November 13, 2020

Dear Health and Fiscal Committee Members:

In 2019, the Washington State Legislature enacted ESSB 5526 (Section 6), requiring the Washington Health Benefit Exchange (WAHBE or Exchange), in consultation with the Health Care Authority and the Office of the Insurance Commissioner, to develop a plan to implement and fund a state premium subsidy program, with a goal that customers at or below 500% of the federal poverty level (FPL) spend no more than ten percent of their income on health insurance premiums. The Exchange was also directed to assess the impact of subsidies on the uninsured rate, and the impact of providing state cost-sharing reductions (CSRs) to plan participants. We engaged Wakely Consulting Group to analyze the impact of various subsidy mechanisms and amounts on Exchange customers and the individual market.

We are grateful for the opportunity you provided to dive deeply into Washington specific data and explore the value of a state-based subsidy. We have concluded that a premium subsidy would have a powerful impact on the twin goals of affordability and access. Specifically, a state-based subsidy funded at two hundred million dollars would provide customers a fixed subsidy of $135 per month[1], resulting in almost twenty-four thousand currently uninsured people purchasing coverage, and 94% of people buying insurance on the Exchange would spend less than 10% of their income on premiums. A premium subsidy could also be paired with a state-based CSR subsidy to provide additional assistance to customers who need to utilize their care the most, including older customers and customers with chronic or severe illness.

Increasing Uninsured Rate & Affordability Challenges

Now, in the face of the global pandemic, and the resulting wave of unemployment and associated loss of employer-sponsored health coverage, making insurance affordable for Washington residents has never been more important.[2] As a state, we are losing the gains made under the Affordable Care Act (ACA) that drove the Washington uninsured rate to a historic low of 5.4%. According to the Office of Financial Management, the uninsured rate among newly unemployed workers has risen from 10% to over 40% during the course of the pandemic.[3]

The ACA subsidies for low to moderate income residents were key to increasing insurance coverage for many people in Washington state, and across the country.[4] However, the ACA did not solve affordability

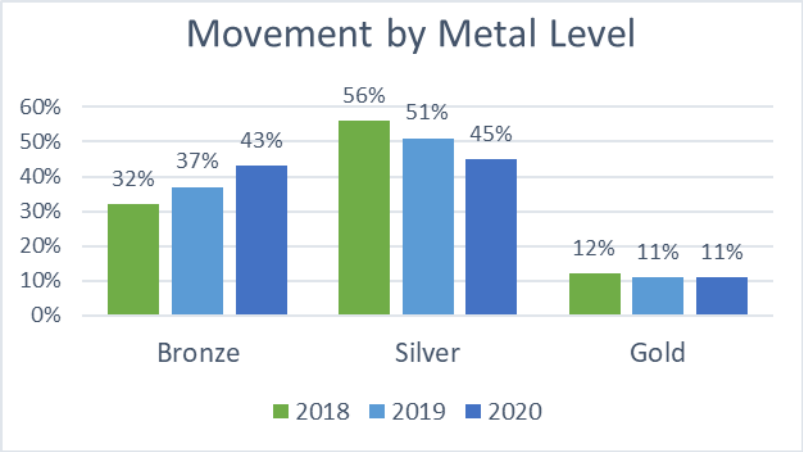
[1] In a fixed subsidy structure, people receive a specific subsidy amount regardless of income. Some people may receive less than $135.00 per month if the full subsidy would reduce their monthly premium cost below zero dollars (or below another identified threshold)

[2] In April 2020, the Washington unemployment rate rose from 5.1% to 16.3%, a loss of over 525,00 jobs. A slow recovery returned the rate to 7.8% as of September, 2020 (compared to 4.1 percent in September 2019). https://esd.wa.gov/newsroom/september-2020-monthly-employment-report.

