wakely.com

Washington Health Benefits Exchange

Analysis of Options for a State Health Insurance Mandate

December 15, 2020

Prepared by:
Wakely Consulting Group, LLC

Brittney Phillips, ASA, MAAA
Consulting Actuary

Julie Peper, FSA, MAAA
Principal

Michael Cohen, PhD
Senior Consultant, Policy Analytics

Table of Contents

Introduction

The Washington Health Benefits Exchange (WAHBE or Exchange) retained Wakely Consulting Group, LLC (Wakely) to analyze the impact of a potential state individual health insurance mandate. Wakely considered the effects of a mandate on individual market enrollment, individual market premiums, the uninsured rate, and state revenue. Three different mandate options with varying levels of enforcement were considered in the analysis. Wakely was also asked to include background on other states that have implemented individual mandates. Finally, operational or other considerations that Washington should consider are discussed.

This report is organized as follows:

- The executive summary discusses the potential types of state mandates analyzed and the impact of each on enrollment. The potential revenue and key considerations are also discussed.
- The main body of the report includes a background on the individual mandate, findings for each of the key scenarios, and key considerations.
- The appendices include the detailed methodology and assumptions used in the analysis.

The analysis assumes a 2022 implementation year.[1] **Consequently, these estimates should be viewed as the long-term impacts of a state mandate if a steady-state environment occurred in 2022. Given current operational limitations, Wakely believes that the effects and revenues are likely an over-estimate for the initial years of operation.**

The results presented include scenarios that highlight a range of possible overall and population-specific outcomes; however, there is uncertainty around the results. The impact of COVID-19 has been modeled but could vary significantly from estimates shown here. There is also limited information available on the impact of current state mandates currently operated by other state-based marketplaces.[2] State level mandates are often combined with other market stabilization initiatives (such as state based subsidies or reinsurance), so it can be difficult to isolate their effect. Finally, while the impacts of a Supreme Court ruling that eliminates the federal mandate are discussed, all of these estimates assume that there are no changes to the current federal

[1] This implementation year aligns with the previously conducted state premium subsidy implementation plan analysis, and assumes no operational impediments to implementing a state level mandate. This analysis assumes, for example, that the coverage and demographic data needed for the Exchange to conduct outreach to and determine eligibility for available exemptions would be fully available. Further discussion among impacted state agency partners would be needed to confirm Implementation details and timing.

[2] Six state-based marketplaces that have enacted a state level mandate: CA (2020), MA (2006), NJ (2019), Rhode Island (2020), Vermont (2020), and the District of Columbia (2019).

requirement to have minimum essential coverage, with zero penalty. Additional caveats are listed in Appendix D.

This document has been prepared for the sole use of WAHBE. It is our understanding that it will be provided to the legislature by December 15, 2020. Using the information in this report for other purposes may not be appropriate. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements.

Executive Summary

The Washington State Legislature directed the Exchange to analyze the impact of a potential state mandate on revenue, individual market enrollment, individual market premiums, and the number of uninsured.[3] In order to calculate the market impacts of implementing a state mandate, Wakely developed a baseline database to estimate the environment in 2022, including the on and off-Exchange enrollment in the individual market and the uninsured landscape. The table below shows a summary of the baseline individual market in 2022, prior to the implementation of any state mandate program.[4]

Table 1: Baseline Individual Market and Uninsured – Best Estimate

Baseline Average Enrollment	2019 Actuals	2020 Estimate	2022 Estimate
On Exchange - Subsidized	120,500	113,400	129,300
On Exchange - Unsubsidized	71,300	73,500	80,000
Off Exchange	37,900	29,100	27,600
Total	**229,700**	**215,900**	**236,900**
On-Exchange Only - % Subsidized	62.8%	60.7%	61.8%
Number of Uninsured			456,600

The best estimate baseline, displayed above, uses our most likely set of assumptions related to enrollment and premium changes in the individual market between 2020 and 2022, including changes in the Washington uninsured market and the impact of COVID-19. In addition to a best estimate of 2022 baseline enrollment, Wakely also conducted scenario testing with different baseline scenarios, given uncertainty based on current market conditions. The low and high baseline estimates provide a range of estimates, with the individual market enrollment ranging from 187,000 to 280,400 and the uninsured from 442,200 to 473,400. However, it is possible for

[3] ESSB 6168 (Section 214(10)) available at: https://app.leg.wa.gov/billsummary?BillNumber=6168&Initiative=false&Year=2019

[4] Please note that the baseline assumes no major policy change relative to the legal status quo that exists when this report was submitted.

actual results to fall outside these ranges. The range of uninsured take-up and mandate penalty revenue can vary significantly based on reasonable changes in the baseline assumptions. For further details please see Appendix B.

State Mandate Options

Wakely modeled the impact of a potential state mandate on Washington's individual market and uninsured populations. The state identified three mandate options to consider:

- **Strong Mandate (Mandate with Penalty and Enforcement):** For this option, Wakely analyzed a mandate in which the state of Washington is able to successfully implement a mandate and taxpayer penalty similar to the Federal mandate before the penalty was reduced to zero in 2019. In particular, Wakely used the 2018 mandate structure[5] as the closest approximation for a steady-state implementation of a state mandate. This option implies that an apparatus exists to track coverage status, implement exemptions based on income, and enforce a penalty. Every state that has enacted a state level mandate with a penalty uses their income tax structure to implement the mandate. This model assumes Washington has enacted a state income tax. Of all the options presented, the financial penalties and enforcement mechanisms are considered the strongest.
- **Moderate Strength Mandate (Mandate with Penalty):** For this option, Wakely analyzed a mandate consistent with SB 5840[6], in which a penalty is imposed but exemptions are broader than the 2018 federal mandate exemptions and, more importantly, there is no clear enforcement for non-payment of penalties according to the scenario provided by WAHBE. Additional exemptions contemplated in the bill include, for example, that all individuals under 18 years old and over 64 would be exempt from the penalty. We estimate that this reduces the number of uninsured subject to a penalty by approximately 10%. Individuals subject to a state penalty and not eligible for an exemption would receive communication from the state as to their non-compliance with the coverage requirement and requesting payment. The penalty amount would be consistent with the Strong Mandate scenario above and is calculated similar to the Federal mandate before the penalty was reduced to zero in 2019. No long term penalty for non-payment is contemplated in SB 5840.This option implies that the state has a rigorous system to track individuals who are subject to the penalty as well as determine if they are exempt from it (including via income). Two key sources of uncertainty are the level of verification required for hardship exemptions, as well as the willingness for individuals to pay the penalty/state to collect the penalty without financial or legal consequences for non-payment.

[5] 2018 federal exemption requirements, in practice, were broader than in the prior two years.

[6] Text of SB 5840 available online at http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bill%20Reports/Senate/5840%20SBA%20HLTC%2019.pdf?q=20201117082603

- **Low Strength (Mandate without Penalty):** For this option, Wakely analyzed a policy in which the state passes a law and highly publicizes a requirement for having health insurance coverage, but there is no associated penalty for non-compliance with the law. This approach is similar to the mandate that has been implemented in Vermont, where the legislature has passed a mandate, but has not as yet passed a penalty or enforcement structure.

As Fiedler (2018) notes, isolating the empirical effects of an individual mandate on health coverage is extremely challenging since the federal mandate was implemented at the same time as other major coverage provisions.[7] For example, the mandate was implemented at the same time as subsidies in the individual market were implemented, which greatly improved affordability and reduced the number of uninsured, in their own right.[8] Furthermore, the ending of the mandate occurred at a time of extensive policy changes which also prevents an exact measurement of its effects. This uncertainty is compounded by the uncertainty as to the number of uninsured in 2022. The ongoing COVID-19 pandemic and resulting economic shortfall results in a wide range in the number and income distribution of the uninsured. As a result, for all options Wakely produced a range of outcomes, varying both the effect of the mandate and number of uninsured for all options.

