NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

May 12, 2023

The Honorable Janet Yellen
Secretary of the Treasury

Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services

Department 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 New York's application for a Section 1332 State Innovation Waiver as soon as possible.

New York is requesting that Sections 36B(c)(2)(B) and 18071(b) be waived for a period of five years beginning calendar year 2024 through 2028 to enable New York to extend its successful "Essential Plan" program to more low- and moderate-income New Yorkers. This waiver is in compliance with federal guardrails established by Section 1332 of the Affordable Care Act and associated federal regulations.

In the interest of reducing coverage disruptions to as many consumers as possible, and given the administrative burden for both the federal government and the state to conduct a Basic Health Program blueprint, New York is requesting a suspension of its Basic Health Program for the duration of the waiver and the maintenance of New York's current Basic Health Plan trust fund to be used for the currently allowable uses.

Timely approval is requested due to the 2024 individual market premium rate submission schedule, and the requirement that the New York State Department of Financial Services finalize the approval of those rates in early fall 2023.

In last year's budget, New York's Legislature passed and Governor Hochul signed into law, language authorizing the Commissioner of Health to expand New York's Essential Plan to individuals with incomes up to 250% of the Federal Poverty Level using Section 1332 waiver authority. This year's budget, passed by New York's Legislature and signed into law by Governor Hochul, authorizes and outlines the requirements of the program. The Essential Plan currently provides affordable, comprehensive, health insurance to more than one million New Yorkers, and under this waiver nearly 100,000 more New Yorkers are estimated to gain access.

As outlined in the enclosed actuarial analysis, the waiver is estimated to expand coverage to previously uninsured individuals and save eligible individuals an average of $4,200 per year.

If implemented by January 1, 2024, the waiver will have the added benefit of smoothing the affordability "cliff" for many New Yorkers who transition from Medicaid, as the state implements the end of continuous coverage requirements under the Consolidated Appropriations Act.

Granting this waiver will allow New York to make important strides in broadening access to affordable health insurance coverage and advancing health equity among the remaining uninsured in New York.

It is the state's intent to include the Deferred Action for Childhood Arrivals (DACA) population in the State Innovation Waiver program upon implementation of the HHS proposed federal rule to extend Affordable Care Act coverage to DACA recipients. The State is also seeking new federal solutions to support coverage of undocumented New Yorkers.

We are submitting this application now in recognition of the time needed to implement changes impacting New York's individual insurance market by January 2024 and would submit any expanded scope waiver request for a subsequent phase of approval.

Sincerely,

James V. McDonald, M.D., M.P.H.
Acting Commissioner

New York Section 1332 Innovation Waiver

Essential Plan Expansion

May 12, 2023

Submitted by the New York State Department of Health

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Section 1: Waiver Request and Essential Plan Overview

In an effort to continue to address the affordability of health insurance for New Yorkers, the State of New York is seeking approval on a proposed Section 1332 Waiver. The waiver will allow an expansion of New York's successful Essential Plan (EP), currently operated under the Basic Health Program (BHP) authority of Section 1331 of the Affordable Care Act. The Essential Plan has operated since 2015, providing more affordable and more comprehensive coverage to Premium Tax Credit (PTC)-eligible individuals with incomes up to 200% of the Federal Poverty Level (FPL).[1] The waiver will allow New York to expand the Essential Plan beyond the statutory population, reaching New Yorkers with incomes up to 250% of the FPL who would otherwise be eligible for subsidized coverage on the marketplace. Pass-through savings derived from the waiver will support the affordability of the Essential Plan for enrollees and innovation in care and quality to benefit enrollees.

The waiver would be in effect from January 1, 2024 through December 31, 2028. New York is seeking a waiver of Section 36B of the Affordable Care Act concerning premium tax credits for individuals up to 250% of the FPL and Section 1402 of the Affordable Care Act concerning cost-sharing reductions for individuals up to 250% of the FPL. New York residents who would otherwise be eligible for Advance Premium Tax Credits (APTC) or the Basic Health Program when they enroll in health coverage would be required to enroll in New York's Essential Plan to access affordability programs and would be ineligible for PTC and cost-sharing reductions. New York would use the pass-through savings derived from the current Basic Health Program spending and the forgone premium tax credits to fund the Essential Plan.

While the waiver is in effect, New York is requesting a suspension of its current Basic Health Program blueprint. This suspension is requested to account for two elements of the program. The first is that maintaining a certified blueprint for the Basic Health Program is part of New York's without-waiver baseline policy. In the event that the waiver is not in operation, New York must have its without-waiver environment operating for consumers. Second, the 1332 waiver is, by definition, a time-limited project. At the end of the waiver, if the state or the federal government chose not to renew the waiver, New York would immediately revert back to the Basic Health Program model. In the interest of reducing coverage disruptions to as many consumers as possible, and given the administrative burden on both the federal government and the state to conduct a Basic Health Program blueprint, New York is requesting a suspension of its Basic Health Program for the duration of the waiver and the maintenance of New York's current Basic Health Plan trust fund to be used for the currently allowable uses.

The current Essential Plan is a "standard health plan" as defined under Section 1331 of the ACA and its implementing regulations (42 CFR 600 Subpart E). Under the waiver, New York would maintain the Essential Plan in direct alignment with the definition of a standard health plan. As

[1] New York began its transition into a BHP on April 1, 2015, with individuals between 0-138% of the FPL who are lawfully present non-citizens and do not qualify for federal financial participation in Medicaid due to their immigration status. These individuals were enrolled in Medicaid in New York, if otherwise eligible, without federal financial participation (NY-MA) and became eligible for the BHP. Beginning the 2015 open enrollment period for coverage that begins January 1, 2016, enrollment in BHP was opened to all individuals under age 65 between 138-200% of the FPL who are not eligible for Medicaid or CHIP and do not have minimum essential coverage.

such, the Essential Plan will include coverage of all Essential Health Benefits, and additional benefits, such as dental and vision. Any Essential Plan carriers that are defined as insurance companies will be required to operate the Essential Plan at a minimum medical loss ratio of at least 86%.

Current Essential Plan Enrollees

The waiver will not impact the experience for the current enrollees in the Essential Plan. While the formal authority for the program would shift from a Section 1331 program to a Section 1332 waiver, no eligibility or enrollment processes would change, no premium or cost-sharing would change, no benefits would change and there would be no change in choice of plans due to the waiver. In practice, the operation of the Essential Plan Expansion would be no different than the current Essential Plan experience for this population.

Current 200-250% of the FPL Marketplace Enrollees

Under the waiver, individuals who would otherwise be PTC-eligible up to 250% of the FPL will be enrolled in the Essential Plan. New consumers entering the market will experience the same eligibility and enrollment processes as a new enrollee with an income of up to 200% of the FPL currently experiences. Those consumers currently enrolled in a qualified health plan (QHP) who have been deemed PTC eligible and for whom any updated data suggests an income level at or below 250% of the FPL will be automatically enrolled in an Essential Plan, mapped to their same carrier, or auto-assigned into a plan if they do not choose one. Of the over 90,000 expected enrollees in the Essential Plan in this group, fewer than 300 are enrolled with a carrier that does not offer an Essential Plan. These enrollees will be offered a choice of insurers with an Essential Plan and will be auto-assigned into a plan if they do not choose one.

Persons who are newly enrolling (i.e., not transitioning from a QHP on the marketplace) will apply and have eligibility determined through New York's single streamlined eligibility system. If a person is deemed eligible for the Essential Plan, the individual will have a choice of plans for enrollment, or will be auto-assigned into a plan if they do not choose one. Enrollment for the Essential Plan is open all year, consistent with New York's Medicaid and Children's Health Insurance Program (CHIP).

Enrollees Transitioning to the Essential Plan as a Result of the end of the Continuous Coverage Requirement

New York is proposing to initiate its waiver plan during the planned unwind of the continuous coverage requirement from the Families First Coronavirus Response Act and amended by the Consolidated Appropriations Act of 2023. Under that requirement, persons enrolled in Medicaid or in New York's current Essential Plan have not been terminated from coverage even if their income exceeds eligibility guidelines. Effective July 2023, the state will begin to redetermine eligibility for persons who are currently enrolled in these programs and offer alternative coverage options if their eligibility has changed. The expansion being requested here would smooth the affordability for many consumers who transition from Medicaid or the current Essential Plan to the expanded with-waiver Essential Plan.

Coverage Transitions before January 1, 2024

Those losing Medicaid or Essential Plan coverage before January 1, 2024 will experience the following transition:

Current Program	**New Eligibility***	**State Action**
Medicaid	Essential Plan (138-200% of FPL)	Automatic Enrollment in EP plan with same insurer**
Medicaid	QHP (>200% of FPL)	Consumer directed to marketplace to choose a plan
Essential Plan	Medicaid	Automatic Enrollment in Medicaid Managed Care plan with same insurer or they will be autoassigned**
Essential Plan	Different Level of Essential Plan (Cost-sharing levels are based on income)	Automatic Enrollment in new EP plan with same insurer
Essential Plan	QHP (>200% FPL)	Consumer directed to marketplace to choose a plan

*This new eligibility is based on information received from the consumer as part of the renewal process. If a consumer does not respond in a timely manner, their enrollment will be terminated without enrollment in a different program.
**In the event that the current insurer does not offer a plan in the consumer's location, the consumer will be automatically assigned to another health plan.

Coverage Transitions on or after January 1, 2024

Those losing Medicaid or Essential Plan coverage after January 1, 2024 will experience the following transition:

Current Program	**New Eligibility***	**State Action**
Medicaid	Essential Plan (138-250% FPL)	Automatic Enrollment in EP plan with same insurer**
Medicaid	QHP (>250% FPL)	Consumer directed to marketplace to choose a plan
Essential Plan	Medicaid	Automatic Enrollment in Medicaid Managed Care plan with same insurer or they will be autoassigned**
Essential Plan	Different Level of Essential Plan (Cost-sharing levels are based on income)	Automatic Enrollment in new EP plan with same insurer
Essential Plan	QHP (>250% FPL)	Consumer directed to marketplace to choose a plan

*This new eligibility is based on information received from the consumer as part of the renewal process. If a consumer does not respond in a timely manner, their enrollment will be terminated without enrollment in a different program.
**In the event that the current insurer does not offer a plan in the consumer's location, the consumer will be automatically assigned to another health plan.

Waivable Provision

To carry out its waiver plan, New York proposes to waive section 36B of the Internal Revenue Code, as permitted under section 1332(a)(2) and will waive any other provisions the Departments deem necessary to implement this waiver plan.

Section 36B Waiver
New York would waive section 36B(c)(2)(B) to the extent it would otherwise provide that a month is a "coverage month" (and therefore PTC or APTC may be permitted for that month) if an individual is under age 65 and has in effect a determination by the Exchange that their estimated household income is at or below 250% of the federal poverty level (FPL). In effect, the months in which the NY State of Health determines individuals eligible for the with-Waiver Essential Plan are months in which they are not eligible for PTC or APTC, and vice versa.

Waiving this provision is integral to the waiver plan and to eligibility for pass-through funding. The waiver plan requires that most individuals with estimated household incomes at or below 250% of the FPL—generally those who are eligible for the new Essential Plan—be ineligible for APTC and PTC. However, PTC must be available to narrow groups of these individuals. First, individuals who receive APTC after being projected to have estimated household incomes above 250% of the FPL, including through state or federal data sources, but then end up with income at or below 250% of the FPL for the year must be eligible for PTC to avoid owing back the APTC they have received. PTC must also be available to otherwise-eligible individuals who purchase a QHP without applying for financial assistance and then end up with income at or below 250% of the FPL for the year.

