiver. The use of the RAND study was limited to the development of assumptions related to the morbidity and utilization trends that the state could expect from new enrollees in the QHP market to assess premium impact. The report also included a number of modeling results focused on potential policy solutions under consideration by Connecticut, but those elements were not considered in the Washington analysis.

There is limited data available on expected utilization of services for undocumented persons that obtain health insurance coverage. The RAND report brought together two elements that confirmed Washington's approach in its modeling - specifically, the morbidity of undocumented persons and the expected utilization of care for undocumented persons who receive coverage. As such, Washington's actuarial analysis expected that undocumented persons would have lower morbidity than the currently enrolled population in the market. Additionally, it is expected that newly enrolled undocumented persons would have a much lower expected utilization of services than the currently enrolled population. It is important to note that the RAND study was not the only study used to arrive at the factors used in Washington's actuarial and economic analysis. Washington's analysis used other research to initially arrive at its assumptions/factors used in the

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[11] https://www.rand.org/pubs/research_reports/RRA1964-1.html

model and used the RAND report to confirm the usage of its initial assumptions. The modeling did not apply RAND's specific factors.

These findings used by the RAND report are accepted by Washington and are described as follows by RAND:

Undocumented immigrants are likely to have lower health care spending than U.S. citizens and legal residents. Two reasons in particular are important for us to consider:
- *the "healthy immigrant effect" (Antecol and Bedard, 2006), which refers to the fact that immigrants tend to be healthier on average than legal residents*
- *the fact that undocumented immigrants are far less likely to carry health insurance than legal residents (KFF, 2021), thereby making them less likely to use health care services.*

In this work, it was important for us to understand these effects separately, because we would expect that as undocumented immigrants gain health insurance coverage, their use of health care services and, therefore, their health care costs would increase. Furthermore, undocumented immigrants who are inclined to enroll in health insurance might tend to have relatively high 12 expenditures, even if—in general—the undocumented immigrant population is healthier than the legally present population. Most estimates of health care spending or utilization among undocumented immigrants do not control for factors such as age, health status, or health insurance status. Without controlling for such factors, health care spending for undocumented immigrants appears to be two to four times lower than that of the legally present population (Flavin et al., 2018; Wilson et al., 2020). However, controlling for such factors indicates that health care spending among undocumented immigrants is only 25 percent lower than among legally present residents (Wilson et al., 2020). Therefore, we applied this estimate of health care spending among undocumented immigrants in our modeling.

As discussed, RAND used, based on the Wilson et al., 2020 research, the estimate that utilization for undocumented persons is 25% lower than utilization for legally present resident (which in itself is lower than US-born residents).

Q9. Federal Question (8/22/22): **When estimating the change in premium faced by individuals in Group 3 as a result of the waiver, what was used as the without-waiver premium (e.g., lowest-cost on-Exchange silver premium, lowest-cost off-Exchange silver premium, lowest-cost Cascade Care silver premium, etc.)? Why? How would relying on a different without-waiver premium change the projected enrollment impact of the waiver?**

*A9. State Response***:** The change in premium faced by the individuals in group 3 was calculated as the difference in with-waiver Cascade Care net premium and the without-waiver Cascade Care premium purchased by an on-Exchange member of similar characteristics as Group 3 member based on observed distributions by county and distributions within counties. As the only data available that had these types of distributions was on-Exchange enrollment data, we relied on it rather than less granular off-Exchange data. The with-waiver Cascade Care net premium (silver and gold) was reduced by the state subsidy PMPM amount. Since the modeling was done at a member level, the without-waiver premiums included all on exchange Cascade Care plan premium that would be otherwise available to Group 3 member in absence of waiver. Using a different value for without-waiver premiums (such as off-exchange silver, or lowest-cost

Cascade silver, for everyone) would potentially slightly decrease take up due to the decrease in the net premium change. That said, this approach could introduce additional error by ignoring available data on geography, metal-level, and age.

Q10. Federal Question (8/22/22): **How many enrollees were reallocated from Group 2 to Group 1 as part of the so-called "Family Glitch" analysis (as described on p. 4 of the actuarial analysis)? Of those, how many were projected to have enrolled in Exchange coverage in response to the introduction of Cascade Care Savings?**

State Response: Please see the summary below as to switching from Group 2 to Group 1. Wakely only modeled the family glitch change in a scenario in which Cascade subsidies were available and cannot isolate the effects of the subsidies on the family glitch. Based on the numbers, there should be de minimis effects of the interaction of Cascade Care and family glitch changes.

Description	With ARP	Without ARP
Number of existing enrollees reallocated from Group 2 to Group 1 due to family glitch change	800	400

Q11. Federal Question (8/22/22): **Does the muting factor applied to the initial take-up rate of coverage incorporate the unique barriers undocumented people face when signing up for public benefits? Is the muting factor applied only in 2024 (the first year of the waiver), or is there a muting factor applied in subsequent years? If so, what assumptions were made with respect the phase-out of the muting factor?**

For background, it seems the muting factor is derived from California's recent experience with subsidies that are offered through Covered California and are not available to the undocumented. Academic research and surveys suggest immigrants in general are extremely hesitant to sign up for benefits out of fear (one recent example can be found here: https://policylab.chop.edu/blog/thawing-chill-public-charge-will-take-time-and-investment).

State Response: The muting factors used in modeling undocumented individuals take up of coverage were 10% higher than the muting factors used to model other uninsured uptake to reflect hesitancy and barriers of the undocumented individuals generally face as well as potential alternative options for take-up (off Exchange premiums, Washington programs, etc.). The muting factors also varied by program year, with highest factors in 2024 and scaling down over time, to increase take-up over time as members become more familiar with program. Table below summarizes the best estimate scenario muting factors for the uninsured and undocumented members.

Year	Uninsured Muting Factor	Undocumented Muting Factor

2024	75%	82%
2025	71%	78%
2026	67%	74%
2027	63%	70%
2028	60%	65%

Q12. Federal Question (8/22/22): **As mentioned in Wakely's actuarial report and as the State has indicated in past responses, there are currently several coverage options available to members of the undocumented population in Washington. Does Wakely's analysis assume that, given they meet the Cascade Care Savings eligibility criteria, individuals eligible for (and currently enrolled in) other forms of coverage will enroll in QHPs instead? If so, to what extent are these individuals estimated to enroll in QHPs in 2024 or over the course of the waiver period?**

State Response: Wakely assumed that these people would not transition into QHPs. Even under the waiver, many of these programs would continue to provide more affordable coverage than the Marketplace for these populations. In addition, prior experience (e.g., high risk pools) is that sicker individuals, who are likely enrolled in these programs, have higher inertia factors are unlikely to transition away from particular programs/providers, given ongoing treatment needs. Consequently, no transitions were estimated. This also reinforced our assumptions around a healthier morbidity for the incoming undocumented individuals into QHPs.

Q13. Federal Question (8/22/22): **For the scenarios (1–6) described on pp. 23–24 of the updated actuarial analysis, are the cited morbidities for Groups 1, 2, and 3 relative to existing Exchange population morbidities of 1.00 in all scenarios? In other words, if we think of the existing Exchange population (before the introduction of Cascade Care Savings) as Group 0, are the morbidities of Group 0 in all the scenarios set to 1.00? Or are the Group 0 morbidities slightly less than 1.00 in the "high enrollment" scenarios and slightly more than 1.00 in the "low enrollment" scenarios? For example, do the estimates in the low enrollment scenarios assume that the uninsured individuals taking up coverage (with a 0.85 morbidity) are 15% less costly than existing Exchange enrollees in that scenario or 15% less costly than existing Exchange enrollees in the best enrollment scenarios?**

State Response: The morbidity impacts in each scenario are calculated relative to a baseline for that particular scenario, where the baseline is the projected scenario with state subsidy in place but without the waiver. This model was chosen because the introduction of Cascade Care Savings for Groups 1 and 2 will be implemented regardless of waiver approval. The overall assumed morbidity of the baseline differs by scenario.

Illustrative example of best ARP scenario:

BEST Estimate Scenario	**Baseline**	**Waiver**
# enrolled	**1000**	**1000**

BEST Estimate Scenario	Baseline	Waiver
<-Cost	1.00	1.00
New Group 3 Enrollees		**9**
< Expected Cost		0.73
Total Enrollment	**1000**	**1009**
< Expected Cost	1.00	0.9976
Change in Total Pop Expected Cost Relative to Prior Baseline		-0.241%

In this example, Baseline is Groups 1 and 2, while Group 3 is represented in the New Group 3 Enrollees category. B The model expects the new Group 3 enrollees to account for 0.8% of the total enrollment and have a utilization 27% lower than the Baseline group. In total, that results in a reduction of overall expected cost reduction of 0.241%.

Q14. Federal Question (8/22/22): **In assigning morbidities to the uninsured taking up coverage in each group (Groups 1, 2, and 3), how—if at all—did the analysis account for the demand-side factors, such as the fact that Exchange coverage will likely continue to be more affordable for individuals in Group 1 than for those in Groups 2 and 3? Specifically, Washington's application notes in Table 1A on p. 4 of its application that average net premiums for APTC-eligible individuals are projected to be $6 PMPM with ARP subsidy levels and $50 PMPM absent ARP subsidy levels. By contrast, average net premiums under the waiver, for those not eligible for APTC, are projected to be $312 PMPM with ARP subsidy levels and $307 PMPM without ARP subsidy levels. When assigning morbidities to each group taking up coverage, were the expected values of insurance coverage for individuals in each group taken into account?**

A14. State Response: Yes, Wakely took into account the expected values of insurance coverage when considering assigning the values. Given the uniqueness of the program (e.g., quasi-public program, state-based subsidy), Washington's expected outreach, differences in the population (citizenship status), transaction costs, and other non-utility based factors, Wakely opted for a simplified approach. In particular, it relied on previous analysis as to the marginal cost of unsubsidized enrollees. For both populations, the combination of utility and non-utility calculations would likely result in larger morbidity impacts than estimated but given the level of uncertainty, we opted for a more conservative approach.