[3] Office of Financial Management, Estimated Impact of COVID-19 on Washington State's Health Coverage (ongoing reporting)

[4] The ACA provides Advance Premium Tax Credits to eligible people with incomes below 400 *percent* of the federal poverty line (about $50,000 for a single person, about $100,000 for a family of four), and Cost-Sharing Reduction subsidies to those with incomes below 250% of the federal poverty level (about $30,000 for a single person, about $65,000 or a family of four).

issues for some groups, most notably, those in the "family glitch"[5] and those facing the "subsidy cliff".[6] Under the ACA, undocumented workers have also been left out.[7] And unfortunately, even with federal subsidies many people do not find insurance affordable. Others have increasingly resorted to purchasing coverage with higher deductibles and cost sharing in order to lower their monthly premium contributions. This trend is illustrated by Exchange enrollment data, which shows the increasing number of customers purchasing bronze plans.



WAHBE Data from Spring Enrollment Report (2020)

Uninsured people at all income levels consistently cite cost as the greatest barrier to coverage.[8] Currently, Exchange customers spend up to 30% of their income on healthcare premiums.[9] Tens of thousands of our customers drop health care coverage mid-year, and many report doing so because it they cannot afford the premiums. Customers with coverage report skipping necessary appointments and tests because of cost.

People need more help in getting high-value health care plans at a premium they can afford, that they can also afford to use (with lower deductibles and more services before the deductible). With the launch of Cascade Care, the state has taken a strong step to meet this need. The state subsidy initiative is the essential third leg of the stool to complete what the Legislature began with Cascade Care to make health care affordable to Washingtonians who rely on individual market coverage.

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[5] The "family glitch" occurs when a worker receives job-based coverage costing less than 9.6% of household income for *self-only* coverage. Under current rules this qualifies as affordable coverage and the *entire* household is not eligible for federal subsidies, even if the *family* coverage is prohibitively expensive.

[6] The "subsidy cliff" refers to the steep drop-off of premium subsidies for those with an annual income of just over 400% of FPL. It can be challenging for people to determine if their income has risen over the limit, as it can depend on factors like where you live, your age, and how many people are in your family. A slight change in income can cost a household thousands of dollars in subsidies.

[7] While under the ACA lawfully present immigrants are eligible to purchase qualified health plans and receive subsidies, undocumented workers may not currently purchase Exchange qualified health plans and are not ACA subsidy eligible. State-based marketplaces have explored waiving this provision of the ACA using a 1332 waiver, which would need to be approved by federal regulators.

[8] Congressional Oversight Hearing on the Impact of the Administration's Policies Affecting the Affordable Care Act 9Feb. 2019) https://docs.house.gov/meetings/AP/AP07/20190206/108858/HHRG-116-AP07-Wstate-PeckJ-20190206.pdf

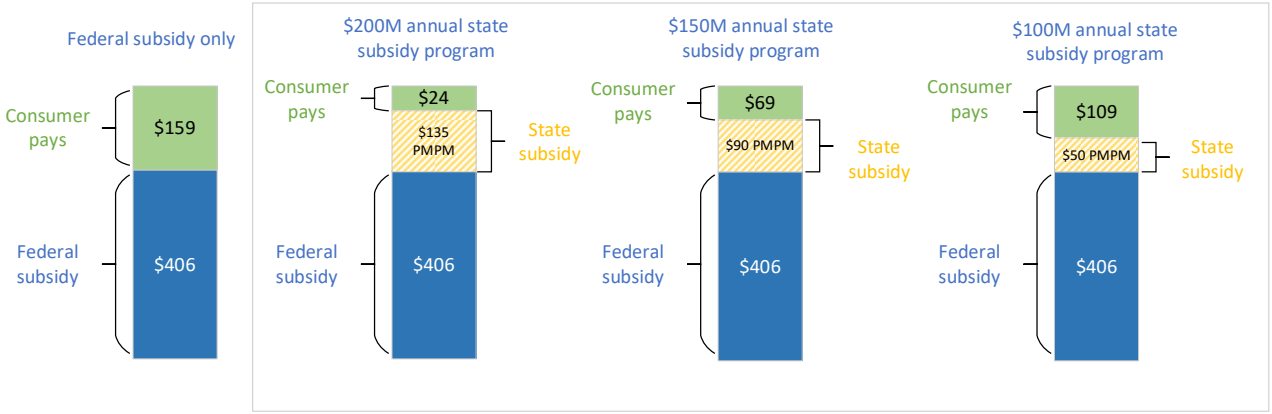
[9] Even the legislative affordability goal of getting customers to 10% or less is likely still too high for low-income people such as those who churn off Medicaid and does not include the impact of cost sharing expenditures.