PTC must also be available to individuals with EP-eligible incomes who are age 65 and over and are not eligible for Medicare. Under normal BHP rules, individuals age 65 and over and not eligible for Medicare are excluded from the BHP and thus may be eligible for PTC even in states with a BHP in place. New York is seeking to maintain that structure of eligibility under the waiver, so individuals over 65 will need to continue to be eligible for PTC.

The waiver addresses these constraints by denying PTC (and thus APTC) to individuals under age 65 for months when they have in effect a determination by the Exchange that their estimated household income is up to 250% of the FPL. Specifically, New York would waive the definition of "coverage month" in section 36B(c)(2). Under section 36B, a "coverage month" is a month when an individual may be eligible for PTC (and therefore APTC). Under the waiver, a month would not be a coverage month for an individual under age 65 if a determination by the Exchange was in effect that the individual had an estimated household income at or below 250% of the FPL. As a result, individuals who apply at the Marketplace and are determined to have incomes at or below 250% of the FPL would not be eligible for APTC or PTC, even if they chose to enroll in a QHP and pay the full premium out-of-pocket. However, individuals who are determined by the Exchange to have incomes over 250% of the FPL, or who are not determined eligible for financial assistance, or who are over 65, could still be eligible for PTC if they enroll in a QHP. This is consistent with current BHP operations.

This structure would ensure that individuals found eligible for EP cannot receive APTC or PTC but that PTC continues to be available where appropriate. Reinforcing this policy is New York's position as a state-based Marketplace that has full integration with its public programs (Medicaid, CHIP, and BHP) and QHPs with and without APTC for both eligibility and enrollment processes. Under this waiver, New York will leverage existing safeguards to prevent members from becoming eligible to enroll in more than one program. This would preserve the savings from suspending the BHP to support pass-through funding.

Section 18071 Waiver

New York would waive section 18071(b) of U.S. Code Title 42 to the extent that it would otherwise provide that an individual is an "eligible individual" (and therefore eligible for Cost Sharing Reductions (CSR)) if an individual is under age 65 and has in effect a determination by the Exchange that their estimated household income is at or below 250% of the FPL. In effect, individuals that NY State of Health determines eligible for the with-Waiver Essential Plan are not eligible for QHPs with CSRs, and vice versa.

Waiving this provision is necessary to clarify that a person who is deemed eligible for the with-Waiver Essential Plan, and as such ineligible for PTC or APTC, is not able to enroll in a QHP that provides CSRs in the form of an increased actuarial value (AV) level. Individuals that would qualify for 94% AV plan would instead be eligible for a with-Waiver Essential Plan that would be defined at 97.7% AV using the Actuarial Value calculator. Other enrollees would be eligible for a with-Waiver Essential Plan that would be defined at 91.9% AV using the Actuarial Value calculator. All plans also include dental and vision benefits, the value of which are not included in the Actuarial Value Calculator. Additionally, enrollees meeting the definition of American Indian/Alaska Native would be enrolled in a with-Waiver Essential Plan with no cost sharing.

Specifically, New York would waive the definition of "eligible individual" in section 18071(b), adding an exclusion if an individual is under age 65 and has in effect a determination by the Exchange that their estimated household income is at or below 250% of the FPL. As a result, individuals who apply at the Marketplace and are determined to have income at or below 250% of the FPL would not be eligible to enroll in a QHP supported by CSRs for their given income range. Individuals can choose to enroll in a standard AV QHP, but, due to the waiver of section 36B, they would pay the full premium out-of-pocket.

This approach would not require any substantial new effort by the IRS. All 1095-A reporting and return processing could occur using the normal rules. The IRS could make a small change in Pub. 974 (Premium Tax Credit) to note the special firewall rule in New York state.

Essential Plan Detailed Description

The Essential Plan is an affordable coverage alternative to be offered to waiver populations through this waiver proposal. Though the state will not be operating a Basic Health Program as described under Section 1331 of the ACA, the Essential Plan will exactly mirror the requirements of a "standard health plan" as defined by Basic Health Program statutes and rules. New York's Essential Plan covers all 10 essential health benefits in alignment with New York's

EHB benchmark plan, while also covering dental and vision benefits. The Essential Plan provides these comprehensive benefits, with no monthly premium, no annual deductible, free preventive care, and low copayments. The benefit design of the Essential Plan leads to a plan with a much lower cost sharing burden for enrollees, equivalent to a 91.9% AV based on CMS's Actuarial Value Calculator. The Essential Plan offers coverage comparable to Minimum Essential Coverage (MEC).

The Essential Plan is a standardized set of benefits and cost-sharing designs, offered solely to eligible populations by private companies in New York (similar to Medicaid Managed Care).

New York currently funds the administration of the Essential Plan through a state appropriation ($75 million in State Fiscal Year 22-23). This appropriation is provided to the Department of Health for personnel and contracts to support oversight, compliance, customer service, navigators, IT system upgrades and maintenance, among other administrative functions. This state appropriation would continue under the waiver.

New York's experience with the Essential Plan under its Basic Health Program demonstrates the importance of making affordable coverage available to low-income consumers. New York recently took steps to both increase the affordability and enhance the benefits for low-income New Yorkers enrolled in the Essential Plan. In June 2021, New York eliminated monthly consumer premiums and added dental and vision benefits with no cost-sharing for individuals enrolled in the Essential Plan. Compared to a QHP, the Essential Plan reduced both premium and out-of-pocket costs for enrollees by more than $1,600, saving New Yorkers an estimated $940 million a year in 2022.

The take-up rate in the Essential Plan is in part demonstrative of how critical affordability is in driving enrollment. Among individuals determined eligible for the Essential Plan, take-up is 97 percent, compared with 47 percent for consumers determined eligible for QHP. The Essential Plan continues to be very popular in 2023, with over one million enrollees.

Comparing the Essential Plan to Qualified Health Plans

The following table describes the differences between the Essential Plan and Qualified Health Plans:

Plan Management Functions	QHP Policy	Essential Plan Policy
Licensure and solvency requirements	Be licensed as an insurer under Articles 32 or 42 of the NY State Insurance Law, or a corporation or organization under 43 of NY State Insurance Law, or an organization certified under Article 44 of NY Public Health Law, in good standing, and in compliance with state solvency requirements at the time the application is submitted; or Have applied for such licensure and reasonably anticipate being (1) licensed or certified prior to September 1, 2022, and (2) demonstrate to the satisfaction of the DOH that they have the capacity to be fully operational by September 1, 2022.	Under the State BHP statute, an "eligible" EP/BHP organization must be a licensed Health Insurance Company under Article 42 of the NY State Insurance Law, a licensed Non-profit Medical Indemnity or Health and Hospital Services Corporation under Article 43 of the NY State Insurance Law, or certified HMO under Article 44 of the NY State Public Health Law. See NY State Social Service Law (SSL) section 369-gg(1)(a). Currently, all EP issuers are either licensed under NY Insurance Law Article 43 as non-profits or HMOs under article 44 of the Public Health Law. The commissioner (or her designee) approves eligible organization through our EP certification process. See NY SSL section 369-gg(1)(b). Types of Eligible EP/BHP Organizations: 1. Licensed for-profit Insurance Companies (currently none in NY) 2. Licensed non-profit Medical Indemnity or Health and Hospital Services Corporations (currently 5 in NY) 3. Certified Health Maintenance Organizations (currently 9 in NY)

Plan Management Functions	QHP Policy	Essential Plan Policy
Health Insurer Product Offerings	Must offer the standard products determined by NYSOH and are allowed to offer up to 2 Non-Standard Plans per metal level (subject to other requirements in the plan invitation). Standard benefit designs for QHPs: https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20-%202023%20Standard%20Plans%20revised%207-13-22.pdf	Must offer the standard product for each EP tier determined by NYSOH. There will be 5 EP tiers: • EP 200-250 (200-250% FPL): $15 premiums, $0 deductibles, MOOP = $2,000 • EP 1 (150-200% FPL): $0 premiums, $0 deductibles, MOOP = $2,000 • EP 2 (138-150% FPL): $0 premiums, $0 deductible, MOOP = $200 • EP 3 (100-138% FPL): $0 premiums, $0 deductible, MOOP = $200 • EP 4 (0-100% FPL): $0 premiums, $0 deductible, MOOP = $0 Standard benefit designs for Essential Plan: https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20G%20-%20EP%20Benefits%20and%20Cost-Sharing_1.pdf
Benefits Standards	Covers Essential Health Benefits	Covers Essential Health Benefits, vision and dental. Former state-funded Medicaid population is also eligible for additional benefits, such as non-emergency transportation, orthodontia, etc.
Network Adequacy	Maintains sufficient network to meet NYS standards regarding access, availability and network composition. Ensure issuers submit for review appointment availability.	Same as QHP
Quality Assurance	Systems/mechanisms in place to support quality assurance activities, including quality strategy implementation, quality improvement and quality reporting.	Same as QHP

Plan Management Functions	QHP Policy	Essential Plan Policy
Reporting	Must meet quality and encounter data reporting standards.	Same as QHP.
Marketing	Complies with all NYS marketing laws and regulations and make marketing materials available upon request.	Same as QHP.
Rates of premium/ capitation payments	Submitted by Issuers and approved by the NY State Department of Financial Services (DFS) Rate filing instructions are released annually by DFS: https://www.dfs.ny.gov/system/files/documents/2022/04/2023_rate_filing_instructions_04082022.pdf	Department of Health contracts with an actuary to develop capitation rates (in a manner that largely aligns with Medicaid Managed Care) to take into account the adequacy of rates of payment in relation to the population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards. Unlike in the QHP market where the issuer bears the financial risk if approved premium rates do not appropriately account for the claims experience for its members, the State is the primary entity that bears the financial risk for the EP. If expected health care utilization/costs exceed capitation rates paid to plans, mid-year rate adjustments will continue to be made as is done today. In other words, by making rate updates as needed the state is taking on the risk of the program rather than insurers. For example, when COVID-19 case rates and testing increased in early 2022 due to the Omicron variant, the actuary developed, and EP trustees approved, a rate adjustment.
Definition under state law	"Qualified health plan" means a health plan that meets the criteria for certification described in § 1311(c) of the Patient Protection and Affordable Care Act (P.L. 111-148), and is offered to individuals through the health insurance exchange marketplace.	"Basic health insurance plan' means a standard health plan, separate and apart from qualified health plans, that is issued by an approved organization and certified in accordance with this section." N.Y. Soc. Serv. Law § 369-gg(1)(e) (McKinney).

Plan Management Functions	QHP Policy	Essential Plan Policy
Contracting	Insurers are required to file with and receive approval from the Superintendent of the Department of Financial Services, its premium rates and policy or contract forms pursuant to the insurance law and/or this chapter. The Department of Health enters 5-year contracts with participating organizations participating in the NY State of Health marketplace.	"'Approved organization' means an eligible organization approved by the [Commissioner of Health] to underwrite a basic health insurance plan …." The Department of Health enters 5-year contracts with participating organizations. N.Y. Soc. Serv. Law § 369-gg(1)(b) (McKinney).

Timeline for Implementation

Because New York already offers the Essential Plan that would be basically unchanged, implementation of the expansion focuses on systems changes, marketing and outreach efforts, and developing rates based on the new population.