Under current law, the best estimate impact of the waiver is approximately 0.2% premium reduction. This was arrived using prior research showing the cost difference of a marginal unsubsidized enrollees was approximately 27% less than the market average. Given prior research, Wakely assumed that this newly eligible population would be no more expensive than a marginal unsubsidized enrollee, which given the prior research we felt was a conservative decision. Additionally, Wakely approximated the potential claim cost of a currently unsubsidized undocumented immigrant in the individual market and then cost difference to an uninsured undocumented immigrant. The result was a larger cost difference than what was included in the best estimate. Given the uncertainties, the analysis used the smaller cost difference. Under the waiver, the expected average cost per enrollee is the weighted average of the average cost of

current enrollees (normalized to 1.0) and the average cost of new enrollees (.73). Under the current law scenario (ARP continues no family glitch fix), new enrollees increase enrollment by 0.9%. This results in an overall average cost of 99.76, or a 0.24% reduction. Or more mathematically;

$(1*1 + 0.9\% * 0.73) / 1.009 = 1 -0.241\%$

Q15. *Federal Question*: Are there any studies other than those referenced in the materials sent so far that demonstrate that undocumented individuals in Washington are expected to have lower health care costs (controlling for insurance status)? Washington has noted that RAND has relied on a similar assumption that the uninsured undocumented are roughly 25% less costly than those lawfully present, which in turn comes from a 2020 study by Wilson et al. Wilson et al note several key limitations of their study (for example, the LAFANS data used to develop the machine learning model is from 2000–2002 and from 2006–2008, and the composition of the undocumented population has changed over time; the LAFANS data is from a small sample of individuals in LA County, which may differ in composition from populations elsewhere, etc.).

State Response: Yes, Wakely reviewed Flavin et al (2018) meta-analysis for 188 peer reviewed publications from 2000 to 2018. Their conclusion aligned with the assumptions for the modeling, although did produce a wide range in morbidity differences. Two specific citations in the Flavin piece included Tarraf et al (2012)[12] and Ku (2009).[13] Other work on the health status such Riosmena et al (2017) found the population healthier. Wakely acknowledges that there is a lack of large-scale data given a variety of factors, which is why a wide range of assumptions were used.

Q16. *Federal Question:* What causes the Total Exchange Premium PMPM to be higher in the Scenarios 4, 5, and 6 (with the ARP subsidy levels) relative to Scenarios 1, 2, and 3? For example, is this a function of the age distribution of enrollees (i.e., that the PTC expansion is most generous for older individuals)? In other words, are the SLCSP premiums for a sample individual expected to be lower under the PTC expansion scenarios, even if the average premiums are expected to be higher?

State Response: The difference in the average premium is driven by the metal mix differences in ARP and no ARP scenarios. More individuals are enrolled in silver plan under ARP (4,5,6) and fewer are enrolled in bronze plans relative to no ARP scenarios (1,2,3), given the larger subsidies under ARP are available.

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[12] Tarraf YW, Miranda MP, Gonzalez MH. Medical expenditures among immigrant and nonimmigrant groups in the United States: findings from the Medical Expenditures Panel Survey (2000–2008). Med Care. 2012;50(3):233–242.
[13] Ku L. Health insurance coverage and medical expenditures of immigrants and native-born citizens in the United States. Am J Public Health. 2009;99(7):1322–1328.

Q17. Federal Question: **The state noted that "the state did consider whether there would be pent-up demand among the newly enrolled population" and "We do not expect pent-up demand to significantly affect claims among those who newly enroll under the waiver, for two reasons"….Did the state expect that some newly enrolled, who may not have had insurance before, would have claims or utilization in the first year of the waiver, and future years?**

State response: In addition to plans on the off-Exchange market, the following coverage programs include WA residents who are undocumented:

- Apple Health for Kids (Medicaid & CHIP look-alike, up to 317% FPL for those at or below age 18)
- Apple Health for Pregnancy & After Pregnancy (Medicaid & CHIP look-alike, up to 198% FPL, includes 12 months of postpartum and coverage for 1st year of baby's life)
- Family Planning Only (up to 260%)
- Alien Emergency Medical (income limits vary)
- State-only Long Term Care
- Medical Care Services
- Kidney Disease Program (up to 220% FPL and meet other eligibility criteria)
- Breast & Cervical Cancer Screening (up to 300% FPL and meet other eligibility criteria)
- HIV/AIDS Early Intervention (up to 425% FPL and meet other eligibility criteria)
- WA State Health Insurance Pool (state's high-risk insurance pool created by the state legislature)

Given the unique and expansive programs that the state of Washington offers its residents, we believe that pent-up demand would be less than what is observed in other states among newly enrolled individuals. For enrollees who have not utilized Washington's numerous programs for the uninsured, it is possible they will exhibit pent-up demand. However, this population would also continue to experience barriers to access (e.g., language, familiarity with system, etc.) in the initial years of the program. Wakely's assessment is these countervailing forces would largely offset one another, producing a de minimis impact to premiums. Part of its reasoning is that in prior research, undocumented immigrants' current expenditures are approximately 50% relative to US born individuals (Flavin et al). Our assumption assumes higher costs than the 50% relative difference, despite the fact that it is unlikely that all barriers to access will be met in the first year of the program.

Q18. Federal Question: **The state's application noted that "In addition to providing subsidies, the state of Washington is expected to have significant outreach and a public campaign." Could you please provide additional details on what steps the state plans to take to encourage eligible individuals to enroll?**

State Response: The Exchange requested and received from the state-legislature $750k for community-led outreach and engagement related to Section 1332 Waiver implementation leading up to the program launch. This funding is supporting a multi-channel campaign to inform WA residents of the new coverage options available to them. This effort will include outreach to

communities through trusted organizations and messengers, including local community groups, as well as a broad campaign using community-informed messages and methods. A presentation detailing the steps the state will be taking over the next year to engage the immigrant community is available here: https://www.wahbexchange.org/content/dam/wahbe-assets/events/health-equity-tac/HBE-HETAC_20220903_Outreach.pdf.

Washington is in close contact with other states that are extending new coverage to persons with different immigration status and will leverage learnings from those states to develop effective communication strategies.

The Exchange will also be building a simple and accessible method to enroll in coverage through *Washington Healthplanfinder* to help residents and assisters effectively enroll new members and, in collaboration with the Governor's office, will also be seeking additional funding during the upcoming state legislative session to build upon and continue community engagement efforts during the first year of waiver implementation.

Q19. Federal Question (8/31/22): **Table 11 appears consistent with Tables 1A and 1B and suggests that the state subsidy PMPM available to the Group 2 population is the same with- and without-waiver in each year. To clarify, is the point simply that the waiver will impact the funding sources, or is the waiver somehow providing a benefit to the family glitch population? If the latter, it is still not clear what that benefit is.**

A19. State Response (9/2/22): It is correct that Table 11 (of actuarial report) and Tables 1A and 1B (of the application) are consistent and that the expected state subsidy PMPM to the Group 2 population is the same with and without waiver. The policy of WA would be that persons without federal subsidy (Group 2 in baseline and Group 2/3 in waiver) are treated the same in either scenario. Under the waiver, the persons that are currently prevented from accessing APTC due to the "family glitch" would benefit from the slight reduction in overall premium.

Q20. Federal Question (9/6/22): **Thank you for the clarification that the without-waiver premiums would be the Cascade Care premiums purchased by an on-Exchange member of similar characteristics as Group 3 members. Please elaborate on what these characteristics included. For example, was income one of the characteristics considered? Additionally, were the "similar" on-Exchange members restricted to those not eligible for PTC, or did they include PTC-eligible individuals?**

A20. State Response (9/15/22): The only characteristic of the undocumented pool of eligible Washingtonians that was available for this analysis was distribution of income by FPL range. Wakely used the distribution of the undocumented immigrants in Washington shown in Table 1 and allocated the number of undocumented to the on-exchange enrollees not eligible for PTC by FPL[14] to match this target distribution, assuming only undocumented individuals up to 250% FPL (eligible for the waiver savings) would enroll as a result of the waiver. Thus, within each

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[14] Note that since PTC ineligible individuals commonly do not provide their income information at enrollment, Wakely imputed the missing income information based on Census Survey income distributions.

income bracket, all other characteristics of on-Exchange PTC ineligible enrollees (observable in the data) and the undocumented individuals in that income category were assumed to be similar. These include age, gender, county of residence, plan purchased, and other characteristics (e.g., member months of enrollment, ethnicity, carrier). For example, for an undocumented immigrant with an FPL of 150%, we assumed their age, gender, plan selection, etc. would mirror those of the currently enrolled members that have estimated incomes between 139% and 200% FPL and are ineligible for PTC. Note that the average age of the subsidized (group 1) population is 45, and the average age of unsubsidized population is 41, which is consistent with the expected characteristics of the undocumented population to be generally younger.[15]

Table 1. Immigration Status and Family Income Level of Washington State's Uninsured Population, 2018

Family Income as Percent of Federal Poverty Level	Undocumented Immigrant (%)
Income unknown	1.3
0-138%	32.9
139-200%	19.0
201-300%	22.9
301-400%	14.8
401-500%	5.9
501%+	3.2
Total	100.0

Source: American Community Survey 2018 1-year PUMS with OFM adjustment for Medicaid enrollment.

