INCREASING ENROLLMENT IN HEALTH INSURANCE AMONG YOUNG ADULTS IN WASHINGTON STATE

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Executive Summary
his report examines efforts to expand health insurance coverage among young adults by attracting them into the Washington Health Benefit Exchange and to offer policy recommendations to accomplish that goal. Young adults are seen as having a uniquely challenging profile to bring to the Exchange, and their utilization patterns could lead to a broadening of the risk pool and aid in curbing overall growth in health insurance premiums. We explore the problems facing the state, including rising premiums, which can prevent young people from buying insurance, as well as a lack of understanding of the value of health insurance and an associated feeling of “invincibility.”

Next, we discuss our process of gathering data and building a framework for analyzing policy options. We then examine a range of policy recommendations that have been proposed to help curb premium growth and make young people more likely to participate in the Exchange. From the options considered, we propose:

(1) Introducing a premium subsidy, or “wrap,” that would lower the percentage of income that consumers between 139% and 400% of the federal poverty line (FPL) pay for premiums;

(2) Offering a State-procured public option on the Exchange, with the goal of offering a more affordable option for those who are not eligible for a premium subsidy; and

(3) Introducing standardized plans to help consumers understand the value proposition of health insurance and easily compare across plans, as well as potentially increasing the value of having insurance.

We also suggest some communication and engagement frameworks to build on the state of Washington’s success in making the case for insurance among young adults.

We believe that this suite of policy recommendations are appropriate and responsive to the challenge of further reducing the rate of uninsurance among young adults in Washington state. While they would be most effective pursued concurrently, we believe that the political momentum behind a public option should not obscure a focus on premium subsidies as an essential element of making health insurance affordable for individuals who qualify for subsidies, as young adults are over-represented in this target population.
Introduction
The state of Washington has a long tradition of being an innovator and leader on expanding access to health care. After the passage of the Affordable Care Act, Washington successfully designed and implemented its own Exchange, which connects more than 200,000 residents with health insurance - about two-thirds of whom are subsidized with federal tax credits.

The state was successful in achieving steep declines in the number of uninsured after the ACA's passage, with the fall in uninsurance far outstripping the national decline. But recent progress has slowed; Washington state's uninsurance rate among 26- to 45-year-olds fell from 24% in 2013 to 10% in 2015, but the number has stalled there without additional progress being made in the years since. At the same time, growth in health insurance premiums has accelerated.

This report builds on the Exchange's efforts to address the challenge of bringing young people to the marketplace. In our **Problem Statement**, we identify and discuss two major challenges that young people face in the decision to purchase health insurance: cost and comprehension of the value proposition. We also track broad trends in health insurance among young adults and spotlight the unique needs of disadvantaged populations.

Next, we discuss our **Methodology** for choosing solutions and the metrics we used for evaluating policy proposals, examining each of the options considered along feasibility and impact. Finally, we offer three **Policy Recommendations**: (1) State investment in premium subsidies, on top of the ACA's premium subsidies, to make health insurance more affordable for the low-income population; (2) A public option as a potentially more-affordable option for the unsubsidized population, and; (3) Introducing standardized plans to better inform consumer choice about the value proposition of health insurance plans.

We also discuss a **Communications Framework** that we believe would help best increase awareness of the policy strategies which we recommend.

As part of the Exchange’s efforts to target this population, the report seeks to better understand the dynamics of increasing health insurance enrollment among young adults in the state of Washington.

The authors are a group of Master’s of Public Affairs students at Princeton University’s Woodrow Wilson School of Public and International Affairs, and this report is prepared in fulfillment of our degree requirement for an immersive policy workshop and associated policy proposal. This report is informed by our own research, as well as a week spent interviewing key stakeholders, policymakers, and advocates in Seattle, Olympia, and Spokane in October 2018.
Since the implementation of the Affordable Care Act, the state of Washington has seen a significant reduction in the percentage of uninsured individuals, outstripping the progress made nationally. According to the American Community Survey, the overall uninsured rate in Washington fell by 42% from 2013 to 2016, from 14.1% to 5.9% percent, where it remained relatively constant in 2017.\(^1\)

Over this period of substantial progress, the uninsured rate dropped for every demographic group, with decreases of more than 10 percentage points for individuals who self-identified as Hispanic, American Indian and Alaska Native, and other races.\(^2\) The primary drivers were Medicaid expansion and the success of the Washington Health Benefit Exchange, as developed under the Affordable Care Act.

At the same time, premiums in Washington state have been rising, potentially stalling further progress in bringing down the uninsured rate by increasing disenrollment and acting as a barrier to new enrollments. The average price of a "benchmark" silver plan rose by 56% over the past two years, to $381 for 2019.\(^3\) Rising premiums have the potential to undermine the progress that Washington state has made in reducing the fraction of its residents who are uninsured. The impact of high premiums is most likely to affect price-sensitive individuals, such as young people.

Rising premiums affect enrollment along two paths. First, increased premiums could cause more individuals to disenroll from the marketplace. The Exchange regularly sees about 21-23% of QHP participants disenroll, with 49% of those in 2017 and 56% in 2018 coming from the unsubsidized population.\(^4\) That population does not receive advanced premium tax credits (APTCs), meaning that they feel the full freight of premium increases. A common hypothesis we heard in Washington was that this population might include many young adults, and the Exchange’s data backs that up, with the highest disenrollment rates among participants under age 35.

A second channel through which increased premiums may contribute to lower Exchange enrollment is by making it less likely that the currently-uninsured will seek out insurance. For instance, individuals without insurance may see news reports about rate increases and decide against looking for insurance, even though they may in fact qualify for tax credits.
Barriers for Unenrolled Young Adults

Young adults are both particularly impacted by the high premiums as well as a potential key to lowering health insurance premiums. Young people tend to be healthier, with lower average expected costs than older enrollees. Their premium payments therefore help cover costlier consumers and result in less risk in the insurance market overall, potentially lowering premiums for all consumers. Increasing young adult participation in the marketplace can broaden the risk pool, leading to lower premiums – a 2015 study found that for each percentage point young adult enrollment increased in the individual marketplace, overall premiums fell by about 0.4 percentage points. 

This has a feedback effect: In the absence of the penalty associated with the individual mandate, rising premiums may mean fewer enrollees, leading to even-higher costs, pushing more individuals out of the marketplace and threatening the long-term stability of the health insurance market in Washington. **Getting young adults into the individual marketplace is crucial for the long-term stability of the broader health insurance market.**

With that in mind, we identified the following barriers preventing young people from entering the marketplace:

1. **Costly Insurance Premiums**

Young adults tell surveys that the main barrier keeping them from health insurance is high prices. Among uninsured young adults nationwide, 42% said that the reason they did not purchase insurance was due to cost. For Washingtonians age 26-34, the average monthly premiums are $148 for the subsidized population and $324 unsubsidized individuals.

We see this borne out in the data, which show that in Washington, individuals under 35 had the highest drop in insurance coverage from 2017 to 2018 across all net premium increase categories. The number of new unsubsidized enrollees declined substantially – by 21% – from 2017-2018, while the unsubsidized population (over 400% PFL) saw their monthly premiums increase by 42%.

The individual mandate was meant to mitigate the potential problem of people opting not to purchase insurance, but the Tax Cuts and Jobs Act of 2017 removed the teeth from the mandate.
Additionally, the Trump Administration's moves to slash funding to navigators and expand access to short-term plans, while less directly relevant in the context of Washington's health insurance market and regulations, could still be salient due to the potential to sow confusion among young adults. The full impact of a penalty-less mandate remains to be seen.

2. Failure to Comprehend Value of Insurance

In interviews, health care advocates cited a lack of understanding of health insurance as a major barrier to coverage, particularly among young people. Navigators stated that they often had to explain the basics of health insurance to individuals and that many young people did not have an understanding of what premiums, deductibles, coinsurance, and co-pays are or how they work. Health insurance literacy is particularly an issue for young individuals, who use the health care system infrequently, and particularly so for those who were covered on their parents' plans until recently. Part of that could be due to the low implicit value young adults assign to insurance due to their lower probability of needing to utilize the health care system, earning them the nickname “Young Invincibles.” In 2017, 15.5% of 19-34 year olds in Washington were uninsured, the largest age brackets to go without insurance in the state (roughly 59% of this group were male.)

Individuals also do not know the cost of common medical conditions and how insurance would help. The Washington Healthplanfinder website attempts to solve this problem by summarizing the difference in costs related to common conditions such as having a baby, Type 2 diabetes, or a simple fracture. But we heard from many stakeholders that the prevalence of understanding of health insurance terminology and the value of having insurance still remains low.
Unique Challenges Facing Underserved Populations

Washington is home to large Hispanic, American Indian, and Alaska Native (AIAN) populations. These groups face a number of unique challenges related to health insurance.

**Hispanic Population**

The Hispanic community has consistently had uninsured rates above the national average, and this trend continues even post-Affordable Care Act. Individuals of Hispanic descent have the highest uninsured rate, 19.2%, of any racial/ethnic group in the state.

While they make up 12.7% of the state’s population, they make up only 3% of those enrolled in the Exchange.\(^1\) Additionally, an estimated 3.6% of the state’s population are undocumented, and many of them are Hispanic.\(^2\)

We heard that one of immigrants’ largest barriers to insurance is fear. Undocumented immigrants are ineligible for Medicaid or APTCs, and avoid interacting with the government for fear of deportation and other legal repercussions. They often live in so-called “mixed status” households, where some family members may be naturalized or native-born citizens, with others being undocumented residents.

In these mixed-status households, even legal resident members may choose to not get health insurance for fear of the impact that being in government databases could have on their undocumented cohabitants. Additionally, because of the fear that permeates immigrant communities, many are unaware of their potential eligibility for assistance.