Each of the three mandate options were modeled using the three different baseline enrollment estimates. In addition, two sets of assumptions were used for each mandate option, one representing a higher take-up rate in coverage and the other a lower take-up rate. The higher take-up rate could represent less exemptions and/or higher compliance while the lower take-up assumption could represent more exemptions and/or lower compliance. The range of take-up estimates also reflects the general uncertainty of the impact of a mandate due to the challenges in isolating the effects of an individual mandate, as noted above.

Table 2 below outlines Wakely's range of estimates based on the different subsidy structures outlined above and using the Best estimate for the baseline enrollment and uninsured levels. Wakely also developed an estimated range of impacts of each program on the 2022 individual market, shown below in the Detailed Results section. While the vast majority of the take-up from uninsured shown below is anticipated to occur in the individual market, some of the take-up shown below will impact other markets, such as Medicaid and employer coverage. The table below shows the number of remaining uninsured individuals not paying the penalty. This number includes the number of individuals who receive an exemption, as well as those who do not receive an exemption but do not pay the penalty. The latter includes non-tax filers, those who may owe a

[7] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/05/31/new-evidence-the-acas-individual-mandate-substantially-increased-insurance-coverage/
[8] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01433

penalty but do not have a tax refund from which to deduct the penalty, and, under the Moderate option, those who are subject to the penalty but choose not to pay due to the lack of enforcement.

The range of impacts under the Low and High baseline estimates as well as the difference between take-up in the individual market and other markets is shown in the Detailed Results section and Appendix F. The range of take-up and revenue generated can vary significantly based on reasonable changes in assumptions[9]. For example, while the best estimate of the Strong option estimates revenue between $77.1 and $84.5 million, that range becomes $64.6 to $98.6 million under the different baseline scenarios.

Table 2: Estimates for State Mandate Results by Mandate Option
2022 Best Estimate Baseline

2022 Baseline Scenario	Strong Mandate		Moderate Strength Mandate		Low Strength Mandate	
	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up
Total Enrollment - Individual Market	261,200	244,400	237,900	236,900	237,400	236,900
Change in Individual Market Premiums due to individual mandate	-3%	-1%	0%	0%	0%	0%
Take-Up Coverage						
Individual Market	24,300	7,500	900	0	500	0
Other (Medicaid, ESI, etc.)	9,600	3,000	400	0	100	0
Total	33,900	10,500	1,300	0	600	0
Remaining Uninsured						
Paying Penalty	206,200	191,200	4,800	0	0	0
Not Paying Penalty	216,500	255,000	450,500	456,600	456,000	456,600
Total	422,700	446,200	455,300	456,600	456,000	456,600
Change in Number of Uninsured	**-7%**	**-2%**	**0%**	**0%**	**0%**	**0%**
Households Paying Penalty	105,800	98,500	2,000	0	0	0
Total Penalty Revenue (Millions)	**$84.5**	**$77.1**	**$2.8**	**$0.0**	**$0.0**	**$0.0**

As can be seen above, the range of potential outcomes from an individual mandate are fairly large. Wakely assumed that in options without an enforcement mechanism for paying a penalty or absence of a penalty (Moderate and Low option, respectively) the impact would be significantly

[9] The low and high estimates were based on the range of enrollment and premium changes seen on the Exchange historically as well as an estimated adjustment to reflect the impact of COVID-19 on the individual and uninsured markets in 2020.

reduced as it would be purely based on an individual's voluntary willingness to pay the penalty or obtain coverage when there are no financial or legal consequences for non-payment. There is additional uncertainty, because of the uncertainty of the size of Washington's uninsured population, and also because the exact details of the specific mandate are unknown, such as what specific law(s) would be passed and what regulatory and operational decisions would be made (how extensive are the penalties, how difficult is it to gain an exemption, what enforcement is there for payment of the mandate, how well is the information communicated to the public, etc.). An important note is that the analyses assume a steady-state environment (continuation of a federal mandate without a penalty).

Table 2 highlights that having an enforceable mandate significantly increases the take-up of coverage and the annual penalty revenue. The vast majority of the take-up is expected in the individual market but some take-up is also expected in other markets, primarily Medicaid and group coverage. While the Moderate Strength option has limited take-up and penalty revenue, if the state can implement an effective enforcement mechanism, take-up and penalty revenue would likely both increase significantly (but likely still less than the Strong option due to expanded exemptions). Since the Low Strength option is similar to the current federal mandate, in that it is in name only, minimal take-up is expected. Modest take-up is possible if the state significantly promotes the mandate.

The uninsured population is expected to have lower morbidity (i.e., better health) than the current markets. Thus, as take-up is increased it could improve the overall morbidity of the current markets, which should lower average claims costs for the covered population. The mandate therefore could result in overall lower premiums, if it encourages healthier individuals to enroll in the individual market. For the Strong Mandate option (Mandate with Penalty and Enforcement) it is estimated that the individual market enrollment would increase by 3% to 10%, which could reduce premiums approximately 1% to 3%. However, in Moderate and Low options individual market enrollment would increase at most 0.5% and the impact on premiums would likely be negligible.

Additional Considerations

- **Operations**: As noted earlier, Wakely modeled the impact of a state mandate in 2022 as if the program were in a steady-state environment. Extensive legislative and operational changes would need to occur to be able to identify individuals that are uninsured, verify their exemption status, and collect revenue from those individuals for which the mandate penalty applies. Given the timeline it is very unlikely that revenue from a steady-state operation would be available before 2024. In particular, this is because of the lack of state income tax, which would likely be the most effective way to determine an individual's income as well assess penalties. Additionally, a state would need a method of tracking individuals' coverage status. Even if the state were operationally ready to implement a mandate in 2022, the earliest revenue would be collected would be 2023.

The estimates for both the Strong and Moderate mandate options would likely require the state to implement a process to measure both income and coverage status. Data quality and completeness will impact the estimates. Finally, implementation of exemptions and how they differ from what was done for the 2018 Federal mandate for Washington state residents could impact the results. As a result of the unknown implementation structure, there is considerable uncertainty as to the ultimate revenue collections.

- **Funding Avenues**: A state-specific mandate could provide an important policy tool that simultaneously provides improvements to the risk pool and a potential source of revenue for other policies that could further improve affordability and market stability. In California, mandate revenue is assisting in the state budget funding for a state premium subsidy. Several other states, such as New Jersey and Rhode Island, have allocated revenue from an individual mandate program to assist in financing a state reinsurance program.

  Revenue estimates from a mandate indicate the calendar year for which the determination is applicable. Penalties assessed on coverage status (i.e., 2022) would not be collected at least until the following year (i.e., 2023). Thus, the timing of the actual revenue collection should be considered in how the revenue would be used.

- **Impact on Other Programs/State Costs**: While a state mandate could generate revenue it will also increase state costs. A state mandate would have both initial and steady-state operations costs from identifying individuals for whom the mandate applies, processing exemptions, collecting revenue, advertising the mandate, etc. A mandate may also indirectly increase states costs in the form of higher Medicaid enrollment.

  There could also be interactions with other policies that should be understood. For example, if Washington implemented a state premium subsidy that would be funded from the individual mandate revenue, the impact and costs for such a program would be higher than those estimated by Wakely in its report[10] given the higher individual market enrollment. Similarly, if Washington implements both a premium subsidy program and a mandate, there may be less revenue collected than estimated in this report, because the uninsured rate would be lower. An enforced mandate combined with a premium subsidy program would result in more members enrolled (given lower premiums for subsidy eligible members) and thus, fewer individuals to pay the penalties.

- **Additional Enforcement Tools:** One of the key differences in estimates (both the increase in the number of insured and mandate revenue) is the enforcement mechanism. Enforcement in Washington could be achieved in a number of ways but would ultimately require the ability to either collect money from individuals directly or have some long term financial or legal penalty for non-compliance. A mandate penalty could be effective without a fully functioning income tax although it would require many of the same elements, such as income verification to determine the penalty amount.

[10] "Wakely – WAHBE Premium Subsidy Analysis_2020.11.13.pdf"

- **Overall Uncertainty on a State-Level Mandate**: There is considerable uncertainty as to the ultimate steady-state impact of a state-level mandate as only one state, Massachusetts, has had a state mandate without a national mandate for a significant length of time. This uncertainty is increased as the Federal legal environment is uncertain. Currently, the Supreme Court is reviewing a challenge to the Affordable Care Act in California v. Texas[11]. Alterations to the ACA or the Federal mandate either by the Supreme Court or Congress in response to California v. Texas, could impact the effects of a state mandate.

