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Subsidy Study

Joan Altman, Director or 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

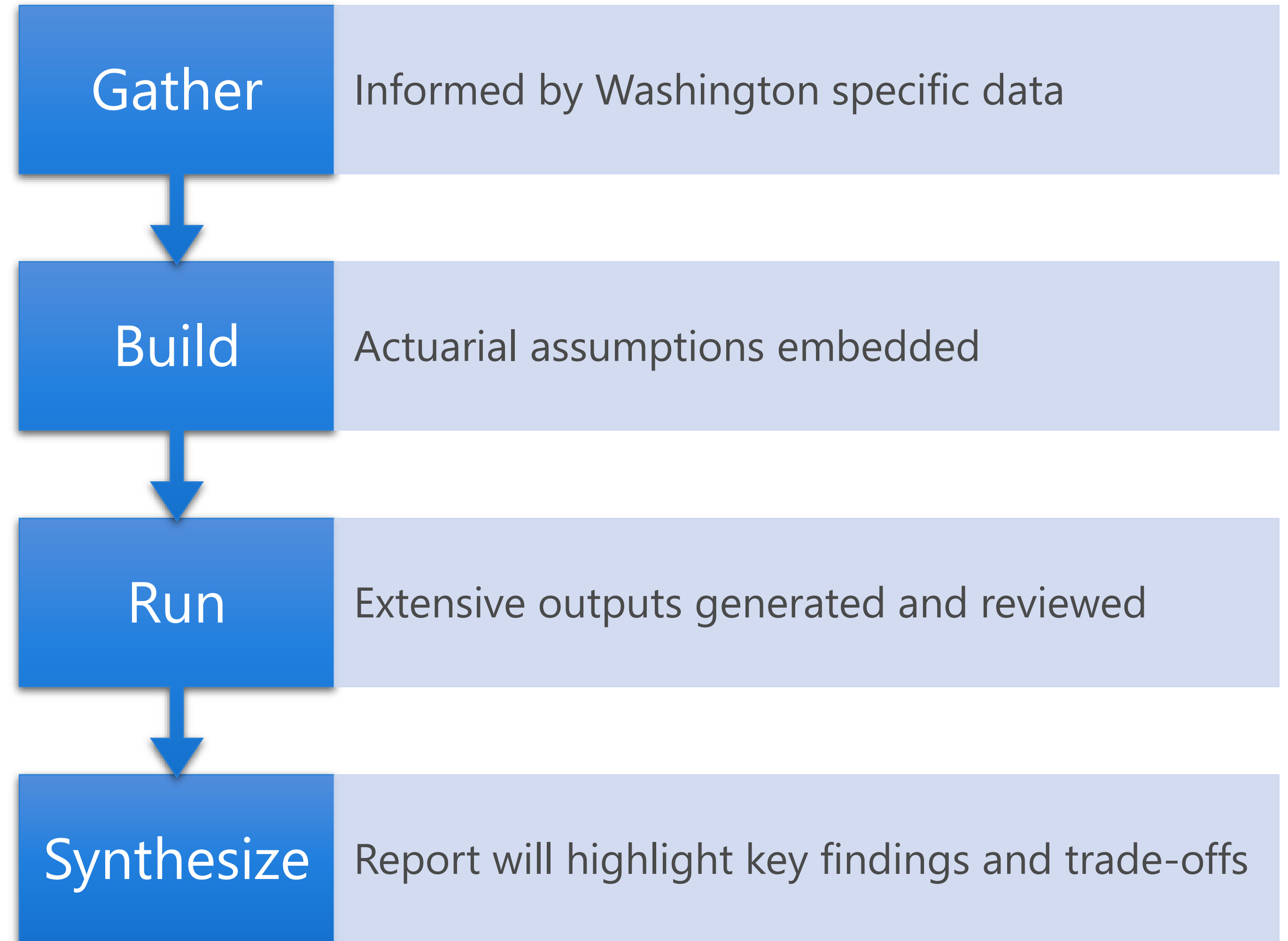
Key Exchange Subsidy Goals & Considerations

- 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.



