Cascade Care Workgroup

Jan. 22, 2025

washington healthbenefitexchange
powering washington healthplanfinder

Cascade Care Workgroup Agenda

Time	Topic	Facilitator
10:00	Welcome & Introductions	Laura Kate Zaichkin, *Director of Market Competition & Affordability (she/her)*
10:05	2026 Market Landscape: Affordability & Access Risks	Spencer Budd, *Senior Policy Analyst (he/him)* Joan Altman, *Director of Coverage Strategies & Expansion (she/her)*
10:25	Access & Affordability Risk Mitigation Considerations	Joan Altman Spencer Budd
11:00	Cascade Care Tactics: Standard Plan Designs & Cascade Care Savings	Kristin Villas, *Senior Policy Analyst (she/her)* Julia Nestor, *Policy Analyst (she/her)*
11:55	Next Steps & Adjourn	Laura Kate Zaichkin

Goal: Keep Washingtonians Covered

risk mitigation strategies under consideration

COVERAGE ACCESS

- Protect immigrant health expansion
- Consider transitional solution for coverage after Medicaid loss
- Leverage Exchange sponsorship

COVERAGE AFFORDABILITY

- Maximize federal premium tax credits
  - Standardized Silver loading
- Make premiums and care more affordable
  - Public option
  - Standard plan designs
- Maintain and maximize available premium subsidies
  - Tobacco rating
  - Cascade Care Savings

ACCESS & AFFORDABILITY RISKS

2026 Market Landscape

Enhanced premium tax credits

Set to expire end of 2025

Background on enhanced federal subsidies

- Federal subsidies, also known as advance premium tax credits (APTC) are a federal tax credit that offsets some of the cost of premiums for Exchange customers.
- The American Rescue Plan Act of 2021 (ARPA) enhanced federal subsidies in two ways:
  - Eligible customers under 400% of the federal poverty level (FPL) received a larger APTC amount;
  - Eligible customers over 400% FPL became eligible for APTC for the first time.
- Enhanced federal subsidies will expire in December 2025 under current law.

Enhanced premium tax credits increased subsidies for every income group

Enhanced premium tax credits (ePTC) lower the maximum percent of income customers are asked to contribute to a benchmark plan.

FPL (%)	Annual Income (single person household, 2025)	Pre-ARPA Maximum percent of income	ARPA Maximum percent of income
<=150%	<$22,590	3.10%-4.14%	0.0%
151-200%	$22,591-$30,120	4.14%-6.52%	0.0%-2.0%
201-250%	$30,121-$37,650	6.52%-8.33%	2.0%-4.0%
251-300%	$37,651-$45,180	8.33%-9.83%	4.0%-6.0%
301-400%	$45,181-$60,240	9.83%	6.0%-8.5%
>400%	>$60,240	N/A	8.5%

Congressional reauthorization is needed to keep people covered

Set to expire at the end of 2025, federal ePTCs are critical to ensuring health insurance is accessible and affordable in Washington state.

270,000

Number of residents enrolled in qualified health plans (QHPs).

219,000

Number of QHP enrollees who are eligible for enhanced premium tax credits.

$1,300

Average yearly decrease in premium costs with enhanced premium tax credits.

$1,900

Average yearly decrease in premium costs for 55- to 64-year-old residents with enhanced premium tax credits.

Washingtonians face steep premium increases and many will forgo health insurance

The effect of enhanced premium tax credits expiring in Washington state:

72%

Amount net premiums will increase for enhanced premium tax credits recipients.

$275M

Amount of lost federal funds from enhanced premium tax credits.

80,000

Number of enhanced premium tax credits recipients who will forgo coverage.

Coverage expansions

Federal watch areas

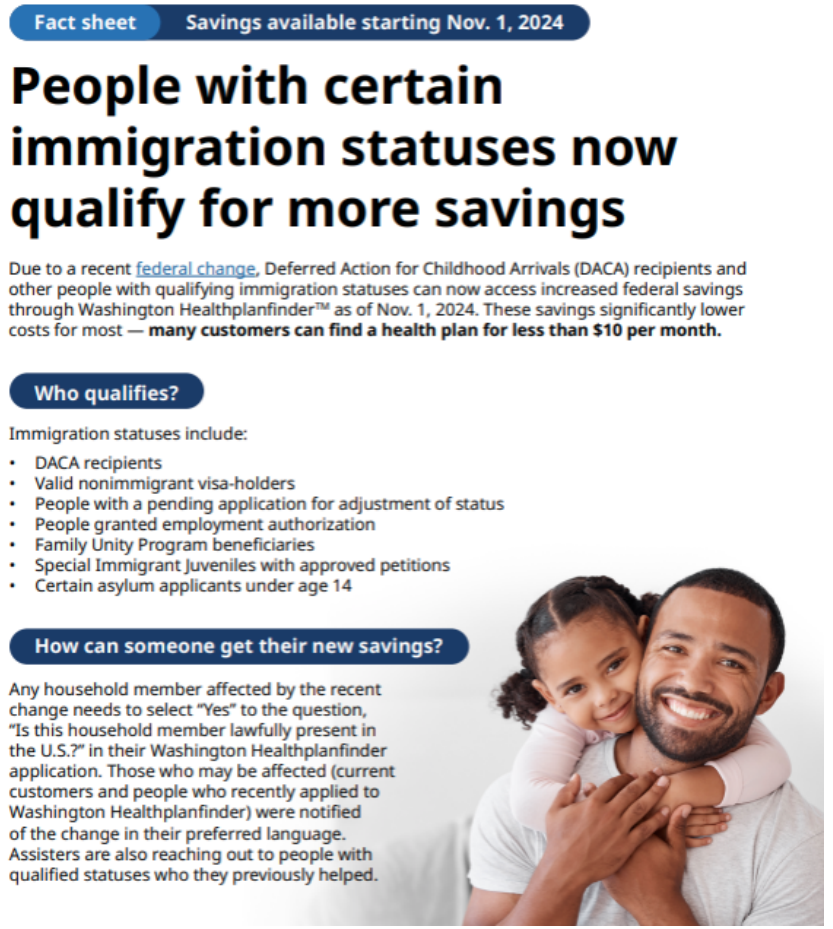
Coverage expansion portfolio

- Access to affordable coverage is critical for those unable to access federal subsidies and who are low income.

- Federal watch areas:
  - Loss of enhanced federal subsidies
  - DACA rule
  - **1332 waiver**
  - Continuity of coverage challenges if broader ACA or program/eligibility changes (e.g., Marketplaces, Medicaid, Medicare)

Deferred Action for Childhood Arrivals (DACA)

- DACA recipients and other people with qualifying immigration statuses able to access coverage with premium tax credits as of Nov. 1, 2024.
- Federal rule focus of ongoing litigation and potential future administrative action.
- Access maintained in WA for time being; contingency planning with HCA and DSHS
- More information available at https://www.wahbexchange.org/about-the-exchange/initiatives/daca/



Fact sheet | Savings available starting Nov. 1, 2024

People with certain immigration statuses now qualify for more savings

Due to a recent federal change, Deferred Action for Childhood Arrivals (DACA) recipients and other people with qualifying immigration statuses can now access increased federal savings through Washington Healthplanfinder™ as of Nov. 1, 2024. These savings significantly lower costs for most — **many customers can find a health plan for less than $10 per month.**

Who qualifies?

Immigration statuses include:

- DACA recipients
- Valid nonimmigrant visa-holders
- People with a pending application for adjustment of status
- People granted employment authorization
- Family Unity Program beneficiaries
- Special Immigrant Juveniles with approved petitions
- Certain asylum applicants under age 14

How can someone get their new savings?

Any household member affected by the recent change needs to select "Yes" to the question, "Is this household member lawfully present in the U.S.?" in their Washington Healthplanfinder application. Those who may be affected (current customers and people who recently applied to Washington Healthplanfinder) were notified of the change in their preferred language. Assisters are also reaching out to people with qualified statuses who they previously helped.

Immigrant Health Coverage – 1332 Waiver

- Washington's 1332 waiver allows all Washingtonians, regardless of immigration status, to purchase QHPs & QDPs, and access state subsidies, if applicable.
  - Immigrant Health Coverage: Qualified Health Plan Expansion Data Snapshot (October 2024)
  - Updated data available post-OE
- Waiver approved from Jan. 1, 2024 – Dec. 31, 2028, but is subject to ongoing federal approval.
- Contingency planning underway — in partnership with Tribes, Governor's office, AG, OIC, HCA, carriers and community partners.