Essential Plan Expansion Implementation	
Quarter 2, 2023	● Finalize business requirements for IT system changes to the NY State of Health application portal to update eligibility and enrollment rules for the Essential Plan. ● Build new eligibility and enrollment rules based on business requirements. Begin testing of new rules. ● Begin the rate-setting process for PY24 EP inclusive of waiver populations. ● Provide issuer guidance for EP and QHP market given the transition of 200-250% of the FPL population to QHPs. ● Develop outreach plan to waiver populations, especially to the small population of QHP members 200-250% of the FPL who do not have an Essential Plan matching plan. ● Insurers submit rate and form filings for QHPs ● Department of Health reviews and updates contracts for Essential Plan insurers.
Quarter 3, 2023	● Trainings on Essential Plan expansion for NY State of Health staff, Certified Enrollment Assistors, Customer Service Center, and Appeals Staff are developed and delivered. ● DFS reviews and approves QHP plan filings and rates. ● Essential Plan rates released and approved by the Department of Health. Participating insurers are briefed on the rates and provided an opportunity to comment. ● Systems changes and testing are complete and are prepared for implementation. Internal Quality Assurance group conducts review of eligibility determinations and enrollments prior to notice release to consumers. ● Paid advertising, in-person, and virtual outreach campaign begins, including partnerships with community organizations.
Quarter 4, 2023	● Auto-renewal process occurs, and currently covered waiver populations are mapped to Essential Plan offerings. ● Open enrollment for new enrollees begins and mapped auto-renewals can choose different Essential Plan options.
Quarter 1, 2024	● New Essential Plan coverage begins. ● Initial enrollment figures are shared with federal partners.

Expected Federal Savings and Pass-through Request

The Essential Plan proposes a model of coverage that will result in the opportunity for pass-through from PTC savings. The waivable provision will create pass-through as PTC spending would no longer be available for eligible consumers that the marketplace determines to have incomes at or below 250% of the FPL. The total pass-through amount would be reduced by an expected slight increase in PTC outlay for individuals that remain PTC eligible in the individual market. New York expects a slight increase in risk pool acuity resulting from the removal of the 200–250% of the FPL enrollees from the market, causing limited premium increases in the QHP market.

New York requests pass-through funding in the amount of the savings in federal expenditures for premium tax credits as a result of the implementation of the Essential Plan Expansion.

New York proposes that the pass-through funding will support the affordability of the Essential Plan for all enrollees. The following tables describe the expected enrollment, premium, and federal spend for the Essential Plan under the waiver.

Impacts of Waiver Compared to Baseline: Enrollment

Enrollment	2024	2025	2026	2027	2028	5-Year Total
Individual Market Enrollment						
Without Waiver	302,692	302,094	273,412	273,592	273,784	1,425,574
With Waiver	232,024	231,365	208,157	207,980	207,812	1,087,338
Difference	(70,669)	(70,729)	(65,255)	(65,612)	(65,972)	(338,236)
Percent Difference	-23%	-23%	-24%	-24%	-24%	-24%
Essential Plan Enrollment						
Without Waiver	1,049,766	1,075,921	1,103,125	1,125,773	1,147,847	5,502,433
With Waiver	1,139,016	1,175,895	1,196,324	1,219,287	1,241,677	5,972,200
Difference	89,250	99,974	93,199	93,514	93,830	469,767
Percent Difference	9%	9%	8%	8%	8%	9%
Total Enrollment						
Without Waiver	1,352,459	1,378,015	1,376,537	1,399,365	1,421,631	6,928,007
With Waiver	1,371,040	1,407,260	1,404,481	1,427,267	1,449,489	7,059,537
Difference	18,581	29,245	27,945	27,902	27,857	131,530
Percent Difference	1.4%	2.1%	2.0%	2.0%	2.0%	1.9%

Impacts of Waiver Compared to Baseline: Premiums

Premiums	2024	2025	2026	2027	2028	5-Year Total
Individual Market Average Premium (PMPM)						
Without Waiver	$721	$755	$793	$831	$871	$792
With Waiver	$740	$775	$815	$854	$895	$813
Difference	$19	$20	$22	$23	$24	$21
Percent Difference	2.6%	2.6%	2.8%	2.8%	2.8%	2.7%
Essential Plan Average Premium (PMPM)						
Without Waiver	$563	$585	$608	$633	$658	$610
With Waiver	$569	$592	$615	$640	$665	$617
Difference	$6	$7	$7	$7	$7	$7
Percent Difference	1.1%	1.2%	1.1%	1.1%	1.1%	1.1%

Impacts of Waiver Compared to Baseline: Federal Spend

Federal Spend/Deficit	2024	2025	2026	2027	2028	5-Year Total
Individual Market Federal Spend						
Without Waiver (millions)	$703	$774	$443	$492	$544	$2,956
With Waiver (millions)	$517	$570	$267	$296	$328	$1,978
Difference (in millions)	($186)	($203)	($176)	($195)	($216)	($977)
Percent Difference	-26%	-26%	-40%	-40%	-40%	-33%
Essential Plan Federal Spend						
Without Waiver (millions)	$9,647	$10,363	$10,241	$10,953	$11,705	$52,908
With Waiver (millions)	$0	$0	$0	$0	$0	$0
Difference (millions)	($9,647)	($10,363)	($10,241)	($10,953)	($11,705)	($52,908)
Percent Difference	-100%	-100%	-100%	-100%	-100%	-100%
Employer Penalty Revenue Reduction						
Without Waiver (millions)	($3)	($3)	($3)	($3)	($4)	($16)
With Waiver (millions)	$0	$0	$0	$0	$0	$0
Difference (millions)	$3	$3	$3	$3	$4	$16
Percent Difference	-100%	-100%	-100%	-100%	-100%	-100%
Total Federal Spend						
Without Waiver (millions)	$10,348	$11,134	$10,681	$11,441	$12,245	$55,849
With Waiver (millions)	$517	$570	$267	$296	$328	$1,978
Difference (millions)	($9,831)	($10,563)	($10,414)	($11,145)	($11,918)	($53,870)
Percent Difference	-95%	-95%	-97%	-97%	-97%	-96%

Summary of Federal Savings and Requested Passthrough (Dollars in $ Millions)

	2024	2025	2026	2027	2028	5-Year Total
PTC Savings (BHP Suspension)	$9,647	$10,363	$10,241	$10,953	$11,705	$52,908
PTC Savings (200 – 250% of the FPL)	$186	$203	$176	$195	$216	$977
Loss in Employer Shared Responsibility Fees	($3)	($3)	($3)	($3)	($4)	($16)
Total Federal Savings	**$9,831**	**$10,563**	**$10,414**	**$11,145**	**$11,918**	**$53,870**
Requested Passthrough	$9,831	$10,563	$10,414	$11,145	$11,918	$53,870
Federal Savings After Passthrough	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Investments in the Essential Plan

In addition to the affordability programs under the waiver, New York would use pass-through to support a Quality Incentive Pool for Essential Plan insurers. This pool is currently in existence under the Basic Health Program authority and would continue to operate in the same manner. Established in 2022, the Quality Incentive Pool is awarded to participating Essential Plan carriers based on results from their health plan quality data submissions managed by the NY State Department of Health's Office of Quality and Patient Safety. In recent years, New York's Quality Incentive Pool scoring methodology emphasized improved race/ethnicity reporting in quality data and the administration of social determinants of health screenings for all Essential Plan enrollees. The State also intends to make available community-based long-term services and supports to members who need them.

New York is also considering investing in a range of benefit enhancements that are intended to increase access for consumers, promote equity across program tiers, and address barriers to care utilization. In 2023, the state will add incentives for health plans to offer benefits in the areas of social determinants of health (SDOH) and behavioral health (BH) that are intended to improve overall health and access to care, particularly for populations that experience disparities in health outcomes. SDOH interventions that have proven successful in Medicaid will become available to Essential Plan enrollees, beginning with addressing food insecurity and providing housing and/or utilities assistance. To address widespread concern about mental health and well-being, New York will implement a series of incentives that bolster the BH workforce, increase access to care, and add additional covered benefits, such as mobile crisis services and crisis diversion.
Next, to make services more accessible and affordable for Essential Plan enrollees, New York is planning to reduce or eliminate cost sharing for some or all services. Reducing consumers out-of-pocket costs is expected to increase utilization and reduce barriers to care. Finally, New York will make an investment of up to $800 million to create reimbursement parity across all Essential Plan premium groups for hospital, inpatient, outpatient, and physician services starting in Calendar Year 2023 to improve access to health care providers.

Medicaid Continuous Coverage and the Consolidated Appropriations Act, 2023

Under the Families First Coronavirus Relief Act, states were eligible for enhanced matching funds for Medicaid enrollees for keeping them enrolled for the duration of the COVID-19 Public Health Emergency (PHE). New York received CMS approvals to extend this policy to CHIP and the BHP. With the subsequent passage of the Consolidated Appropriations Act in late 2022, the continuous coverage requirement will end after March 31, 2023. In accordance with CMS guidance, New York expects to begin redeterminations for Medicaid, BHP, and CHP enrollees in April for individuals with a coverage end date of June 30, 2023, and completing the redetermination process with cases with May 31, 2024 end dates. Included in this draft application are enrollment estimates that consider coverage transitions that are expected in this so-called “PHE unwind” process.

Section 2: Analysis of Proposed Waiver

Impact on 1332 Statutory Guardrails

The proposed waiver will meet all four ACA Section 1332 guardrails, described in detail below. The guardrail analysis is centered on the individual market. New York does not project a measurable impact on the small group market as an effect of the waiver.

The analyses presented here and in the actuarial analysis assume current law. Specifically, the analyses presume the current subsidy structure under the Affordable Care Act through plan year 2025, as enacted by the Inflation Reduction Act. For additional scenarios, see the actuarial analysis.

Impact of Waiver in the Individual Market

The following section discusses the impact of the waiver's individual market elements on the four Section 1332 waiver statutory guardrails. The analysis considers the alternative coverage structure and the use of pass-through funding to support the affordability for the Essential Plan under the waiver.

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

   The waiver proposes to increase the affordability of coverage for the waiver population. As a result, New York expects an increase in overall enrollment.

   A total of 21,602 new consumers are expected to gain coverage for PY 2024 due to the Waiver. New York estimates a small loss of 3,020 consumers from off-exchange market and those that are subsidy-ineligible due to the increased premium impact of moving consumers with incomes of 200–250% of the FPL out of the individual market risk pool. However, the increased enrollment due to the increased affordability under the waiver eclipses by several fold the coverage losses among higher income consumers whose incomes exceed financial assistance levels. New York does not project any loss in insurer participation as a result of the waiver.

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

   The Essential Plan expansion creates a coverage program that is significantly more affordable for consumers with incomes of 200–250% of the FPL than the currently available options. For current APTC/QHP consumers with incomes of 200 to 250% of the FPL, the Essential Plan premium will be $15 per month per enrollee.

   It is important to note that for consumers with incomes of 200–250% of the FPL, the affordability analysis considers total out-of-pocket cost, not just premiums. Given the current premium and subsidy structure, there are consumers on the New York marketplace who are eligible for Bronze plans at premiums under $15, including nearly $0 premiums. However, these plans include a significant cost sharing burden on consumers. While there is a $15/month premium in the Essential Plan for these members ($180/year), there is no deductible and the maximum out-of-pocket is limited to $2,000. The Actuarial Value of the Essential Plan is 91.9% compared to a weighted Actuarial Value of 72.2.% for consumers with incomes of 200–250% of the FPL in the market today. An average of 65,109 consumers per year migrating from the QHP market will experience a cost savings of $4,200 per year ($2,250 in premiums, $1,950 in out-of-pocket spend), resulting in $1.4 billion over the life of the waiver. The affordability increase of $4,200 per year is roughly 11% of income for the population 200–250% of the FPL.

   The migration of the population with incomes of 200–250% of the FPL from the QHP market to the Essential Plan is expected to increase premiums by 0.5–2.2% in the remaining QHP market for PY 2024 compared to the baseline Without-Waiver scenario. The 2.2% increase was used in the waiver estimates to model the higher range which

would result in increased federal spend for PTCs and potential loss due to the premium increase. Due to the expanded tax credits under the IRA, consumer premium contributions are capped at the affordability threshold set by the IRS for all subsidized On-Exchange consumers. Consumers above 250% of the FPL who are ineligible for APTCs and those buying Off-Exchange will experience an increase in premiums by 2.2% under the waiver. An average of 100,054 consumers per year from 2024 to 2028 will experience an increase of $259 per year, resulting in $129 million over the life of the waiver. The increase of $259 per year falls in the range of 0.1% to 0.5% of income for subsidy-ineligible, on-exchange and off-exchange consumers. Since New York requires pure community rating, and age and tobacco status are not factored into premiums, older consumers are not disproportionately impacted by this premium increase.