Concerns within immigrant communities became even more pronounced after the Trump Administration’s proposed change to the “public charge” rule. The proposed change may lead to citizenship applications being denied if applicants are deemed to be “public charges,” or dependent on government programs. The Administration’s expanded “public charge” definition could lead to applicants being denied residency if they have used or applied for public benefits, though technically, APTCs are not counted as part of the public charge calculation. At the time of this writing, this rule has not yet been officially implemented, but it has further expanded the rift between immigrant communities and government.\(^3\)

Unless local governments forge stronger relationships with immigrant communities, many immigrants, including those of Hispanic heritage, may continue to remain uninsured.
American Indian and Alaska Native Communities

American Indian and Alaska Native communities in Washington are geographically dispersed and often economically disadvantaged. These communities also face a litany of chronic illnesses, including high rates of liver disease, heart disease, diabetes and suicide.¹⁴ AIANs have the shortest life expectancy and the highest rate of infant mortality and premature births of all ethnic and racial groups. These health challenges are often compounded by a sense of isolation that exists between these communities and local and state government.

A common thread emerged from our conversations with relevant stakeholders: AIAN communities feel as though they are often facing these problems on their own. In 2017, AIANs continued to have one of the highest uninsured rates at 12.3%.¹⁵
Methodology
In this section, we describe the policy solutions considered as well as the framework we used to evaluate options. To develop a set of recommendations, we first laid the groundwork with background research on the state of the Affordable Care Act, including a comparison of the challenges faced across different states. The policy options that were developed and evaluated are briefly described below. For a more detailed description of each option, please see the recommendations section and the Appendix.

- **Standardized plans**: By developing a requirement for standardized plans, the Exchange would define standard parameters required to list plans on the marketplace in order to help consumers with an apples-to-apples comparison of plans.

- **Public option**: The State would procure a health insurance plan that could be offered on the Exchange. It would use its purchasing power to lower costs and take advantage of Medicaid provider networks. Insurance carriers would bid to manage the public option through a competitive process.

- **Medicaid buy-in**: This proposal would allow Exchange users to purchase a Medicaid managed care plan, with benefits similar to Washington’s existing Apple Health Medicaid plans offered at competitive prices.

- **Basic health plan**: The State would apply to offer a Basic Health Option as provided for in the ACA. This plan would subsidize coverage for residents at and below 200% FPL under plans contracted by the State outside of the Exchange.

- **Premium subsidy**: A premium subsidy, or "wrap," would be a State-provided subsidy, layered on top of federal APTCs, to lower subsidized consumers' maximum allowable premium costs.

- **Individual mandate**: An individual mandate would create a penalty for people who choose not to purchase insurance in a given year as a way to incentivize coverage.

- **Reinsurance**: Reinsurance would help shield carriers from high losses by insuring carriers against high medical costs, thus helping to stabilize the individual market.

**Impact**

To assess the impact of a policy proposal, we considered the potential effect on the costs to the consumer, coverage, and equity:

- **Cost**: One key challenge to young people entering the marketplace is the total cost to the consumer. As a result, we evaluated each plan’s likely impact on premiums, deductibles, co-pay and other costs to the consumer, including the unsubsidized cost of care.
• **Coverage / access:** The goal for the Exchange is to increase health care coverage, particularly among young people. We analyzed direct effects of the policy solutions on health care coverage, i.e., whether individuals would have greater overall access to health care as a result.

• **Equity:** State agencies, as well as advocates we interviewed, were concerned with equity in coverage, particularly among vulnerable populations such as immigrants and lower-income young people. We examined whether each policy solution would make the availability, and, ideally, affordability, of health insurance more equitably distributed.

### Feasibility

All of these policy options would need to overcome financial, political, and implementation capacity challenges to be executed successfully. These criteria were used to assess whether the policy option is feasible at the state level:

• **Financial impact:** Here, we focused on cost to the State, as opposed to the consumer (see above: costs). In this section, we weighted cost of each solution and its potential impact on Washington’s budget against policymaker support and potential benefits, for example, expanding access to healthcare.

• **Political:** Based on conversations with political actors across Washington, we rated each policy option on political feasibility, assessing whether a policy option is likely to make it through the necessary legislative and/or administrative approval process. We paid particular attention to policymakers’ appetite for the option weighted against cost to the state (see above: financial impact), potential waiver requirements, and stakeholders opinions. Options that required a federal waiver were given a lower priority relative to options that could pass on State authority alone, due to the burden of applying for federal approval as well as the stated health care priorities of the current Administration.

• **Implementation capacity:** Finally, we evaluated, to the best extent possible, how robust is the State’s capacity to implement each policy solution. Examples of variables considered in this section were administrative demands and procurement processes.

### Option Consideration Matrix

In the following matrix, we list each option considered, along our analysis along the six dimensions of our matrix. Further descriptions of each option considered, as well as a summary version of the matrix, can be found in the Appendix. For this table, **green** denotes positive impact or strong feasibility; **yellow** denotes limited impact or possible feasibility; and **red** denotes negative impact or lack of feasibility.
Prioritization

Options that received at least one red box in the “feasibility” criteria were automatically stricken from consideration as infeasible. The Basic Health Plan and reinsurance were eliminated from consideration due to consensus among policymakers that the political will was not there, based on the costs (whether financial or human capital). The Medicaid buy-in and individual mandate also dropped from the list of feasible options due to concerns over how to institute each policy: the Medicaid buy-in would require unlikely federal support for a waiver, while the individual mandate had no state income tax to implement. For more details on this process, see the Appendix.

Next, we evaluated each of the most feasible options to determine how they might interact. Given the challenges at hand, we determined that the key areas of concern for young people – costs and value proposition – would be adequately addressed by this set of options. In the next section, we elaborate on these recommendations.
Policy Recommendations
Three policy options show the most promise for encouraging young adult enrollment by addressing cost and communicating the value proposition of health insurance:

1. Premium subsidies that lower the percentage of income consumers pay for premiums who are between 139% FPL and 400% FPL;

2. A state-procured “public option” plan offered on the Exchange alongside commercial plans; and

3. Standardized, or “consumer-centered” plans.

A premium subsidy program and public option would address the problem of high premium costs, while standardized plans would be primarily aimed at making it easier to compare health plans, and would make it easier to communicate the value of coverage especially to young consumers.

In addition to these three policy recommendations, we also provide communication frameworks for the Exchange to keep in mind as part of its marketing and outreach strategy. Like standardized plans, these recommendations would seek to clarify the value of health insurance for young adult consumers. Our communications suggestions include:

(a) A framework identifying core messaging strategies for the new policy options; and

(b) Building on the success of the Healthplanfinder tools to ensure features that continually improve in communicating the value of coverage to users.

In the following section, we describe our recommendations in detail. First, we provide an overview of each policy, its relevance to Washington, and the challenges we expect it to address. Next, we outline the potential pros and cons of each recommendation. Then, we provide a case study from a peer state that has explored or implemented each policy. Finally, we discuss next steps for Washington.

With the introduction of Gov. Inslee’s “Cascade Care” option, the public option may have the political momentum, but we believe that these recommendations would have the most impact if pursued in concert with one another.

At the same time, we recognize the challenge of simultaneously pursuing, much less implementing, several major policy changes. With that in mind, we target each recommendation to a particular challenge or population and offer recommendations.

The public option is the most complex recommendation, and would require the most political capital and cooperation across state agencies. It could also have the most impact on premium costs, and potentially on costs across the state’s health care system. A public option has the potential to benefit all Exchange consumers through lower prices, but it would likely have the largest positive impact on consumers with incomes above 400% FPL who are not eligible for tax credits and bear the full incidence of premium increases.
Additionally, state-provided **premium subsidies** may be less politically challenging but comes with an ongoing cost to the state, both financially and administratively. It would narrowly target lower-income people currently eligible for federal tax credits (139%-399% FPL), lowering their premium costs.

Requiring insurance carriers to offer **standardized plans** on the Exchange may not have much of an effect on cost, but it could enhance value and would be intended to provide a valuable tool for consumers at all income levels to compare coverage, as well as potentially incentivize carriers to offer better products.

Finally, our **communication recommendations** are likely the easiest to implement by integrating into the already-successful outreach to young people, aiming to keep them enrolled or convince them to enroll in health insurance.
Proposal: Provide State-funded premium “wrap” for the 139-399% population

A premium subsidy, or premium “wrap,” is an additional subsidy paid on behalf of individuals to insurers to decrease the cost of their insurance premium. It is applied after Advanced Premium Tax Credits (APTCs) are calculated and is “wrapped” around those subsidies to lower the consumer’s out-of-pocket costs. The wrap can be constructed either to provide a fixed dollar or a set percentage of income to increase affordability and increase enrollment in health insurance. The ambition, design, and scope of a premium wrap can be adjusted to meet budgetary limits.

The goal of a premium subsidy or “wrap” is to directly reduce premium costs, leading to increased enrollment that could improve the risk pool and in turn increase affordability. A market stabilization analysis from Wakely estimated the impact of a premium wrap applied to the unsubsidized population. They measured the impact of a $150 million investment into “wraps” for the unsubsidized population and estimated a premium reduction of 45% for unsubsidized members on the Exchange, or a 15% reduction for all of the unsubsidized (both on and off the Exchange).

In an effort to shore up the success of the Exchange for the subsidized population, we recommend a premium wrap, in which the population with incomes between 138-400% of FPL would receive an additional premium subsidy from the State. As will be discussed in our case study section, Massachusetts and Vermont currently operate some form of premium wrap. Our proposed model, built on the example of Vermont’s premium subsidies, is intended to complement our recommendation of a public option by subsidizing coverage for the already-subsidized population, while the public option would be intended to appeal to the unsubsidized population.

About 4 in 10 young adults (age 25-34) in Washington have incomes between 150-399% of FPL, about the same proportion that have incomes above 400% of FPL. Given limited resources, the State will receive more “bang for its buck” by investing on the margin for low-income populations, rather than trying to induce a similar response among the 400%+ population.