POLICY CONSIDERATIONS FOR DISCUSSION

Access & Affordability Risk Mitigation

Immigrant Health Coverage – 1332 Waiver

- Contingency planning - guiding principles:
  - Maintain current 1332 waiver as long as possible
  - Maintain privacy for IHC customers
  - Avoid mid-year coverage disruption, if possible
  - Maintain a coverage pathway and access to state subsidies

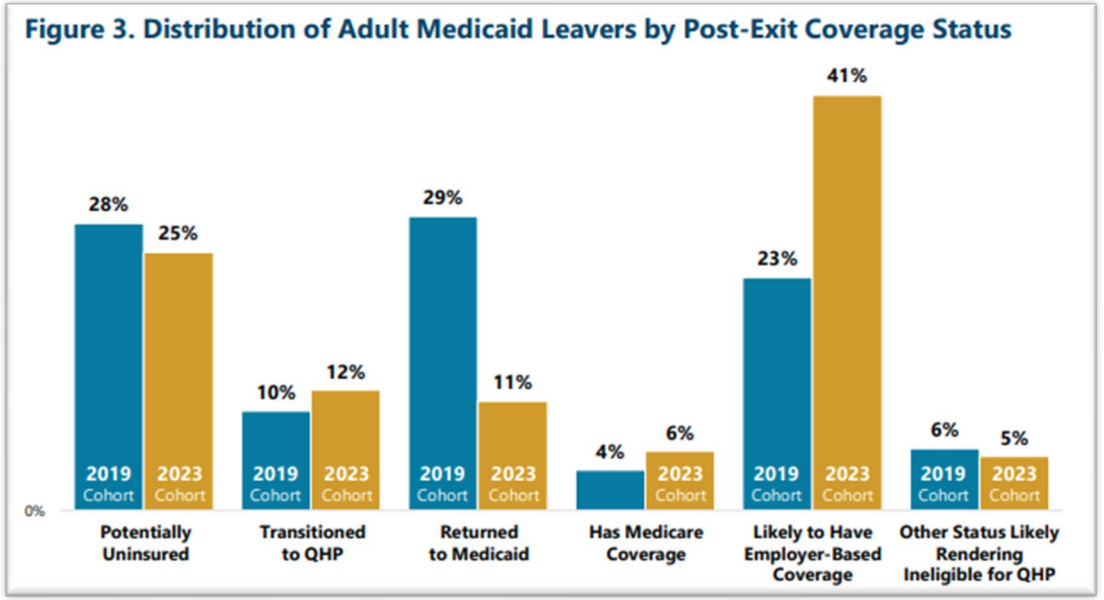
- Potential alternative coverage pathways via Washington Healthplanfinder — for further discussion with implementation partners (Jan/Feb)
  - Leverage off-Exchange market
  - Leverage state-only Medicaid program
  - Create new population-specific plan(s)

Immigrant Health Coverage – 1332 Waiver

- Recent activity
  - Monitoring federal transition and peer state 1332 waiver activities
  - Community-based engagement (fear/uncertainty)
  - Exploring additional privacy protections (in partnership with Gov. office, AG's office, agency and community-based partners)
- Next steps
  - Further engagement with implementation partners
  - 2025 leg session considerations (state subsidy, privacy, authority)

Additional Potential Continuity of Coverage Challenges

- Changes in federal eligibility criteria significantly affect Washington Healthplanfinder customers
  - Federal changes to marketplace, Medicaid or Medicare eligibility would raise continuity of coverage challenges.
  - Recent example — Medicaid Unwind. Detailed DSHS analysis available in recently submitted legislative report (continuing health coverage for people losing Medicaid).
- Affordability efforts critical to helping mitigate potential coverage losses and helping to address current health disparities.



Standardized Silver loading

What is standardized Silver loading?

Challenge: Inconsistent Silver loading reduces benchmark plan prices, reducing APTC and increasing net premiums for all subsidized customers.

Opportunity: Set consistent expectations for carriers.

- First, carriers must use the same assumptions, for all metal tiers, about the relationship between cost-sharing and utilization. (*standardized induced demand*)
- Second, carriers must use the same assumptions about the distribution of Silver enrollees among plans with varying AV. (*standardized enrollment assumptions*)

A 2020 analysis estimated standardized Silver loading would increase APTC by up to **$110M annually**.*

*Source: Axene Health Partners. The ACA's Silver Bulletin.

Impact on Customers

- **Who is helped by standardized Silver loading?**
  - Anyone enrolled in a plan other than on-exchange Silver (*153K, 51%, of enrollees*)
- **Who is not affected by standardized Silver loading?**
  - Anyone eligible for APTC *who remains* enrolled in an on-exchange Silver plan. (*129K, 44%, of enrollees*)
- **Who is potentially negatively impacted by standardized Silver loading?**
  - Anyone ineligible for APTC *who remains* enrolled in an on-exchange Silver plan. (*17K, 6%, of enrollees*)

**Source: Lewis & Ellis. (2024). Cost Sharing Reductions and Silver Loads: Presented to the Green Mountain Care Board.*

States Adopting Standardized Silver Loading

- Seven states have adopted a version of standardized Silver loading.
- Six states have standardized both induced demand factors and silver enrollment distribution assumptions:
  - Maryland (PY2018)
  - Pennsylvania (PY2021)
  - New Mexico (PY2022)
  - Texas (PY2023)
  - Vermont (PY2025)
  - Illinois (PY2026)
- Colorado (PY2022) has adopted only the standardized induced demand piece.

The effect in other states

- Marketplace enrollment in Texas **grew by 31%** in open enrollment the first year of standardized Silver loading (PY2023). Enrollees in Gold plans **increased from 9% to 23%.**
- In New Mexico, the proportion of marketplace enrollees receiving high-deductible coverage in bronze or low-AV silver **fell from 49% to 23%**.
- In Pennsylvania, the average lowest-cost Bronze premium **decreased by 9%** and average lowest-cost Gold premium **decreased by 12%.**

Tobacco rating

Tobacco rating background

- ACA and corresponding regulations permit insurers in the individual and small group markets to charge tobacco users premiums up to **1.5 times higher** than those they charge for people who don't use tobacco.
- This is commonly called "tobacco rating."
- The amount of a consumer's premium tax credit and cost-sharing reductions (CSRs) are calculated after the insurer adjusts the premium to reflect the consumer's age and geographic region, but before "rating up" for tobacco use.
  - **Note:** Cascade Care Savings works differently.
    It is applied to the tobacco rated premium.
- This often results in significantly higher health insurance premiums and cost-sharing for people who self-identify as tobacco users on the application.

Policy rationale for eliminating tobacco rating

- There is little evidence to suggest raising a customer's insurance premium is an effective way to end tobacco addiction.
  - Charging higher rates for tobacco use **likely raises uninsurance rates**. Those who might be especially well-served by coverage including access to tobacco cessation benefits may be unable to afford it.
  - Some research suggests that many **people fail to accurately report tobacco usage** on the coverage application, resulting in penalizing those who are truthful and exposing others to potential liability for the omission.
- Tobacco usage and tobacco-related health issues are higher among persons of color, those with low or moderate incomes and people in rural areas. Changing state policy may increase health coverage rates overall and among these target populations.
- Additionally, eliminating tobacco rating is estimated to free up more than **$2M in annual Cascade Care Savings funding**.

Tobacco rated premium limits in other states

Ten states have limited or eliminated tobacco rated premiums. Three states have set a maximum rated premium below the 50% allowed by the ACA.

Policy	States	Notes
Eliminated tobacco rated premiums	CA, CT*, DC, MA, NJ, NM**, NY, RI, VT, VA***	*Only for plans sold via state's health insurance exchange **New as of 2023, only for individual market ***For 2024 and 2025 only
Set maximum rated premium	AR: 20% CO: 15% KY: 40%	

Sources:
Issuers are prohibited from using tobacco use as a rating factor in the Small Group market in accordance with CGS §38a -567. AHCT will not permit tobacco rating in the Individual market.
https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/can-i-be-charged-higher-premiums-in-the-marketplace-if-i-smoke/
https://www.healthinsurance.org/faqs/will-smokers-be-unable-to-afford-insurance-under-the-aca/

DRAFTS FOR DISCUSSION

PY 2026 Cascade Care tactics

Expanding the standard plan shelf

Today’s discussion

- Recap: Cascade Care plan stakeholdering process
- Need for additional standard plans
- Review proposed options for public comment and next steps
  - Public comment, Jan. 9-29
  - Public comment meeting Jan. 29

Standard plan design background

Exchange standard plan program

- Have designed five years of standard plans starting in 2021.
- Essential, high value services at co-pay before deductible in all metal levels (primary care, mental/behavioral health, urgent care, generic Rx).

