Washington Health Benefits Exchange (WAHBE)
2024 Cascade Care Savings (CCS) Subsidy Amount Analysis

DISCLOSURES AND LIMITATIONS

Responsible Actuary. I, Ksenia Whittal, am the actuary responsible for this communication. I am a Member of the American Academy of Actuaries and an Associate of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to issue this analysis. Michael Cohen and Darren Johnson have made significant contributions to this analysis.

Purpose. The purpose of this analysis is to provide estimated changes in the Cascade Care subsidy (CCS) PMPM amounts for 2024 benefit year, incorporating August 2023 enrollment, tobacco rating, the impact of WAH expansion program effecting July 1, 2024, potential DACA enrollment, and the preliminary filed 2024 premium rates. The goal for this analysis is to facilitate discussions with stakeholders on potential revisions to the CCS PMPM amounts.

The estimates are based on 2023 experience data as of August 18, 2023 and 2024 projected market experience. Future market changes such as significant changes in the risk pool, metal mix changes, changes in the starting number of eligible persons (for Group 2 and Group 3 cohorts), regulatory and economic changes would impact these estimates.

Intended Users. This information has been prepared for the sole use of the Washington Health Benefits Exchange (WAHBE). It is our understanding that these results will be provided to members of the stakeholder group, including WA HCA, for review. This analysis cannot be distributed to or relied on by any other third party without the prior written permission of Wakely. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this analysis are inherently uncertain, and numerous projection assumptions may be refined before the subsidy amounts are finalized for 2024. 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 the projected values included in the analysis. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are 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. For some estimates, there are multiple sources of information, including public sources. In some cases, the different sources produce meaningfully different data/information. In this draft version of the model, we have reviewed the data for reasonableness, however, we continue to review the various sources of information and subsequent versions may incorporate adjustments to better reflect the market in Washington.

Subsequent Events. Changes to federal or state law or regulation could impact the results. Additionally, changes to economic conditions could material affect results**. Changes to the current 1332 waiver or its approval status as a result of the policy changes analyzed here were not included in the analysis and could materially impact the results.** There are no 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 constitute the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of my knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations. In developing these standard plan designs and the resulting actuarial certification, Wakely followed applicable Actuarial Standards of Practice (ASOP) including:

ASOP No. 23 Data Quality;
ASOP No. 25 Credibility Procedures;
ASOP No. 41 Actuarial Communications;
ASOP No. 56 Modeling.

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The workbook contains the following tabs:

Tab	Tab Description	Tab Link
Methodology	This tab summarizes the methodology and assumptions underlying the estimates.	Link
Summary	This tab summarizes the 2024 estimates along with two sets of 2024 projected enrollment and CCS subsidy amounts with the final 2024 rates - best and high enrollment scenarios.	Link

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Methods and Assumptions

2024 projections of enrollment of waiver population by varying levels of Cascade Care Savings (CCS) premium subsidy amounts were developed using August 18, 2023 WAHBE enrollment snapshot data provided to Wakely by WAHBE staff. The data included several components including enrollment by county, age, income-level, subsidized status, and premium information. Premium and APTC information was also provided in this dataset. The member level experience was summarized to a cohort level and used in the subsidy modeling.

There are three specific groups of members enrolled on-Exchange eligible for Cascade Care Savings (CCS) state premium subsidies:

- Group 1 enrollees are QHP-eligible residents of Washington State who are eligible for both APTC Federal subsidies and for CCS state premium subsidies.
- Group 2 enrollees are QHP-eligible residents of Washington State who are not eligible for APTC Federal subsidies but eligible for CCS state premium subsidies.
- Group 3 enrollees are undocumented residents of Washington State who are not eligible for APTC Federal subsidies but eligible for CCS state premium subsidies under it's 1332 waiver.