A premium wrap is best suited for those facing extreme price sensitivity, such as those who are in the 138-400% range of income who will likely feel any reduction in premium incidence more
<table>
<thead>
<tr>
<th>Federal Poverty Line* ($)</th>
<th>2019 allowable % of income ($)</th>
<th>2019 allowable % of income w/ 1% 'wrap'</th>
<th>Max consumer savings (annual)*</th>
<th>Max consumer savings (monthly)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>139 - 150%</td>
<td>3.48 – 4.15%</td>
<td>2.48 – 3.15%</td>
<td>$168.75 – $182.10</td>
<td>$14.06 – $15.18</td>
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<td>($16,874 – $18,210)</td>
<td>($587 – $756)</td>
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<tr>
<td>151 - 200%</td>
<td>4.15 – 6.54%</td>
<td>3.15 – 5.54%</td>
<td>$182.10 – $242.80</td>
<td>$15.18 – $20.23</td>
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<td>($756 – $1,588)</td>
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<td>201 - 250%</td>
<td>6.54 – 8.56%</td>
<td>5.54 – 7.56%</td>
<td>$242.80 – $303.50</td>
<td>$20.23 – $25.29</td>
</tr>
<tr>
<td>($24,280 – $30,350)</td>
<td>($1,588 – $2,598)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>251 - 300%</td>
<td>8.56 – 9.86%</td>
<td>7.56 – 8.86%</td>
<td>$303.50 – $364.20</td>
<td>$25.29 – $30.35</td>
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<td>($2,598 – $3,591)</td>
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<td></td>
</tr>
<tr>
<td>301 - 399%</td>
<td>9.86%</td>
<td>8.86%</td>
<td>$364.20 – $485.60</td>
<td>$30.35 – $40.47</td>
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<td>($3,591 – $4,788)</td>
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</tbody>
</table>

* Calculated for a single childless individual at given income relative to 2018 FPL

strongly. Additionally, because the subsidized population is insulated from the direct cost of rising premiums, they will not feel the benefit from a public option and could even be harmed by it if the plan is successful in lowering the cost of the benchmark plan (thus lowering their subsidy.) As a point of comparison, Vermont offers an additional premium reduction of 1.5% of income on top of the APTCs that subsidized individuals receive through the ACA. We propose a broader reach, with a slightly less generous wrap, offering an additional 1% in subsidies for the population between 139% and 399% of FPL.

The above chart illustrates the change to the maximum allowable premium as a percentage of income. The second column provides the status quo under the ACA, with the next column showing our proposed “wrapped” allowable premium. The final columns show the amount of money that would go back into the pockets of Exchange consumers on both an annual and monthly basis. Using the Kaiser Family Foundation’s Marketplace Calculator, this adjustment would mean a childless 30-year-old married couple living in Yakima with an income at 399% of the poverty line ($65,675) could see their premiums for a benchmark plan fall by $56/month ($672/year). As another illustration, a single young adult living in Kent at 250% of the poverty line ($30,350) would see his expected monthly premium drop by $25, saving $300 annually.

In 2018, there were 132,258 QHP enrollees on the Exchange with incomes between 139-400% of FPL, with net monthly premiums averaging $86 to $203 across income thresholds. If the lack of a penalty due to the repeal of the individual mandate causes attrition in the individual marketplace, the additional premium subsidy could counterbalance that trend, potentially attracting some disenrollees back to coverage.

80% of Washington’s uninsured 25-34 year olds, and 84% of uninsured 35-44 year olds, are below 400% of the Federal Poverty Line.
**Pros & Cons**

The premium wrap we suggest would directly address our target population, making insurance more affordable. The average monthly net premium (after APTCs) for a person between 201-250% of FPL is $148, $197 per month for those making between 250-300% of FPL, and $203 for someone between 300-400% of FPL. According to data from the Office of Financial Management, 80% of Washington’s uninsured 25-34 year olds, and 84% of 35-44 year olds, are below 400% of FPL. The Kaiser Family Foundation estimates that 35% of currently uninsured Washingtonians are potentially eligible for Medicaid or other public programs, and another 19% are eligible for APTCs. For younger people, whose premiums tend to be below the average, the wrap would go further in making insurance affordable.

A premium wrap is legally feasible. The statutory language of the Affordable Care Act specifically empowers states to make payments to (or on behalf of) an individual on top of any tax credits or cost-sharing reductions to enable purchase of a QHP. There is also little political downside to creating the mechanism of a premium wrap. Numerous interviewees we spoke to suggested premium wraps as a tool to increase the number of covered individuals, with potential support from both carriers and providers.

The overall effect of premium wraps on premium prices remains uncertain. It is hoped that incentivizing more people, especially young adults, to enroll in coverage with extra subsidies would expand the risk pool and potentially lower premium costs. In its report on a premium wrap for the unsubsidized population, Wakely estimated an increase of 6.7% in unsubsidized enrollment, leading to a decrease in premiums by 14% for unsubsidized enrollees both on and off the Exchange. Though not analogous to a premium wrap for the subsidized population, they do happen to be roughly similar in scale to academic literature suggesting that for each percentage point that young adult enrollment increases on the exchange, premiums fall by about 0.4 percentage points. If we believe that young adults are a population with a heightened price sensitivity to premiums, a premium wrap could be an effective way of inducing signup and benefiting from an overall reduction in premiums.

The biggest hurdle to implementing a premium wrap is allocating the necessary financial resources. The price tag of this plan is large and uncertain. The wrap estimated by Wakely would cost $150 million, a figure selected to match the expected cost of a reinsurance program. A back-of-the-envelope estimate suggests that the 1% wrap across the APTC-eligible population we propose would likely be less than that amount, though in the same ballpark, and a full actuarial analysis would need to be performed to estimate how much would need to be invested. However, the flexibility of a wrap allows the parameters of the subsidy to be drawn more or less generously to adjust to funding constraints.

Beyond financial concerns, we heard skepticism from some industry groups that the premium wrap would have any significant impact on enrollment. There seemed to be varying degrees of consensus around the theory that young people do not see the value proposition of health insurance and that the price would have to be lowered, in the words of one stakeholder, “pretty close to zero” to induce many new individuals into purchase of a QHP. Advocates stressed
concerns that any premium subsidies not be paid for in a regressive manner, such as a sales tax increase. Officials in other states flagged the importance of clearing any proposal with legal review, particularly if the wrap were to be based on characteristics other than income (such as age).

Nationally, Washington is the state with the eighth-highest percentage (44%) of uninsured people who are ineligible for APTCs (or Medicaid) due to citizenship status (19% of the uninsured), access to employer-sponsored insurance (15%), and incomes over 400% FPL (11%).22 A premium wrap, built on the underlying structure of the ACA and its tax credits, would do nothing to address their ability to access care, except by potentially inducing enough new take-up to broaden the base and lead to lower rates.

Case Studies

Vermont: As part of the state’s pre-ACA “Global Commitment to Health,” Vermont introduced a form of premium assistance and expanded the program in 2014 due to the ACA’s relatively less-affordable income premium limits.23 Vermont lowers QHP enrollees’ maximum allowable percentage of income paid towards premiums by 1.5%. For instance, Vermont Premium Assistance (VPA) would lower the allowable premium paid by an individual making 200% FPL from 6.3% to 4.8% of income. In designing their wrap program, Vermont initially considered further expanding financial aid to lower points on the income distribution. However, they determined their hold-harmless restriction meant that aid needed to be allocated equally across the eligible range to prevent upper portions of the wrap population from paying relatively more in premiums.

To be eligible for the VPA program, individuals must be eligible for APTCs, must not be Medicaid eligible, and have a household income of 300% of FPL or lower.24 In its first year, the greatest number of VPA recipients were in the 150-199% of FPL category, with an average premium reduction paid (across all income levels) of $38 per month. Because the Vermont plan offers a flat 1.5% reduction at all income levels, the total value of the wrap increases the further up the income scale the recipient is. The VPA has been funded by both state general funds and the pre-existing “Global Commitment” Medicaid federal waiver – $7.1 million was appropriated to fund the program in FY19. The total amount of federal payments for this purpose is capped, and these payments fall within the Vermont global waiver’s total budget neutrality requirements.25

The marginal impact of premium subsidies on coverage in Vermont is impossible to calculate because it is part of a suite of simultaneous policies that predated the ACA. Kaiser data suggest Vermont also has a much larger population that is eligible for tax credits (33% of uninsured Vermonters are ineligible for ACA assistance, compared to Washington’s 44%).26

The QHP-enrolled population on Vermont Health Connect is just over one-third the size of QHP enrollees on the Washington Exchange, and is also a little older than Washington’s. Just under 70% of their 80,440 QHP enrollees – or about 56,000 enrollees – are eligible to receive Vermont Premium Assistance (VPA), and the cost for that program was $6.6 million in FY2018.27 In addition, because the size of the subsidy will mechanically increase the further up you slide the income scale (1% of income is larger when income is 300% of FPL compared to 200% of FPL), the Vermont price tag should not be used to compare with Washington’s estimated total.
**Minnesota:** Another premium subsidy approach was seen in 2017 in Minnesota, which launched a limited-duration “premium relief” program for those who buy an unsubsidized plan on the individual exchange. This policy was intended as a temporary measure until Minnesota's reinsurance program was stood up. The program reimbursed Minnesota residents enrolled in an individual QHP who were ineligible for APTCs at 25% of their monthly premium. The State earmarked roughly $300 million from reserves to pay for the program, though total costs in 2017 came in roughly two-thirds below the budgeted costs. The rebates were paid directly by the state to the carrier and were reflected on the individual's premium. Despite some implementation challenges, roughly 100,000 residents received premium rebates in the year the program operated. *(Massachusetts also has a premium wrap program, initiated as part of their pre-ACA reform and grandfathered into the ACA, making their model less relevant to discussions in other states.)*

An alternative option that has been discussed, but not implemented, is the prospect of age-based subsidies, as proposed by, among others, the Commonwealth Fund. Their proposal would target an additional $50 per month in a premium subsidy for young adults 19-30, phasing out over the next five years of age. In a national simulation, they estimated that age-based subsidies would induce higher take-up among adults 19-34, while not doing anything to alter individual market sign-ups among age groups over 35. The estimates also found a small (0.6%) reduction in unsubsidized premiums for all age groups. When an age-based subsidy was brought up with carriers, some expressed hesitation that an age-related subsidy might lead to relatively-more expensive insurance for older ages. Some stakeholders also expressed questions about the legality of age-based targeting for insurance subsidies.