Background

The ACA, starting in 2014, required all Americans to have health care coverage or pay a penalty. The individual mandate penalty amount was phased in between 2014 and 2016. From 2014 through 2018, the ACA levied a penalty on people who were uninsured and did not obtain an exemption.. The theory behind the initial legislation is that without a sufficient penalty, healthier individuals may avoid getting and maintaining health coverage. In particular, the idea was that without an individual mandate, too many healthy individuals would exit the market, thus pushing up premiums for those remaining in the pool and even putting the individual market at risk for a death spiral.

While subsequent research has shown that the federal premium subsidy structure insulates the individual market from significant reductions in enrollment, there is considerable research that a mandate does help increase individual market take-up. In its steady state form (2016 to 2018) individuals paid the greater of $695 or 2.5% of their income, unless they had health coverage or obtained an exemption. In these three years, around 105,000 households in Washington paid the penalty, which resulted in around $80 million in revenue. One of the key differences between each year is the availability of exemptions and ease of obtaining an exemption to the individual mandate. Although, the law itself regarding the individual mandate and exemption requirements did not change from 2017 to 2018 and the number of uninsured in Washington did not change significantly, there was a decrease in the number of households paying the penalty and resulting penalty revenue in 2018, likely due to an easier process for obtaining an exemption in 2018.

[11] https://www.supremecourt.gov/docket/docketfiles/html/public/19-840.html

Table 3: Data on Penalty Payments and Revenue for the Mandate for Washington

Year	Number of Households Paying Penalty	Mandate Revenue (Millions)
2016	108,850	$78.9
2017	110,710	$86.5
2018	96,010	$80.6

In December of 2017, federal legislation passed that, among other things, eliminated the penalties associated with the ACA's individual mandate, effectively repealing the provision starting in 2019. Washington's enrollment, specifically its unsubsidized enrollment, has decreased after peaking in 2018.

Given the change in Federal policy, several states have already implemented, or are in the process of developing, a state mandate program given the potential benefits to the state risk pool and potential for additional state revenue. Currently five states and the District of Columbia have a state individual mandate in effect, with a number of those states using revenue from the mandate to assist in funding programs that improve affordability in the individual market (either via reinsurance or state subsidies).[12] Table 4 shows the current landscape of state-sponsored state mandate programs.

Table 4: State Mandates Currently in Effect[13]

State	Effective Year of Requirement	Additional Information
California	2020	California implemented a state subsidy program at the same time as it implemented a state mandate
District of Columbia	2019	DC has established a financial penalty and an enforcement mechanism
Massachusetts	2008	Massachusetts mandate was not in effect while the Federal mandate was being enforced
New Jersey	2019	Penalty revenues earmarked to finance state-operated reinsurance program
Rhode Island	2020	Penalty revenues earmarked to finance state-operated reinsurance program
Vermont	2020	State has not established a financial penalty or other enforcement mechanism

[12] What is Your State Doing to Affect Access to Health Insurance | Commonwealth Fund, https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/what-your-state-doing-affect-access-adequate-health

[13] Information in the table is from https://www.commonwealthfund.org/blog/2020/state-efforts-preexisting-conditions and discussions with WAHBE.

The states have generally followed the original ACA individual mandate design albeit many include more exemptions (i.e., based on income) or different definitions of minimum essential coverage (for example to exclude association health plans). Vermont's individual mandate does not include a penalty. Given the recency of the enactment (or re-enactment in the case of Massachusetts) there is insufficient data to determine their long term effects of enrollment or state revenue.

Detailed Results

Listed below are the detailed results of a potential state mandate in the state of Washington. For all scenarios Wakely assumed a steady-state in which operations are in place to enforce and communicate the policy in place.

Option #1: Strong Mandate (Mandate with Penalty and Enforcement)

Summary of Program

For this option, Wakely analyzed the impacts of Washington successfully implementing a mandate with a penalty and enforcement structure similar to the Federal mandate that existed from 2016 to 2018. In particular, Wakely used the 2018 federal structure as the closest approximation for a steady-state implementation of a state mandate (2018 exemption requirements were broader than in previous years). Of all the options presented, the financial penalties and enforcement mechanisms are considered the strongest. This option also implies that the state would implement a state income tax regime, although an alternative with an equally effective data collection and equally strong enforcement mechanisms could potentially result in similar outcomes.

The table below shows the results of the modeling for the Strong Mandate option for each scenario (Best, Low, and High baseline as well as a High and Low take-up estimate).

Table 5: Strong Mandate Estimates by Baseline Scenario

Strong Mandate	Best Estimate Baseline		Low Baseline		High Baseline	
	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up
Total Enrollment - Individual Market	261,200	244,400	206,200	192,400	309,200	289,500
Change in Individual Market Premiums due to Individual Mandate	-3%	-1%	-3%	-1%	-3%	-1%
Take-Up Coverage						
Individual Market	24,300	7,500	19,200	5,400	28,800	9,100
Other (Medicaid, ESI, etc.)	9,600	3,000	10,700	3,000	10,100	3,200
Total	33,900	10,500	29,900	8,400	38,900	12,300
Remaining Uninsured						
Paying Penalty	206,200	191,200	87,300	80,500	125,600	118,000
Not Paying Penalty	216,500	255,000	324,900	353,300	308,900	343,100
Total	422,700	446,200	412,200	433,800	434,500	461,100
Change in Number of Uninsured	**-7%**	**-2%**	**-7%**	**-2%**	**-8%**	**-3%**
Households Paying Penalty	105,800	98,500	87,300	80,500	125,600	118,000
Total Penalty Revenue (Millions)	**$84.5**	**$77.1**	**$71.6**	**$64.6**	**$98.6**	**$90.9**

Key Takeaways

- **Consumer Impact:** In this option Wakely estimates that between 8,400 and 38,900 fewer individuals would be uninsured as a result of a Strong mandate with both a penalty and strong enforcement mechanism. The vast majority of these individuals would gain coverage in the individual market. The result of this includes an increase in enrollment in the individual market of between 3% and 10%, which could reduce individual market premiums up to 3%. Despite the increase in enrollment, some individuals will remain uninsured and be subject to a penalty. We estimate that between 80,500 and 125,600 households would pay a penalty under this option, with an average penalty per household of approximately $800. This would generate state revenue between approximately $64.6 million and $98.6 million.

- **Key Benefits:** There are both direct and indirect benefits to such a program. Individual mandates with a substantial penalty would decrease the number of uninsured, increase the number of individuals in the individual market, increase revenue for the state, and improve market stability. The additional revenue could be used for other programs.

- **Key Uncertainties:** The largest source of uncertainty is operationalization of the program. The state would need to enact an income tax or establish a similarly strong system to track data on insurance coverage and assess and collect a penalty. Additionally, it may

take several years before data quality is sufficient to accurately gauge household income. Another source of uncertainty is how exemptions to the mandate are defined and implemented. Despite having the same legal structure, IRS collections from the state of Washington varied greatly between 2017 and 2018 because of changes to regulations around the individual mandate as well as verification requirements. Consequently, the exact revenue generated by a mandate is uncertain. The exact impact of imposition of a state mandate on enrollment decisions is uncertain.[14] As Fiedler notes, there is significant disagreement amongst researchers as to the impact the Federal individual mandate had. While Wakely believes the range of outcomes is reasonable, there remains uncertainty as to the exact number of individuals that may take-up coverage. Finally, Wakely did not estimate additional costs the states would incur (e.g., operations, Medicaid take-up, etc.).