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

   The Essential Plan Expansion does not impact the comprehensiveness of coverage available to New York consumers. The Essential Plan provides the essential health benefits to enrollees in the same manner as a QHP and includes adult dental and vision benefits.

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

   New York anticipates that the waiver will meet the deficit neutrality guardrail and generate savings for the federal government.

Summary of Guardrail Compliance

Guardrail	Estimated Impact With Waiver Compared to Without Waiver
Comprehensiveness	The 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 experience an increase in comprehensiveness. • 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 Waiver is projected to meet the affordability guardrail as the overall affordability across the market is improved compared to the baseline without waiver scenario. • Affordability for current Essential Plan members 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 $1.4 billion over the 5 years of the Waiver. ○ This is an average annual savings of $4,200 under the Waiver ($2,250 in premiums and $1,950 in out-of-pocket spend), which is approximately 11% 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 expected to decrease slightly as premiums are expected to increase by an additional 2.2% in 2024 under the Waiver. ○ This is an average annual increase of $259 under the Waiver, which falls in the range of 0.1–0.5% of income for On-Exchange consumers above 250% of the FPL and Off-Exchange consumers.
Coverage	The 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 1.4% for PY 2024, 2.1% for PY 2025, 2.0% for PY 2026, 2.0% for PY 2027, and 2.0% for PY 2028.
Deficit Neutrality	The 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 $9.8 Billion in PY 2024 and $53.9 Billion over the 5-year waiver period, before pass-through funding. • The net federal spend under the Waiver is estimated to remain the same in PY 2024 and over the 5-year Waiver period, after accounting for pass-through funding.

Impact on Health Equity

New York has centered efforts to advance health equity for more than a decade and the expansion of the Essential Plan 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."[2]

With this waiver, New York seeks to increase affordability for a group of lower-income individuals for whom the current affordability levels can still be financially challenging.

Health coverage is a critical building block toward overall health in the American system. The National Institutes of Medicine (IoM) connected these issues in their seminal 2001 "Coverage Matters: Insurance and Health Care".[3] In this study, the IoM highlights that persons without coverage are less likely to have a usual source of care and less likely to receive health care services, even for significant needs.

This waiver represents a significant opportunity to extend coverage to communities in the state that are disproportionately uninsured when measured by racial/ethnic identity by extending the affordability of the Essential Plan to higher income levels. 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.

[2] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf
[3] Institute of Medicine (US) Committee on the Consequences of Uninsurance. Coverage Matters: Insurance and Health Care. Washington (DC): National Academies Press (US); 2001.

Section 3: Authority Under State Law

Evidence of sufficient authority under state law(s) in order to meet the PPACA section 1332(b)(2)(A) requirement for purposes of pursuing the requested waiver.

On April 9, 2022, Governor Hochul signed into law Chapter 56 of the Laws of 2022. Part BBB of the chapter authorizes the commissioner of health to seek a Section 1332 waiver to support the expansion of the Essential Plan to New Yorkers under 250% of the Federal Poverty Level and enable Essential Plan members who become pregnant the choice to stay within the Essential Plan.

On May 3, 2023, Governor Hochul signed into law Chapter 57 of the Laws of 2023, which includes Section 369-ii of the Social Services Law of New York, which provides for State actions under a waiver, including implementation of the State plan detailed in this application.

Section 4: Evidence of Public and Tribal Consultation and Comment

New York held a public comment period beginning on February 9, 2023 and ending on March 11, 2023. The State provided multiple channels and opportunities for the public to provide comment on the draft 1332 Waiver Application. The State's public notice and comment procedures complied with the requirements specified in 31 CFR 33.112 and 45 CFR 155.1312. The State received federal approval on November 9, 2022 to hold virtual public hearings during to the COVID-19 public health emergency (PHE), as permitted under 31 C.F.R. § 33.118 and 45 C.F.R. § 155.1318.2.

On February 9, 2022, the State posted the public notice for the 30-day public comment period, draft 1332 Waiver Application and Actuarial and Economic Analysis, and public hearing information on a dedicated webpage at https://info.nystateofhealth.ny.gov/1332. The State also emailed 6,483 stakeholders on the DOH email listserv on February 10, 2023 to inform them of the comment period, and the public notice was released statewide by the State Register on March 1, 2023. A copy of the public notice is included as Appendix B of this waiver application.

Public Comment and Tribal Consultation Process

The public was provided the opportunity to comment on the draft waiver online via email, online through a survey, orally during public hearings, and through the mail. In addition, a tribal consultation was held for federally recognized tribes in New York. The following table provides the total number of comments received during the 30-day public comment period.

Comment Collection Channel	Total Number of Comments Received
Email	1,571
Online Survey	90
Public Hearings	18
Mail	0
Tribal Consultation	0
Total	**1,679**

Some commenters submitted multiple comments through different channels or submitted multiple emails. A total of 98 comments were identified as duplicates.

Summary of Public Hearings

The State held two public hearings with options for virtual attendance through Webex. The first hearing was scheduled on Wednesday, February 22, 2023 from 1:00 – 4:00 P.M. Eastern Time, and the second hearing was scheduled on Thursday, February 23, 2023 from 12:00 – 3:00 P.M. Eastern Time. Both hearings ended early after comments had been received from attendees.

The two public hearings followed the same format. Each began with an overview by DOH staff of the 1332 Waiver proposal followed by comments from the public. Commenters who pre-registered were provided an opportunity to comment first. Other attendees who had not pre-registered were then provided an opportunity to speak. Sign language and Spanish interpreters were available for the duration of the hearings. Comments provided by speakers in Spanish were interpreted into English, and audience members could opt into a Spanish interpretation line to hear the full presentation translated into Spanish.

The hearing presentation was posted online at https://info.nystateofhealth.ny.gov/1332 on February 24, 2023. A copy of the presentation is included in Appendix B. The hearings were recorded through Webex and posted on March 10, 2023 at https://info.nystateofhealth.ny.gov/1332. The presentation and comments from the hearings were transcribed via Webex closed captioning. The transcripts were edited for readability and posted on the website on March 20, 2023.

A total of 56 members from the public attended the hearings virtually and 18 provided oral comment. New York Assemblymember González-Rojas and Assemblymember Levenberg provided comments. Comments were received on behalf of the following organizations:

- Citizen Action of New York
- Committee of Interns and Residents
- Community Service Society of New York
- Healthcare Education Project (1199 SEIU United Healthcare Workers/Greater NY Hospital Association)
- Make the Road New York
- New York Lawyers for the Public Interest
- New York Health Plan Association

Seventeen commenters urged the State to modify the waiver to expand Essential Plan coverage to undocumented immigrants, with several citing the availability of surplus funding and the benefit of Medicaid savings. Several commenters shared their personal challenges with access to healthcare due to their immigration status, and others explicitly opposed the waiver due to the exclusion of immigrants. Two commenters spoke to proposed expansion of the Essential Plan to 250% of the FPL and were in favor the policy, with one noting concerns with the potential rise in individual market premiums from the expansion and potential loss of coverage.

Summary of Tribal Consultation

The State followed its standard process for consulting with federally recognized tribes. A letter was emailed to the points of contact for the eight tribes on February 13, 2023. The letter included a description of the draft 1332 Wavier Application, where to find more information online, and invited the tribes to attend a virtual meeting to learn more and provide comment.

The tribal consultation was scheduled for February 28, 2023 from 2:30 – 4:00 P.M. Eastern Time. It started with a presentation by DOH staff on the waiver followed by an opportunity to receive comments and questions. Four attendees joined the tribal consultation. There were no

comments or questions. The recording of the consultation was posted online at https://info.nystateofhealth.ny.gov/1332 on March 10, 2023. The Webex closed captioning transcript was edited for readability and posted online on March 20, 2023.

Online Comments Received from Organizations

The State received a total of thirty comments from thirty-eight organizations online, either through the survey or via email. Comments were received from:

- 1199SEIU (United Healthcare Workers East)
- Center for the Independence of the Disabled, NY (CIDNY)
- Citizen Action of New York
- Coalition of New York State Public Health Plans
- Community Health Care Association of New York State
- Community Healthcare Network (CHN)
- Community Service Society of New York (CSS)
- CUNY Graduate School of Public Health and Health Policy (CUNY SPH)
- Empire Justice Center
- Greater New York Hospital Association
- Health Care for All New York (HCFANY)
- Healthcare Association of New York State (HANYS)
- Labor-Religion Coalition of NYS
- Make the Road New York (MRNY)
- Medicaid Matters New York
- Medical Society of the State of New York (MSSNY)
- New York City Department of Health and Mental Hygiene
- New York Health Foundation (NYHealth)
- New York Health Plan Association (HPA)
- New York State Nurses Association
- NYC Family Advocacy and Information Resource (FAIR)
- NYS Coalition for Children's Behavioral Health (CCBH)
- New York University Wagner Graduate School of Public Service, Dean Sherry Glied and Professor Laura Wherry
- Pharmaceutical Research and Manufacturers of America (PhRMA)
- Planned Parenthood Empire State Acts (PPESA)
- Primary Care Development Corporation (PCDC)
- Schuyler Center for Analysis and Advocacy
- The Legal Aid Society
- United Hospital Fund (UHF)
- Letter From Multiple Associations
    - American Heart Association
    - American Lung Association
    - Cancer Action Network

- Epilepsy Foundation
- Hemophilia Federation of American
- Immune Deficiency Foundation
- Leukemia & Lymphoma Society
- National Multiple Sclerosis Society
- National Organization for Rare Disorders

Twenty-two letters explicitly support the expansion of eligibility up to 250% of the FPL. Twenty-six strongly urge the State to also include coverage for undocumented immigrants and/or oppose the exclusion of this population. Several commented on the fiscal benefits to the State to immigrants through Medicaid savings and use of surplus funding. A handful of comment letters provided suggestions for implementation and recommendations for minimizing potential impacts on the individual market.

A copy of all organizational comments received may be found on https://info.nystateofhealth.ny.gov/1332.

Online Comments Received from Individuals

The State received 1,631 individual comments from online, either through the survey or via email. Over 1,500 comments followed a standard template from the Coverage For All Coalition, urging the State to expand coverage to undocumented immigrants and/or opposed the waiver because it excludes immigrants.

Several comments received from individuals were identified as not directly relevant to the waiver. Some commenters shared their own personal struggles with access to healthcare. A few commented that they opposed expansion to the undocumented population. One commenter shared the need to subsidize employer coverage. A copy of all individual comments received may be found on https://info.nystateofhealth.ny.gov/1332.

Response to Public Comments

The State reviewed all comments and appreciates the input received. All comments were considered equally. The following outlines the predominant themes from commenters:

- Request for Expansion to Undocumented Immigrants
- Support for Expansion Up To 250% of the FPL
- Concern for Potential Impacts on Individual Market
- Suggested Additional Policy Considerations
- Implementation Considerations

<u>Request for Expansion to Undocumented Immigrants</u>

Summary of Comments: Over 1,500 comments received on the draft waiver urge the Governor and State of New York to modify the waiver to expand coverage to undocumented immigrants. Most comments explicitly opposed the waiver because it excluded immigrants. Several commenters noted that the Essential Plan surplus could be used to fund the expansion to this

population, and the State would also receive savings in Medicaid. Several commenters noted that coverage should be for all, although they did not explicitly mention undocumented immigrants in their letters. Most commenters urging for expansion to immigrants did not indicate whether they supported or opposed the expansion of the Essential Plan from 200% to 250% of the FPL.