Overview of State Subsidies

State subsidies have proven to be an effective tool in several states to both lower the cost of insurance and reduce the uninsured rate. At a basic level, a state subsidy gives people financial assistance to afford the cost of insurance premiums, additional out-of-pocket expenses, or both. The state subsidy overlays any existing federal subsidy, in what is called a "subsidy wrap". So, for people who qualify for federal premium tax credits, a state premium subsidy would increase their overall level of financial assistance. State premium assistance can enable customers to stay at their current "metal level" of coverage and pay significantly less in monthly premiums. Alternatively, customers can use their state premium assistance amounts to "buy up" to a higher metal level with resulting reductions in cost sharing.

Illustrative Example: State subsidy combines with federal subsidies to increase affordability

(Premium based on 2020 silver plan average: $565/monthly)



The state determines the goal of its own state subsidy program; typical goals include affordability and reducing the number of uninsured. Based on those goals, the state must choose the structure of the subsidy and level of support individuals will receive, the overall size of the program and corresponding appropriations, and the requisite eligibility requirements. California, Massachusetts, and Vermont currently offer state-based premium subsidy programs, and other states including New Jersey, Colorado, and Maryland are in the process of developing premium subsidy programs.[10]

As a foundation to this report, WAHBE has commissioned an interactive model based on Washington data that will allow us to input a wide variety of potential subsidy scenarios and evaluate their impact on consumer behavior and our marketplace. A detailed analysis of six possible scenarios is included in the Wakely report, but WAHBE can and has run dozens of scenarios targeting varying levels of subsidy to specific populations, e.g. by income, by federal subsidy status, by age, and were able to see impact both on market conditions, including insurance uptake, plan movement, and group morbidity, and by demographic groups including on individual net premium by age, income, county of residence, race and ethnicity, and federal subsidy status. The model is an invaluable tool that will provide objective guidance in structuring Washington's subsidy to meet its goals.

[10] Appendix E of the Wakely report contains a chart detailing state subsidy programs implemented or being explored by other states.

There are two common structures for a state premium subsidy: enhanced APTC, and fixed dollar.[11]

- In the enhanced APTC structure, state premium subsidies are set on a sliding scale, following the model of the current federal Advanced Premium Tax Credit (APTC) subsidy program. That model calculates subsidies for people based on the difference between the premium income limit determined by a member's income level and the premium charged for a benchmark plan, the second lowest cost Silver plan. In other words, APTCs cap the percentage of income that an individual spends on health care premiums by providing a subsidy to cover the difference between the cap and their premium (up to the cost of the benchmark). As a result, the enhanced APTC structure provides greater assistance to lower-income customers. A state subsidy using the enhanced APTC structure would lower the cap still more, subject to funding limits and eligibility decisions. The modelling also factored in extending APTC-like subsidies up to 500% FPL and providing state subsidies to customers under 400% FPL who are not eligible for federal subsidies due to factors such as the "family glitch".
- In the fixed structure, people receive a fixed monthly amount per month regardless of income level. Recognizing that their premium costs are higher, variants of the fixed structure were also modelled that provide a higher amount to customers who are not eligible for federal subsidies.

While the Exchange can implement either subsidy structure, the Exchange recommends enacting a fixed dollar subsidy, given that the structure performs better across several key access and affordability goals.