***Q21. Federal Question:* Thank you for providing additional information on the higher muting factor for the undocumented. When applying this muting factor, were hesitancy and health status assumed to be correlated?**

A21. State Response: Yes, we did assume that hesitancy and health status were inversely correlated. When the health status (morbidity) is improved, hesitancy increases. This is demonstrated by a lower take-up. In the sensitivity analysis higher hesitancy among the take-up population was assumed to have a worse-case mix. In particular, the low enrollment take-up scenario morbidity of the take-up population was worse than the best estimate while in the high take-up scenario the morbidity is better than the best estimate. Table 2 below summarizes the waiver population take up under ARP continues for the three enrollment scenarios, along with the morbidity assumption.

Table 2.

Enrollment Scenario	2024 Take up (ARP) Under Waiver	Morbidity Assumption
Low	1,600	0.85
Best	2,500	0.73
High	3,900	0.64

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[15] https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/US

Q22. Federal Question: **Did the State develop any additional sensitivity analyses that assumed there would be transitions out of these other coverage programs and into individual market coverage in response to the waiver? How sensitive are the State's projections to the assumption that there would be no transitions?**

A22. State Response: We did not explicitly model transitions out of these coverage program. Transitions out of these other coverage programs should be rare. Individuals who are high utilizers would face higher costs in Exchange coverage. Additionally, high utilizers may need to change providers, which reduce incentives to shift and studies have shown that less healthy individuals tend to change coverage less. [16] As such, shifts out of the previously available coverage programs would be attributed to individuals who are healthier (i.e., less ongoing treatment or acute need) or due to confusion in available options, which Washington will be acting to minimize. Preliminary examination of the data led us to believe some transitions would likely result in waiver impacts that were within the range of estimates provided.

Q23. Federal Question: **Can an individual remain enrolled in an existing program (e.g., Kidney Disease Program) and also take up coverage in a QHP?**

A23. State Response: There are a range of existing programs that are available to undocumented residents in Washington; however, not all programs would qualify as Minimum Essential Coverage (MEC) – including family planning, alien emergency medical and disease specific programs. For programs that are not MEC, individuals will be able to enroll in a QHP and receive state subsidy while also maintaining enrollment in the specialized coverage program. Those claims costs that are attributable to the specialized program will continue to be paid by the specialized program. If a consumer is enrolled in a QHP, the QHP would cover the claims costs for those claims not associated with the specialized program.

For the purposes of modeling, the data available in Washington does not consider enrollment in non-MEC programs to be insurance and therefore enrollees in these non-MEC programs are considered uninsured. Wakely did not specifically model the take-up of QHP coverage among those enrolled in existing state coverage programs. Enrollment details, including a breakdown of enrollment by income, was not available. As such, it is likely that Wakely's approach to morbidity did not capture the claims costs that will continue to be covered by specialized coverage programs and slightly overestimates predicted costs of the population.

Q24. Federal Question: **Will the SBE enrollment portal direct eligible individuals to these coverage options? Put differently, even if those currently covered by these programs do not transition (because of inertia), does the State project that—under the waiver—individuals who *would be* newly eligible for one of these programs might instead opt for individual market coverage?**

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[16] https://www.sciencedirect.com/science/article/abs/pii/S004727272200024X

A24. State Response: The WA Health Benefit Exchange administers an integrated eligibility system for Medicaid and APTC/QHP coverage. Before being determined eligible for QHP coverage, applicants will be screened for program eligibility and enrolled into any state or federal Medicaid program for which they are eligible. As discussed above, though, if the coverage program is not MEC, the individual will be allowed to both purchase individual market coverage and access state subsidies (if otherwise eligible).

There are limited instances where a person would be eligible for a state-based coverage program that is considered MEC but choose instead to enroll in individual coverage. First, if they were eligible for MEC, they would not be eligible for Cascade Care Savings and would face premiums that are significantly higher than the state-based coverage program currently available to them. Additionally, since the eligibility system would have first found the individual eligible for the state-based coverage program, the individual would need to decline that coverage (that would be $0 or extremely low premium) and then choose the full premium QHP plan, Washington does not expect any described enrollment.

Q25. Federal Question: **Thank you for the additional information. To clarify the question, we would generally expect individuals to take up coverage when they would expect to be better off with insurance (after paying for premiums and any cost-sharing) than they would be without insurance. The State's estimated net premium for individuals in Groups 2 and 3 is quite similar to the market-wide estimated net premium and much higher than the net premium faced by Group 1 individuals. Did the State's analyses of Group 3 take-up of insurance and relative morbidity consider the expected health spending an individual in Group 3 would need to find insurance worth taking up, even in face of such a high premium?**

A25. State Response: The relative morbidity of Group 3 enrollees is directly related to expected health spending in the model, as it would be for any model of uninsured take-up of a new coverage program. Wakely conducted extensive analysis before using the factors employed in the model. One of the methods, was to examine potential spending patterns of the currently unsubsidized. Undocumented immigrants currently have the option of purchasing coverage off-Exchange, no different than other populations that are ineligible for APTCs. Consequently, unsubsidized enrollees, in the baseline, have the same potential premiums. While data does not exist of the plan choices or exact claims cost of the two populations (both documented and undocumented), given that their potential premiums (e.g., the full gross premium) are similar, the off exchange unsubsidized population was determined to be a reasonable proxy to begin with. The conclusions of the analysis that are described in more detail below were as follows:

- In all scenarios tested (all eight alternative scenarios denoted in tables 3A and 3B of the actuarial appendix as well as the three scenarios listed below), the claim cost of the new waiver population was below the claim costs of the existing market average. Costs were lower than the market average by anywhere between 10% and 63%.
- Had Wakely used off exchange costs as a reference point for modeling the waiver population premium impacts (rather than total market average cost), the resulting cost would still be below market average cost.

- 42% of off exchange unsubsidized enrollment consisted of healthier members enrolling in Bronze plans, with premiums similar to those faced by waiver undocumented populations (net of state subsidy), showing that healthier members are willing to pay for coverage.
- Wakely's analysis of allowed cost differences of individuals in CSR variants relative to the market average, shows that lower income individuals in the individual market spend less, all things equal. Since the target waiver populations have lower incomes than the off exchange enrollees, this finding also supports lower spending by the undocumented under 250% FPL.

It's important to note these are not exact equal populations. There are a number of factors that are unmeasurable between the groups that may lead to differences between the two populations. Studies[17] suggest that the undocumented population is generally healthier. Also, undocumented persons tend to use fewer services than a population with similar morbidity. The limited direct research of the undocumented population, and the unprecedented nature of this program, led Wakely to use conservative models to assume utilization.

Given the uncertainty, Wakely conducted a series of sensitivity tests using its proprietary database of national 2019 ACA Individual market experience, limiting it to the West regions of the country. Since undocumented enrollees have access to off-Exchange coverage currently, Wakely analyzed allowed claims cost of off-Exchange enrollees in WACA. As noted above there is uncertainty as to the exact population that undocumented enrollees represent. Consequently, Wakely used three separate starting points. The first is the average cost of all off-Exchange enrollees. The second is a starting point of a more risk-selected group of off-Exchange enrollees (e.g., those enrolled in non-bronze coverage). Finally, we selected a group of more favorably selected enrollees that had bronze coverage. Wakely trended forward 2022 bronze premiums in Washington's market to estimated 2024 levels (standardized rates for average age 40 ranging from $323 to $377 PMPM by rating area) and determined those rates to be similar to the net Cascade Care silver premiums Group 3 would experience with a waiver after $185 PMPM state subsidy (standardized rates for average age 40 net premiums ranging from $343 to $399 PMPM by rating area).

Additionally, while the average net premium after state subsidy for Groups 2/3 ($312 PMPM) is higher than the Group 1 net premium ($6 PMPM) and higher than those receiving Federal subsidies only ($184 PMPM), it is lower than the remaining individuals who are not eligible for any type of subsidy ($514)[18]. The overall market average net premium is also lower than Groups 2/3 net premium at $207 PMPM. Please see Table 3 below for the details.

[17] https://pubmed.ncbi.nlm.nih.gov/33306118/
[18] The figures are based on 2024 under waiver, with ARP scenario, without family glitch, best estimate enrollment.

Table 3. Summary of Gross Premium, Net Premium, and Subsidy Amounts by Cohort[19]

Cohort	Gross Premium PMPM	Net Premium PMPM	Fed Subsidy PMPM	State Subsidy PMPM
Receiving Only Federal Subsidies	$574	$184	$390	$0
Receiving Only State Subsidies (Group 2/3)	$495	$312	$0	$184
Receiving Federal and State Subsidies (Group 1)	$576	$6	$539	$31
Unsubsidized	$514	$514	$0	$0
Total	**$557**	**$207**	**$334**	**$16**

From there, Wakely applied several adjustments to the allowed costs. First, since distributions by demographics were different between the overall market and off exchange only enrollment, we adjusted to control for age and gender distribution differences between the cohorts to ensure that the average costs are comparable. Secondly, we adjusted the allowed amounts by the difference in spending between unsubsidized enrollees who are legally present and those who are not legally present (line [1]). These estimates rely on the previously cited research finding that individuals without proper documentation spending is approximately 25% lower than among those legally present[20]. Finally, we adjusted the amounts to account for the difference between those currently have coverage and those that take-up coverage (line [2]). While the newly enrolled should be healthier than the existing enrollees, given uncertainty of take-up and resulting morbidity difference, Wakely applied different factors for the cost differences. In particular, we applied a lower cost difference (85%) in the high morbidity/low take-up scenario and low morbidity/high take-up (64%).