State Response: The State appreciates the comments received and recognizes the importance of access to health care coverage for vulnerable populations. At the time of this waiver submission, the State only has authority to expand coverage of the Essential Plan up to 250% of the FPL for those otherwise eligible. It is critical the State continue to move forward with the submission of the current waiver in order to receive timely federal approval for implementation of the expansion for January 1, 2024. This implementation timeline is important because of the impact on the Qualified Health Plan market. The State is also seeking new federal solutions to support coverage of individuals otherwise ineligible for subsidized coverage due to their immigration status.

Support for Expansion Up To 250% of the FPL

Summary of Comments: Approximately 100 comments explicitly support the expansion of the Essential Plan. Commenters shared that the expansion to 250% of the FPL will improve accessibility and affordability. Others commented that it would improve health equity and the overall health of New Yorkers.

State Response: The State appreciates the support for the expansion and agrees with commenters' observations on the beneficial impact it will have for the health of our residents.

Concern for Potential Impacts on the Individual Market

Summary of Comments: A handful of commenters expressed concerns for the potential impact on premiums due to the migration of consumers from 200 – 250% of the FPL out of the individual market and potential loss in coverage. One commenter suggested the State proactively develop a plan to mitigate the QHP market impact, review rate filings to ensure future rates are sufficient, and consider mid-year updates for QHPs as necessary.

State Response: The State appreciates these concerns and has taken a conservative approach to estimate how the migration of the 200–250% of the FPL population could potentially impact the individual market. The actuarial and economic analysis provides a 10-year projection which is focused on demonstrating compliance with the four guardrails. The impact of the waiver on individual market premiums is estimated to be between 0.5 and 2.2%. The analysis assumed a 2.2% increase to model the higher end range which would result in increased federal spend on APTCs/PTCs. Due of the enhanced APTC/PTCs under the Inflation Reduction Act, the vast majority of consumers in the individual market will not feel the impact of these market changes. The estimated loss in off-exchange enrollment due to the premium increase is based on an applied price elasticity factor from studies demonstrating the correlation between increasing costs, income, and consumers opting out of the market. However, it is important to note that these are estimates to model what could happen to the individual market under the waiver. Overall, the analysis estimates that more consumers will gain more affordable coverage than

choose to leave the market due to the waiver. The State is committed to working with insurers to manage assumptions and risks for changing market dynamics with the PHE unwind and implementation of the waiver.

Suggested Additional Policy Considerations

Summary of Comments: A handful of comments received provide suggestions for additional policy considerations. One commenter suggested expanding coverage to a higher FPL. Another commenter suggested that the 200 – 250% of the FPL group have $0 monthly premiums. Another commenter suggested investing additional program funds into behavioral health support. Another suggested a supplemental kick payment for newborns whose birthing parent is covered under the Essential Plan.

State Response: At the time of this waiver submission, the State only has authority to expand coverage of the Essential Plan to 250% of the FPL. The proposed $15 monthly premiums for the 200 – 250% of the FPL population is to have parity with the monthly premiums for coverage for children under CHIP at this income level. The State appreciates the suggestions for how to use surplus funding and will continue to identify opportunities once implemented to make investments to improve health outcomes for the Essential Plan population.

Implementation Considerations

Summary of Comments: A few commenters noted the compressed timeline and provided suggestions for the State to collaborate with insurers to minimize disruption for consumers. Another commenter asked for clarity on where the fund originated.

State Response: The State appreciates the suggestions and will work closely with insurers to effectively communicate and provide guidance for implementation. The funding for the proposed 1332 Waiver comes from the APTC/PTC payments the federal government would have otherwise spent on the BHP and for consumers 200 – 250% of the FPL in the QHP market absent the waiver.

Section 5: Additional Information

Administrative Burden

The Essential Plan Expansion will cause minimal administrative burden for the State of New York and the federal government. However, new Essential Plan enrollees who were previously covered with PTC-funded QHPs will no longer need to reconcile tax credits on their federal tax returns. Individual health insurers will not experience administrative burden as enrollees shift from one coverage program to another, as this is a current process that insurers already perform across all programs administered by NY State of Health, including all insurers that participate in the Essential Plan and QHP (11 of 12 insurers).

New York has the staff and resources necessary to absorb the following administrative tasks that would be required under the waiver:

- Administer the Essential Plan
- Account for and distribute federal pass-through funds
- Conduct appropriate eligibility determinations
- Monitor compliance with federal law
- Collect and analyze data related to the waiver
- Perform reviews of the implementation of the waiver
- Submit all required reports to the federal government

The waiver will require the federal government to perform the following administrative tasks:

- Review any documented complaints related to the waiver
- Review State reports
- Periodically evaluate the State's waiver program
- Calculate and facilitate the transfer of pass-through funds to the State

New York believes that the above administrative tasks are similar to other administrative functions currently performed by the federal government, so that their impact is minimal.

Implementation of Non-Waived ACA Provisions

The implementation of this waiver application 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

Because New York shares borders with Connecticut, Massachusetts, New Jersey, Pennsylvania, and Vermont, insurer service areas and networks that cover border counties generally contain providers in those states, especially in areas where the closest large hospital system is located in the border state. It is expected that provider networks in service areas where out-of-state providers are commonly used will include those out-of-state providers. In general, there is a high degree of overlap between QHP and EP provider networks (over 95%).

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

The New York State Department of Health will submit quarterly and annual reports as specified in 45 CFR 155.1324.

Each quarterly report will include the following:

1) The progress of the section 1332 waiver;
2) Data necessary to demonstrate compliance with Section 1332(b)(1)(A) through (D) of the ACA;
3) A summary of the annual post-award public forum, held in accordance with 45 CFR 155.1320 (c), including all public comments received at the forum regarding the progress of the waiver, and any actions taken in response to comments received;
4) Other information the New York Department of Health determines necessary to evaluate the waiver and accurately calculate the pass-through payments to be made by CMS; and
5) Reports of ongoing operational challenges, if any, and plans for, and results of, corrective actions that have been taken.

The New York State Department of Health will submit a draft annual report within ninety (90) days after the end of the first waiver year, and each subsequent year that the waiver is in effect. The Department will publish the draft annual report on its website within thirty (30) days of submission of the draft report to CMS. Within sixty (60) days of receipt of comments from CMS on the draft annual report, the Department will submit the final annual report for the waiver year. That submission will include a summary of the comments received, as well as a copy of the comments submitted to the Department on the draft annual report. Once the final annual report is approved by CMS, the Department will publish the final annual report on its website within thirty (30) days of that approval.

The annual report prepared by the Department will include the following:

1) Metrics to assist evaluation of the waiver's compliance with the requirements found in section 1332(b)(I):
    a. Actual individual market enrollment in the state
    b. Actual Essential Plan enrollment in the state

c. Actual average individual market premium rate (i.e., total individual market premiums divided by total member months of all enrollees)

d. The actual Second Lowest Cost Silver Plan (SLCSP) premium under the waiver and an estimate of the SLCSP premium as it would have been without the waiver, for a representative consumer (e.g., a 2l-year old non-smoker) in each rating area.

e. The actual amount of APTC paid, by rating area, for the plan year.

f. The actual number of APTC recipients for the plan year. The number should be the number summed over all 12 months and divided by 12 to provide an annualized measure.

g. An estimate of the amount of APTC that would have been paid without the waiver.

h. An estimate of the number of APTC recipients for the plan year. The number should be the number summed over all 12 months and divided by 12 to provide an annualized measure.

2) Changes to the waiver programs, including the funding level the program will be operating at for the next plan year, or other program changes

3) Notification of changes to State law that may impact the waiver

4) Reporting of:

a. Federal pass-through funding spent on Essential Plan payments to carriers by eligibility group

b. The unspent balance of federal pass-through funding for the reporting year, if applicable.

5) Any rate changes made mid-year to account for unexpected utilization of health care services.

6) A description of any incentives for providers, enrollees, and plan issuers to continue participating in the Essential Plan.

Quarterly and other Reports - Pursuant to 45 CFR 155.1320(b), and 45 CFR 155.1324(a), the Department will conduct periodic reviews related to the implementation of the waiver. A report on the operation of the Essential Plan Expansion available due to this waiver will be submitted by April 30, 2024. The Department will report on the operation of the waiver quarterly, including, but not limited to providing reports of any ongoing operational challenges, and plans and results of associated corrective actions, no later than sixty (60) days following the end of each calendar quarter. The Department will submit its annual report in lieu of their fourth quarter report. The Department will submit and publish annual reports by the deadlines established in 45 CFR 155.1324(c) or the deadlines established by the terms of the waiver.

Section 6: Actuarial and Economic Analysis of Waiver

State of New York
Section 1332 Innovation Waiver Plan Year (PY) 2024 – 2028
Actuarial and Economic Analysis

May 12, 2023

Contents

Section 1: New York 1332 Waiver Background

1.1 – Background

New York's Essential Plan

Since 2015, the State of New York Department of Health (DOH) has operated a Basic Health Program (BHP), called the Essential Plan, under Section 1331 of the Affordable Care Act (ACA). The Essential Plan is offered through the State's Health Insurance Exchange (NY State of Health), which is a division of DOH.

There are nine rating regions for the Essential Plan. A total of twelve health insurers offer the Essential Plan through NY State of Health. The Essential Plan has no premiums, no deductible, very low cost-sharing, and offers medical benefits that align with the Essential Health Benefits required by the ACA, in addition to dental and vision coverage, for eligible consumers up to 200% of the Federal Poverty Level (FPL).

Unlike individual market health insurance, DOH sets capitation rates for insurers of the Essential Plan in a manner similar to Medicaid Managed Care. The rates are approved by the Essential Plan Board of Trustees. The rates consider the adequacy of payment in relation to the population to be served. The rates are adjusted for case mix, the scope of health care services approved organizations must provide, the utilization of such services, the network of providers required to meet state standards, and any new policy changes.

There are two groups of members within the Essential Plan. The first group are members with incomes above 138% up to 200% of the FPL who would otherwise be eligible for Qualified Health Plans (QHPs) and Advance Premium Tax Credits (APTCs). The other group is made up of former state-funded Medicaid members (known as the Aliessa population[1]) with incomes up to 138% of the FPL. In addition to the Medical, Dental, and Vision benefits provided by the Essential Plan, this population is also eligible for additional benefits, such as non-emergency transportation and orthopedic services.

Table 1.1.1: New York Essential Plan Rate Cohorts for Plan Year (PY) 2023

Rate Cohorts	Population	Income	Ages	Premium	Deductible	Cost Sharing	Max Out-Of-Pocket
1	Non-Medicaid	151 – 200% FPL	19-64	$0	$0	Yes	$2,000
2	Non-Medicaid	139 – 150% FPL	19-64	$0	$0	RX only	$200
3	Aliessa	100 – 138% FPL	19-64	$0	$0	RX only	$200
4	Aliessa	< 100% FPL	19-64	$0	$0	No	$0

[1] The Aliessa population is composed of lawfully present individuals who have lived in the United States for 5 years or less and are not eligible for federally-funded Medicaid but have been covered by New York State from 2001-2014 in state-funded Medicaid and since 2015 through the BHP.

The State receives annual federal funding for the Essential Plan equivalent to 95% of what eligible individuals enrolled in the Essential Plan would have received in PTCs for QHPs on a per-member basis. For the annual BHP payment, the State has the choice of receiving annual federal payments for the Essential Plan population based on either actual premium growth on New York's QHP market or the "Premium Trend Factor"[2].

New York's Individual Market

Twelve insurers offer plans in the individual market, both On- and Off-Exchange. New York's Department of Financial Services (DFS) sets the rating regions and reviews and approves QHP and Stand-Alone Dental Plan (SADP) premium rates. There are eight rating regions for the individual market, which are different than the nine regions for the Essential Plan. New York requires community rating. Age and tobacco status are not factored into the premium rates.

