New York Section 1332 Innovation Waiver

Essential Plan Expansion

Draft Request

Draft

Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

November 27, 2024

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Yellen and Secretary Becerra,

The State of New York respectfully requests that the U.S. Department of Treasury and U.S. Department of Health and Human Services grant approval of New York's request to set the term of the approved Section 1332 State Innovation Waiver in alignment with the amendment approved on September 25, 2024 for coverage starting January 1, 2025. Specifically, we are requesting approval for the waiver amendment to be in effect for a full five-year term from the implementation date of January 1, 2025 through December 31, 2029. The terms of the waiver would be the same in 2029 as in 2028 and earlier years when the amended waiver is in effect.

New York received approval for its Section 1332 Waiver on March 1, 2024, with an effective date of April 1, 2024. The original waiver expanded eligibility of the State's Essential Plan to consumers up to 250% of the Federal Poverty Level mid-year on April 1, 2024. New York received approval of a waiver amendment on September 25, 2024, with an effective date of January 1, 2025. The amendment permits the use of passthrough funding for consumer subsidies to further increase the affordability and reduce the cost sharing burden for New Yorkers buying Qualified Health Plans starting January 1, 2025. The amended waiver was approved through December 31, 2028—a period of four years.

This waiver term request does not seek to waive additional provisions of the Affordable Care Act, change the approved waiver design, nor impact New York's compliance with the 1332 waiver guardrails.

The estimated impact of the waiver on individual market premiums and federal spend for 2029 is shown in the Actuarial & Economic analysis provided in the amended application (see Appendix Tables E).

New York will open a 10-day public comment period beginning November 27, 2024, and hold three public forums on December 2, 3, and December 4. This application will be updated to include a summary of and responses to comments received.

New York respectfully requests that the Departments grant approval for New York's proposed waiver term alignment. Given the Departments' recent review and approval of New York's initial waiver and amendment, and that the changes requested do not modify program elements of the Essential Plan expansion under the approved amended 1332 Wavier, we are requesting an expedited review of this alignment request.

We appreciate the Departments' commitment and ongoing partnership in expanding access and affordability of healthcare coverage to more New Yorkers.

Sincerely,

James V. McDonald, M.D., M.P.H
Commissioner of Health

Table of Contents

Section 1: Waiver term change request........ 5

Section 2: Evidence of Public Comment Period, Hearings, and Tribal Consultation........ 5

Section 3: Comment Summaries and Responses........ 5

Section 4: New York's approved 1332 waiver amendment (September 25, 2024)........ 5

Section 5: Updated Actuarial Tables........ 6

Draft

Section 1: Waiver term change request

New York requests to set the term of the approved Section 1332 State Innovation Waiver in alignment with the amendment approved on September 25, 2024, for coverage starting January 1, 2025. Specifically, we are requesting approval for the waiver amendment to be in effect for a full five-year term from the implementation date of January 1, 2025, through December 31, 2029. The terms of the waiver would be the same in 2029 as in 2028 and earlier years when the amended waiver is in effect.

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This waiver term alignment request does not seek to waive additional provisions of the Affordable Care Act, change the approved waiver design, nor impact New York's compliance with the 1332 waiver guardrails.

The estimated impact of the waiver on individual market premiums and federal spend for 2029 is shown in the Actuarial & Economic analysis provided in the amended application (see Appendix Tables E).

Section 2: Evidence of Public Comment Period, Hearings, and Tribal Consultation

New York will open a 10-day public comment period beginning November 27, 2024, and hold three public forums on December 2, 3, and December 4.

Section 3: Comment Summaries and Responses

[To be completed after the Public Comment period]

Section 4: New York's approved 1332 waiver amendment (September 25, 2024)

The attached amendment application—submitted on June 28, 2024—generally includes all the information needed for approval to be extended through 2029. The actuarial analysis includes detailed projections of the waiver's effects and compliance with the 1332 guardrails for a 10-year

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period through 2033. The effects in 2029 are all consistent in both direction and magnitude with those in 2028.[1]

See Appendix 1.

Section 5: Actuarial Certification and Updated Actuarial Tables

Please see attached an actuarial certification and updated with and without-waiver actuarial tables extending the budget window through 2034 (appendix E tables E2, E4, and E6)

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[1] The waiver's methodology begins on page 17 of the actuarial analysis.

Actuarial Certification

Steven N. Wander is a Principal with Deloitte Consulting LLP. He is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He meets the Academy's qualification standards for rendering the actuarial opinions contained in this analysis.

The State of New York retained Deloitte Consulting to develop its actuarial and economic analysis for the State of New York 1332 Waiver Application approved on March 1, 2024 and 1332 Waiver Amendment approved on September 25, 2024.

The following tables are intended to serve as supplements to the actuarial and economic analysis provided for New York's 1332 Waiver Amendment demonstrating the impact of the waiver amendment through 2034. The 2034 estimates rely upon the same data, assumptions, and trend factors as relied upon in the 1332 Waiver Amendment. Estimates are based on an actuarial analysis of future costs and enrollment for PY 2024–2034. It may be expected that actual experience will vary from the values shown in this analysis.

I certify that the estimates presented in this analysis:

- Address requirements and prohibitions of section 45 CFR 155.1308(f)(iv)(A)-(D) for the requested waiver amendment approval period of 2025 - 2029
- Are consistent with the CMS "Checklist for Section 1332 State Relief and Empowerment Waivers Applications" (updated July 2019)
- Have been developed in accordance with applicable Actuarial Standards of Practice (ASOP) requirements, specifically No. 23 (Data Quality), No. 41 (Actuarial Communication), and No. 56 (Modeling)
- Are consistent with the assumptions in New York's approved 1332 Waiver Amendment, applying trends from the original analysis for an additional year to develop 2034 estimates.

This document is intended solely for the information and use of the State of New York in support of its 1332 Waiver and is not for the benefit of or to be relied upon by any other person or entity.

Steven N. Wander, FSA, MAAA
Principal, Deloitte Consulting LLP

11/27/2024
Date

Updated Table E2. Baseline Without-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2034

Baseline Without Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	6-Year Total	11-Year Total
Unsubsidized On/Off-Exchange												2024-2029	2024-2034
Enrollment[1]	127,311	127,646	142,641	158,071	173,797	189,821	206,148	222,782	239,729	256,992	274,577	153,214	192,683
Average Premium PMPM	$741	$779	$818	$859	$902	$948	$996	$1,047	$1,101	$1,157	$1,216	$852	$999
Subsidized On-Exchange													
Enrollment[1]	222,570	224,760	182,740	184,551	186,381	188,228	190,095	191,980	193,883	195,806	197,748	198,205	196,249
Average Premium PMPM	$706	$743	$778	$818	$861	$906	$953	$1,002	$1,054	$1,109	$1,167	$797	$914
Average APTC PMPM	$430	$452	$477	$502	$528	$555	$584	$615	$647	$680	$716	$488	$560
Total Individual Market													
Enrollment[1]	349,881	352,406	325,380	342,623	360,177	378,049	396,242	414,762	433,612	452,799	472,326	351,419	388,932
Average Premium PMPM	$719	$756	$795	$837	$881	$927	$975	$1,026	$1,080	$1,136	$1,196	$821	$956
Aggregate Premiums (millions)	$3,018	$3,197	$3,105	$3,441	$3,807	$4,205	$4,637	$5,108	$5,619	$6,174	$6,776	$20,773	$49,087
Projected Federal Spend (millions)	$1,096	$1,164	$999	$1,062	$1,128	$1,199	$1,273	$1,353	$1,437	$1,527	$1,622	$6,649	$13,862
Essential Plan													
Enrollment[1]	1,250,807	1,290,634	1,306,011	1,327,110	1,348,632	1,370,058	1,391,828	1,413,947	1,436,422	1,459,257	1,482,459	1,315,542	1,370,651
Average Premium PMPM	$616	$632	$654	$677	$701	$726	$751	$778	$806	$835	$866	$669	$735
Aggregate Premiums (millions)	$9,267	$9,787	$10,239	$10,771	$11,332	$11,920	$12,541	$13,196	$13,888	$14,618	$15,388	$63,316	$132,946
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,350	$2,475
LTSS Coverage (millions)	$0	$0	$135	$137	$139	$141	$143	$146	$148	$150	$153	$552	$1,292
SDoH/BH Grant Program (millions)	$25	$71	$71	$71	$71	$71	$71	$71	$71	$71	$71	$378	$732
Total Program Costs (millions)	$9,517	$10,083	$10,670	$11,203	$11,766	$12,357	$12,980	$13,638	$14,331	$15,064	$15,836	$65,596	$137,445
Projected Federal Spend (millions)	$11,757	$12,445	$12,604	$13,476	$14,409	$15,402	$16,463	$17,597	$18,810	$20,105	$21,490	$80,093	$174,559
Other Federal Spend/Revenue													
Pregnancy Medicaid Spend[2] (millions)	$33	$97	$110	$118	$126	$135	$145	$155	$166	$180	$195	$619	$1,459
DACA Medicaid Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ESRP Revenue (millions)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($16)	($30)
Combined Totals													
Enrollment[1]	1,600,688	1,643,040	1,631,391	1,669,733	1,708,809	1,748,107	1,788,070	1,828,709	1,870,034	1,912,056	1,954,785	1,666,961	1,759,584
Projected Federal Spend (millions)	$12,883	$13,704	$13,711	$14,653	$15,661	$16,733	$17,879	$19,102	$20,410	$21,809	$23,305	$87,345	$189,850

[1] 6- and 11-year totals are straight averages.

[2] Pregnancy Medicaid Spend accounts for individuals 200-250% FPL who would receive APTCs on the individual market under current law or are within the State's Aliessa population.

Updated Table E4. Amended With-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2034

Amended Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	6-Year Total	11-Year Total
Unsubsidized On/Off-Exchange												2024-2029	2024-2034
Enrollment[1]	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849	274,432	153,093	192,552
Average Premium PMPM	$741	$779	$818	$859	$902	$948	$996	$1,047	$1,101	$1,157	$1,216	$852	$999
Subsidized On-Exchange													
Enrollment[1]	160,726	149,543	106,765	107,823	108,891	109,971	111,061	112,162	113,274	114,397	115,532	123,953	119,104
Average Premium PMPM	$702	$778	$827	$870	$915	$963	$1,013	$1,065	$1,121	$1,179	$1,240	$829	$957
Average APTC PMPM	$425	$452	$476	$501	$527	$555	$583	$614	$646	$679	$715	$483	$554
Total Individual Market													
Enrollment[1]	287,982	277,056	249,272	265,759	282,552	299,654	317,070	334,804	352,861	371,247	389,964	277,046	311,656
Average Premium PMPM	$719	$778	$822	$863	$907	$953	$1,002	$1,053	$1,107	$1,164	$1,223	$842	$983
Aggregate Premiums (millions)	$2,486	$2,588	$2,458	$2,753	$3,076	$3,428	$3,812	$4,231	$4,687	$5,184	$5,725	$16,788	$40,427
Projected Federal Spend (millions)	$783	$774	$583	$619	$658	$699	$743	$789	$838	$891	$946	$4,117	$8,324
Essential Plan Expansion Program Costs													
Enrollment[1]	1,350,395	1,429,674	1,448,713	1,472,119	1,495,985	1,519,749	1,543,863	1,568,379	1,593,291	1,618,631	1,644,379	1,452,772	1,516,834
Average Premium PMPM	$624	$649	$672	$696	$720	$746	$773	$800	$829	$859	$890	$686	$755
Aggregate Premiums (millions)	$10,115	$11,143	$11,687	$12,293	$12,934	$13,606	$14,314	$15,062	$15,851	$16,684	$17,564	$71,777	$151,252
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,350	$2,475
LTSS Coverage (millions)	$0	$0	$137	$144	$152	$160	$168	$177	$186	$196	$206	$594	$1,528
SDoH/BH Grant Program (millions)	$25	$71	$71	$71	$71	$71	$71	$71	$71	$71	$71	$378	$732
IRIP Payment (millions)	$51	$71	$67	$75	$84	$94	$104	$115	$128	$141	$156	$442	$1,087
Approved Waiver EP Admin Costs (millions	$84	$108	$107	$104	$104	$105	$107	$109	$111	$112	$114	$611	$1,165
CSR 87 250-350% FPL (millions)	$0	$263	$260	$277	$294	$312	$332	$352	$374	$398	$423	$1,406	$3,285
CSR 73 350-400% FPL (millions)	$0	$14	$14	$15	$16	$17	$18	$19	$20	$22	$23	$76	$178
Diabetes (millions)	$0	$25	$27	$28	$30	$32	$33	$35	$37	$39	$41	$142	$327
Maternity Care (millions)	$0	$4	$4	$5	$5	$6	$6	$7	$8	$8	$9	$24	$62
Total Program Costs (millions)	$10,500	$11,923	$12,599	$13,237	$13,914	$14,627	$15,379	$16,173	$17,011	$17,897	$18,832	$76,801	$162,091
Projected Federal Spend (millions)	$2,939	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,939	$2,939
Other Federal Spend/Revenue													
Pregnancy Medicaid Spend[2] (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DACA Medicaid Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ESRP Revenue (millions)	($1)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1)	($1)
Combined Totals													
Enrollment[1]	1,638,376	1,706,730	1,697,985	1,737,878	1,778,537	1,819,403	1,860,933	1,903,183	1,946,152	1,989,877	2,034,344	1,729,818	1,828,491
Projected Federal Spend (millions)	$3,722	$774	$583	$619	$658	$699	$743	$789	$838	$891	$946	$7,055	$11,262

[1] 6- and 11-year totals are straight averages. 2024 enrollment, premium, and APTC amounts reflect the average monthly enrollment for the 12-month period.

[2] Pregnancy Medicaid Spend accounts for individuals 200-250% FPL who would receive APTCs on the individual market under current law or are within the State's Aliessa population.

Note: The program investments for Quality Incentive Pool and SDoH/BH Grant Program for 2024 are displayed as total costs over all 12 months. The first 3 months of these amounts would be incurred under the BHP and the last 9 months would be incurred under the 1332 Waiver.

Updated Table E6. Baseline Without Waiver and Amended With-Waiver Annual Funding Estimates, PY 2024-2034

Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Individual Market											
Without Waiver PTCs	$1,096,127,678	$1,164,471,071	$999,461,412	$1,061,856,027	$1,128,146,783	$1,198,577,021	$1,273,405,279	$1,352,906,247	$1,437,371,775	$1,527,111,943	$1,622,456,201
With Waiver & CSRs PTCs	$783,022,373	$774,288,326	$582,931,057	$619,320,667	$657,982,484	$699,058,416	$742,699,236	$789,065,135	$838,326,313	$890,663,598	$946,269,117
Difference	$313,105,305	$390,182,745	$416,530,356	$442,535,359	$470,164,299	$499,518,605	$530,706,043	$563,841,112	$599,045,462	$636,448,344	$676,187,084
Essential Plan											
Without Waiver BHP Funding	$11,756,762,973	$12,444,846,543	$12,604,114,297	$13,476,116,145	$14,409,279,829	$15,401,969,008	$16,463,046,880	$17,597,224,901	$18,809,539,114	$20,105,372,505	$21,490,478,906
With Waiver & CSRs BHP Funding	$2,939,190,743	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference	$8,817,572,230	$12,444,846,543	$12,604,114,297	$13,476,116,145	$14,409,279,829	$15,401,969,008	$16,463,046,880	$17,597,224,901	$18,809,539,114	$20,105,372,505	$21,490,478,906
Other Federal Spend/Savings											
Pregnancy Medicaid Total Enrollment	4,118	12,098	14,245	14,530	14,820	15,117	15,419	15,728	16,042	16,363	16,690
Pregnancy Medicaid Reduction	$33,004,003	$97,109,932	$110,245,599	$117,849,718	$125,984,280	$135,185,437	$144,883,812	$154,889,254	$165,799,409	$179,818,071	$194,720,494
DACA Medicaid Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employer Penalty Loss	($2,592,000)	($2,598,818)	($2,615,230)	($2,641,383)	($2,667,797)	($2,694,475)	($2,721,419)	($2,748,633)	($2,776,120)	($2,803,881)	($2,831,920)
Combined Totals											
Without Waiver Federal Spend	$12,883,302,654	$13,703,828,727	$13,711,206,078	$14,653,180,507	$15,660,743,096	$16,733,036,992	$17,878,614,551	$19,102,271,769	$20,409,934,178	$21,809,498,638	$23,304,823,682
With Waiver & CSRs Federal Spend	$3,722,213,116	$774,288,326	$582,931,057	$619,320,667	$657,982,484	$699,058,416	$742,699,236	$789,065,135	$838,326,313	$890,663,598	$946,269,117
Total Federal Savings	**$9,161,089,538**	**$12,929,540,402**	**$13,128,275,021**	**$14,033,859,839**	**$15,002,760,612**	**$16,033,978,576**	**$17,135,915,315**	**$18,313,206,633**	**$19,571,607,865**	**$20,918,835,040**	**$22,358,554,564**
Requested Pass-through	$9,130,677,535	$12,835,029,288	$13,020,644,653	$13,918,651,505	$14,879,444,128	$15,901,487,613	$16,993,752,923	$18,161,066,013	$19,408,584,576	$20,741,820,849	$22,166,665,990
Net Federal Savings	**$30,412,003**	**$94,511,113**	**$107,630,369**	**$115,208,335**	**$123,316,484**	**$132,490,963**	**$142,162,392**	**$152,140,620**	**$163,023,289**	**$177,014,190**	**$191,888,574**

Combined Totals	6-Year Total	11-Year Total
Without Waiver Federal Spend	$87,345,298,054	$189,850,440,872
With Waiver & CSRs Federal Spend	$7,055,794,066	$11,262,817,465
Total Federal Savings	**$80,289,503,989**	**$178,587,623,406**
Requested Pass-through	$79,685,934,723	$177,157,825,074
Net Federal Savings	**$603,569,266**	**$1,429,798,332**

Note: For 2024 due to the April 1 implementation date, there will still be 1 quarter of BHP funding compared to the other years of the Waiver.

Appendix 1

Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

June 28, 2024

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Yellen and Secretary Becerra,

The State of New York respectfully requests that the U.S. Department of Treasury and U.S. Department of Health and Human Services grant approval of New York's amendment application for its Section 1332 State Innovation Waiver. New York received approval for its Section 1332 Waiver on March 1, 2024, which expanded eligibility of the State's Essential Plan to consumers up to 250% of the Federal Poverty Level (FPL). The State is seeking an amendment for the approved use of passthrough funding to include consumer subsidies to further increase the affordability and reduce the cost sharing burden for New Yorkers buying Qualified Health Plans (QHP) starting January 1, 2025 through the end of the waiver period on December 31, 2028. The amendment does not seek to waive additional provisions of the Affordable Care Act, change the approved waiver, nor impact New York's compliance with the 1332 waiver guardrails.

New York is proposing to expand the allowable use of passthrough funding under the waiver in accordance with state authority granted to the Department of Health in the New York State Fiscal Year 2025 budget, section 268-c(26) of the New York Public Health Law (HMH SFY 25 Part J). The law gives the Commissioner authority "to establish a program to provide subsidies for the payment of premium or cost sharing or both to assist individuals who are eligible to purchase qualified health plans through the marketplace." Pursuant to this authority, the amendment provides for passthrough funding to be used for premium and cost-sharing subsidies for Marketplace enrollees. Beginning January 1, 2025, the State is proposing to implement three new initiatives on the Exchange: 1) Provision of a Cost Sharing Reduction (CSR) wrap to broadly reduce cost-sharing for individuals with incomes up to 400% of the FPL; 2) Provision of a CSR wrap for individuals seeking services to manage their Diabetes; and 3) Provision of a CSR wrap for individuals who are pregnant or postpartum.

The State will use passthrough funding to reimburse insurers for cost-sharing that consumers would have otherwise paid based on information from actual claims. As such, the amendment is not estimated to have an impact on individual market premiums, does not impact the benefits of the plans, and does not impact the actuarial values of the underlying plans. Given uncertainty

about enhanced federal premium subsidies, the State may modify or implement additional subsidies in subsequent years. In that case, the State will notify the Departments of the proposed change and provide updated modeling showing the changes do not affect compliance with the guardrails. The State understands that if the costs of these initiatives exceed the available federal passthrough payments, excess costs will be the responsibility of the State.

New York respectfully requests that the Departments grant approval for New York's proposed uses of surplus passthrough funding as outlined above. Given the Departments' recent review and approval of New York's waiver, and that the changes requested do not impact the core program elements of the Essential Plan expansion under the approved 1332 Wavier, we are requesting an expedited review so consumers may benefit from these cost sharing reductions starting in 2025.

We appreciate the Departments commitment and ongoing partnership in expanding access and affordability of healthcare coverage to more New Yorkers.

Sincerely,

James V. McDonald, M.D., M.P.H
Commissioner of Health

New York Section 1332 Innovation Waiver

Essential Plan Expansion

Amendment Application

June 28, 2024

Submitted by the New York State Department of Health

Table of Contents

Section 1: Waiver Amendment Request and Overview 3
Permitting Pass-through Funding to be Spent on Marketplace Subsidies 3
Proposed Consumer Subsidies for 2025 3
Approach and Timeline for Implementation 4
Section 2: Analysis of Proposed Waiver Amendment 5
Impact of 2025 Subsidies on Consumers 5
Impact of the Amendment on 1332 Statutory Guardrails 6
Impact on Health Equity 8
Section 3: Authority Under State Law 8
Section 4: Evidence of Public and Tribal Consultation and Comment 9
Section 5: Additional Information 11
Section 6: Actuarial and Economic Analysis of Waiver 13
Section 7: Attached Materials 49
Appendix A – Authorizing Legislation 50
Appendix B – Public Hearing Notice and Presentation 54
Appendix C – Comments Received 68

Section 1: Waiver Amendment Request and Overview

On March 1, 2024, the State of New York received approval for its Section 1332 State Innovation Waiver. One of the primary goals of the waiver is to expand access and affordability of healthcare coverage for New Yorkers. The approved waiver expanded eligibility of the State's Essential Plan to consumers up to 250% of the Federal Poverty Level (FPL). To build upon these critical goals, the State is seeking an amendment for the approved use of pass-through funding for premium and cost-sharing reduction subsidies for New Yorkers buying Qualified Health Plans (QHP) starting January 1, 2025 through the end of the waiver period on December 31, 2028. The State is proposing to implement three cost sharing reductions (CSRs) beginning in 2025 and requests approval to use pass-through funding on additional consumer subsidies in future years. The amendment does not seek to waive additional provisions of the Affordable Care Act, change the approved waiver, or affect compliance with the section 1332 waiver guardrails.

Permitting Pass-through Funding to be Spent on Marketplace Subsidies

New York is proposing to expand the allowable uses of pass-through funding under the waiver in accordance with state authority granted to the Department of Health in the New York State Fiscal Year 2025 budget, section 268-c(26) of the New York Public Health Law (HMH SFY 25 Part J). The law gave the Commissioner authority "to establish a program to provide subsidies for the payment of premium or cost sharing or both to assist individuals who are eligible to purchase qualified health plans through the marketplace." Pursuant to this authority, the amendment would provide for pass-through funding to be used for premium and cost-sharing subsidies for Marketplace enrollees.

Beginning January 1, 2025, the State will implement three new initiatives on the Exchange: 1) Provision of a Cost Sharing Reduction (CSR) wrap to broadly reduce cost-sharing for individuals with incomes up to 400% of the FPL; 2) Provision of a CSR wrap for individuals seeking services to manage their Diabetes; and 3) Provision of a CSR wrap for individuals who are pregnant or postpartum. The State will use pass-through funding to reimburse insurers for cost-sharing that consumers would have otherwise paid based on information in actual claims. As such, the amendment is not estimated to have an impact on individual market premiums, does not impact the benefits of the plans, and does not impact the actuarial values of the underlying plans. Given uncertainty about federal subsidies, the State may modify these subsidies in subsequent years. In that case, the State will notify the federal government and provide updated modeling showing the changes do not affect compliance with the guardrails.

Proposed Consumer Subsidies for 2025

1) *Reduction in Cost Sharing for Individuals Up to 400% of the FPL*

The State is proposing to provide a CSR wrap to individuals with incomes up to 400% of FPL who are not Essential Plan eligible, by expanding eligibility for existing Silver CSR 87 variants to consumers eligible for Advance Premium Tax Credit (APTC) with incomes up to 350% of the FPL and eligibility for existing Silver CSR 73 variants to consumers with incomes above

350% up to 400% of the FPL. These changes are being proposed for several reasons. Cost-sharing reductions will help increase access to care, address consumer complaints about high out-of- pocket costs and reduce provider uncompensated care.

To negate potential premium impacts in the individual market, the State will use surplus pass-through funding to reimburse insurers' actual claims cost for reducing cost-sharing in CSR Silver variants relative to the standard Silver 70 plans for the newly eligible population following a similar methodology used for federal cost-sharing reduction payments prior to 2017.

2) Reduction in Cost-Sharing for Diabetes Services

The State is proposing to create a cost-sharing wrap that reimburses insurers to reduce cost-sharing for non-hospital-based diabetes-related services, supplies and prescription drugs, for all QHP consumers in all metal levels. Consumers will be able to receive this cost sharing reduction while remaining in the plan of their choice. There will be no change to plan premiums, benefits, or actuarial values.

Consumers will have $0 out-of-pocket costs for diabetes-related services. To negate potential premium impacts in the individual market, the State will use pass-through funding to reimburse insurers for the cost sharing they would have otherwise received from their consumers based on claims.

3) Reduction in Cost-Sharing for Pregnancy and Postpartum Care

The State is proposing to create a cost-sharing wrap that reimburses insurers to reduce cost-sharing for outpatient pregnancy and postpartum care, inclusive of mental health services, for all QHP members in all metal levels. Consumers will be able to receive this cost sharing reduction while remaining in the plan of their choice. There will be no change to plan premiums, benefits, or actuarial values.

Currently, there is already limited cost-sharing permitted for maternal health services in QHPs. There is no cost sharing for services defined by the United States Preventive Services Task Force (USPSTF), which defines preventive pregnancy services broadly to include office visits, prenatal vitamins, breast pumps, pre-eclampsia, and supplies. Examples of maternal health services that do still have cost-sharing include prescription drugs and postpartum mental health benefits.

Consumers will have $0 out-of-pocket costs for all outpatient covered services, supplies, and prescription drugs during pregnancy and postpartum. To negate potential premium impacts in the individual market, the State will use pass-through funding to reimburse insurers for the cost sharing they would have otherwise received from their consumers based on actual claims information. Cost-sharing will continue to apply for delivery and hospital stays.

Approach and Timeline for Implementation

The CSRs will be implemented beginning January 1, 2025. Implementation is focused on the system changes, consumer notification, and coordination with insurers for cost-sharing payments. The State has been in conversations with the insurers on the approach for the three CSRs and included instructions in the 2025 Plan Invitation. There are no associated impacts on

2025 plan and rate filings.

For consumers with incomes up to 400% of the FPL enrolled in Silver plans without CSR for 2024, the State will auto renew eligible consumers into the respective Silver CSR 87 and Silver CSR 73 variants which will be effective January 1, 2025. Consumers will receive a notice and will be able to change plans during Open Enrollment. For consumers with incomes up to 400% of the FPL enrolled in other metal level plans for 2024, the State will auto renew eligible consumers into their same plans for 2025. These consumers will receive email and text messages from NY State of Health about their eligibility for Silver CSR 87 and Silver CSR 73 variants and will need to take action to select to enroll in these plans for 2025. Beginning January 2025, the State intends to issue monthly advance CSR payments to health plans for their enrollees in these variants, with a reconciliation based on actuals following the claims run out period.

For defined diabetes and maternity services, insurers will not charge consumers the portion of their cost-sharing obligations under their enrolled QHPs. Insurers are currently in the process of updating their billing systems and will provide semi-annual reports to the State on the owed cost sharing payments along with justification on claims paid. The State intends to issue semi-annual payments to health plans for the diabetes and maternity CSRs based on these reports.

CSR and Waiver Amendment Implementation Key Milestones

Activity	Target Date
Issue instructions in the 2025 Plan Invitation for the CSRs	May 3, 2024 (complete)
Finalize methodology & reporting approach for CSR payments with QHP insures	September 2024
Finalize system changes for Silver 87 and 73 plan eligibility	September 2024
Implement training for assisters and customer service staff on CSRs	October 2024
Launch consumer communications (email/text) for CSR	November 2024
Auto-enroll consumers into plans for Open Enrollment 2025	November 2024
Issue monthly CSR payment to insurers for 2025 Silver Plan variants (continue monthly)	January 2025
Receive reports from insurers on Diabetes and Maternal health claims paid (to continue semi-annually)	July 2025

Section 2: Analysis of Proposed Waiver Amendment

Impact of 2025 Subsidies on Consumers

The CSRs are estimated to improve affordability for an average of 117,687 consumers annually 2025 – 2028. The CSRs are estimated to result in a total of $307 million in consumer savings in 2025 and a total of $1.3 billion from 2025 – 2028.

- Expanding eligibility for the Silver CSR 87 Plan variants to consumers up to 350% of the

FPL is estimated to improve affordability for an average of 79,117 consumers annually for 2025 – 2028 with an average annual savings of $3,456 per consumer.

- Expanding eligibility for the Silver CSR 73 Plan variants to consumers up to 400% of the FPL is estimated to improve affordability for an average of 20,224 consumers annually for 2025 – 2028 with an average annual savings of $734 per consumer.
- The reduction in cost sharing for diabetes services is estimated to improve affordability for an average of 16,737 consumers annually for 2025 – 2028 with an average annual savings of $1,648 per consumer.
- The reduction in cost sharing for pregnancy and post-partum care is estimated to improve affordability for an average of 1,610 consumers annually for 2025 – 2028 with an average annual savings of $2,819 per consumer.