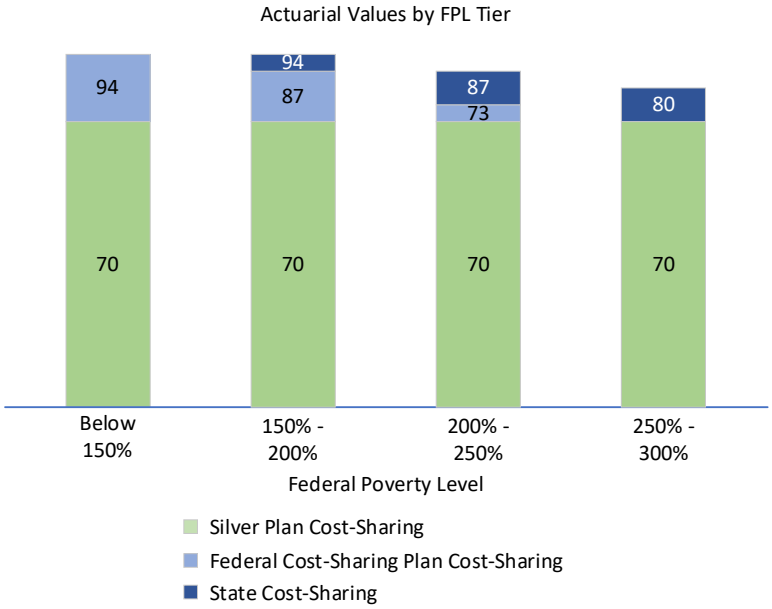
Consideration	Enhanced APTC	Fixed-Dollar Subsidy	Comments
Lower uninsured rate		X	Fixed-$ brings in ~4,000 more from uninsured.
Improved morbidity for entire individual market		X	Fixed-$ improves market morbidity by 2.5% vs 2.1%.
Increased Exchange enrollment		X	Fixed-$ brings in more consumers to HBE (26,305 vs. 23,722).
Everyone up to 500% FPL pays no more than 10% on premiums	X		Enhanced-APTC meets affordability goal (100%) v. Fixed-$ (93%).
Impact on non-federally subsidized	X		Enhanced-APTC brings those not eligible for federal subsidies to parity with the subsidized, and caps 400%-500% below 10% of income.
Impact on Black, Indigenous, People of Color		X	Both approaches have a similar impact by race and ethnicity. Fixed-$ maximized uptake, thus helping more Black, Indigenous, and People of Color.
Impact on older individuals	X		Enhanced-APTC provides greater assistance to older/unsubsidized individuals.
Impact on younger individuals		X	Fixed-$ helps more younger individuals.
Impact on rural vs urban populations	--	--	Similar impact across rural areas sampled.

In addition to subsidizing monthly premiums, states can also provide a direct subsidy to reduce out-of-pocket costs such as deductibles, copayments, and coinsurance. The ACA provides cost-sharing subsidies, but unlike the federal premium tax credits (which can be applied toward any metal level of coverage), federal cost-sharing reductions (CSRs) are only available through a silver metal level plan. As

[11] The Wakely report contains a detailed description of these structures and several scenarios that apply different funding levels and eligibility requirements to the structures.

operationalized at the federal level, the CSRs increase the actuarial value (amount covered by the health insurance plan) of a silver metal level plan, in some cases making the plan more like a gold or platinum plan. Several states, including California and Vermont, have implemented state-based cost-sharing programs that layer additional cost-sharing assistance on top of the federal CSRs.

Illustrative example of state cost-sharing subsidy lies on top of the ACA cost-sharing subsidies



The Exchange supports additional state-based CSR subsidies as a mechanism to further assist Exchange customers, particularly older customers and customers with severe or chronic illnesses, in reducing their out-of-pocket expenses by lowering deductibles and other cost-sharing. A state-based CSR program would allow these customers to not have to forgo needed health care.

Financing State-Based Subsidies

Financing state-based subsidies in the current budget environment is a challenge. With our newly developed model, we are able to understand the impact of various financing levels on the goals established by the Legislature. Budgetary and subsidy design decisions necessarily entail tradeoffs. Lower state funding levels lead to reduced assistance and take up but can yield somewhat different outcomes depending on the subsidy structure and amounts chosen.