NY State of Health issues a Plan Invitation each year outlining the conditions to offer QHPs on the Exchange. A total of eleven insurers offer coverage for both QHPs and the Essential Plan.

1.2 – Proposed Waiver

The State is submitting a Section 1332 Waiver Application to the U.S. Department of Health & Human Services (HHS) and U.S. Department of Treasury (Treasury) seeking to expand eligibility for the Essential Plan to the following new group:

- Residents with incomes above 200% up to 250% of the FPL, ages 19 to 64 years, who are currently eligible to purchase Qualified Health Plans (QHPs) on the Exchange and receive PTCs.

Under the Waiver, DOH is seeking to suspend the Essential Plan as a BHP under Section 1331 and implement an identical Essential Plan (referred to as the "with-Waiver Essential Plan") under Section 1332 beginning PY 2024. This with-Waiver Essential Plan will be in its own risk pool. A new Essential Plan type will be created with expanded eligibility for consumers 200 – 250% of the FPL.

The State proposes to waive section 36B of the Internal Revenue Code, as permitted under section 1332(a)(2). Specifically, New York would waive section 36B(c)(2)(B) to the extent it would otherwise provide that a month is a "coverage month" (and therefore PTC or APTC may be permitted for that month) if an individual is under age 65 and has in effect a determination by the Exchange that their estimated household income is at or below 250% of the FPL. In effect, an individual is not eligible for PTC or APTC for the months in which NY State of Health determines them eligible for the with-Waiver Essential Plan.

The proposed Waiver requires that most individuals with incomes up to 250% of the FPL—generally those who are eligible for the with-Waiver Essential Plan—be ineligible for APTC and PTC. However, PTC would still be available for:

[2] https://www.federalregister.gov/documents/2022/05/25/2022-11047/basic-health-program-federal-funding-methodology-for-program-year-2023-and-proposed-changes-to-basic

1. Individuals who receive APTC after being projected to have income above 250% of the FPL but then end up with income below 250% for the year (i.e. they will not owe back the APTC they have received).
2. Individuals who purchase a QHP without applying for financial assistance and then end up with income below 250% of the FPL for the year.
3. Individuals with EP-eligible income who are age 65 and over and are not eligible for Medicare. Under normal BHP rules, individuals who are age 65 and over and not eligible for Medicare are excluded from the BHP and thus may be eligible for PTC even in states with a BHP in place. New York is seeking to maintain that structure of eligibility under the Waiver, so individuals age 65 and over will continue to be eligible for PTC.

Table 1.2.1: New York Proposed With-Waiver Essential Plan Rate Cohorts

Rate Cohorts	Population	Income	Ages	Premium	Deductible	Cost Sharing	Max Out-Of-Pocket
EP 200-250%	Non-Medicaid	200 – 250% FPL	19-64	$15/mo	$0	Yes	$2,000
EP 1	Non-Medicaid	150 – 200% FPL	19-64	$0	$0	Yes	$2,000
EP 2	Non-Medicaid	138 – 150% FPL	19-64	$0	$0	RX only	$200
EP 3	Aliessa	100 – 138% FPL	19-64	$0	$0	RX only	$200
EP 4	Aliessa	< 100% FPL	19-64	$0	$0	No	$0

In order for HHS and Treasury to approve New York's 1332 Waiver, the State must demonstrate that the Waiver satisfies the four "guardrails" pursuant to 45 CFR 155.1308(f) (iv)(A)-(D) as listed below.

- **Comprehensiveness** – The proposal will provide coverage that is at least as comprehensive as coverage defined in ACA section 1302(b) and offered through Exchanges.
- **Affordability** – The proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of Title I of the ACA.
- **Coverage** – The proposal will provide coverage to at least a comparable number of residents as the provisions of Title I of the ACA would provide.
- **Deficit Neutrality** – The proposal will not increase the federal deficit.

This actuarial and economic analysis estimates the Waiver meets the four guardrails in each of the ten years of the Waiver.

1.3 – Federal Savings and Requested Passthrough

The federal government is expected to generate significant PTC savings from the suspension of New York's BHP and the migration of consumers with incomes of 200–250% of the FPL to the with-Waiver Essential Plan. Under the Waiver, the federal government is projected to experience a net reduction in deficits in each year. Therefore, the State is requesting the full PTC savings minus lost revenue from employer mandate collections, passed through to the State to support the 1332 Waiver. This analysis reflects PTC savings from the reduction in PTC spending for consumers with incomes between 0–250% of the FPL, including current QHP consumers migrating from the individual market and current BHP consumers migrating to the with-Waiver Essential Plan. The reduction in PTC spending due to QHP consumers between 200–250% of the FPL migrating from the individual market to the with-Waiver Essential Plan is offset by increased PTC spending for the remaining individual market consumers, due to a 2.2% estimated increase to individual market premiums. Section 5.3 includes details related to calculation of the estimated premium increase.

The federal government is expected to experience some loss in revenue from employer mandate penalty collections due to the migration of consumers 200–250% of the FPL to the Essential Plan. The impact of the lost revenue was included in the analysis.

New York operates a State-based Exchange called the NY State of Health. As such, the Waiver will not impact user fees for the Federally–facilitated Exchange.

The expansion of the with-Waiver Essential Plan to new populations could potentially result in slightly fewer individuals covered in employer sponsored insurance (ESI). This would slightly increase federal tax revenues, as employers increase taxable compensation to offset lower ESI spending. Any such impact would be very small in size and would not affect the satisfaction of the guardrails, since the Waiver is deficit neutral without this effect. As such, this impact was not included in the analysis.

Section 2: Actuarial and Economic Analysis Summary

2.1 Overview

DOH engaged Deloitte Consulting LLP (Deloitte) to perform an actuarial and economic analysis of the potential effects of the proposed 1332 Waiver over 5- and 10- year timeframes. This document contains the results, data, assumptions, and methods used in the analyses in alignment with the Actuarial Standard of Practice (ASOP) requirements for ASOP No.23 – Data Quality, ASOP No. 41 – Actuarial Communication, and ASOP No. 56 – Modeling.

This document has been prepared for the sole use of the State of New York to demonstrate the estimated impact of the proposed 1332 Waiver on the four guardrails. It complies with the Centers for Medicare & Medicaid Services (CMS) "Checklist for Section 1332 State Relief and Empowerment Waivers Applications" (July 2019). Using the information in this report for other purposes may not be appropriate. Other sections of the 1332 Waiver Application contain the non-actuarial portions of the 1332 Waiver requirements.

A total of six different scenarios were analyzed. The following two scenarios are the primary focus of the actuarial and economic analysis. They assess the impact of the proposed expansion of the Essential Plan to consumers with incomes up to 250% of the FPL who would otherwise be eligible for QHPs and APTCs, based on current law.

1. **Scenario A, Baseline Without-Waiver (WoW)** assumes the Essential Plan continues as a BHP; that Medicaid, Essential Plan, and Child Health Plus (CHP) redeterminations resume in 2023 following the end of the Public Health Emergency (PHE)[3]; and the expanded premium tax credits for QHPs under the Inflation Reduction Act (IRA) are not extended after PY 2025.
2. **Scenario A, With-Waiver (WW)** assumes the Essential Plan operates under Section 1332 starting PY 2024 with expanded eligibility for consumers with incomes up to 250% of the FPL who would otherwise be eligible for QHPs and APTCs; that Medicaid, Essential Plan, and CHP redeterminations resume in 2023 following the end of the PHE; and the expanded premium tax credits for QHPs under IRA are not extended after PY 2025.

The following two scenarios were analyzed to assess the impact of the Waiver if the enhanced subsidies under the IRA are extended beyond PY 2025. The Scenario B analysis may be found in Appendix B.

3. **Scenario B, Baseline Without-Waiver (WoW)** assumes the Essential Plan continues as a BHP; that Medicaid, Essential Plan, and CHP redeterminations resume in 2023 following the end of the PHE; and the expanded premium tax credits for QHPs under the IRA are extended for all the years of the Waiver. While the expanded tax credits are set to expire at the end of PY 2025 under current law, this may be a likely scenario given that they have been in place since PY 2021.
4. **Scenario B, With-Waiver (WW)** assumes the Essential Plan operates under Section 1332 starting PY 2024 with expanded eligibility for consumers with incomes up to 250% of the FPL who would otherwise be eligible for QHPs and APTCs; that Medicaid, Essential Plan, and CHP redeterminations resume in 2023 following the end of the PHE; and the expanded premium tax credits for QHPs under the IRA are extended for all the years of the Waiver.

The following two scenarios were analyzed to assess the impact of the proposed policy and operational change to the Essential Plan allowing individuals who become pregnant in the with-Waiver Essential Plan to have the choice of staying in the Essential Plan rather than automatically moving to Medicaid. This scenario is modeled under current law. The Scenario C analysis may be found in Appendix C.

5. **Scenario C, Baseline Without-Waiver (WoW)** assumes the Essential Plan continues as a BHP; that Medicaid, Essential Plan, and Child Health Plus (CHP) redeterminations resume in

[3] The analysis assumes that Medicaid, BHP, and CHP redeterminations which were paused under the Public Health Emergency (PHE) will resume midway through 2023.

2023 following the end of the PHE, and the expanded premium tax credits for QHPs under the IRA are not extended after PY 2025.

6. **Scenario C, With-Waiver (WW)** assumes the Essential Plan operates under Section 1332 starting PY 2024 with expanded eligibility for consumers with incomes up to 250% of the FPL who would otherwise be eligible for QHPs and APTCs; that Medicaid, Essential Plan, and CHP redeterminations resume in 2023 following the end of the PHE; that individuals enrolled in the with-Waiver Essential Plan who report being pregnant are provided the choice of staying in the with-Waiver Essential Plan rather than automatically moving to Medicaid; and the expanded premium tax credits for QHPs under IRA are not extended after PY 2025.

The analysis estimates that the Waiver meets each of the four guardrails for the five years of the Waiver and 10-year analysis for Scenarios A, B, and C. The data, resources, and assumptions used for the actuarial and economic analysis can be found in Section 3. The methodology can be found in Section 4. The results of sensitivity testing performed on pertinent assumptions for Scenario A can be found in Section 5.

2.2 Waiver Impact Assessment and Guardrail Compliance

The table below shows the summary results for the Waiver's guardrail compliance.

Table 2.2.1: High-Level Guardrail Compliance of the 1332 Waiver (Scenario A)

Guardrail	Estimated Impact With-Waiver Compared to Without-Waiver
Comprehensiveness	The 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 experience an increase in comprehensiveness. • 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 Waiver is projected to meet the affordability guardrail as the overall affordability across the market is improved compared to the Baseline Without-Waiver Scenario.
	• Affordability for current Essential Plan members 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 $1.4 billion over the 5 years.
	  ○ This is an average annual savings of $4,200 under the Waiver ($2,250 in premiums and $1,950 in out-of-pocket spend), which is approximately 11% 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 expected to decrease slightly as premiums are expected to increase by an additional 2.2% in 2024 under the Waiver.
	  ○ This is an average annual increase of $259 under the Waiver, which falls in the range of 0.1–0.5% of income for subsidy-ineligible On-Exchange consumers above 250% of the FPL and Off-Exchange consumers.

Guardrail	Estimated Impact With-Waiver Compared to Without-Waiver
Coverage	The 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 1.4% for PY 2024, 2.1% for PY 2025, 2.0% for PY 2026, 2.0% for PY 2027, and 2.0% for PY 2028.
Deficit Neutrality	The 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 $9.8 billion in PY 2024 and $53.9 billion over the 5-year Waiver period, before pass-through funding. • The net federal spend under the Waiver is estimated to remain the same in PY 2024 and over the 5-year Waiver period, after accounting for pass-through funding.