Impact of the Amendment on 1332 Statutory Guardrails

The 1332 Waiver with the proposed amendment to use pass-through funding for the state CSRs is estimated to continue to meet the 1332 waiver statutory guardrails. The following outlines how the Amended With Waiver (with CSRs) are estimated to impact the guardrails compared to the Approved Waiver.

1. Comprehensiveness (1332(b)(1)(A)):

   There are no estimated changes with the CSRs.

2. Affordability (1332(b)(1)(B)):

   There is an estimated improvement in affordability with the CSRs for an average of 117,687 consumers annually 2025 – 2028, resulting in a total of $307 million in consumer savings in 2025 and a total of $1.3 billion from 2025 – 2028. Consumers are estimated to experience a 20.1% increase in affordability in 2025 and an average annual increase in affordability of 20.4%.

3. Scope of Coverage (1332(b)(1)(C)):

   There is an estimated increased in enrollment in the individual market by 3,160 (0.2%) for PY 2025, 2,974 (0.2%) for PY 2026, 3,004 (0.2%) for PY 2027, and 3,034 (0.2%) for PY 2028.

4. Deficit Neutrality (1332(b)(1)(D)):

   Compared to the Approved Waiver, the Amended With Waiver is estimated to increase spend in PTCs by $0 million in 2024, $24 million (3.2%) for 2025, $96 million (2.9%) 2024 – 2028, and $248 million (3.5%) 2024 – 2033 due to the CSR for consumers up to 400% of the FPL. This increase is assumed to be deducted from pass-through funding.

   The estimated costs of the CSRs to the State are $0 in 2024, $307 million (2.6% waiver program increase) in 2025, $1.3 billion (2.1%) 2024-2028, and $3.4 billion (2.4%) over

the ten years 2024 - 2033. It is estimated the Amended Waiver will be fully funded by pass-through.

Summary of 1332 Waiver Guardrail Compliance with Amendment

<table>
<tr><th>Guardrail</th><th>Estimated Impact of Amended With Waiver Compared to Baseline Without Waiver</th></tr>
<tr><td>Comprehensiveness</td><td>The Amended Waiver is projected to meet the comprehensiveness guardrail as consumers have access to more comprehensive coverage compared to the Baseline Without-Waiver Scenario.
Consumers with incomes between 200–250% of the FPL will receive more comprehensive coverage.
There are no expected impacts for other consumers in the individual market.
There are no expected impacts for other consumers in the Essential Plan.</td></tr>
<tr><td>Affordability</td><td>The Amended With Waiver is projected to meet the affordability guardrail as the affordability across the market is improved compared to the Baseline Without-Waiver Scenario.
Affordability for current Essential Plan consumers is not expected to change.
Affordability for consumers with incomes between 200–250% of the FPL is expected to improve under the Waiver for an aggregate savings of $2.3 billion over the 5 years.
This is an average annual savings of $6,091 under the Waiver ($3,540 in premiums and $2,551 in out-of-pocket spend), which is approximately 15% of income for consumers 200 – 250% of the FPL.
Affordability of premiums for on- and off-Exchange consumers is not estimated to change under the Waiver due to the IRIP/
Affordability of cost-sharing for on-Exchange consumers is estimated to improve with the CSRs for an average of 117,687 consumers annually 2025 – 2028. The CSRs are estimated to result in a total of $1.3 billion savings from 2025 – 2028.
This is an average annual savings of $1,376 per on-exchange consumer for 2025 – 2028.</td></tr>
<tr><td>Coverage</td><td>The Amended With Waiver is projected to meet the coverage guardrail as more consumers are expected to enroll in coverage compared to the Baseline, Without-Waiver Scenario.
Overall enrollment for the Essential Plan and individual market is expected to increase by a combined 2.4% for PY 2024, 3.9% for PY 2025, 4.1% for PY 2026 – 2028.</td></tr>
<tr><td>Deficit Neutrality</td><td>The Amended With Waiver is projected to meet the deficit neutrality guardrail and generate savings for the federal government.
The federal spend is estimated to decrease by $9.1 billion in PY 2024 and $64.3 billion over the 5-year Waiver period, before pass-through funding.
The estimated pass-through to the State is estimated to be $9.1 billion in PY 2024 and $63.8 billion over the 5-years.
The net federal spend is estimated to decrease by $30.4 million in PY 2024 and $471.1 million over the 5-year Waiver period, after accounting for pass-through funding.</td></tr>
</table>

Impact on Health Equity

New York has centered efforts to advance health equity for more than a decade, and the proposed waiver amendment is a key strategy to continue that effort. In fact, as part of its New York State Prevention Agenda: 2019-2024, New York has defined its overarching strategy to "implement public health approaches that improve the health and well-being of entire populations and achieve health equity."[1]

With this waiver amendment, New York seeks to lower costs and increase benefits for consumers on the exchange. The intent of these initiatives is to reduce consumer out-of-pocket costs for QHP coverage to increase their affordability and improve access to care, which disproportionately pose a barrier to lower income communities of color.

In addition to generally lowering cost-sharing for members with incomes at or below 400% of FPL, the amendment proposes removes cost barriers for diabetes-related care for QHP enrollees in the individual market. Reducing consumers' out-of-pocket costs is expected to improve consumers' ability to manage diabetes by improving access to recommended care, reducing the likelihood of unnecessary hospitalizations, and improving overall health. Leveraging the experience of state-based marketplaces, including Washington, D.C., by pursuing health equity focused plan designs, the objective is to address health inequities by focusing on conditions that disproportionately impact lower-income communities, including communities of color.

Finally, New York proposes eliminating pregnancy and postpartum cost sharing for QHP enrollees in the individual market. New York is committed to reducing racial and ethnic disparities in infant and maternal mortality and associated health outcomes. Eliminating cost-sharing for this group reduces barriers to accessing the full suite of prenatal and postnatal healthcare. New York sees this opportunity to address coverage disparities, and through coverage, advance health equity in the state as a key success factor for the waiver amendment.

Section 3: Authority Under State Law

Authority for the State's CSRs was established in the State Fiscal Year (SFY) 2025 budget. Signed on April 20, 2024 by Governor Hochul, SYF 2025 budget included legislative authority in section 268-c(26) of the New York Public Health Law to permit subsidies to be extended to low- and moderate-income New Yorkers for premium and cost-sharing reductions for QHPs through the Marketplace (HMH SFY 25 Part J) starting January 1, 2025.

> *Subject to federal approval if required, the use of state funds and the availability of funds in the 1332 state innovation program fund established pursuant to section ninety-eight-d of the state finance law, the commissioner shall have the authority to establish a program to provide subsidies for the payment of premium or cost sharing or both to assist individuals who are eligible to purchase qualified health plans through the marketplace, or take such other action as appropriate to reduce or eliminate qualified health plan premiums or cost-sharing or both.*

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[1] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf

Section 4: Evidence of Public and Tribal Consultation and Comment

On May 7, 2024, the State posted notice for a joint 1332 Annual Public Forum and Public Hearing on June 12, 2024 and June 14, 2024 on its dedicated 1332 waiver webpage at https://info.nystateofhealth.ny.gov/1332. New York released its draft amendment application on the website with instructions on how to provide public comment and register for the hearings on May 28, 2024. New York held a 30-day public comment period on the draft amendment on May 28, 2024 and ending on June 27, 2023. The State provided multiple channels and opportunities for the public to provide comment on the draft 1332 Waiver Application.

In addition, the State also emailed over 6,600 stakeholders on a DOH email listserv on May 28, 2024 to inform them of the comment period. The State also followed its standard process for consulting with federally recognized tribes. A letter was emailed to the points of contact for the eight tribes on May 28, 2024. The letter included a description of the proposed changes to the 1332 Wavier Application, where to find more information online, and invited the tribes to attend the public hearings or request a separate tribal consultation. No tribes requested a separate meeting. The State's public notice and comment procedures complied with the requirements specified in 31 CFR 33.112 and 45 CFR 155.1312.

The public was provided the opportunity to comment on the draft waiver online via email, orally during virtual public hearings, and through the mail.

Total Number of Comments Received:

- Email = 14
- Public Hearings = 0
- Mail = 0

Public Hearings

The State held two public hearings with options for virtual attendance through Webex. The first hearing was scheduled on Wednesday, June 12, 2024 at 2:00 P.M. Eastern Time, and the second hearing was scheduled on Friday, June 14, 2024 at 9:00 A.M. Eastern Time.

The two public hearings followed the same format. Each began with an overview by DOH staff of the 1332 Waiver implementation status followed by a review of the proposed changes under the draft amendment. Then the public hearing was opened for comments. The public was provided an option to register in advance to provide comment; none pre-registered. Attendees were also given an option to provide comment during the session. Sign language and Spanish interpreters were available for the duration of the hearings.

The hearing presentation was posted online at https://info.nystateofhealth.ny.gov/1332 on June 13, 2024. A copy of the presentation is included in Appendix B. Hearing transcripts were posted on the website on June 20, 2024.

A total of 119 members from the public attended the hearings. No attendees provided public comment. Two attendees asked questions. The first question was on the type of Social

Determinants of Health provisions available. The second question was if the presentation would be posted after the hearing.

Written Comments

The state received a total of fourteen (14) written comments, one comment from an individual and thirteen (13) comments from the following organizations:

- American Cancer Society Cancer Action Network
- Coalition of New York State Public Health Plans
- Community Service Society
- CUNY Graduate School of Public Health & Health Policy
- Cystic Fibrosis Foundation
- Emblem Health
- Greater New York Hospital Association
- Healthcare for All New York
- Health People
- Housing Works
- Leukemia & Lymphoma Society
- New York Health Plan Association
- Primary Care Development Corporation

Summary of Public Comments Received

The State appreciates the comments received on the draft amendment. All commenters were in favor of the amendment, and many requested the State to consider additional initiatives or populations to include to further enhance affordability. All comments received are included in Appendix C.

The following outlines the main themes raised from commenters about the changes proposed under the amendment:

- Support for increasing access and affordability of health coverage for more residents.
- Support of expanding healthcare coverage and reducing cost-sharing as it greatly impacts early detection, management, and prevention of diseases and chronic conditions, many of which disproportionally impacts low-income individuals.
- Support for eliminating cost-sharing for pregnant and post-partum individuals to reduce disparities in maternal health outcomes among persons of color.
- Support for eliminating cost-sharing to reduce medical debt among those with low incomes.
- Support for expanding access to quality and affordable insurance as it increases coverage for vulnerable populations, expands access to primary care, and builds healthier communities.
- Support for pursuing both CSR subsidies and premium subsidies in future years.
- Support the initiative to enroll individuals up to 400% of the FPL in reduced cost-sharing programs as it reduces the number of New Yorkers that struggle to pay for

plans that have out-of-pocket medical costs exceeding 10% of their gross annual income.
- Request to eliminate hospital-related cost sharing for labor and delivery.
- Request to adopt policies that make health insurance coverage accessible to and affordable for as many New Yorkers as possible.
- Request to include coverage for undocumented immigrants.
- Request to use $9.1 billion to cover immigrants.
- Request to expand eligibility for the Silver 87% AV plan to all individuals with incomes up to 400% FPL.
- Request to use pass-through funds to provide premium subsidies to consumers.
- Request to add premium assistance to reduce the impact of the ending of enhanced subsidies under the American Rescue Plan.
- Request for peer delivered self-management education services be included in services covered within the diabetes cost-sharing initiative.
- Request to expand affordability initiatives for Medicare coverage.

State Response

The State appreciates all comments received. Due to the multiple comments received requesting to use of pass-through funding for premium subsidies and additional cost sharing reductions, the State updated the submitted 1332 Waiver amendment application to seek approval from the Departments to allow pass-through funding to be used on additional consumer subsidies in the future and will continue to identify opportunities to further increase affordability for consumers as funding allows. The State will also evaluate policy guidance and statute to find ways to enhance access to diabetes self-management programs and continue to monitor the stability of the individual market.

The $9.1 billion referenced in one comment received is the estimated total federal pass-through funding the State will receive for 2024 which will be spent on the full Essential Plan expansion and proposed cost sharing reductions for QHP consumers; it does not reflect excess pass-through. The State does not currently have authority to expand the Essential Plan to additional eligibility groups, including undocumented immigrants. DACA recipients will be eligible for Essential Plan coverage beginning August 1, 2024 under the approved waiver.

Section 5: Additional Information

Administrative Burden Baseline Without Waiver, Approved Waiver, and Amended Waiver

The proposed amendment will result in no additional administrative burden for the federal government. The CSR proposals will result in minimal administrative burden for the State for implementation and operations. New York has the staff and resources necessary to absorb the necessary administrative tasks. QHP insurers will experience minimal administrative burden to implement the necessary technology and reporting changes for the CSRs. New York provides regular, timely notice of changes to insurers in order to minimize operational burdens on insurers.

Implementation of Non-Waived ACA Provisions

The implementation of the waiver amendment does not have any impact on the implementation of those provisions of the ACA that are not being waived.

Impact on Residents Who Need to Obtain Health Care Services Out-of-State

The implementation of the waiver amendment does not impact residents obtaining health care services out-of-state.

Compliance, Waste, Fraud, and Abuse

The New York State Department of Health is responsible for regulatory and contractual compliance for Essential Plan carriers, eligibility and enrollment program integrity and providing consumer outreach. The New York State Department of Financial Services (DFS) is responsible for regulating, licensing, and ensuring regulatory compliance and monitoring the solvency of all health insurance companies and performing market conduct analysis, examinations, and investigations. DFS investigates complaints that fall within its regulatory authority.

State Reporting Requirements and Targets

With this amendment, the State will include CSR payments within pass-through funding reporting in the requirement 1332 Waiver quarterly and annual reports as specified in 45 CFR 155.1324.

1332 Waiver Amendment Actuarial & Economic Analysis

Background

The State of New York submitted a final Section 1332 State Innovation Waiver Application to the U.S. Department of Health & Human Services (HHS) and Department of Treasury on December 18, 2023. The State received approval for its waiver on March 1, 2024. The waiver expanded eligibility of the State's Essential Plan (EP) to consumers with incomes up to 250% of the Federal Poverty Level (FPL) beginning April 1, 2024 and to eligible Deferred Action for Childhood Arrivals (DACA) recipients beginning August 1, 2024.

The State is submitting an amendment to its 1332 Waiver Application seeking approval to expand the allowable use of pass-through dollars to fund consumer premium and cost sharing reduction subsidies to further increase the affordability for New Yorkers buying Qualified Health Plans (QHPs) on the NY State of Health Marketplace (on-Exchange).

The State plans to implement three Cost Sharing Reduction (CSR) for consumers buying on-Exchange beginning January 1, 2025:

1. Reduction in Cost-Sharing for Consumers up to 400% of the FPL.
2. Reduction in Cost-Sharing for Diabetes-related Services.
3. Reduction in Cost-Sharing for Pregnancy and Postpartum Care.

The State will reimburse insurers the portion of the cost-sharing consumers would have otherwise been responsible for absent the CSRs. As such, the CSR proposals are not estimated to impact individual market premiums, benefits of the plans, nor plan actuarial values.

Approach

This actuarial and economic analysis includes estimates for the impact of the CSRs on consumer affordability and enrollment and the estimated cost of the programs to the State. It also includes estimates for the impact of the CSRs on the 1332 Waiver, the four guardrails, and pass-through funding.

Appendix D: Scenario D Detailed 10-Year Estimates (Current Law, Pregnancy, Choice, Inclusion of DACA Recipients & Insurer Reimbursement) from the December 18, 2023 waiver application reflects the approved waiver scenario. The baseline ***Without Waiver*** and ***With Waiver*** tables from *Appendix D* have been updated for this amendment, where applicable, with the latest data and assumptions in *Appendix E: Amendment Detailed 10-Year Waiver Estimates with CSRs* of this amendment. The ***Baseline Without Waiver*** and ***Approved Waiver*** tables have also been updated to reflect the final federal rule published on May 8, 2024 modifying the definition of "lawfully present" granting DACA recipients eligibility to enroll in Basic Health

Programs beginning November 2024 and Qualified Health Plans (QHPS) with Premium Tax Credits (PTCs) beginning December 2024. New tables have also been added to *Appendix E* to include the estimated impact of the ***Amended With Waiver*** with the proposed 1332 Waiver amendment.

Summary Impact of CSRs on the 1332 Waiver (2025 – 2028)

The reduction in cost-sharing for medical services is expected to improve management of chronic conditions, improve pregnancy and postpartum care, and mitigate the increasing out of pocket costs for consumers when the enhanced premium tax credits under the Inflation Reduction Act expire at the end of 2025. The CSRs are estimated to increase affordability for consumers in the QHP market and result in an increase in on-Exchange enrollment.

Urban Institute estimated that the CSRs will drive a total enrollment increase of 5,283 in on-Exchange enrollment for 2025; 3,160 new consumers are estimated to join the market that were previously uninsured or in employer sponsored coverage and 2,123 consumers are estimated to transition from off- to on-Exchange coverage. Urban Institute also estimated that the CSRs will drive a total average enrollment increase 5,190 over the four remaining years of the waiver (2025 – 2028), with 3,043 from uninsured or employer coverage and 2,147 migrating from off-exchange.

The CSRs are estimated to improve affordability for an average of 117,687 consumers annually 2025 – 2028. The CSRs are estimated to result in a total of $307 million in consumer savings in 2025 and a total of $1.3 billion from 2025 – 2028. An individual consumer could be impacted by more than one of these CSRs, for example, CSR 87 and CSR for diabetes service); estimates for the annual average savings per consumer adjusts for this assumed overlap. To the extent there are consumers impacted by multiple CSRs, the cost savings was attributed hierarchically consistent with the order below. For example, for the consumers who are within the 250 – 350% of the FPL band and also have diabetes, the CSR 87 cost savings estimate below would account for the full estimated consumer savings as a result of the CSR 87 shift, and the diabetes cost savings accounts only for incremental cost savings for these consumers above and beyond the CSR 87 savings. Note, the sum of the average consumers by CSR below differs from the average consumers impacted by the CSRs in aggregate due to rounding.

- Expanding eligibility for the Silver CSR 87 Plan variants to consumers up to 350% of the FPL is estimated to improve affordability for an average of 79,117 consumers annually for 2025 – 2028 with an average annual savings of $3,456 per consumer.
- Expanding eligibility for the Silver CSR 73 Plan variants to consumers up to 400% of the FPL is estimated to improve affordability for an average of 20,224 consumers annually for 2025 – 2028 with an average annual savings of $734 per consumer.
- The reduction in cost sharing for diabetes services is estimated to improve affordability for an average of 16,737 consumers annually for 2025 – 2028 with an average annual savings of $1,648 per consumer.

- The reduction in cost sharing for pregnancy and post-partum care is estimated to improve affordability for an average of 1,610 consumers annually for 2025 – 2028 with an average annual savings of $2,819 per consumer.

Estimated 10-year Impact of CSRs on 1332 Waiver Guardrails (2025 – 2033)

Comprehensiveness

The proposed CSRs have no estimated impact on the comprehensiveness of coverage.

Affordability

The proposed CSRs are estimated to improve affordability for eligible consumers buying on-exchange by $307 million in 2025, $1.3 billion from 2025 – 2028, and $3.4 billion from 2025 – 2033. The CSRs are not estimated to have any impact on individual market premiums nor impact the affordability of consumers not eligible for the CSRs.

The table below displays Urban Institute's 10-year annual estimated enrollment on-Exchange and the estimated per consumer cost savings with the three CSRs. The cost savings accounts for an assumed increase in enrollment and utilization with the CSRs. The per member per year cost savings was calculated by aggregating the total estimated savings for each of the CSRs, averaged over total on-Exchange enrollment, and trended forward from 2024 using the QHP Premium Annual Trend assumption of 5.2%. Please note, the analysis is consistent with current law and assumes that when the enhanced PTC available through the Inflation Reduction Act expire in 2025, overall enrollment will decline in 2026.

Table 1: Estimated Consumer Cost Savings from CSR Wrap

Amendment With Waiver With CSR	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Average 2025-2028	Average 2025-2033
On-Exchange CSR Enrollment	**250,496**	**241,672**	**213,660**	**229,793**	**246,229**	**262,969**	**280,021**	**297,387**	**315,073**	**333,082**	**232,838**	**268,876**
CSR 87 250-350% FPL	0	82,160	77,333	78,100	78,874	79,655	80,445	81,242	82,048	82,861	79,117	80,302
CSR 73 350-400% FPL	0	21,000	19,769	19,964	20,162	20,362	20,563	20,767	20,973	21,181	20,224	20,527
Diabetes	0	16,534	16,638	16,804	16,973	17,142	17,314	17,487	17,662	17,838	16,737	17,155
Maternity Care	0	1,650	1,507	1,595	1,686	1,777	1,870	1,965	2,062	2,161	1,610	1,808
Aggregate Cost Savings (millions)	**$0**	**$307**	**$305**	**$325**	**$345**	**$367**	**$389**	**$414**	**$439**	**$467**	**$1,282**	**$3,357**
CSR 87 250-350% FPL (millions)	$0	$263	$260	$277	$294	$312	$332	$352	$374	$398	$1,094	$2,862
CSR 73 350-400% FPL (millions)	$0	$14	$14	$15	$16	$17	$18	$19	$20	$22	$59	$155
Diabetes (millions)	$0	$25	$27	$28	$30	$32	$33	$35	$37	$39	$110	$286
Maternity Care (millions)	$0	$4	$4	$5	$5	$6	$6	$7	$8	$8	$18	$53
Per CSR Member Per Year Cost Saving	**$0**	**$1,269**	**$1,428**	**$1,412**	**$1,402**	**$1,394**	**$1,390**	**$1,390**	**$1,394**	**$1,401**	**$1,376**	**$1,387**
CSR 87 250-350% FPL	$0	$3,200	$3,366	$3,542	$3,726	$3,919	$4,123	$4,338	$4,563	$4,801	$3,456	$3,960
CSR 73 350-400% FPL	$0	$681	$713	$751	$794	$835	$875	$920	$968	$1,020	$734	$841
Diabetes	$0	$1,524	$1,603	$1,687	$1,775	$1,848	$1,925	$2,005	$2,089	$2,175	$1,648	$1,853
Maternity Care	$0	$2,606	$2,742	$2,884	$3,034	$3,192	$3,358	$3,532	$3,716	$3,909	$2,819	$3,266

**The decline in enrollment from 2024 to 2025 for On-Exchange is due to the migration of some consumers out of the market to the EP starting April 1, 2024. 2024 On-Exchange Enrollment with Waiver includes Q1 2024 QHP enrollment.*

Coverage

Urban Institute estimates the proposed CSRs to increase enrollment in the individual market by 3,160 in 2025, 3,043 from 2025 – 2028, and 3,088 from 2025 – 2033. In addition, 2,123 are estimated by Urban Institute to migrate from off to on-exchange for 2025, and average of 2,147 from 2025 – 2028, and an average of 2,206 from 2025 – 2033.

The table below displays Urban Institute's estimated enrollment increase on-Exchange from the CSRs.

Table 2: Estimated Enrollment Increase From CSRs

Amendment With Waiver With CSR	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Average 2025-2028	Average 2025-2033
Total On-Exchange Enrollment	**250,496**	**241,672**	**213,660**	**229,793**	**246,229**	**262,969**	**280,021**	**297,387**	**315,073**	**333,082**	**232,838**	**268,876**
On-Exchange Enrollment with Waiver	250,496	236,389	208,554	224,634	241,016	257,703	274,699	292,010	309,640	327,593	227,648	263,582
Additional Enrollment with CSRs	0	5,283	5,106	5,159	5,213	5,267	5,321	5,377	5,433	5,489	5,190	5,294
CSR 87 250-350% FPL	*0*	*2,160*	*2,033*	*2,053*	*2,074*	*2,094*	*2,115*	*2,136*	*2,157*	*2,178*	*2,080*	*2,111*
CSR 73 350-400% FPL	*0*	*1,000*	*941*	*951*	*960*	*970*	*979*	*989*	*999*	*1,009*	*963*	*977*
Diabetes	*0*	*2,073*	*2,086*	*2,107*	*2,128*	*2,149*	*2,171*	*2,192*	*2,214*	*2,236*	*2,098*	*2,151*
Maternity Care	*0*	*50*	*46*	*48*	*51*	*54*	*57*	*60*	*62*	*65*	*49*	*55*
Aggregate Cost Savings	**$0**	**$307**	**$305**	**$325**	**$345**	**$367**	**$389**	**$414**	**$439**	**$467**	**$320**	**$373**
Per Member Per Year Cost Savings	**$0**	**$1,269**	**$1,428**	**$1,412**	**$1,402**	**$1,394**	**$1,390**	**$1,390**	**$1,394**	**$1,401**	**$1,376**	**$1,387**

**The decline in enrollment from 2024 to 2025 for On-Exchange is due to the migration of some consumers out of the market to the EP starting April 1, 2024. 2024 On-Exchange Enrollment with Waiver includes Q1 2024 QHP enrollment.*

Deficit Neutrality

Federal pass-through from the waiver is estimated to fully fund the cost of the CSR proposals while maintaining compliance with the federal deficit neutrality guardrail.

After accounting for the cost of the EP Expansion and CSRs, the resulting pass-through surplus is estimated to be $4.0 billion for the five years of the waiver (2024 – 2028) and $14.1 billion over ten years (2024 – 2033).

The table below displays the estimated cost of the CSRs.

Table 3: Estimated CSRs Impact on Pass-through Funding

Amendment With Waiver With CSR	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Total 2024-2028	Total 2024-2033
Reduction in Cost Sharing												
Proposed Costs of CSRs (millions)	**$0**	**$307**	**$305**	**$325**	**$345**	**$367**	**$389**	**$414**	**$439**	**$467**	**$1,282**	**$3,357**
CSR 87 250-350% FPL (millions)	$0	$263	$260	$277	$294	$312	$332	$352	$374	$398	$1,094	$2,862
CSR 73 350-400% FPL (millions)	$0	$14	$14	$15	$16	$17	$18	$19	$20	$22	$59	$155
Diabetic Care Proposed (millions)	$0	$25	$27	$28	$30	$32	$33	$35	$37	$39	$110	$286
Maternity Care Proposed (millions)	$0	$4	$4	$5	$5	$6	$6	$7	$8	$8	$18	$53
Deduction for Increased APTCs (millions)	**$0**	**$24**	**$22**	**$24**	**$25**	**$27**	**$29**	**$30**	**$32**	**$34**	**$96**	**$248**

Data Sources and Reliance

Unless otherwise noted, *Appendix E* tables use the same data as outlined in the *1332 Waiver Actuarial and Economic Analysis Appendix D* submitted December 18, 2023. In addition, the following data was collected for this amendment:

- Updated estimated monthly enrollment for 2024 – 2033 from the Urban Institute Health Policy Simulation Model (HIPSM) for the EP population based on actual enrollment through 2024, the 200 - 250% of the FPL EP expansion population, and for the pregnancy provision population.
- EP estimated enrollment by county and FPL for Q1 of 2024, provided by NY State of Health.
- Actual distribution of enrollment by EP cohort, provided by NY State of Health.
- Approved 2024 EP premium rates (capitation rates) and non-claim/administrative amounts from NY State of Health.
- QHP enrollment by county and plan as of March 7, 2024 from NY State of Health.

- Estimated DACA recipients in New York by FPL and health coverage status with and without the waiver for 2024 – 2028 from the Urban Institute, which is based on state administrative data as well as available survey data.
- Estimated APTC to PTC reconciliation factor based on the latest available APTC, net PTC, and Excess APTC Repayment from the 2021 IRS Statistics of Income (SOI) Table. Table.
- Estimated per member per month (PMPM) APTC amount for subsidized on-Exchange consumers.

The additional data received from NY State of Health and the Urban Institute for the amendment were reviewed for reasonableness and consistency during the work; however, it was not audited by the team conducting the actuarial and economic analysis. NY State of Health conducts a third-party audit on its program; Urban Institute likewise has validation mechanisms for its economic microsimulation model.

All data was reviewed for appropriateness, sufficiency, and a reasonable effort was made to identify data values that were questionable or relationships that were significantly inconsistent. The actuarial guidelines related to reliance on models developed by others as outlined in Actuarial Standard of Practice No. 56 were followed. It was assumed that all data and information provided was accurate and complete; if it was not, the results of the analysis may likewise be inaccurate or incomplete.

The scope of the actuarial certification and the intended use of the analysis being performed to determine the nature of the data needed was considered. Additionally, the actuarial guidelines on utilizing imperfect data and considering the quality of data in the actuarial analysis as outlined in Actuarial Standard of Practice No. 23 were followed. The team relied on the NY State of Health enrollment and premium data highlighted. Based on reasonableness checks, the team believes it is a credible and reasonable data source to assess the impact of the Waiver on the State's individual market population.

Methodology and Assumptions

Unless otherwise noted, *Appendix E* tables use the same methodology and assumptions as outlined in the *1332 Waiver Actuarial and Economic Analysis Appendix D* submitted December 18, 2023. The following adjustments were made for this amendment.

EP (BHP) Population Enrollment (< 200% of the FPL)

The estimated enrollment and distribution of the EP population up to 200% of the FPL in both the with and without waiver scenarios was updated using data provided as of April 2024. Estimated enrollment growth was provided by Urban Institute and reflects the experience of the State since the COVID-19 Public Health Emergency (PHE) ended, and the emerging experience throughout 2023 and 2024. Enrollment estimates also reflect the impact of several state policy changes, including the State's ex parte system and mitigation strategy, and the impact of Section 1902(e)(14) waivers.