The key components of 2024 CCS estimates and the associated member enrollment include the following:

Effectuation adjustment for starting point data. Enrollment data for August 18, 2023 did not include complete effectuation from the open enrollment period. Therefore, we adjusted effectuated enrollment to reflect historical changes in effectuation during a similar time period in prior years. A portion of currently not effectuated as of 8/18/2023 was assumed to become effectuated in 2023, based on 2022 enrollment experience as of July 2022 and December 2022. Similarly, a small portion (1%) of the effectuated members as of August 18, 2023 were assumed to be retroactively terminated later in the year.

Member attrition from prior year (2023) modeled as a function of 2024 premium increases. The attrition dampening factors were calibrated using actual member attrition experience between 2022 and 2023 and varied by age, income, plan metal tier, and plan type (CC, CC Select and Non-CC plans). The factors were smoothed and dampened to remove extreme values when selecting factors for 2024 projection.

Member persistency through the year. The basis for the member persistency during the benefit year was experience in 2021 for the subsidized and 2022 for the unsubsidized, with an additional improvement in persistency assumed as a result of CCS program in effect starting in 2023 and continuing in 2024. Additionally, August snapshot enrollment was adjusted by comparing the enrollment as of August, 2022 with ultimate average number of members enrolled in 2022. Overall, this adjustment had a small negative impact on the projected enrollment.

Medicaid redetermination related take up. Using information provided by WAHBE, we included an increase in enrollment on the Exchange due to Medicaid redetermination. Using the end date of WAH coverage, we identified QHP enrollees after the start of Medicaid redetermination (4/1/2023) in August data. Based on this information, we revised the monthly redetermination enrollment estimates by month. We also assumed an additional 3% monthly attrition (beyond typical QHP attrition) of these members after six months of QHP enrollment, due to coverage changes (e.g., employment coverage).

SEP related take up. The SEP member take up is modeled using the same assumption as in the last years analysis and based on MA experience of a similar program. Only incremental SEP enrollment that would not already be captured in the August enrollment data was included as an incremental increase in enrollment.

Off Exchange migration. Off-Exchange enrollment as of August 2021 by issuer, age and gender and was provided by WAHBE. This summary did not include enrollment information by rating area or income. We used 2022 risk adjustments report billable membership to back out the on-Exchange enrollment and estimate off-Exchange enrollment in aggregate, assuming similar distribution by rating area. We also assumed that these members would not be eligible for premium subsidies and that their income would be similar to unsubsidized members on the Exchange, with the majority of enrollees with income over 400% FPL. As such, we have assumed little take-up from off-Exchange enrollment but did reflect some movement based on the same elasticity function used to reflect movement from non-Cascade Care plans on-Exchange into Cascade Care plans given the additional subsidies available.

Uninsured take up (due to CCS and also general take up). The number of uninsured individuals was estimated based on the average uninsured individuals reported through ACS for 2019 and not revised at this time. To project the 2023 data to 2024, the enrollment changes were modeled as a function of change in 2024 premiums by county and also assumed general enrollment growth independent on the premium changes. The take up dampening factors were calibrated using actual member take up experience between 2022 and 2023 and varied by age, income and plan metal tier. The factors were smoothed and dampened to remove extreme values when selecting factors for 2024 projection.

Undocumented take up was modeled consistent with prior modeling assumptions. The number of uninsured undocumented members (by age and income) was updated from the prior 2019 estimates provided by WAHBE based on the information received from State of Washington OFM and based on 2021. The elasticity function as described above was used to estimate the number of undocumented individuals that may choose to take up coverage with the availability of the state premium subsidies, however the elasticity was dampened to reflect that these individuals may be hesitant to sign up for coverage, particularly in the first couple years of the program.

- **Washington Apple Health (WAH) Expansion.** In the 2023 legislative session, the legislature directed the Health Care Authority to provide Apple Health-like coverage to individuals up to 138% FPL who previously ineligible for the program based on their immigration status. A range of uptake scenarios were used to estimate the impact of WAH expansion on Cascade Care subsidies, resulting in a minimal impact. This model will be updated when more information from the Health Care Authority is available on WAH expansion implementation.
- **Deferred Action for Childhood Arrivals (DACA) Impact.** In April 2023, the U.S. Department of Health and Human Services (HHS) released a proposed rule to expand health care for DACA recipients. This analysis assumes the finalization of the proposed rule, resulting in a minimal impact on Cascade Care subsidies.