Option #2: Moderate Strength Mandate (Mandate with Penalty)

Summary of Program

For this option, Wakely analyzed a mandate penalty that has similar calculated penalties as the Strong Mandate (i.e., federal) scenario however with several differences in terms of who is ultimately subject to the penalty and the enforcement of the penalty. The first key difference is about exemptions. Relative to the Strong scenario this scenario has more exemption categories (e.g. individuals may be exempt based on age) and exemptions are more likely to be granted. The ease of receiving an exemption was assumed because a) individuals do not necessarily need to be proactive to receive one[15] And b) verification of individuals applying for exemptions would be minimal. For example, Wakely assumed that verification of hardship exemptions and exemptions more generally would be minimal. For example, individuals could self-attest to hardship with limited or no additional verification from the state and that there was no enforcement mechanism for requiring individuals to pay mandate penalty.

The table below shows the results for of the modeling for the Moderate Strength Mandate option for each scenario (Best, Low, and High baseline as well as a High and Low take-up estimate).

[14] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01433

[15] As communicated to Wakely by WAHBE, for this scenario, there is no long term penalty for non-payment for mandate fees.

Table 6: Moderate Strength Mandate Estimates by Baseline Scenario

Moderate Strength Mandate	Best Estimate Baseline		Low Baseline		High Baseline	
	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up
Total Enrollment - Individual Market	237,900	236,900	187,900	187,000	281,400	280,400
Change in Individual Market Premiums due to Individual Mandate	0%	0%	0%	0%	0%	0%
Take-Up Coverage						
Individual Market	900	0	900	0	1,000	0
Other (Medicaid, ESI, etc.)	400	0	500	0	300	0
Total	1,300	0	1,400	0	1,300	0
Remaining Uninsured						
Paying Penalty	4,800	0	1,900	0	2,100	0
Not Paying Penalty	450,500	456,600	438,900	442,200	469,900	473,400
Total	455,300	456,600	440,800	442,200	472,000	473,400
Change in Number of Uninsured	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Households Paying Penalty	2,000	0	1,900	0	2,100	0
Total Penalty Revenue (Millions)	**$2.8**	**$0.0**	**$2.6**	**$0.0**	**$2.9**	**$0.0**

Key Takeaways

- **Consumer Impact:** In this option Wakely estimates that up to 1,900 fewer individuals would be uninsured as a result of a Moderate Strength mandate. The vast majority of these individuals would gain coverage in the individual market. The result is an estimated increase in enrollment in the individual market of up to 0.5%, which would likely have a negligible impact on premiums.

  Given that exemptions are assumed be easier to be obtain and the lack of enforcement of the penalty, the households that choose to pay the penalty are estimated to be very low compared to the Strong Mandate option. We estimate that up to 2,100 households would pay a penalty under this option, with an average penalty per household of approximately $1,400, which would generate state revenue of approximately $2.9 million. The penalty amount per household under this scenario is assumed to be similar to the federal calculation reflected in the Strong option. However, we are estimating that those paying the penalty in the Moderate option will be relatively higher income groups compared to the Strong option, due to the assumptions below. This results in a higher average penalty per household under the Moderate option compared to the Strong option. The income-based exemptions that are included in this scenario, but not in the Strong Mandate scenario, include the following:

- Automatic exemptions for those with income below approximately $15,000
- Exemptions for “family glitch” members, whose incomes are below 400% FPL
- Those with lower incomes will be more likely to receive other types of exemptions (e.g., hardship exemption than those in higher income groups)

Despite this scenario showing some revenue collection under the high take-up estimates, under the steady-state assumption individuals may recognize the lack of enforcement and choose not to pay the penalty. Therefore the revenue generated under this option could be negligible.

- **Key Benefits:** While to a much lesser extent than the Strong option, there is the possibility for some enrollment gains and revenue from this option. This benefit is highly contingent on how exactly the program is operationalized.

- **Key Uncertainties:** There are extensive uncertainties surrounding this option. The state would need to have some mechanism for evaluating individuals’ income and insurance status in order to assess a penalty. Additionally, as described to Wakely, this option would not have an enforcement mechanism if individuals do not pay the penalty. This would greatly reduce the effectiveness of the penalty. The exact details for enforcement of a penalty are key for the long term impacts (both for enrollment and revenue). If there is an insufficient mechanism for enforcing penalties, then revenue and individual enrollment decisions would be entirely norm based. While Wakely has made reasonable assumptions of such an effect, estimating Washington specific norm-driven behavior is difficult and prone to uncertainty.

- **Modified Option:** If there is an enforcement mechanism to the penalty then revenues and enrollment would be far closer to the Strong scenario. The exemptions for the family glitch and ages would likely not result in a dramatically different number of eligible individuals paying the penalty (for example, those who would have an exemption due to the family glitch are estimated to be less than 2% of the uninsured[16] and those under 18 and over 64 would represent approximately 10% of those uninsured with some overlap with other exemption categories). Consequently, revenue and market impact would be dramatically higher than what is currently estimated for the Moderate scenario with a strong enforcement mechanism. It is likely that even with strong enforcement, the effects (i.e., revenue, enrollment take-up) may still be lower than those under the Strong mandate option for several reasons:

[16] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.1491

- Additional exemptions for certain income and age groups relative to the strong scenario
- Obtaining an exemption was estimated to be easier (i.e., automatic exemptions for certain individuals without requiring an exemption request, verification standard for exemptions is lower, etc.)
- The enforcement mechanism may be less effective without an income tax.

Option #3: Low Strength Mandate (Mandate without Penalty)

Summary of Program

For this option, Wakely analyzed a policy in which the state passes a law and highly publicizes a requirement for having health insurance coverage, but there is no associated penalty for non-compliance with the law.

The table below shows the results for of the modeling for the Moderate Strength Mandate option for each scenario (Best, Low, and High baseline as well as a High and Low take-up estimate).

Table 7: Low Strength Mandate Estimates by Baseline Scenario

Low Strength Mandate	Best Estimate Baseline		Low Baseline		High Baseline	
	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up
Total Enrollment - Individual Market	237,400	236,900	187,500	187,000	280,900	280,400
Change in Individual Market Premiums due to Individual Mandate	0%	0%	0%	0%	0%	0%
Take-Up Coverage						
Individual Market	500	0	400	0	500	0
Other (Medicaid, ESI, etc.)	100	0	300	0	200	0
Total	600	0	700	0	700	0
Remaining Uninsured						
Paying Penalty	0	0	0	0	0	0
Not Paying Penalty	456,000	456,600	441,500	442,200	472,700	473,400
Total	456,000	456,600	441,500	442,200	472,700	473,400
Change in Number of Uninsured	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Households Paying Penalty	0	0	0	0	0	0
Total Penalty Revenue (Millions)	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**

Key Takeaways

- **Consumer Impact:** In this option Wakely estimates that up to 700 fewer individuals would be uninsured as a result of a Low Strength mandate. The vast majority of these individuals would gain coverage in the individual market. Due to the lack of penalty and enforcement of the mandate, the impact of this option is significantly smaller than the Strong and Moderate Strength options. As there is no associated penalty, no revenue is expected to be generated under this option.

- **Key Benefits:** The benefit of this program is that it may encourage some individuals that may otherwise be uninsured to maintain or gain coverage.

- **Key Uncertainties:** There is some uncertainty as to the program, as the exact effects of such an option are related to the type and effectiveness of communication of a mandate without a penalty. The more effective the messaging and outreach of such a policy, the more likely the effects will be positive rather than a continuation of the current status quo (i.e., a mandate without a penalty).

Implementation Considerations

In addition to the change in uninsured and potential revenue from a state mandate, there are several other considerations regarding the implementation and ongoing operation of such a program. The details included in the section below reflect some, though not all, of the additional considerations that were outside the scope of the modeling, and therefore not included in the results discussed above.

- **Timing:** Given the complexity of establishing a tracking and reporting system for a state mandate without an existing income tax, it may take time to establish a system to track accurate and actionable data.. Consequently, it may take a number of years until there is sufficient operational capacity and sufficient data quality to fully enforce a state mandate as contemplated under the Strong and Moderate options. There will also be delays in collections relative to the year for which the mandate is enforced. For example, a mandate applied to 2022 would not result in revenues to the state until sometime in 2023.