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)

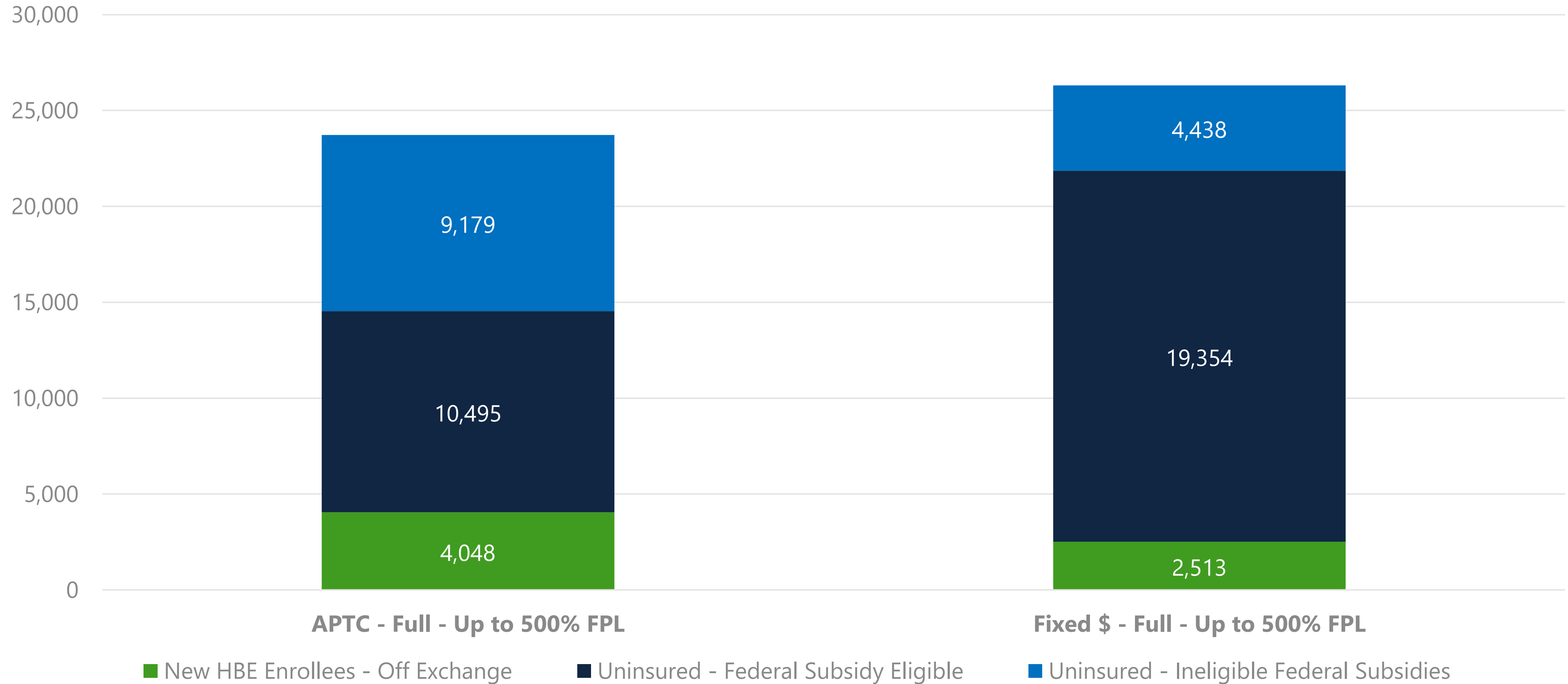
Consideration	Enhanced APTC	Fixed-Dollar Subsidy
Lower uninsured rate		X
Number getting state affordability assistance		X
Improved risk mix for entire individual market		X
Increased Exchange market enrollment		X
Everyone up to 500% pays no more than 10% on premiums	X	
Brings more consumers to/toward paying $0 premium		X
Additional federal $ draw down		X