**Next Steps**

As discussed, one of the benefits of a premium wrap subsidy is its flexibility; both the population in question and the amount of the subsidized percentage of income can be adjusted for budgetary impact. The Exchange’s first steps should include obtaining sound estimates on the cost of a premium wrap and adjusting policy design, if need be, to fit with fiscal realities. The Exchange should also speak to state officials in Vermont, Minnesota, and Massachusetts to learn how they operationalized the new subsidies and built a system for getting payments to providers. Vermont's experience should prove especially instructive in the trials of synchronizing federal, state, and private carrier systems to ensure APTCs and premium subsidies are correctly calculated and applied. The Exchange would seem to be the preferred stakeholder to operate a state-based premium support, but additional staff may be required.

Concern about the sticker shock for insurance premiums among the unsubsidized population (400% of FPL and above) led some interviewees to target a different population with the idea of a premium wrap. We heard the idea of a section 1332 waiver to capture potential savings from a public option and redirect them towards a premium wrap for this population. In 2018, the average monthly premium for the on-Exchange population who reported an income above 400% of FPL was $464, up nearly one-third from 2017. However, based on the demographic profile of our target population, we believe a premium wrap for the subsidized Exchange population will be a way to shore up the success of the marketplace and induce coverage among low-income young adults.
Public Option

Proposal: Seek a more affordable Marketplace option via State-procured plan

A public option, or state-procured health insurance plan, could lower premiums for Washington consumers, including young people, by introducing a more affordable option into the marketplace and encouraging competition among private carriers.

Though having a “public option” was part of the debate leading up to the passage of the ACA, it was not ultimately included in the legislation after it faced opposition from private insurance carriers, providers and conservatives. With no action at the federal level, states looking to expand coverage and improve affordability have begun exploring what a public option might look like at the state level. Several state proposals were termed “Medicaid buy-in,” a broad label placed on proposals that would allow individuals with income above Medicaid eligibility (138% FPL in states that expanded Medicaid) to participate in coverage that resembles Medicaid.

From these proposals, two paths for “Medicaid buy-in” have emerged:

(1) a pure Medicaid buy-in, in which people above eligibility levels for traditional Medicaid can “buy in” to a Medicaid managed care plan by paying premiums and cost-sharing; and

(2) a state-level public option, in which the State procures a plan that meets ACA Qualified Health Plan (QHP) standards and therefore can be sold on an exchange alongside other commercial plans.

We recommend Washington pursue option (2), a state-procured plan that meets QHP standards and is sold on the Exchange, and in which enrollees are added to the existing individual market risk pool. We believe this policy could stabilize the individual market and lower premium costs for consumers at all income levels, but will have a particularly positive impact on unsubsidized consumers with incomes above 400% FPL.

As premiums rise, APTCs adjust with the price of the second lowest cost silver (“benchmark”) plan, shielding subsidized consumers from the full impact of price increases. Unsubsidized consumers bear the full brunt of premium increases, and would therefore be most likely to benefit from an affordable plan procured by the state. Two key reasons we recommend pursuing a public option, rather than a “pure” Medicaid buy-in that allows any individual to purchase a Medicaid-like plan outside the marketplace, are:

(1) the potential stabilizing effect of keeping public plan enrollees in the same risk pool as the rest of the individual commercial market; and

(2) the State’s ability to pursue this option without applying for a federal 1332 waiver.

Stakeholders expressed concern about “bifurcating” the market by offering a public option separate from other commercial plans, as the state did previously through its Basic Health Plan.
They emphasized the importance of keeping enrollees in the larger individual market risk pool. Interviewees also expressed concern about the viability of applying for a section 1332 waiver.

Under the approach we recommend, the State would procure a plan from a private carrier (likely one of the carriers already offering certified QHP plans in the state) that could be offered on the Washington Health Benefit Exchange along with commercial plans. This would allow the State to leverage its purchasing power to offer consumers a more affordable coverage option, increase competition among carriers, and put downward pressure on premiums.

Under the ACA, APTCs can only be applied to plans that meet QHP standards and are therefore eligible to be sold on an exchange. In Washington, the Health Benefit Exchange and the Office of the Insurance Commissioner (OIC) certify plans as QHPs, ensuring they offer the required essential health benefits (EHBs) and meet ACA-established limits on cost-sharing. In order to allow consumers to apply premium tax credits to a plan that does not meet these standards, the State would need to pursue federal approval in the form of a section 1332 waiver. Applying for a waiver would place a heavy administrative burden on the State, and would be subject to a lot of uncertainty. This is of particular concern following recent guidance from the Trump Administration on section 1332 waivers.

In October 2018, the Centers for Medicare and Medicaid Services (CMS) released new guidelines for 1332 waivers that could allow states to apply APTCs to non-ACA compliant plans, including short-term plans with less comprehensive coverage, and states a preference for increasing private market coverage over public programs. It is unclear whether a publicly procured plan in Washington would meet the Administration’s new standards, but it is possible that CMS officials would see it as an expansion of government involvement in health care provision and deny the State’s request for that reason. Relying on cooperation with the Administration may be politically unpopular in Washington, as well.

**Pros & Cons**

As we indicated in our matrix, **we rate a public option as having high political feasibility and moderate financial and implementation capacity feasibility.** Based on our conversations with stakeholders, there seems to be support for pursuing a public option in the Washington legislature. A state-procured public option could be a politically-practical option that channels popular sentiment for bold steps in health care reform without completely disrupting the broader health care system.

If the publicly procured plan meets QHP standards, **subsidy-eligible consumers could apply their APTCs to the publicly-procured plan,** potentially allowing the state to avoid applying for a federal 1332 waiver, a major benefit of this approach for Washington. Because no state has successfully implemented a public option, however, this may need further legal analysis.

Though the uncharted territory of a public option presents potential difficulties, **it also presents the opportunity for Washington to build upon its reputation as a progressive leader in health care policy.** Washington can capitalize on political momentum around “Medicare for All,” for
example, and serve as an example for other states with low uninsured rates and high premiums wishing to expand access and affordability.

Another benefit of this approach is that enrollees of the state-procured plan would be in the same risk pool as other enrollees in the individual market. This could stabilize the individual market overall by adding more risk pool participants, and everyone in the market could potentially benefit if this results in lower premiums. This option could also improve consumers’ choices in areas with few plans being offered on the Exchange. This is an important consideration because, for 2019, fourteen counties in Washington have only one insurer offering coverage in the Exchange.

A drawback of this approach is its ability to have a dramatic impact on premium costs without significant State funding. With a public option plan that does not include additional State subsidies directed to premiums and cost-sharing, subsidized consumers may see little benefit, or even see the size of their tax credit decrease if the cost of the benchmark silver plan decreases (of course, if the benchmark plan drops, premiums would overall be dropping.) However, depending on its price level, this could make coverage more available to individuals ineligible for APTCs due to immigration status.

Consumers might see only marginal changes in the price of coverage if a public option is pursued with limited state dollars, in which enrollees cover the majority of costs through premiums and the State funds start-up and administrative costs. In the example of the proposed Minnesota Care buy-in program, explained in detail in the following section, the full costs of premiums was estimated at $469 – still a high price, especially for those just above tax credit eligibility, and for young people in particular. It is difficult to project costs without an actuarial analysis, but a report from Wakely cited the state average claim costs at $444 per member per month (PMPM), and estimated that if a state-procured plan were able to obtain a contractual agreement with a carrier to reimburse providers 20% less than current commercial rates, average claim costs could decrease to $415 PMPM.

Provider reimbursement rates are an important consideration for any public option proposal. Rates present both a challenge and an opportunity for Washington. In order to have a significant impact on premium costs – and therefore have the most potential to attract cost-sensitive young people into the market – a public option would need to set rates below the average commercial plan rates. Stakeholders told us the high premium prices in Washington reflected the high underlying costs of care, and that prices will not meaningfully decrease until and unless high costs are addressed. Setting reimbursements lower than commercial rates could create significant opposition from providers, but it could also give carriers more incentive to compete for the state plan, giving them more certainty about their ability to cover costs.

Case Studies

**New Mexico:** One of the most recent feasibility studies of a Medicaid buy-in or public option program is from New Mexico, where the Legislature authorized a committee to explore the
implications of such a policy in its 2018 session. A report outlining several ways in which New Mexico could pursue this policy, released in December 2018, examined the kind of QHP public option we recommend for Washington. The report confirms our reasoning that an on-Marketplace public option would benefit those not receiving APTCs and could lead to increased competition among plans. It presents the option of applying for a 1332 waiver to re-capture the potential federal savings resulting from lower premiums on the Marketplace but cautions that approval is uncertain.35

Minnesota: Of the states with proposals for a public program buy-in, Minnesota’s is one of the most well-developed and the most relevant to Washington. Like Washington, Minnesota expanded Medicaid early and has a low uninsured rate, but faces rising premiums, high deductibles and areas of the state with few carriers.36 In 2017, Minnesota lawmakers proposed a plan for allowing individual market consumers to buy in to its MinnesotaCare Basic Health Plan (BHP). The existing BHP is available to those with incomes at or below 200% FPL. The proposal would allow Minnesotans with incomes above that level to buy in to a MinnesotaCare plan. MinnesotaCare would offer two plans on Minnesota’s Health Insurance Marketplace, MNsure—a silver plan and a gold plan, covering 70% and 80% of costs, respectively. Enrollees would cover the full cost of the program through premiums, with the state covering only a $12 million start-up cost. In its proposal, Minnesota estimates the unsubsidized full cost of MinnesotaCare premiums at $469 per month, 13% lower than the average $538 per month premium price of commercial plans on Minnesota’s Exchange. In rural areas with fewer choices and higher premiums, this could mean potentially significant savings, particularly for unsubsidized consumers.37 The proposed MinnesotaCare buy-in would keep costs down in part by reimbursing providers at lower rates than commercial plans. Setting reimbursement at Medicare rates was part of Minnesota’s proposal for its BHP buy-in program. Minnesota expects it would need a 1332 waiver approval in order for tax credit-eligible consumers to apply their APTCs to the cost of their premiums.38