EP 200 – 250% of the FPL Enrollment

The estimated enrollment for consumers 200 – 250% of the FPL in the Essential Plan was updated by Urban Institute based on actuals provided as of April 2024. Ramp up of the programs has occurred faster than initially estimated in the December 18, 2023 waiver application. A total of 120,290 consumers between 200 – 250% of the FPL were enrolled in EP coverage in April 2024. This includes an estimated 78,000 consumers previously enrolled in QHPs on-Exchange between 200 – 250% of FPL who transitioned to EP coverage.

Through the rest of 2024, the estimated increase of consumers 200 – 250% of the FPL into the EP is due to the transition of individuals from Medicaid due to the PHE unwind, with limited estimated growth from the uninsured or from employer sponsored coverage given the high initial take-up rate of consumers enrolling in EP coverage in April 2024.

On-Exchange Enrollment

The estimated enrollment for consumers buying on-exchange was updated by Urban Institute as of April 2024. The overall enrollment of on-Exchange consumers was higher than estimated in the December 2023 waiver application. The difference is primarily driven by higher unsubsidized enrollment on-exchange after Open Enrollment 2024, including consumers 200 – 250% of the FPL who migrated to the EP. Enrollment growth and distribution was updated by Urban Institute to account for the remaining PHE unwind cohorts and monthly enrollment trend. New York requires pure community rating, and age and tobacco status are not factored into premiums on the individual market.

Off-Exchange Enrollment

The estimated enrollment for consumers buying off-exchange was updated by Urban Institute based on actuals as of February 2024. The overall enrollment of off-Exchange consumers was lower than estimated in the December 18, 2023 waiver application. Adjustments were made to estimated enrollment growth and distribution by Urban Institute to account for the remaining PHE unwind cohorts and monthly enrollment trend.

Administrative Funding

The administrative costs for the Essential Plan Expansion are added to the ***Approved Waiver*** and ***Amended With Waiver*** appendix tables for 2024 and beyond, consistent with the State's payment schedule submitted to CMS in March 2024.

SDOH/BH Grants

Additional funding was added to SDOH ***Approved Waiver*** and ***Amended With Waiver*** tables in the appendix based on current proposals for 2025 and beyond.

BHP Funding

The baseline without waiver BHP funding is based on the Per Member Per Month (PMPM) CMS paid New York for Q1 of 2024 in December 2023, updated for actual BHP enrollment in Q1 as of March 2024. The BHP PMPM was trended by 5.2% for each year 2024 – 2033. In alignment

with the methodology from the December 18, 2023 waiver application, this amount was adjusted in the ***Baseline Without Waiver***, ***Approved Waiver***, and ***Amended With Waiver*** scenarios to account for the change in Income Reconciliation Factor (IRF) for 2024.

Second Lowest Cost Silver Premiums (SLCSP)

The SLCSPs shown in *Appendix E* have been updated to reflect actual values for 2024. This was based on the 2024 SLCSPs for individual adults reflected in the State's system for the 2024 Open Enrollment Period. Estimated enrollment for Q1 of 2024 was used to calculate weighted average SLCSPs by Rating Area for 2024.

DACA Final Rule

Estimated enrollment was adjusted by Urban Institute to reflect the final federal rule published May 8, 2024 expanding eligibility for BHP and QHPs with PTCs to DACA recipients.

- Consistent with the December 18, 2023 submission, the ***Approved Waiver*** and ***Amended With Waiver*** tables include estimated enrollment of DACA recipients provided by Urban Institute between 0 – 250% of the FPL within the EP beginning in August 2024.
- As a result of the DACA Final Rule, starting in November 2024, the ***Baseline, Without Waiver*** tables include estimated enrollment of DACA recipients provided by Urban Institute 0 – 200% of the FPL within the BHP. As a result of the DACA Final Rule, starting December 2024, the ***Baseline, Without Waiver*** tables include estimated enrollment for on-Exchange DACA recipients provided by Urban Institute over 200% of the FPL with PTCs. The ***Approved Waiver*** and ***Amended With Waiver*** tables include estimated enrollment for on-Exchange DACA recipients provided by Urban Institute over 250% of the FPL with PTCs. Although a small number of on-Exchange DACA recipients may lose MEC coverage after October 2024 be eligible for QHPs with APTCs starting November 2024, the modeling is consistent with the expected timing for the majority of DACA recipients under the DACA Final Rule.

Reduction in Cost Sharing for Consumers up to 400% of FPL

The impact of expanding eligibility of the Silver CSR 87 Plan variants to consumers up to 350% of the FPL and Silver CSR 73 Plan variants to consumers up to 400% of the FPL beginning in 2025 uses estimates provided by Urban Institute for consumer savings, new enrollment, and adjusted plan selections with the CSR. The analysis assumes eligible consumers enrolled in Silver plans for 2024 would be automatically enrolled into the new variant for 2025 and eligible consumers enrolled in non-Silver plans would need to take action to enroll in the Silver CSR 87 and 73 Plan during Open Enrollment. Urban Institute estimated the levels of take-up in CSR plans for eligible consumers enrolled in non-Silver plans. The expected impact of the expiration of the enhanced subsidies under the Inflation Reduction Act (IRA) is consistent with the impact on the overall QHP enrollment starting in 2026.

Reduction in Cost Sharing for Diabetes Services

The estimates for the impact of covering out-of-pocket costs for diabetic care for on-Exchange consumers is based on utilization and cost of services data from the State's All-Payer Database for 2019 for claims with primary diagnosis codes "Diabetes" and "Diabetic Retinopathy." 2019 data was the most recent complete data available which avoided COVID-19 distortions. Costs and enrollment were trended to estimate PY 2025 total costs. No changes were assumed in diabetes prevalence for 2025 compared to 2019. Consumer out-of-pocket costs were estimated using the claims data and actuarial values of the State Standard Plans by metal level. Metal level enrollment distribution among diabetic consumers is assumed to remain the same as 2019.

The analysis estimates 2,073 off-exchange consumers with diabetes will migrate to on-exchange plans for 2025 with the CSR. This was estimated by assuming the same prevalence of diabetes for on-exchange and off-exchange consumers. The consumers migrating from off-exchange plans are assumed to be ineligible for premium tax credits.

The reduction in consumer out-of-pocket costs is estimated to increase utilization of preventive diabetic services, as well as result in a shift in enrollment from higher to lower metal plans. An increase in utilization was applied to account for the change. Bronze plans are expected to have the largest increase in utilization due to the largest reduction in cost-sharing experienced, while Platinum plans are expected to have the lowest increase in utilization.

The expiration of the enhanced subsidies under the Inflation Reduction Act (IRA) are expected to reduce overall QHP enrollment, but the analysis assumes consumers with diabetes are less likely to exit the QHP market. To conservatively estimate the cost of the CSR, the analysis assumes no decrease in QHP consumers with diabetes with the expiration of the enhanced subsidies under the IRA at the end of 2025.

The estimated cost of the reduction in cost sharing for diabetes assumes implementation of the *CSR for Consumers up 400% FPL* to avoid double-counting for consumers impacted by both benefits.

Reduction in Cost Sharing for Pregnancy and Postpartum Care

The estimates for the impact of covering out-of-pocket costs for pregnancy and postpartum care are based upon data provided by the State. The metal levels of on-exchange pregnant consumers were estimated using an enrollment extract from the state by age, gender, and metal level. The analysis applied the same prevalence of pregnancy to the off-Exchange population, to estimate a small number (50) migrating from off to on-Exchange with the reduction in cost sharing. Consumers migrating from off-Exchange are assumed to be ineligible for PTCs. The expected impact of the expiration of the enhanced subsidies under the Inflation Reduction Act (IRA) is consistent with the impact on the overall QHP enrollment starting in 2026.

Data summaries from the New York All Payer Database for 2023 were used to estimate the out-of-pocket costs for pregnancy and postpartum services in addition to the cost of services for a pregnant consumer under the Summary of Benefits and Coverage (SBC) for each metal level.

The estimated cost of the pregnancy and postpartum reduction in cost sharing assumes implementation of the *CSR for Consumers up to 400% FPL and Reduction in Cost Sharing for*

Diabetic Services to avoid double-counting for consumers impacted by all benefits. The overlapping impact of the *CSR for Individuals with incomes up to 400% FPL* was estimated by scaling the expected out-of-pocket consumer cost-sharing from the SBC examples based on the change in AV for consumers up to 400% FPL expected to enroll in their respective CSR plan.

2024 Results in the Appendix E Tables

Throughout the Appendix tables, the ***Approved Waiver*** Summary of Enrollment, Premium, and Cost Estimates (Appendix Table E3) display 2024 Approved With Waiver enrollment, premium, and APTC amounts as 12-month averages for consumers 200 – 250% of FPL spending the first three months of the year in the individual market and last nine months in the Essential Plan.

The aggregated premiums under the Essential Plan reflect the capitation rate paid by the State to insurers. The implementation of the CSRs on January 1, 2025 will not impact the estimates provided for 2024.

2024 ***Baseline, Without Waiver*** DACA estimates were modified to account for the final federal rule allowing DACA enrollment beginning November 1, 2024, for the Basic Health Plan and December 1, 2024 for QHPs with PTCs.

The following table depicts how the enrollment and premium estimates were calculated for the year 2024 accounting for the following:

- April 1, 2024, implementation date of the 1332 Waiver,
- August 1, 2024, implementation date for EP coverage of DACA recipients, and
- November 1, 2024 implementation date for expanded eligibility and PTCs for DACA recipients in BHP.
- December 1, 2024, implementation date for expanded eligibly of QHPs and PTCs for DACA recipients on-Exchange.

Please note, the aggregated premiums under the Essential Plan reflect the capitation rate paid by the State to insurers.

Approved Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024

	200-250% FPL	DACA Recipients	All Other FPL	200-250% FPL	DACA Recipients	All Other FPL	200-250% FPL	DACA Recipients	All Other FPL	200-250% FPL	DACA Recipients	All Other FPL
Approved Waiver - Scenario E	1/1/24-3/31/24			4/1/24-7/31/24			8/1/24-11/30/24			12/1/24-12/31/24		
Unsubsidized On/Off-Exchange												
Enrollment	0	132	120,877	0	132	128,084	0	0	130,236	0	0	130,236
Average Premium PMPM	$0	$741	$741	$0	$741	$741	$0	$741	$741	$0	$741	$741
Subsidized On-Exchange												
Enrollment	63,477	0	124,131	410	0	148,490	410	0	153,524	410	621	153,524
Average Premium PMPM	$713	$0	$702	$713	$0	$702	$713	$0	$702	$713	$0	$813
Average APTC PMPM	$406	$0	$425	$406	$0	$425	$406	$0	$425	$406	$0	$498
Total Individual Market												
Enrollment	63,477	132	245,007	410	132	276,575	410	0	283,759	410	621	283,759
Average Premium PMPM	$713	$741	$721	$713	$741	$720	$713	$0	$720	$713	$0	$780
Aggregate Premiums (millions)	$136	$0	$530	$1	$0	$797	$1	$0	$613	$0	$0	$221
Projected Federal Spend (millions)	$74	$0	$151	$1	$0	$241	$0	$0	$187	$0	$0	$73
Essential Plan												
Enrollment	0	0	1,252,738	121,860	0	1,245,002	123,196	14,196	1,258,621	123,108	14,196	1,257,717
Average Premium PMPM	$0	$0	$617	$718	$0	$617	$718	$587	$617	$718	$587	$617
Aggregate Premiums (millions)	$0	$0	$2,320	$350	$0	$3,075	$354	$33	$3,109	$88	$8	$777
Quality Incentive Pool Costs (millions)		$56			$75			$75			$19	
LTSS Coverage (millions)		$0			$0			$0			$0	
SDoH/BH Grant Program (millions)		$6			$8			$8			$2	
IRIP Payment (millions)		$0			$23			$23			$6	
Approved Waiver EP Admin Costs (millions)		$0			$37			$37			$9	
Total Program Costs (millions)		$2,383			$3,568			$3,639			$909	
Projected Federal Spend (millions)		$2,939			$0			$0			$0	

Note: $22M in State Funded BHP Administrative Costs from 1/1/2024 – 3/31/2024.

Actuarial Certification

Steven N. Wander is a Principal with Deloitte Consulting LLP. He is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He meets the Academy's qualification standards for rendering the actuarial opinions contained in this analysis.

The State of New York retained Deloitte Consulting to develop this actuarial and economic analysis, a component of the State of New York's 1332 Waiver application.

I certify that the estimates presented in this analysis:

- Address requirements and prohibitions of section 45 CFR 155.1308(f)(iv)(A)-(D)
- Are consistent with the CMS "Checklist for Section 1332 State Relief and Empowerment Waivers Applications" (updated July 2019)
- Have been developed in accordance with applicable Actuarial Standards of Practice (ASOP) requirements, specifically No. 23 (Data Quality), No. 41 (Actuarial Communication), and No. 56 (Modeling)

In this analysis, we relied on enrollment, premium, funding, loss ratio, and trend data provided to Deloitte as outlined in the Data Sources and Reliance section above. All data was reviewed for appropriateness, sufficiency, and a reasonable effort was made to identify data values that were questionable or relationships that were significantly inconsistent; however, we have not audited the data we received. If the underlying data or information provided is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

Estimates developed by Deloitte are based on an actuarial analysis of future costs and enrollment for PY 2024–2033. It may be expected that actual experience will vary from the values shown in this analysis.

This document is intended solely for the information and use of the State of New York in support of its 1332 Waiver Application and is not for the benefit of or to be relied upon by any other person or entity.

Steven N. Wander, FSA, MAAA
Principal, Deloitte Consulting LLP

6/28/2024
Date

Appendix E: Scenario E Waiver Amendment Detailed 10-Year Estimates (Current Law, Pregnancy Choice, DACA Recipients, Insurer Reimbursement, & Cost-Sharing Reductions)

The following provides updated estimates for the approved 1332 Waiver inclusive of ***Baseline Without Waiver*** and ***Approved Waiver*** tables for 2024 – 2033. The analysis includes updated tables from the December 18, 2023 1332 Waiver Application Appendix D based on actual enrollment experience through 2024, impact of the waiver implementation, and continued unwinding of the PHE. The tables also include the estimated impacts of the change in federal policy to modify the definition of lawfully present to expand eligibility of the Basic Health Program and PTCs to include DACA recipients.

The following also includes new ***Amended With Waiver*** tables to illustrate the impact of the following cost-sharing reductions proposals on the 1332 waiver guardrails:

1. Reduction in Cost-Sharing for Consumers up to 400% of the FPL.
2. Reduction in Cost-Sharing for Diabetes Services.
3. Reduction in Cost-Sharing for Pregnancy and Postpartum Care.

The Amended With Waiver, inclusive of the CSRs, is estimated to continue to meet the four guardrails for the five years of the waiver and 10-year analysis.

Table E1. Scenario E High-Level Guardrail Compliance of 1332 Waiver

The summary table below reflects the estimated impact of the existing waiver on the four guardrails and the impact of the proposed amended waiver.

- **Updated Estimated Impact of Approved Waiver:** This column reflects the estimated summary impact of the approved waiver on the four guardrails relative to the without waiver scenario. This column from the December 2023 Waiver application, has been updated based on data and assumptions as of April 2024 which are described in the data and methodology section.
- **Estimated Incremental Impact of CSRs:** This column identifies the impact of the CSRs on each of the guardrails relative to approved waiver estimate.
- **Estimated Impact of Amended With Waiver:** This column reflects the aggregated impact of the approved waiver and CSRs compared with the without waiver scenario.

Guardrail	Updated Estimated Impact of Approved Waiver Compared to Baseline Without Waiver	Estimated Incremental Impact of CSRs (Amended With Waiver Compared to Approved Waiver)	Estimated Impact of Amended With Waiver Compared to Baseline Without Waiver
Comprehensiveness	The Approved Waiver is projected to meet the comprehensiveness guardrail as consumers have access to more comprehensive coverage compared to the Baseline Without-Waiver Scenario. • Consumers with incomes between 200–250% of the FPL will receive more comprehensive coverage. • There are no expected impacts for other consumers in the individual market. • There are no expected impacts for other consumers in the Essential Plan.	There are no estimated changes.	The Amended With Waiver is projected to meet the comprehensiveness guardrail as consumers have access to more comprehensive coverage compared to the Baseline Without-Waiver Scenario. • Consumers with incomes between 200–250% of the FPL will receive more comprehensive coverage. • There are no expected impacts for other consumers in the individual market. • There are no expected impacts for other consumers in the Essential Plan
Affordability	The Approved Waiver is projected to meet the affordability guardrail as the affordability across the market is improved compared to the Baseline Without-Waiver Scenario. • Affordability for current Essential Plan consumers is not expected to change. • Affordability for consumers with incomes between 200–250% of the FPL is expected to improve under the Waiver for an aggregate savings of $2.3 billion over the 5 years.	There is an estimated improvement in affordability for an average of 117,687 consumers annually 2025 – 2028, resulting in a total of $307 million in consumer savings in 2025 and a total of $1.3 billion from 2025 – 2028. Consumers are estimated to experience a 20.1% increase in affordability in 2025 and an average annual increase in affordability of 20.4%.	The Amended With Waiver is projected to meet the affordability guardrail as the affordability across the market is improved compared to the Baseline Without-Waiver Scenario. • Affordability for current Essential Plan consumers is not expected to change. • Affordability for consumers with incomes between 200–250% of the FPL is expected to improve under the Waiver for an aggregate savings of $2.3 billion over the 5 years.

Guardrail	Updated Estimated Impact of Approved Waiver Compared to Baseline Without Waiver	Estimated Incremental Impact of CSRs (Amended With Waiver Compared to Approved Waiver)	Estimated Impact of Amended With Waiver Compared to Baseline Without Waiver
	○ This is an average annual savings of $6,091 under the Waiver ($3,540 in premiums and $2,551 in out-of-pocket spend), which is approximately 15% of income for consumers 200 – 250% of the FPL. • Affordability for subsidized On-Exchange consumers is not expected to change under the Waiver. • Affordability for subsidy-ineligible On-Exchange consumers and Off-Exchange consumers is also not expected to change under the Waiver, as premiums will be calculated at without-waiver levels as part of the insurer reimbursement program.		○ This is an average annual savings of $6,091 under the Waiver ($3,540 in premiums and $2,551 in out-of-pocket spend), which is approximately 15% of income for consumers 200 – 250% of the FPL. • Affordability of premiums for on- and off-Exchange consumers is not estimated to change under the Waiver due to the IRIP. • Affordability of cost-sharing for on-Exchange consumers is estimated to improve with the CSRs for an average of 117,687 consumers annually 2025 – 2028. The CSRs are estimated to result in a total of $1.3 billion savings from 2025 – 2028. ○ This is an average annual savings of $1,376 per member per year across all on-exchange consumers for 2025-2028.
Coverage	The Approved Waiver is projected to meet the coverage guardrail as more consumers are expected to enroll in coverage compared to the Baseline Without-Waiver Scenario. • Overall enrollment for the Essential Plan and individual market is expected to increase by a combined 2.4% for PY 2024, 3.7% for PY 2025, 3.9% for PY 2026, 3.9% for PY 2027, and 3.9% for PY 2028.	There is an estimated increased in enrollment in the individual market by 3,160 (0.2%) for PY 2025, 2,974 (0.2%) for PY 2026, 3,004 (0.2%) for PY 2027, and 3,034 (0.2%) for PY 2028.	The Amended With Waiver is projected to meet the coverage guardrail as more consumers are expected to enroll in coverage compared to the Baseline, Without-Waiver Scenario. • Overall enrollment for the Essential Plan and individual market is expected to increase by a combined 2.4% for PY 2024, 3.9% for PY 2025, 4.1% for PY 2026 – 2028.

Guardrail	Updated Estimated Impact of Approved Waiver Compared to Baseline Without Waiver	Estimated Incremental Impact of CSRs (Amended With Waiver Compared to Approved Waiver)	Estimated Impact of Amended With Waiver Compared to Baseline Without Waiver
	• Individuals who become pregnant may opt to remain in the Essential Plan, this is estimated to increase enrollment by 4,118 (average monthly enrollment over the 9 months of implementation) for 2024, 12,098 for 2025, 14,245 for 2026, 14,530 for 2027, and 14,820 for 2028. • The expansion of the Essential Plan to DACA recipients starting August 1, 2024 is estimated to increase enrollment by 3,678 for 2024, 1,788 for 2025, 2,025 for 2026, 1,804 for 2027 and 1,793 for 2028.		
Deficit Neutrality	The Approved Waiver is projected to meet the deficit neutrality guardrail and generate savings for the federal government. • The federal spend under the Waiver is estimated to decrease by $9.1 billion in PY 2024 (which reflects the impact of the April 1, 2023 implementation date) and $64.4 billion over the 5-year Waiver period, before pass-through funding. • The estimated pass-through to the State is estimated to be $9.1 billion in PY 2024 and $63.9 billion over the 5-years. • The net federal spend under the waiver is estimated to decrease by $30.4 million in PY 2024 and $471.1 million over the 5-year waiver period, after accounting for pass-through funding.	Compared to the Approved Waiver, the Amended With Waiver is estimated to increase spend in PTCs by $0 million in 2024, $24 million (3.2%) for 2025, $96 million (2.9%) 2024 – 2028, and $248 million (3.5%) 2024 – 2033 due to the CSR for consumers up to 400% of the FPL. This increase is assumed to be deducted from pass-through funding. The estimated costs of the CSRs to the State are $0 in 2024, $307 million (2.6% waiver program increase) in 2025, $1.3 billion (2.1%) 2024-2028, and $3.4 billion (2.4%) over the ten years 2024 – 2033. It is estimated the Amended Waiver will be fully funded by pass-through.	The Amended With Waiver is projected to meet the deficit neutrality guardrail and generate savings for the federal government. • The federal spend under the Waiver is estimated to decrease by $9.1 billion in PY 2024 and $64.3 billion over the 5-year waiver period, before pass-through funding. • The estimated pass-through to the State is estimated to be $9.1 billion in PY 2024 and $63.8 billion over the 5-years. • The net federal spend under the waiver is estimated to decrease by $30.4 million in PY 2024 and $471.1 million over the 5-year waiver period, after accounting for pass-through funding.

Table E2. Baseline Without-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

Basline Without Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	127,311	127,646	142,641	158,071	173,797	189,821	206,148	222,782	239,729	256,992	145,893	184,494
Average Premium PMPM	$741	$779	$818	$859	$902	$948	$996	$1,047	$1,101	$1,157	$827	$966
Subsidized On-Exchange												
Enrollment[1]	222,570	224,760	182,740	184,551	186,381	188,228	190,095	191,980	193,883	195,806	200,200	196,099
Average Premium PMPM	$706	$743	$778	$818	$861	$906	$953	$1,002	$1,054	$1,109	$777	$889
Average APTC PMPM	$430	$452	$477	$502	$528	$555	$584	$615	$647	$680	$475	$544
Total Individual Market												
Enrollment[1]	349,881	352,406	325,380	342,623	360,177	378,049	396,242	414,762	433,612	452,799	346,093	380,593
Average Premium PMPM	$719	$756	$795	$837	$881	$927	$975	$1,026	$1,080	$1,136	$798	$926
Aggregate Premiums (millions)	$3,018	$3,197	$3,105	$3,441	$3,807	$4,205	$4,637	$5,108	$5,619	$6,174	$16,568	$42,311
Projected Federal Spend (millions)	$1,096	$1,164	$999	$1,062	$1,128	$1,199	$1,273	$1,353	$1,437	$1,527	$5,450	$12,239
Essential Plan												
Enrollment[1]	1,250,807	1,290,634	1,306,011	1,327,110	1,348,632	1,370,058	1,391,828	1,413,947	1,436,422	1,459,257	1,304,639	1,359,470
Average Premium PMPM	$616	$632	$654	$677	$701	$726	$751	$778	$806	$835	$657	$721
Aggregate Premiums (millions)	$9,267	$9,787	$10,239	$10,771	$11,332	$11,920	$12,541	$13,196	$13,888	$14,618	$51,396	$117,558
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
LTSS Coverage (millions)	$0	$0	$135	$137	$139	$141	$143	$146	$148	$150	$411	$1,140
SDoH/BH Grant Program (millions)	$25	$71	$71	$71	$71	$71	$71	$71	$71	$71	$308	$661
Total Program Costs (millions)	$9,517	$10,083	$10,670	$11,203	$11,766	$12,357	$12,980	$13,638	$14,331	$15,064	$53,239	$121,609
Projected Federal Spend (millions)	$11,757	$12,445	$12,604	$13,476	$14,409	$15,402	$16,463	$17,597	$18,810	$20,105	$64,691	$153,068
Other Federal Spend/Revenue												
Pregnancy Medicaid Spend[2] (millions)	$33	$97	$110	$118	$126	$135	$145	$155	$166	$180	$484	$1,265
DACA Medicaid Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ESRP Revenue (millions)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($3)	($13)	($27)
Combined Totals												
Enrollment[1]	1,600,688	1,643,040	1,631,391	1,669,733	1,708,809	1,748,107	1,788,070	1,828,709	1,870,034	1,912,056	1,650,732	1,740,064
Projected Federal Spend (millions)	$12,883	$13,704	$13,711	$14,653	$15,661	$16,733	$17,879	$19,102	$20,410	$21,809	$70,612	$166,546

[1] 5- and 10-year totals are straight averages.

[2] Pregnancy Medicaid Spend accounts for individuals 200-250% FPL who would receive APTCs on the individual market under current law or are within the State's Aliessa population.

Table E3. Approved Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

Approved Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849	145,774	184,364
Average Premium PMPM	$741	$779	$818	$859	$902	$948	$996	$1,047	$1,101	$1,157	$827	$966
Subsidized On-Exchange												
Enrollment[1]	160,726	146,383	103,790	104,819	105,858	106,907	107,967	109,037	110,119	111,210	124,315	116,682
Average Premium PMPM	$703	$739	$769	$809	$851	$896	$942	$991	$1,043	$1,097	$766	$873
Average APTC PMPM	$423	$447	$471	$496	$521	$549	$577	$607	$639	$672	$466	$533
Total Individual Market												
Enrollment[1]	287,982	273,896	246,297	262,755	279,518	296,590	313,975	331,679	349,706	368,060	270,090	301,046
Average Premium PMPM	$720	$758	$797	$839	$883	$929	$978	$1,029	$1,082	$1,139	$799	$930
Aggregate Premiums (millions)	$2,079	$2,490	$2,357	$2,646	$2,962	$3,307	$3,683	$4,094	$4,542	$5,030	$12,533	$33,189
Projected Federal Spend (millions)	$783	$750	$561	$596	$633	$672	$714	$759	$806	$856	$3,322	$7,130
Essential Plan												
Enrollment[1]	1,350,395	1,429,674	1,448,713	1,472,119	1,495,985	1,519,749	1,543,863	1,568,379	1,593,291	1,618,631	1,439,377	1,504,080
Average Premium PMPM	$624	$649	$672	$696	$720	$746	$773	$800	$829	$859	$674	$741
Aggregate Premiums (millions)	$10,115	$11,143	$11,687	$12,293	$12,934	$13,606	$14,314	$15,062	$15,851	$16,684	$58,171	$133,688
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
LTSS Coverage (millions)	$0	$0	$137	$144	$152	$160	$168	$177	$186	$196	$434	$1,321
SDoH/BH Grant Program (millions)	$25	$71	$71	$71	$71	$71	$71	$71	$71	$71	$308	$661
IRIP Payment (millions)	$51	$68	$64	$72	$81	$90	$100	$111	$124	$137	$336	$898
Approved Waiver EP Admin Costs (millions)	$84	$108	$107	$104	$104	$105	$107	$109	$111	$112	$506	$1,050
Total Program Costs (millions)	$10,500	$11,614	$12,291	$12,909	$13,566	$14,257	$14,985	$15,755	$16,567	$17,425	$60,880	$139,870
Projected Federal Spend (millions)	$2,939	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,939	$2,939
Other Federal Spend/Revenue												
Pregnancy Medicaid Spend[2] (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DACA Medicaid Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ESRP Revenue (millions)	($1)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1)	($1)
Combined Totals												
Enrollment[1]	1,638,376	1,703,570	1,695,010	1,734,874	1,775,503	1,816,339	1,857,839	1,900,058	1,942,997	1,986,690	1,709,467	1,805,126
Projected Federal Spend (millions)	$3,722	$750	$561	$596	$633	$672	$714	$759	$806	$856	$6,261	$10,068

[1] 5- and 10-year totals are straight averages. 2024 enrollment, premium, and APTC amounts reflect the average monthly enrollment for the 12-month period.

[2] Pregnancy Medicaid Spend accounts for individuals 200-250% FPL who would receive APTCs on the individual market under current law or are within the State's Aliessa population.

Note: The program investments for Quality Incentive Pool and SDoH/BH Grant Program for 2024 are displayed as total costs over all 12 months. The first 3 months of these amounts would be incurred under the BHP and the last 9 months would be incurred under the 1332 Waiver.