Goals for standard plans from Cascade Care Legislation

- Lower deductibles and access to services before the deductible.
- Prioritize copays, where possible, to provide predictability for consumers when seeking services.
- Limit premium impacts.
- Maximize tax credits with Silver plan design.

Typical timeline of stakeholder and Exchange Board engagement on standard plan design

April – July

Determine areas of focus and next steps for research

August-October

Model different plan designs, share findings

October-November

Hold public comment period and meeting

December

Present plan options for Board approval

Exchange Board approved three 2026 standard plans in December

Benefits	2026 Standard Gold	2026 Standard Silver	2026 Standard Bronze
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$1,000	$2,500	$6,000
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$7,000	$9,750	$10,150
Office Visits			
Preventive Care/Screening/Immunization	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$15	$20***	$40***
Specialist Visit	$40	$65	$100
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	$15	$20***	$40***
Emergency/Urgent Care Services			
Emergency Care Services	$450	$800	40%
Urgent Care	$35	$65	$100
Ambulance	$375	$375	40%
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$350	$600	40%
Outpatient Surgery Physician/Surgical Services	$75	$200	40%
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$15	$30	40%
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	$20	$40	40%
X-rays and Diagnostic Imaging	$30	$65	40%
Advanced Imaging (CT/PET Scans, MRIs)	$300	30%	40%
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	$525*	$800*	40%
Skilled Nursing Facility	$350**	$800**	40%
Pharmacy			
Generics	$10	$25	$32
Preferred Brand Drugs	$60	$75	40%
Non-Preferred Brand Drugs	$100	$250	40%
Specialty Drugs (i.e. high-cost)	$100	$250	40%
All Other Benefits			
Speech Therapy	$25	$40	40%
Occupational and Physical Therapy	$25	$40	40%
Durable Medical Equipment (DME)	20%	30%	40%
Home Health	$15**	$30**	$50**
Hospice	$15**	$30**	$50**
All Other Benefits	20%	30%	40%
AV	81.81%	71.84%	64.97%

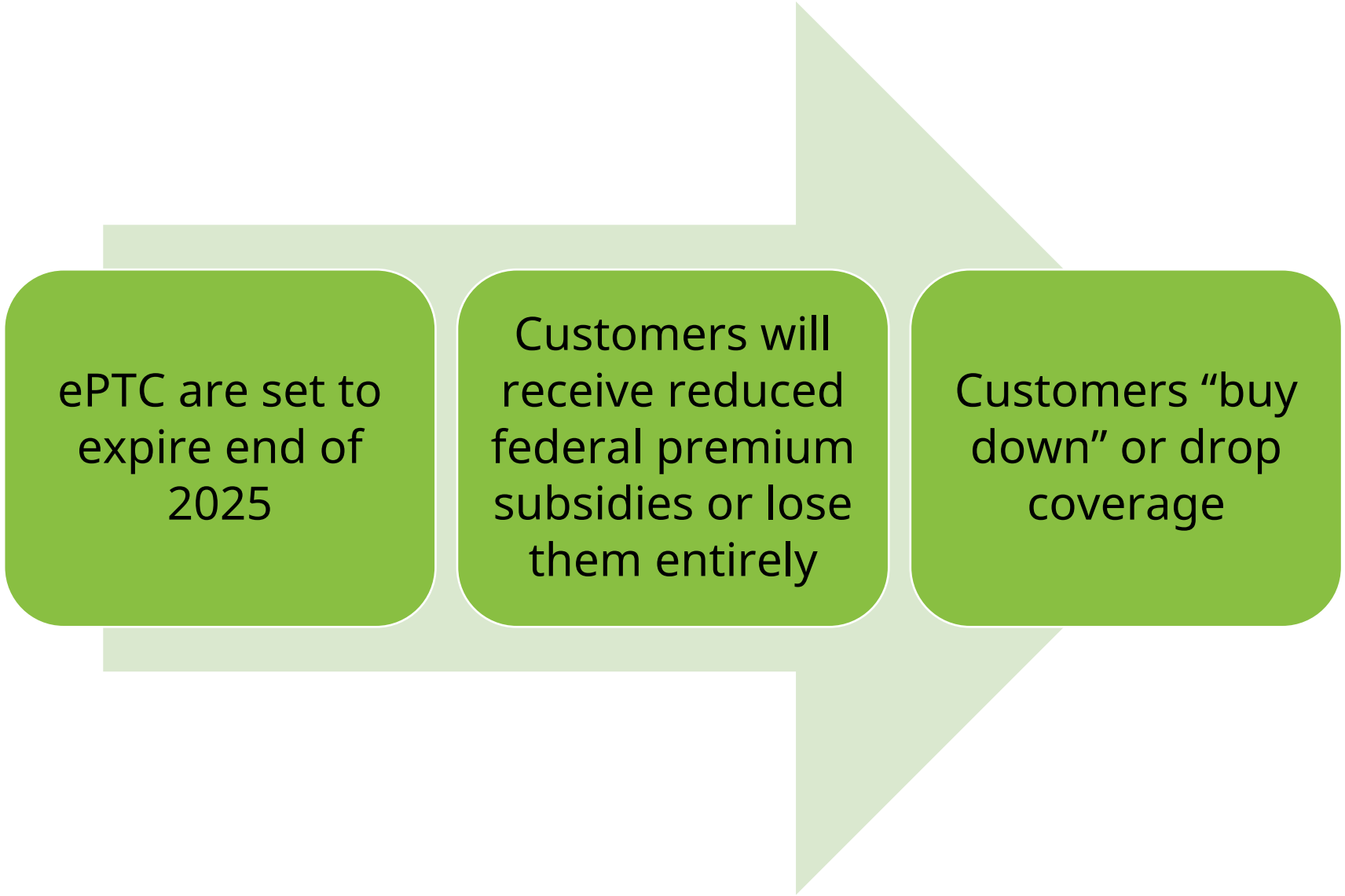
Blue shaded items are not subject to deductible. Board also approved Silver cost-sharing reduction (CSR) variants.

* Per day copay, maximum of five copays per stay.

** Per day copay.

*** Eligible for two visits at $1 copay, after which stated cost-sharing applies.

Expiration of ePTCs drives need for additional standard plans



Proposing two additional 2026 standard plan designs to meet market needs

- The Exchange has legislative authority under SB 5377 to design up to three standard plans per metal level.
- Design concepts are:
  - A Bronze high-deductible health plan (HDHP) that is health savings account (HSA) compatible, with low actuarial value (AV).
  - A Low AV Gold plan close in AV to standard Silver.
- Goals are to promote affordability and keep people covered with plan options that work for customers across the spectrum.

Bronze HDHP HSA plan to help unsubsidized customers maintain coverage

- Potential customer*
  Higher income (400%+ FPL)
  Was receiving tax credits prior to ePTC expiration
  Would otherwise drop coverage if a very low premium plan is unavailable
- Plan key facts:
  - Meets IRS High Deductible Health Plan Requirements for 2026
  - Per HDHP rules, no services other than preventive before deductible
  - Plan type only available in 30 counties for 2025
  - Low AV intended to ensure low premium, minimal coverage option

* Recognize some customers with little disposable income may select plan because of low premium — seeking stakeholder feedback on impact and risks

Standard Bronze HSA options

All options have out-of-pocket maximum (MOOP) of $10,150

- Option 1 – Deductible is increased by $100
- Option 2 – Deductible is increased by an additional $4,050 (same as MOOP)

Shaded items are not subject to Deductible

*Eligible for two visits at $1 copay, after which stated cost-sharing applies

**Per day copay

Benefits	Bronze HSA		
	2026 Approved Bronze (reference)	Option 1	Option 2
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$6,000	$6,100	$10,150
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$10,150	$10,150	$10,150
Office Visits			
Preventive Care/Screening/Immunization	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$40*	40%	100%
Specialist Visit	$100	40%	100%
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	$40*	40%	100%
Emergency/Urgent Care Services			
Emergency Care Services	40%	40%	100%
Urgent Care	$100	40%	100%
Ambulance	40%	40%	100%
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	40%	40%	100%
Outpatient Surgery Physician/Surgical Services	40%	40%	100%
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	40%	40%	100%
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	40%	40%	100%
X-rays and Diagnostic Imaging	40%	40%	100%
Advanced Imaging (CT/PET Scans, MRIs)	40%	40%	100%
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	40%	40%	100%
Skilled Nursing Facility	40%	40%	100%
Pharmacy			
Generics	$32	40%	100%
Preferred Brand Drugs	40%	40%	100%
Non-Preferred Brand Drugs	40%	40%	100%
Specialty Drugs (i.e. high-cost)	40%	40%	100%
All Other Benefits			
Speech Therapy	40%	40%	100%
Occupational and Physical Therapy	40%	40%	100%
Durable Medical Equipment (DME)	40%	40%	100%
Home Health	$50**	40%	100%
Hospice	$50**	40%	100%
All Other Benefits	40%	40%	100%
AV	64.97%	61.01%	59.20%

Low Gold AV plan for comprehensive coverage

- Potential customer:
  - Average utilization
    - Unlikely to hit MOOP or have conditions requiring ER visits or high-cost drugs
  - Wants comprehensive coverage, but not eligible for cost-sharing reductions (CSRs) in Silver plan
    - May also not be eligible for tax credits
- Plan facts:
  - Depending on carrier, low Gold plan premiums may be the same price or lower than Silver premium
    - Intent to pair with standardized Silver loading
  - May have higher premiums than non-standard Gold plans
    - Predictability of copays in standard plan benefit design encourages use of insurance, which increases plan pricing

Standard low Gold AV options

- Compared to 2026 approved Gold
  - Option 1 raises the deductible by $900 and MOOP by $1,800; Keeps many cost shares the same
  - Option 2 raises the deductible by only $500 MOOP by only $550 but increases many cost shares

Shaded items are not subject to deductible.