Minnesota Governor Mark Dayton supported the plan along with members of his Democratic-Farmer-Labor (DFL) party, but the state’s Republican-controlled Legislature did not consider the bill. Governor-elect Tim Walz expressed support for the plan during his 2018 campaign, and new DFL members of the Legislature could mean the proposal will be reintroduced in 2019.39

Next Steps

In order to pursue this recommendation, Washington would need to determine implementation responsibilities across various state agencies. First and foremost, the Legislature would need to pass legislation authorizing the State to procure a plan and setting the parameters under which it may do so, including provider reimbursement rates. The Washington Health Care Authority (HCA), which administers both the Apple Health Medicaid program and public employee benefits programs, may be best positioned to lead the procurement process given its experience contracting with MCOs in the Medicaid context. The Exchange and OIC would be instrumental in certifying the plan as a QHP in compliance with all ACA requirements – or pursuing a section 1332 waiver if this is not the case.
As mentioned above, Washington APTC-eligible consumers could potentially apply their subsidies to a plan deemed a QHP in compliance with ACA requirements without the State applying for a section 1332 waiver. However, the State may want to investigate the legal parameters of this question further. Additionally, even if a state-procured plan that meets QHP standards does not need federal approval to have APTCs paid toward its premiums, Washington could still want to consider pursuing a section 1332 waiver for a different purpose, such as the aforementioned wrap.

Assuming a public option puts downward pressure on premiums, therefore lowering the cost of the benchmark plan and APTCs, Washington could, theoretically, pursue a waiver that seeks to apply to difference in federal tax credit dollars (‘pass-through’) to another purpose. Premium subsidies for the 400%+ population to complement the subsidies for tax credit eligible consumers we propose in the previous section.

**Percent of Uninsured 25- to 34-year-olds by FPL**

- **Less than 138% of FPL**
- **139-199% of FPL**
- **200-299% of FPL**
- **300% of FPL or more**
Proposal: Require carriers to offer standardized benefit offerings.

Consumers make trade-offs between health insurance plans with limited information about each plan’s expected costs, benefits, and overall quality. By requiring certain essential health benefits to be covered in all qualified health plans, the ACA ensured that customers could expect access to comprehensive coverage that covers the services they need. However, the financial cost-sharing characteristics of health insurance plans can make it difficult for consumers to decide which plan offers the best value proposition. Estimating the value of a plan may be particularly challenging for young consumers, who may have limited health insurance literacy or experience with concepts like “deductibles” and “co-pays.”

In 2017, the Washington Health Benefit Exchange unveiled the Smart Planfinder to help consumers compare their health plan options based upon their personal coverage needs, including prescriptions, doctors, and health care facilities. This tool is a useful step toward simplifying the expected costs and benefits of plans. **Washington can further support the customer’s understanding of health insurance’s value proposition by requiring carriers on the marketplace to offer standardized plans for all metal tiers.**

Standardized plans are plan designs that all insurers would be required to sell on the marketplace, with fixed deductibles and co-pays for a specified set of medical services. Standardized plans could be designed to have defined or identical cost-sharing for covered health services, making it easier for customers to understand what they will have to pay upfront for a doctor’s visit, medication, or other types of health care. A state can require some medical services to be exempt from the deductible, such as urgent care, mental health services, and diagnostic tests. For the consumer, this means that they know the expected costs upfront even if they haven’t reached their deductible yet.

**We recommend requiring carriers to only offer standardized plans on the Exchange at the bronze, silver, and gold metal tiers.** Allowing non-standard plans on the marketplace may undermine consumers’ ability to compare plans “apples-to-apples.” According to a report by the Urban Institute, several states were not meeting the stated policy goals of standardized benefit designs because they allowed non-standardized options on the marketplace and failed to implement web-based decision support tools to help consumers clearly differentiate between plan options. Customers will likely find it confusing to compare non-standard and standard plans, so we therefore recommend only allowing standardized plans to streamline the choices available.

**Pros & Cons**

The primary benefit of creating standardized plans is to help consumers understand the value proposition each health insurance plan offers. The current marketplace structure requires customers to have a moderately advanced understanding of deductibles, premiums, and the expected costs of injury or illness. By requiring all insurance providers to offer a consistent, standard plan at each metal tier, customers have a more transparent way to compare on costs.
Currently, the customers find it difficult to compare their options based on the quality of the care, and may resort to choosing plans with the lowest premiums, without taking into account the costs of a high deductible. Many of the stakeholders we spoke with in Washington emphasized the importance of making health insurance easier to understand for all consumers. Researchers have found that standardized plans affect consumer choice. For example, consumers in Massachusetts chose more generous plans and different brands once standardization was adopted. Research suggests that prior to standardization, individuals chose either the cheapest or most generous coverage in the absence of fully understanding their choices. Post-standardization, consumers first chose a financial package that met their needs and then chose among carriers.43

Standardized plans could give the Exchange authority over benefit design to improve the value of coverage available to consumers. Designing plans to include certain services pre-deductible can help consumers experience the value of coverage when they fill their prescriptions or visit their doctors for a low co-pay.

Requiring carriers to standardize plans encourages competition among benefits and premium price points. For example, after California introduced standardized plans, they found that carriers competed on services such as an expanded network of doctors; in-language services or in-home doctor services; and remote access to doctors through telehealth apps. While the lack of flexibility may be seen as a challenge, the Exchange can likely mitigate concerns by working with insurers during the standardized benefit design stage.

Standardized plans will likely have a fairly modest impact on costs to consumers. A 2018 Wakely analysis suggests that QHPs can be structured with lower deductibles, more services before the deductible, and co-pays (replacing coinsurance) without significantly impacting premiums.44 There is some uncertainty about whether standardization would impact premiums because the plans must still fall within the actuarial value limits imposed by the ACA. Of the three recommendations we are proposing, standardized plans are least likely to significantly impact premiums and most likely to increase consumers’ understanding of the value of coverage.

While one major insurer expressed support for standardized plans, another carrier thought that standardization would have little effect on reducing costs for customers, suggesting that customers would want insurance plans that cover their doctor, and that standardization would do nothing to reduce the costs of a broad network. There were other concerns about whether standardizing benefits could actually backfire by raising costs. Engaging with insurers throughout the standardized plan design process will be critical to ensure that standardized plans do not have significant adverse impact on costs.

Implementing standardized plans will require careful planning to avoid challenges. One of the main challenges will be creating benefit designs that meet the actuarial values (AV) limits under the ACA. If the priority is to keep the deductible low, this may mean that some co-pays will need to be higher to keep the plan in line with the AV limits. According to the Urban Institute, providing coverage prior to the deductible can be challenging since enrollees must cover 40% of the cost of covered services.
Examples of relevant questions that Exchange staff would need to consider in this phase include:

- Would it be best to include standardized plans for all metal tiers, or to limit them to specific plans (e.g., bronze and silver)?
- Which services should be subject to the deductible, and at which metal tiers?
- How best to ensure that standardized plans do not adversely affect costs?

Answering these questions and designing patient-centered benefit designs will require state engagement and coordination with insurers, clinicians, hospitals, and consumer advocates.

**Case Study**

Eight state-based marketplaces (California, Connecticut, Washington D.C., Massachusetts, Maryland, New York, Oregon and Vermont) require all carriers on the Exchange to offer a standard plan on the bronze, silver, and gold metal levels. In all of these states except New York, standardized benefit plans include pre-deductible doctor’s visits for non-preventive primary care, specialty care, mental health and substance use disorder treatment and urgent care. Every state prioritized lowering cost-sharing for consumers to reduce barriers to health care services.

**California.** Of the states with standardized benefit plans, California is the only state that does not allow non-standard plans to be offered alongside standard plans in their Exchange. By only allowing standard plans on the marketplace, California has kept their website simple for customers to navigate without having to flag standardized plans as unique from other options.

California’s standardized plan includes separate deductibles for medical care and prescription drugs. The plans minimize the use of co-insurance, limits out-of-pocket costs for high-prescription drugs, and offers low copays for primary care visits and generic drugs. Prior to open enrollment, Covered California released their 2019 Patient-Centered Benefit Designs by Metal Tier for both medical cost shares and prescription drugs, which can be found at the end of this section. Benefits shown in blue are not subject to any deductible. By presenting this information in an easy-to-read table, Covered California has made it easier for consumers to understand the deductible and co-payments for each metal tier. Carriers can continue to compete on premium price, plan type, and other plan features such as a health savings account.

According to analysis from the Urban Institute, some California officials stated that the primary reason they decided to require standardized benefit designs was to create better value for their customers. However, the actuarial value targets prescribed by the ACA mean that lowering cost-sharing for certain services means increasing the costs of another set of goods or services. Washington will need to choose among these and consider how these choices will impact specific patient populations. An evaluation challenge that California and other states face is timely data collection to assess the impact of pre-deductible coverage. Most officials did not have the data to determine whether access to these services has improved.
## Required Predeductible Services with State-Prescribed Copayments

**2017 Individual Silver Standard Plans**

<table>
<thead>
<tr>
<th>State</th>
<th>Deductible</th>
<th>Primary Care</th>
<th>Specialist</th>
<th>Mental Health / Substance Abuse</th>
<th>Urgent Care</th>
<th>Generic Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>$2,500</td>
<td>$35</td>
<td>$75</td>
<td>$35</td>
<td>$35</td>
<td>$15</td>
</tr>
<tr>
<td>Connecticut</td>
<td>$4,000</td>
<td>$35</td>
<td>$50</td>
<td>$35</td>
<td>$50</td>
<td>$5</td>
</tr>
<tr>
<td>D.C.</td>
<td>$2,000</td>
<td>$25</td>
<td>$50</td>
<td>$25</td>
<td>$90</td>
<td>$15</td>
</tr>
<tr>
<td>Massachusetts&lt;sup&gt;a&lt;/sup&gt;</td>
<td>$2,000</td>
<td>$30</td>
<td>$50</td>
<td>$30</td>
<td>$50</td>
<td>$20</td>
</tr>
<tr>
<td>New York&lt;sup&gt;b&lt;/sup&gt;</td>
<td>$2,000</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Oregon</td>
<td>$2,500</td>
<td>$35</td>
<td>$70</td>
<td>$35</td>
<td>$70</td>
<td>$15</td>
</tr>
<tr>
<td>Vermont</td>
<td>$2,150</td>
<td>$25</td>
<td>$65</td>
<td>$25</td>
<td>$60</td>
<td>$15</td>
</tr>
</tbody>
</table>


<sup>a</sup> This information refers to the Massachusetts Health Connector for individuals with income above 300% of FPL. The deductible is a combined medical and prescription drug deductible.