The result, as can be seen be below in Table 4, is that in all scenarios the cost of the new waiver population was below the costs of the existing market average. Costs were lower than the market average by anywhere between 10% and 63%.

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[19] The figures are based on 2024 under waiver, with ARP scenario, without family glitch, best estimate enrollment.
[20] https://pubmed.ncbi.nlm.nih.gov/33306118/

Table 4. Allowed cost comparison between Off Exchange enrollment and Wakely Assumed Group 3 Cost

Individual ACA Market (West Region)	Total	Off Exchange Only		
	On and Off Exchange	Total	Healthy (Bronze)	Selected (Silver/ Gold/ Platinum)
Allowed PMPM, [a]	**$417**	$513	$285	$686
Unsubsidized non-citizen (25% lower cost), [1] = [a] Off Exch x 0.75		$385	$214	$514
Unsubsidized non-citizen & uninsured (27% lower cost), [2] = [1] x 0.73		$281	$156	$375
Wakely Assumed Group 3 Morbidity (Best/Low/High), [c]		0.73	0.64	0.85
Wakely Assumed Group 3 Cost PMPM, [3] = $417 x [c]		$304	$267	$354
Difference, [2] / [3] - 1		-8%	-42%	6%
Difference relative to unadjusted market average, [2] / $417 - 1		-33%	-63%	-10%

We recognize the inherent uncertainty present in these utilization and morbidity assumptions. For this reason, Wakely has conducted rigorous sensitivity testing and ran eight different scenarios testing a variety of regulatory and take up conditions, where morbidity was one of the key assumptions that was varied and tested.

It should be noted two key factors were not included in the above calculations. The first is that the waiver population would have lower incomes (FPL) than the average unsubsidized enrollee (whether citizen or undocumented). This should put further downward pressure on allowed cost. Two data point support the consideration that lower income enrollment should put further downward pressure on rates. Wakely's previously described analysis of allowed cost differences of individuals in CSR variants relative to the market average, shows that lower income individuals in the individual market spend less, all things equal. Wakely determined the RAND study as applicable in this consideration because it is the most systematic U.S. study ever conducted on the impact of various factors - including income and medical spending - and its findings were used to validate induced demand factors included in CMS's Actuarial Value Calculator.

Secondly, the estimates do not include the effects of Washington's outreach campaign. If the waiver is approved, the Exchange would put forth a substantial outreach and marketing campaign for those currently uninsured to increase awareness and take-up. Initial community engagement efforts have already begun. Wakely's model projects the morbidity and expected cost of the newly enrolled population based on a price sensitivity elasticity model. In this model, price sensitivity (also referred to as hesitancy) is inversely correlated with morbidity as well as expected cost. However, increased and supported outreach efforts are likely to induce healthier enrollees by reducing price sensitivity. While marketing and outreach is clearly a part of the implementation plan of the waiver, a lack of empirical estimates in the literature of the effect of

marketing on premiums led Wakely to leave marketing effects out of the assumptions, despite its likely improving impact on take-up and premiums. This determination aligns with previous analysis used by CMS in its review of Georgia's Section 1332 waiver application.[21]

Finally, it's important to note that undocumented individuals can already get coverage off-Exchange. Those individuals whose utility calculations find unsubsidized premiums find coverage beneficial would already have coverage. Consequently, the effects of the waiver is the marginal difference from existing premiums to the waiver approved lower premiums. Since the premiums for the undocumented population will be lower should the waiver be approved, the factor used may understate the effects as the marginal enrollee should be healthier than the factor applied (i.e., the thousandth enrollee that takes-up coverage should be healthier than the 0.73 applied given compounding improvements). Given that in all scenarios, even with the exclusion of potential further downward pressures, the conclusions remained unchanged with minor variations in the decrease of the average market premium, this gives us further confidence in the directionality of the results of the waiver analysis and modeling.

Q26. Federal Question: **Has the State considered the possibility for induced demand as well? Specifically, individuals who know they have kidney disease or HIV may already have certain health needs met by existing programs. However, there may be individuals who are unaware that they have an underlying health condition but will receive diagnoses once they have coverage and receive various screenings.**

A26. State Response: Induced demand is typically defined as variation in utilization driven by more favorable cost sharing (e.g., for members with same morbidity, those purchasing platinum plans generally exhibit higher utilization of services due to the lower cost sharing incurred at the point of care, than members purchasing bronze plans). Consequently, there should be no difference in increased utilization for this population than any other newly insured population. It's important to note that existing claims cost difference between uninsured undocumented immigrants and residents with insurance is far greater than the factor employed (Wilson et al). In other words we assumed the claims cost for the waiver population cost that takes up coverage is less than what exists between those that are uninsured without coverage given potential induced demand effects.

What the question may be getting at is the portion of a pent-up demand for individuals without prior coverage (those previously uninsured), that arises as individuals begin interacting with healthcare system and learning about previously unknown health needs. Induced demand was considered in our analysis of pent-up demand generally. As previously discussed, we expect that in this population any pent-up demand would be swamped by countervailing forces due to lower comfort with using the healthcare system and cultural, language, income and other access barriers, which published research[22] indicates would lead the waiver population to underutilize medical services after gaining coverage for the reasons mentioned above. Therefore, any pent-up

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[21] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Waiver-Acumen-Analysis.pdf
[22] https://www.rand.org/pubs/research_reports/RRA1964-1.html

demand utilization would likely result in waiver impacts that were within the range of estimates provided.

Finally, the pent-up demand alluded to in the question (and the morbidity in general) is not unique to the undocumented population that is targeted by this waiver. Pent-up demand and induced demand concerns could also be the case for the reinsurance program if it encourages uninsured to enroll, and only a small subset of the uninsured typically enroll. Those who are enrolling will be composed of some more healthy, some less healthy, and on average the assumption is that they are 27% healthier. There is currently no evidence to suggest that there would be a significant difference when dealing with enrollment of the uninsured undocumented individuals.

Q27. Federal Question: **Follow-up with respect to several questions: How did the State think about the distribution of morbidities within the uninsured undocumented population? Did the State assume that all individuals in the uninsured undocumented population would be 27% less costly than existing enrollees? If not, did the State assume that the distribution of individuals taking up coverage in response to the waiver would mirror the distribution of the uninsured undocumented population in general, and why?**

A27. State Response: Since the waiver modeling was not stochastic in nature, we did not make assumptions about the distribution of Group 3 (undocumented) population morbidity. Rather, the best estimate morbidity value of 0.73 can be thought of as an average expected value of an unknown distribution around (higher and lower) the overall expected value. Deterministic models are well-established and accepted modeling tools used by actuaries in accordance with Actuarial Standards and Practices (ASOP) 56, Modeling.

The best estimate morbidity value of 0.73 applies to the Group 3 enrollees, not the entire uninsured undocumented population. The entire uninsured undocumented population exhibits a far larger morbidity difference. Taffar et al (2012)[23] found that undocumented immigrants spend approximately 60% less than U.S. citizens on health services. Consequently, the difference in expenditures between only the insured U.S. citizens compared to only uninsured undocumented individuals would produce a cost difference for the entire undocumented uninsured population far more significant than 0.73 value applied. Considering the best estimate morbidity value to be similar to an average expected value negates considering distributions of the morbidity in the enrolled population versus the population in general. See Table 5 below for the summary of assumptions by population type discussed and cited above in responses to questions 7 and 8.

Table 5. Summary of Morbidity Estimates by Population

Population	Morbidity Relativity from Literature (Varied in scenarios in application)
Uninsured population	0.64 to 0.85 relative to insured
Uninsured undocumented population	0.40 relative to documented uninsured
Insured undocumented population	0.50 to 0.75 relative to documented insured

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[23] https://pubmed.ncbi.nlm.nih.gov/22222383/

Overall, Wakely relied heavily on the meta-analysis conducted by Flavin et al. The analysis systematically examined all peer reviewed material post-2000 on medical expenditures by the immigrant population. Each key research article was reviewed by Wakely (Wakely did not examine all 188 pieces of literature that the study examined and took into account) and concluded that the undocumented population is in fact healthier than the citizen population. Wakely believes that the thorough review of the literature included in the meta-analysis constituted a key finding in its own right, and given the finding as well as the lack of evidence in peer reviewed literature that the waiver population was healthier than the average population.

We estimated the incoming population to be healthier than individuals that would take up unsubsidized coverage that are currently uninsured. However, we included more conservative assumptions to mirror the uninsured with documentation in the best estimate. Research by Ku (2009)[24] and supported by the meta-analysis[25] estimates that expenditures for insured undocumented immigrants are only half to two-thirds as much of insured U.S. born adults. The Ku study was particularly useful, as it not only provided a thorough analysis of Medical Expenditures Panel Survey (MEPS) data but also conducted analysis attempting to control for differences in coverage status, health status, race, and other factors. Given the size of the dataset and complexity of the analysis, Wakely considered it as its main source for modeling assumptions.