- **Revenue is uncertain:** As noted previously, revenue is highly uncertain. There are multiple decisions that could impact revenue, including capacity issues, communication strategy and how exemptions are determined, both in terms of what legal categories are eligible for exemptions and how the exemptions are ultimately implemented (e.g., ease of obtaining an exemption). The state will need to trade-off burden on individuals/the state for getting an exemption and the policy goal of requiring individuals to have coverage and/or paying a penalty.

- **Cost of implementation:** Wakely did not include any start-up or ongoing operational/implementation costs for a mandate in this report. In order to meet the estimates in this report, the state would likely incur costs related to some or all of the following: marketing costs to communicate the mandate, costs for collecting information on income and health coverage, collecting mandate penalties, determining exemptions, and communicating with the public/households that owe a penalty.

- **Federal Uncertainty**: Currently, the Supreme Court is deciding a case on the constitutionality of the ACA in California v. Texas. It is possible that a ruling could declare the individual mandate unconstitutional, or more broadly jeopardize the ACA. Such a change to the status quo could affect the estimates. Furthermore, Congress could pass a law to change the mandate (for example by including a minimal fee) to avoid an adverse ruling against the ACA. Consequently changes to Federal policy could impact the estimates.

  To the extent that the Federal mandate is repealed, the enrollment in the individual market in the baseline estimate may be lower than that reflected in this report by a negligible to modest amount as the mandate is currently not being enforced. It is possible that the resulting enrollment and uninsured estimates may result in a similar estimate to that shown here, though the impact would be greater due to the lower starting baseline estimates.

- **Mandate Revenue**: While not included in the analysis, states could use revenue from the mandate for affordability or other market stability programs. For example, several states have used the revenue to help fund state subsidy and reinsurance programs. As noted above given the uncertainty and timing around mandate revenue, initial state funding may be needed in the initial years of such programs.

Appendix A: Additional Background Information

The additional background information provided in this Appendix were provided by WAHBE. The details included in this section are non-actuarial in nature, and Wakely is reliant on WAHBE for the information included in this section.

BACKGROUND – FEDERAL INDIVIDUAL MANDATE

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, included a requirement that all individuals, unless they meet certain exemptions, must maintain minimum essential health care coverage for themselves and their dependents.[17] Minimum essential coverage includes government sponsored coverage, employer-sponsored health plans (ESI), individual market health plans, grandfathered health plans, and other coverage such as through health benefits risk pools.[18] Exemptions from the individual mandate are provided to persons with certain religious affiliations, those not lawfully present in the United States, and individuals who are incarcerated. Certain other categories of individuals who are not exempt from the mandate were exempted from having to pay the taxpayer penalty that existed through 2018, including individuals whose required premium contribution to remain covered would exceed 8% of the individual's household income, individuals with income below the tax filing threshold, members of Indian tribes, individuals with short coverage gaps, and individuals with certain hardships.

Beginning in January 2013, anyone not exempted from the mandate, or exempted from having to pay the penalty, was required to pay a taxpayer penalty for failing to meet the coverage requirements for one or more months in a year. The penalty for going without insurance during its most recent year of enforcement [2018] was $695 per uninsured adult or 2.5% of income, whichever amount was higher, capped at the national average premium for a bronze level health plan. The individual mandate and corresponding taxpayer penalty were subjected to several early legal challenges, including the 2012 landmark case, National Federation of Independent Business (NFIB) v. Sebelius[19], in which the Supreme Court ruled the mandate was a constitutional exercise of Congress's taxing power.

In 2017, Congress enacted the Tax Cuts and Jobs Act (TCJA), reducing the ACA's individual mandate taxpayer penalty to $0. Although not technically a full repeal of the mandate, the impact was similar. Petitioners have since brought the individual mandate back before the Supreme Court as the focus in California v. Texas. At issue, in addition to whether the plaintiffs have

[17] 26 U.S.C. § 5000A
[18] 26 C.F.R. § 1.5000A-2
[19] *National Federation of Independent Business v. Sebelius,* 567 U.S. 519 (2012)

standing to sue, is whether the individual mandate remains constitutional following enaction of the TCJA and whether the rest of the ACA could be severed if the mandate is found unconstitutional. Oral arguments were heard in November 2020, and the outcome of the case and continued existence of the federal individual mandate, remain pending.[20]

BACKGROUND – OTHER STATE INDIVIDUAL MANDATES

Massachusetts, and every other state that has associated a taxpayer penalty with the requirement to maintain health coverage, utilizes a state income tax structure to track state residents, determine who has maintained the required health coverage, and to collect and enforce the penalty. As it stands, Washington State lacks this key ingredient but has not foreclosed the consideration of implementing an individual mandate. In 2018, State Senator Annette Cleveland proposed Senate Bill 6084, which would have established a state-level individual mandate in Washington, modelled off of the federal requirement to maintain minimum essential coverage, but absent a penalty or enforcement mechanism.[21] Such a proposal, if enacted, would function similarly to the individual mandate that became effective in Vermont on January 1, 2020, which includes a requirement to maintain minimum health care coverage and a self-reporting structure, but to date has no associated penalty or enforcement provisions.[22]

Senator Cleveland again proposed the enactment of an individual mandate during the 2019 legislative session (SB 5840).[23] The Senator's 2019 bill included a series of reporting protocols to require executive branch partners at Licensing, Revenue, the Office of the Insurance Commissioner, and the Exchange to develop a list of known state residents, track whether residents maintained health coverage, and to assess penalties on those who do not meet an exemption and do not maintain affordable coverage. While the bill largely mirrors the exemptions in the federal mandate, there are a few notable exceptions: Individuals in the "family glitch" and all individuals under 18 or over 64 would be exempt. The Senator's proposed 2018 and 2019 bills serve as frameworks for two of the three individual mandate structures that the Exchange modelled as part of this report.

[20] Severing of the mandate has the potential to implicate the continued filing of 1095 tax forms, which provide reporting on individuals' health insurance coverage status. These forms were envisioned as a key-piece of the reporting protocols in the Moderate Strength Mandate envisioned in SB 5840 and modelled here. Roll-back of these reporting requirements could have implications for the feasibility of the Moderate Strength Mandate structure.

[21] SB 6840 (2018) - https://app.leg.wa.gov/billsummary?BillNumber=6084&Year=2017&Initiative=false

[22] 32 V.S.A. §10452

[23] SB 5840 (2019) - https://app.leg.wa.gov/billsummary?BillNumber=5840&Year=2019&Initiative=false

Appendix B: Methodology and Assumptions - Baseline

The analyses in this report utilized multiple data sources and methodologies. This section describes the key elements of the methodology and assumptions used for various calculations and analyses. Data reliance is discussed in Appendix D.

Data Collection

WAHBE provided Wakely with detailed, member-level on-Exchange enrollment information for customers enrolled in 2020. This data set contained detailed member level information such as premiums, APTC information, FPL, county, metal level, age, and other enrollment specifications.

2022 Baseline Development

In order to calculate the impact of the program changes, Wakely developed a baseline database to best estimate the environment in 2022. Assumptions were developed based on Wakely internal modeling, emerging 2020 experience, conversations with WAHBE, and public source information to project the 2020 enrollment data to the 2022 time period.

The 2022 base data included member-level details as well as household-level details. Adjustments were made to the 2020 base data at a household level basis to generate an estimate of the 2022 baseline as described below.

Enrollment: To develop a 2022 enrollment estimate, for our best estimate, we assumed that the historical enrollment changes would continue, then separately layered on an impact on enrollment due to COVID-19.

- **On-Exchange**: Historical enrollment increases were used as the basis for the assumed enrollment change from 2020 to 2022. We reviewed the annual enrollment change from 2017 to 2020 separately for subsidized and unsubsidized on-Exchange customers and assumed the same average enrollment increase would continue from 2020 to 2022.

- **Off-Exchange**: Detailed enrollment information for off-Exchange customers was not available. Therefore, Wakely relied on the 2019 risk adjustment report and appendices - Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year [24] released by CMS to estimate enrollment. The 2019 risk adjustment report included information for the entire individual market in Washington. Off-Exchange enrollment and

[24] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf

premiums were estimated by backing out the on-Exchange data as provided by WAHBE for 2019 by rating area.