Plan switching from non-CC plans to CC plans. The switching dampening factors were calibrated using actual member switching experience between 2022 and 2023 and varied by age, income and plan metal tier. The factors were smoothed and dampened to remove extreme values when selecting factors for 2024 projection. We assumed no meaningful changes in the Cascade Care plan offerings or premium amounts that may differ from the overall market from 2023 to the projection year.

Plan switching from non-LCCS plans to LCCS plans. While the gross final premiums and SLCS were changed minimally between draft and final versions (gross premiums decreased by 0.2%, and SLCS decreased by 0.3% on average), the LCCS rates decreased by 1.3% on average relative to the draft LCCS rates. Given this, it is likely that there will be more members switching to LCCS plan in 2024 in order to minimize the net premium, which we reflected in this projection.

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Morbidity. The estimated market-wide impact to morbidity due to uninsured enrollees taking up coverage was estimated based on the CEA study, which estimated that new market entrants are estimated to have 27% lower morbidity than those already enrolled in the individual market. This assumption was varied in the low and high estimates. The morbidity assumptions for the uninsured and undocumented were adjusted by two additional considerations: 1) refinement by age based on age-factors from Wakely's pooled ACA experience (nationwide), and 2) refinement to reflect selection based on a percent of all eligible enrolling, developed using a claim probability distribution, and scaled by income level. The selection is assumed to be higher when a low portion of eligibles are choosing to enroll and also when the net premiums are higher (assuming those with higher medical needs are choosing to enroll in both instances). The adjusted factors are used to project the risk pool morbidity changes.

- The morbidity of SEP individuals is based on the overall take up percentage, with the higher the portion enrolling implying the lower the morbidity of those enrolled.
- The morbidity of redetermination members was assumed to be the same as of the currently enrolled in QHP in low and best scenarios, and 5% higher in the high scenario.
- The 2024 premiums assume that any morbidity changes as a result of increased enrollment will be reflected by carriers simultaneously with the increased enrollment and are included in the 2024 premium rates. In reality, this impact may be built in by insurers over time.

2024 premium rate increases. The final 2024 premium rates filed by issuers were provided by WAHBE by plan and county for all plans. For the terminated plans, plan crosswalk to the continuing or new plans was available and used.

Family Glitch. It was assumed that 2023 enrollment experience reflects the family glitch eligible enrollment and no additional uptake was added for 2024.

The take up, attrition and plan switching discussed below were modeled based on the elasticities estimated by the Congressional Budget Office (CBO (1)), and Saltzman et al (July 2021) research on selection in the ACA Exchanges (2). The function computes expected enrollment change based on premium rate changes. Dampening factors were applied to this take-up function. The dampening factor is intended to reflect the ramp-up factor of introducing a new premium subsidy program. This analysis is meant to reflect the impact in the first year of the program. It will require member outreach and education and therefore, the take-up of new enrollees in the first year will likely be lower than the steady-state enrollment levels. The dampening adjustment was determined based on the ramp-up levels researched by ASPE, which assumed it would take 3-5 years for programs to reach steady state enrollment (3).

The two scenarios (best and high) reflect the following assumptions:

Best scenario: This scenario reflects best estimate of market enrollment based on WAHBE experience and best estimates of assumptions for:

Effectuation rates consistent with 2022 experience;
Member persistency improvement due to CCS program;
Enrollment growth in absence of CCS (organic growth) consistent with 2023 experience;
Enrollment attrition due to premium changes consistent with 2023 experience;
SEP and Medicaid redetermination impact on enrollment consistent with 2023 experience;
CC plan switching consistent with 2023 experience;
Uninsured take up consistent with 2023 experience;
Undocumented take up with average dampening reflective of average hesitancy;
27% lower morbidity of the uninsured and undocumented taking up coverage.