Comprehensiveness

Consumers with incomes between 200–250% of the FPL who will be migrating from QHPs to the Essential Plan under the Waiver will experience an increase in comprehensiveness as the Essential Plan includes Dental and Vision benefits as well as the Essential Health Benefits required under the ACA. There are no expected impacts on comprehensiveness for individual market consumers with incomes over 250% of the FPL or current Essential Plan members compared to without the Waiver.

Affordability

Affordability for current consumers within the Essential Plan is not expected to change under the Waiver.

Affordability for consumers with incomes of 200–250% of the FPL who are expected to migrate from the QHP market to the Essential Plan starting in PY 2024 will improve under the Waiver. While there is a $15/month premium in the Essential Plan for these members ($180/year), there is no deductible, and the maximum out of pocket costs are limited to $2,000. The Actuarial Value of the Essential Plan is 91.9% compared to a weighted Actuarial Value of 72.2% for consumers with incomes of 200-250% of the FPL in the market today, based on the distribution of plan selections for these consumers in 2022. Assuming consumers 200–250% of the FPL maintain similar service utilization patterns, out-of-pocket spending for these consumers will be reduced between $1,750 and $2,150 per year under the Waiver[4]. Approximately 20% of 200 – 250% of the FPL consumers enrolled in bronze and silver plans[5] have premiums below $15 per month who will pay more in monthly premiums under the Essential Plan, however, these premium increases will be offset by reduced out-of-pocket expenditures. The total number of consumers impacted for the duration of the Waiver is an average 93,953 per year, including

[4] The estimated reduction in out-of-pocket spend for 200-250% of the FPL consumers is based on weighted average actuarial value calculations which provide a close approximation to the actual average spending by a wide range of consumers in a standard population. There may be some 200-250% of the FPL consumers who do not utilize any services during a year, and therefore would not feel the effect of plan design/actuarial value changes. Conversely, there will also be consumers who utilize a greater volume of services and/or require more expensive services who will see larger out-of-pocket spending reductions.

[5] 59% of 200-250% consumers in bronze plans and 4% of 200-250% consumers in silver plans have premiums that are less than $15 per month.

those migrating from the QHP market and those that enter the market due to the waiver. An average of 65,109 consumers per year migrating from the QHP market from 2024 to 2028 will experience a cost savings of $4,200 per year ($2,250 in premiums, $1,950 in out-of-pocket spend), resulting in $1.4 billion over the life of the Waiver.

The migration of the current 200–250% of the FPL consumers from the QHP market to the Essential Plan is expected to increase premiums by 0.5–2.2% in the remaining QHP market for PY 2024 compared to the baseline Without-Waiver scenario[6]. The 2.2% increase was used in the With-Waiver estimates to model the higher range which would result in increased federal spend for PTCs in the individual market and potential losses of coverage in the Off-Exchange market due to the premium increase. Details related to the methodology used to estimate the 0.5–2.2% premium impact can be found in Section 5.3. An average of 100,054 consumers per year from 2024 to 2028 will experience an increase of $259 per year, resulting in $129 million over the life of the waiver. The increase of $259 per year falls in the range of 0.1% to 0.5% of income for subsidy-ineligible, On-Exchange and Off-Exchange consumers.

Due to the expanded tax credits under the IRA, consumer premium contributions are capped at the affordability threshold set by the IRS for all subsidized On-Exchange consumers. Therefore, the increase in QHP premiums should not negatively impact affordability for APTC recipients for PY 2024 or PY 2025. Starting in PY 2026, however, consumers above 400% of the FPL will not be eligible for premium tax credits and therefore will experience the impact of the 2.2% increase in premiums. This will impact an estimated 123,238 consumers per year above 400% of the FPL expected to buy On-Exchange or Off-Exchange from 2026 through 2028 at an average annual increase of $257 per consumer. Consumers above 400% of the FPL experience a small decrease in affordability for the last three years of the Waiver because of the expanded premium tax credits from the IRA ending after PY 2025. Subsidy-ineligible On-Exchange consumers and Off-Exchange consumers will similarly experience a small decrease in affordability from the 2.2% increase to premiums. This impacts an estimated 49,161 Off-Exchange consumers per year from 2024 through 2028 at an average annual increase of $226 per consumer, and an estimated 50,893 subsidy-ineligible On-Exchange consumers per year from 2024 through 2028 at an average annual increase of $290 per consumer. Details on the estimated premium increases for the impacted consumers are included in the appendices.

Since New York does not use age-rating in the individual market, and prescribes premium differences by metal level (i.e., bronze, silver, gold, platinum), the impact of the 2.2% premium increase will be relatively consistent from consumer to consumer. Therefore, older consumers will not be disproportionally impacted by the estimated premium increases in comparison to other consumers.

More consumers in the individual market are expected to experience a slight increase in premiums compared to the number of consumers who experience costs savings under the Waiver due to the migration of the 200–250% of the FPL group out of the individual market and into the

[6] The methodology for estimating the 2.2% individual market premium impact incorporates market-wide loss ratio data by metal level, as well as enrollment distributions for the exiting 200-250% of the FPL population by metal level.

Essential Plan. However, the total dollar value of the cost savings for consumers 200–250% of the FPL exceeds the total dollar value of the premium increase for consumer that remain in the individual market, with more economically vulnerable populations experiencing improved affordability.

- Consumers above 250% of the FPL who are ineligible for APTCs and those buying Off-Exchange will experience an increase in premiums of 2.2% under the Waiver. An average, 100,054 consumers per year from 2024 to 2028 will experience an increase of $259 per year, resulting in $129 million over the life of the Waiver. The affordability reduction of $259 per year falls in the range of 0.1% to 0.5% of income for subsidy-ineligible On-Exchange and Off-Exchange consumers.
- Consumers 200–250% of the FPL will experience a decrease in premiums and out of pocket expenditures. An average of 65,109 consumers per year migrating from the QHP market from 2024 to 2028 will experience a cost savings of $4,200 per year ($2,250 in premiums, $1,950 in out-of-pocket spend), resulting in $1.4 billion over the life of the Waiver. The affordability increase of $4,200 per year is roughly 11% of income for the 200-250% of the FPL population.

The Waiver meets the affordability guardrail as the overall affordability across the market is improved, with consumers with lower incomes between 200–250% of the FPL experience substantial improvement in affordability across all five years of the Waiver. The 5- and 10-year estimates for enrollment, premium increases, and individual out-of-pocket expenses by income, health insurance status, and age groups are included in the appendices.

Coverage

With the expansion of the Essential Plan to lower income residents, more consumers are expected to be covered under the Waiver compared to the baseline who would otherwise be uninsured. A total of 21,602 new consumers are expected to gain coverage for PY 2024 and 31,038 for PY 2028 compared to the baseline Without-Waiver scenario.[7] A total of 3,020 consumers are expected to leave the market for PY 2024 due to premium increases, and 3,180 for PY 2028 compared to the baseline Without-Waiver scenario. Overall enrollment for the Essential Plan and individual market combined is expected to increase by 1.4% for PY 2024, 2.1% for PY 2025, 2.0% for PY 2026, 2.0% for PY 2027, and 2.0% for PY 2028 compared to without the Waiver.

Deficit Neutrality

The Waiver is expected to generate substantial savings for the federal government across two areas:

1. Savings from the PTC spend with the suspension of the BHP
2. Savings from the PTC spend for consumers with incomes of 200 – 250% of the FPL

[7] Approximately 94% of those expected to take up coverage under the Waiver would otherwise be uninsured. Except for a handful in the Nongroup market, the remainder would have employer-sponsored coverage

The Waiver is expected to generate a loss in revenue for the federal government in one area:

1. Loss of payments collected under the employer shared responsibility provision with the migration of consumers 200 – 250% of the FPL to the Essential Plan.

PTC Savings from BHP Suspension

With the suspension of the BHP under Section 1331 of the ACA, the federal government is expected to save $9.6 billion for PY 2024, $52.9 billion for the five years of the Waiver, and $124.7 billion for the 10-year analysis on PTC spend for the BHP.

PTC Savings for Migration of Consumers with Incomes 200 – 250% of the FPL

With the migration of consumers between 200–250% of the FPL out of the QHP market and to the Essential Plan, the federal government is expected to save $186 million for PY 2024, $977 million for the five years of the Waiver, and $2.4 billion for the 10-year analysis on PTC spend. This reflects the saving due to consumers in the 200–250% of the FPL not receiving PTC, offset by a small increase in PTC cost due to the 2.2% premium increase in the remaining market, as discussed above.

Loss in Employer Shared Responsibility Fees

Under Section 4980H(b) of the Internal Revenue Code (IRC), applicable large employers (generally employers with at least 50 full-time or full-time-equivalent employees) that do not offer full-time employees and their dependents the opportunity to enroll in affordable, minimum essential coverage under an eligible employer-sponsored plan may owe an assessable payment, referred to as the Employer Shared Responsibility Payment (ESRP) for each full-time employee who receives the PTC. By generally shifting individuals with incomes between 200% and 250% of the FPL into the Essential Plan, the Waiver is expected to reduce the number of individuals who would receive PTC and thus trigger the ESRP.[8]

The Office of Management and Budget (OMB) projects $432 million in ESRP collection for fiscal year 2024 nationwide. The projection for fiscal year 2024 was then used as a proxy for the calendar year 2023. This projection is based on current law that the enhanced subsidies under the Inflation Reduction Act end after PY 2025. When considering the impact of the Section 1332 Waiver, Urban Institute estimates 0.6% of workers employed by large firms who are not offered affordable coverage and purchase QHPs with PTCs are New Yorkers with incomes between 200% and 250% of the FPL. The estimate of 0.6% was then applied to the projected $432 million to calculate a reduction of $2.6 million in ESRP revenue in PY 2024, and $15.6 million over the gives years of the Waiver and $44.6 million over the estimated 10 years.

Net Federal Savings

The estimated net federal spend under the Waiver is provided in the table below.

[8] OMB has ESRP collection projections for 2024 – 2027. 2028 and future years were assumed to have a 15% increase compared to 2027 (for conservatism), with the same 0.6% application for each year to calculate projected reductions in ESRP revenue.

Table 2.2.2: Federal Savings Under the Waiver (Scenario A) ($ in Millions)

	FY 2024	5-Years	10 Years
PTC Savings (BHP Suspension)	$9,647	$52,908	$124,729
PTC Savings (QHPs)*	$186	$977	$2,425
Loss in Employer Shared Responsibility Fees	($3)	($16)	($45)
Total Federal Savings**	**$9,831**	**$53,870**	**$127,109**
Requested Passthrough	$9,831	$53,870	$127,109
Federal Savings After Passthrough	**$0**	**$0**	**$0**

* Reflects PTC savings due to consumers in the 200 – 250% of the FPL range not receiving PTC, offset by an increase in PTC spend due to premium increases in the remaining market.
**Totals may not sum due to rounding.

The following tables show the baseline Without-Waiver and With-Waiver estimates for Scenario A. 10-year estimates of each table are included in Appendix A.