The 2019 off-Exchange enrollment was then trended to 2020 based on the average reduction from 2017-2019 based on the same methodology. To estimate enrollment in 2022, it was assumed that the increase in unsubsidized on-Exchange enrollment would be offset 1-to-1 by a decrease in off-Exchange enrollment.

- **COVID-19 Adjustment**: The enrollment effect due to COVID-19 reflects an increase in individual market enrollment as a result of the increased unemployment rate and individuals losing employer coverage. The estimated impact of COVID-19 on individual market enrollment was based on a study released by the Urban Institute and Robert Wood Johnson Foundation, How the COVID-19 Recession Could Affect Health Insurance Coverage.[25] The report included estimates on the change in enrollment at various unemployment rates both nationally and at a state-level. Wakely calculated the implied increase in individual market enrollment for a 1 percent change in unemployment in the state of Washington. This change was then applied based on the difference between the unemployment rate in Washington as of January 2020 as reported by the Bureau of Labor Statistics[26] and the estimated unemployment rate in 2022, estimated by the June 2020 Economic and Revenue Forecast[27] for Washington. This approach resulted in an estimated increase in individual market enrollment of approximately 5 percent. This increase was applied consistently for on-Exchange subsidized and unsubsidized, and off-Exchange enrollment.

As noted above, the enrollment was allocated separately for subsidized on-Exchange, unsubsidized on-Exchange, and off-Exchange. The resulting impact was an increase of 14.0 percent of subsidized enrollment on-Exchange, 8.9 percent of unsubsidized enrollment on-Exchange, and a reduction of 5.1 percent of off-Exchange customers from 2020 to 2022.

Premium (Before Federal Subsidies): The premium changes from 2020 to 2021 were estimated from final rate filings for 2021 premiums. The 2020 to 2021 premium change is assumed to follow with historical average increases. The overall gross premium increase from 2020 to 2022 is estimated to be 7.6 percent, due to aging and rising medical and pharmacy claim cost trend.

High Level Premium Adjustments: Annual trends from 2020 to 2022.

- **2020 to 2021**: The average rate increase from 2020 to 2021 in the final rate filings reported by carriers is -1.8 percent. When adjusted to reflect the impact of current customers aging,

[25] https://www.urban.org/research/publication/how-covid-19-recession-could-affect-health-insurance-coverage/view/full_report
[26] https://www.bls.gov/news.release/archives/laus_03162020.pdf
[27] https://erfc.wa.gov/sites/default/files/public/documents/publications/jun20pub.pdf

gross premiums were assumed to increase 2 percent from 2020 to 2021, both on and off-Exchange.

- **2021 to 2022**: The baseline projection assumes, based on aging and medical and pharmacy claim cost trend, that premiums will increase approximately 6 percent from 2021 to 2022. Actual annual changes in premium have varied significantly since the introduction of the ACA and the Health Benefit Exchange, with the average premium change ranging from approximately -3 percent to +14 percent (excluding the rate change from 2017-2018, which included the impact of CSR de-funding). Due to this variability, this assumption assumes that the premium rates in 2021 are adequate and that the rate change from 2021 to 2022 will be similar to medical and pharmacy claim cost trend.
- **COVID-19 Adjustment**: No adjustment was made to the premium levels for the impact of COVID-19. It is our understanding that carriers generally did not adjust their 2021 premium rates for COVID-19, and we are assuming that will continue from 2021 to 2022.

The table below summarizes the 2019 to 2022 high level Washington market statistics based on the issuer data and adjustments as discussed above to project to the baseline. The 2022 estimates reflect the best estimate assumptions. The premiums are combined for the customers and include both subsidized and unsubsidized customers.

Table 9: 2019 to 2022 Baseline Average Enrollment and Premium Data / Estimates – Best Estimate Scenario

2022 Baseline	2019	2020	2022	2022 / 2020
Enrollment				
On Exchange - Subsidized	120,511	113,376	129,278	14.0%
On Exchange - Unsubsidized	71,318	73,467	80,041	8.9%
Off Exchange	37,885	29,094	27,611	-5.1%
Total	229,714	215,937	236,930	9.7%
% Subsidized of Total	52.5%	52.5%	54.6%	
Premiums PMPM	$563	$529	$569	7.6%

Uninsured: In order to estimate take-up from the uninsured as a result of the subsidy program, we also needed to project a baseline estimate of the uninsured in 2022. Wakely relied on the 2018 Small Area Health Insurance Estimates (SAHIE)[28] as the starting point. This provided information on the uninsured in Washington by county, FPL group, and age group. We also utilized estimates provided by the Office of Financial Management (OFM) in Washington to separate individuals eligible for Medicaid and those ineligible for enrollment in Qualified Health Plans (QHPs) due to immigration status. We further split the uninsured estimate by income.

This data was then projected to 2022. We assumed that in the absence of COVID-19, the uninsured rate and population would be steady from 2018-2022. In looking at the estimated

[28] https://www.census.gov/library/publications/2020/demo/p30-07.html

uninsured rate as reported by the American Community Survey (ACS) from 2015-2018, the uninsured rate has remained relatively steady in Washington. We then layered on an estimate for the increase in uninsured due to COVID-19. This was based on the same process described above to adjust enrollment. The result was an estimated increase in the number of uninsured of approximately 7 percent. Based on these adjustments, the table below shows the best estimate for 2022 uninsured by age and FPL.

Table 10: 2022 Baseline Estimate of Uninsured by FPL – Best Estimate Scenario

	BELOW 139%	139-400% FPL	Over 400% FPL	Total
Estimate of Uninsured	125,300	232,500	98,800	456,600

The regulatory environment, both at the federal and state level, does impact enrollment and premiums. The assumed regulatory environment in 2022 reflects the status quo, as follows:

- We assumed silver loading on-Exchange would continue.
- We assumed the current federal mandate would remain in statute, with no penalty being enforced.
- No other proposed regulatory changes were included within the 2022 Baseline. This assumes that there are no changes to the Affordable Care Act (ACA), whether due to executive orders, Congressional activity or Supreme Court rulings (such as on California v. Texas).

Based on the assumptions above, Wakely adjusted the 2020 member level detailed data to produce the detailed 2022 Baseline environment.

Adjustments for Low and High Baseline Estimates

The assumptions used in the development of the analysis are inherently uncertain. Adjustments were made to the baseline or “Best” estimate to develop a range of estimates, reflecting “Low” and “High” outcomes. The range of estimates are not representative of the lowest and highest possible outcome but rather apply a set of more and less conservative assumptions. The low and high estimates were based on the range of enrollment and premium changes seen on the Exchange historically. The impact of COVID-19 in the low and high estimates were based on a range of unemployment levels in Washington in 2022. The low estimate assumes the unemployment rate is similar to that in January 2020 and the high estimate assumes that the unemployment rate in 2022 is similar to the higher level seen in July 2020.

A summary of the best, low, and high estimate baseline assumptions is shown in Table 11.

Table 11: 2020 to 2022 Baseline Data Adjustments

Key Adjustments	Best Estimate	Low Range	High Range
Baseline (without state mandate) Projection			
Enrollment Changes:			
2020-2021 Enrollment Changes:			
Subsidized, On-Exchange	*4.3%*	*-1.3%*	*10.2%*
Unsubsidized, On-Exchange	*1.9%*	*-9.9%*	*10.5%*
Off-Exchange	*-4.9%*	*-23.4%*	*0.0%*
2021-Beyond: Annual Change			
Subsidized, On-Exchange	*4.3%*	*-1.3%*	*10.2%*
Unsubsidized, On-Exchange	*1.9%*	*-9.9%*	*10.5%*
Off-Exchange	*-4.9%*	*-23.4%*	*0.0%*
Premium Changes:			
2020-2021			
Gross Premium Change, On-Exchange	*2.2%*	*6.2%*	*-1.8%*
Gross Premium Change, Off-Exchange	*2.2%*	*6.2%*	*-1.8%*
2021-Beyond: Annual Change			
Gross Premium Change, On-Exchange	*5.6%*	*10.0%*	*0.0%*
Gross Premium Change, Off-Exchange	*5.6%*	*10.0%*	*0.0%*
Change in Number Uninsured:			
2020-2021	*0.0%*	*0.6%*	*-0.7%*
2021-Beyond	*0.0%*	*0.6%*	*-0.7%*
Impact of COVID-19 on 2022 Estimates			
Enrollment Changes:			
Subsidized, On-Exchange	*4.9%*	*0.0%*	*9.4%*
Unsubsidized, On-Exchange	*4.9%*	*0.0%*	*9.4%*
Off-Exchange	*4.9%*	*0.0%*	*9.4%*
Change in Number Uninsured:			
2022 with COVID-19 relative to Baseline	*6.8%*	*0.0%*	*14.8%*

Appendix C: Methodology and Results – State Mandate Options

A state mandate program would require Washingtonians to purchase eligible health coverage or pay a penalty. Certain households would be eligible for exemption from the rule. Both the exemptions and penalty amount varied based on the option as described below.

