Subsidy Study

Joan Altman, Director of Government Affairs & Strategic Partnerships
Exchange Board Meeting
October 22, 2020
Today’s Topics

• Review of scope of upcoming legislative report
• Discuss topline subsidy model outputs
• Review stakeholder feedback
• Review timeline and next steps
Background: Cascade Care Bill

✓ **Standard Qualified Health Plans (QHPs):** Requires HBE, in consultation with HCA, OIC, and an actuary and other stakeholders, to design and implement standard QHP plans for 2021 plan year

✓ **Public Option:** Requires HCA, in consultation with HBE, to contract with health carriers to offer state procured standard QHPs (public option plans) for 2021 plan year that have provider reimbursement rate caps and must include quality and value requirements

❑ **Subsidy Implementation Plan:** Requires HBE, in consultation with HCA and OIC, to develop and submit a plan for implementing premium subsidies through Exchange for individuals up to 500% FPL
Cascade Care Bill Implementation:

• January 2019: Cascade Care bill introduced
• May 2019: Cascade Care bill signed by Governor
• June – February 2020: Standard plans developed
• February 2020: HCA’s Public option procurement released
• May 2020: 2021 standard plan and public option filings submitted to OIC
• July: HCA announced apparently successful public option bidders
• September 2020: Cascade Care plans approved by Exchange Board
• October 2020: HCA public option contracts finalized
• **November 2020: Subsidy Implementation Plan & Bill Language submitted**
• January 2021: State legislative session begins
Legislative Mandate: Subsidy Implementation Plan

- Plan to implement and fund a state premium subsidy program
- Developed by Exchange in consultation with HCA and OIC
- Plan must include:
  - Assessment of the impact of subsidies on the uninsured rate
  - Assessment of providing cost-sharing reductions to plan participants
  - Implementing legislation
- Limited to individuals purchasing coverage on the Exchange
- Limited to individuals up to 500% FPL
- Affordability goal: limit participant premium spend to no more than 10% of income
Subsidy Team

• Joan Altman, Director of Government Affairs & Strategic Partnerships
• AnnaLisa Gellerman, Senior Policy Advisor
• Evan Klein, Senior Policy Analyst
• James Manual, Policy Analyst
• Karen Merriken, Health Policy Consultant
• Wakely Consulting Actuaries & Healthcare Specialists
Key Exchange Subsidy Goals & Considerations

• Lower Washington’s uninsured rate
• Increase access
• Lower premiums
• Support continuity of coverage and retention
• Build credible and scalable model that can be used now and, in the future, to determine impacts on premiums, enrollment, state costs and the uninsured rate
Wakely Subsidy Model

The Exchange contracted with Wakely to provide actuarial consulting services. Wakely has developed a flexible model that looks at the market impact of providing a state-based subsidy.

- **Gather**: Informed by Washington specific data
- **Build**: Actuarial assumptions embedded
- **Run**: Extensive outputs generated and reviewed
- **Synthesize**: Report will highlight key findings and trade-offs
Data Analysis

• Main subsidy distribution methods examined
  • Enhanced APTC – Applies state income limits, structured after federal APTC, across FPL-bands
  • Fixed-$ Subsidy – Provides a flat-dollar amount subsidy to individuals by FPL-band

• Examined multiple scenarios within each method
  • Informed by discussions with stakeholders and other state-based marketplaces
  • Looked at varied eligibility and funding levels
  • Looked at subsidy distribution methods separately and in combination

• Objectives for selecting scenarios to include in leg. report
  • Uptake among uninsured;
  • Improved morbidity/risk pool
  • Equity considerations - Who benefits most?
  • Legislative affordability goal: 10%
Data Analysis

• Looked at impact on:
  • Total state cost
  • Number of uninsured gaining coverage
  • Number receiving state assistance
  • Average premium reduction
  • Morbidity/Risk pool
  • Increase in federal spending on premium tax credits
  • Percentage of individuals under 500% FPL Paying <10% of Income on Premium