* Per day copay, maximum of five copays per stay

** Per day copay

*** Eligible for two visits at $1 copay, after which stated cost-sharing applies

Benefits	Low AV Gold		
	2026 Approved Gold	Option 1	Option 2
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$1,000	$1,900	$1,500
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$7,000	$8,800	$7,550
Office Visits			
Preventive Care/Screening/Immunization	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$15	$15	$20***
Specialist Visit	$40	$40	$45
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	$15	$15	$20***
Emergency/Urgent Care Services			
Emergency Care Services	$450	$800	$800
Urgent Care	$35	$35	$45
Ambulance	$375	$375	$375
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$350	$350	$600
Outpatient Surgery Physician/Surgical Services	$75	$75	$200
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$15	$15	$30
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	$20	$30	$35
X-rays and Diagnostic Imaging	$30	$30	$40
Advanced Imaging (CT/PET Scans, MRIs)	$300	$300	$300
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	$525*	$650*	$800*
Skilled Nursing Facility	$350**	$350**	$800**
Pharmacy			
Generics	$10	$10	$20
Preferred Brand Drugs	$60	$75	$75
Non-Preferred Brand Drugs	$100	$200	$250
Specialty Drugs (i.e. high-cost)	$100	$200	$250
All Other Benefits			
Speech Therapy	$25	$30	$35
Occupational and Physical Therapy	$25	$30	$35
Durable Medical Equipment (DME)	20%	20%	20%
Home Health	$15**	$15**	$30**
Hospice	$15**	$15**	$30**
All Other Benefits	20%	20%	20%
AV	81.81%	78.06%	78.02%

Comparison: 2026 Silver to low Gold options

- Compared to 2026 approved Silver
  - Option 1 lowers the deductible by $600 and lowers many cost shares
  - Option 2 lowers the deductible by $1,000; Keeps many cost shares the same

Shaded items are not subject to deductible.
* Per day copay, maximum of five copays per stay
** Per day copay
*** Eligible for two visits at $1 copay, after which stated cost-sharing applies

Benefits	Low AV Gold		
	2026 Approved Silver (Reference)	Option 1	Option 2
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$2,500	$1,900	$1,500
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$9,750	$8,800	$7,550
Office Visits			
Preventive Care/Screening/Immunization	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$20***	$15	$20***
Specialist Visit	$65	$40	$45
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	$20***	$15	$20***
Emergency/Urgent Care Services			
Emergency Care Services	$800	$800	$800
Urgent Care	$65	$35	$45
Ambulance	$375	$375	$375
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$600	$350	$600
Outpatient Surgery Physician/Surgical Services	$200	$75	$200
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$30	$15	$30
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	$40	$30	$35
X-rays and Diagnostic Imaging	$65	$30	$40
Advanced Imaging (CT/PET Scans, MRIs)	30%	$300	$300
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	$800*	$650*	$800*
Skilled Nursing Facility	$800**	$350**	$800**
Pharmacy			
Generics	$25	$10	$20
Preferred Brand Drugs	$75	$75	$75
Non-Preferred Brand Drugs	$250	$200	$250
Specialty Drugs (i.e. high-cost)	$250	$200	$250
All Other Benefits			
Speech Therapy	$40	$30	$35
Occupational and Physical Therapy	$40	$30	$35
Durable Medical Equipment (DME)	30%	20%	20%
Home Health	$30**	$15**	$30**
Hospice	$30**	$15**	$30**
All Other Benefits	30%	20%	20%
AV	71.84%	78.06%	78.02%

Proposed relationship with other Cascade Care program requirements

Plan	Cascade Care Savings Eligible	Required for Carriers to Offer (Silver Loading)	Required for Carriers to Offer (No Silver Loading)
Bronze HSA*			
Low AV Gold	✓	✓	

*Propose standard Bronze HSA is not a plan offered by Public Option carriers

Discussion — Balancing affordability without contributing to choice overload

- Promoting affordability and coverage
  - Which option will best help Exchange customers who are facing significant premium increases stay covered?
  - Which Bronze HSA plan design offers the best low-premium option to customers losing access to federal subsidies?
- Understandable market shelf
  - If adopted, how might we mitigate choice error for customers only considering lowest premium when they would financially benefit in a different plan?
  - Balancing market overcrowding and the potential affordability cliff, should either the low-AV gold and/or bronze HSA standard plans be required for carriers to offer?
- Are there any variables that were not presented that you believe would better address the goals of these potential additional standard plans?

2026 Cascade Care plan design next steps

- Options available for public comment through Jan. 29
- Public comment meeting 11:30 a.m., Jan. 29
- Feb. 6: Exchange Board presented with additional 2026 standard plan designs for approval

Cascade Care Savings policy

PY 2026 Cascade Care Savings Policy Timeline

October-November 2024

Exchange published PY 2026 Cascade Care Savings policy options for public comment

December 2024

Exchange released initial PY 2026 draft Cascade Care Savings policy for stakeholder feedback

January 2025

Final PY 2026 draft policy published for public comment; public comment meeting

By April 2025

Exchange finalizes PY 2026 Cascade Care Savings policy

	Initial Draft	Final Draft For Public Comment
Refine metal level eligibility	Silver Cascade plan for customers 200% FPL and below who qualify for federal cost sharing reductions Silver or Gold Cascade Care plans for customers above 200% FPL to 250% FPL and customers who do not qualify for federal cost sharing reductions	Included as initially proposed ✓
Encourage full use of available federal subsidy or other coverage opportunities to maximize state investment	Proposed customers ineligible for state subsidies are: • Customers with other affordable minimum essential coverage • Customer that has indicated they do not intend to file taxes • Customers that have failed to file or reconcile taxes for the past two years without attestation of having filed or reconciled An exception process will be available or customers with taxable income below the tax filing threshold	Included as initially proposed ✓
Bronze standard plans for selective groups	Not included in initial draft Current consideration: Customers who do not qualify for federal subsidies and enrolled in Bronze Cascade Care plans are eligible for CCS	Requires tradeoffs discussion with workgroup
Minimum contribution	Initial draft: Proposed minimum contribution at $10 for all CCS eligible customers Current consideration: Tiered minimum contribution by FPL	Requires tradeoffs discussion with workgroup

Consideration: Bronze Standard Plans for Selective Groups

Expanding Bronze Standard plans to customers without access to federal cost sharing reductions

- Financial impact: ~$1M increase
- Total Exchange enrollment: Remains about the same
- CCS enrollment increase: ~400

Customer Impact

- Positive impact on older customers with more expensive plans
- Customers already in Bronze standard plans will become eligible for CCS
- Not likely to attract new customers to the Exchange

Intersections with waiver alternative pathways being considered

As proposed, HSA compatible plan would not be required nor eligible for CCS

Bronze Standard Plan for Selective Groups Illustrative Example

	Bronze Standard Not Eligible	Bronze Standard CCS Eligible
Per member per month (PMPM) amount scenario	Federally subsidized: $70 Non-federally subsidized: $200	Federally subsidized: $70 Non-federally subsidized: $200
Total CCS Spend	~$55.6M	~$56.5M
CCS Enrollment	Federally subsidized: ~68,175 Non-federally subsidized: ~2,015	Federally subsidized: ~68,175 Non-federally subsidized: ~2,410
Average net premiums	Federally subsidized: ~$183 Non-federally subsidized: ~$325	Federally subsidized: ~$183 *Non-federally subsidized: ~$338

*Change in premium largely driven by older customers with higher gross premiums

As proposed, HSA compatible plan would not be required nor eligible for CCS

Consideration: Tiered Minimum Contribution

Policy

Final Draft may include tiered contribution:

- Customers up to 150% FPL contribute: $0
- Customers 150% - 200% FPL contribute: $10
- Customers above 200% FPL contribute: $15

Exchange Impacts:

- Financial impact: ~$7.5M savings
- Total Exchange enrollment: ~700 customer increase
- CCS enrollment increase: More than 400 customer increase (model does not include eligible for, but receiving $0 of CCS)

Stakeholder Considerations

Premium parity

- A minimum contribution would allow the Exchange to reinvest the 'savings' into customers without federal subsidies, including the IHC population, and create premium parity

ARP/No ARP

- Without ePTC there is already a natural 'minimum contribution'
- Minimum contribution is more financially impactful if ePTC continues
- Expectation is that the new federal administration will not continue ePTC

Tiered Minimum Contribution Illustrative Example

	No Minimum Contribution	Tiered Minimum Contribution
Per member per month (PMPM) amount scenario	Federally subsidized: $70 Non-federally subsidized: $200	Federally subsidized: $70 Non-federally subsidized: $315
Total CCS Spend	~$55.6M	~$55.3M
*CCS Enrollment	Federally subsidized: ~68,175 Non-federally subsidized: ~2,015	Federally subsidized: ~67,450 Non-federally subsidized: ~3,195
Average net premiums	Federally subsidized: ~$183 Non-federally subsidized: ~$325	Federally subsidized: ~$192 Non-federally subsidized: ~$186

*CCS enrollment represented here in chart is low because model does not include customers eligible for, but receiving $0 of CCS

Minimum Contribution Requirement Example

Current Cascade Care Savings Calculation:

Calculation	Example
Customer Premium in benchmark plan	$100
Customer APTC	- $75
Net premium in benchmark plan	= $25
Customer CCS	$25

Proposed Future Cascade Care Savings Calculation (150%-200% FPL):

Calculation	Example
Customer Premium in benchmark plan	$100
Customer APTC	- $75
Net premium in benchmark plan	= $25
Minimum Contribution	Up to $10
Customer CCS	= $15

Proposed Future Cascade Care Savings Calculation (150%-200% FPL):

Calculation	Example
Customer Premium in benchmark plan	$100
Customer APTC	- $95
Net Premium in benchmark plan	= $5
Minimum Contribution	Up to $10
Customer CCS	$0

For Consideration: Tobacco Rating

CCS Policy current state:

- CCS applies to tobacco rating
- Covers the additional portion of the premium that APTC does not

Consideration for future state:

- CCS only applies to eligible Cascade Care plans that do not tobacco rate
  - Could save ~$2M in CCS
- Working with OIC & carriers to find a regulatory and/or voluntarily pathway

Reaction:

- What is your feedback on this policy idea?

2026 Cascade Care Savings policy next steps

- Final draft CCS policy will be released by the end of January for public comment
- PY 2026 policy will be finalized by the end of April

Cascade Care Workgroup Next Steps

- **Cascade Care plan design**: Additional designs public comment period closes Jan. 29. Will be presented to Exchange Board for approval Feb. 6.
- **Public option**: HCA PY 2026 renewal priorities expected Q1 (current carriers).
- **Cascade Care Savings**: Final draft of 2026 policy released for public comment this month.

February Cascade Care Workgroup meeting will take place as needed

Scheduled for 1 p.m., Feb. 11

- Cascade Care Workgroup roster
- Background information:
- ePTC expiration impacts
- Silver loading
- Tobacco rating
- Allowable AV ranges by metal

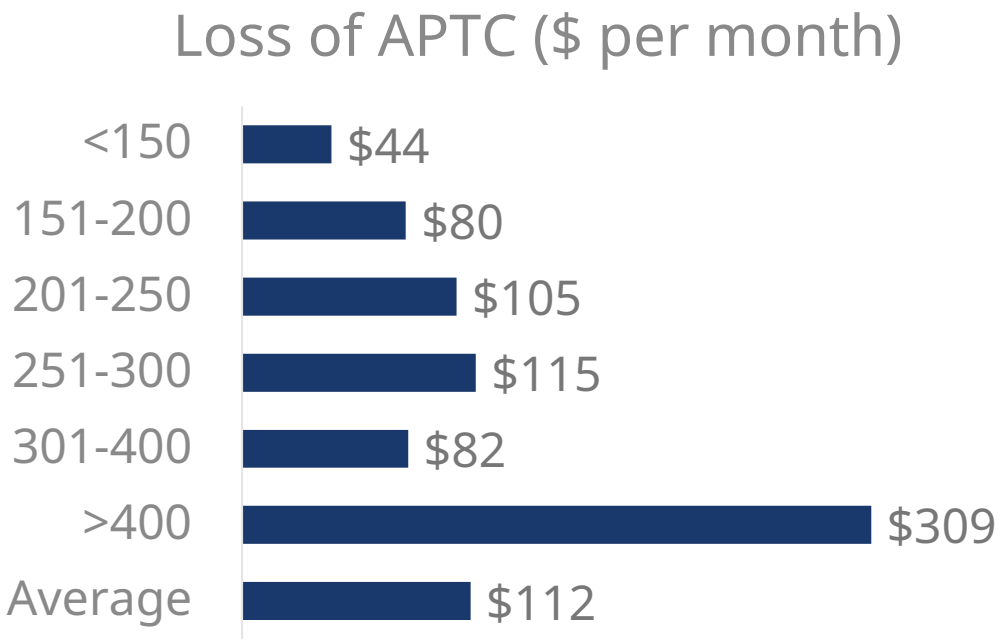
Appendix

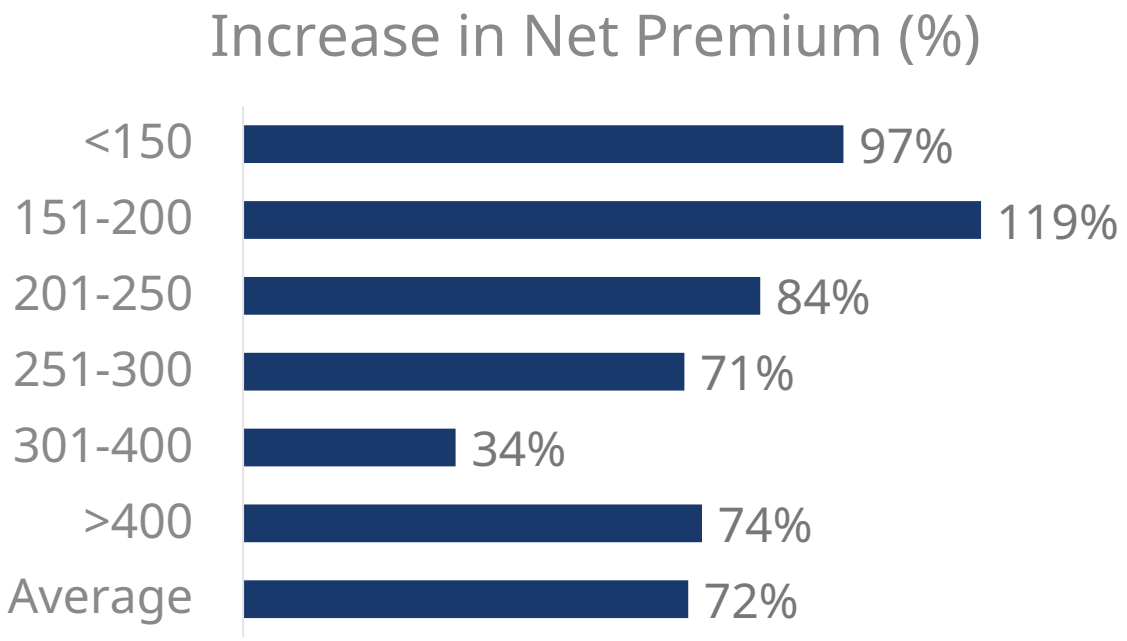
Cascade Care Workgroup Members

- Jane Beyer / Ned Gaines, *Office of the Insurance Commissioner*
- Jennifer Brackeen, *Summit Pacific Medical Center*
- Emily Brice, *Northwest Health Law Advocates*
- John-Pierre Cardenas, *Kaiser Permanente*
- Dekker Dirksen, *Community Health Plan of Washington*
- Jim Freeburg, *Patient Coalition of Washington*
- Stu Freed, *Confluence Health retired*
- Carrie Glover, *Dziedzic Public Affairs*
- Sean Graham, *Washington State Medical Association*
- Rhonda Hauff, *Yakima Neighborhood Health Services*
- David Iseminger, *Health Care Authority*
- Kristin Meadows, *Premera/Lifewise*
- Daphne Pie, *Public Health-Seattle & King County*
- Vacant position, *Washington State Hospital Association*
- Susanne Towill, *Coordinated Care*