As the ACA enactment has likely reduced this difference, we relied on reasonable sensitivity testing for differences of morbidity in a population. The sensitivity testing around the assumed expected value of the morbidity (varying the morbidity assumption from 0.64 to 0.85) anticipates that the morbidity of those uninsured undocumented who choose to enroll in coverage may have morbidity differences from the uninsured undocumented population in general. The analysis of the off-exchange unsubsidized enrollment presented in the response to Question 6 suggest that the morbidity is not skewed to only one direction (higher or lower than the overall individual market) and has a large share of healthier enrollees. In the higher morbidity scenario, Wakely's assumption appears to be more conservative than suggested by the higher morbidity of the silver/gold/platinum off-exchange market experience, after adjusted for residency and prior coverage status.

Q28. Federal Question: **We were hoping to confirm how Washington imputed the missing income information for PTC-ineligible individual market enrollees (based on Wednesday's call, we understand that this is based on a subset of Census data), as well as whether undocumented enrollees were modeled to look like unsubsidized on-Exchange enrollees or off-Exchange enrollees (the State's latest round of responses seems to provide two different explanations—see the State's responses to Departments' questions 1 and 7).**

A28. State response (10/7/22): The missing income information for PTC-ineligible individual market enrollees (which was about 20% of the total enrollment) was imputed using 2019 ACS data of the individuals with direct purchase of insurance (excluding those 65 and older) by FPL, in combination with WA exchange enrollment data. Using the difference in the distributions by

[24] https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2008.144733
[25] http://www.pnhp.org/docs/ImmigrationStudy_IJHS2018.pdf

FPL between the census data and individual market data (which would include off exchange enrollment and also those on exchange who did not report their income), Wakely estimated that 80% of individuals who did not report income would have incomes over 400% FPL.

The undocumented enrollees were modeled to look like the unsubsidized on-Exchange enrollees, since there is very little information available on off-Exchange enrollees.

Q29. Federal Question: **Did Washington use the 2018 or 2019 ACS to impute income (2018 is cited in the most recent response, but 2019 is cited in the original application)?**

*A29. State Response***:** We apologize for the confusion. Confirming that Wakely relied on 2019 ACS for the purposes of imputing missing income information.

*Q30. Federal Question***: About how many undocumented people does Washington estimate to be enrolled in or to make use of non-MEC coverage programs in a given month (e.g., long-term care, Alien Emergency Medical, Medical Care Services, Kidney Disease, Breast & Cervical Cancer, and HIV/AIDs early prevention)?**

*A30. State Response***:** This information was requested from state-agency partners. Current executive orders and state laws in many cases prevent the capture and/or sharing of information related to immigration status.

An estimated range of the non-citizens currently enrolled in non-MEC state coverage programs, based on program totals/information received to date is: ~3,620 – 4220. In addition to the programs listed above, it also includes individuals in a state family planning program.

*Q31. Federal Question***: About how many people (of any immigration status) are estimated to be enrolled in/covered both by one of the non-MEC coverage programs and by ACA-compliant coverage in a given month?**

*A31. State Response***:** This is not data that the Exchange is able to gather.

*Q32. Federal Question***: Do the lowest-premium Cascade Care silver plans generally have lower premiums than the lowest-premium off-Exchange silver plans? If so, by how much and in which geographies (e.g., rating area, zip code, county)?**

*A32. State Response***:** Please see Table 1 below for the comparison of 2023 final age 21 rates by county, showing the difference between the lowest silver Cascade Care plans and the lowest cost silver on or off exchange plans. In 22 of 39 counties, the lowest cost silver Cascade Care plans are the same price as the lowest cost silver on or off exchange plans.

Table 1 – Age 21 2023 Final WA Rate comparison for Cascade Care Silver vs. Any Lowest Silver On- or Off-Exchange

County name	Rating Area	Lowest Cost Silver Cascade Care (CC), [1]	Lowest Cost Silver on Exchange, [2]	Lowest Cost Silver (LCS) On or Off Exchange, [3]	% Diff CC / LCS, [1] / [3] - 1
King	Rating Area 1	279.79	279.79	266.51	5%
Lewis	Rating Area 2	293.75	293.75	293.75	0%
Pacific	Rating Area 2	293.75	293.75	293.75	0%
Wahkiakum	Rating Area 2	293.75	293.75	293.75	0%
Jefferson	Rating Area 2	317.45	301.12	301.12	5%
Kitsap	Rating Area 2	317.45	301.12	301.12	5%
Cowlitz	Rating Area 2	353.76	353.76	327.97	8%
Clallam	Rating Area 2	372.42	372.42	372.42	0%
Grays Harbor	Rating Area 2	436.49	436.49	378.47	15%
Klickitat	Rating Area 3	276.79	276.79	276.79	0%
Skamania	Rating Area 3	276.79	276.79	276.79	0%
Clark	Rating Area 3	349.07	349.07	312.35	12%
Spokane	Rating Area 4	276.79	276.79	276.79	0%
Stevens	Rating Area 4	276.79	276.79	276.79	0%
Ferry	Rating Area 4	298.08	283.74	283.74	5%
Lincoln	Rating Area 4	299.13	283.74	283.74	5%
Pend Oreille	Rating Area 4	299.13	283.74	283.74	5%
Thurston	Rating Area 5	299.29	299.29	299.29	0%
Mason	Rating Area 5	305.73	305.73	305.73	0%
Pierce	Rating Area 5	305.73	305.73	302.75	1%
Benton	Rating Area 6	281.97	281.97	281.97	0%
Franklin	Rating Area 6	281.97	281.97	281.97	0%
Kittitas	Rating Area 6	298.08	289.05	289.05	3%
Yakima	Rating Area 6	298.08	289.05	289.05	3%
Chelan	Rating Area 7	324.48	324.48	324.48	0%
Douglas	Rating Area 7	324.48	324.48	324.48	0%
Grant	Rating Area 7	324.48	324.48	324.48	0%
Okanogan	Rating Area 7	324.48	324.48	324.48	0%
Adams	Rating Area 7	338.69	338.69	338.69	0%
Snohomish	Rating Area 8	282.53	282.53	282.53	0%
Island	Rating Area 8	345.65	345.65	314.10	10%
San Juan	Rating Area 8	345.65	345.65	345.65	0%
Skagit	Rating Area 8	345.65	345.65	314.10	10%
Whatcom	Rating Area 8	345.65	345.65	314.10	10%
Walla Walla	Rating Area 9	290.22	290.22	290.22	0%

County name	Rating Area	Lowest Cost Silver Cascade Care (CC), [1]	Lowest Cost Silver on Exchange, [2]	Lowest Cost Silver (LCS) On or Off Exchange, [3]	% Diff CC / LCS, [1] / [3] - 1
Whitman	Rating Area 9	290.22	290.22	290.22	0%
Asotin	Rating Area 9	290.53	290.53	290.53	0%
Columbia	Rating Area 9	313.98	297.82	297.82	5%
Garfield	Rating Area 9	313.98	297.82	297.82	5%

Q33. Federal Question: **Washington has suggested that some undocumented individuals with incomes above 250% of FPL would be expected to take up coverage in response to the waiver. Could the State please confirm if that's the case (for example, Table 14 in the latest actuarial analysis submission does not seem to reflect this)?**

A33. State Response: For modeling purposes, Wakely assumed that very few individuals without federally recognized status and with incomes above 250% FPL would be taking up coverage, given that these individuals would receive no benefit from the state subsidy program. Currently, these individuals have the opportunity to buy unsubsidized coverage off-Exchange. Given the change for this population under the waiver is only based on how convenient it is to enroll, Wakely expects the impact to be minimal. Additionally, people who are sicker will enroll regardless of convenience, therefore those with the most utility for (and utilization of) health coverage are presumed to already be in the individual market risk mix. Those who may enroll under the waiver with an income over 250% FPL, given more convenience and targeted outreach to the undocumented population, are expected to have a lower morbidity than the overall current market. Thus, had Wakely attempted to quantify the impact of this group, the effect would have been to further reduce premiums and increase pass-through.

Q34. Federal Question: **Any information that the State could share, to the extent it's available, on monthly expenditures (e.g., allowed amounts, total claims, or whatever might be available) among those who are unsubsidized and very low-income (on- or off-Exchange) would be helpful.**

A34. State Response: The Exchange does not have claims data analysis based on subsidy status or for enrollees off-Exchange. But we do have data for all Exchange enrollees, regardless of subsidy status, by income level. The most recent data available from WA's all payor claims database, from 2017 and 2018, is provided in the chart below:

Total Exchange Enrollee Expenditures	HIGH ≥$6,000	MEDIUM <$6,000, ≥$1,500	LOW <$1,500, >$0	NO CLAIMS $0	OVERALL
PY 2017					
Number of Enrollees	16,665	30,638	75,655	45,577	168,535

Subsidized	60%	59%	57%	60%	59%
FPL					
<139%	5%	11%	43%	41%	100%
139-150%	11%	18%	42%	28%	100%
151-200%	11%	18%	43%	29%	100%
201-250%	10%	18%	44%	28%	100%
251-400%	10%	19%	46%	25%	100%
401-600%	9%	19%	47%	25%	100%
>600%	10%	20%	46%	25%	100%
Did not report	10%	19%	47%	23%	100%
PY 2018					
Number of Enrollees	18,015	29,638	90,499	50,309	188,461
Subsidized	57%	57%	57%	61%	58%
FPL					
<139%	5%	10%	45%	39%	100%
139-150%	11%	17%	44%	28%	100%
151-200%	10%	16%	45%	29%	100%
201-250%	9%	15%	48%	28%	100%
251-400%	9%	15%	50%	26%	100%
401-600%	8%	14%	52%	26%	100%
>600%	10%	16%	51%	23%	100%
Did not report	11%	18%	49%	23%	100%

One takeaway from this utilization data is a focus on the outlier data for the <139% FPL population. Given Washington's extensive Medicaid programming, the <139% FPL population is primarily made up of persons that are ineligible for Medicaid due immigration status (5-year-bar population). Washington considers this population to be a close approximation for the undocumented population.