• Looked at population specific outcomes, including:
  • Subsidy status
  • Age
  • Income
  • Race
  • Ethnicity
  • Geography
Main Findings:

Enhanced APTC vs Fixed-Dollar Subsidy

Comparison of subsidy distribution methods at $200million total program cost
### Subsidy Scenario: Main Take-Aways

**Enhanced APTC vs Fixed-Dollar Subsidy up to 500% ($200M)**

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Enhanced APTC</th>
<th>Fixed-Dollar Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower uninsured rate</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Number getting state affordability assistance</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Improved risk mix for entire individual market</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Increased Exchange market enrollment</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Everyone up to 500% pays no more than 10% on premiums</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Brings more consumers to/toward paying $0 premium</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Additional federal $ draw down</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
**Subsidy Scenario: Main Take-Aways**

*Enhanced APTC vs Fixed-Dollar Subsidy up to 500% ($200M)*

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Enhanced APTC</th>
<th>Fixed-Dollar Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on non-federally subsidized</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Impact on Black, Indigenous, People of Color</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Impact on older individuals (55+)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Impact on younger individuals (under 35)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Impact on rural vs urban populations</td>
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</tbody>
</table>
Detailed Look: Uptake By Race

From Uninsured & Off-Exchange

- **Asian Indian**: 483
- **Black/African American**: 343, 405
- **Chinese**: 731, 1,015
- **Other Asian/Pacific Islander**: 414, 513
- **Vietnamese**: 558, 576

- APTC - Full - Up to 500% FPL
- Fixed $ - Full - Up to 500% FPL
Detailed Look: Uptake By Age

From Uninsured & Off-Exchange

- 17 and under: 412 (APTC - Full - Up to 500% FPL) and 1,017 (Fixed $ - Full - Up to 500% FPL)
- 18-34: 3,203 (APTC - Full - Up to 500% FPL) and 4,709 (Fixed $ - Full - Up to 500% FPL)
- 35-54: 7,965 (APTC - Full - Up to 500% FPL) and 10,420 (Fixed $ - Full - Up to 500% FPL)
- 55 and over: 11,941 (APTC - Full - Up to 500% FPL) and 10,159 (Fixed $ - Full - Up to 500% FPL)
Detailed Look: Uptake By Urban/Rural

- APTC - Urban
- Fixed $ - Urban
- APTC - Rural
- Fixed $ - Rural

King | Grays Harbor | Mason | Okanagan
## Detailed Look: Average Net Premium By Age
### For Enrollees Receiving State Subsidy

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Subsidy Status</th>
<th>17 &amp; Under</th>
<th>18-34</th>
<th>35-54</th>
<th>55 &amp; Over</th>
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<tbody>
<tr>
<td>APTC – Up to 500% FPL</td>
<td>Fed Sub</td>
<td>$118.10</td>
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<td></td>
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<td>$77.22</td>
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<td>$109.37</td>
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<td>$117.19</td>
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<tr>
<td></td>
<td>Fed Unsub</td>
<td>$157.20</td>
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<td></td>
<td></td>
<td></td>
<td>$151.73</td>
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<td></td>
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<td>$207.88</td>
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<td>$238.02</td>
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<tr>
<td>Fixed $ - $135 – Up to 500% FPL</td>
<td>Fed Sub</td>
<td>$42.11</td>
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<td>$32.47</td>
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<td>$71.77</td>
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<tr>
<td></td>
<td>Fed Unsub</td>
<td>$157.30</td>
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<td>$196.05</td>
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<td>$330.39</td>
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<td>$687.55</td>
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*Net premium amounts shown are only for those individuals receiving a state subsidy*
How do outputs change at varied funding levels?
### Illustrative Scenarios: $200M; $150M; $100M