<sup>b</sup> Although New York gives insurers the option to provide a standardized benefit design that includes three non-preventive primary care visits pre-deductible, it is not required on the silver level. The only required pre-deductible services are for prescription drugs.

## Next Steps

Standardized plans can help Washington achieve its goal of helping consumers understand the value of health insurance plans. This step would first require legislation authorizing the Exchange to create standardized plans. In the interviews we conducted across the state, stakeholders are already familiar with the policy idea, and a bill seems like it could pass, though the requirement that gold, silver, and bronze plans all be standardized would likely require political capital to be exerted.

The next phase would be for the Exchange to coordinate with stakeholders to design standardized plans. The Exchange should engage with insurers, providers, hospital representatives and consumer representatives when deciding appropriate co-pays for benefits and which benefits are subject to a deductible. The Washington Healthplanfinder site should continue to use the Smart Planfinder as a decision support tool for customers to decide which plan offers the benefits they need.
### 2019 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in **blue** are NOT subject to a deductible. Benefits in **blue** with a white corner are subject to a deductible after the first three visits.

<table>
<thead>
<tr>
<th>Coverage Category</th>
<th>Minimum Coverage</th>
<th>Bronze</th>
<th>Silver</th>
<th>Enhanced Silver 73</th>
<th>Enhanced Silver 87</th>
<th>Enhanced Silver 94</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percent of cost coverage</strong></td>
<td>Cover 6% until out-of-pocket maximum is met</td>
<td>Cover 6% of average annual cost</td>
<td>Cover 7% of average annual cost</td>
<td>Cover 8% of average annual cost</td>
<td>Cover 9% of average annual cost</td>
<td>Cover 8% of average annual cost</td>
<td>Cover 9% of average annual cost</td>
<td>Cover 9% of average annual cost</td>
</tr>
<tr>
<td><strong>Cost-sharing Reduction Single Income Range</strong></td>
<td>N/A</td>
<td>$40 to $30,350 (≥200% to ≤250% FPL)</td>
<td>$18,211 to $24,280 (≥150% to ≤200% FPL)</td>
<td>up to $18,210 (100% to ≤150% FPL)</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Wellness Exam</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>$75**</td>
<td>$40</td>
<td>$35</td>
<td>$15</td>
<td>$5</td>
<td>$30</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75**</td>
<td>$40</td>
<td>$35</td>
<td>$15</td>
<td>$5</td>
<td>$30</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>$105*</td>
<td>$80</td>
<td>$75</td>
<td>$25</td>
<td>$8</td>
<td>$55</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Facility</td>
<td>Full cost per service until out-of-pocket maximum is met</td>
<td>$350</td>
<td>$350</td>
<td>$100</td>
<td>$50</td>
<td>$325</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$40</td>
<td>$35</td>
<td>$35</td>
<td>$15</td>
<td>$8</td>
<td>$35</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>X-Rays and Diagnostics</td>
<td>Full cost until deductible is met</td>
<td>$75</td>
<td>$75</td>
<td>$30</td>
<td>$8</td>
<td>$55</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td>$300</td>
<td>$300</td>
<td>$100</td>
<td>$50</td>
<td>$275 copay or 20% coinsurance***</td>
<td>$75 copay or 10% coinsurance***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Generic Drugs)</td>
<td>Full cost per script until out-of-pocket maximum is met</td>
<td>$15**</td>
<td>$15**</td>
<td>$15 or less</td>
<td>$3 or less</td>
<td>$15 or less</td>
<td>$5 or less</td>
<td></td>
</tr>
<tr>
<td>Tier 2 (Preferred Drugs)</td>
<td>Full cost per script until out-of-pocket maximum is met</td>
<td>$55**</td>
<td>$50**</td>
<td>$20**</td>
<td>$10 or less</td>
<td>$55 or less</td>
<td>$15 or less</td>
<td></td>
</tr>
<tr>
<td>Tier 3 (Non-preferred Drugs)</td>
<td>Full cost per script until out-of-pocket maximum is met</td>
<td>$80**</td>
<td>$75**</td>
<td>$35**</td>
<td>$15 or less</td>
<td>$25 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4 (Specialty Drugs)</td>
<td>Full cost per script until out-of-pocket maximum is met</td>
<td>20% up to $250 per prescription</td>
<td>20% up to $250 per prescription</td>
<td>15% up to $150 per prescription</td>
<td>10% up to $150 per prescription</td>
<td>20% up to $250 per prescription</td>
<td>10% up to $250 per prescription</td>
<td></td>
</tr>
<tr>
<td>Medical Deductible</td>
<td>N/A</td>
<td>Individual: $6,300</td>
<td>Family: $12,600</td>
<td>Individual: $2,500</td>
<td>Family: $5,000</td>
<td>Individual: $2,200</td>
<td>Family: $4,400</td>
<td>Individual: $650</td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>N/A</td>
<td>Individual: $500</td>
<td>Family: $1,000</td>
<td>Individual: $200</td>
<td>Family: $400</td>
<td>Individual: $175</td>
<td>Family: $350</td>
<td>Individual: $50</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$7,900 individual only</td>
<td>$7,550 individual $15,100 family</td>
<td>$7,550 individual $15,100 family</td>
<td>$6,300 individual $12,600 family</td>
<td>$2,600 individual $5,300 family</td>
<td>$1,000 individual $2,000 family</td>
<td>$7,200 individual $14,400 family</td>
<td>$3,350 individual $6,700 family</td>
</tr>
</tbody>
</table>

Drug prices are for a 30-day supply:
* *Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.
** Price is after pharmacy deductible amount is met.
*** See plan Evidence of Coverage for imaging cost share.
The purpose of this section is to provide a communications strategy for the three policy recommendations proposed in this report. The communications strategy for each policy proposal will follow a common framework comprised of five components informed by *A Field Guide to Designing Health Communications Strategy: A Resource for Health Communication Professionals.*

**Promise:** The first section will focus on the promise or primary benefit ascribed to each policy. This will serve as an anchor for the remaining components of the communications strategy.

**Support:** The second section will highlight the research or compelling anecdotal stories supporting the promises. This will make the message credible to the audience.

**Competition:** Messages are not delivered in a vacuum. The policy proposals will face competing arguments, which will limit the audience’s ability to connect with the proposal and the associated benefits. This section’s goal is to identify those opposing arguments, and signal to the audience why your product or policy proposal is still the best option.

**Long-term impression:** When the message is delivered, what are people taking home with them? In other words, when people are sitting at the dinner table making pocket book decisions, how do they think the proposal is going to impact them?

**Key messaging points:** This section packages the last four sections into talking points. The taking points will be used by the organization tasked with implementing the proposals.

### Examples of Policy Communication Framework

<table>
<thead>
<tr>
<th></th>
<th><strong>Premium Subsidies</strong></th>
<th><strong>Public Option</strong></th>
<th><strong>Standardized Plans</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Promise</strong></td>
<td>Make premiums cheaper for low-income households</td>
<td>Lower premiums and avoid bare counties by increased competition</td>
<td>Standardized plans will offer more value and be more understandable</td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td>Premium assistance in Vermont has reduced out-of-pocket costs</td>
<td>This plan is based on a legacy of previous successful innovation</td>
<td>California has successfully implemented standardized plans</td>
</tr>
<tr>
<td><strong>Competition</strong></td>
<td>“The government can’t afford to pay even more for low-income families”</td>
<td>“This is a big government attempt to put private insurers out of business”</td>
<td>“This will limit consumer choice and make health insurance more expensive”</td>
</tr>
<tr>
<td><strong>Long-term impression</strong></td>
<td>Part of an ongoing commitment to ensuring insurance access for all</td>
<td>Public option is a guarantee of access to health insurance</td>
<td>Health insurance is complex; standardized plans reduce confusion</td>
</tr>
<tr>
<td><strong>Key messaging points</strong></td>
<td>Subsidies make health care more affordable for working families</td>
<td>The public option is about creating better choices for consumers</td>
<td>Standardized plans make it easier for individuals to comparison shop</td>
</tr>
</tbody>
</table>
Website Navigation

Since the website is the end point where communications and engagement strategies will ultimately guide consumers, it is critical that the site be as helpful as possible and keeps consumers engaged so that they follow through in their choice to purchase insurance. The Exchange has made significant strides toward ensuring that the Healthplanfinder website meets consumer needs and balances comprehensiveness with ease of use. Client focus group findings show that people trust the website and view the plan summaries, layouts, and side-by-side comparisons favorably. The following suggestions include strategies for further improving the site navigation and content to engage and assist consumers.50

Easy-to-follow navigation is key for improving the overall user experience and reducing bounce rates. While consumers indicated that website navigation is generally good, there are opportunities to engage on the following areas:

Reassessing Income Information Requirements

Since income is essential for determining financial assistance, there should be additional guidance to ensure consumers are properly informed and prepared to answer questions related to income. Interviews with stakeholders revealed that consumers occasionally do not list their income on the site and are thus unaware that they qualify for a tax credit. One possible reason for this refusal is the coupling of the Medicaid application and the concerns around public charge. While being sensitive to this population, a potential approach would be to require users to list an income before proceeding, with the option to list their weekly income, as not all users know their monthly or annual income. For those consumers who may not be able to accurately determine their income, an income range option should be available in order to not deter those who may otherwise be apprehensive about entering an exact dollar amount. A pop-up could also be used to show that a childless individual making less than roughly $48,000 (400% of the Federal Poverty Level) could receive a tax credit. This feature would help those consumers who may otherwise believe their income to be too high to receive financial assistance.