Additionally, given that this data is from 2017 and 2018, it represents an environment where persons over 400% FPL are not subsidized. Despite this, there is not a difference in utilization pattern at the 400% subsidy cliff. This further supports Washington's analysis regarding the morbidity/utilization estimates of the waiver population.

Q35. Federal Question: **Please address the Departments' concerns about projected new take-up under the waiver.**

*A35. State Response***:** This document responds to concerns raised on and before September 21, 2022 by the Departments' staff about projections of uptake among undocumented individuals in Washington's Section 1332 waiver application. Wakely's actuarial analysis for Washington to date estimates that about 2,500 undocumented individuals will newly enroll in 2024, if the waiver is approved. This is a large enough group that it includes a relatively broad distribution of health statuses. Given the lower utilization by undocumented individuals relative to similarly

situated citizens, Wakely estimates that the average expected cost of the new enrollees would be about 0.73 of the average cost of current enrollees.

The Departments expressed skepticism that so many people would indeed newly enroll given that they would face an average net premium price of about $300 per month. Under the Departments' reasoning, individuals who will find it worthwhile to enroll at this price point will be primarily those expecting very high utilization. Since very few undocumented individuals expect utilization that high, they posit uptake far lower than Wakely projects.

We believe that this reasoning is inconsistent with empirical evidence from Washington. Specifically, the best available evidence suggests that large numbers of low-income Washingtonians will make the decision to purchase coverage at a similar price point.

As described in the 1332 waiver application, Washington will be providing state-based premium assistance (Cascade Care Savings) to three groups – Group 1 are those currently eligible for PTC, Group 2 are those currently eligible to purchase QHP but not eligible for PTC, and Group 3 are those that would gain the ability to purchase QHP due to the waiver but would continue to be ineligible for PTC. Group 2 is currently a known population to the Washington Exchange, and those Group 2 enrollees that are under 250% FPL are most analogous to the Group 3 population whose enrollment is projected for the purposes of the 1332 waiver application.

Group 2 currently consists of persons subject to the family glitch, persons that are eligible for other minimum essential coverage, and those that do not meet APTC program rules (e.g., do not provide FTI consent, do not intend to file taxes, married and do not intend to file jointly).

For the past 4 years, the number of non-federally subsidized enrollees at/below 250% FPL has consistently been substantial, both in absolute terms and as a fraction of total non-subsidized enrollees. These non-federally subsidized enrollees at or below 250% FPL are paying on average $370-$425 for their monthly health insurance premiums—a larger amount than Group three enrollees would pay under the waiver. As under the waiver, the low-income consumers are facing a premium that some might consider unaffordable – yet they make the decision to enroll.

	2019	2020	2021	2022
Total Non-Subsidized QHP Enrollees	67,498	70,053	53,712	50,295
Total Non-Subsidized QHP Enrollees at/below 250% FPL	4,748	4,568	3,093	2,743
Average Net Premium Non-Subsidized QHP Enrollees at/below 250% FPL	$375	$391	$373	$423

Data as of post-enrollment (March) each year

With regard to Wakely's projected take-up rate of undocumented uninsured residents at or below 250% FPL of less than 4%, current data are not sufficient to produce a "take-up rate" among unsubsidized individuals, because we do not know how many otherwise-uninsured QHP-eligible Washington residents below 250% of FPL are subsidy-ineligible. But that number must be quite

small, especially with ARP subsidy enhancements in place. A rough approximation may be helpful. In 2019, there were an estimated 100,000 uninsured citizens and lawfully present individuals between 138% and 250% of FPL. Even if 40,000 were APTC-ineligible (which seems unrealistically high), this would mean a take-up rate of approximately 12% -- far higher than the 4% Wakely assumes at a similar income and price point. In short, low-income Washingtonians seem to value health insurance enough that large numbers of them will enroll even if they face a premium that seems large relative to their income. This evidence seems inconsistent with the Departments' suggestion that only small numbers of the sickest individuals are likely to enroll under the waiver.

There are several reasons that this non-subsidized group at or below 250% FPL (and by extension the projected waiver population) would take up coverage. Specifically, as CBO has noted, changes in social norms[26] and ease of enrollment through effective eligibility and enrollment portals are key drivers. These drivers are applicable in Washington with both higher insurance rates than the national average (driving social uptake of insurance) and a successful and easy to navigate enrollment portal (*Washington Healthplanfinder)* that will be used for waiver population enrollment. As such, Washington will use the same models for enrollment when determining eligibility for the waiver population[27], which should also put upward pressure on the probability of take-up, especially among the relatively healthier.

In addition, in the event of an approved waiver, the Exchange has prepared an extensive public outreach campaign, targeted at the waiver population. This should increase awareness of coverage options and has the potential to improve attitudes towards coverage, which again should serve to increase the probability of take-up of coverage, especially among healthier individuals.[28,29] In addition to our typical, robust outreach efforts, we expect an additional annual budget of approximately $700,000 solely for waiver specific efforts. The waiver specific outreach and marketing campaign should have a positive impact on enrollment, including among undocumented immigrants above 250% FPL. Note that individuals above 250% FPL were not included in the modeling, nor was the positive impact on enrollment due to increased outreach and marketing, given uncertainty as to the point estimate effect. The enrollment impact of Washington's outreach and marketing campaign is expected to be proportional to other campaigns undertaken in the subsidized health insurance market, as measured by Goldin, Lurie, and McCubbin (2019).[30] The study is comparable to Washington's implementation efforts, as it considers a specific outreach treatment to eligible but uninsured persons, that resulted in a 1.3% increase in enrollment. While the expected enrollment impacts have been measured, Washington did not include that impact in its modeling, choosing instead to take a conservative approach. Other analyses of waiver impacts have included the effects of outreach and marketing in their modeling. For example, in its modeling on Georgia's 1332 waiver, Acumen considered the Aizawa & Kim study and assumed a parameter of approximately 0.05 impact for state spending

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[26] Modeling the Effects of the Individual Mandate on Health Insurance Coverage (cbo.gov)
[27] HISIM2: The Health Insurance Simulation Model Used in Preparing CBO's July 2021 Baseline Budget Projections
[28] *Ibid.*
[29] Public and Private Provision of Information in Market-Based Public Programs: Evidence from Advertising in Health Insurance Marketplaces (nber.org)
[30] Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach (nber.org)

on advertising.[31] Consequently, due to the conservative nature of the modeling, one should expect enrollment benefits of the waiver to not only be direct for those below 250% FPL receiving state subsidies (as modeled in the waiver application) but also across the income spectrum due to indirect effects of outreach and marketing.

There could also be other reasons that low-income Washington residents assign a higher value to being insured than standard utility models would suggest. What matters is that, for whatever reason, the best evidence is that they do indeed value insurance in this way.

Washington also looked for any available information about utilization among the non-subsidized enrollees at or below 250% FPL. While the non-subsidized at or below 250% FPL is not broken out in the data, overall utilization by income group is available. It should be noted that the latest data available is from 2018, and therefore represents enrollment in plans with appreciably higher net premiums than currently available due to enhanced subsidies. For plan years 2017 and 2018, utilization patterns do not change given FPL, other than a significant number of non-utilizers at the <139% FPL level.

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[31] 20220426_GA_1332_Waiver_Report_Acumen_STLDI_v2_CCIIO (cms.gov)

Total Exchange Enrollee Expenditures	HIGH ≥$6,000	MEDIUM <$6,000, ≥$1,500	LOW <$1,500, >$0	NO CLAIMS $0	OVERALL
PY 2017					
Number of Enrollees	16,665	30,638	75,655	45,577	168,535
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151-200%	11%	18%	43%	29%	100%
201-250%	10%	18%	44%	28%	100%
251-400%	10%	19%	46%	25%	100%
401-600%	9%	19%	47%	25%	100%
>600%	10%	20%	46%	25%	100%
Did not report	10%	19%	47%	23%	100%
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Number of Enrollees	18,015	29,638	90,499	50,309	188,461
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<139%	5%	10%	45%	39%	100%
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151-200%	10%	16%	45%	29%	100%
201-250%	9%	15%	48%	28%	100%
251-400%	9%	15%	50%	26%	100%
401-600%	8%	14%	52%	26%	100%
>600%	10%	16%	51%	23%	100%
Did not report	11%	18%	49%	23%	100%

One takeaway from this utilization data is a focus on the outlier data for the <139% FPL population. Given Washington's extensive Medicaid programming, the <139% FPL population is primarily made up of persons that are ineligible for Medicaid due immigration status (5-year-bar population). This population is likely to be a close approximation for the undocumented population. This population has significantly fewer high-utilizers, and significantly more none-utilizers, which aligns with the assumptions made in the model for the morbidity of waiver enrollees and aligns with the research on immigrant populations (both documented and undocumented).