Subsidy Scenario: Main Take-Aways

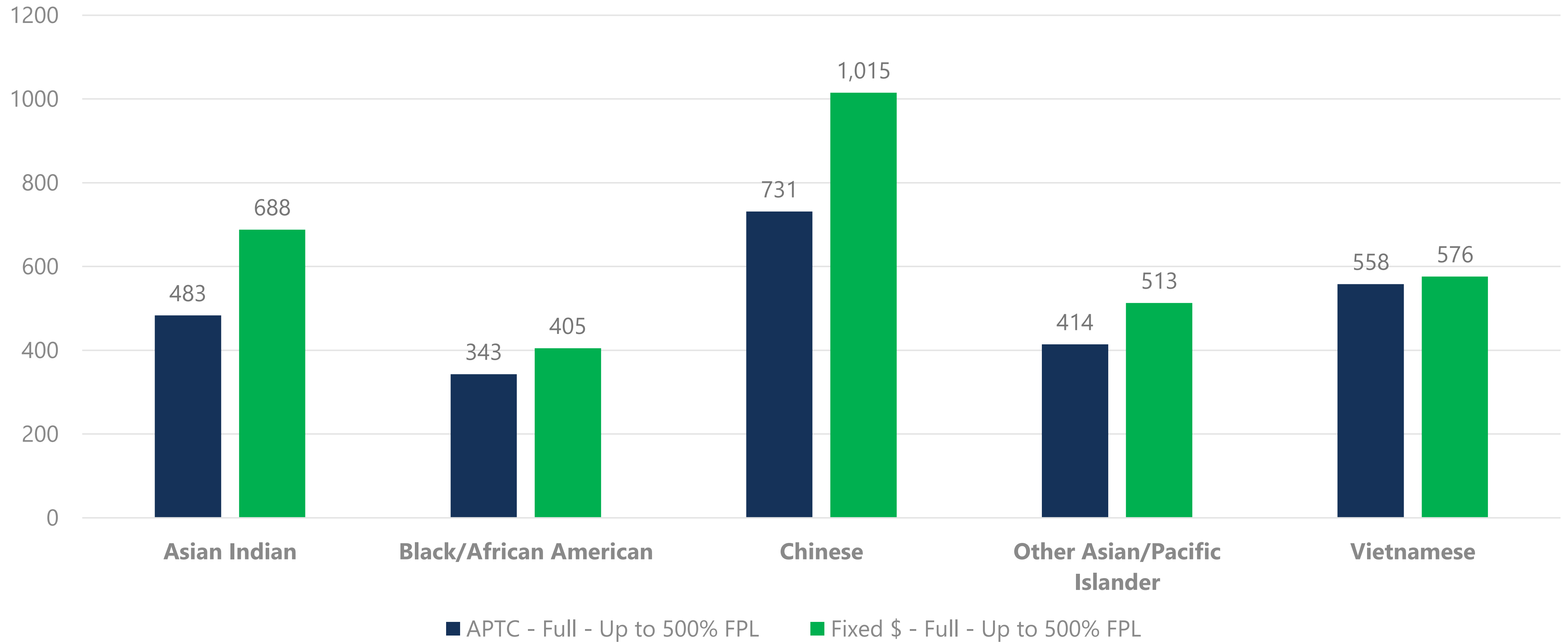
Enhanced APTC vs Fixed-Dollar Subsidy up to 500% ($200M)

Consideration	Enhanced APTC	Fixed-Dollar Subsidy
Impact on non-federally subsidized	X	
Impact on Black, Indigenous, People of Color		x
Impact on older individuals (55+)	X	
Impact on younger individuals (under 35)		X
Impact on rural vs urban populations	--	--