Strengthening Use of Smart Planfinder

One concern is that consumers may see the process of enrolling as too complicated with too many options and thus they drop off. The Smart Planfinder is a valuable tool to help consumers choose the right plan and feel supported in their choice. In order to maximize the benefit of this tool, it should be made clearer which options are considered a “Smart Choice.” Currently there is only a small, blue, round button that says “Smart Choice” that may not be readily visible to users. One option to improve upon this would be to only show the top three “Smart Choice” plans and require that a user click a button at the bottom that says “See More” in order to see additional options. By only showing the top three plans, Healthplanfinder would tighten a user’s choice architecture and make the website easier for the user to manage.

Furthermore, the Smart Planfinder pop-up appears immediately after inputting one’s information to ask “Do you need help shopping for a plan?” This pop-up may be better-suited if it appeared after
users have had a chance to browse and decide whether or not they need assistance. If this pop-up appeared after 30 seconds or 1 minute of browsing, users may see it as more helpful tool than the way it is currently set up.

Finally, to provide more transparency, it could be helpful to include a cost comparison among the varying levels of expected annual doctor visits and the average number of prescriptions. Users may simply choose the lowest number of each because of cost concerns and it would be helpful for users to know how much these options vary depending on the option chosen without being required to recalculate using Smart Planfinder each time.

**Additional Website Improvements**

*Estimates of Out-of-Pocket Costs With No Insurance*

Providing examples of ways in which health insurance may assist with various scenarios such as having a baby or a simple fracture gives consumers concrete illustrations of an otherwise seemingly intangible investment. One way to improve upon this would be to capitalize on the idea of "loss aversion," and consumers what these scenarios may cost without any insurance. It could be discouraging to see how much one needs to pay out-of-pocket because of a high deductible, and a row that shows how much more it could be without any insurance could ease this. An additional row within “Plan Summary” could show the average cost *without* insurance of an injury or event such as having a baby, which would allow consumers to see the additional money they may otherwise spend as compared to the provider-negotiated total with insurance. This would give consumers a better idea of the value of insurance in a straightforward and tangible way that would appeal to someone fitting a “Young Invincibles” persona, possibly persuading them to purchase insurance.

*Broadening a Digital Engagement Strategy*

The US is a mature mobile market and users at all age groups are increasingly adopting mobile technology. The Exchange could ensure that consumers receive more of a wraparound service by requiring that a QHP provide a comprehensive digital strategy and app to keep consumers informed of their healthcare needs. This could include setting certain requirements, such as:

- **Medical records**: access to one’s allergies, immunizations, ongoing health conditions, and test results
- **Pharmacy**: a list of current prescriptions and ability to fill as needed. A pharmacy locator using a street address or Zip code
- **Appointments**: view current appointments, past appointments, and create new appointments
- **Bill pay**: view/pay bills and view bill history
- **Messages**: message your doctor and receive test results
Providing a more personalized healthcare experience, being more user-friendly, and informing consumers of health plan utilization information is the next step in marketing and communications. While the Exchange may not be able to provide all of these services itself, encouraging providers to offer a wraparound approach to health care could increase the value of health insurance, better engage current consumers, and potentially increase enrollment in the health insurance system.

**Envisioning the Future of the Marketplace**

With the state at nearly 95% insured, the Exchange may see its goal as no longer simply enrolling additional Washingtonians but to also keep the enrolled engaged with more wraparound services. This could include assistance with insurance utilization information and more end-to-end services such as calendaring appointments and more detail on what a consumer is paying for. These recommendations would help the Exchange meet consumers where they are and provide a more comprehensive approach to consumer engagement and utilization.
Throughout this report, we have highlighted some of the key challenges facing the Washington State Health Benefits Exchange in attracting young people to purchase health insurance, as well as some potential policy solutions. First and foremost among the barriers to insurance for young people is the high cost of insurance premiums among both subsidized and unsubsidized populations. To address this key challenge, we recommend a public option to drive down the cost of insurance among the unsubsidized population, as well as a premium wrap to support insurance for the more price-sensitive subsidized population.

A second key barrier mentioned is the lack of understanding among young people of the value proposition. To help clarify the relative benefits of insurance plans, we propose that Washington adopt standardized plans, requiring all insurance carriers to offer a similar slate of benefits at each metal tier. This policy would introduce an apples-to-apples comparison to help consumers, as well as clarify what benefits insurance would provide.

Third, the younger population is typically more skeptical of their need for health insurance, a tendency that has earned them the persona of “Young Invincibles.” Addressing this concern, this report includes a section on potential communications frameworks to support these new policy initiatives, as well as small website user interface changes that could support the market. Thinking creatively about marketing and communication tactics has been a strength of Washington’s efforts in the past, and we hope this report contributes additional support for the investments that have been made in this area.

Moving forward, adoption of the solutions will ultimately depend on feasibility both politically and in terms of implementation. While we would most strongly support these three approaches as complementary, we also recognize the inherent challenges and would prioritize on the basis of keeping insurance costs low for consumers, to encourage maximum participation in the market. Thus, we would suggest prioritizing the premium subsidies proposal as a way of shoring up the success of the Exchange among the subsidized population in the absence of the individual mandate penalty, while pursuing the public option as a longer-term goal, if need be.

Since the ACA passed, the state of Washington has had a strong culture of leadership in health care that has helped set the bar for other states in terms of enrollment and communications. The suggestions included in this report are intended to build on this success and address the concern of rising premiums before they adversely impact the overall track record of success.
### Summary Feasibility Matrix

<table>
<thead>
<tr>
<th></th>
<th><strong>Impact</strong></th>
<th><strong>Costs</strong></th>
<th><strong>Coverage</strong></th>
<th><strong>Equity</strong></th>
<th><strong>Financial</strong></th>
<th><strong>Political</strong></th>
<th><strong>Capacity</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Standardized Plans</strong></td>
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<td></td>
<td>Unlikely to</td>
<td>Depends on</td>
<td>Depends on</td>
<td>Little to no</td>
<td>Positive response</td>
<td>Strong political</td>
<td>Initial capacity</td>
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<td></td>
<td>change premiums</td>
<td>how it is structured;</td>
<td>design, has</td>
<td>direct impact</td>
<td>so far in states</td>
<td>momentum</td>
<td>requirement to</td>
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<td></td>
<td>significantly</td>
<td>could compel</td>
<td>potential to</td>
<td>on State’s</td>
<td>with standardized</td>
<td>with regard to</td>
<td>pass authorizing</td>
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<td></td>
<td>(possibly 1-6%</td>
<td>some carriers to</td>
<td>improve</td>
<td>budget.</td>
<td>plans (support</td>
<td>cost; long-</td>
<td>legislation and set</td>
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<td></td>
<td>lower.)</td>
<td>withdraw from</td>
<td>consumer choice</td>
<td></td>
<td>for easier consumer</td>
<td>term constraints</td>
<td>term standards;</td>
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<tr>
<td><strong>Public Option</strong></td>
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<td></td>
<td>Would likely lead to</td>
<td>Would expand</td>
<td>Would likely help with affordability, depending on state investment into subsides.</td>
<td>Depends on dollars directed towards subsidized; could have limited impact without sufficient investment.</td>
<td></td>
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<tr>
<td></td>
<td>lower premiums, depending on</td>
<td>choices for consumers in one-carrier counties</td>
<td>financially</td>
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<td></td>
<td>state purchasing power and risk pool.</td>
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<tr>
<td><strong>Medicaid Buy-In</strong></td>
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<tr>
<td></td>
<td>Potential to lower premiums. Estimated cost of roughly $400 per member per month.</td>
<td>Could broaden access for some currently uninsured (could also bifurcate the market by taking consumers out of the market.)</td>
<td>Some low-income uninsured individuals may still be unable to afford plan without subsidies.</td>
<td>Could require high amount of subsidy if premiums are not enough to cover the cost of use.</td>
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<tr>
<td><strong>Basic Health Plan</strong></td>
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</tr>
<tr>
<td></td>
<td>Would very likely produce lower-cost health coverage for low-income (up to 200% FPL) consumers.</td>
<td>Likely to increase number of people covered but could also bifurcate the market by taking consumers out of the market.</td>
<td>Likely to increase insurance among under 200% FPL, and to reduce marketplace-Medicaid “churn”. Could cover immigrants.</td>
<td>Administrative costs not eligible for federal funding (but could use federal funding for plan purchase).</td>
<td></td>
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</tr>
<tr>
<td><strong>Premium Subsidy</strong></td>
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</tr>
<tr>
<td></td>
<td>Would lower premiums and could have spillover affect for those not receiving wrap.</td>
<td>Could be most effective in combating movement away from Exchange after repeal of mandate penalty.</td>
<td>Depends on population targeted by the wrap (we suggest 139-399% of FPL).</td>
<td>Requires heavy financial investment and doesn’t reduce underlying cost of care.</td>
<td></td>
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</tr>
<tr>
<td><strong>Individual Mandate</strong></td>
<td>Impact of mandate on premiums is empirically unclear, but theoretically should lead to lower premiums.</td>
<td>Would likely increase coverage due to requirement to purchase insurance or otherwise pay penalty.</td>
<td>Would apply to most Washingtonians (some exemptions due to income, religion, etc.); some concerns about equity.</td>
<td>No direct cost to the state.</td>
<td>Political appeal of the individual mandate was the weakest part of the ACA.</td>
<td></td>
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<tr>
<td><strong>Reinsurance</strong></td>
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<tr>
<td></td>
<td>Would likely lead to somewhat lower premiums by reducing carrier risk.</td>
<td>Lower risk of high-cost outcomes could induce more carriers to compete, driving down premiums and leading to more take-up.</td>
<td>Impact would be most strongly felt among the unsubsidized (400%+) population.</td>
<td>High rate of unsubsidized and low federal pass-through could leave large state investment with relatively modest impact.</td>
<td>No political solution to dispute over funding mechanism.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Options that received at least one red box in the “feasibility” criteria were automatically stricken from consideration as infeasible.
Options Not Recommended

Reinsurance

Reinsurance helps protect carriers from unexpectedly high losses by guaranteeing reimbursement for high medical costs, thereby stabilizing the individual market. Carriers purchase a policy to cover claims that exceed a certain amount, called an "attachment point", after which reinsurance typically covers a percentage of the claim up to a cap. Reinsurance has reduced premiums by guaranteeing carriers don’t face large losses and incentivizes carriers to participate in additional markets, thereby increasing competition and driving down premiums.50

Reinsurance was initially implemented under the ACA in 2014 as a temporary measure, called the transitional reinsurance program (TRP). While the federal program no longer exists, it now serves as a model for state-based reinsurance programs created through 1332 reinsurance waivers.