The 2022 baseline was used in determining the impact of a state mandate program.

Strong Option (Mandate with Penalty and Enforcement)

Under this option, we assumed that the state mandate program would operate similarly to the federal program, prior to the elimination of the penalty. We assumed that the enforcement of this option would also operate similarly to the federal program and any penalties would be assessed through a state income tax. As Washington does not currently have an income tax, this would require the implementation of a state income tax. The implementation requirements and operational costs of such a tax was considered outside the scope of this analysis.

The take-up from the baseline uninsured was determined by comparing the actual drop in enrollment in Washington in 2019 (after the federal penalty was removed) to the enrollment in 2017. This was compared to the enrollment change implied by an enrollment elasticity function based on the published research literature – "the cross-price elasticity for people currently insured in the nongroup market is –1.18."[29] The total difference was assumed to be attributable to the removal of the federal mandate. This created the high estimate of take-up under the Strong Mandate Option.

The low estimate of take-up was developed in a similar manner as above, except enrollment in 2019 was compared to 2018. As mentioned above, the individuals qualifying for exemptions under the federal program was expanded in 2018 compared to prior years, resulting in a decrease in enrollment from 2017-2018 and smaller enrollment change from 2018-2019 relative to the high scenario above.

To calculate revenue collected from the penalty for this option, the remaining number of uninsured was calculated after the take-up described above. The number of households paying the penalty in 2018 by income level[30] was compared to the estimated uninsured in 2018 to calculate the ratio of penalty paying households to uninsured. This ratio was assumed to be similar in 2022 under

[29] https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf

[30] IRS, Individual Income and Tax Data, by State and Size of Adjusted Gross Income, https://www.irs.gov/statistics/soi-tax-stats-individual-statistical-tables-by-size-of-adjusted-gross-income

the state program as the qualifying exemptions under this option would be similar to the federal program. The amount of the penalty was calculated in three cross-sections. At the lowest income levels, the minimum penalty amount was determined based on the 2018 minimum federal penalty, trended to 2022 based on the National Health Expenditures CPI growth from 2018 to 2022.[31] The maximum penalty was assumed to be equal to the average bronze plan premium in Washington in 2022 as projected based on the Baseline scenario development described above. Between the minimum and maximum, the penalty is assumed to be 2.5% of household income. In the low take-up estimate, the take-up and revenue assumptions were reduced 10% for individuals below 400% FPL and 20% for individuals above 400% FPL to reflect the impact of expanded exemptions beyond the federal program.

Moderate Strength Option (Senate Bill 5840)

This scenario is based on the model proposed in Senate Bill 5840 during the 2019 Washington State Legislative session. The option assumes that there are more exemptions than under the Strong (Mandate with Penalty and Enforcement) option and that some exemptions would not require an application to qualify. For example, all individuals under age 18 or over 64 would automatically be exempt. It is our understanding that the mandate would be enforced through letters that would be sent to uninsured individuals, indicating the penalty owed. It is uncertain what, if any, consequences individuals would face if they do not pay the penalty.

The high estimate of take-up under this option was developed based on the results of an outreach study in which the IRS sent informational letters to households that paid a mandate penalty[32]. The study found the on average, the intervention induced an average of 1 out of 52 contacted individuals to elect coverage in the following year.

The low take-up estimate assumes that due to the lack of enforcement of a penalty and limited incentive to purchase coverage, no individuals choose to take-up coverage and no individuals pay a penalty.

Revenue collected under this option was calculated similarly to the Strong Mandate option above, with the following changes:

- Individuals with income below $15,000 and those considered in the “family glitch” would be exempt. The $15,000 income limit is an estimate for the tax filing threshold in 2022.

[31] National Health Expenditure Data | CMS, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData

[32] https://economics.harvard.edu/files/economics/files/ms32492.pdf?m=1598903856

    - Due to the limited information available on the uninusred population, we are not able to identify the members that fall in the “family glitch” grouping, therefore these members have not explicitly been removed from the members paying the penalty.
- Undocumented non-citizens would be exempt
- Individuals under age 18 or over age 64 would be exempt

The high take-up scenario assumes that the number of households paying the penalty was muted by 90%, to reflect the lack of enforcement of a penalty. We assumed a very small number of individuals would still pay the penalty as they may not be aware there is no enforcement mechanism.

Low Strength Option (Mandate without Penalty)

This option assumes that the mandate does not apply a penalty and that it is in name only, similar to the current federal mandate. The high take-up estimate assumes that due to marketing efforts and increased awareness of the mandate, a modest number of individuals newly take-up coverage. This was estimated as half the impact of the high take-up estimate under the Moderate (Senate Bill 5840) option. In the absence of a penalty, we assumed fewer individuals would be incentivized to take-up relative to the Moderate option. Similar to the Moderate option above, the low take-up estimates assume no change from the current baseline and no change to the uninsured due to the state mandate program.

No penalty revenue is anticipated under this option.

Appendix D: Reliances and Caveats

Reliances

Wakely has utilized data provided by WAHBE as well as public data in the analyses described in this report.

- 2019 and 2020 enrollment data through September 2020, including county, plan, metal level, premiums (before and after APTC), APTC, household, income, age, race, ethnicity, effectuation status
- 2021 Final Rate data for all carriers by plan, age, and county
- OFM FPL and Immigration Status of the Uninsured: 2018
- Information on implementation considerations and requirements for WAHBE to administer the programs discussed in this report

In addition to the data described above, Wakely relied on the following public data sources to inform the assumptions used in the analyses:

- Small Area Health Insurance Estimates: 2018[33]
- Medical Loss Ratio Data: Public Use File for 2018[34]
- Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year[35]
- Robert Wood Johnson Foundation and Urban Institute "How the COVID-19 Recession Could Affect Health Insurance Coverage"[36]
- Congressional Budget Office (CBO) Background Paper "The Price Sensitivity of Demand for Nongroup Health Insurance"[37]
- CBO "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans"[38]

[33] https://www.census.gov/library/publications/2020/demo/p30-07.html
[34] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Public-Use-File-2018.zip
[35] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf
[36] https://www.rwjf.org/en/library/research/2020/05/how-the-covid-19-recession-could-affect-health-insurance-coverage.html
[37] https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/66xx/doc6620/08-24-healthinsurance.pdf
[38] https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf

- Kaiser Family Foundation Distribution of Nonelderly Uninsured Individuals who are Ineligible for Financial Assistance[39]
- Uniform Rate Review Templates for 2020 plan filings[40]
- SOI Tax Data (Historical Table 2)[41]
- Matt Fiedler "How did the ACA's individual mandate affect insurance coverage?" Brooking Institute[42]
- Maansa Kona and Sabrina Corlette "State Efforts to Protecting Preexisting Conditions Unsustainable Without ACA"[43]
- CMS "National Health Expenditures and Selected Economic Indicators, Level and Annual Percent Change: Calendar Years 2012-2028"[44]
- Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach"[45]

Caveats

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

- **Data Limitations.** The entire year of 2020 was not yet available, nor was information on the results of the open enrollment period for 2021. As a result, there is uncertainty on attrition patterns or other changes to the 2020 year. Changes to base estimates could influence estimates. Secondly, IRS data on household's who paid the mandate are limited. For example, there is no age breakdowns of this population. There is also limited information as to which Washingtonians received exemptions or the reasons for the exemptions. While Wakely made reasonable assumptions there remains uncertainty given data limitations. Finally, data on individual market and uninsured incomes income levels includes a certain level of error and unknown. The extent to which incomes of either the currently insured or uninsured differ from the estimates

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

[40] https://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview

[41] https://www.irs.gov/statistics/soi-tax-stats-historic-table-2

[42] https://www.brookings.edu/research/how-did-the-acas-individual-mandate-affect-insurance-coverage-evidence-from-coverage-decisions-by-higher-income-people/

[43] https://www.commonwealthfund.org/blog/2020/state-efforts-preexisting-conditions

[44] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData

[45] https://economics.harvard.edu/files/economics/files/ms32492.pdf?m=1598903856

may result in material changes in the estimates.