ePTC expiration: Impact will vary by income level

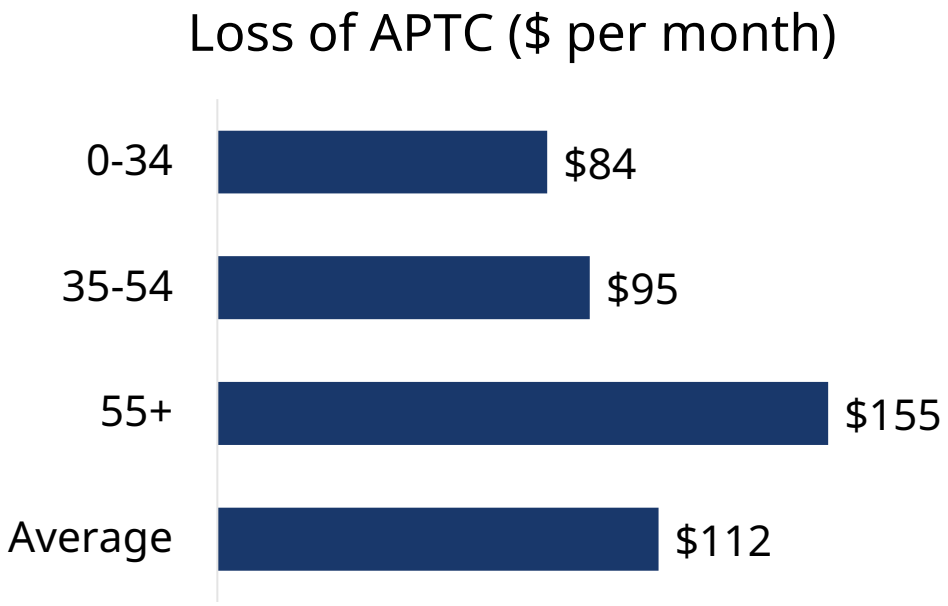
- People at higher income levels will experience larger losses of APTC ($). Those at lower income levels will experience larger (%) increases in net premium.

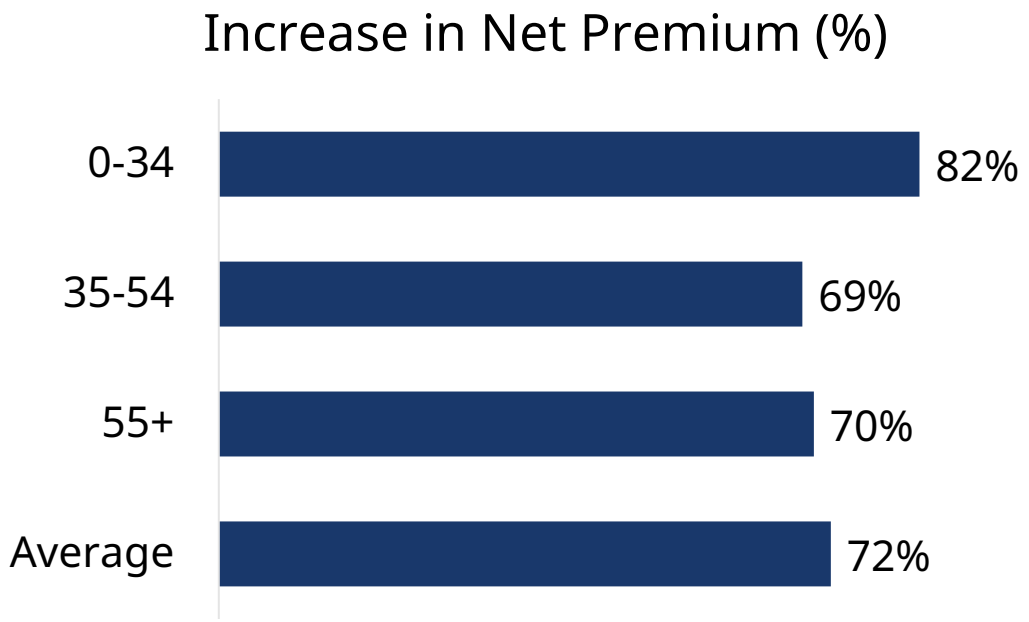




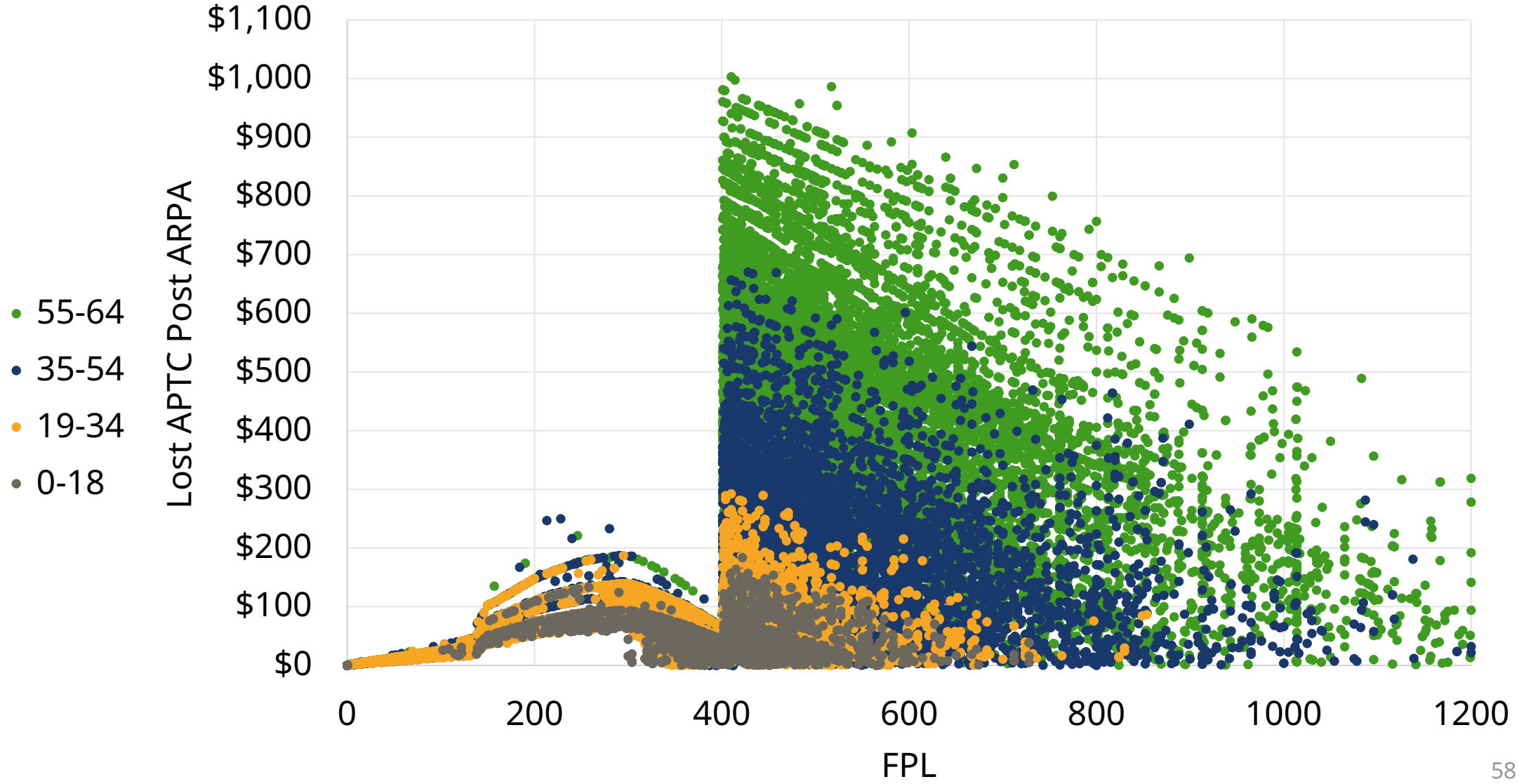
ePTC expiration: Impact is largest for youngest and oldest customers

- Enrollees over age 55 will lose the most tax credits on average — a total of $155 per month.
- Enrollees under age 35 will see a smaller than average decrease in their tax credits because their premiums are lower. But their net premium will almost double — an 82% increase.