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</thead>
<tbody>
<tr>
<td>APTC - Full - Up to 500% FPL</td>
<td>175,389</td>
<td>23,722</td>
<td>19,674</td>
<td>$526</td>
<td>$4,021</td>
<td>$216,937,000</td>
<td>$48,704,000</td>
<td>100%</td>
<td>-2.1%</td>
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<tr>
<td>Fixed $ ($135) Up to 500% FPL</td>
<td>179,766</td>
<td>26,305</td>
<td>23,792</td>
<td>$1,126</td>
<td>$1,594</td>
<td>$217,059,000</td>
<td>$91,469,000</td>
<td>93%</td>
<td>-2.5%</td>
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<tr>
<td>Fixed $ ($90) Up to 500% FPL</td>
<td>173,820</td>
<td>20,360</td>
<td>18,684</td>
<td>$837</td>
<td>$1,065</td>
<td>$152,142,000</td>
<td>$78,359,000</td>
<td>92%</td>
<td>-2.0%</td>
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<tr>
<td>Fixed $ ($58) Up to 500% FPL</td>
<td>168,698</td>
<td>15,233</td>
<td>14,153</td>
<td>$579</td>
<td>$688</td>
<td>$100,733,000</td>
<td>$64,396,000</td>
<td>92%</td>
<td>-1.5%</td>
</tr>
</tbody>
</table>
Stakeholder Engagement
High Level of Stakeholder Engagement

• Cascade Care Workgroup meetings
• All-Carrier meetings
• Legislator meetings
• Inter-agency Cascade Care Meetings (OIC, HCA, HBE)
• Coordinating with HCA & Universal Health Care Workgroup on actuarial assumptions and projections
• Coordinating with OFM on COVID-19 uninsured projections
• Committee and Workgroup presentations
## Cascade Care Workgroup Meetings

<table>
<thead>
<tr>
<th>Date</th>
<th>Session Description</th>
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<tbody>
<tr>
<td>May 21</td>
<td>CC Session 1: Introduction, Background, Legislation, Timeline</td>
</tr>
<tr>
<td>June 24</td>
<td>CC Session 2: Review Initial Model</td>
</tr>
<tr>
<td>July 22</td>
<td>CC Session 3: Review Model Revisions</td>
</tr>
<tr>
<td>Aug 26</td>
<td>CC Session 4: Review Model Revisions</td>
</tr>
<tr>
<td>Sept 14</td>
<td>CC Technical Session: Walk-through of Final Model</td>
</tr>
<tr>
<td>Sept 29</td>
<td>CC Session 5: Review Initial Policy Recommendations &amp; Finalize Funding Approach</td>
</tr>
</tbody>
</table>
Main Areas Feedback Solicited

• Actuarial assumptions
• Model outputs/display
• Priority populations
• Subsidy distribution method/scenarios
• Tying to Cascade Care plans
• Cost-sharing reduction design
• Financing preferences
Stakeholder Feedback – Toplines

• Recognition that COVID-19 has created a greater need for access to affordable insurance, while straining state budget

• Some members want to maximize new enrollees from the uninsured population, some want to maximize assistance for both lower-income and older populations

• Mixed interest in tying subsidies to Cascade Care among carriers

• Strong interest in a broad funding source that limits impact on consumers
  • Financing should be broad-based, stable, and scalable
  • Concern over financing mechanisms that would raise health care costs
  • Pursue federal waiver authority to draw-down federal funds

• Strong desire from consumer advocates to assist those that are undocumented
Next Steps
Ongoing Analysis

- Impact of tying subsidies to Cascade Care plans
- Impact of enhanced cost-sharing reduction subsidies
- Impact of three subsidy financing methods (premium tax; covered lives assessment; claims tax)
- Operational considerations and implementation timing
Upcoming

• Presentation to Universal Health Care Work Group
• Participation on Health Care Cost Transparency Board
• #6 Cascade Care Workgroup meeting (Oct 28)
• Subsidy implementation plan and legislative language due to legislature (November 15)
• Individual mandate assessment due to legislature (Dec. 15)
• Governor’s budget (Dec)
• Legislative session (Jan - May)
Cascade Care Workgroup Membership