Recognizing the need to enable the Legislature to see both budgetary and design tradeoffs, we have modelled the total state investment at three different levels using variants of the enhanced APTC and fixed dollar approaches. Individuals with the greatest affordability gaps are those who do not qualify for federal subsidies. However, it requires greater per person state expenditures to achieve affordability parity for these individuals, particularly if they are older. Many low- and moderate-income individuals struggle with affordability even with the federal subsidies and require lower per person state

expenditures to bring coverage within reach. These variants illustrate the impact these policy choices have on the state goals of affordability, reduction in the uninsured, and populations affected.

We have been very broad in our consideration of how to finance a state subsidy.[12] The Wakely modelling centers on the three mechanisms contemplated most recently by the Legislature to help address affordability in the individual market: a health insurance premium tax, a claims-based assessment, and a covered lives assessment.

Subsidy Program	Financing Mechanism	Estimated Rate
$200 Million State Subsidy Program	Covered Lives	$3.52 PMPM
	Premium Tax	1.6%
	Claims Tax	1.0%

Furthering Cascade Care

The passage of ESSB 5526 not only directed the development of a state affordability program, but also established Cascade Care plans (standard and public option plans). The Exchange recommends the Legislature strongly consider tying state premium and/or cost sharing subsidies to Cascade Care plans, which are now available in the Exchange market, to provide greater value to subsidy recipients.

There are hundreds of plans available on the Exchange of varying quality and value; it is important to assure that state dollars are spent on plans that are designed to provide the highest level of customer value. The Legislature has long recognized that the investment of state dollars should be directed to products that provide the highest value for customers and set a high market standard. All major state subsidization of health care programs (PEBB, SEBB, Medicare, Medicaid) is linked to a specific benefit plan and structure. Cascade Care plans have been designed to provide meaningful access to enrollees, with low cost-sharing and significant benefits provided prior to deductible. Adding an additional state premium wrap would both lower premiums and ease the burden of cost sharing for enrollees.

Other states have similarly used multiple levers to achieve maximum value from state subsidy dollars and mutually reinforce state policy objectives. For example, Massachusetts ties receipt of subsidies to enrollment in the lowest cost silver plan available (with some additional subsidization for select other silver plans). In California, the state subsidy is paired with an individual mandate. Both California and Massachusetts only offer standard plans on their Exchanges. New Mexico is considering tying receipt of a state premium subsidy to enrollment in a silver plan for customers under 200% FPL, and enrollment in a gold plan for customers over 200%FPL, as a way to both maximize available CSR subsidies and further lowering customers out-of-pocket costs.

[12] Included in the Wakely report is a summary chart of the different financing approaches contemplated by the Legislature over the past few years.

Cascade Care plans are broadly available across the state and are available at all metal levels and from every health carrier on the Exchange. If a state subsidy were tied to these new products, customers would be able to access any carrier they like, with the benefit of increased purchasing power.

To further illustrate the impact of tying a state subsidy to Cascade Care, consider the following 3 examples: Rosie, Leo, and Carol and Javier are each currently enrolled in the lowest cost bronze or silver plan available in their counties, and are provided $135 per month as part of a state-run fixed-dollar premium subsidy program. The subsidies allow each enrollee to purchase up to a Cascade Care Silver plan while paying a lower net monthly premium. Leo, Carol and Javier would even be able to purchase up to a Cascade Care gold plan for a lower monthly cost. With lower deductibles and more services covered before the deductible, Cascade Care plans would provide customers with out-of-pocket savings that extend beyond the reach of a premium subsidy program.

Rosie			**Current**	**State Subsidy - $135/mo**		
			Non-Standard Bronze	Non-Standard Bronze	CC Silver	CC Gold
Age	40	Monthly Premium	$274	$274	$373	$425
County	King	Federal Premium Subsidy	$152	$152	$152	$152
Income	$31,896	State Premium Subsidy	$0	$135	$135	$135
FPL	250%	Net Premium	**$122**	**$0**	**$86**	**$138**
		Premium as % of Income	*5%*	*0%*	*3%*	*5%*
		Health Plan Combined Deductible (individual)	**$3,000**	**$3,000**	**$2,000**	**$500**