Table E3. Approved Waiver PY 2024 Break-Out

	200-250% FPL	DACA Recipients	All Other FPL	200-250% FPL	DACA Recipients	All Other FPL	200-250% FPL	DACA Recipients	All Other FPL	200-250% FPL	DACA Recipients	All Other FPL
Approved Waiver - Scenario E	1/1/24-3/31/24			4/1/24-7/31/24			8/1/24-11/30/24			12/1/24-12/31/24		
Unsubsidized On/Off-Exchange												
Enrollment	0	132	120,877	0	132	128,084	0	0	130,236	0	0	130,236
Average Premium PMPM	$0	$741	$741	$0	$741	$741	$0	$741	$741	$0	$741	$741
Subsidized On-Exchange												
Enrollment	63,477	0	124,131	410	0	148,490	410	0	153,524	410	621	153,524
Average Premium PMPM	$713	$0	$702	$713	$0	$702	$713	$0	$702	$713	$0	$813
Average APTC PMPM	$406	$0	$425	$406	$0	$425	$406	$0	$425	$406	$0	$498
Total Individual Market												
Enrollment	63,477	132	245,007	410	132	276,575	410	0	283,759	410	621	283,759
Average Premium PMPM	$713	$741	$721	$713	$741	$720	$713	$0	$720	$713	$0	$780
Aggregate Premiums (millions)	$136	$0	$530	$1	$0	$797	$1	$0	$613	$0	$0	$221
Projected Federal Spend (millions)	$74	$0	$151	$1	$0	$241	$0	$0	$187	$0	$0	$73
Essential Plan												
Enrollment	0	0	1,252,738	121,860	0	1,245,002	123,196	14,196	1,258,621	123,108	14,196	1,257,717
Average Premium PMPM	$0	$0	$617	$718	$0	$617	$718	$587	$617	$718	$587	$617
Aggregate Premiums (millions)	$0	$0	$2,320	$350	$0	$3,075	$354	$33	$3,109	$88	$8	$777
Quality Incentive Pool Costs (millions)		$56			$75			$75			$19	
LTSS Coverage (millions)		$0			$0			$0			$0	
SDoH/BH Grant Program (millions)		$6			$8			$8			$2	
IRIP Payment (millions)		$0			$23			$23			$6	
Approved Waiver EP Admin Costs (millions)		$0			$37			$37			$9	
Total Program Costs (millions)		$2,383			$3,568			$3,639			$909	
Projected Federal Spend (millions)		$2,939			$0			$0			$0	

Table E4. Amended With-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

Amended Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849	145,774	184,364
Average Premium PMPM	$741	$779	$818	$859	$902	$948	$996	$1,047	$1,101	$1,157	$827	$966
Subsidized On-Exchange												
Enrollment[1]	160,726	149,543	106,765	107,823	108,891	109,971	111,061	112,162	113,274	114,397	126,750	119,461
Average Premium PMPM	$702	$778	$827	$870	$915	$963	$1,013	$1,065	$1,121	$1,179	$806	$930
Average APTC PMPM	$425	$452	$476	$501	$527	$555	$583	$614	$646	$679	$470	$539
Total Individual Market												
Enrollment[1]	287,982	277,056	249,272	265,759	282,552	299,654	317,070	334,804	352,861	371,247	272,524	303,826
Average Premium PMPM	$719	$778	$822	$863	$907	$953	$1,002	$1,053	$1,107	$1,164	$817	$952
Aggregate Premiums (millions)	$2,486	$2,588	$2,458	$2,753	$3,076	$3,428	$3,812	$4,231	$4,687	$5,184	$13,360	$34,702
Projected Federal Spend (millions)	$783	$774	$583	$619	$658	$699	$743	$789	$838	$891	$3,418	$7,377
Essential Plan Expansion Program Costs												
Enrollment[1]	1,350,395	1,429,674	1,448,713	1,472,119	1,495,985	1,519,749	1,543,863	1,568,379	1,593,291	1,618,631	1,439,377	1,504,080
Average Premium PMPM	$624	$649	$672	$696	$720	$746	$773	$800	$829	$859	$674	$741
Aggregate Premiums (millions)	$10,115	$11,143	$11,687	$12,293	$12,934	$13,606	$14,314	$15,062	$15,851	$16,684	$58,171	$133,688
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
LTSS Coverage (millions)	$0	$0	$137	$144	$152	$160	$168	$177	$186	$196	$434	$1,321
SDoH/BH Grant Program (millions)	$25	$71	$71	$71	$71	$71	$71	$71	$71	$71	$308	$661
IRIP Payment (millions)	$51	$71	$67	$75	$84	$94	$104	$115	$128	$141	$348	$931
Approved Waiver EP Admin Costs (millions)	$84	$108	$107	$104	$104	$105	$107	$109	$111	$112	$506	$1,050
CSR 87 250-350% FPL (millions)	$0	$263	$260	$277	$294	$312	$332	$352	$374	$398	$1,094	$2,862
CSR 73 350-400% FPL (millions)	$0	$14	$14	$15	$16	$17	$18	$19	$20	$22	$59	$155
Diabetes (millions)	$0	$25	$27	$28	$30	$32	$33	$35	$37	$39	$110	$286
Maternity Care (millions)	$0	$4	$4	$5	$5	$6	$6	$7	$8	$8	$18	$53
Total Program Costs (millions)	$10,500	$11,923	$12,599	$13,237	$13,914	$14,627	$15,379	$16,173	$17,011	$17,897	$62,174	$143,259
Projected Federal Spend (millions)	$2,939	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,939	$2,939
Other Federal Spend/Revenue												
Pregnancy Medicaid Spend[2] (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DACA Medicaid Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ESRP Revenue (millions)	($1)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1)	($1)
Combined Totals												
Enrollment[1]	1,638,376	1,706,730	1,697,985	1,737,878	1,778,537	1,819,403	1,860,933	1,903,183	1,946,152	1,989,877	1,711,901	1,807,905
Projected Federal Spend (millions)	$3,722	$774	$583	$619	$658	$699	$743	$789	$838	$891	$6,356	$10,316

[1] 5- and 10-year totals are straight averages. 2024 enrollment, premium, and APTC amounts reflect the average monthly enrollment for the 12-month period.

[2] Pregnancy Medicaid Spend accounts for individuals 200-250% FPL who would receive APTCs on the individual market under current law or are within the State's Aliessa population.

Note: The program investments for Quality Incentive Pool and SDoH/BH Grant Program for 2024 are displayed as total costs over all 12 months. The first 3 months of these amounts would be incurred under the BHP and the last 9 months would be incurred under the 1332 Waiver.

Table E5. Baseline Without Waiver and Approved Waiver Annual Funding Estimates, PY 2024-2033

Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Individual Market										
Without Waiver PTCs	$1,096,127,678	$1,164,471,071	$999,461,412	$1,061,856,027	$1,128,146,783	$1,198,577,021	$1,273,405,279	$1,352,906,247	$1,437,371,775	$1,527,111,943
With Waiver PTCs	$783,022,373	$750,288,326	$560,522,563	$595,513,444	$632,689,199	$672,186,284	$714,149,677	$758,733,413	$806,101,150	$856,426,767
Difference	$313,105,305	$414,182,745	$438,938,849	$466,342,583	$495,457,584	$526,390,737	$559,255,602	$594,172,834	$631,270,625	$670,685,176
Essential Plan										
Without Waiver BHP Funding	$11,756,762,973	$12,444,846,543	$12,604,114,297	$13,476,116,145	$14,409,279,829	$15,401,969,008	$16,463,046,880	$17,597,224,901	$18,809,539,114	$20,105,372,505
With Waiver BHP Funding	$2,939,190,743	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference	$8,817,572,230	$12,444,846,543	$12,604,114,297	$13,476,116,145	$14,409,279,829	$15,401,969,008	$16,463,046,880	$17,597,224,901	$18,809,539,114	$20,105,372,505
Other Federal Spend/Savings										
Pregnancy Medicaid Total Enrollment	4,118	12,098	14,245	14,530	14,820	15,117	15,419	15,728	16,042	16,363
Pregnancy Medicaid Reduction	$33,004,003	$97,109,932	$110,245,599	$117,849,718	$125,984,280	$135,185,437	$144,883,812	$154,889,254	$165,799,409	$179,818,071
DACA Medicaid Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employer Penalty Loss	($2,592,000)	($2,598,818)	($2,615,230)	($2,641,383)	($2,667,797)	($2,694,475)	($2,721,419)	($2,748,633)	($2,776,120)	($2,803,881)
Combined Totals										
Without Waiver Federal Spend	$12,883,302,654	$13,703,828,727	$13,711,206,078	$14,653,180,507	$15,660,743,096	$16,733,036,992	$17,878,614,551	$19,102,271,769	$20,409,934,178	$21,809,498,638
With Waiver Federal Spend	$3,722,213,116	$750,288,326	$560,522,563	$595,513,444	$632,689,199	$672,186,284	$714,149,677	$758,733,413	$806,101,150	$856,426,767
Total Federal Savings	**$9,161,089,538**	**$12,953,540,402**	**$13,150,683,515**	**$14,057,667,063**	**$15,028,053,897**	**$16,060,850,707**	**$17,164,464,874**	**$18,343,538,355**	**$19,603,833,028**	**$20,953,071,871**
Requested Pass-through	$9,130,677,535	$12,859,029,288	$13,043,053,146	$13,942,458,728	$14,904,737,413	$15,928,359,745	$17,022,302,481	$18,191,397,735	$19,440,809,740	$20,776,057,681
Net Federal Savings	**$30,412,003**	**$94,511,113**	**$107,630,369**	**$115,208,335**	**$123,316,484**	**$132,490,963**	**$142,162,392**	**$152,140,620**	**$163,023,289**	**$177,014,190**

Combined Totals	5-Year Total	10-Year Total
Without Waiver Federal Spend	$70,612,261,063	$166,545,617,190
With Waiver Federal Spend	$6,261,226,648	$10,068,823,939
Total Federal Savings	**$64,351,034,414**	**$156,476,793,250**
Requested Pass-through	$63,879,956,111	$155,238,883,493
Net Federal Savings	**$471,078,304**	**$1,237,909,758**

Note: For 2024 due to the April 1 implementation date, there will still be 1 quarter of BHP funding compared to the other years of the Waiver.

Table E6. Baseline Without Waiver and Amended With-Waiver Annual Funding Estimates, PY 2024-2033

Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Individual Market										
Without Waiver PTCs	$1,096,127,678	$1,164,471,071	$999,461,412	$1,061,856,027	$1,128,146,783	$1,198,577,021	$1,273,405,279	$1,352,906,247	$1,437,371,775	$1,527,111,943
With Waiver & CSRs PTCs	$783,022,373	$774,288,326	$582,931,057	$619,320,667	$657,982,484	$699,058,416	$742,699,236	$789,065,135	$838,326,313	$890,663,598
Difference	$313,105,305	$390,182,745	$416,530,356	$442,535,359	$470,164,299	$499,518,605	$530,706,043	$563,841,112	$599,045,462	$636,448,344
Essential Plan										
Without Waiver BHP Funding	$11,756,762,973	$12,444,846,543	$12,604,114,297	$13,476,116,145	$14,409,279,829	$15,401,969,008	$16,463,046,880	$17,597,224,901	$18,809,539,114	$20,105,372,505
With Waiver & CSRs BHP Funding	$2,939,190,743	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference	$8,817,572,230	$12,444,846,543	$12,604,114,297	$13,476,116,145	$14,409,279,829	$15,401,969,008	$16,463,046,880	$17,597,224,901	$18,809,539,114	$20,105,372,505
Other Federal Spend/Savings										
Pregnancy Medicaid Total Enrollment	4,118	12,098	14,245	14,530	14,820	15,117	15,419	15,728	16,042	16,363
Pregnancy Medicaid Reduction	$33,004,003	$97,109,932	$110,245,599	$117,849,718	$125,984,280	$135,185,437	$144,883,812	$154,889,254	$165,799,409	$179,818,071
DACA Medicaid Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employer Penalty Loss	($2,592,000)	($2,598,818)	($2,615,230)	($2,641,383)	($2,667,797)	($2,694,475)	($2,721,419)	($2,748,633)	($2,776,120)	($2,803,881)
Combined Totals										
Without Waiver Federal Spend	$12,883,302,654	$13,703,828,727	$13,711,206,078	$14,653,180,507	$15,660,743,096	$16,733,036,992	$17,878,614,551	$19,102,271,769	$20,409,934,178	$21,809,498,638
With Waiver & CSRs Federal Spend	$3,722,213,116	$774,288,326	$582,931,057	$619,320,667	$657,982,484	$699,058,416	$742,699,236	$789,065,135	$838,326,313	$890,663,598
Total Federal Savings	**$9,161,089,538**	**$12,929,540,402**	**$13,128,275,021**	**$14,033,859,839**	**$15,002,760,612**	**$16,033,978,576**	**$17,135,915,315**	**$18,313,206,633**	**$19,571,607,865**	**$20,918,835,040**
Requested Pass-through	$9,130,677,535	$12,835,029,288	$13,020,644,653	$13,918,651,505	$14,879,444,128	$15,901,487,613	$16,993,752,923	$18,161,066,013	$19,408,584,576	$20,741,820,849
Net Federal Savings	**$30,412,003**	**$94,511,113**	**$107,630,369**	**$115,208,335**	**$123,316,484**	**$132,490,963**	**$142,162,392**	**$152,140,620**	**$163,023,289**	**$177,014,190**

Combined Totals	5-Year Total	10-Year Total
Without Waiver Federal Spend	$70,612,261,063	$166,545,617,190
With Waiver & CSRs Federal Spend	$6,356,735,650	$10,316,548,348
Total Federal Savings	**$64,255,525,413**	**$156,229,068,842**
Requested Pass-through	$63,784,447,109	$154,991,159,085
Net Federal Savings	**$471,078,304**	**$1,237,909,758**

Note: For 2024 due to the April 1 implementation date, there will still be 1 quarter of BHP funding compared to the other years of the Waiver.

Table E7. Difference Table Annual Funding Estimates, PY 2024-2033: Baseline Without Waiver and Approved Waiver Compared with Baseline, Without Waiver and Amended With Waiver

Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Individual Market										
Without Waiver PTCs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
With Waiver & CSRs PTCs	$0	$24,000,000	$22,408,494	$23,807,223	$25,293,285	$26,872,132	$28,549,559	$30,331,722	$32,225,163	$34,236,832
Difference	$0	($24,000,000)	($22,408,494)	($23,807,223)	($25,293,285)	($26,872,132)	($28,549,559)	($30,331,722)	($32,225,163)	($34,236,832)
Essential Plan										
Without Waiver BHP Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
With Waiver & CSRs BHP Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Federal Spend/Savings										
Pregnancy Medicaid Total Enrollment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Pregnancy Medicaid Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
DACA Medicaid Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employer Penalty Loss	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Combined Totals										
Without Waiver Federal Spend	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
With Waiver & CSRs Federal Spend	$0	$24,000,000	$22,408,494	$23,807,223	$25,293,285	$26,872,132	$28,549,559	$30,331,722	$32,225,163	$34,236,832
Total Federal Savings	**$0**	**($24,000,000)**	**($22,408,494)**	**($23,807,223)**	**($25,293,285)**	**($26,872,132)**	**($28,549,559)**	**($30,331,722)**	**($32,225,163)**	**($34,236,832)**
Requested Pass-through	$0	($24,000,000)	($22,408,494)	($23,807,223)	($25,293,285)	($26,872,132)	($28,549,559)	($30,331,722)	($32,225,163)	($34,236,832)
Net Federal Savings	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Combined Totals	5-Year Total	10-Year Total
Without Waiver Federal Spend	$0	$0
With Waiver & CSRs Federal Spend	$95,509,001	$247,724,408
Total Federal Savings	**($95,509,001)**	**($247,724,408)**
Requested Pass-through	($95,509,001)	($247,724,408)
Net Federal Savings	**$0**	**($0)**

Table E8. SLCSP Premium Baseline Without Waiver, Approved Waiver, and Amended With Waiver by Rating Area, PY 2024 – 2033

Basline Witout Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$600	$631	$664	$698	$734	$773	$813	$855	$900	$946
Rating Area 2	$512	$539	$567	$596	$627	$660	$694	$731	$769	$808
Rating Area 3	$744	$782	$823	$866	$911	$958	$1,008	$1,061	$1,116	$1,174
Rating Area 4	$808	$850	$894	$941	$990	$1,041	$1,095	$1,152	$1,212	$1,275
Rating Area 5	$598	$629	$662	$696	$732	$770	$810	$853	$897	$944
Rating Area 6	$617	$649	$682	$718	$755	$794	$836	$879	$925	$973
Rating Area 7	$612	$644	$677	$712	$749	$788	$829	$872	$918	$966
Rating Area 8	$775	$815	$857	$902	$949	$998	$1,050	$1,105	$1,162	$1,222
Approved Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$600	$631	$664	$698	$734	$773	$813	$855	$900	$946
Rating Area 2	$512	$539	$567	$596	$627	$660	$694	$731	$769	$808
Rating Area 3	$744	$782	$823	$866	$911	$958	$1,008	$1,061	$1,116	$1,174
Rating Area 4	$808	$850	$894	$941	$990	$1,041	$1,095	$1,152	$1,212	$1,275
Rating Area 5	$598	$629	$662	$696	$732	$770	$810	$853	$897	$944
Rating Area 6	$617	$649	$682	$718	$755	$794	$836	$879	$925	$973
Rating Area 7	$612	$644	$677	$712	$749	$788	$829	$872	$918	$966
Rating Area 8	$775	$815	$857	$902	$949	$998	$1,050	$1,105	$1,162	$1,222
Amended Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$600	$631	$664	$698	$734	$773	$813	$855	$900	$946
Rating Area 2	$512	$539	$567	$596	$627	$660	$694	$731	$769	$808
Rating Area 3	$744	$782	$823	$866	$911	$958	$1,008	$1,061	$1,116	$1,174
Rating Area 4	$808	$850	$894	$941	$990	$1,041	$1,095	$1,152	$1,212	$1,275
Rating Area 5	$598	$629	$662	$696	$732	$770	$810	$853	$897	$944
Rating Area 6	$617	$649	$682	$718	$755	$794	$836	$879	$925	$973
Rating Area 7	$612	$644	$677	$712	$749	$788	$829	$872	$918	$966
Rating Area 8	$775	$815	$857	$902	$949	$998	$1,050	$1,105	$1,162	$1,222

Table E9. Baseline Without Waiver Average Annual Enrollment by Metal Level, PY 2024 – 2033

Basline Without Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,598,452**	**1,629,181**	**1,617,093**	**1,655,434**	**1,694,510**	**1,733,808**	**1,773,771**	**1,814,410**	**1,855,735**	**1,897,757**
Unsubsidized On/Off-Exchange Enrollment	127,311	127,646	142,641	158,071	173,797	189,821	206,148	222,782	239,729	256,992
Catastrophic	872	875	880	889	898	907	916	925	934	944
Bronze	57,630	57,782	65,384	73,188	81,142	89,247	97,507	105,923	114,498	123,233
Silver	47,142	47,266	52,140	57,151	62,258	67,460	72,761	78,161	83,662	89,265
Gold	12,946	12,980	14,689	16,454	18,253	20,087	21,955	23,858	25,798	27,773
Platinum	8,721	8,744	9,548	10,389	11,246	12,119	13,009	13,915	14,838	15,778
Subsidized On-Exchange Enrollment	222,570	224,760	182,740	184,551	186,381	188,228	190,095	191,980	193,883	195,806
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	108,402	109,468	87,972	88,844	89,725	90,614	91,512	92,420	93,336	94,262
Silver	89,338	90,217	76,890	77,653	78,423	79,201	79,986	80,780	81,581	82,390
Gold	17,438	17,610	12,688	12,813	12,940	13,068	13,198	13,329	13,461	13,594
Platinum	7,392	7,465	5,190	5,241	5,293	5,345	5,398	5,452	5,506	5,560
Essential Plan Enrollment	**1,250,807**	**1,290,634**	**1,306,011**	**1,327,110**	**1,348,632**	**1,370,058**	**1,391,828**	**1,413,947**	**1,436,422**	**1,459,257**
EP1	614,074	627,946	635,293	645,670	656,254	666,792	677,499	688,378	699,431	710,662
EP2	171,947	175,831	177,888	180,794	183,758	186,708	189,706	192,752	195,848	198,992
EP3	78,400	80,171	81,109	82,434	83,785	85,131	86,498	87,887	89,298	90,732
EP4	384,149	392,827	397,422	403,914	410,536	417,128	423,826	430,631	437,546	444,572
DACA Recipients[1]	2,236	13,859	14,299	14,299	14,299	14,299	14,299	14,299	14,299	14,299

[1] The DACA Recipient EP enrollment amounts are displayed as 12-month averages for 2024. Under the Baseline Without Waiver Scenario due to the DACA final rule, DACA recipients would be eligible for EP coverage beginning 11/1/2024.

Table E10. Approved Waiver Average Annual Enrollment by Metal Level, PY 2024 – 2033

Approved Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,638,376**	**1,703,570**	**1,695,010**	**1,734,874**	**1,775,503**	**1,816,339**	**1,857,839**	**1,900,058**	**1,942,997**	**1,986,690**
Unsubsidized On/Off-Exchange Enrollment	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849
Catastrophic	871	872	877	886	895	904	913	922	931	940
Bronze	57,610	57,732	65,334	73,138	81,091	89,196	97,456	105,871	114,445	123,180
Silver	47,126	47,227	52,100	57,111	62,217	67,420	72,720	78,119	83,620	89,222
Gold	12,937	12,959	14,668	16,433	18,232	20,065	21,933	23,836	25,775	27,751
Platinum	8,712	8,723	9,528	10,369	11,225	12,098	12,988	13,893	14,816	15,756
Subsidized On-Exchange Enrollment	160,726	146,383	103,790	104,819	105,858	106,907	107,967	109,037	110,119	111,210
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	87,024	79,201	57,478	58,048	58,624	59,206	59,793	60,387	60,986	61,591
Silver	53,147	48,478	34,815	35,159	35,507	35,858	36,213	36,572	36,934	37,299
Gold	14,417	13,118	8,188	8,269	8,351	8,434	8,517	8,602	8,687	8,773
Platinum	6,138	5,585	3,310	3,343	3,376	3,410	3,444	3,478	3,512	3,547
Essential Plan Enrollment	**1,350,395**	**1,429,674**	**1,448,713**	**1,472,119**	**1,495,985**	**1,519,749**	**1,543,863**	**1,568,379**	**1,593,291**	**1,618,631**
EP1	616,296	635,932	644,827	655,395	666,174	676,910	687,819	698,904	710,168	721,614
EP2	172,569	178,067	180,558	183,517	186,535	189,541	192,596	195,700	198,854	202,059
EP3	78,590	80,365	81,307	82,636	83,991	85,341	86,712	88,105	89,521	90,959
EP4	385,081	393,777	398,392	404,903	411,544	418,156	424,875	431,701	438,638	445,685
DACA Recipients[1]	5,915	15,647	16,138	16,091	16,036	15,977	15,886	15,805	15,725	15,670
200%-250% FPL Population	91,944	125,886	127,492	129,578	131,705	133,823	135,976	138,163	140,385	142,644

[1] The DACA Recipient EP enrollment amounts are displayed as 12-month averages for 2024. EP coverage for DACA recipients will begin 8/1/2024 during the first year of the waiver.

Note: There is a decrease from the Baseline Without Waiver scenario (~0.1% in total) for the off-exchange population. This is due to DACA recipients who previously enrolled in off-exchange full pay non-group plans who transition to EP.

Table E11. Amended With-Waiver Average Annual Enrollment by Metal Level, PY 2024 – 2033

Amended Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,638,376**	**1,706,730**	**1,697,985**	**1,737,878**	**1,778,537**	**1,819,403**	**1,860,933**	**1,903,183**	**1,946,152**	**1,989,877**
Unsubsidized On/Off-Exchange Enrollment	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849
Catastrophic	871	872	877	886	895	904	913	922	931	940
Bronze	57,610	57,732	65,334	73,138	81,091	89,196	97,456	105,871	114,445	123,180
Silver	47,126	47,227	52,100	57,111	62,217	67,420	72,720	78,119	83,620	89,222
Gold	12,937	12,959	14,668	16,433	18,232	20,065	21,933	23,836	25,775	27,751
Platinum	8,712	8,723	9,528	10,369	11,225	12,098	12,988	13,893	14,816	15,756
Subsidized On-Exchange Enrollment	160,726	149,543	106,765	107,823	108,891	109,971	111,061	112,162	113,274	114,397
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	87,024	25,838	3,677	3,710	3,742	3,775	3,808	3,841	3,875	3,909
Silver	53,147	115,429	102,106	103,123	104,151	105,188	106,236	107,295	108,364	109,444
Gold	14,417	5,676	682	688	694	701	707	713	719	726
Platinum	6,138	2,600	299	302	304	307	310	313	316	318
Essential Plan Enrollment	**1,350,395**	**1,429,674**	**1,448,713**	**1,472,119**	**1,495,985**	**1,519,749**	**1,543,863**	**1,568,379**	**1,593,291**	**1,618,631**
EP1	616,296	635,932	644,827	655,395	666,174	676,910	687,819	698,904	710,168	721,614
EP2	172,569	178,067	180,558	183,517	186,535	189,541	192,596	195,700	198,854	202,059
EP3	78,590	80,365	81,307	82,636	83,991	85,341	86,712	88,105	89,521	90,959
EP4	385,081	393,777	398,392	404,903	411,544	418,156	424,875	431,701	438,638	445,685
DACA Recipients[1]	5,915	15,647	16,138	16,091	16,036	15,977	15,886	15,805	15,725	15,670
200%-250% FPL Population	91,944	125,886	127,492	129,578	131,705	133,823	135,976	138,163	140,385	142,644

[1] The DACA Recipient EP enrollment amounts are displayed as 12-month averages for 2024. EP coverage for DACA recipients will begin 8/1/2024 during the first year of the waiver.

Note: There is a decrease from the Baseline Without Waiver scenario (~0.1% in total) for the off-exchange population. This is due to DACA recipients who previously enrolled in off-exchange full pay non-group plans transitioning to EP.

Note: There is an increase from the Approved Waiver scenario (~2.9% in total) for the on-exchange subsidized population. This is due to new members entering the market from uninsured or employer sponsored insurance to enroll in the CSR 73% AV and CSR 87% AV plans.

Table E12. Baseline Without Waiver Average Annual Enrollment by FPL, PY 2024 – 2033

Basline, Without Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,600,688**	**1,643,040**	**1,631,391**	**1,669,733**	**1,708,809**	**1,748,107**	**1,788,070**	**1,828,709**	**1,870,034**	**1,912,056**
Unsubsidized On/Off-Exchange Enrollment	127,311	127,646	142,641	158,071	173,797	189,821	206,148	222,782	239,729	256,992
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	9,627	19,284	29,132	39,176	49,418	59,860	70,507	81,361
501% - 600%	0	0	4,562	9,051	13,631	18,300	23,062	27,918	32,868	37,914
Over 600%	26,263	26,333	26,499	26,764	27,031	27,302	27,575	27,851	28,129	28,410
Do Not Report	101,047	101,313	101,953	102,972	104,002	105,042	106,093	107,154	108,225	109,307
Subsidized On-Exchange Enrollment	222,570	224,760	182,740	184,551	186,381	188,228	190,095	191,980	193,883	195,806
Below 139%	889	891	837	846	854	863	871	880	889	898
139% - 150%	248	249	234	236	239	241	244	246	249	251
151% - 200%	2,043	2,048	1,925	1,944	1,964	1,983	2,003	2,023	2,043	2,064
201% - 250%	78,021	78,788	79,363	80,150	80,945	81,748	82,558	83,377	84,204	85,039
251% - 300%	44,209	44,740	42,131	42,548	42,968	43,393	43,822	44,255	44,693	45,135
301% - 350%	38,328	38,607	36,318	36,680	37,044	37,413	37,784	38,160	38,540	38,923
351% - 400%	23,058	23,296	21,930	22,147	22,367	22,588	22,812	23,038	23,266	23,497
401% - 500%	24,422	24,619	0	0	0	0	0	0	0	0
501% - 600%	11,352	11,522	0	0	0	0	0	0	0	0
Over 600%	0	0	0	0	0	0	0	0	0	0
Do Not Report	0	0	0	0	0	0	0	0	0	0
Essential Plan Enrollment	**1,250,807**	**1,290,634**	**1,306,011**	**1,327,110**	**1,348,632**	**1,370,058**	**1,391,828**	**1,413,947**	**1,436,422**	**1,459,257**
Below 150%	636,360	660,328	668,233	678,955	689,892	700,780	711,843	723,083	734,505	746,109
Over 151%	614,447	630,306	637,778	648,155	658,740	669,278	679,985	690,863	701,917	713,148

Table E13. Approved Waiver PY Average Annual Enrollment by FPL, PY 2024 – 2033

Approved Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,638,376**	**1,703,570**	**1,695,010**	**1,734,874**	**1,775,503**	**1,816,339**	**1,857,839**	**1,900,058**	**1,942,997**	**1,986,690**
Unsubsidized On/Off-Exchange Enrollment	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	9,627	19,284	29,132	39,176	49,418	59,860	70,507	81,361
501% - 600%	0	0	4,562	9,051	13,631	18,300	23,062	27,918	32,868	37,914
Over 600%	26,263	26,333	26,499	26,764	27,031	27,302	27,575	27,851	28,129	28,410
Do Not Report	100,992	101,180	101,819	102,837	103,866	104,904	105,954	107,013	108,083	109,164
Subsidized On-Exchange Enrollment	160,726	146,383	103,790	104,819	105,858	106,907	107,967	109,037	110,119	111,210
Below 139%	889	891	837	846	854	863	871	880	889	898
139% - 150%	248	249	234	236	239	241	244	246	249	251
151% - 200%	2,043	2,048	1,925	1,944	1,964	1,983	2,003	2,023	2,043	2,064
201% - 250%	16,177	411	414	418	422	426	430	435	439	444
251% - 300%	44,209	44,740	42,131	42,548	42,968	43,393	43,822	44,255	44,693	45,135
301% - 350%	38,328	38,607	36,318	36,680	37,044	37,413	37,784	38,160	38,540	38,923
351% - 400%	23,058	23,296	21,930	22,147	22,367	22,588	22,812	23,038	23,266	23,497
401% - 500%	24,422	24,619	0	0	0	0	0	0	0	0
501% - 600%	11,352	11,522	0	0	0	0	0	0	0	0
Over 600%	0	0	0	0	0	0	0	0	0	0
Do Not Report	0	0	0	0	0	0	0	0	0	0
Essential Plan Enrollment	**1,350,395**	**1,429,674**	**1,448,713**	**1,472,119**	**1,495,985**	**1,519,749**	**1,543,863**	**1,568,379**	**1,593,291**	**1,618,631**
Below 150%	640,982	664,754	673,195	683,957	694,927	705,848	716,919	728,178	739,620	751,266
151% - 200%	617,243	638,438	647,412	657,972	668,743	679,469	690,364	701,436	712,687	724,124
Over 201%	92,170	126,481	128,106	130,190	132,315	134,432	136,581	138,765	140,984	143,240

Note: There is a decrease from the Baseline Without Waiver scenario (~0.1% in total) for the off-exchange population. This is due to DACA recipients who previously enrolled in off-exchange full pay non-group plans transitioning to EP.