- Workgroup has formal representation from business, consumer advocates, issuers, hospitals, and providers
- Additional engagement from state partners at OIC, HCA, OFM, and the Legislature
- Cascade Care meetings are open-public meetings, several additional stakeholders routinely attend.
- Carrier-specific workgroup of all Washington carriers has also met to discuss technical/implementation-related issues

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patrick Connor</td>
<td>Washington State Director</td>
<td>National Federation of Independent Business</td>
</tr>
<tr>
<td>Erin Dziedzic</td>
<td>Principal</td>
<td>Dziedzic Public Affairs</td>
</tr>
<tr>
<td>Sean Graham</td>
<td>Director of Legislative &amp; Political Affairs</td>
<td>Washington State Medical Association</td>
</tr>
<tr>
<td>Bill Wehrle</td>
<td>Vice President, Health Insurance Exchanges</td>
<td>Kaiser Permanente</td>
</tr>
<tr>
<td>Sybill Hyppolite</td>
<td>Legislative Director</td>
<td>Washington State Labor Council, AFL-CIO</td>
</tr>
<tr>
<td>Kristin Meadows</td>
<td>Director of Individual Strategy</td>
<td>Premera</td>
</tr>
<tr>
<td>Daphne Pie</td>
<td>Health Services Administrator</td>
<td>Public Health-Seattle &amp; King County</td>
</tr>
<tr>
<td>Shirley Prasad</td>
<td>Policy Director – Government Affairs</td>
<td>Washington State Hospital Association</td>
</tr>
<tr>
<td>Andrea Tull Davis</td>
<td>Senior Director, Government &amp; External Relations</td>
<td>Coordinated Care</td>
</tr>
<tr>
<td>Marilyn Watkins</td>
<td>Policy Director</td>
<td>Economic Opportunity Institute</td>
</tr>
<tr>
<td>Janet Varon</td>
<td>Executive Director</td>
<td>Northwest Health Law Advocates</td>
</tr>
</tbody>
</table>
Cascade Care Implementation Website: Subsidy Study Materials

Subsidy Study Materials

Stakeholder Feedback

- Summary of May 21 Meeting Feedback
- Summary of June 24 Meeting Feedback
- Summary of July 22 Meeting Feedback

Background Research & Data

Washington State Research

- FPL and Immigration Status of the Uninsured
- Washington State’s Uninsured Rate – Washington State Health Services Research Project – OFM 2019
- American Community Survey 2018 – Percent Uninsured by FPL

National & Other State Research

- Background on Affordability
  - California
    - Covered California Program Eligibility by FPL
    - Covered California State Subsidy Program Design (2020)
  - Massachusetts
    - MIT Economics Study of Massachusetts Subsidies for Low-Income Adults (2019)
    - Massachusetts ConnectorCare Fact Sheet
  - Vermont
    - Vermont Health Connect 2020 Subsidy Eligibility Thresholds

Financing & Data Analysis

- Funding Model Review Chart
- Health Insurance Provider Fee Background
- Colorado
  - Colorado Senate Bill 20-215 – Colorado HIT Tax

Weekly Reports

- Stakeholder Subsidy Analysis Model – 07/17/2020

For more information on the Exchange’s Cascade Care implementation work please contact Cascade Care Workgroup at cascade@wahbexchange.org