PY 2017 Total Exchange Enrollee Expenditures by FPL
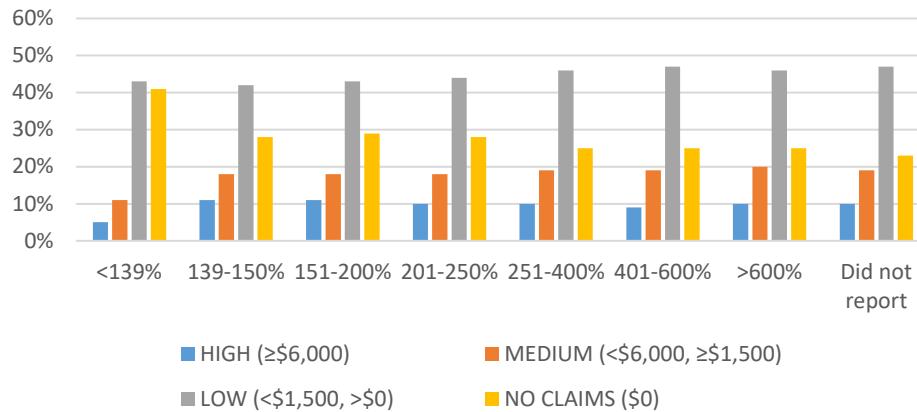
PY 2018 Total Exchange Enrollee Expenditures by FPL
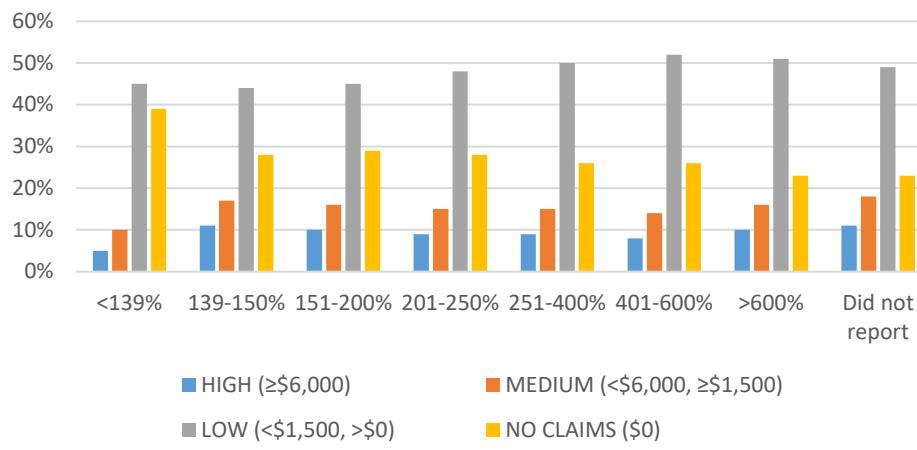
Additionally, given that this data is from 2017 and 2018, it represents an environment where persons over 400% FPL are not subsidized. Despite this, utilization does not increase (indeed it slightly decreases) when crossing the 400% income threshold. Under the Departments' hypothesis that those who purchase full-cost health coverage are higher utilizers than the average enrollee, we would expect to see utilization increase at this subsidy cliff. But that is not reflected in Washington's data, which shows consistent utilization (or lack thereof) among all income groups above 139% FPL. This further supports Washington's analysis regarding the morbidity and utilization estimates for the waiver population.

We have no reason to expect a different trend among undocumented individuals. Therefore, new enrollees under the waiver are likely to have similar utilization to other undocumented immigrants. As discussed in earlier communications, research suggests undocumented immigrants as a group have substantially lower utilization than citizens, holding insurance status

and other characteristics constant. As such, Wakely made conservative assumptions about the utilization by new enrollees under the waiver, assuming 27% less than current enrollees.

Q36. Federal Question (9/9/22): **Given the change in federal law with the Inflation Reduction Act, we wanted to request an updated analysis that reflects the impact of the IRA on the baseline and with waiver to inform decision-making on the waiver. More specifically, we are requesting an update to Table 10 in the actuarial analysis. The analysis should reflect current law but the state would be welcome to provide any additional sensitivities they think useful, such as the family glitch.**

A36. State Response (10/10/22): Attached is an updated 10-year table (includes comparison to prior projections) that takes the IRA/extended federal premium subsidies into account. Below is the written summary of the updates.

Updated 10-year projections:

Wakely has updated the 10-year baseline and waiver projections based on the recent passage of the Inflation Reduction Act (IRA) which extends expanded premium subsidies by American Rescue Plan Act (ARPA) through 2025. The main changes between the prior 10-year projections and these new estimates are centered on the 2024 and 2025 projection years, in which ARPA-level subsidies stay in place. As a result of the IRA, the market enrollment and APTC subsidy amounts are higher than the previous estimates, since previously ARPA subsidies would have expired at the end of 2022. For enrollment impacts in 2024 and 2025: the IRA results in 1) a higher baseline market enrollment and 2) a slightly higher waiver population enrollment. The result of these two changes is that there is less of an impact of the waiver on the overall risk pool morbidity than in prior estimates. Beyond enrollment changes, the amount of APTCs is higher in baseline with expanded subsidies in place. The combination of the lower waiver morbidity impact and greater APTC amounts results in a slight increase ($0.53-$0.56 million) in the passthrough amounts in 2024 and 2025, relative to no ARP 10-year projections. Overall, the waiver still meets all guardrails in each year of the 10-year estimates.

Additionally, since the submission of the waiver application, new Washington market specific information has become available. Wakely analyzed the impact of the emerging enrollment trends in 2022, 2023 final approved premiums, and the estimated impact of the end of the public health emergency on the individual market risk pool. In addition, Wakely also included refinements in the methodology in analyzing the program's effect, such as updating the reference premium for the take-up calculations by the uninsured/off/undocumented individuals to use the lowest silver rate in the county on or off exchange for the PTC-ineligible, and the lowest silver rate in the county on exchange for the PTC-eligible uninsured. Inclusion of this new information and methodology changes resulted in lower state subsidy amounts for Group 1 with lower take up as a result (e.g., lower enrollment in the baseline). However, the changes had a much smaller impact on the waiver population's take up (Group 3 take up was lower by 200 members in 2024). The results were driven by higher gross premium increases in 2023 than originally anticipated, combined with lower increases for the second lowest cost silver benchmark plans by county.

Family Glitch Fix - Impact on Waiver

On April 5, 2022, the Treasury Department and the Internal Revenue Service (IRS) released a notice of proposed rulemaking that would change eligibility for Advanced Premium Tax Credits (APTCs). The so-called "Family Glitch" precludes APTC eligibility for an entire family that is offered employer-sponsored coverage if the cost for the employee's self-only coverage is deemed affordable, even if the family coverage is not affordable. The proposed rule would extend access to APTCs if the family coverage is unaffordable. This change, if finalized, will cause some shifts in enrollment. Wakely previously modeled the impact of the Family Glitch regulation if finalized as proposed and effective in 2024, with ARP continuing and discontinuing. Based on that analysis, the overall impact of the Family Glitch regulation on the waiver projections was minimal, with up to a 1.6% increase in the Federally subsidized enrollment in the baseline (before waiver) and after waiver, with the increase in enrollment coming from those already enrolled in Group 2 and the uninsured. Overall, there was no material changes on the waiver's impact on enrollment, affordability (e.g., average state subsidy utilization, the average final net premiums), or the federal deficit (e.g., estimated pass-through). As a result, if the estimate incorporated the Family Glitch fix, we expect similar impacts to what is included in the 10-year waiver estimates and for all the guardrails to be met, consistent with the original waiver.

I. Updated 10-year projection tables
Table 2 - Enrollment Estimates 2024-2033 with Waiver

	2024	**2025**	**2026**	**2027**	**2028**
Baseline	(ARPA)	(ARPA)			
Total Individual Enrollment	259,300	261,300	242,800	246,100	249,700
Total Exchange Enrollment	234,800	238,500	221,100	225,800	230,800
APTC Enrollment	169,600	171,400	136,800	139,700	142,800
APTC and State Subsidy Enrollment	88,000	89,300	68,700	68,900	70,200
State Subsidy Only Enrollment	3,900	3,900	3,600	3,600	3,500
Not Eligible for Subsidies	61,300	63,100	80,700	82,500	84,400
Off-Exchange Enrollment	24,500	22,800	21,700	20,300	18,900
After Waiver					
Total Individual Enrollment	261,800	264,000	245,900	249,300	253,100
Total Exchange Enrollment	237,300	241,200	224,200	229,000	234,200
APTC Enrollment	169,600	171,400	136,800	139,700	142,800
APTC and State Subsidy Enrollment	88,000	89,300	68,700	68,900	70,200
State Subsidy Only Enrollment	6,400	6,700	6,800	6,900	6,900
Not Eligible for Subsidies	61,300	63,100	80,700	82,500	84,400
Off-Exchange Enrollment	24,500	22,800	21,700	20,300	18,900
Percent Change in Total Enrollment	1.0%	1.0%	1.3%	1.3%	1.4%

	2029	2030	2031	2032	2033
Baseline					
Total Individual Enrollment	253,500	257,500	261,400	265,500	269,200
Total Exchange Enrollment	235,800	240,900	245,900	251,000	255,700
APTC Enrollment	146,000	149,100	152,300	155,300	158,000
APTC and State Subsidy Enrollment	71,500	72,700	73,800	74,800	74,400
State Subsidy Only Enrollment	3,500	3,400	3,400	3,400	3,400
Not Eligible for Subsidies	86,300	88,300	90,300	92,300	94,400
Off-Exchange Enrollment	17,700	16,600	15,500	14,500	13,500
After Waiver					
Total Individual Enrollment	257,000	261,000	265,000	269,200	273,000
Total Exchange Enrollment	239,300	244,400	249,500	254,700	259,500
APTC Enrollment	146,000	149,100	152,200	155,300	158,000
APTC and State Subsidy Enrollment	71,500	72,700	73,800	74,800	74,400
State Subsidy Only Enrollment	6,900	6,900	7,000	7,100	7,200
Not Eligible for Subsidies	86,300	88,300	90,300	92,300	94,400
Off-Exchange Enrollment	17,700	16,600	15,500	14,500	13,500
Percent Change in Total Enrollment	1.4%	1.4%	1.4%	1.4%	1.4%