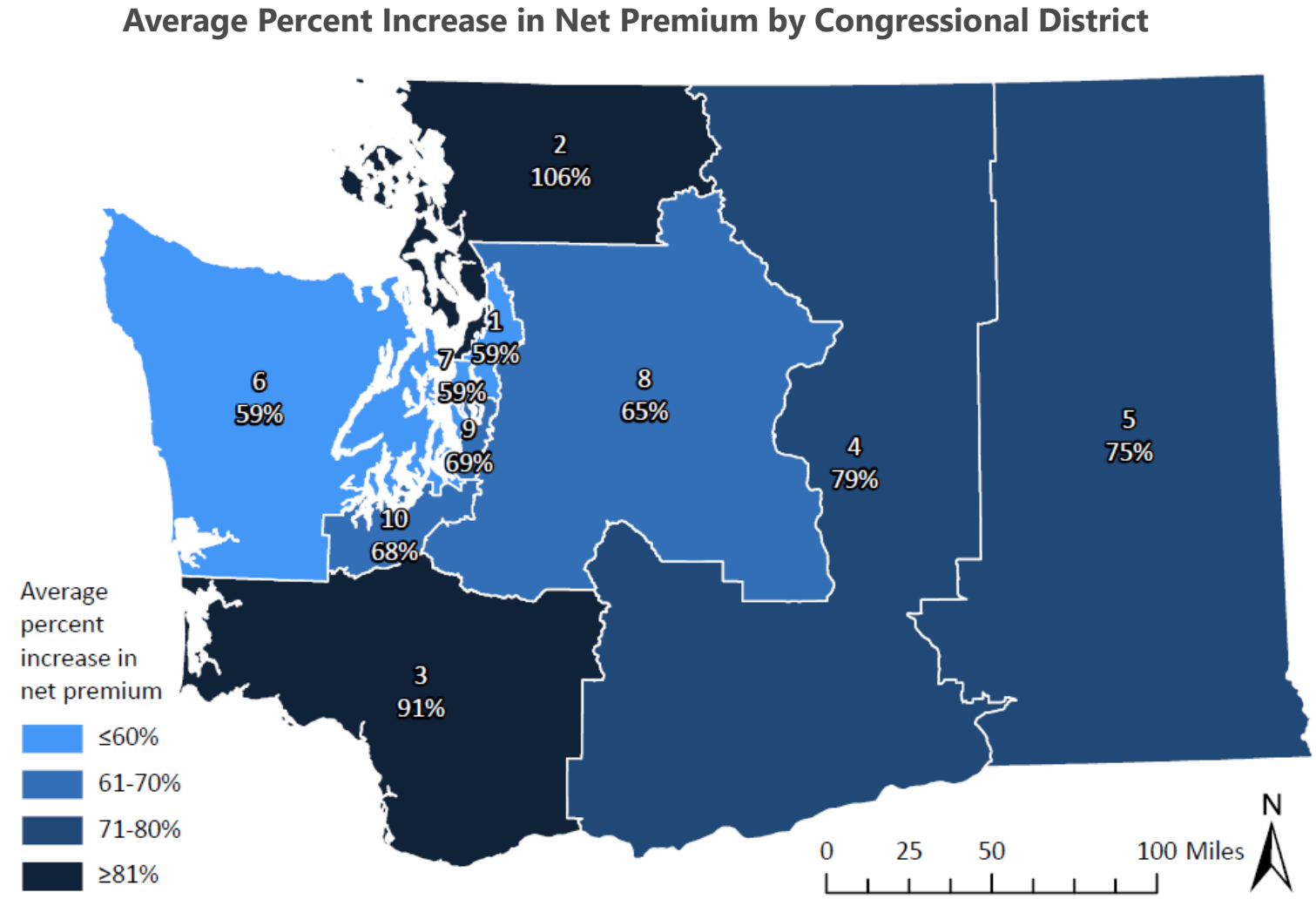


ePTC expiration: The subsidy cliff will particularly impact older enrollees



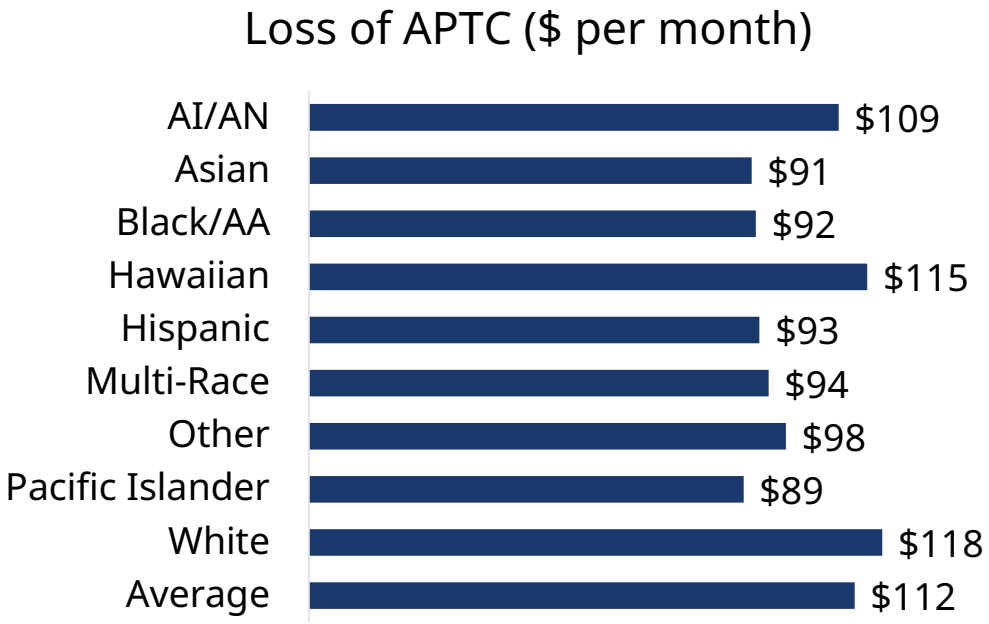
ePTC expiration: Effect is highest in rural communities

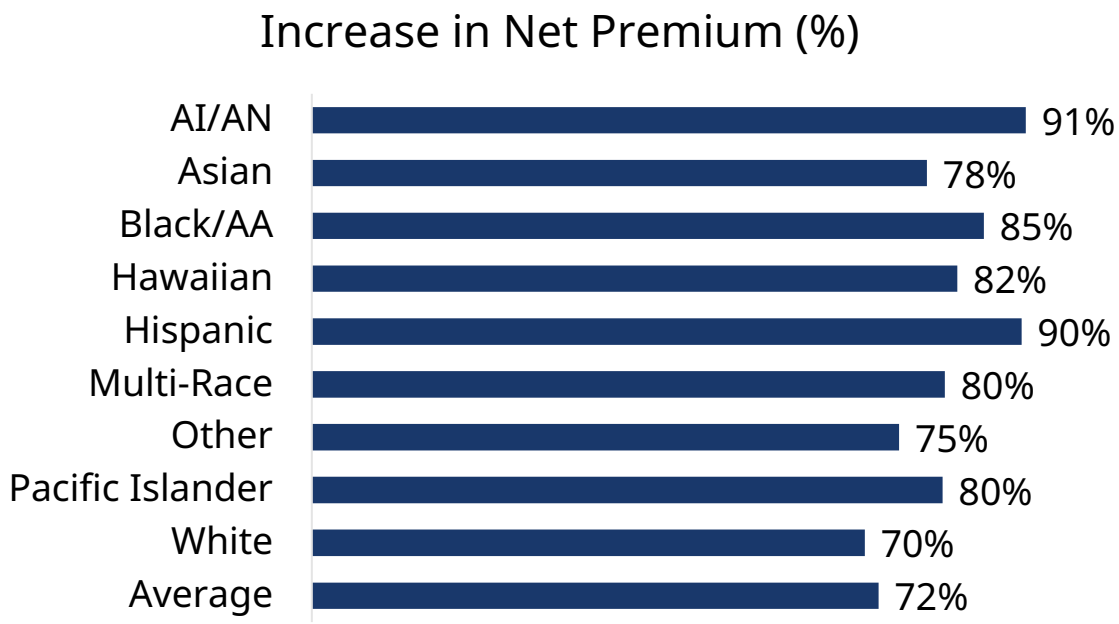
- Enrollees in rural counties will experience greater increases in net premium (80%) than enrollees in urban counties (70%).
- The Exchange is also analyzing the affected by congressional district to inform efforts in Washington, DC.