Two major problems exist in Washington that prevent reinsurance from serving as a viable option. Firstly, Washington’s market is unique in that there is a large share of the unsubsidized population. This means that the federal pass-through funding with a 1332 waiver would generally be smaller than a state with a lower unsubsidized population, and therefore Washington would need to front a larger share of funding for the program, on the order of $120-150 million per year (the pass-through would have only paid about 25% of the cost.)

Coupled with this high cost, Washington state does not have a state income tax. As a result, it does not have an easily-tapped source of general fund dollars that could be used for the reinsurance program. Carriers were opposed to the idea of the plan being funded by an assessment on premiums. Washington's Office of the Insurance Commissioner proposed a financing mechanism using a claims-based approach that was similar to the way that the federal program was financed, which led to a political battle in which national labor unions opposed the proposal on the grounds of opposing the costs being borne by third-party administrators. Based on our interviews, there appears to be no political appetite to revisit that fight.

Individual Mandate

A healthy insurance pool, where risk is effectively diluted, will attract more insurance companies and keep premiums stable and affordable. For these reasons, the individual mandate was thought to be an indispensable component of the ACA. However, the Tax Cuts and Jobs Act of 2017 removed the teeth from the individual mandate and as a result, there is no mechanism to punish individuals who forgo health insurance at the federal level. However, some states have acted to re-impose a mandate on their health insurance markets.51

New Jersey: In 2018, New Jersey became the second state to impose an individual mandate.52 The law dictates that all eligible New Jersey residents must have minimum coverage during each month of the year or face a penalty equivalent to the premium for a bronze plan in the state’s insurance market. Revenues from the penalty will be used to fund the state’s reinsurance program.
**Washington, D.C.:** Following tax reform, Washington D.C. convened a working group consisting of insurers, small businesses, consumer advocates, and healthcare providers. The working group was tasked with identifying policy levers to stabilize the local insurance market, and unanimously recommended an individual mandate, which was signed into law in August 2018. The mandate penalty is equivalent to $695 or 2% of income, whichever is greater. Revenues collected from the penalty are used to conduct outreach and enroll uninsured individuals in health coverage.

**Vermont:** Vermont’s legislature voted to adopt an individual mandate, but the mechanisms for enforcement of the penalty were left to the legislature to determine in 2019.

Other states that explored a state-level individual mandate, but as of this writing have not imposed one, include **Maryland**, which considered a proposal to send the uninsured a form notifying them of the consequences of not having health insurance. Unless the uninsured took action, the state government would use the penalty to enroll them in a health insurance plan. If the uninsured wished to opt-out from this option, they would have to check a box indicating they wanted to avoid health coverage and instead pay the fine to the government. The proposal had two advantages: 1) it framed the mandate as a “down payment” towards health insurance rather than a tax, and 2) it opted people into the health insurance market, while allowing them to choose to opt-out.

In **Connecticut**, lawmakers considered a bill that have introduced a penalty equal to $695 or 2% of income, whichever is greater. Another bill would have drawn on the ACA’s definition of “affordability,” which states that all payments required by a plan not exceed 9.66% of an individual’s annual income, and imposed a similar fee. By imposing a penalty equivalent to the maximum amount that someone would spend on health insurance, a person would theoretically be compelled to purchase insurance rather than incurring a fee with no tangible benefits. Both bills failed to pass out of their respective committees.

Because the state of Washington lacks an income tax, a typical mechanism to enforce the mandate, its prospects of adopting an individual mandate are substantially less likely. Nevertheless, in last year’s legislative session, Sen. Annette Cleveland introduced a bill to create an individual mandate. She also introduced a complementary bill, which instructs the Office of the Insurance Commissioner to identify potential enforcement mechanisms for the mandate or develop other incentives to encourage individuals to get health coverage. However, neither of those bills advanced out of committee. Without a viable enforcement mechanism, the individual mandate does not appear to be a feasible option.

**Basic Health Plan**

The Basic Health Plan Option would build on the prior Washington State Basic Health Plan, which offered cheaper health care to low-income residents up to 200% FPL, who did not qualify for Medicaid. The Affordable Care Act offers a way for states to use the initial Washington model, with flexibility to contract out plans outside of the Exchange, for example, leveraging Medicaid administrative structures for eligibility determination and enrollment policies. Advantages of this approach include reducing costs to consumers, eliminating Premium Tax Credit reconciliation for
those least able to afford uncertainty, and potentially increasing the number of low-income people who are insured.

At this time, it seems unlikely that the state of Washington will move forward with a Basic Health Plan option due to costs and potential effects on the Marketplace. First, administrative costs would not be eligible for federal funding, despite the explicit availability of a basic plan in the ACA. There seems to be little appetite for taking on associated costs. Second, this strategy could undermine the existing Exchange, by, for example, channeling low-income young people to a new structure and shrinking the risk pool.

While there is some evidence in Massachusetts that a small Exchange can be sustainable, interviews revealed that state policymakers are hesitant to experiment with pushing people off of the Exchange. Additionally, while the public option could be a strong alternative to the Basic Health Plan, it should be noted that advocates for migrant populations tend to support a BHP-like option, so there would likely be an interest in determining how best to address immigrant and migrant population needs via the public option.
We are grateful for the people who generously shared their time and expertise to provide invaluable insight into Washington state’s health care system. We are especially thankful for our clients in the Washington State Health Benefit Exchange, especially Molly Voris and Michael Marchand, as well as many others who offered their time and insights during our research process, including those listed below.

Instructors Heather Howard and Daniel Meuse provided indispensable advice and suggestions throughout the process of researching, interviewing, and drafting the report. Finally, we would like to thank the Woodrow Wilson School of Public and International Affairs, particularly the Graduate Program Office, for funding and supporting our work.

**Washington Health Benefit Exchange**

Molly Voris  
Michael Marchand  
Nelly Kinsella  
and the whole Exchange team

**Office of Governor Jay Inslee**

Jason McGill, Senior Health Policy Advisor

**Other Stakeholders and Advocates**

Jorge Baron, Northwest Immigrant Rights Project  
Rep. Eileen Cody, Chair, House Health Care and Wellness Committee  
Meg Jones, Association of Washington Healthcare Plans  
Dr. Aaron Katz, University of Washington  
Toni Lodge, The NATIVE Project  
MaryAnne Lindeblad, Washington State Health Care Authority  
Bob Marsalli, Washington Association for Community Health  
Daphne Pie, Public Health - Seattle & King County  
Aren Sparck, Seattle Indian Health Board  
Janet Varon, Northwest Health Law Advocates  
Staff at Kaiser Permanente and Premera Blue Cross
Endnotes

20. Patient Protection and Affordable Care Act, 42 U.S. Code §18082(e).
47. Covered California. 2018.
Participant Biographies

Patrick Brown grew up in Redmond, Wash., and spent time working in the non-profit sector before studying domestic policy at the Wilson School. He holds a B.A. in political science and economics from the University of Notre Dame, and his writing on anti-poverty policy has appeared at The Washington Post, National Review, America magazine, and other publications.

Erin Cheese is originally from Omaha, Nebraska and graduated from Creighton University in 2015. Prior to coming to Princeton, she worked for two years as a Science and Technology Policy Fellow at the Department of Energy’s Solar Office in Washington, D.C. She is studying domestic policy while at Princeton, with a focus on energy policy.

Michelle Conway is from New Jersey and graduated from Columbia University in 2013. Before returning to her home state for graduate school, she spent four years working in New Orleans, first with Habitat for Humanity and then in the Office of Mayor Mitchell J. Landrieu. At Princeton, Michelle studies domestic policy with a focus on health policy.

Rem Dekker is originally from the San Francisco Bay Area and graduated from the University of California–Berkeley in 2010. Prior to enrolling in the MPA program at the Woodrow Wilson School, Rem spent seven years in education policy at a variety of organizations including a higher education advocacy nonprofit, a research institute, a think-tank, and a California state government agency. He is studying domestic policy while at Princeton, with a focus on technology policy.

Javier Rojo was born and raised in Albuquerque, New Mexico. He completed his undergraduate education at the University of New Mexico where he studied economics, philosophy and statistics. Prior to graduate school, he was a grant writer for the Center of Southwest Culture, a nonprofit that works to revitalize New Mexico’s rural economy by introducing innovative business models.

Karen Scott is from Connecticut and studied economics at Wellesley College. Prior to Princeton, Karen served as an adviser to President Obama’s White House National Economic Council and managed a scholarship program evaluation with the Massachusetts Institute of Technology. As a graduate student, she is studying economic and health policy.

Zack Zappone was born and raised in Spokane. He majored in American Studies at Georgetown University. He taught middle school in Kennewick for three years and was a Fulbright teaching assistant in Colombia. He interned at Seattle Department of Transportation and the New Jersey Office of the Secretary of Higher Education, and plans on returning to Washington to work on social and economic mobility after graduation. He enjoys traveling, hiking, and bowling.