Table E14. Amended With-Waiver PY Average Annual Enrollment by FPL, PY 2024 – 2033

Amended Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,638,376**	**1,706,730**	**1,697,985**	**1,737,878**	**1,778,537**	**1,819,403**	**1,860,933**	**1,903,183**	**1,946,152**	**1,989,877**
Unsubsidized On/Off-Exchange Enrollment	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	9,627	19,427	29,397	39,544	49,877	60,400	71,118	82,037
501% - 600%	0	0	4,562	9,118	13,754	18,472	23,276	28,168	33,152	38,229
Over 600%	26,263	26,771	26,939	27,165	27,401	27,645	27,896	28,152	28,414	28,681
Do Not Report	100,992	100,742	101,379	102,226	103,109	104,022	104,960	105,921	106,902	107,902
Subsidized On-Exchange Enrollment	160,726	149,543	106,765	107,823	108,891	109,971	111,061	112,162	113,274	114,397
Below 139%	889	891	837	846	854	863	871	880	889	898
139% - 150%	248	249	234	236	239	241	244	246	249	251
151% - 200%	2,043	2,048	1,925	1,944	1,964	1,983	2,003	2,023	2,043	2,064
201% - 250%	16,177	411	414	418	422	426	430	435	439	444
251% - 300%	44,209	45,896	43,220	43,647	44,079	44,514	44,955	45,399	45,848	46,301
301% - 350%	38,328	39,610	37,263	37,633	38,007	38,385	38,767	39,152	39,541	39,935
351% - 400%	23,058	24,296	22,871	23,098	23,327	23,558	23,791	24,027	24,265	24,505
401% - 500%	24,422	24,619	0	0	0	0	0	0	0	0
501% - 600%	11,352	11,522	0	0	0	0	0	0	0	0
Over 600%	0	0	0	0	0	0	0	0	0	0
Do Not Report	0	0	0	0	0	0	0	0	0	0
Essential Plan Enrollment	**1,350,395**	**1,429,674**	**1,448,713**	**1,472,119**	**1,495,985**	**1,519,749**	**1,543,863**	**1,568,379**	**1,593,291**	**1,618,631**
Below 150%	640,982	664,754	673,195	683,957	694,927	705,848	716,919	728,178	739,620	751,266
151% - 200%	617,243	638,438	647,412	657,972	668,743	679,469	690,364	701,436	712,687	724,124
Over 201%	92,170	126,481	128,106	130,190	132,315	134,432	136,581	138,765	140,984	143,240

Note: There is a decrease from the Baseline Without Waiver scenario (~0.1% in total) for the off-exchange population. This is due to DACA recipients who previously enrolled in off-exchange full pay non-group plans transitioning to EP.

Note: There is an increase from the Approved Waiver scenario (~2.9% in total) for the on-exchange subsidized population. This is due to new members entering the market from uninsured or employer sponsored insurance to enroll in the CSR 73% AV and CSR 87% AV plans.

Table E15. Baseline Without Waiver, Approved Waiver, and Amended With-Waiver Monthly Federal Funding PMPM by Metal Level and Rate Cohort, PY 2024 – 2033

Basline Without Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$430	$452	$477	$502	$528	$555	$584	$615	$647	$680
Catastrophic	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Bronze	$408	$429	$451	$475	$499	$525	$553	$582	$612	$644
Silver	$468	$493	$518	$545	$573	$603	$635	$668	$702	$739
Gold	$397	$418	$440	$463	$487	$512	$538	$566	$596	$627
Platinum	$360	$379	$398	$419	$441	$464	$488	$513	$540	$568
Essential Plan BHP Funding	**$783**	**$804**	**$804**	**$846**	**$890**	**$937**	**$986**	**$1,037**	**$1,091**	**$1,148**
EP1	$706	$743	$713	$750	$789	$830	$873	$918	$966	$1,016
EP2	$773	$813	$811	$854	$898	$945	$994	$1,046	$1,100	$1,157
EP3	$837	$880	$917	$965	$1,015	$1,068	$1,123	$1,181	$1,243	$1,308
EP4	$864	$909	$954	$1,003	$1,055	$1,110	$1,168	$1,229	$1,292	$1,360

Approved Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$425	$447	$471	$496	$521	$549	$577	$607	$639	$672
Catastrophic	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Bronze	$408	$429	$451	$475	$499	$525	$553	$582	$612	$644
Silver	$468	$493	$518	$545	$573	$603	$635	$668	$702	$739
Gold	$397	$418	$440	$463	$487	$512	$538	$566	$596	$627
Platinum	$360	$379	$398	$419	$441	$464	$488	$513	$540	$568
Essential Plan BHP Funding	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
EP1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EP2	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EP3	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EP4	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Amended Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$425	$452	$476	$501	$527	$555	$583	$614	$646	$679
Catastrophic	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Bronze	$408	$429	$451	$475	$499	$525	$553	$582	$612	$644
Silver	$468	$503	$529	$557	$586	$616	$648	$682	$717	$754
Gold	$397	$418	$440	$463	$487	$512	$538	$566	$596	$627
Platinum	$360	$379	$398	$419	$441	$464	$488	$513	$540	$568
Essential Plan BHP Funding	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
EP1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EP2	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EP3	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EP4	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Table E16. Baseline Without Waiver, Approved Waiver, and Amended Waiver 5-Year Enrollment, Premium, and Federal Deficit Estimates, PY 2024 – 2033

Basline Without Waiver - Scenario E	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Unsubsidized On-exchange & Off-exchange Enrollment	127,311	127,646	142,641	158,071	173,797	189,821	206,148	222,782	239,729	256,992
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	9,627	19,284	29,132	39,176	49,418	59,860	70,507	81,361
501% - 600%	0	0	4,562	9,051	13,631	18,300	23,062	27,918	32,868	37,914
Over 600%	26,263	26,333	26,499	26,764	27,031	27,302	27,575	27,851	28,129	28,410
Do Not Report	101,047	101,313	101,953	102,972	104,002	105,042	106,093	107,154	108,225	109,307
Unsubsidized On-exchange Enrollment	89,770	90,006	104,763	119,815	135,158	150,796	166,732	182,973	199,522	216,383
Off-exchange Enrollment	37,541	37,640	37,877	38,256	38,639	39,025	39,415	39,809	40,207	40,610
Approved Waiver - Scenario E	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Unsubsidized On-exchange & Off-exchange Enrollment	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	9,627	19,284	29,132	39,176	49,418	59,860	70,507	81,361
501% - 600%	0	0	4,562	9,051	13,631	18,300	23,062	27,918	32,868	37,914
Over 600%	26,263	26,333	26,499	26,764	27,031	27,302	27,575	27,851	28,129	28,410
Do Not Report	100,992	101,180	101,819	102,837	103,866	104,904	105,954	107,013	108,083	109,164
Unsubsidized On-exchange & Off-exchange Premium Increase (Annual)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unsubsidized On-exchange Enrollment	89,770	90,006	104,763	119,815	135,158	150,796	166,732	182,973	199,522	216,383
Unsubsidized On-exchange Premium Increase (Annual)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Off-exchange Enrollment	37,486	37,507	37,744	38,121	38,502	38,887	39,276	39,669	40,066	40,466
Off-exchange Premium Increase (Annual)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Amended Waiver - Scenario E	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Unsubsidized On-exchange & Off-exchange Enrollment	127,256	127,513	142,507	157,936	173,660	189,683	206,008	222,642	239,587	256,849
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	9,627	19,427	29,397	39,544	49,877	60,400	71,118	82,037
501% - 600%	0	0	4,562	9,118	13,754	18,472	23,276	28,168	33,152	38,229
Over 600%	26,263	26,771	26,939	27,165	27,401	27,645	27,896	28,152	28,414	28,681
Do Not Report	100,992	100,742	101,379	102,226	103,109	104,022	104,960	105,921	106,902	107,902
Unsubsidized On-exchange & Off-exchange Premium Increase (Annual)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unsubsidized On-exchange Enrollment	89,770	92,129	106,895	121,971	137,337	152,999	168,960	185,225	201,798	218,685
Unsubsidized On-exchange Premium Increase (Annual)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Off-exchange Enrollment	37,486	35,384	35,612	35,966	36,323	36,684	37,049	37,417	37,789	38,164
Off-exchange Premium Increase (Annual)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Note: Due to IRIP, there are no expected increases of premiums for consumers that remain in the individual market compared to Without Waiver.

Note: There is a decrease from the Baseline Without Waiver scenario (~0.1% in total) for the off-exchange population. This is due to DACA recipients who previously enrolled in off-exchange full pay non-group plans transitioning to EP.

Table E17. Baseline Without, Approved Waiver, and Amended Waiver Annual Out-of-Pocket Expenses by FPL, PY 2024 – 2033

Basline Without Waiver - Scenario E - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,609	$2,745	$2,888	$3,038	$3,196	$3,362	$3,537	$3,721	$3,914	$4,118	$2,898	$3,326
251% - 300%	$2,505	$2,636	$2,773	$2,917	$3,068	$3,228	$3,396	$3,572	$3,758	$3,954	$2,777	$3,185
301% - 350%	$2,522	$2,654	$2,792	$2,937	$3,089	$3,250	$3,419	$3,597	$3,784	$3,981	$2,795	$3,207
351% - 400%	$2,541	$2,673	$2,812	$2,959	$3,112	$3,274	$3,444	$3,624	$3,812	$4,010	$2,816	$3,231
401% - 500%	$2,558	$2,691	$2,831	$2,978	$3,133	$3,296	$3,467	$3,647	$3,837	$4,037	$2,845	$3,491
501% - 600%	$2,584	$2,718	$2,860	$3,008	$3,165	$3,329	$3,502	$3,685	$3,876	$4,078	$2,875	$3,526
Over 600%/Do Not Report	$2,684	$2,824	$2,971	$3,125	$3,288	$3,459	$3,639	$3,828	$4,027	$4,236	$2,981	$3,421
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$8	$8	$9	$9	$9	$10	$10	$10	$11	$11	$9	$10
Over 151%	$136	$142	$147	$153	$159	$166	$172	$179	$186	$194	$148	$164

Approved Waiver - Scenario E - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,656	$2,794	$2,939	$3,092	$3,253	$3,422	$3,600	$3,787	$3,984	$4,191	$2,807	$3,155
251% - 300%	$2,505	$2,636	$2,773	$2,917	$3,068	$3,228	$3,396	$3,572	$3,758	$3,954	$2,777	$3,185
301% - 350%	$2,522	$2,654	$2,792	$2,937	$3,089	$3,250	$3,419	$3,597	$3,784	$3,981	$2,795	$3,207
351% - 400%	$2,541	$2,673	$2,812	$2,959	$3,112	$3,274	$3,444	$3,624	$3,812	$4,010	$2,816	$3,231
401% - 500%	$2,558	$2,691	$2,831	$2,978	$3,133	$3,296	$3,467	$3,647	$3,837	$4,037	$2,845	$3,491
501% - 600%	$2,584	$2,718	$2,860	$3,008	$3,165	$3,329	$3,502	$3,685	$3,876	$4,078	$2,875	$3,526
Over 600%/Do Not Report	$2,684	$2,824	$2,971	$3,125	$3,288	$3,459	$3,639	$3,828	$4,027	$4,236	$2,981	$3,421
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$8	$8	$9	$9	$9	$10	$10	$10	$11	$11	$9	$10
151% - 200%	$136	$142	$147	$153	$159	$166	$172	$179	$186	$194	$148	$164
Over 201%	$238	$247	$257	$267	$278	$289	$301	$313	$325	$338	$259	$288

Table E17 continued. Baseline Without, Approved Waiver, and Amended Waiver Annual Out-of-Pocket Expenses by FPL, PY 2024 – 2033

Amended Waiver - Scenario E - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,656	$2,751	$2,894	$3,045	$3,203	$3,370	$3,545	$3,729	$3,923	$4,127	$2,788	$3,122
251% - 300%	$2,505	$1,007	$1,059	$1,114	$1,172	$1,233	$1,297	$1,365	$1,436	$1,511	$1,371	$1,370
301% - 350%	$2,522	$1,014	$1,066	$1,122	$1,180	$1,242	$1,306	$1,374	$1,445	$1,521	$1,381	$1,380
351% - 400%	$2,541	$2,693	$2,833	$2,980	$3,135	$3,298	$3,469	$3,650	$3,839	$4,039	$2,835	$3,255
401% - 500%	$2,558	$2,542	$2,674	$2,814	$2,960	$3,114	$3,276	$3,446	$3,625	$3,814	$2,550	$2,550
501% - 600%	$2,584	$2,573	$2,706	$2,847	$2,995	$3,151	$3,315	$3,487	$3,669	$3,859	$2,578	$2,578
Over 600%/Do Not Report	$2,684	$2,631	$2,768	$2,911	$3,063	$3,222	$3,390	$3,566	$3,751	$3,946	$2,813	$3,204
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$8	$8	$9	$9	$9	$10	$10	$10	$11	$11	$9	$10
151% - 200%	$136	$142	$147	$153	$159	$166	$172	$179	$186	$194	$148	$164
Over 201%	$238	$247	$257	$267	$278	$289	$301	$313	$325	$338	$259	$288

Table E18. Baseline Without and Amended Waiver Annual Out-of-Pocket Expenses by Age, PY 2024 – 2033

Basline Without Waiver - Scenario E - Age	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$1,041	$1,095	$1,152	$1,212	$1,275	$1,342	$1,412	$1,485	$1,562	$1,643	$1,156	$1,343
21 - 25 Years	$1,038	$1,092	$1,149	$1,209	$1,272	$1,338	$1,407	$1,480	$1,557	$1,638	$1,152	$1,338
26 - 30 Years	$1,380	$1,452	$1,528	$1,607	$1,691	$1,779	$1,871	$1,969	$2,071	$2,179	$1,532	$1,779
31 - 35 Years	$1,658	$1,744	$1,835	$1,930	$2,031	$2,136	$2,247	$2,364	$2,487	$2,616	$1,841	$2,138
36 - 40 Years	$1,811	$1,906	$2,005	$2,109	$2,219	$2,334	$2,455	$2,583	$2,717	$2,859	$2,011	$2,337
41 - 45 Years	$2,028	$2,133	$2,244	$2,361	$2,484	$2,613	$2,749	$2,892	$3,042	$3,200	$2,251	$2,616
46 - 50 Years	$2,388	$2,512	$2,642	$2,780	$2,924	$3,076	$3,236	$3,405	$3,582	$3,768	$2,650	$3,079
51 - 55 Years	$2,940	$3,093	$3,254	$3,423	$3,601	$3,789	$3,986	$4,193	$4,411	$4,640	$3,263	$3,791
56 - 60 Years	$3,597	$3,784	$3,981	$4,188	$4,406	$4,635	$4,876	$5,130	$5,396	$5,677	$3,992	$4,638
61 - 65 Years	$4,424	$4,654	$4,896	$5,150	$5,418	$5,700	$5,996	$6,308	$6,636	$6,981	$4,909	$5,704
Essential Plan - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$35	$36	$38	$39	$41	$42	$44	$46	$48	$49	$38	$42
21 - 25 Years	$35	$36	$37	$39	$41	$42	$44	$46	$47	$49	$38	$42
26 - 30 Years	$46	$48	$50	$52	$54	$56	$58	$61	$63	$66	$50	$56
31 - 35 Years	$55	$58	$60	$62	$65	$67	$70	$73	$76	$79	$60	$67
36 - 40 Years	$60	$63	$65	$68	$71	$74	$77	$80	$83	$86	$66	$73
41 - 45 Years	$68	$70	$73	$76	$79	$82	$86	$89	$93	$96	$73	$82
46 - 50 Years	$80	$83	$86	$90	$93	$97	$101	$105	$109	$113	$86	$96
51 - 55 Years	$98	$102	$106	$110	$115	$119	$124	$129	$134	$140	$106	$118
56 - 60 Years	$120	$125	$130	$135	$140	$146	$152	$158	$164	$171	$130	$145
61 - 65 Years	$148	$154	$160	$166	$173	$180	$187	$194	$202	$210	$160	$178

Table E18 continued. Baseline Without and Amended With Waiver Annual Out-of-Pocket Expenses by Age, PY 2024 – 2033

Amended Waiver - Scenario E - Age	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$1,037	$1,091	$1,148	$1,208	$1,271	$1,337	$1,406	$1,479	$1,556	$1,637	$1,151	$1,338
21 - 25 Years	$1,034	$1,088	$1,145	$1,204	$1,267	$1,333	$1,402	$1,475	$1,552	$1,632	$1,145	$1,338
26 - 30 Years	$1,375	$1,447	$1,522	$1,601	$1,684	$1,772	$1,864	$1,961	$2,063	$2,170	$1,524	$1,777
31 - 35 Years	$1,652	$1,738	$1,828	$1,923	$2,023	$2,128	$2,239	$2,355	$2,478	$2,606	$1,831	$2,134
36 - 40 Years	$1,805	$1,898	$1,997	$2,101	$2,210	$2,325	$2,446	$2,573	$2,707	$2,848	$2,001	$2,333
41 - 45 Years	$2,020	$2,125	$2,236	$2,352	$2,474	$2,603	$2,738	$2,881	$3,031	$3,188	$2,240	$2,612
46 - 50 Years	$2,378	$2,502	$2,632	$2,769	$2,913	$3,065	$3,224	$3,392	$3,568	$3,753	$2,636	$3,075
51 - 55 Years	$2,929	$3,081	$3,242	$3,410	$3,587	$3,774	$3,970	$4,177	$4,394	$4,622	$3,247	$3,785
56 - 60 Years	$3,584	$3,770	$3,966	$4,172	$4,389	$4,617	$4,858	$5,110	$5,376	$5,655	$3,973	$4,631
61 - 65 Years	$4,407	$4,636	$4,877	$5,131	$5,398	$5,678	$5,974	$6,284	$6,611	$6,955	$4,886	$5,694
Essential Plan - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$40	$41	$43	$45	$47	$48	$50	$52	$55	$57	$43	$48
21 - 25 Years	$40	$41	$43	$45	$46	$48	$50	$52	$54	$57	$43	$48
26 - 30 Years	$53	$55	$57	$59	$62	$64	$67	$69	$72	$75	$57	$64
31 - 35 Years	$63	$66	$69	$71	$74	$77	$80	$83	$87	$90	$69	$77
36 - 40 Years	$69	$72	$75	$78	$81	$84	$88	$91	$95	$99	$75	$84
41 - 45 Years	$78	$81	$84	$87	$91	$94	$98	$102	$106	$110	$84	$94
46 - 50 Years	$91	$95	$99	$103	$107	$111	$116	$120	$125	$130	$99	$110
51 - 55 Years	$112	$117	$122	$127	$132	$137	$142	$148	$154	$160	$122	$136
56 - 60 Years	$138	$143	$149	$155	$161	$167	$174	$181	$188	$196	$149	$166
61 - 65 Years	$169	$176	$183	$190	$198	$206	$214	$223	$232	$241	$184	$204

Table E19. Baseline Without and Amended With Waiver Annual Enrollment by Age, PY 2024 – 2033

Basline Without Waiver - Scenario E - Age	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Enrollment - Age												
Total Enrollment	349,881	352,406	325,380	342,623	360,177	378,049	396,242	414,762	433,612	452,799	346,093	380,593
00 - 20 Years	18,574	18,627	17,374	18,197	19,034	19,887	20,754	21,637	22,536	23,450	18,361	20,007
21 - 25 Years	19,408	19,648	18,084	18,923	19,881	20,856	21,849	22,860	23,895	24,948	19,189	21,035
26 - 30 Years	31,235	31,812	29,290	30,862	32,389	33,946	35,533	37,151	38,794	40,570	31,117	34,158
31 - 35 Years	32,380	32,962	30,397	32,108	33,779	35,480	37,213	38,978	40,774	42,531	32,325	35,660
36 - 40 Years	30,383	30,770	28,383	29,981	31,603	33,253	34,932	36,640	38,378	40,075	30,224	33,440
41 - 45 Years	29,565	29,754	27,415	28,961	30,538	32,143	33,777	35,438	37,129	38,843	29,247	32,356
46 - 50 Years	30,298	30,378	27,944	29,471	31,070	32,698	34,353	36,038	37,752	39,501	29,832	32,950
51 - 55 Years	36,921	37,018	34,115	35,947	37,812	39,711	41,644	43,612	45,615	47,698	36,363	40,009
56 - 60 Years	46,849	46,972	43,407	45,676	47,987	50,339	52,734	55,171	57,652	60,177	46,178	50,697
61 - 65 Years	69,097	69,279	64,170	67,448	70,785	74,182	77,640	81,159	84,742	88,388	68,156	74,689
65+ Years	5,172	5,186	4,803	5,049	5,299	5,553	5,813	6,077	6,345	6,618	5,102	5,591
Essential Plan - Enrollment - Age												
Total Enrollment	1,250,807	1,290,634	1,306,011	1,327,110	1,348,632	1,370,058	1,391,828	1,413,947	1,436,422	1,459,257	1,304,639	1,359,470
00 - 20 Years	87,297	89,296	90,300	91,775	93,280	94,778	96,300	97,846	99,417	101,013	90,390	94,130
21 - 25 Years	145,862	150,429	151,465	153,125	155,591	158,046	160,541	163,076	165,695	168,356	151,294	157,219
26 - 30 Years	146,198	153,043	154,707	156,953	158,703	160,442	162,221	164,041	165,861	168,480	153,921	159,065
31 - 35 Years	146,847	153,787	155,993	158,785	161,093	163,390	165,727	168,105	170,524	172,441	155,301	161,669
36 - 40 Years	149,510	155,149	157,380	160,264	163,156	166,036	168,957	171,921	174,926	177,442	157,092	164,474
41 - 45 Years	144,627	148,740	150,826	153,595	156,449	159,293	162,176	165,099	168,064	171,028	150,848	157,990
46 - 50 Years	126,063	128,910	130,418	132,549	135,048	137,538	140,063	142,623	145,219	147,888	130,598	136,632
51 - 55 Years	121,205	123,943	125,393	127,442	129,531	131,611	133,724	135,871	138,053	140,597	125,503	130,737
56 - 60 Years	101,776	104,075	105,293	107,013	108,767	110,514	112,288	114,091	115,923	117,785	105,385	109,753
61 - 65 Years	81,421	83,260	84,234	85,610	87,014	88,411	89,831	91,273	92,739	94,228	84,308	87,802
65+ Years	-	-	-	-	-	-	-	-	-	-	-	-

Table E19 continued. Baseline Without and Amended With Waiver Annual Enrollment by Age, PY 2024 – 2033

Amended Waiver - Scenario E - Age	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Enrollment - Age												
Total Enrollment	287,982	277,056	249,272	265,759	282,552	299,654	317,070	334,804	352,861	371,247	272,524	303,826
00 - 20 Years	17,747	17,732	16,466	17,279	18,108	18,951	19,809	20,683	21,572	22,476	17,466	19,082
21 - 25 Years	14,557	13,647	12,067	12,892	13,792	14,709	15,643	16,594	17,566	18,556	13,391	15,002
26 - 30 Years	23,989	22,800	20,191	21,685	23,166	24,675	26,214	27,783	29,378	31,062	22,366	25,094
31 - 35 Years	26,091	25,164	22,488	24,104	25,709	27,344	29,010	30,707	32,435	34,153	24,711	27,721
36 - 40 Years	24,619	23,684	21,198	22,705	24,237	25,797	27,385	29,002	30,648	32,282	23,289	26,156
41 - 45 Years	23,779	22,706	20,281	21,737	23,222	24,734	26,274	27,841	29,436	31,057	22,345	25,107
46 - 50 Years	24,508	23,373	20,876	22,333	23,842	25,379	26,943	28,536	30,157	31,810	22,987	25,776
51 - 55 Years	30,304	29,028	26,053	27,805	29,588	31,405	33,255	35,139	37,057	39,035	28,556	31,867
56 - 60 Years	39,054	37,578	33,926	36,101	38,316	40,571	42,868	45,207	47,588	50,012	36,995	41,122
61 - 65 Years	58,161	56,112	50,881	54,026	57,229	60,491	63,812	67,193	70,635	74,140	55,282	61,268
65+ Years	5,172	5,231	4,845	5,091	5,342	5,597	5,856	6,121	6,390	6,663	5,136	5,631
Essential Plan - Enrollment - Age												
Total Enrollment	1,350,395	1,429,674	1,448,713	1,472,119	1,495,985	1,519,749	1,543,863	1,568,379	1,593,291	1,618,631	1,439,377	1,504,080
00 - 20 Years	88,858	91,894	93,075	94,599	96,154	97,703	99,276	100,875	102,499	104,150	92,916	96,908
21 - 25 Years	154,495	162,826	164,310	166,084	168,767	171,439	174,156	176,917	179,770	182,669	163,296	170,143
26 - 30 Years	159,279	171,650	174,084	176,613	178,585	180,551	182,565	184,637	186,718	189,685	172,042	178,437
31 - 35 Years	158,338	170,358	173,362	176,467	179,023	181,570	184,153	186,789	189,473	191,617	171,509	179,115
36 - 40 Years	159,215	168,778	171,494	174,644	177,797	180,935	184,106	187,322	190,581	193,308	170,385	178,818
41 - 45 Years	153,497	160,909	163,238	166,245	169,342	172,425	175,541	178,699	181,897	185,098	162,646	170,689
46 - 50 Years	134,669	140,657	142,306	144,631	147,368	150,093	152,850	155,643	158,471	161,378	141,926	148,807
51 - 55 Years	131,031	137,342	138,949	141,219	143,534	145,839	148,181	150,560	152,978	155,792	138,415	144,543
56 - 60 Years	113,351	119,857	121,259	123,240	125,260	127,272	129,315	131,392	133,502	135,645	120,594	126,009
61 - 65 Years	97,661	105,402	106,636	108,377	110,154	111,923	113,720	115,546	117,401	119,287	105,646	110,611
65+ Years	-	-	-	-	-	-	-	-	-	-	-	-

Section 7: Attached Materials

1 necessary", for a multiple source drug for which a specific upper limit
2 of reimbursement has been established by the federal agency, in addition
3 to writing "d a w" in the box provided for such purpose on the
4 prescription form, payment under this title for such drug must be made
5 under the provisions of subparagraph (ii) of such paragraph.
6 § 7. This act shall take effect October 1, 2024; provided that
7 the amendments to paragraph (e) of subdivision 7 of section 367-a of the
8 social services law made by section five of this act shall not affect
9 the repeal of such paragraph and shall be deemed repealed therewith; and
10 provided further, that the amendments to subdivision 9 of section 367-a
11 of the social services law made by section six of this act shall not
12 affect the expiration of such subdivision pursuant to section 4 of chap-
13 ter 19 of the laws of 1998, as amended, and shall expire therewith.