All Cascade Care Workgroup meeting materials available online: https://www.wahbexchange.org/about-the-exchange/cascade-care-2021-implementation/
<table>
<thead>
<tr>
<th>State</th>
<th>Type of financial assistance</th>
<th>Additional Information</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>Premium subsidy</td>
<td>State provides premium subsidies for enrollees with incomes up to 300% FPL. Individuals must purchase lowest-cost silver plan to receive state premium assistance and federal-APTCs (with annual exceptions provided to allow purchase of other plans)</td>
<td>Available to all individuals under 300% FPL who are eligible for APTCs and purchase a Silver plan. Individuals in this program have a smaller number of participating carriers/plans to choose from.</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Premium subsidy (2017 only)</td>
<td>For 2017 only, state provided premium subsidies for enrollees not eligible for federal premium tax credits, Medicaid, or the Basic Health Program</td>
<td>Individuals 138% - 200% FPL</td>
</tr>
<tr>
<td>Vermont</td>
<td>Premium subsidy</td>
<td>State provides sliding-scale premium and cost-sharing subsidies for enrollees with incomes up to 300% FPL (subsidies are in addition to federal premium tax credits and cost-sharing assistance)</td>
<td>Individuals are eligible for Vermont Premium Assistance if they are at or below 300% FPL and enroll in a QHP. Any metal level for the premium subsidy, silver only for CSRs.</td>
</tr>
<tr>
<td>New York</td>
<td>Basic Health</td>
<td>Offers a Basic Health Program (Essential Plan) available to those under 200% FPL, under 65, without access to other sponsored programs (CHIP, Medicaid)</td>
<td>Individuals at or below 200% FPL</td>
</tr>
<tr>
<td>California</td>
<td>Premium Subsidy</td>
<td>Provides state-APTC premium subsidies to Californian’s earning between 400-600% FPL. Premiums for those earning 600% of the FPL are capped at 18% of income.</td>
<td>Individuals up to 400% FPL who are eligible for APTCs and individuals between 400-600% FPL.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Premium Subsidy (Beginning 2021)</td>
<td>Premium subsidies for individuals earning up to 400% FPL, w/ an estimated annual subsidy of $564 (individual) / $2,256 (family of 4). With a new Exchange, NJ has no mechanism for targeting subsidies in year one and is anticipated to provide a flat-dollar subsidy.</td>
<td>Individuals up to 400% FPL. Unclear yet whether eligibility will be tied to federal APTCs.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Premium Subsidy (Beginning 2022)</td>
<td>Beginning in 2022, Colorado will provide funds from its HIT tax to fund subsidies for individuals receiving APTCs and under 300% FPL and ineligible for APTCs.</td>
<td>All individuals up to 300% FPL and individuals 300-400% FPL and eligible for federal APTCs. Must not be eligible for Medicaid, Medicare, or CHIP.</td>
</tr>
<tr>
<td>Maryland</td>
<td>Studying Premium Subsidies</td>
<td>Analyzing impact of premium subsidies targeting: (1) Individuals between ages 18-34 earning under 400% FPL; and (2) Adults w/ incomes between 400-600% FPL.</td>
<td>Program parameters not yet set.</td>
</tr>
</tbody>
</table>

**State-Sponsored Premium Assistance**
Subsidy Scenarios - Descriptions

- **APTC Full - Up to 500%**
  Applies a state subsidy benchmarked to state income limits by FPL-bands, to all individuals earning up to 500% FPL.

- **APTC Full - Up to 250%**
  Applies a state subsidy benchmarked to state income limits by FPL-bands, to all individuals earning up to 250% FPL.

- **APTC Full - 400-500%**
  Applies a state subsidy benchmarked to state income limits by FPL-bands, to all individuals earning between 400-500% FPL.

- **APTC Diff - Up to 500%**
  Applies a state subsidy benchmarked to state income limits by FPL-bands to all individuals earning up to 500% FPL who receive federal subsidies. Applies a state subsidy to individuals up to 500% FPL who are not receiving federal subsidies based on the difference between the federal APTC and state subsidy income limits.

- **APTC Diff - Up to 250%**
  Applies a state subsidy benchmarked to state income limits by FPL-bands to all individuals earning up to 250% FPL who receive federal subsidies. Applies a state subsidy to individuals up to 250% FPL who are not receiving federal subsidies based on the difference between the federal APTC and state subsidy income limits.

- **Fixed $ ($135) - Up to 500%**
  Provides a $135 flat subsidy to all individuals earning up to 500% FPL.