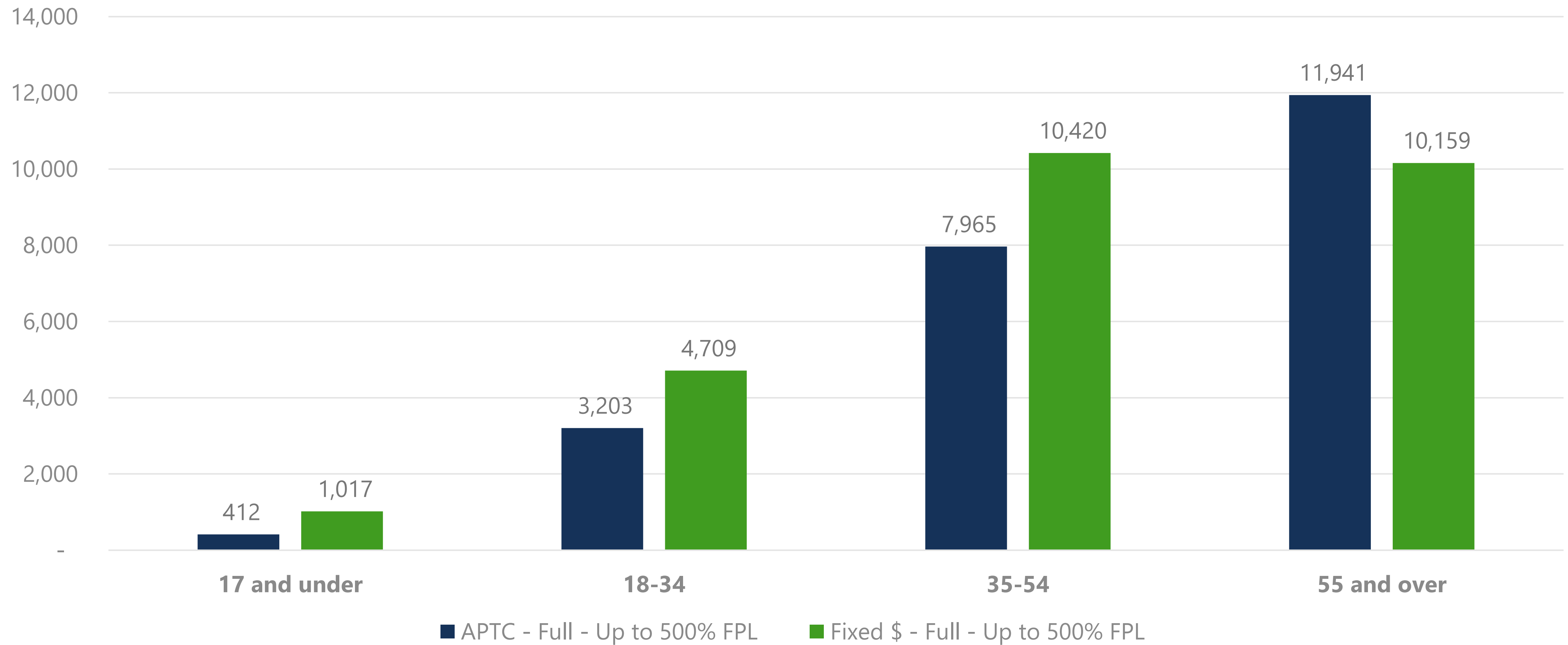
Detailed Look: Overall Uptake



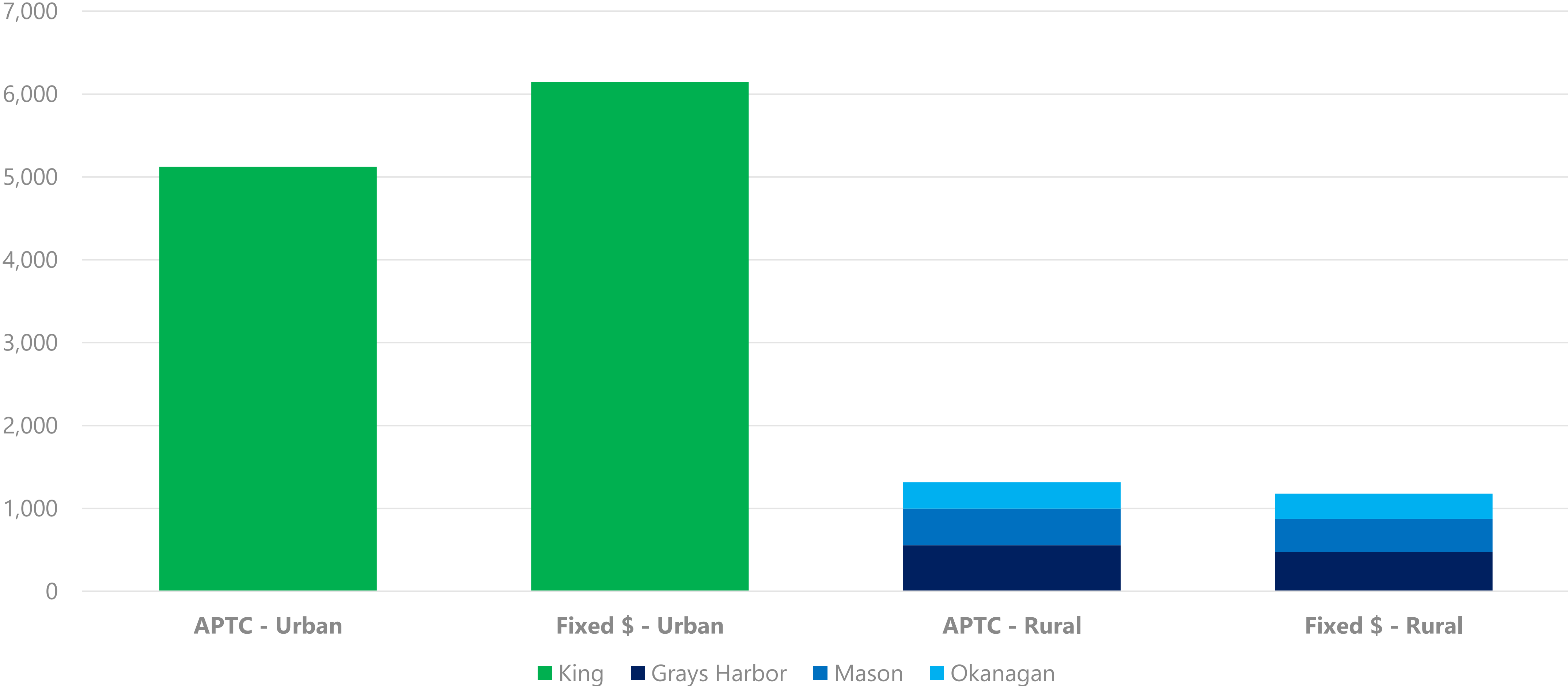
Detailed Look: Uptake By Race



Detailed Look: Uptake By Age



Detailed Look: Uptake By Urban/Rural



Detailed Look: Average Net Premium By Age

For Enrollees Receiving State Subsidy

Scenario	Subsidy Status	17 & Under	18-34	35-54	55 & Over
APTC – Up to 500% FPL	*Fed Sub*	**$118.10**	**$77.22**	**$109.37**	**$117.19**
	Fed Unsub	**$157.20**	**$151.73**	**$207.88**	**$238.02**
Fixed $ - $135 – Up to 500% FPL	*Fed Sub*	**$42.11**	**$32.47**	**$51.97**	**$71.77**
	Fed Unsub	**$157.30**	**$196.05**	**$330.39**	**$687.55**