ePTC expiration: Impact is highest for non-white and Hispanic residents

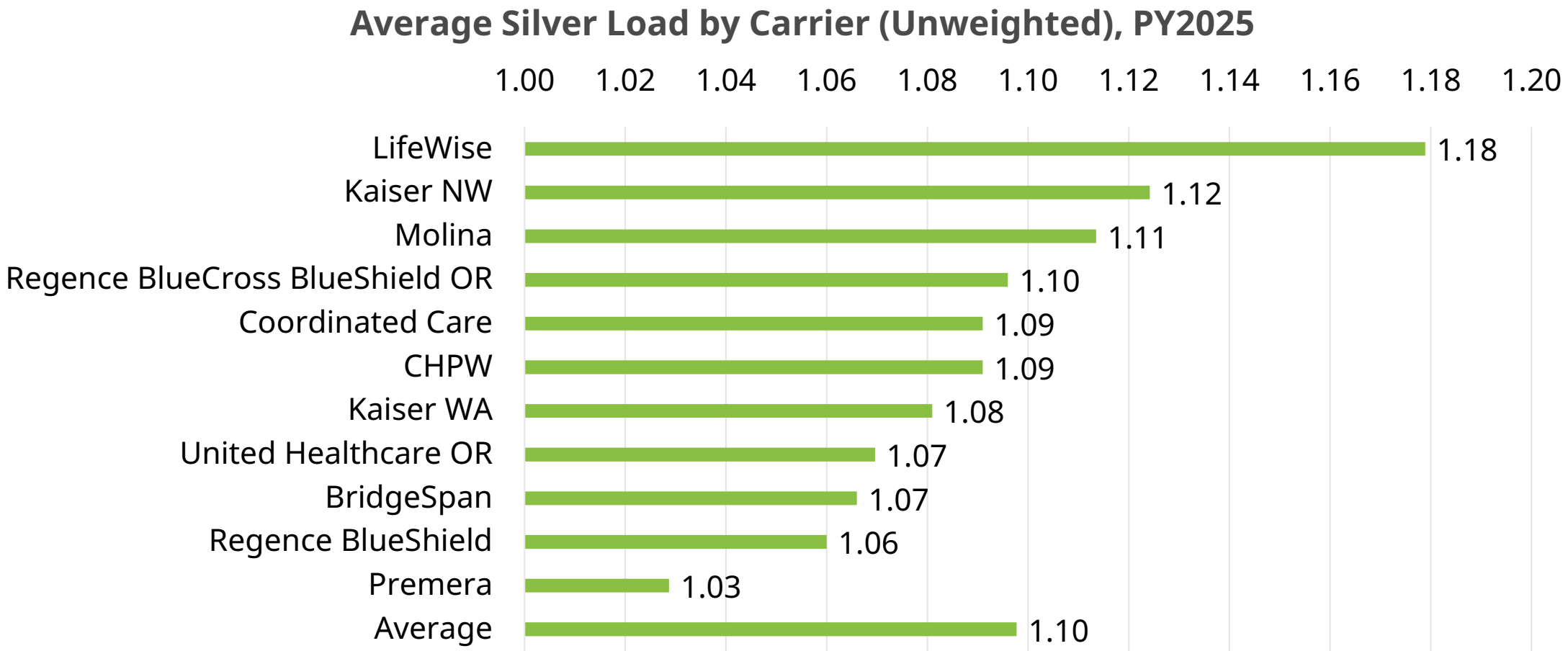
- Groups who will experience the largest increase in net premiums are American Indian/Alaska Natives (91%), Hispanic (90%), Black/African American (85%), Hawaiian (82%), Pacific Islander (80%) and those reporting multiple races (80%).





WA PY2025 Silver Load Amounts

Average (unweighted) silver load by carrier in PY2025 is 1.10.

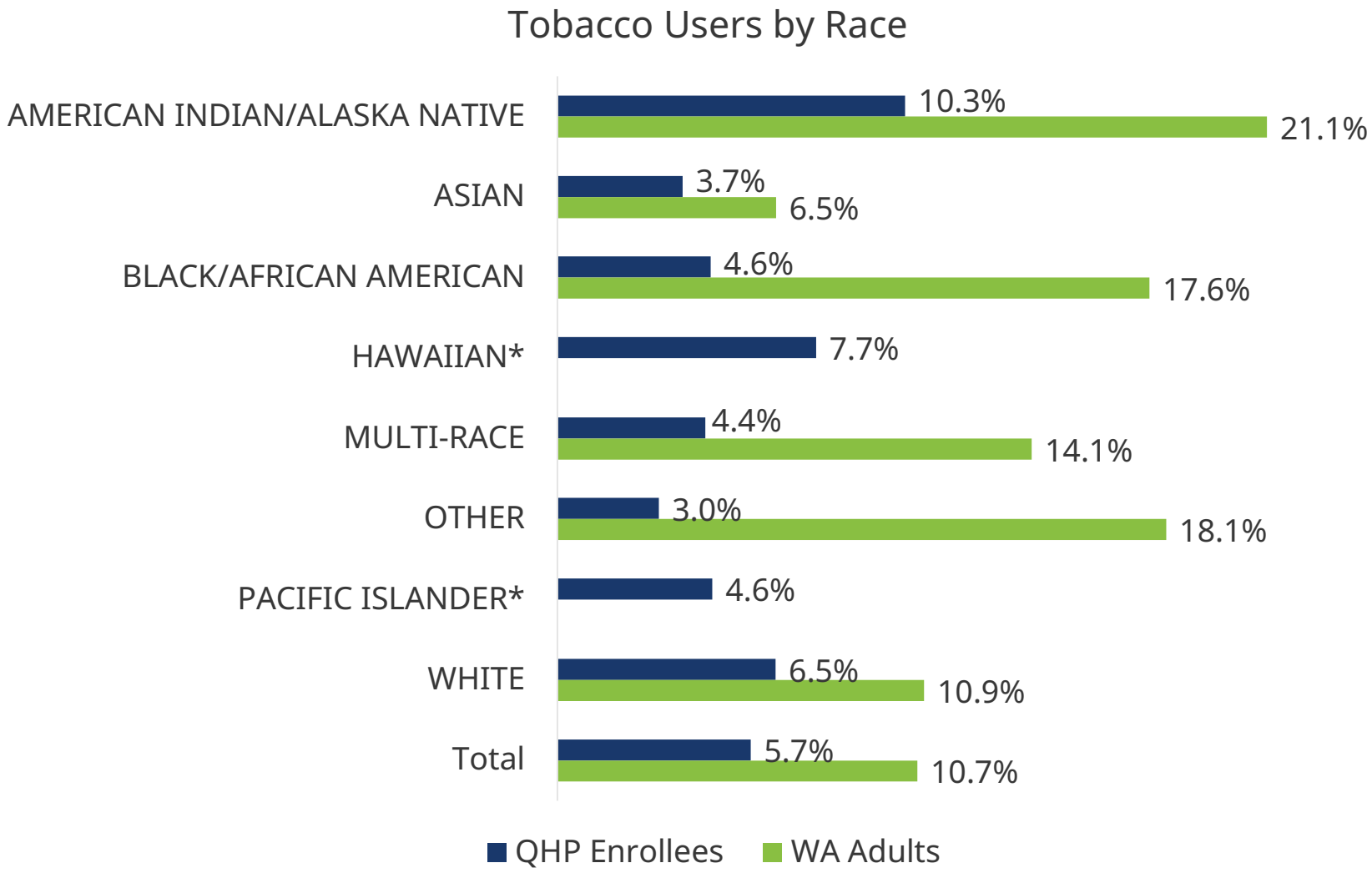


Standardized Silver loading options for discussion

1. Continue to allow carrier flexibility to silver load (1.10 average load, range of 1.03 to 1.18)
2. Provide additional guidance around silver loading:
   a) Standardize induced demand factors (IDF)
   b) Standardize IDF and price Silver plans based on current market enrollment distribution (~82% AV, 1.30 Silver load)
   c) Standardize IDF and price Silver plans based on rational market enrollment distribution (~90% AV, 1.42 Silver load)

Tobacco User Demographics

- Tobacco use is likely underreported by the Exchange enrollees across all demographic groups.
- Tobacco users may also be less likely to enroll in QHP coverage.
- QHP enrollees who report tobacco use are more likely to be older, lower income and from a rural county.



**Suppressed due to sample size*

CMS allowable variation in AV ranges

Metal	AV Range
Bronze	58%-62%
Expanded Bronze (includes pre-deductible benefit other than Preventive Care)	58%-65%
Silver	70%-72%
Gold	78%-82%

Source: Final 2026 Actuarial Value Calculator Methodology

Cascade Care

Cascade Care makes health insurance accessible and affordable for every *Washington Healthplanfinder* customer.

- Lower premiums
- Higher quality benefits
- Lower copays
- Easier plan shopping
- Available in all counties
- Extra savings for those who qualify

washington
healthplanfinder

click. compare. covered.

www.waheathplanfinder.org | www.wahbexchange.org | 1-855-923-4633