- **Fixed $ ($135) - Up to 250%**
  Provides a $135 flat subsidy to all individuals earning up to 250% FPL.

- **Fixed $ ($135) - 400-500%**
  Provides a $135 flat subsidy to all individuals earning between 400 and 500% FPL.

- **Fixed $ ($90) - Up to 500%**
  Provides a flat dollar $90 subsidy to all individuals earning up to 500% FPL.

- **Fixed $ ($90) - Up to 250%**
  Provides a flat dollar $90 subsidy to all individuals earning up to 250% FPL.

- **Fixed $ ($90) - Up to 500%**
  Provides a flat dollar $90 subsidy to all individuals earning between 400-500% FPL.

- **Fixed $ ($58) – Up to 500%**
  Provides a flat dollar $58 subsidy to all individuals earning up to 500% FPL.

- **Fixed $ ($50-Sub & $200-Unsub) Up to 500% FPL**
  Provides a flat dollar $50 subsidy to those receiving federal APTCs and a flat dollar $200 subsidy for unsubsidized individuals up to 500% FPL.

- **Fixed $ ($50-Sub & $100-Unsub) Up to 500% FPL**
  Provides a flat dollar $50 subsidy to those receiving federal APTCs and a flat dollar $200 subsidy for unsubsidized individuals up to 500% FPL.
**CASCADE CARE - SUBSIDY FUNDING MODEL REVIEW**

This chart is provided in accordance with HBE’s work “to develop a plan to implement and fund premium subsidies” pursuant to ES8 5526 (2019). The chart provides an overview of assessments, fees, premiums, and taxes that have been proposed or enacted in Washington, in other states, or at the federal level.

*The level of assessment, revenue, and expenditures are provided for illustrative purposes where available, and are not meant to constitute the modeling of a state subsidy funding mechanisms. This chart is not intended to be an exhaustive list of all funding options available to policymakers.*

### WA Covered Lives Assessment

<table>
<thead>
<tr>
<th>Entity</th>
<th>Assessments on Fully-Insured &amp; Self-Funded Insurance</th>
<th>Assessments on Fully-Insured Insurance</th>
<th>Assessments on In-Hospital</th>
<th>Assessments on Out-Patient</th>
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</thead>
<tbody>
<tr>
<td>PALs</td>
<td>Proposed</td>
<td>Encouraged</td>
<td>Proposed</td>
<td>Proposed</td>
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<tr>
<td></td>
<td>$2.8-$4.2 million, incl. Medicaid, Medicare Services; Washington Health Insurance Commission (WHIC)</td>
<td>Encouraged</td>
<td>$20 million (2020)</td>
<td>Proposed</td>
</tr>
</tbody>
</table>

### Type of Assessment

- **HB 2901 (2020) - Riccelli**: $1.9 million (2019) = 4.8% of SB 20-215 (2020) - Assessment on Employers

### WA Carrier Surplus Tax

- **WA Premium Tax**: $2.9 billion (2020) - Proposed
- **Colorado Tax / Assessment**: $29 million (2019)

### Mass. Employer Fair-Share Contribution

- **Mass. Employer Medical Assistance Contribution**: $1.8 billion (2021)
- **Mass. Employer Medical Assistance Contribution**: $1.0 billion (2022)

### Washington Paid Family & Medical Leave

- **Individual Mandate Penalty**: $54.9 million (2021) / $104.4 million (2022-on)

### State Revenue

<table>
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<tr>
<th>Source</th>
<th>Amount</th>
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<tbody>
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<td>Reinsurance</td>
<td>$20 million (2019)</td>
</tr>
<tr>
<td>Partnership Agreement Line &amp; Third-Party Administrators (TPA)</td>
<td>$10 million (2019)</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>$20 million (2019)</td>
</tr>
</tbody>
</table>