- **Political Uncertainty**. There is significant policy uncertainty. Future federal actions such as additional unemployment insurance payments or other Federal actions could change the estimates enclosed in this report. Additionally, the timing of the end of the Federal emergency declaration over COVID-19 could affect enrollment. Changes to Federal laws and regulations, such as a Supreme Court ruling on California v. Texas, may also impact the estimates. Finally, policy changes at the state level, such as regulations around standard plan designs or public option may influence outcomes.
- **Enrollment Uncertainty.** Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual member or firm responses to these changes also has uncertainty. There is considerable uncertainty as to enrollment patterns due to the economic downturn.
- **Premium Uncertainty.** Given the potential change in enrollment, metal level enrollment decisions, or other enrollment decisions could influence the average premium in the market.
- **Economic Uncertainty.** There remains considerable uncertainty as to the economic conditions in 2021 and 2022, which could impact the number of uninsured as well those with employer-sponsored insurance coverage, which could impact enrollment and premium levels. This uncertainty could impact both the costs of the programs and financing options.
- **Implementation Uncertainty.** There is significant uncertainty as to how many of scenarios above would be implemented. How the programs are ultimately implemented could have material impact on enrollment and costs. For example, the method and potential reconciliation of income data. For purposes of this analysis, Wakely assumed reported income would be used for determination of subsidy eligibility. The extent to which verification of income or after the benefit year reconciliation is different from those assumptions could impact the estimates contained in this report. Similarly, Wakely did not account for any interactions with the current Health Reimbursement Arrangements (HRA) requirements. Eligibility for the program based on employer offers could influence the number of firms that shift employees into the individual market and therefore impact the estimates. Finally, Wakely did not include any costs associated with implementation or assume that those costs (or other costs) would impact the options analyzed.

Appendix E: Disclosures and Limitations

Responsible Actuaries. Brittney Phillips and Julie Peper are the actuaries responsible for this communication. Brittney is an Associate of the Society of Actuaries and Julie is a Fellow of the Society of Actuaries. Both are Members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen was also a key contributor to the analyses and report.

Scope of Services. Unless otherwise explicitly indicated, Wakely's work is limited to actuarial estimates and related consulting services. Wakely is not providing accounting or legal advice. The users of this report should retain its own experts in these areas. In addition, Washington is responsible for successful administrative operations of all of its programs, including those which are the subject of Wakely's actuarial work.

Intended Users. This information has been prepared for the sole use of WAHBE and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We do recognize and grant that the report can be used in the development of the broader proposal for the state individual mandate that will be submitted to the Washington Legislature in December 2020. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. It may be difficult for a non-actuarial audience to fully comprehend the information provided in the report. Therefore, it may be prudent to use actuarial experts to interpret the results.

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

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

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete

or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Methodology and Assumptions' and 'Reliances' sections identifies the key data and reliances.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. Material changes as a result of new federal or state laws or regulations may also have a material impact on the results. The full impact of the COVID-19 pandemic is unknown at the time of this report. The pandemic is a significant source of uncertainty that could have a material impact on Exchange enrollment and needed funding in 2022. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document and the supporting exhibits/files constitutes the entirety of actuarial report and supersede any previous communications on the project.

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

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

ASOP No. 56, Modeling

Appendix F: Table of Option Results

2022 Baseline Scenario		Baseline w/o Mandate	Strong Mandate		Moderate Strength Mandate		Low Strength Mandate	
			High Take-Up	Low Take-Up	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up
Best	**Total Enrollment - Individual Market**	**236,900**	**261,200**	**244,400**	**237,900**	**236,900**	**237,400**	**236,900**
	Change in Individual Market Premiums due to Individual Mandate		-3%	-1%	0%	0%	0%	0%
	Take-Up Coverage		**33,900**	**10,500**	**1,300**	**-**	**600**	**-**
	Individual Market		24,300	7,500	900	-	500	-
	Other (Medicaid, ESI, etc.)		9,600	3,000	400	-	100	-
	Remaining Uninsured	**456,600**	**422,700**	**446,200**	**455,300**	**456,600**	**456,000**	**456,600**
	Paying Penalty		206,200	191,200	4,800	-	-	-
	Not Paying Penalty		216,500	255,000	450,500	456,600	456,000	456,600
	Change in Number of Uninsured		**-7%**	**-2%**	**0%**	**0%**	**0%**	**0%**
	Households Paying Penalty		105,800	98,500	2,000	-	-	-
	Penalty Amount per Household		$800	$780	$1,380	$0	$0	$0
	Total Penalty Revenue (Thousands)		**$84,500**	**$77,100**	**$2,800**	**$0**	**$0**	**$0**
Low	**Total Enrollment - Individual Market**	**187,000**	**206,200**	**192,400**	**187,900**	**187,000**	**187,500**	**187,000**
	Change in Individual Market Premiums due to Individual Mandate		-3%	-1%	0%	0%	0%	0%
	Take-Up Coverage		**29,900**	**8,400**	**1,400**	**-**	**700**	**-**
	Individual Market		19,200	5,400	900	-	400	-
	Other (Medicaid, ESI, etc.)		10,700	3,000	500	-	300	-
	Remaining Uninsured	**442,200**	**412,200**	**433,800**	**440,800**	**442,200**	**441,500**	**442,200**
	Paying Penalty		87,300	80,500	1,900	-	-	-
	Not Paying Penalty		324,900	353,300	438,900	442,200	441,500	442,200
	Change in Number of Uninsured		**-7%**	**-2%**	**0%**	**0%**	**0%**	**0%**
	Households Paying Penalty		87,300	80,500	1,900	-	-	-
	Penalty Amount per Household		$820	$800	$1,380	$0	$0	$0
	Total Penalty Revenue (Thousands)		**$71,600**	**$64,600**	**$2,600**	**$0**	**$0**	**$0**

2022 Baseline Scenario		Baseline w/o Mandate	Strong Mandate		Moderate Strength Mandate		Low Strength Mandate	
			High Take-Up	Low Take-Up	High Take-Up	Low Take-Up	High Take-Up	Low Take-Up
High	**Total Enrollment - Individual Market**	**280,400**	**309,200**	**289,500**	**281,400**	**280,400**	**280,900**	**280,400**
	Change in Individual Market Premiums due to Individual Mandate		-3%	-1%	0%	0%	0%	0%
	Take-Up Coverage		**38,900**	**12,300**	**1,300**	**-**	**700**	**-**
	Individual Market		28,800	9,100	1,000	-	500	-
	Other (Medicaid, ESI, etc.)		10,100	3,200	300	-	200	-
	Remaining Uninsured	**473,400**	**434,500**	**461,100**	**472,000**	**473,400**	**472,700**	**473,400**
	Paying Penalty		125,600	118,000	2,100	-	-	-
	Not Paying Penalty		308,900	343,100	469,900	473,400	472,700	473,400
	Change in Number of Uninsured		**-8%**	**-3%**	**0%**	**0%**	**0%**	**0%**
	Households Paying Penalty		125,600	118,000	2,100	-	-	-
	Penalty Amount per Household		$780	$770	$1,380	$0	$0	$0
	Total Penalty Revenue (Thousands)		**$98,600**	**$90,900**	**$2,900**	**$0**	**$0**	**$0**

Not all numbers may add up to the total due to rounding