**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

Subsidy Scenario	Individuals Receiving State Premium Assistance	New HBE Enrollees - Total	New HBE Enrollees - Uninsured	Avg. Annual State Subsidy Per Federally Subsidized Enrollee Receiving State Subsidies	Avg. Annual State Subsidy Per Federally Unsubsidized Enrollee Receiving State Subsidies	Annual State Appropriation	Additional APTC Assistance	Percent of Individuals Under 500% FPL Eligible to Pay 10% or Less of Income on Premium	Morbidity Impact on Premiums
APTC - Full - Up to 500% FPL	175,389	23,722	19,674	$526	$4,021	**$216,937,000**	$48,704,000	100%	-2.1%
Fixed $ ($135) Up to 500% FPL	179,766	26,305	23,792	$1,126	$1,594	**$217,059,000**	$91,469,000	93%	-2.5%
Fixed $ ($90) Up to 500% FPL	173,820	20,360	18,684	$837	$1,065	**$152,142,000**	$78,359,000	92%	-2.0%
Fixed $ ($58) Up to 500% FPL	168,698	15,233	14,153	$579	$688	**$100,733,000**	$64,396,000	92%	-1.5%

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

Date	Session
May 21	CC Session 1: Introduction, Background, Legislation, Timeline
June 24	CC Session 2: Review Initial Model
July 22	CC Session 3: Review Model Revisions
Aug 26	CC Session 4: Review Model Revisions
Sept 14	CC Technical Session: Walk-through of Final Model
Sept 29	CC Session 5: Review Initial Policy Recommendations & Finalize Funding Approach
Oct 28	CC Session 6: Review Policy Recommendations & Preliminary Report

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)

Appendix

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

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

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

- Estimated Impact of COVID-19 on Washington State's Health Coverage – OFM 2020
- 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

Wakely 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 cascadecare@wahbexchange.org

All Cascade Care Workgroup meeting materials available online:
https://www.wahbexchange.org/about-the-exchange/cascade-care-2021-implementation/

State-Sponsored Premium Assistance

State	Type of financial assistance	Additional Information	Eligibility
Massachusetts	Premium subsidy Cost-sharing subsidy	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)*	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.
Minnesota	Premium subsidy (*2017 only*)	For 2017 only, state provided premium subsidies for enrollees not eligible for federal premium tax credits, Medicaid, or the Basic Health Program	Individuals 138% - 200% FPL
Vermont	Premium subsidy Cost-sharing subsidy	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)	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
New York	Basic Health	Offers a Basic Health Program (Essential Plan) available to those under 200% FPL, under 65, without access to other sponsored programs (CHIP, Medicaid)	Individuals at or below 200% FPL
California	Premium Subsidy	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.	Individuals up to 400% FPL who are eligible for APTCs and individuals between 400-600% FPL
New Jersey	Premium Subsidy (Beginning 2021)	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.	*Individuals up to 400% FPL. Unclear yet whether eligibility will be tied to federal APTCs.*
Colorado	Premium Subsidy (Beginning 2022)	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.	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.
Maryland	*Studying Premium Subsidies*	*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.*	*Program parameters not yet set.*

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 different 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 different 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 500%	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 STUDY - 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 ESSB 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, revenues, and expenditures are provided for illustrative purposes where available, and are not meant to constrain the modelling of a state subsidy funding mechanism. This chart is not intended to be an exhaustive list of all funding options available to policymakers. **