### Dedicated Uses

<table>
<thead>
<tr>
<th>Activity</th>
<th>Type of Cost</th>
<th>WA Covered Lives Assessment</th>
<th>Individual &amp; Employee Payroll</th>
<th>Federal Health Insurance Programs</th>
<th>Reinsurance</th>
<th>Washington Capital Gains Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$20 million (2021)</td>
<td>$20 million (2022-on)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Notes


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This chart is not intended to be an exhaustive list of all funding options available to policymakers. It is provided for illustrative purposes where available, and is not meant to constitute the modeling of a state subsidy funding mechanisms.
# Uninsured Rates

Immigration Status and Family Income Level of Washington State’s Uninsured Population, 2018

<table>
<thead>
<tr>
<th>Immigration Status</th>
<th>Income unknown</th>
<th>0-138%</th>
<th>139-200%</th>
<th>201-300%</th>
<th>301-400%</th>
<th>401-500%</th>
<th>501%+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen</td>
<td>11,556</td>
<td>66,556</td>
<td>37,945</td>
<td>71,914</td>
<td>47,407</td>
<td>30,897</td>
<td>50,978</td>
<td>317,252</td>
</tr>
<tr>
<td></td>
<td>3.6%</td>
<td>21.0%</td>
<td>12.0%</td>
<td>22.7%</td>
<td>14.9%</td>
<td>9.7%</td>
<td>16.1%</td>
<td></td>
</tr>
<tr>
<td>Lawfully Present</td>
<td>334</td>
<td>11,793</td>
<td>3,992</td>
<td>7,649</td>
<td>5,274</td>
<td>1,584</td>
<td>2,404</td>
<td>33,031</td>
</tr>
<tr>
<td></td>
<td>1.0%</td>
<td>36.7%</td>
<td>12.1%</td>
<td>23.2%</td>
<td>16.0%</td>
<td>4.8%</td>
<td>7.3%</td>
<td></td>
</tr>
<tr>
<td>Undocumented</td>
<td>1,588</td>
<td>38,671</td>
<td>22,927</td>
<td>26,903</td>
<td>17,333</td>
<td>6,959</td>
<td>3,751</td>
<td>117,501</td>
</tr>
<tr>
<td></td>
<td>1.4%</td>
<td>32.9%</td>
<td>19.0%</td>
<td>22.9%</td>
<td>14.8%</td>
<td>5.9%</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>13,478</td>
<td>117,020</td>
<td>64,234</td>
<td>106,466</td>
<td>70,014</td>
<td>39,440</td>
<td>57,133</td>
<td>467,784</td>
</tr>
<tr>
<td></td>
<td>2.9%</td>
<td>25.0%</td>
<td>13.7%</td>
<td>22.8%</td>
<td>15.0%</td>
<td>8.4%</td>
<td>12.2%</td>
<td></td>
</tr>
</tbody>
</table>

Source: American Community Survey 2018 1-year PUMS with OFM adjustment for Medicaid enrollment.
NEW SECTION. Sec. 6. (1) The Washington health benefit exchange, in consultation with the health care authority and the insurance commissioner, must develop a plan to implement and fund premium subsidies for individuals whose modified adjusted gross incomes are less than five hundred percent of the federal poverty level and who are purchasing individual market coverage on the exchange. The goal of the plan is to enable participating individuals to spend no more than ten percent of their modified adjusted gross incomes on premiums. The plan must also include an assessment of providing cost-sharing reductions to plan participants and must assess the impact of premium subsidies on the uninsured rate.

(2) The Washington health benefit exchange must submit the plan, along with proposed implementing legislation, to the appropriate committees of the legislature by November 15, 2020.

(3) This section expires January 1, 2021.
Sec 214

(10) $100,000 of the general fund—state appropriation for fiscal 2021 is provided solely for the exchange to contract with an independent actuarial consultant to conduct an assessment of the impact of a state requirement that individuals enroll in health coverage. The assessment shall consider the effects of this requirement on revenue, individual market enrollment, individual market premiums, and the uninsured rate. The exchange shall submit assessment findings to the chairs of the health committees of the legislature no later than December 15, 2020.