High scenario: This scenario reflects generally higher estimate of market enrollment, driven by lower premium increases and low morbidity of those enrolling:

Higher effectuation rates relative to the best scenario;
Higher member persistency relative to the best scenario;
Higher enrollment growth in absence of CCS (organic growth) relative to the best scenario;
Lower enrollment attrition due to higher premium changes relative to the best scenario;
Higher SEP and Medicaid redetermination impact on enrollment relative to the best scenario;
Higher CC plan switching relative to the best scenario;
Higher uninsured take up relative to the best scenario;
Higher undocumented take up with the dampening reflective of lower hesitancy relative to the best scenario;
36% lower morbidity of the uninsured and undocumented taking up coverage.

Except for the impacts described above, we did not assume any significant changes to enrollment or plan offerings in 2024. We are assuming that the August 2023 enrollment is representative of enrollment going forward. Changes to federal law, state law (beyond what was modeled), or economic conditions could materially impact the estimates. We have assumed that the distribution of members' income as a federal poverty limit (FPL) in 2024 is similar to the current 2023 Exchange enrollment. We have assumed that individuals that are ineligible for federal subsidies due to Medicaid eligibility will also not be eligible for the state program. We assumed that the state subsidies funding levels would remain the amounts estimated as part of the 1332 application. We also assumed the same subsidy structure would apply as currently in force, with the subsidy amount capped at the lowest cost silver Cascade Care rate in a county. Additionally, we assumed the 1332 waiver would not be impacted by the changes of the policy. Wakely did not evaluate the potential for the policies to impact the 1332 waiver or the guardrails necessary for the waiver to maintain approval status. The premium subsidy estimates shown here are based on Advanced Premium Tax Credits (APTCs). The actual final Premium Tax Credit (PTC) may differ once income is verified through the tax filing process each year. Finally, we relied on the determination of CCS eligibility provided by WAHBE at a member level in 8/18 enrollment data. Per discussion with WAHBE team, members with “NULL” CCS amounts were deemed as ineligible and were treated consistently in the 2024 projections.

References:

(1) https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/66xx/doc6620/08-24-healthinsurance.pdf
(2) NBER WORKING PAPER SERIES. INERTIA, MARKET POWER, AND ADVERSE SELECTION IN HEALTH INSURANCE: EVIDENCE FROM THE ACA EXCHANGES. Saltzman et al. http://www.nber.org/papers/w29097. July 2021
(3) https://aspe.hhs.gov/system/files/pdf/77161/ib_Targets.pdf
(4) Age and Family Income Level of Washington State's Undocumented Immigrants Who Were Uninsured, 2021, provided by WAHBE on July 12, 2023.

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	Mar 15 Enrollmen 2023 Best Estimate	*Aug 18 Enrollment* 2023 Best Estimate Updated	**Updated CCS PMPMs for 2024 With Final 2024 Rates** Best	High
Source Tab:	**[1]**	**[2]**	**[3]**	**[4]**
CCS Maximum Subsidy:				
Group 1	$155	$155	$155	$155
Group 2/3	$155	$155	$250	$250
Enrollment:				
Group 1	50,970	60,870	74,480	89,840
Group 2/3	1,480	2,040	7,690	9,760
Total Exchange Enrollment	218,430	217,980	214,760	250,730
CCS Expenditures (in millions):				
Group 1	$17.4	$24.4	$32.6	$41.8
Group 2/3	$2.8	$3.8	$23.0	$29.2
Total	**$20.2**	**$28.2**	**$55.7**	**$71.0**
CCS Utilization PMPM:				
Group 1	$28.44	$34.34	$36.52	$38.72
Group 2/3	$155.00	$155.00	$249.32	$249.33
Total	**$32.02**	**$38.26**	**$56.44**	**$59.36**