	Assessments on Fully-insured & Self-funded Insurance					Assessments on Fully-insured Insurance		Assessment on Insurance & Hospitals	Assessment on Employers			Assessment on Individuals	
	WA Covered Lives Assessment	**PALs**	**WSHIP Assessment**	**WA Claims Tax**	**Federal Health Insurance Tax (HIT)**	**WA Carrier Surplus Tax**	**WA Premium Tax**	**Colorado Tax / Assessment**	**Mass. Employer Fair-Share Contribution**	**Mass. Employer Medical Assistance Contribution**	**Washington Paid Family & Medical Leave**	**Individual Mandate Penalty**	**Capital Gains Tax**
	SB 6062 (2018) - Cleveland *[HB 2355 - Cody]*	HB 2728 (2020) - Slatter	RCW 48.41.090	HB 2901 (2020) - Riccelli	Sec. 9010 of PPACA, P.L. 111-148	HB 2679 (2020) - Robinson *[SB 6451 - Frockt]*	HB 2821 (2020) - Cody	SB 20-215 (2020)	956 CMR 11 (2007-2014)	956 CMR 12 (2014-Present)	RCW 50A.10	SB 5840 (2019) - Cleveland	SB 5222 (2019) - Hasegawa
	Proposed	**Enacted**	**Enacted**	*Proposed*	*Repealed, effective 2021*	*Proposed*	*Proposed*	**Enacted**	*Repealed in 2014*	**Enacted**	**Enacted**	*Proposed*	*Proposed*
Entities Assessed	Fully-insured Carriers & Third-Party Administrators (TPA)	Fully-insured Carriers, Employers that provide insurance, & Self-funded Multiple Employer Welfare Agreements (MEWA)	Disability & Stop-loss insurers, HCSCs, HMOs, & Self-funded MEWAs	Fully-insured Carriers, TPAs, & Employers offering self-funded coverage	Fully-insured individual, small group, and large group health plans, Medicaid managed care, Medicare Part D, and Medicare Advantage	Fully-insured Carriers	Fully-insured Carriers & Managed Care Organizations (MCO)	Fully-insured Carriers & Hospitals	Employers w/ 11 or more FTEs that does not make a fair-share contribution to employee premiums	All employers w/ 6 or more employees	Employers & Employees	Uninsured Washington Residents	Washington Residents earning capital gains
Type of Assessment	Assessment on covered lives	Assessment on covered lives	Assessment on covered lives	Claims Tax	Fee on health insurance premiums	Non-profit Carriers = Fee on excessive surplus For-profit Carriers = Tax on depreciation deductibles	Premium Tax	Carrier Fee = percentage of annual premiums Hospital Assessment = annual $20 million	Employer Assessment	Employer Assessment	Employer & Employee Payroll Premiums	Individual Mandate Penalty	Capital Gains Tax
Tax / Fee %	Assessment on entity's covered lives as a fraction of total covered lives in WA, necessary to equal $200 million total (estimated at $5 pmpm)	Assessment on entity's covered lives as a fraction of total covered lives in WA, necessary to equal program expenses	Assessment on entity's covered lives as a fraction of total covered lives in WA, necessary to equal program expenses (estimated at $0.68 pmpm - 2019)	1% on all paid claims	Fee on 50% of net premiums between $25 and $50 million and 100% on net premiums above $50 million (~2.2% of premiums). Based on insurer's market share.	Non-profit Carriers = Payment of 3% of all Surplus above 600% RBC For-profit Carriers = 3% tax of all depreciation deductibles	2.2% (2021) & 1.5% (2022-on)	Non-profit carriers = 1.15% of annual premiums For-profit carriers = 2.1% of annual premiums Hospital Assessment = $20 million	$295 *or* the sum of a Fair Share Employer Contribution and the Per Employee Cost of Unsreimbursed Physician Care (whichever was less)	0.36% of all wages up to the Massachusetts unemployment insurance taxable wage base (~$50 per employee per year in 2014)	2019-20 total premium rate of 0.4% of wages, with review for annual adjustments beginning in 2021. ~1/3 paid by employers & ~2/3 paid by employee	2.5% of an individual's annual income or $695, whichever is greater, capped at the avg bronze premium in WA	8.5% of the inidivudal's Washington capital gains