Leo			**Current**	**State Subsidy - $135/mo**		
			Non-Standard Silver	Non-Standard Silver	CC Silver	CC Gold
Age	60	Monthly Premium	$890	$890	$893	$956
County	Chelan	Federal Premium Subsidy	$523	$523	$523	$523
Income	$44,664	State Premium Subsidy	$0	$135	$135	$135
FPL	350%	Net Premium	**$367**	**$232**	**$235**	**$298**
		Premium as % of Income	*10%*	*6%*	*6%*	*8%*
		Health Plan Combined Deductible (individual)	**$5,650**	**$5,650**	**$2,000**	**$500**

Carol & Javier			**Current**	**State Subsidy - $135/mo**		
			Non-Standard Silver	Non-Standard Silver	CC Silver	CC Gold
Age	50	Monthly Premium	$962	$962	$1,010	$1,106
County	Spokane	Federal Premium Subsidy	$0	$0	$0	$0
Income	$77,580	State Premium Subsidy	$0	$270	$270	$270
FPL	450%	Net Premium	**$962**	**$692**	**$740**	**$836**
		Premium as % of Income	*15%*	*11%*	*11%*	*13%*
		Health Plan Combined Deductible (family)	**$11,300**	**$11,300**	**$4,000**	**$1,000**

Conclusion

The attached Wakely report provides a deeper discussion of scenarios and options we have only touched on here. As you consider them, we stand ready to answer your questions. Using our new model, we can also provide detailed impacts of scenarios in addition to those presented by Wakely. The report[13] and enclosed proposed implementing legislation (required by ESSB 5526) also highlight how the Exchange is well positioned to implement a state subsidy program, in a manner consistent with how we administer the over $600M annual federal premium subsidy program.

[13] Please see page 14 of the Report for a discussion of implementation considerations.

We have appreciated the opportunity to explore a state subsidy and look forward to continued engagement on this important topic.

Sincerely,

Pam MacEwan
Exchange CEO

Cc: Sue Birch, Director of the Washington State Health Care Authority
Mike Kreidler, Washington State Insurance Commissioner

Draft Implementing Legislation

ESSB 5526 (Section 6) requires that in addition to the plan, that the Exchange submit proposed implementing legislation. Below is the proposed bill language to satisfy this requirement.

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

(1) Subject to the availability of amounts appropriated for this specific purpose, the exchange:

(a) Shall establish a premium assistance program and annually set the amount of premium assistance provided to eligible individuals; and

(b) May establish a cost sharing reduction program to provide cost sharing assistance to eligible individuals.

(2) The exchange must establish:

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

(b) Procedural requirements for facilitating payments to carriers.

(3) An individual is eligible for premium assistance and cost sharing reductions under this section if the individual:

(a) Is a resident of the state;

(b) Has income that is up to five hundred percent of the federal poverty level;

(c) Is enrolled in a standardized qualified health plan established under RCW 43.71.096;

(d) Applies for and accepts all advance premium tax credits for which he or she may be eligible;

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

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

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

(a) No longer meets the eligibility criteria in subsection (3) of this section;

(b) Fails, without good cause, to comply with any procedural or documentation requirements established by the exchange in accordance with subsection (2) of this section;

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

(d) Voluntarily withdraws from the program; or

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

(6) Premium assistance under this section must be available no later than the 2023 plan year.

(8) The exchange shall annually report to the governor and the legislature on the implementation of the premium assistance program.

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

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

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

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

(1) The exchange may apply to the secretary of health and human services under 42 U.S.C. Sec. 18052 for a state innovation waiver to:

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

(b) Increase access to qualified health plans; and

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

(2) If the exchange submits an application under this section, the board must notify the chairs and ranking minority members of the house of representatives health care and wellness committee and appropriations committee and the senate health care committee and ways and means committee.

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

[FINANCING SECTION]

NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05 RCW to read as follows:

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

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

(a) All proceeds from the **[insert assessment type, from Financing Section, here]** imposed in section 3 of this act;

(b) Any grants, donations, or contributions of money collected for purposes of the premium assistance or cost sharing reduction programs established in section 1 of this act;

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

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