Table 3 - Effect of Waiver Relative to Baseline on Federal Savings

Year	Federal APTC Savings ($M)	Federal PTC Savings ($M)
2024	$2.36	$2.28
2025	$2.68	$2.59
2026	$2.43	$2.22
2027	$2.62	$2.40
2028	$2.80	$2.56
2029	$2.95	$2.70
2030	$3.09	$2.82
2031	$3.37	$3.08
2032	$3.35	$3.06
2033	$3.68	$3.36

Table 5 - Effect of Waiver Relative to Baseline on Premiums

Year	Change in Premiums
2024	-0.2%
2025	-0.3%
2026	-0.3%
2027	-0.3%
2028	-0.3%
2029	-0.3%
2030	-0.3%
2031	-0.4%
2032	-0.4%
2033	-0.4%

Table 6 - Effect of Waiver Relative to Baseline on Enrollment

Year	Change in Enrollment
2024	1.0%
2025	1.0%
2026	1.3%
2027	1.3%
2028	1.4%
2029	1.4%
2030	1.4%
2031	1.4%
2032	1.4%
2033	1.4%

Table 7 - Effect of Waiver Relative to Baseline on Federal Savings

Year	Federal PTC Savings ($M)
2024	$2.28
2025	$2.59
2026	$2.22
2027	$2.40
2028	$2.56
2029	$2.70
2030	$2.82
2031	$3.08
2032	$3.06
2033	$3.36

II. Prior 10-year projections

Table 2 - Enrollment Estimates 2024-2033 with Waiver

	2024	2025	2026	2027	2028
Baseline					
Total Individual Enrollment	237,900	239,200	242,800	246,100	249,700
Total Exchange Enrollment	213,000	216,000	221,100	225,800	230,800
APTC Enrollment	132,200	133,400	136,800	139,700	142,800
APTC and State Subsidy Enrollment	66,300	67,100	68,700	68,900	70,200
State Subsidy Only Enrollment	3,600	3,700	3,600	3,600	3,500
Not Eligible for Subsidies	77,200	78,900	80,700	82,500	84,400
Off-Exchange Enrollment	24,900	23,200	21,700	20,300	18,900
After Waiver					
Total Individual Enrollment	240,500	242,200	245,900	249,300	253,100
Total Exchange Enrollment	215,600	219,000	224,200	229,000	234,200
APTC Enrollment	132,200	133,500	136,700	139,600	142,900
APTC and State Subsidy Enrollment	66,300	67,100	68,700	68,900	70,200
State Subsidy Only Enrollment	6,200	6,600	6,800	6,900	6,900
Not Eligible for Subsidies	77,200	78,900	80,700	82,500	84,400
Off-Exchange Enrollment	24,900	23,200	21,700	20,300	18,900
Percent Change in Total Enrollment	1.1%	1.3%	1.3%	1.3%	1.4%
	2029	**2030**	**2031**	**2032**	**2033**
Baseline					
Total Individual Enrollment	253,500	257,500	261,400	265,500	269,200
Total Exchange Enrollment	235,800	240,900	245,900	251,000	255,700
APTC Enrollment	146,000	149,100	152,300	155,300	158,000
APTC and State Subsidy Enrollment	71,500	72,700	73,800	74,800	74,400
State Subsidy Only Enrollment	3,500	3,400	3,400	3,400	3,400
Not Eligible for Subsidies	86,300	88,300	90,300	92,300	94,400
Off-Exchange Enrollment	17,700	16,600	15,500	14,500	13,500
After Waiver					
Total Individual Enrollment	257,000	261,000	265,000	269,200	273,000
Total Exchange Enrollment	239,300	244,400	249,500	254,700	259,500
APTC Enrollment	146,000	149,100	152,200	155,300	158,000

APTC and State Subsidy Enrollment	71,500	72,700	73,800	74,800	74,400
State Subsidy Only Enrollment	6,900	6,900	7,000	7,100	7,200
Not Eligible for Subsidies	86,300	88,300	90,300	92,300	94,400
Off-Exchange Enrollment	17,700	16,600	15,500	14,500	13,500
Percent Change in Total Enrollment	1.4%	1.4%	1.4%	1.4%	1.4%

Table 3 - Effect of Waiver Relative to Baseline on Federal Savings

Year	Federal APTC Savings ($M)	Federal PTC Savings ($M)
2024	$1.92	$1.75
2025	$2.22	$2.03
2026	$2.43	$2.22
2027	$2.62	$2.40
2028	$2.80	$2.56
2029	$2.95	$2.70
2030	$3.09	$2.82
2031	$3.37	$3.08
2032	$3.57	$3.26
2033	$3.68	$3.36

Table 5 - Effect of Waiver Relative to Baseline on Premiums

Year	Change in Premiums
2024	-0.3%
2025	-0.3%
2026	-0.3%
2027	-0.3%
2028	-0.3%
2029	-0.3%
2030	-0.3%
2031	-0.4%
2032	-0.4%
2033	-0.4%

Table 6 - Effect of Waiver Relative to Baseline on Enrollment

Year	Change in Enrollment
2024	1.1%
2025	1.3%
2026	1.3%
2027	1.3%
2028	1.4%
2029	1.4%
2030	1.4%
2031	1.4%
2032	1.4%
2033	1.4%

Table 7 - Effect of Waiver Relative to Baseline on Federal Savings

Year	Federal PTC Savings ($M)
2024	$1.75
2025	$2.03
2026	$2.22
2027	$2.40
2028	$2.56
2029	$2.70
2030	$2.82
2031	$3.08
2032	$3.26
2033	$3.36

III. Comparison of updated vs. prior projections

Table 2 - Enrollment Estimates 2024-2033 with Waiver

	2024	2025	2026	2027	2028
Baseline	(ARPA)	(ARPA)			
Total Individual Enrollment	21,400	22,100	0	0	0
Total Exchange Enrollment	21,800	22,500	0	0	0
APTC Enrollment	37,400	38,000	0	0	0
APTC and State Subsidy Enrollment	21,700	22,200	0	0	0
State Subsidy Only Enrollment	300	200	0	0	0
Not Eligible for Subsidies	-15,900	-15,800	0	0	0
Off-Exchange Enrollment	-400	-400	0	0	0
After Waiver					
Total Individual Enrollment	21,300	21,800	0	0	0
Total Exchange Enrollment	21,700	22,200	0	0	0
APTC Enrollment	37,400	37,900	100	100	-100
APTC and State Subsidy Enrollment	21,700	22,200	0	0	0
State Subsidy Only Enrollment	200	100	0	0	0
Not Eligible for Subsidies	-15,900	-15,800	0	0	0
Off-Exchange Enrollment	-400	-400	0	0	0
Percent Change in Total Enrollment	-0.1%	-0.3%	0.0%	0.0%	0.0%
	2029	**2030**	**2031**	**2032**	**2033**
Baseline					
Total Individual Enrollment	0	0	0	0	0
Total Exchange Enrollment	0	0	0	0	0
APTC Enrollment	0	0	0	0	0
APTC and State Subsidy Enrollment	0	0	0	0	0
State Subsidy Only Enrollment	0	0	0	0	0
Not Eligible for Subsidies	0	0	0	0	0
Off-Exchange Enrollment	0	0	0	0	0
After Waiver					
Total Individual Enrollment	0	0	0	0	0
Total Exchange Enrollment	0	0	0	0	0
APTC Enrollment	0	0	0	0	0

APTC and State Subsidy Enrollment	0	0	0	0	0
State Subsidy Only Enrollment	0	0	0	0	0
Not Eligible for Subsidies	0	0	0	0	0
Off-Exchange Enrollment	0	0	0	0	0
Percent Change in Total Enrollment	0.0%	0.0%	0.0%	0.0%	0.0%

Table 3 - Effect of Waiver Relative to Baseline on Federal Savings

Year	Federal APTC Savings ($M)	Federal PTC Savings ($M)
2024	$0.44	$0.53
2025	$0.46	$0.56
2026	$0.00	$0.00
2027	$0.00	($0.00)
2028	($0.00)	($0.00)
2029	$0.00	($0.00)
2030	($0.00)	($0.00)
2031	$0.00	($0.00)
2032	($0.22)	($0.20)
2033	($0.00)	($0.00)

Table 5 - Effect of Waiver Relative to Baseline on Premiums

Year	Change in Premiums
2024	0.1%
2025	0.0%
2026	0.0%
2027	0.0%
2028	0.0%
2029	0.0%
2030	0.0%
2031	0.0%
2032	0.0%
2033	0.0%

Table 6 - Effect of Waiver Relative to Baseline on Enrollment

Year	Change in Enrollment
2024	-0.1%
2025	-0.3%
2026	0.0%
2027	0.0%
2028	0.0%
2029	0.0%
2030	0.0%
2031	0.0%
2032	0.0%
2033	0.0%

Table 7 - Effect of Waiver Relative to Baseline on Federal Savings

Year	Federal PTC Savings ($M)
2024	$0.53
2025	$0.56
2026	$0.00
2027	($0.00)
2028	($0.00)
2029	($0.00)
2030	($0.00)
2031	($0.00)
2032	($0.20)
2033	($0.00)