14 PART J

15 Section 1. The title heading of title 11-D of article 5 of the social
16 services law, as amended by section 1 of part H of chapter 57 of the
17 laws of 2021, is amended to read as follows:
18 [BASIC HEALTH PROGRAM] ESSENTIAL PLAN
19 § 2. Section 3 of part H of chapter 57 of the laws of 2021, amending
20 the social services law relating to eliminating consumer-paid premium
21 payments in the basic health program, is amended to read as follows:
22 § 3. This act shall take effect June 1, 2021 [and]; provided, however,
23 section two of this act shall expire and be deemed repealed should
24 federal approval be withdrawn or 42 U.S.C. 18051 be repealed; provided
25 that the commissioner of health shall notify the legislative bill draft-
26 ing commission upon the withdrawal of federal approval or the repeal of
27 42 U.S.C. 18051 in order that the commission may maintain an accurate
28 and timely effective data base of the official text of the laws of the
29 state of New York in furtherance of effectuating the provisions of
30 section 44 of the legislative law and section 70-b of the public offi-
31 cers law.
32 § 3. Subdivisions (b) and (c) of section 8 of part BBB of chapter 56
33 of the laws of 2022, amending the public health law and other laws
34 relating to permitting the commissioner of health to submit a waiver
35 that expands eligibility for New York's basic health program and
36 increases the federal poverty limit cap for basic health program eligi-
37 bility from two hundred to two hundred fifty percent, are amended to
38 read as follows:
39 (b) section four of this act shall expire and be deemed repealed
40 December 31, [2024] 2025; provided, however, the amendments to paragraph
41 (c) of subdivision 1 of section 369-gg of the social services law made
42 by such section of this act shall be subject to the expiration and
43 reversion of such paragraph pursuant to section 2 of part H of chapter
44 57 of the laws of 2021 when upon such date, the provisions of section
45 five of this act shall take effect; provided, however, the amendments to
46 such paragraph made by section five of this act shall expire and be
47 deemed repealed December 31, [2024] 2025;
48 (c) section six of this act shall take effect January 1, [2025] 2026;
49 provided, however, the amendments to paragraph (c) of subdivision 1 of
50 section 369-gg of the social services law made by such section of this
51 act shall be subject to the expiration and reversion of such paragraph
52 pursuant to section 2 of part H of chapter 57 of the laws of 2021 when
53 upon such date, the provisions of section seven of this act shall take
54 effect; and

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1 § 4. Paragraph (a) of subdivision 1 of section 268-c of the public
2 health law, as added by section 2 of part T of chapter 57 of the laws of
3 2019, is amended to read as follows:
4 (a) Perform eligibility determinations for federal and state insurance
5 affordability programs including medical assistance in accordance with
6 section three hundred sixty-six of the social services law, child health
7 plus in accordance with section twenty-five hundred eleven of this chap-
8 ter, the basic health program in accordance with section three hundred
9 sixty-nine-gg of the social services law, the 1332 state innovation
10 program in accordance with section three hundred sixty-nine-ii of the
11 social services law, premium tax credits and cost-sharing reductions and
12 qualified health plans in accordance with applicable law and other
13 health insurance programs as determined by the commissioner;
14 § 5. Subdivision 16 of section 268-c of the public health law, as
15 added by section 2 of part T of chapter 57 of the laws of 2019, is
16 amended to read as follows:
17 16. In accordance with applicable federal and state law, inform indi-
18 viduals of eligibility requirements for the Medicaid program under title
19 XIX of the social security act and the social services law, the chil-
20 dren's health insurance program (CHIP) under title XXI of the social
21 security act and this chapter, the basic health program under section
22 three hundred sixty-nine-gg of the social services law, the 1332 state
23 innovation program in accordance with section three hundred sixty-nine-
24 ii of the social services law, or any applicable state or local public
25 health insurance program and if, through screening of the application by
26 the Marketplace, the Marketplace determines that such individuals are
27 eligible for any such program, enroll such individuals in such program.
28 § 6. Section 268-c of the public health law is amended by adding a new
29 subdivision 26 to read as follows:
30 26. Subject to federal approval if required, the use of state funds
31 and the availability of funds in the 1332 state innovation program fund
32 established pursuant to section ninety-eight-d of the state finance law,
33 the commissioner shall have the authority to establish a program to
34 provide subsidies for the payment of premium or cost sharing or both to
35 assist individuals who are eligible to purchase qualified health plans
36 through the marketplace, or take such other action as appropriate to
37 reduce or eliminate qualified health plan premiums or cost-sharing or
38 both.
39 § 7. Subparagraph (i) of paragraph (a) of subdivision 4 of section
40 268-e of the public health law, as added by section 2 of part T of chap-
41 ter 57 of the laws of 2019, is amended to read as follows:
42 (i) An initial determination of eligibility, including:
43 (A) eligibility to enroll in a qualified health plan;
44 (B) eligibility for Medicaid;
45 (C) eligibility for Child Health Plus;
46 (D) eligibility for the Basic Health Program;
47 (E) eligibility for the 1332 state innovation program;
48 (F) the amount of advance payments of the premium tax credit and level
49 of cost-sharing reductions;
50 [(F)] (G) the amount of any other subsidy that may be available under
51 law; and
52 [(G)] (H) eligibility for such other health insurance programs as
53 determined by the commissioner; and
54 § 8. Section 268 of the public health law, as added by section 2 of
55 part T of chapter 57 of the laws of 2019, is amended to read as follows:

1 § 268. Statement of policy and purposes. The purpose of this title is
2 to codify the establishment of the health benefit exchange in New York,
3 known as NY State of Health, The Official Health Plan Marketplace
4 (Marketplace), in conformance with Executive Order 42 (Cuomo) issued
5 April 12, 2012. The Marketplace shall continue to perform eligibility
6 determinations for federal and state insurance affordability programs
7 including medical assistance in accordance with section three hundred
8 sixty-six of the social services law, child health plus in accordance
9 with section twenty-five hundred eleven of this chapter, the basic
10 health program in accordance with section three hundred sixty-nine-gg of
11 the social services law, <u>the 1332 state innovation program in accordance</u>
12 <u>with section three hundred sixty-nine-ii of the social service law</u>, and
13 premium tax credits and cost-sharing reductions, together with perform-
14 ing eligibility determinations for qualified health plans and such other
15 health insurance programs as determined by the commissioner. The Market-
16 place shall also facilitate enrollment in insurance affordability
17 programs, qualified health plans and other health insurance programs as
18 determined by the commissioner, the purchase and sale of qualified
19 health plans and/or other or additional health plans certified by the
20 Marketplace pursuant to this title, and shall continue to have the
21 authority to operate a small business health options program ("SHOP") to
22 assist eligible small employers in selecting qualified health plans
23 and/or other or additional health plans certified by the Marketplace and
24 to determine small employer eligibility for purposes of small employer
25 tax credits. It is the intent of the legislature, by codifying the
26 Marketplace in state statute, to continue to promote quality and afford-
27 able health coverage and care, reduce the number of uninsured persons,
28 provide a transparent marketplace, educate consumers and assist individ-
29 uals with access to coverage, premium assistance tax credits and cost-
30 sharing reductions. In addition, the legislature declares the intent
31 that the Marketplace continue to be properly integrated with insurance
32 affordability programs, including Medicaid, child health plus and the
33 basic health program, <u>the 1332 state innovation program</u>, and such other
34 health insurance programs as determined by the commissioner.
35 § 9. Subdivision 8 of section 268-a of the public health law, as added
36 by section 1 of part PP of chapter 57 of the laws of 2021, is amended to
37 read as follows:
38 8. "Insurance affordability program" means Medicaid, child health
39 plus, the basic health program, <u>the 1332 state innovation program,</u> post-
40 partum extended coverage and any other health insurance subsidy program
41 designated as such by the commissioner.
42 § 10. This act shall take effect immediately and shall be deemed to
43 have been in full force and effect on and after April 1, 2024; provided,
44 however, that section six of this act shall only take effect upon the
45 commissioner of health obtaining and maintaining all necessary approvals
46 from the secretary of health and human services and the secretary of the
47 treasury based on an amended application for a waiver for state inno-
48 vation pursuant to section 1332 of the patient protection and affordable
49 care act (P.L. 111-148) and subdivision 25 of section 268-c of the
50 public health law; and provided, further, that the commissioner of
51 health shall notify the legislative bill drafting commission upon the
52 occurrence of the enactment of the legislation provided for in section
53 six of this act in order that the commission may maintain an accurate
54 and timely effective data base of the official text of the laws of the
55 state of New York in furtherance of effectuating the provisions of

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1 section 44 of the legislative law and section 70-b of the public offi-
2 cers law.

3 PART K

4 Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266
5 of the laws of 1986, amending the civil practice law and rules and other
6 laws relating to malpractice and professional medical conduct, as
7 amended by section 1 of part F of chapter 57 of the laws of 2023, is
8 amended to read as follows:
9 (a) The superintendent of financial services and the commissioner of
10 health or their designee shall, from funds available in the hospital
11 excess liability pool created pursuant to subdivision 5 of this section,
12 purchase a policy or policies for excess insurance coverage, as author-
13 ized by paragraph 1 of subsection (e) of section 5502 of the insurance
14 law; or from an insurer, other than an insurer described in section 5502
15 of the insurance law, duly authorized to write such coverage and actual-
16 ly writing medical malpractice insurance in this state; or shall
17 purchase equivalent excess coverage in a form previously approved by the
18 superintendent of financial services for purposes of providing equiv-
19 alent excess coverage in accordance with section 19 of chapter 294 of
20 the laws of 1985, for medical or dental malpractice occurrences between
21 July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988,
22 between July 1, 1988 and June 30, 1989, between July 1, 1989 and June
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41 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [and]
42 between July 1, 2023 and June 30, 2024, and between July 1, 2024 and
43 June 30, 2025 or reimburse the hospital where the hospital purchases
44 equivalent excess coverage as defined in subparagraph (i) of paragraph
45 (a) of subdivision 1-a of this section for medical or dental malpractice
46 occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988
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54 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002

Individuals & Families

Employers

Assistors & Brokers

Info & Events

Language Support

» NY State of Health 1332 Waiver Information Page

NY State of Health 1332 Waiver Information Page

5/28/24 Update: New York released a draft amendment for its approved 1332 Waiver

Overview

On March 1, 2024, the U.S. Department of Health and Human Services (HHS) and U.S. Department of Treasury approved New York's Section 1332 State Innovation Waiver application to expand the Essential Plan. Section 1332 State Innovation Waivers allow states to pursue innovative strategies for providing residents with access to high quality, affordable health insurance. The waiver was approved for five years, from 2024 through 2028.

- Read Governor Hochul's press release on this approval
- Read the HHS fact sheet on this approval
- Learn more about the Essential Plan
- Use the Essential Plan Expansion Communications Tool Kit to promote this change

Key Components of the Waiver

This approved State Innovation waiver expands health insurance and covers health-related social needs, improving health care and advancing health equity. The waiver includes the following key components:

- Extending Affordable Health Insurance to Over 100,000 New Yorkers – The Essential Plan will be expanded to New Yorkers with incomes between 200 and 250 percent of the FPL, making the high quality, affordable program available to over 100,000 additional New Yorkers.
- Social Determinants of Health Grants – Complementing New York's recently approved Medicaid Demonstration waiver, this approved Essential Plan State Innovation waiver seeks to address social determinants of health through grants in the following focus areas:
  - Food insecurity, including medically tailored meals, food pharmacies, and personalized coaching
  - Preparing for climate change by providing enrollees with persistent asthma with an air conditioner to protect their health, reduce the number of Emergency Department visits, and help communities prepare for extreme weather
  - Knowledge sharing, including provider training on mental health services and social determinants of health
- Behavioral Health Grants – This waiver seeks to improve behavioral health for Essential Plan enrollees through grants to insurers support improved access to behavioral health services, including mobile crisis units, crisis diversion centers, and crisis respite centers
- Promoting Individual Market Premium Stability – Federal funding from this waiver will also support an Insurer Reimbursement Implementation Plan established to mitigate premium increases for individual market enrollees from the impact of the population with estimated household income 200-250% of FPL moving to the Essential Plan. In addition to maintaining stable premiums in the individual market, this waiver will also support stability with respect to plan participation for the individual market.

Guidance on the Expansion

- Guidance for Health Plans
- Training Webinar for Enrollment Assistors

Timeline of the Waiver Application Process

5/28/24 Update: New York released a draft amendment for its approved 1332 Waiver. The State will receive comments during a 30-day public comment period from May 28, 2024 - June 27, 2024 for consideration prior to submitting an amendment application to the U.S. Department of Health & Human Services and U.S. Department of Treasury. The State will hold a combined annual 1332 Waiver public forum and public hearing on the draft amendment on June 12, 2024 at 2:00PM and June 14, 2024 at 9:00AM. The draft amendment is available for review **here**.

Overview of Draft 1332 Waiver Amendment

The State Fiscal Year 2025 Enacted Budget granted the Commissioner of Health authority to provide premium or cost sharing subsidies to improve affordability for consumers in the Qualified Health Plan (QHP) market. New York submitted a **Letter of Intent** to the Departments of Health & Human Services and Treasury on April 26, 2024 to use passthrough funding on cost sharing subsidies. The State received a **Response Letter** on May 24, 2024.

New York is submitting an amendment to its approved 1332 Waiver for approval to use federal passthrough funding to further increase affordability and reduce the cost sharing burden for New Yorkers enrolled in QHPs beginning January 1, 2025. The amendment does not seek to waive additional provisions of the Affordable Care Act nor does it change the approved waiver programs. The draft amendment remains in compliance with statutory guardrails.

New York intends to use passthrough funding to implement three cost sharing reduction (CSR) subsidies for consumers 1) with incomes up to 400% of the FPL, 2) consumers receiving diabetes services, and 3) consumers receiving pregnancy and postpartum care services beginning in 2025. An average of 117,687 consumers are estimated to benefit from the CSRs annually, resulting in a total of $1.3 billion of consumer savings over four years under the waiver.

Public Hearings

New York will hold two virtual public hearings to provide updates on the implementation of the approved 1332 Waiver and solicit comments on the draft amendment. American Sign Language (ASL) interpreters will be available virtually. The State will provide other accommodations and language interpretation services to members of the public who request these services by emailing NYSOH.Team@health.ny.gov by 4PM Eastern on Friday, June 7, 2024.

Public Hearing 1: Wednesday, June 12, 2024 at 2:00PM Eastern Time (ET)

- Pre-registration by 4PM ET on Tuesday, June 11, 2024 is required for anyone who wants to provide a comment.
- Please **register here**.
- Please provide “SPK” in front of your first name when registering if you want to provide comments.
- You will receive a calendar invite to log in.

Public Hearing 2: Friday, June 14, 2023 at 9:00AM Eastern Time (ET)

- Pre-registration by 4PM ET on Wednesday, June 12, 2024 is required for anyone who wants to provide a comment.
- Please **register here**.
- Please provide “SPK” in front of your first name when registering if you want to provide comments.
- You will receive a calendar invite to log in.

Written Comments

Members of the public may also submit written comments on New York’s draft 1332 Waiver Amendment. The State will consider all comments received.

- Comments may be emailed to nysoh@health.ny.gov through June 27, 2024.
- Mailed comments must be postmarked by June 27, 2024 and sent to:

Attn: 1332 Waiver

Empire State Plaza

Corning Tower, Room 2580

Albany, NY 12237

5/7/24 Update: Announcement of 1332 Waiver Annual Public Forum & Public Hearing on June 12 & June 14

NY State of Health intends to hold two virtual public forums on Wednesday, June 12, 2024 at 2:00 PM Eastern and Friday, June 14, 2024 at 9:00 AM Eastern. The purpose of the forums is to provide an update on the progress of the waiver and to receive comments on a proposed waiver amendment. Both sessions with be held virtually through WebEx. Additional information on the proposed amendment and how to register to attend and provide comment will be posted here.

12/18/23 Update: New York has submitted updates to its 1332 Waiver Application to the Department of Health and Human Services (HHS) and Department of Treasury for the expansion of its Essential Plan. The application has been revised to reflect comments received and now includes Deferred Action for Childhood Arrivals (DACA) recipients as part of the proposed Essential Plan expansion. The updated materials are available for review here.

11/14/23 Update: New York has submitted updates to its 1332 Waiver Application to the Department of Health and Human Services (HHS) and Department of Treasury for the expansion of its Essential Plan. The updated materials are available for review here. New York will be holding two public hearings on the proposed changes on Friday, November 17, 2023 at 10:00AM Eastern Time (ET) and Tuesday, November 28, 2023 at 10:00AM ET.

Federal Comment Period

The federal government will also be accepting written comments on New York's proposed changes through December 2, 2023. To submit a written comment, email stateinnovationwaivers@cms.hhs.gov. Visit https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers for details.

6/6/23 Update: The Centers for Medicare & Medicaid Services (CMS) under the Department of Health and Human Services (HHS), and the Department of the Treasury, have determined New York's application complete and opened the Federal public comment period for New York's Section 1332 waiver application. The waiver completeness letter is available below. The Federal Public Comment Period will be open until July 5, 2023. To submit a public comment, please email stateinnovationwaivers@cms.hhs.gov. The CMS notice is available for review **here**.

5/12/23 Update: New York submitted its final Section 1332 State Innovation Waiver application to expand the Essential Plan to New Yorkers with incomes up to 250% of the Federal Poverty Level to the U.S. Departments of Health and Human Services and Treasury. Through this expansion of Essential Plan coverage, the State seeks to increase access to high quality, affordable health insurance for low- and moderate-income individuals.

The final application materials are available for review **here**.

The public comments and materials related to the public comment period are available for review as follows:

- Read comments from organizations
- Read comments from individuals

2/10/23 Update: The NYS Department of Health issued a press release on its intention to submit a proposal for the expansion of the Essential Plan. Read it here.

New York State Section 1332 Waiver

Annual Public Forum and Hearing
June 12 and June 14, 2024

Para la línea de interpretación en español, por favor marque
+1-518-549-0500
(Código de acceso: 161 948 3498
459 67 643 desde teléfonos y sistemas de vídeo)

Agenda

#	Topic	Presenter
1	Welcome and Instructions	Georgia Wohnsen
2	1332 Waiver Implementation Updates	Danielle Holahan
3	Proposed Waiver Amendment	Sonia Sekhar
4	Open for Public Comments	Georgia Wohnsen
5	Closing	Danielle Holahan

The purpose of this public hearing is to share updates on New York's 1332 Waiver implementation and solicit comments on the proposed amendment.

Hay Intérpretes de Español en Vivo También

Para la línea de interpretación en español, por favor marque +1-518-549-0500

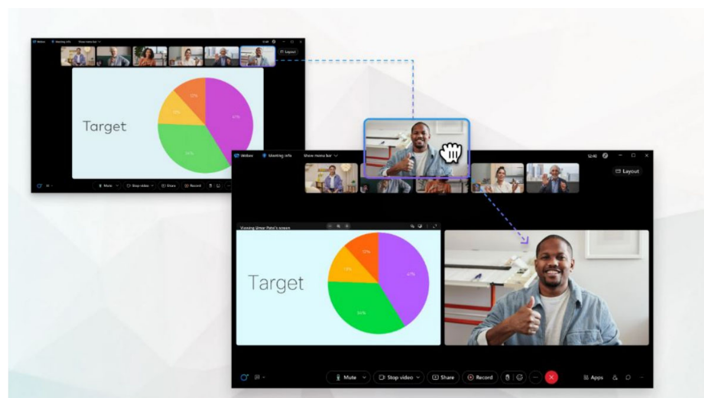
Código de acceso: 161 948 3498

Password: 459 67 643 desde teléfonos y sistemas de vídeo

ASL Interpreters Are Available

To move an American Sign Language (ASL) interpreter to the WebEx presentation stage, please do the following:

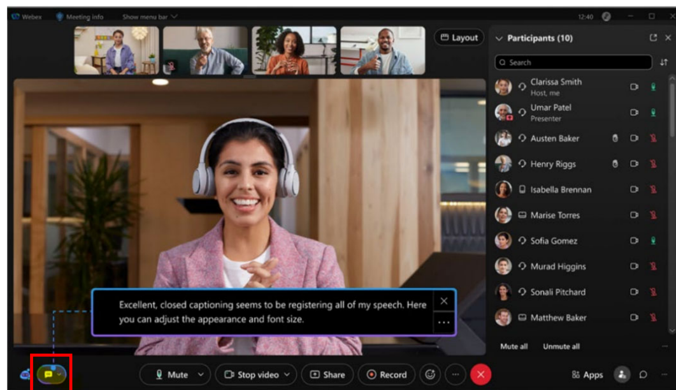
1. Right click on the ASL interpreter's video icon.
2. Select "Move to Stage."



Closed Captions Are Available

To enable closed captions during the webinar, please do the following:

1. Click on the "cc" icon on the bottom left of the screen.
2. Select "Show Closed Captions."



Instructions for Commenters

- Those that registered in advance and included "SPK" with their name are already on the speakers list.
- If you did not register and want to provide comment or ask a question, please enter your name into the chat throughout the presentation.
- After the presentation, the lines for speakers will be opened.

1332 Waiver Implementation Updates

About 1332 Waivers

- Under Section 1332 of the Affordable Care Act (ACA), states may request to waive parts of the ACA to pursue **innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA** using a Section 1332 State Innovation Waiver.
- 1332 Waivers are approved by the U.S. Department of Health & Human Services (HHS) and U.S. Department of Treasury (Treasury).
- 1332 Waivers must comply with four statutory guardrails:
  - **Coverage:** Provide coverage to at least a comparable number of residents as absent the waiver.
  - **Comprehensiveness:** Provide coverage at least as comprehensive as absent the waiver.
  - **Affordability:** Be at least as affordable for consumers as absent the waiver.
  - **Deficit Neutrality:** Not increase the federal deficit.
- Federal savings from the waiver are redirected to the State as passthrough funding.

New York's Approved 1332 Waiver

- New York submitted an initial 1332 Waiver Application on May 12, 2023 and an updated application on December 18, 2023, which included:
  - Expanded eligibility of the Essential Plan to consumers up to 250% of the FPL starting April 1, 2024.
  - Expansion of the Essential Plan to Deferred Action for Childhood Arrival (DACA) recipients starting August 1, 2024.
  - A pregnancy choice provision to allow pregnant consumers to remain in the Essential Plan.
  - An Insurer Reimbursement Implementation Plan to prevent potential increases in individual market premiums due to the wavier.
- CMS and Treasury approved the 1332 Waiver Application on March 1, 2024.
- The waiver was implemented on April 1, 2024.
- The waiver is in effect until December 31, 2028.

Implementation Updates

- Consumers were notified in March 2024 of their EP 200 – 250 eligibility and auto re-enrolled into plans starting April 1, 2024.
- Ramp up of the program has occurred faster than initially estimated.
- Over 120,000 consumers between 200 – 250% of the FPL were enrolled in EP coverage as of April.
  - 78,000 individuals were seamlessly moved from Qualified Health Plan coverage to EP, with an average annual savings of $4,700.
  - 42,000 individuals have newly enrolled in EP since April 1, 2024. This enrollment ramp up has occurred more quickly than originally anticipated.
- The State is on track to begin enrolling DACA recipients with incomes up to 250% of the FPL into the Essential Plan beginning August 1, 2024.
- The Essential Plan under the 1332 Waiver is expected to be fully funded by federal passthrough funding.

Proposed 1332 Waiver Amendment

Cost-Sharing Reductions (CSRs) for QHP Enrollees

- The SFY25 Enacted Budget allows the Commissioner of Health to provide premium or cost sharing subsidies to improve affordability for consumers in the QHP market.
- New York is submitting a waiver amendment to secure federal approval to use passthrough funding on additional initiatives that improve affordability for consumers.
- The State is proposing to implement three Cost Sharing Reduction (CSR) subsidies in the QHP market starting January 1, 2025 for:
    1. Individuals with incomes up to 400% of the FPL
    2. Diabetes Services
    3. Pregnancy and Postpartum Care
- Nearly 118,000 consumers will benefit from these cost sharing subsidies, resulting in $307 Million in consumer savings in 2025 and $1.3 Billion from 2025 – 2028.

CSR for Individuals with Incomes up to 400% of the FPL

Approach

- NYSoH will leverage existing standard CSR products to provide cost sharing reductions to QHP enrollees with incomes up to 400% FPL:
  - Individuals with incomes **250 – 350% FPL** will be eligible for the **Silver 87 Plan** (87% AV) which has a maximum out of pocket of $3,050.
  - Individuals with incomes **350 – 400% FPL** will be eligible for the **Silver 73 Plan** (73% AV), which has a maximum out of pocket of $7,350.
- Consumers will be able to enroll in these plans starting in November 2024 for Open Enrollment 2025.

Estimated Impact

- **Approximately 100,000** consumers are expected to benefit annually:
  - ~79,000 individuals 250 – 350% FPL (~$3,500 per person annual savings).
  - ~20,000 individuals 350 – 400% FPL (~$700 per person annual savings).

CSR for Diabetes Services

Approach

- The Diabetes CSR will modify all QHPs (excluding catastrophic) to **eliminate cost sharing for the following services related to diabetes care:**
  - Medical care
  - Lab Services
  - Diabetic Supplies
  - Prescription drugs, including insulin
- Consumers will not be charged copays, deductibles, or coinsurance for these services.
- Cost sharing will remain for hospitalization and most specialist office visits.

Estimated Impact

- **Approximately 17,000** consumers are expected to benefit annually (~ $1,650 per person annual savings).

CSR for Pregnancy & Post Partum Care

Approach

- The CSR will build on current federal regulations that prohibit cost sharing for maternal health services.
- With the exception of delivery and hospital stays, copays will be waived for **all** services and prescription drugs for pregnant and postpartum individuals.
- Prior authorization for blood pressure monitors will be prohibited.

Estimated Impact

- **Approximately 1,600** consumers are expected to benefit annually (~ $2,800 per person annual savings).

Summary Impact of CSRs

- NYS will pay QHP insurers the value of the CSR subsidies to mitigate any premium impact. ***This is a consumer subsidy paid through issuers.***
- The proposed CSRs are estimated to cost $307 million in 2025 and $1.3 billion over the duration of the waiver from 2025 – 2028.
- The CSRs are estimated to be fully funded with federal passthrough funding.

Amendment With Waiver With CSR	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Average 2025-2028	Average 2025-2033
On-Exchange CSR Enrollment	**250,496**	**241,672**	**213,660**	**229,793**	**246,229**	**262,969**	**280,021**	**297,387**	**315,073**	**333,082**	**232,838**	**268,876**
CSR 87 250-350% FPL	0	82,160	77,333	78,100	78,874	79,655	80,445	81,242	82,048	82,861	79,117	80,302
CSR 73 350-400% FPL	0	21,000	19,769	19,964	20,162	20,362	20,563	20,767	20,973	21,181	20,224	20,527
Diabetes	0	16,534	16,638	16,804	16,973	17,142	17,314	17,487	17,662	17,838	16,737	17,155
Maternity Care	0	1,650	1,507	1,595	1,686	1,777	1,870	1,965	2,062	2,161	1,610	1,808
Aggregate Cost Savings (millions)	**$0**	**$307**	**$305**	**$325**	**$345**	**$367**	**$389**	**$414**	**$439**	**$467**	**$1,282**	**$3,357**
CSR 87 250-350% FPL (millions)	$0	$263	$260	$277	$294	$312	$332	$352	$374	$398	$1,094	$2,862
CSR 73 350-400% FPL (millions)	$0	$14	$14	$15	$16	$17	$18	$19	$20	$22	$59	$155
Diabetes (millions)	$0	$25	$27	$28	$30	$32	$33	$35	$37	$39	$110	$286
Maternity Care (millions)	$0	$4	$4	$5	$5	$6	$6	$7	$8	$8	$18	$53
Per CSR Member Per Year Cost Saving	**$0**	**$1,269**	**$1,428**	**$1,412**	**$1,402**	**$1,394**	**$1,390**	**$1,390**	**$1,394**	**$1,401**	**$1,376**	**$1,387**
CSR 87 250-350% FPL	$0	$3,200	$3,366	$3,542	$3,726	$3,919	$4,123	$4,338	$4,563	$4,801	$3,456	$3,960
CSR 73 350-400% FPL	$0	$681	$713	$751	$794	$835	$875	$920	$968	$1,020	$734	$841
Diabetes	$0	$1,524	$1,603	$1,687	$1,775	$1,848	$1,925	$2,005	$2,089	$2,175	$1,648	$1,853
Maternity Care	$0	$2,606	$2,742	$2,884	$3,034	$3,192	$3,358	$3,532	$3,716	$3,909	$2,819	$3,266

Projected Impact on 1332 Waiver Guardrails

1332 Guardrail	Estimated Impact of Amended Waiver vs Approved Waiver
Comprehensiveness *(Consumer Benefits)*	• There are no estimated changes.
Affordability *(Consumer Savings)*	• There is an estimated improvement in affordability for an average of 117,687 consumers annually 2025 – 2028, resulting in a total of $307 million in consumer savings in 2025 and a total of $1.3 billion from 2025 – 2028.
Coverage *(Enrollment)*	• There is a slight estimated increased in enrollment in the individual market by 3,160 (0.2%) for PY 2025, 2,974 (0.2%) for PY 2026, 3,004 (0.2%) for PY 2027, and 3,034 (0.2%) for PY 2028.
Deficit Neutrality *(Federal Savings)*	• There is an estimated increase spend in PTCs by $0 million in 2024, $24 million for 2025, $96 million 2024 – 2028, and $248 million 2024 – 2033 due to the CSR for consumers up to 400% of the FPL. This increase is assumed to be deducted from passthrough funding, which would still be sufficient to fully fund the programs under the waiver.

Key Target Dates

Activity	Date
Publish Draft Waiver Amendment	May 28, 2024
Hold Public Hearing #1	June 12, 2024 @ 2 PM
Hold Public Hearing #2	June 14, 2024 @ 9 AM
Close State Public Comment Period	June 27, 2024
Submit Waiver Amendment to Federal Government	July 1, 2024
Receive Federal Waiver Approval	September 16, 2024
Implement for Open Enrollment 2025	**November 1, 2024**

Open for Public Comments

Instructions for Public Comment

1. Commenters are asked to **limit their comments to five (5) minutes.**
2. Please enter your name in the chat if you want to give a comment or ask a question.

Closing

Written Public Comment

- You may also submit written comments on New York's proposed 1332 Waiver Amendment via email at nysoh@health.ny.gov through June 27, 2024.
- Comments may also be sent through the mail at the address below. Mailed comment must be postmarked by June 27, 2024.

NY State of Health
Attn: 1332 Waiver
Empire State Plaza
Corning Tower
Room 2580
Albany, NY 12237

The proposed waiver amendment is available online at https://info.nystateofhealth.ny.gov/1332

From:
Sent: Sunday, June 9, 2024 12:11:10 PM
To: doh.sm.NYSOH <nysoh@health.ny.gov>
Subject: NY State of Health 1332 Waiver

As a beneficiary of the recently expanded access to NYS Essentials Plan, I am in FAVOR of any further expansion offering better access to health care in NYS using public funds if necessary.