Dedicated Uses	Reinsurance	Partnersnhip Access Line & Psychiatry Consulation Line @ UW (to fund non-Medicaid portion of calls)	WSHIP Program Administration	**Premium assistance** for individuals w/ income btwn 133-500% FPL, enrolled in a QHP	**Federal Advance Premiunce Tax Credits**	**Subsidies** for unsubsidized & Foundational Public Health	**Low-income health insurance programs**	Reinsurance / **Subsidies** for subsidized population / Subsidies for unsubisizided population	***In par t* - Subsidized low monthly-premium** insurance through ConnectorCare program	***In part* - Subsidized low monthly-premium** insurance through ConnectorCare program	Paid Family & Medical Leave	Admin of penalty / outreach to uninsured / **activities to increase availability of health insurance or affordability of premiums**	Funding for a Universal Health Care trust program
State Revenue	$200 million (yr 1) & ~$160 million (yr 2-on)	Indeterminate	$28 million (2019)	*Indeterminate - Mechanism to track claims or assess TPAs/Employers*	-	~$57 million /yr in excess surplus [*although true amounts unknown*] Tax amounts = unkown	$291 million (2021) & $199 million (2022-on)	$54.9 million (2021) / $104.4 million (2022) / $109.7 million (2023)	-	-	Employer Contribution = ~$213 million / yr Employee contribution = ~$367 million / yr	*Indeterminate - Commonwealth fund estimated a potential for $165 million in revenue based on 2019 data*	*~$1.3 billion annually*
Federal Revenue	$40 million /yr	-	-	-	$15.5 billion (2020)	-	$97.4 million (2021) & $66 million (2022-on), *used to offset taxes on MCOs*	~$88 (2021) - $175 (2023) million	-	-	-	None proposed, but 1332 possibility given reduction in premiums	-
Expenditures	$200 million / yr	Indeterminate ($510,000 in 2020)	$29 million (2019)	-	-	-	(Offsets to PEBB/SEBB/Medicaid costs)	$182.4 million (2021) up to $314.8 million (2023)	-	-	-	-	-
Administrative Costs	Differs annually, between$120,000 to $400,000 - OIC	$294,000 /yr	$1.9 million (2019)… = 4.8% of total expenses	-	-	$109,000 - OIC	-	$2.8-$4.2 million	-	-	-	-	-
Other Notes	Required establishment of a TPA registration program & federal 1332 waiver	-	-	Premium assistance is set on a sliding scale by HCA and must be applied-for	-	Concerns expressed around getting to a dollar-figure based on RBC. May need to adjust assessment calculation.	HCA has questions around whether the FMAP/dedicated use of funds align with CMS policies.	Federal match based on 1332 waiver	-	-	-	Commonwealth Fund projects a 15% reduction in premiums (based on 2019 data)	-
Other State/Federal Activity	Federal - Transitional Reinsurance Covered Lives Assessment (2014-2016)	-	-	Vermont - Health Care Claims Tax [includes TPAs & PBMs] (32 V.S.A. 243)	-	-	Washington - Insurer Premium Tax(RCW 48.14.020) Vermont - Insurance Premiums Tax (32 V.S.A. 211) Oregon - 1.5% premium tax on insurers, including PEBB to fund reinsurance and Medicaid programs (HB 2391 (2017)) N.J. - 2.75% premium tax to replace HIA (AB 4389 (2020))	-	-	-	Oregon - PFML Payroll Tax (HB 2005 (2019))	Federal - ACA Individual Mandate (2014-2018)	-

Uninsured Rates

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

Immigration Status	Family Income as Percent of Federal Poverty Level							
	Income unknown	0-138%	139-200%	201-300%	301-400%	401-500%	501%+	Total
Citizen	11,556	66,556	37,945	71,914	47,407	30,897	50,978	317,252
	3.6%	21.0%	12.0%	22.7%	14.9%	9.7%	16.1%	
Lawfully Present	334	11,793	3,992	7,649	5,274	1,584	2,404	33,031
	1.0%	35.7%	12.1%	23.2%	16.0%	4.8%	7.3%	
Undocumented	1,588	38,671	22,297	26,903	17,333	6,959	3,751	117,501
	1.4%	32.9%	19.0%	22.9%	14.8%	5.9%	3.2%	
Total	**13,478**	**117,020**	**64,234**	**106,466**	**70,014**	**39,440**	**57,133**	**467,784**
	2.9%	25.0%	13.7%	22.8%	15.0%	8.4%	12.2%	

Source: American Community Survey 2018 1-year PUMS with OFM adjustment for Medicaid enrollment.

SB 5526 – Subsidy Implementation Plan

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.

SB 6168 - Individual Market Assessment

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.

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