For the first time in my life I have affordable health insurance that actually works for me. Unfortunately, I will lose eligibility in a few years when I will be forced to accept Medicare. Please consider offering a Medicare option if possible. It would be nice to continue having affordable, usable health insurance in my old age.

June 25, 2024

Danielle Holahan
Executive Director
NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Re: New York 1332 Waiver

Dear Executive Director Holahan:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the New York 1332 Waiver Amendment Request. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

ACS CAN supports a robust marketplace from which consumers can choose a health plan that best meets their needs. Access to health care coverage is paramount for persons with cancer and survivors. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[1] In the United States, over 2 million Americans will be diagnosed with cancer this year – an estimated 122,990 in New York.[2] An additional 18 million Americans are living with a history of cancer – 1.2 million in New York.[3] For these Americans access to affordable health insurance is a matter of life or death.

ACS CAN is committed to ensuring that New York's healthcare programs provide quality and affordable healthcare coverage. We believe the state's proposal to enhance cost-sharing subsidies for Marketplace consumers will advance these objectives. Once implemented, New York's waiver should increase coverage affordability for tens of thousands Marketplace enrollees and improve health equity while satisfying the federal guardrail protections governing waivers. ACS CAN applauds the state's work to improve equitable access to care in New York.

New York's proposed cost-sharing subsidies will lower healthcare costs for individuals above 250% of the federal poverty level. For example, the waiver projects that 79,000 individuals will save an additional average of $3,450 annually as a result of the cost-sharing subsidies. The state anticipates that a total of 118,000 enrollees will experience improved affordability of coverage as a result of this proposal. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income

[1] E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), https://pubmed.ncbi.nlm.nih.gov/18096863/
[2] American Cancer Society. Cancer Facts & Figures: 2022. Atlanta: American Cancer Society, 2022.
[3] American Cancer Society. Cancer Treatment & Survivorship: Facts & Figures 2019-2021. Atlanta: American Cancer Society, 2019.

American Cancer Society Cancer Action Network
655 15th Street, NW, Suite 503, Washington, D.C. 20005
fightcancer.org | 1.202.661.5700

populations.[4] In particular, high deductibles have been shown to make a cancer survivor more likely to experience several types of financial hardship,[5] and lead to significant cancer diagnostic and treatment delays.[6,7] The amendment further estimates that this waiver will improve access to care in New York by producing an enrollment increase of approximately 3,000 consumers per year. ACS CAN supports the proposed cost-sharing subsidies as a method to improve both affordability and accessibility of coverage in New York.

Finally, ACS CAN supports the positive effect that this waiver is expected to have on health equity in New York. Adult Black and Hispanic New Yorkers experience lower levels of health insurance coverage and higher incidences of preventable hospitalizations.[8] Increased affordability of coverage and enrollment can help to address these disparities.

Conclusion

ACS CAN supports this proposal as a method to improve affordability of healthcare for lower income individuals in New York, as well as equitable access to care, while complying with the 1332 waiver statutory guardrails. If you have any questions, please feel free to contact me at michael.davoli@cancer.org.

Sincerely,

Michael Davoli
New York Government Relations Director
American Cancer Society Cancer Action Network

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[4]Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[5] Zheng Z, Jemal A, Han X, Guy GP Jr, Li C, Davidoff AJ, Banegas MP, Ekwueme DU, Yabroff KR. Medical financial hardship among cancer survivors in the United States. Cancer. 2019 May 15;125(10):1737-1747. doi: 10.1002/cncr.31913. Epub 2019 Jan 21. PubMed PMID: 30663039.

[6] Zheng Z, Jemal A, Banegas MP, Han X, Yabroff KR. High-Deductible Health Plans and Cancer Survivorship: What Is the Association With Access to Care and Hospital Emergency Department Use?. J Oncol Pract. 2019 Aug 8;:JOP1800699. doi: 10.1200/JOP.18.00699. [Epub ahead of print] PubMed PMID: 31393809.

[7] Wharam JF et al. Vulnerable And Less Vulnerable Women In High-Deductible Health Plans Experienced Delayed Breast Cancer Care. March 2019. Health Affairs. https://doi.org/10.1377/hlthaff.2018.05026

[8] Department of Health, New York State. New York State Prevention Agenda Dashboard-State Level, 2023. Available at: https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

June 27, 2024

Submitted Electronically

Re: New York State's Section 1332 Waiver Amendment, Revised May 2024

We are writing to submit comments on behalf of the Coalition of New York State Public Health Plans ("PHP Coalition" or "the Coalition") regarding New York State's draft amendment (released in May 2024) to its Section 1332 State Innovation Waiver.

The PHP Coalition represents seven health plans that serve more than 5.5 million New Yorkers enrolled in the State's government-sponsored healthcare programs: "Mainstream" Medicaid Managed Care (MMC), HIV Special Needs Plans (HIV SNPs), Health and Recovery Plans (HARPs), Child Health Plus (CHP), Essential Plan (EP), and subsidized Qualified Health Plan (QHP) coverage offered through the New York State of Health Marketplace. The Coalition's comments stem from our collective, extensive expertise managing care for people enrolled in publicly-funded insurance programs. Our comments also reflect our commitment to preserve, strengthen, and expand New York's healthcare coverage programs.

The Coalition has strongly supported the State's 1332 State Innovation Waiver program and the State's efforts to expand EP eligibility from 200% of the federal poverty level (FPL) up to 250% FPL. However, a major area of concern for Coalition plans in the state's initial application last year was the impact this expansion would have on the individual market. Specifically, we have expressed concern that the State's relatively small individual market would be negatively affected by the projected increase in consumer premiums that would result from lower-income members shifting out of the QHP market and into EP. To mitigate this concern, the State will implement a "Insurer Reimbursement Implementation Plan" (IRIP) that seeks to keep consumer premiums to the level they would be without the waiver. However, as we have discussed with the State, the Coalition still believes it is important for New York to explore rigorous, long-term solutions – such as reinsurance or risk adjustment – to ensure a strong and stable individual market.

Regarding the current amendment, the PHP Coalition strongly supports the use of federal passthrough funds to support cost sharing reductions for individuals up to 400% of the FPL. The Coalition believes that these new subsidies will be important to ensuring continued affordability in the QHP market as existing federal enhanced subsidies expire in 2025. **The PHP Coalition also strongly supports the use of federal passthrough funds to support cost sharing reductions for diabetes care and pregnancy and postpartum care.** We applaud the State in addressing the continued disparities in maternal health and diabetes care outcomes and advancing health equity, and this is a positive step in continuing to promote affordable care for all New Yorkers enrolled in a QHP, regardless of income level. These cost sharing subsidies, however, have the potential to exacerbate the underlying concerns we expressed above regarding premiums in the individual market, if the IRIP does not adequately compensate plans for the increased utilization that may occur because of waived cost sharing. Plans will closely monitor and adequately reflect any changes in the market in their rate filings and expect the State will be open to future feedback.

We greatly appreciate the State's efforts to expand affordability across State programs and leverage the 1332 program to bolster the QHP market. The PHP Coalition strongly supports the core goals of the proposed 1332 State Innovation Waiver amendment and we look forward to continuing our partnership with the State and tackling a long-term solution for individual market stability in the future.

June 26, 2024

Danielle Holahan
Executive Direction
New York State of Health Marketplace
nysoh@health.ny.gov

Re: Revised 1332 Waiver Submission, dated May 28, 2024

Dear Ms. Holahan,

The Community Service Society of New York (CSS) has worked with and for New Yorkers since 1843 to promote economic opportunity and champion an equitable state. CSS's Health Initiatives Department—along with its extraordinary network of community-based partners throughout New York State—has the great honor of helping over 130,000 consumers enroll in and use health insurance coverage, saving them over $80 million, per year. These patients' experiences guide our health policy reports that seek to improve the health care system for all New Yorkers. For example, in 2012, CSS issued: ***Bridging the Gap: Exploring the Basic Health Insurance Option for New York,*** the first report to model the benefit to New York in taking advantage of the Section 1331 Basic Health Program (BHP) provision of the Affordable Care Act.[1] CSS and its partners successfully advocated for the launch of New York's BHP (branded as the "Essential Plan") in 2015, and over 1.1 million New Yorkers have since enrolled, generating a surplus of $2 billion per annum.

At the outset, CSS would like to express its deep gratitude to the Marketplace team for accepting many of our past recommendations made in prior comments, including adopting our recommendations to seek approval from CMS to use surplus funding to eliminate the initially proposed $15 premium and to provide coverage for DACA recipients.

In this letter, CSS would like to offer its enthusiastic support for New York State's proposed Amended 1332 Waiver submission, dated May 28, 2024. Our comments address the following: (1) cost-sharing reductions (CSRs) to individuals with incomes below 400

[1] https://www.cssny.org/publications/entry/bridging-the-gapJune2011RevisedJanuary2012

percent of the federal poverty level (FPL); (2) cost sharing support for diabetes services; (3) cost sharing support for pregnant women; and (4) the use of 1332 waiver funding to provide premium assistance to New Yorkers, should the federal subsidies expire in 2025.

1. Cost-sharing reductions (CSRs) for individuals with incomes below 400 percent of FPL

CSS supports the State's proposal to offer CSRs to individuals enrolled in Qualified Health Plans (QHPs). In partnership with a network of community-based organizations throughout the state, CSS operates both the State's largest Navigator program and the State's Independent Consumer Assistance Program, pursuant to Section 1002 of the Affordable Care Act. Our programs annually assist thousands of consumers enroll in and use their NYSOH coverage. Many of these consumers struggle with out-of-pocket costs.

Much of the reason for these out-of-pocket cost struggles has to do with the degradation of insurance products. Cost-shifting through increasing deductibles is especially problematic, with the Standard Silver deductible at $2,100 and the Bronze deductible at $4,600. These amounts are so high that consumers no longer see the value in a Silver plan. Accordingly, New York has observed a major shift from higher quality products to Bronze plans since the roll out of the NY State of Health Marketplace. In 2014, just 19 percent of New Yorkers were enrolled in Bronze plans; by 2023, this number had increased to 41 percent.[2]

This degradation of the quality of health coverage has real world implications, and the problem of medical debt has intensified. As of 2023, the Urban Institute reports that over 740,000 New Yorkers are experiencing medical debt.[3] As documented in CSS's ***Discharged Into Debt*** series of reports, medical debt has resulted in over 10,000 New Yorkers being sued a year by hospitals, the garnishment of patients' wages, and the imposition of liens on patients' homes.[4] The research also indicates that medical debt disproportionately impacts low- and moderate-income New Yorkers and New Yorkers of color.

[2] *Compare* https://info.nystateofhealth.ny.gov/2014-open-enrollment-report *with* https://info.nystateofhealth.ny.gov/health-insurance-coverage-update-april-2023

[3] https://www.urban.org/research/publication/medical-debt-new-york-state-and-its-unequal-burden-across-communities

[4] Dunker, Amanda, et al., *Discharged Into Debt: Racial Disparities and Medical Debt in Albany County*, Community Service Society of New York, March 2021, https://www.cssny.org/publications/entry/discharged-into-debt-medical-debt-and-racial-disparities-in-albany-county; Benjamin, Elisabeth, et al., *Discharged Into Debt: Hospital Profile – Upstate University Hospital,* Community Service Society of New York, December 2022, https://www.cssny.org/publications/entry/discharged-into-debt-hospital-profile-upstate-university-hospital.

[4] Benjamin, Elisabeth, *Discharged Into Debt: Nonprofit Hospitals File Liens on Patients' Homes*, Community Service Society of New York, November 2021, https://www.cssny.org/publications/entry/discharged-into-debt-

The State's proposal to offer Silver CSR87 products to individuals with incomes up to 350 percent of the FPL is a good approach. The Silver CSR87 plan has just a $275 deductible. This is a manageable amount for most consumers in these income bands. The Silver CSR73 has a deductible of $1,925. While enrollees in the Silver CSR73 receive some benefit from the $175 reduction in the amount of their deductible, it is hard to determine how meaningful that impact would be.

CSS urges the state to simplify its proposal and offer CSR87 to all consumers up to 400 percent of FPL, instead of having a second CSR73 for those with incomes between 350-400 percent of FPL.

2. **Cost-sharing support for diabetes services**

According to the New York State Department of Health, 1.6 million New Yorkers have diabetes, of whom 538,000 use insulin.[5] The prevalence of diabetes in New York is significantly higher among Black adults (14.5 percent) than among Hispanic adults (11 percent) and non-Hispanic White adults (9.2 percent).[6] People of color also experience a higher burden of diabetes-related complications, such as amputation, blindness, and end-stage renal disease.[7] Black New Yorkers are more than twice as likely to die from diabetes compared to White New Yorkers.[8] Low-income adults have a risk of diabetes that is over double that of those not living in poverty.[9] The prevalence of New Yorkers with diabetes is highest in the following urban and rural counties: Bronx, Niagara, Genesee, Cattaraugus, Steuben, Chemung, Wayne, Seneca, Lewis, Oneida, Chenango, Franklin and Washington.

nonprofit-hospitals-file-liens-on-patients-homes; Dunker, Amanda, et al., *Discharged Into Debt: New York's Nonprofit Hospitals Garnish Patients' Wages,* Community Service Society of New York, July 2022, https://www.cssny.org/publications/entry/discharged-into-debt-new-yorks-nonprofit-hospitals-garnish-patients-wages

[5] "Percentage of Adults with Diagnosed Diabetes, by county, New York State, BRFSS 2018," New York State Department of Health. January 2021, 1-2. https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2021-01_ifa_report.pdf.

[6] "BRFSS Brief, Diabetes," New York State Department of Health. 2018, https://www.health.ny.gov/statistics/brfss/reports/docs/2021-06_brfss_diabetes.pdf.

[7] "The Fierce Urgency of Now: Investments to Turn the Tide of the Diabetes Epidemic," New York City Department of Health and Mental Hygiene. November 2023, https://www.nyc.gov/assets/doh/downloads/pdf/diabetes/diabetes-working-group-report.pdf.

[8] "Percentage of Adults with Diagnosed Diabetes, by county, New York State, BRFSS 2018," *New York State Department of Health.* January 2021, 1-2. https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2021-01_ifa_report.pdf.

[9] "BRFSS Brief, Diabetes," *New York State Department of Health.* 2018, https://www.health.ny.gov/statistics/brfss/reports/docs/2021-06_brfss_diabetes.pdf.

These consumers need help. Over the past two decades, just the price of insulin has risen by more than 1,200 percent, not to mention other costs of diabetes care.[10]

Systematic medical literature reviews indicate that the elimination of cost-sharing for chronic conditions significantly increases medication adherence, vastly improving health outcomes and overall health care system savings.[11] One study, led by Blue Cross Blue Shield of Louisiana in 2021, found that eliminating co-pays for prescription medications that treat chronic conditions, including insulin, increased medication adherence for most enrollees, especially those with the lowest incomes. The follow-up evaluation of the program found a *10 percent decrease in medical spending*, leading to an average net savings of $63 per member per month.[12]

Accordingly, CSS enthusiastically supports New York's proposal to ensure that NYSOH enrollees with diabetes will have $0 out-of-pocket costs for diabetes-related services. Moreover, we the State to establish a system with the carriers to closely monitor utilization of health care services to determine and document whether health plans are securing savings—as the literature suggests—for these enrollees as a result of this reform.

3. Cost-sharing support for pregnant people

According to the most recent statistics issued by the New York State Department of Health, 121 pregnancy-related deaths occurred between 2018-2020 (the most recent statistics available).[13] This translated into a very high pregnancy-related mortality ratio of 26 deaths per 100,000—making New York an outlier amongst our peer states in the Northeast, Mountain West and West.[14]

There are myriad studies that indicate cost-sharing poses a barrier to accessing care. People who are pregnant, or who have recently delivered a child, should experience no cost-barriers to accessing care.

Accordingly, CSS enthusiastically supports New York's proposal to ensure that there will be $0 out-of-pocket costs for people who are pregnant or who are postpartum. In fact,

[10] Roberts, D. (2019). The Deadly Costs of Insulin. *AJMC*. https://www.ajmc.com/view/the-deadly-costs-of-insulin.

[11] Fusco et al., "Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systematic literature review," *J Manag Care Spec Pharm*. January 2023, 4-16. doi: 10.18553/jmcp.2022.21270.

[12] Cong et al., "Association of co-pay elimination with medication adherence and total cost," *AJMC,* June 2021, 249-254. doi: 10.37765/ajmc.2021.88664.

[13] https://www.health.ny.gov/press/releases/2024/2024-03-14_maternal_mortality.htm#:~:text=A%20total%20of%20121%20pregnancy,births%20from%202018%20to%202020.

[14] https://usafacts.org/articles/which-states-have-the-highest-maternal-mortality-rates/.

given that so few people will benefit from this measure (only 1,600 per year), CSS recommends eliminating cost-sharing for the inpatient delivery itself as well.

4. **Include the flexibility to use of 1332 waiver funding to provide premium assistance to New Yorkers should the federal subsidies expire in 2025**

Finally, we urge New York State to include flexibility to use the 1332 surplus funds for premium assistance. This flexibility is important to secure, in light of the Congressional Budget Office's new estimates that the rate of uninsurance is likely to rise in the United States from 7.2 percent to 8.9 percent over the next decade.[15]

In 2022, CSS and the Citizens Budget Commission modeled the features and costs of a state-premium assistance program for New York.[16] CSS believes that cost-sharing reductions and premium assistance are key levers to ensuring that New York's uninsurance rate remains at its historic low, secured as a result of the federal COVID-19 Public Health Emergency policies.

CSS would like to thank you for the opportunity to offer our comments about New York State's May 2024 1332 Draft Waiver Amendment proposal.

Very truly yours,

Elisabeth Ryden Benjamin, MPSH, JD
Vice President, Health Initiatives
Community Service Society of New York

[15] Jessica Hale, et. al, "Health Insurance Coverage Projections for the US Population and Source of Coverage, by Age, 2024-2034, *Health Affairs,* June 18, 2024.
[16] CSS & CBC, "Narrowing New York's Health Insurance Coverage Gap," January 2022.

CUNY SPH GRADUATE SCHOOL OF PUBLIC HEALTH & HEALTH POLICY

JUNE 25, 2024

Sent via email to: nysoh@health.ny.gov

Danielle Holahan
Executive Director, NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Dear Executive Director Holahan,

The CUNY Graduate School of Public Health and Health Policy (CUNY SPH) is New York City's *public* school of public health. Our mission is to advance health equity and social justice locally and globally. Our faculty have expertise across various public health disciplines including chronic disease prevention; maternal, child and reproductive health; health care access among underserved urban populations; and health care systems.

CUNY SPH supports New York's proposed 1332 waiver amendment to implement cost-sharing reduction initiatives for individuals with incomes up to 400% of the FPL, individuals seeking services to manage their diabetes, and individuals who are pregnant or postpartum. The Urban Institute estimates that 740,000 New Yorkers have medical debt on their credit report. Communities of color and those with a lower median household income also face higher rates of medical debt. While health insurance coverage is crucial and New York State has a lower uninsured rate than other states, coverage alone may not protect individuals against medical debt due to cost-sharing requirements. One recent poll reported that half of U.S. adults say it is difficult to afford health care costs, and one in four say they or a family member in their household had problems paying for health care in the past 12 months. Another study found that 28% of adults reported delaying or going without either medical care, prescription drugs, mental health care, or dental care due to cost. Cost-sharing subsidies can improve health outcomes by reducing financial barriers and making health care more affordable by reducing out-of-pocket costs.

CUNY SPH is also a proud partner of HealthyNYC, New York City's campaign to improve life expectancy and create a healthier city for all. HealthyNYC aims to accomplish this goal by targeting the major drivers of overall death, excess death, premature death and extreme racial inequities, including chronic and diet-related diseases, screenable cancers, mental health, COVID-19, homicide, and maternal mortality. The subsidies included in the 1332 waiver will directly alleviate cost-sharing for outpatient diabetes, pregnancy and postpartum care, which are key to receiving timely care to prevent poor outcomes. When more people have access to affordable care, the overall population becomes healthier.

We stand ready to collaborate with you to make health care more affordable for all New Yorkers.

Respectfully,

Ayman El-Mohandes, MBBCh, MD, MPH,
Dean, CUNY Graduate School of Public Health and Health Policy
CC: NYS Department of Health Commissioner James V. McDonald, MD, MPH

THE CITY UNIVERSITY OF NEW YORK
55 WEST 125th STREET | NEW YORK, NY 10027 | (646) 364-9600 | SPH.CUNY.EDU

Danielle Holahan
Executive Director
NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Attn: New York 1332 Waiver

Dear Executive Director Holahan:

On behalf of the nearly 1700 people living with cystic fibrosis (CF) in New York, the Cystic Fibrosis Foundation appreciates the opportunity to submit comments on the 1332 Waiver Amendment Request. Specifically, we support New York's request to implement cost sharing reduction (CSR) subsidies for consumers with incomes up to 400% of the federal poverty level (FPL) and for consumers in all metal tiers who receive diabetes-related services. Cost-sharing reduction payments are a critical tool for the health insurance Marketplace, keeping care affordable for many people with CF and other chronic diseases. Together, these proposals will reduce out-of-pocket costs and improve access to care for people living with CF in New York.

About Cystic Fibrosis and Cystic Fibrosis-Related Diabetes

Cystic fibrosis is a life-threatening genetic disease that affects nearly 40,000 children and adults living with cystic fibrosis in the United States, and CF can affect people of every racial and ethnic group. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. While great strides have been made in the treatment of the disease, the lives of young people with cystic fibrosis are still cut far too short; half of young adults with this disease still die before age 37. CF requires an intensive daily treatment regimen to address its many manifestations and eighty-six percent of CF patients also have at least one health complication in addition to cystic fibrosis, including cystic fibrosis-related diabetes (CFRD), asthma, sinus disease, and others.

Cystic fibrosis-related diabetes is one of the most common complications experienced by people with CF, occurring in five percent of adolescents and nearly one in three adults living with CF.[1] Due to the disease's progressive nature, CF can cause scarring or "fibrosis" of the pancreas, which can lead to insulin deficiency and CFRD. Like type-1 and type-2 diabetes, treatment for CFRD relies on insulin and additional supplies such as continuous glucose monitors, test strips, insulin pens, syringes or needles, lancets, and alcohol swabs.

The Cystic Fibrosis Foundation is committed to ensuring that New York's healthcare programs provide quality and affordable healthcare coverage. We believe the state's proposal to enhance cost-sharing subsidies for Marketplace consumers will advance these objectives. Once implemented, New York's waiver should increase coverage affordability for tens of thousands Marketplace enrollees and improve health equity, while satisfying the federal guardrail protections governing waivers. We applaud the state's work to improve equitable access to care in New York and offers the following comments:

Reduction in Cost Sharing for Individuals Up to 400% of the FPL

New York's proposed cost-sharing subsidies will lower healthcare costs for individuals above 250% of the federal poverty level. For example, the waiver projects that 79,000 individuals will save an additional average of $3,450 annually as a result of the cost-sharing subsidies. The state anticipates that a total of 118,000 enrollees will experience improved affordability of coverage as a result of this proposal. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income

[1] https://www.cff.org/sites/default/files/2021-11/Patient-Registry-Annual-Data-Report.pdf

populations.[2] The amendment further estimates that this waiver will improve access to care in New York by increasing enrollment by approximately 3,000 people per year. The Cystic Fibrosis Foundation supports the proposed cost-sharing subsidies as a method to improve both affordability and accessibility of coverage in New York. At the same time, the state's analysis demonstrates that the waiver satisfies four statutory guardrails. While affordability and enrollment will improve, the comprehensiveness of coverage will not be affected. The amendment also states that additional costs will be fully covered by the pass-through surplus from New York's existing 1332 waiver, and we encourage New York to clarify how this amount was calculated to allow a better understanding of how pass-through funds will cover these costs.

Reduction in Cost-Sharing for Diabetes Services

The Cystic Fibrosis Foundation also supports New York's request to create a cost-sharing wrap that reimburses insurers to reduce cost sharing for non-hospital-based diabetes-related services, supplies and prescription drugs, for all Marketplace consumers. As a result, consumers will have $0 out-of-pocket costs for diabetes-related services while remaining in a plan of their choice. We appreciate that New York intends to use passthrough funding to reimburse insurers for cost sharing they would have received from consumers for diabetes-related care, offsetting potential premium increases for the Marketplace.

Reducing out-of-pocket costs for diabetes services will improve access to care for New Yorkers living with CFRD. Due to the high cost of insulin and other prescription drugs, many people with CF—even with the help of financial assistance—are forced to make difficult spending tradeoffs that can impact their health. According to a recent survey conducted by George Washington University of over 1,800 people living with CF and their families, nearly half of those surveyed reported delaying or forgoing care—including skipping medication doses, taking less medicine than prescribed, filling a prescription, or skipping a treatment altogether—due to cost concerns.[3] Further, one in seven people with CF who use diabetes supplies reported having problems paying for them. Diabetic supplies are commonly classified as durable medical equipment and often do not have adequate coverage with commercial insurers, frequently leading to high out-of-pocket costs for people with CF. Those living with CFRD who do not have consistent access to insulin or accompanying supplies may be unable to properly manage their blood sugar levels, putting them at increased risk of irreversible damage, costly hospitalizations, and declining health outcomes.

The cost of insulin and supplies places additional financial strain on patients who may already struggle to afford their care. In the aforementioned survey, people with CF reported having the most difficulty paying for prescription drugs compared to any other component of their health care. Further, more than 70 percent of people with CF said paying for health care has caused financial problems such as being contacted by a collection agency, filing for bankruptcy, experiencing difficulty paying for basic living expenses like rent and utilities, or taking a second job to make ends meet. Eliminating copayments for insulin and diabetes supplies will help mitigate some of the financial burden that accompanies managing cystic fibrosis and CFRD.

The Cystic Fibrosis Foundation supports the proposals in this waiver request as a method to improve affordability of healthcare for lower income individuals in New York, as well as equitable access to care, while complying with the 1332 waiver statutory guardrails.

Thank you for the opportunity to provide comments.

Sincerely,

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President of Policy & Advocacy
Cystic Fibrosis Foundation

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[2] www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost sharing-on-low-income-populations-updated-review-of-research-findings/

[3] https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1056&context=sphhs_policy_briefs

EmblemHealth®

55 Water Street, New York, New York 10041-8190

June 24, 2024

Re: New York State's Draft Amendment to its Section 1332 Waiver

To Whom it May Concern:

On behalf of the EmblemHealth, we are writing in support of the New York State Department of Health's draft amendment to its Section 1332 State Innovation Waiver. EmblemHealth is a nonprofit, mission-based health plan headquartered in New York City serving 2 million New Yorkers, including approximately 100,000 people receiving coverage in the Essential Plan and in qualified health plans (QHPs) on the state health insurance exchange. The issues raised by the proposed waiver amendments are therefore of critical importance to our enterprise and the individuals we serve.

EmblemHealth strongly supports the proposed waiver amendments. Health care can be extremely expensive. For example, the average price of an inpatient hospital stay in New York was over $45,000 in 2022[1] and some prescription drug costs exceed $100,000 each year. Health insurance reduces those costs through benefit structures with cost-sharing that is limited to zero or nominal amounts for services that would otherwise be unaffordable. Health insurance programs also support the state's goals to reduce inequities by making health care more affordable for low- and middle-income people, many of whom are individuals of color and others who have suffered from discrimination in the delivery of health care services.

The waiver amendment supports these goals in three important ways:

- Eliminating cost-sharing in Exchange plans for all outpatient covered services, supplies, and prescription drugs during pregnancy and postpartum. Poor maternal health outcomes including deaths remain too common, especially among Black and Hispanic individuals. The proposed waiver amendment will improve maternal health outcomes in our state. The high cost of maternal care remains a significant barrier for many low- and middle-income individuals. A recent study[2] found the costs of pregnancy, delivery, and post-partum care were almost $20,000 in 2020. Other studies have shown states expanding their Medicaid coverage under the Affordable Care Act experienced significant improvements in maternal health outcomes, especially among Black and Hispanic individuals[3]. Eliminating cost sharing for needed services during pregnancy and

[1] RAND Corporation, "Prices Paid to Hospitals by Private Health Plans" (May 13, 2024).
[2] Kaiser Family Foundation, "Health costs associated with pregnancy, childbirth, and postpartum care" (July 13, 2022).
[3] See for example Georgetown University Health Policy Institute, "Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies" (May 2019).

postpartum services in QHPs will allow New York to increase the availability of no-cost care that improves the health of pregnant individuals and their newborns.

EmblemHealth is committed to improving maternal health outcomes in New York. We have created self-advocacy resources[4] to support individuals as they navigate pregnancy, labor, and delivery and have developed a Healthy Futures Program for expectant individuals who are high-risk. We recently announced[5] a partnership with the company SimpliFed to help create a feeding plan before the baby is due and provide lactation support after leaving the hospital and between doctor's visits. EmblemHealth is also a strong supporter of the state's efforts to expand Medicaid coverage of doula services. For example, we have led a collaborative effort with the New York City Department of Health and Mental Hygiene, Mae Health, Planned Parenthood, and the Community Service Society of New York to develop recommendations for this new benefit including adequate reimbursement for doulas to make the program a success.

The state's proposals to make pregnancy and post-partum services more affordable will help improve our members' health. We greatly appreciate the state's leadership and look forward to continuing to work the Department of Health to improve maternal health outcomes in New York.

- Eliminating cost-sharing for all diabetes services in QHPs. Eliminating cost-sharing for diabetes services in QHPs is consistent with the state's goals to create a more equitable health care system. The U.S. Centers for Disease Control and Prevention (CDC) has noted[6] that diabetes rates among non-white adults are significantly higher than in white Americans. The CDC data also indicate the low- and middle-income individuals are about twice as likely as those with incomes above 500% of the federal poverty level (FPL) to have the disease. Increasing the availability of affordable health care through Medicaid expansion and other health insurance has improved diabetes care outcomes. For example, a 2023 study[7] "found that lack of health care coverage and of an established source of diabetes care were associated with significantly higher HbA1c levels."

  EmblemHealth is working to reduce inequities in diabetes care. We are implementing programs that identify where there are gaps in care among underserved populations and developing targeted strategies to ensure our members with diabetes get the nutrition and other support they need. We will also soon be launching a neighborhood-by-neighborhood approach taking advantage of our affiliated physician practice Advantage Care Physicians of New York (ACPNY); our Neighborhood Care centers that offer classes, food markets, and social services supports; and our wellness company WellSpark to develop tailored strategies to identifying and treating diabetes in New York City. Our first pilots for this approach will be in low-income neighborhoods to ensure we are reaching traditionally underserved populations.

[4] Please see here.
[5] Please see here.
[6] Please see the latest CDC data here.
[7] Pihoker, et. al., "Diabetes Care Barriers, Use, and Health Outcomes in Younger Adults With Type 1 and Type 2 Diabetes" (JAMA Netw Open. 2023 May; 6(5): e2312147).

- Funding new subsidies for individuals up to 400% FPL to buy QHPs. EmblemHealth strongly supports federal and state initiatives that expand access to health insurance among low- and middle-income individuals. As we note above, increasing access to affordable health care improves lives and reduces historical health inequities. A new Urban Institute study[8] finds coverage gains from expanded federal subsidies could be lost if Congress does not renew them next year. The state's proposal will allow many middle-income individuals to get health insurance coverage now and make them more likely to keep it if Congress takes the federal subsidies away next year.

Conclusion

EmblemHealth greatly appreciates this opportunity to comment on New York State's proposed amendments to its section 1332 waiver. We strongly support these amendments, which will play a critical role in improving the health of low- and middle-income New Yorkers and reducing inequities for many of our neighbors. EmblemHealth thanks the Department of Health for its leadership and looks forward to continuing to work with New York State to create healthier futures for New Yorkers.

[8] The Urban Institute, "Who Benefits from Enhanced Premium Tax Credits in the Marketplace?" (June 2024).

GREATER NEW YORK HOSPITAL ASSOCIATION

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June
Twenty-Seven
2 0 2 4

Danielle Holahan
Executive Director, NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Re: NY State of Health Section 1332 Innovation Waiver Essential Plan Expansion Draft Amendment

Dear Ms. Holahan:

Thank you for the opportunity to comment on the New York State Department of Health (DOH) Section 1332 Innovation Waiver Essential Plan Expansion Draft Amendment (the "Waiver Amendment"). As communicated in our previous comments throughout 2023 in support of the 1332 Innovation Waiver Application and Addendums (collectively, the "Waiver"), Greater New York Hospital Association (GNYHA) has strongly supported New York's Essential Plan (EP) since its inception. With the goal of ensuring that more New Yorkers can access affordable and comprehensive coverage, we encouraged efforts to expand EP eligibility, and now also **strongly support the Waiver Amendment's proposal to reduce the cost-sharing burden for New Yorkers in Qualified Health Plans (QHPs).**

New York's State Fiscal Year (SFY) 2025 budget included authority to use State and Waiver funding to provide cost sharing and premium payment assistance for individuals eligible to purchase QHPs through the Marketplace. With this Waiver Amendment, DOH seeks Federal approval to expand the allowable use of passthrough Waiver dollars to address one of the SFY 2025 budget's two stated objectives. Specifically, DOH seeks to implement cost-sharing assistance for individuals up to 400% of the Federal Poverty Level (FPL) by expanding eligibility for existing Silver CSR 87 plan variants to individuals up to 350% of the FPL, and Silver CSR 73 plan variants to individuals between 350% and 400% of the FPL. Additionally, all individuals with diabetes, and those who are pregnant or post-partum, will have cost sharing for outpatient services and supplies and prescriptions related to these conditions eliminated, regardless of the QHP and metal level in which they are enrolled. As proposed, Waiver passthrough funding would be used to make insurers whole for the cost sharing that would have otherwise applied, thereby mitigating the associated impact on individual market premiums, plan benefits, and underlying plan actuarial value.

Importantly, GNYHA supports DOH's goal of advancing health equity through the Waiver Amendment. Reducing consumer out-of-pocket costs for QHP coverage increases affordability and improves access to care. We further support the focus on diabetes and the Waiver Amendment's stated objective of addressing health inequities by focusing on conditions that disproportionately impact lower-income communities, including communities of color. And as it is imperative to reduce racial and ethnic disparities in infant and maternal mortality and associated health outcomes, we strongly support the proposal to eliminate cost

GREATER NEW YORK HOSPITAL ASSOCIATION GNYHA

GNYHA is a dynamic, constantly evolving center for health care advocacy and expertise, but our core mission—helping hospitals deliver the finest patient care in the most cost-effective way—never changes.

sharing for pregnant and post-partum individuals to reduce barriers to accessing the full suite of prenatal and postnatal health care, including postpartum mental health benefits.

We strongly support the cost-sharing reduction proposals in this Waiver Amendment. This focus is particularly important in light of the impending expiration of the enhanced premium tax credits under the Inflation Reduction Act at the end of 2025**. We also encourage DOH to continue exploring opportunities for reducing premiums, as authorized by State law, to further expand access and affordability.**

We note that reducing cost sharing for individuals up to 400% of the FPL provides an important complement to New York's recently amended hospital financial assistance law that, among other provisions, now requires hospitals to provide financial assistance to individuals below 400% of the FPL who are insured but have accrued out-of-pocket medical costs exceeding 10% of their gross income in the last 12 months (the "underinsured"). GNYHA has significant concerns with permitting health insurers to sell high cost-share plans to individuals the New York State Legislature considers unable to afford them. While we believe strongly that cost should not impede access to care, it is misguided to approve and allow insurers to sell plans to individuals and collect premium dollars, and then shift the costs to providers when individuals are unable to pay their share. The associated bad debt more appropriately lies with the insurer selling the product. Using passthrough Waiver funding to enroll individuals up to 400% of the FPL in reduced cost-sharing plan designs has the added benefit of helping to mitigate the number of New Yorkers who are sold plans they cannot afford.

The Waiver is a vehicle for facilitating access to affordable, comprehensive coverage for New Yorkers, and we appreciate DOH's thorough consideration of unintended consequences. We strongly support efforts to ensure that New Yorkers in the QHP individual market do not face increased premiums because of the Waiver Amendment. We encourage DOH to continue evaluating opportunities for using Waiver passthrough funding to subsidize out-of-pocket costs for individuals below 400% of the FPL in QHPs, as well as addressing the cost-shifting concerns raised above.

We look forward to continuing to work with DOH on Waiver implementation. Please contact me with any questions.

Sincerely,

Emily Leish
Senior Vice President, Health Finance and Managed Care

cc: Amir Bassiri

African Service Committee ☙ Center for Independence of the Disabled, NY ☙ Children's Defense Fund-New York
Coalition for Asian American Children and Families ☙ Community Service Society of New York ☙ Consumers Union
Empire Justice Center ☙ Entertainment Community Fund ☙ Hispanic Federation
Hospital Equity and Accountability Project ☙ The Legal Aid Society ☙ Make the Road New York
Medicare Rights Center ☙ Metro New York Health Care for All Campaign ☙ New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York ☙ Raising Women's Voices-New York
Schuyler Center for Analysis and Advocacy ☙ South Asian Council for Social Services ☙ Young Invincibles

June 27, 2024

Submitted by:
Health Care For All New York

Health Care For All New York (HCFANY) would like to thank the New York State of Health Marketplace (NYSOH) for the opportunity to comment on the May 28, 2024, Section 1332 Innovation Waiver Draft Amendment. HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers.

HCFANY writes to express its support for the draft amendment which seeks to improve the affordability of health coverage offered on the NYSOH Marketplace through the following provisions.

- Improving the affordability of Qualified Health Plans (QHP) by offering cost-sharing reduction wraps to people with incomes up to 350 percent of the federal poverty level (FPL).

This proposal would mean that people with incomes below 350 percent of FPL who enroll in silver coverage would have deductibles of just $275, as opposed to $2,100. HCFANY supports this measure because it is deeply concerned about the increasing number of New Yorkers who have had to turn to high-deductible products (e.g., Bronze plans) because the Silver products have become less of a value proposition. As a result, HCFANY is concerned about the ensuing rates of underutilization of health care and medical debt, especially for moderate-income and marginalized communities. Improving cost-sharing through the CSR87 wrap should incentivize New Yorkers to migrate back to Silver plans.

HCFANY supports this provision but urges the state to offer it to all NYSOH consumers with incomes up to 400 percent of the FPL.

- Elimination of cost-sharing for enrollees with diabetes

This proposal would ensure that diabetics enrolled in NYSOH coverage would have $0 out-of-pocket costs for diabetes-related services. New York is experiencing a diabetes epidemic.

Health Care For All New York
c/o Carrie Tracy, Community Service Society of New York
633 Third Avenue, 10th Floor, New York, New York 10017
(212) 614-5312

Diabetes-related services, such as pharmacy and medical equipment, have experienced exponential cost increases, making care management unaffordable and difficult to achieve. Diabetes disparately impacts New Yorkers of color and low- and moderate-income New Yorkers. Elimination of cost-sharing for diabetes-related services will help consumers better manage their health care needs.

HCFANY supports this proposal.

- Elimination of cost-sharing for most health care costs for pregnant and postpartum enrollees

This proposal seeks to eliminate cost-sharing for pregnant people, aside from the actual delivery. New York's maternal mortality rates are very high – as many as 26 people die per 100,000 births. In addition, New York's racial disparities in maternal mortality are of profound concern, with Black women being five times more likely to die than their White counterparts. High out-of-pocket costs deter people from getting the care that they need.

HCFANY supports eliminating cost-sharing for all pregnancy and post-partum care, including hospitalization and delivery-related services.

- HCFANY recommends adding the option to offer premium assistance.

HCFANY is concerned that insurance premiums will rise precipitously for people with incomes under 400 percent of FPL enrolled in NYSOH Marketplace coverage, should the enhanced subsidies under the American Rescue Plan, extended under the Inflation Reduction Act, expire.

HCFANY encourages NYSOH to include the flexibility to offer a state premium assistance program, funded by the 1332 Waiver Surplus, in the event these subsides end.

Thank you for considering our comments. Should you have any questions, please contact Mia Wagner at: mwagner@cssny.org.

From: Chris Norwood <ChrisNorwood@healthpeople.org>
Sent: Tuesday, June 25, 2024 10:50 AM
To: doh.sm.NYSOH <nysoh@health.ny.gov>
Subject: Essential Plan Waiver Comments

Dear NYSOH, We are thrilled that the Essential Plan Waiver emphasizes diabetes. This is so terribly needed.

Within that, however, the current plan is missing absolutely necessary opportunities for effective self-management education. Health People is an entirely peer-educator
Facilitated chronic disease and AIDS prevention and self-care community education organization.
We have almost certainly provided more community-delivered, peer facilitated diabetes
Self-management education than any NY organization.

The current waiver guidelines will drastically limit the use of education services because Title 8 confines these services to being provided by various certified personnel who DO NOT EXIST at hospitals and
Clinics in the neighborhoods with the highest diabetes rates. A Brooklyn Hospital we work with, for example, last year spent 6 months trying to hire registered dietician and finally was only able to get a part-time person.

Fortunately there is an alternative: The Diabetes Self-management Program, a 6 session course, is probably the best evaluated self-management course in the country. It is delivered by two intensively trained peer educators;
It is extensively evaluated and lowers blood sugar, depression, co-morbidities like kidney and heart disease.

Repeated evaluation (including NYCDOH evaluation of our own program) shows that it saves $1,000 to $2,000 per patient in the first 6 months to a year (not even counting long term savings from
Reduced complications.) The bulk of these early savings come from almost immediately reduced emergency visits and hospitalizations---a boon to the system in taking pressure off the front-line personnel.

During the last 1115 waiver, even as a small organization, we were able to work with several PPS's and implement the DSMP for their patients and surrounding community. We engaged more than 2,000
Medicaid patients with Type 2 diabetes in the DSMP. This is the kind of scale that is vitally needed but it can't be accomplished under current Section 8 restrictions.

Hopefully, with the waiver being a time for innovation these guidelines can be reformed to include proven peer delivery.

Not having this outstanding education available under the Essential Plan waiver is really depriving this waiver of one of the most potent, provable---and scalable---strategies to improve diabetes outcomes.

Thank you for your consideration. If I may answer any questions, my direct is 718 585 1064

Chris Norwood
Executive Director
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Preventing and managing chronic disease through sustainable peer outreach, targeted education, and effective clinical partnerships

HOUSING WORKS 57 Willoughby St, 2nd Floor, Brooklyn, NY 11201 WWW.HOUSINGWORKS.ORG

June 26, 2024

NY State of Health
Attn: 1332 Waiver
Empire State Plaza
Corning Tower , Room 2580
Albany, NY 12237

Re: NY Section 1332 Innovation Waiver Essential Plan Expansion May 28, 2024 Draft Amendment

Thank you for the opportunity to provide comments on New York's Draft Amendment to its Section 1332 Innovation Waiver Essential Plan Expansion. I am the Chief Executive Officer of Housing Works, Inc., an organization fully committed to ending the HIV/AIDS epidemic and to serving New York's most marginalized residents. Therefore, while Housing Works certainly supports the stated goal of the Draft Amendment to increase the affordability of Essential Plan coverage for certain New Yorkers, we must continue to oppose New York's 1332 State Waiver because it excludes immigrants.

Housing Works has been a leader in efforts to end HIV/AIDS as an epidemic in New York State. To end HIV equitably, in every population and community, all persons must have access to health coverage. Persons without health insurance are unlikely to go for an HIV test even if they are at high risk for exposure. They are also unlikely to know about pre-exposure prophylaxis or that they can have access to effective HIV prevention. Consequently, far too many New Yorkers (19% Statewide, and 23% Upstate) continue to receive an AIDS diagnosis at the same time they first learn they are HIV positive, and immigrants currently ineligible for health coverage for primary and preventive care are over-represented in this group. These are tragic missed opportunities for the early HIV diagnosis and treatment that sustains optimal health and stops ongoing transmission, and ongoing spread of the virus by persons unaware of their status undermines our ability to end the epidemic for all New Yorkers. To improve opportunities for early HIV diagnosis and advance equitable uptake of PrEP, we must afford immigrants access to health insurance coverage. This is one of many reasons we support health insurance coverage for every New York resident.

At Housing Works, we provide a full range of integrated medical, behavioral health, housing, and support services for over 15,000 low-income New Yorkers annually, with a focus on the most underserved—those facing the challenges of homelessness, HIV, behavioral health issues, other chronic conditions, incarceration, and most recently, new immigrants displaced from their homes due to violence or other crises who seek safety and a better life in the United States. We are pleased to operate two hotels for asylum-seeking families that currently houses over 500 individuals, over half of whom are children. I can tell you that each household we serve is eager to work and has the same hopes and dreams as every wave of immigrants to our City that have made it the rich and diverse place that we love. It is also true, however, that like every group of new immigrants they are dealing with legal, language, and cultural challenges. Every additional barrier to basic survival services such as health care only deepens their marginalization.

We remain deeply dismayed, therefore, that the State's proposed amendment to the current waiver continues to ignore the thousands of public comments submitted to the State over the course of its submission and approval to include Essential Plan coverage for immigrants.

Despite the NYS Governor's 2022 promise to include coverage for immigrants in the Waiver proposal, current fiscal concerns about caring for newly arriving immigrants, and overwhelming support among New York providers, patients, and advocates, New York's Draft Amendment still fails to expand coverage to immigrants. Indeed, the State's Draft Amendment shows that estimated passthrough to the State is estimated to be $9.1 billion in 2024 and $63.8 billion over the 5-year waiver period, the State still does not propose to use any of this surplus to expand coverage to uninsured immigrants. Rather than heed the community's clear call for the urgently needed and cost-effective expansion of coverage for immigrants.

Housing Works calls upon New York State policymakers to revise the Draft Amendment to propose using part of the $9.1 billion surplus to cover immigrants. Government officials should ensure that the 1332 Waiver keeps to its intended purpose, which is to innovatively expand affordable coverage for all uninsured New Yorkers.

Providing health insurance for immigrant communities – including hundreds of thousands of essential workers who kept our state functioning during a three-year pandemic – is both morally and fiscally responsible. Expanding coverage for immigrant New Yorkers through the 1332 Waiver would avoid $500 million in annual Emergency Medicaid costs incurred when uninsured immigrant patients seek emergency care at hospitals. It would also shore up the health care safety net by increasing revenues to health care providers at Federally Qualified Health Centers through essential plan rates, reducing the amount of sliding scale or uncompensated care provided.

Most importantly, we are all safer in the face of global public health threats when everyone has access to quality primary and preventive healthcare. Including immigrants in New York State's 1332 Wavier—just like Colorado and Washington State have done—is economically sensible, it's the right thing to do, and it's essential to equitably ending our NYS HIV epidemic. We hope that you can find a way to work toward a 1332 Waiver that extends essential plan health coverage to vulnerable immigrant New Yorkers.

Thank you.

Sincerely,

Charles King
CEO of Housing Works

LEUKEMIA & LYMPHOMA SOCIETY®

Danielle Holahan
Executive Director
NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Attn: New York 1332 Waiver

Dear Executive Director Holahan:

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on the New York 1332 Waiver Amendment Request.

LLS's mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and to improve the quality of life of patients and their families. We advance that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare, regardless of the source of their coverage.

LLS is committed to ensuring that New York's healthcare programs provide quality and affordable healthcare coverage. We believe the state's proposal to enhance cost-sharing subsidies for Marketplace consumers will advance these objectives. Once implemented, New York's waiver should increase coverage affordability for tens of thousands of Marketplace enrollees and improve health equity while satisfying the federal guardrail protections governing waivers. LLS applauds the state's work to improve equitable access to care in New York and offers the following comments.

New York's proposed cost-sharing subsidies will lower healthcare costs for individuals above 250% of the federal poverty level. For example, the waiver projects that 79,000 individuals will save an additional average of $3,450 annually as a result of the cost-sharing subsidies. The state anticipates that a total of 118,000 enrollees will experience improved affordability of coverage as a result of this proposal.

Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[i] Higher levels of insurance cost-sharing can also contribute to the accrual of medical debt, which has additional negative impacts on consumers and patients: these impacts are compounded by income, by race and ethnicity, *and* by serious health problems such as blood cancer.[ii]

The amendment estimates that this waiver will improve access to care in New York by producing an enrollment increase of approximately 3,000 consumers per year. LLS supports the proposed cost-sharing subsidies as a method to improve both affordability and accessibility of coverage in New York.

At the same time, the state's analysis demonstrates that the waiver satisfies four statutory guardrails. While affordability and enrollment will improve, the comprehensiveness of coverage will not be affected. The amendment also states that additional costs will be fully covered by the pass-through

surplus from New York's existing 1332 waiver, and LLS encourages New York to clarify how this amount was calculated to allow a better understanding of how pass-through funds will cover these costs.

Finally, LLS supports the positive effect that this waiver is expected to have on health equity in New York. Adult Black and Hispanic New Yorkers experience lower levels of health insurance coverage and higher incidences of preventable hospitalizations.[iii] Increased affordability of coverage and enrollment can help to address these disparities.

LLS supports this proposal as a method to improve affordability of healthcare for lower income individuals in New York, as well as equitable access to care, while complying with the 1332 waiver statutory guardrails.

Thank you for the opportunity to provide comments.

Sincerely,

Ernie Davis, Senior Director of State Government Affairs
The Leukemia & Lymphoma Society

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[i]Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[ii] Shameek Rakshit, Matthew Rae, Gary Claxton, Krutika Amin, and Cynthia Cox, "The Burden of Medical Debt in the United States," Peterson-KFF Health System Tracker, February 2024. Available at: https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/

[iii] Department of Health, New York State. New York State Prevention Agenda Dashboard-State Level, 2023. Available at: https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

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June 26, 2024

Danielle Holahan
Executive Director
NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Submitted online

Re: New York Section 1332 Innovation Waiver Essential Plan Expansion May 28, 2024 Amendment

Dear Ms. Holahan,

On behalf of our 11 member plans who participate in the Essential Plan, the New York Health Plan Association (HPA) submits the following comments in response to the Department of Health's (DOH) Section 1332 Innovation Waiver Essential Plan (EP) Expansion application, dated May 28, 2024.

HPA strongly supports the state's proposed 1332 waiver amendment application to use passthrough funding to improve affordability for consumers in the Qualified Health Plan (QHP) market. Specifically, HPA supports the state's proposals to implement three cost sharing reduction (CSR) subsidies in the QHP market, starting January 1, 2025 for:

1. Individuals with incomes up to 400% of the federal poverty level (FPL)
2. Diabetes Services
3. Pregnancy and Postpartum Care

Affordability initiatives for the QHP market are critically important to sustain and build on the state's success in expanding coverage for nearly all New Yorkers. HPA agrees with the state's CSR subsidy approach for 2025. While it is our hope that the federal government will extend authority for enhanced premium subsidies beyond 2025, we support the state's planned approach to pursue both premium and CSR subsidies in future years. We look forward to working collaboratively with the state to assure a smooth implementation process for the CSR subsidies and for payments to and reconciliations with plans as part of the process.

Finally, we also encourage the state to continue to work with the federal government and stakeholders to expand coverage to include income-eligible undocumented immigrants, as we work collaboratively toward the goal of affordable coverage for all New Yorkers.

Sincerely,

Kathleen Preston
Executive Vice President
NY Health Plan Association

June 20, 2024

NY State of Health
Attn: 1332 Waiver
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

VIA ELECTRONIC SUBMISSION

RE: Essential Plan Expansion 1332 Waiver Amendment

To Whom it May Concern:

The Primary Care Development Corporation (PCDC) appreciates the opportunity to comment on the potential expansion of the Essential Plan coverage through New York State Department of Health (NYSDOH). In 2022, New York State's enacted budget included a provision allowing the state's Department of Health to request a Section 1332 State Innovation Waiver from the Centers for Medicare & Medicaid Services (CMS) to expand eligibility for health insurance coverage under the state's Essential Plan to include residents with incomes up to 250 percent of the federal poverty level, up from the existing 200 percent of the federal poverty level. Since then, the Department of Health has added additional elements to the requested 1332 waiver, strengthening its ability to expand access to quality and affordable insurance for more New Yorkers, which will give them access to vital primary care.

As background, PCDC is a national non-profit organization and community development entity founded and based in New York City in 1993. We work to expand access to quality primary care and advance health equity for disinvested communities through capital investment, technical assistance, research, and advocacy. Over the past three decades, PCDC has leveraged more than $1.5 billion to finance over 250 primary care projects, with strategic community investments that have built the capacity to provide 4.7 million primary care visits annually, created or preserved nearly 20,000 jobs in low-income communities, and transformed more than 2.8 million square feet of space into fully functioning primary care and integrated behavioral health practices. Our capacity-building programs have also trained and coached thousands of health workers to deliver superior patient-centered care.

Over 30 years, PCDC's work has impacted more than 62 million primary care patients across 45 states as well as the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa. In New York State alone, we have worked with health care organizations, systems, and providers on over 3,200 financing and technical assistance projects to build, strengthen, and expand primary care operations and services.

High quality, integrated, patient-centered primary care saves lives, leads to better individual and community health, and is central to health equity. Primary care is the foundation of our health care system and is key to preventing treatable outpatient diseases – like diabetes and heart disease – from turning into life threatening conditions. It is the ongoing care that everyone needs in their lives, keeps people healthy while saving money, and is critical to achieving health equity. PCDC is dedicated to expanding affordable health care access while improving the quality of that care. Our organization advocates for policies that will help achieve those goals, including reducing barriers like administrative and cost burdens on our society's most vulnerable.

For these reasons, PCDC supports the expansion of coverage under the Essential Plan proposed in this Amendment to New York's 1332 Waiver. CMS's approval of the NYSDOH's proposal would increase coverage for some of the state's most vulnerable populations and present an opportunity to expand access to primary care. Investments in care similar to this proposal have proven to save the health care system money, but more importantly, have been shown to be a key factor in building healthier communities.[i]

Low income, rural, disinvested communities and communities of color have the least access to primary care and the worst health outcomes.[ii] New Yorkers saw the tragic effects of that during the height of the COVID-19 pandemic, when those communities that had the least access to primary care before the pandemic ended up with the worst outcomes. Since the onset of the pandemic, New York City's neighborhoods with the lowest incomes and lowest rates of having health insurance have experienced the highest rates of COVID-19 infection and death.[iii]

Many New Yorkers who are under-insured, uninsured, or simply cannot access a primary care provider put off seeking care until they must seek emergency care at a hospital. Many times, these emergency room or hospital visits are the result of chronic diseases that would have been preventable or more easily treatable if the patient had regular access to a primary care physician (PCP)[iv]. A recent report highlighted that nearly 32% of adults and 18% of children had no usual source of care – meaning primary care – in 2020.[v]

Increasing a patient's ability to afford care through the Essential Plan is key to increasing access to health care overall and to critical primary care in particular. PCDC supports the State's efforts to lower costs and increase benefits for consumers on the exchange through the proposed amendment. Based on the amendment's estimates, over 117,000 patients will have improved access to care, giving this large group the potential to access a PCP.

PCDC also supports the State's effort to improve health equity by removing cost barriers for diabetes, which can increase access to primary care and, as a result, reduce unnecessary hospitalizations and improve patients' ability to manage acute diseases. Diabetes in particular is a disease that can often be effectively treated and monitored with the oversight of a PCP.

In addition, PCDC believes maternal and behavioral health are crucial parts of primary care and supports integration to improve overall patient care. Reducing cost sharing for all those who become pregnant can ensure that such patients receive the care they need for a healthy pregnancy and post-pregnancy, which has long term impacts on both their own health and the health of their children.

PCDC also strongly supports the State's decision to expand Essential Plan coverage to those with deferred action for childhood arrivals (DACA) status with income up to 250 percent of the federal poverty level. It is estimated that 12,000 people will gain coverage through this measure. However, we continue to oppose the State's decision not to expand access to the Essential Plan for otherwise qualified undocumented individuals more broadly, which could have been accomplished through this waiver.[vi] In 2022, both the legislature and the Governor agreed to explore this opportunity as a critical way to provide needed health care access for New Yorkers who are currently uninsured due to immigration status. Other states, including Washington and Colorado, have already used the 1332 waiver process to expand coverage in this way.[vii]

PCDC strongly urges the State to adopt policies that make health insurance coverage accessible to and affordable for as many New Yorkers as possible, including those who are undocumented. Everyone deserves access to affordable health insurance. Current federal policy prohibits those who are undocumented from accessing any governmental health assistance from programs such as Medicaid, Medicare, and the Affordable Care Act health insurance marketplaces. As a result, these immigrant groups typically pay more into the health care system through taxes than they utilize.[viii] This also causes many to receive their care through costly emergency services, which could have been avoided if they were given access to coverage in the first place. Affordable insurance increases access to primary care, among other health care services, reducing reliance on costly and often unnecessary emergency care and preventing the need for hospitalizations as conditions become more severe.

Once again, PCDC thanks NYSDOH for the opportunity to provide these comments on the proposed Amendment to the 1332 Waiver that are within our expertise. We encourage NYSDOH and CMS to adopt policies most likely to decrease barriers to insurance coverage, lower costs, and increase access to quality primary care. We would be happy to follow up on any of these key points if more information would be useful – feel free to reach out to our Director of Policy, Jordan Goldberg, at jgoldberg@pcdc.org or (212) 437-3947, for any further information.

Sincerely,

Louise Cohen
Chief Executive Officer
Primary Care Development Corporation

[i] *See, e.g.* Center for Budget and Policy Priorities, The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion, October 2020, https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion (last visited March 7, 2023).

[ii] *See,e.g.* Primary Care Development Corporation, *Primary Care Access and Equity in New York's City Council Districts*, July 2021, available for download at https://www.pcdc.org/resources/nyc-council-district-primary-care-access-and-equity-report/.

[iii] X. Zhong et al., *Neighborhood disparities in COVID-19 outcomes in New York city over the first two waves of the outbreak*. 70 Ann Epidemiol. 45, June 2022, *available at* https://pubmed.ncbi.nlm.nih.gov/35487451/.

[iv] Testimony, , David. NYHealth Testimony on Expanding and Strengthening Primary Care. March 2023, available at: https://nyhealthfoundation.org/2023/03/02/nyhealth-testimony-on-expanding-and-strengthening-primary-care/

[v] See, e.g. Milbank Memorial Fund, The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, February 2023, https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/ (last visited March 8, 2023).

[vi] Joel Ario, *The ACA's Section 1332 Waivers: Will We See More State Innovation in Health Care Reform?,* Expert Voices, Manatt Health, August 2016, https://www.manatt.com/getattachment/3543c06f-daeb-4912-94ea-e72980618745/attachment.aspx (last visited March 7, 2023).

[vii] See Centers for Medicaid and Medicare Services, Fact Sheet, *Washington: State Innovation Waiver*, December 2022, *available at* https://www.cms.gov/files/document/1332-wa-fact-sheet.pdf

[viii] Ku L. Who Pays for Immigrants' Health Care in the US? JAMA Netw Open. 2022;5(11):e2241171. doi:10.1001/jamanetworkopen.2022.41171,https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798226 (last visited March 8, 2023)