Table 2.2.3: WoW Summary of Enrollment, Premium, and Cost Estimates (Scenario A)

Baseline - Scenario A	2024	2025	2026	2027	2028	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange							
Enrollment[1]	66,122	64,435	124,043	123,236	122,435	100,054	110,061
Average Premium PMPM	$751	$786	$806	$845	$885	$825	$932
Subsidized On-Exchange							
Enrollment[1]	236,570	237,659	149,369	150,356	151,349	185,061	169,717
Average Premium PMPM	$712	$746	$782	$820	$859	$774	$873
Average APTC PMPM	$265	$291	$265	$292	$321	$285	$347
Total Individual Market							
Enrollment[1]	302,692	302,094	273,412	273,592	273,784	285,115	279,779
Average Premium PMPM	$721	$755	$793	$831	$871	$792	$896
Aggregate Premiums (millions)	$2,618	$2,737	$2,602	$2,729	$2,861	$13,546	$30,081
Projected Federal Spend (millions)	$703	$774	$443	$492	$544	$2,956	$6,587
Essential Plan							
Enrollment[1]	1,049,766	1,075,921	1,103,125	1,125,773	1,147,847	1,100,487	1,159,535
Average Premium PMPM	$563	$585	$608	$633	$658	$610	$680
Aggregate Premiums (millions)	$7,086	$7,553	$8,053	$8,547	$9,063	$40,303	$94,586
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$140	$148	$157	$576	$1,517
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$568	$1,333
Total Program Costs (millions)	$8,236	$8,841	$9,356	$9,866	$10,398	$46,697	$107,937
Projected Federal Spend (millions)	$9,647	$10,363	$10,241	$10,953	$11,705	$52,908	$124,729
Employer Shared Responsibility Revenue							
Projected Federal Revenue (millions)	($3)	($3)	($3)	($3)	($4)	($16)	($45)
Combined Totals							
Enrollment[1]	1,352,459	1,378,015	1,376,537	1,399,365	1,421,631	1,385,601	1,439,313
Projected Federal Spend (millions)	$10,348	$11,134	$10,681	$11,441	$12,245	$55,849	$131,271

[1]5 and 10 year totals are straight averages

Table 2.2.4: WW Summary of Enrollment, Premium, and Cost Estimates (Scenario A)

With Waiver - Scenario A	2024	2025	2026	2027	2028	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange							
Enrollment[1]	63,102	61,122	120,753	120,002	119,255	96,847	106,947
Average Premium PMPM	$772	$809	$827	$866	$908	$847	$956
Subsidized On-Exchange							
Enrollment[1]	168,922	170,243	87,405	87,979	88,556	120,621	105,469
Average Premium PMPM	$728	$763	$799	$838	$878	$786	$883
Average APTC PMPM	$273	$299	$273	$301	$330	$293	$352
Total Individual Market							
Enrollment[1]	232,024	231,365	208,157	207,980	207,812	217,468	212,416
Average Premium PMPM	$740	$775	$815	$854	$895	$813	$920
Aggregate Premiums (millions)	$2,060	$2,151	$2,036	$2,132	$2,232	$10,610	$23,449
Projected Federal Spend (millions)	$517	$570	$267	$296	$328	$1,978	$4,162
Essential Plan							
Enrollment[1]	1,139,016	1,175,895	1,196,324	1,219,287	1,241,677	1,194,440	1,253,904
Average Premium PMPM	$569	$592	$615	$640	$665	$617	$687
Aggregate Premiums (millions)	$7,774	$8,354	$8,830	$9,358	$9,909	$44,226	$103,324
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$138	$147	$155	$571	$1,498
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$568	$1,333
200-250% Member Premiums (millions)	($16)	($18)	($17)	($17)	($17)	($85)	($170)
Total Program Costs (millions)	$8,908	$9,624	$10,115	$10,658	$11,226	$50,531	$116,485
Projected Federal Spend (millions)	$0	$0	$0	$0	$0	$0	$0
Employer Shared Responsibility Revenue							
Projected Federal Revenue (millions)	$0	$0	$0	$0	$0	$0	$0
Combined Totals							
Enrollment[1]	1,371,040	1,407,260	1,404,481	1,427,267	1,449,489	1,411,907	1,466,320
Projected Federal Spend (millions)	$517	$570	$267	$296	$328	$1,978	$4,162

[1]5 and 10 year totals are straight averages

Section 3: Data Sources, Assumptions, and Reliance

This section describes the data relied upon to develop baseline Without-Waiver and With-Waiver assumptions to estimate the effect of the Waiver on coverage, comprehensiveness, affordability, and deficit neutrality requirements.

3.1 State Data Requested and Received

To conduct this analysis, the following data was requested and collected from the New York Department of Financial Services (DFS) and DOH:

- Essential Plan enrollment for 2019–2022
- Essential Plan estimated enrollment for 2023
- Essential Plan capitation rates and claims trends for 2019–2023
- On-Exchange detailed enrollment for 2019–2022, including premiums, APTCs, FPL, county, metal level, age bands, and gender
- Off-Exchange individual market summarized enrollment for 2019–2022
- On- and Off-Exchange estimated enrollment for 2023
- On- and Off-Exchange premiums for 2023
- PY 2023 rate filings for individual market insurers, including actuarial memos, rate tables, and Unified Rate Review Tables (URRTs)
- CMS letter from the Office of the Actuary to the State of New York, dated September 2, 2022, subject "Federal Basic Health Program Payment to New York for October - December (Q4) 2022 and Payment Revision for July – September (Q3) 2022"
- CMS letter from the Office of the Actuary to the State of New York, dated December 21, 2022, subject "Federal Basic Health Program Payment to New York for January–March (Q1) 2023 and Reconciled Payment Adjustments for October–December (Q4) 2019 and January–March (Q1) 2020"
- Medical Loss Ratio reports by metal level from 2022
- New York Emergency Medicaid Spend Data 2019–2022

3.2 Other Data Sources

Additional data sources used in this analysis include:

- Premium growth assumptions for the individual market from the Office of the Actuary (OACT) in the Centers for Medicare & Medicaid Services (CMS) short-term (10-year) projections of health care spending for categories in the National Health Expenditure Accounts (NHEA) produced in March of 2022.[9]
- Basic Health Program; Federal Funding Methodology for Program Year 2023 and Proposed Changes to Basic Health Program Regulations[10]

[9] https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf
[10] https://www.federalregister.gov/documents/2022/05/25/2022-11047/basic-health-program-federal-funding-methodology-for-program-year-2023-and-proposed-changes-to-basic

- Method for Calculation of Section 1332 Reinsurance Waiver 2022 Premium Tax Credit Pass-through Amounts Office of Tax Analysis, Department of Treasury, March 2022[11]
- Health Care Costs – From Birth to Death; sponsored by the Society of Actuaries; Yamamoto, Dale; June 2013[12]
- Economic data/indicators from the U.S. Bureau of Labor Statistics (BLS)
- Employer Shared Responsibility Payment from The Office of Management and Budget (OMB) [13]
- 2019 NY Individual Income and Tax Data[14]
- Nongroup price cross-elasticity from the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT)[15]
- CMS Final 2023 Actuarial Value Calculator Methodology[16]

3.3 Enrollment Projection Data Source

The analysis relied upon enrollment projections from the Urban Institute Health Policy Simulation Model (HIPSM) for the State of New York to project the baseline Without-Waiver and With-Waiver enrollments. HIPSM is a microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. The model uses data from the U.S. Census Bureau's American Community Survey (ACS) to create a distribution of the population by demographic, economic, and health coverage characteristics, which is then calibrated using available Medicaid, Essential Plan, Marketplace administrative data, and Medical Expenditure Panel Survey (MEPS) data. Information on the model and methodology may be found online at Urban.org. [17]

The model is iterative and considers how changes in one market will affect other markets. The model considers many scenarios that would impact the market, including:

- The effects of the PHE unwinding [18] and the impact redeterminations will have on the Essential Plan and marketplace enrollment[19].
- The effects of the expanded premium tax credits under the Inflation Reduction Act on marketplace coverage[20] and the potential impact of ending or extending the expanded tax credits beyond PY 2025.
- Administrative changes due to the final rule from the IRS in 2022 to resolve the "Family Glitch" for PTC eligibility.[21]

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[11] https://www.cms.gov/files/document/1332-ota-methodology-reinsurance-pass-through-amounts-march-2022.pdf
[12] https://www.soa.org/resources/research-reports/2013/research-health-care-birth-death/
[13] https://www.whitehouse.gov/omb/budget/supplemental-materials/
[14] https://www.irs.gov/statistics/soi-tax-stats-historic-table-2-2015-2019
[15] https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf
[16] https://www.cms.gov/sites/default/files/2022-04/Final-2023-AV-Calculator-Methodology.pdf
[17] https://www.urban.org/research/publication/health-insurance-policy-simulation-model-2020
[18] https://www.urban.org/research/publication/estimating-health-coverage-2023
[19] The analysis assumes that Medicaid, BHP, and CHP redeterminations which were paused under the Public Health Emergency (PHE) will resume midway through 2023.
[20] https://www.urban.org/research/publication/what-if-american-rescue-plan-act-premium-tax-credits-expire
[21] https://www.urban.org/research/publication/changing-family-glitch-would-make-health-coverage-more-affordable-many-families

Projections for Non-Group (Off-Exchange and On-Exchange subsidy-ineligible) enrollment, On-Exchange subsidized enrollment, and Essential Plan enrollment were provided by Urban Institute to build the baseline Without-Waiver development. Urban Institute enrollment projections for consumers with incomes 200–250% of the FPL were used for the With-Waiver development. For sections of the analysis that required enrollment breakouts for Off-Exchange vs. On-Exchange subsidy-ineligible enrollment, it was assumed that 75% of Non-Group consumers are Off-Exchange for 2024 and 2025, and 40% Non-Group consumers are Off-Exchange for 2026 through 2033 for Scenario A. It was assumed 75% of Non-Group are Off-Exchange for 2024 through 2033 under Scenario B.

3.4 Premium Growth Data Sources

For the individual market, the analysis applied a premium growth rate trend factor of 6.2% from 2023–2024, and 4.8% for 2025–2033 and beyond based on National Health Expenditure Projections from the Centers of Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) to baseline Without-Waiver premiums.

For the Essential Plan, the analysis applied a premium growth rate trend factor of 4.0% for the for PY 2023–2033. Historically, the trend assumptions for the Essential Plan have been approximately 3% based on claims experience. It was confirmed with DOH that a 4.0% per member per month (PMPM) trend factor is a reasonable assumption for the baseline Without-Waiver scenario.

Essential Plan capitation rates are set by DOH in a manner that largely aligns with the approach for Medicaid Managed Care. Essential Plan rates consider the adequacy of rates of payment in relation to the population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards. If expected health care utilization/costs exceed capitation rates paid to plans, mid-year rate adjustments are made. For example, when COVID-19 case rates and testing increased in early 2022 due to the Omicron variant, the actuarial team developed, and the EP trustees approved, a rate adjustment.

3.5 Reliance

The data received from DFS, DOH, and the Urban Institute were reviewed for reasonableness and consistency during the work; however, it was not audited by the team conducting the actuarial and economic analysis. Enrollment data for NYSOH is audited and validated with CMS and insurers. 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 State of New York 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 of New York's individual market population.

Section 4: Methodology

4.1 Baseline Without-Waiver Development

For the Essential Plan, approved PY 2023 capitation rates were trended forward. Projected enrollment growth for the Essential Plan beginning in 2024 was provided by Urban Institute.

For the individual market, 2022 enrollment distributions for consumers by On- and Off-Exchange status, metal level, income level, and percentage receiving PTCs (by metal level) were used as base data. After reviewing the dataset for reasonability and completeness, it was determined 1.6% of the enrollment records had incomplete data fields (for example, records indicating consumers received PTC's without FPL information) and were removed from the dataset. Consistent with the standards established under ASOP No. 23 – Data Quality, it is the actuary's professional judgement that the removal of these inconsistent data records is reasonable and does not create a significant bias in the dataset and subsequent analyses. For the On-Exchange market, the projected enrollment growth was distributed for PY 2023 based on relationships from insurer filings. For the Off-Exchange market, the projected enrollment for PY 2023 was distributed based on relationships from insurer filings, with slight modifications to the total number of Off-Exchange consumers based on conversations with DFS [22]. It was assumed that all consumers buying Off-Exchange have incomes above 400% of the FPL. Next, the team approved QHP premiums for PY 2023 to finalize expected premium and enrollment for PY 2023 for On- and Off-Exchange.

Projected enrollment growth in the individual market starting in 2024 was provided by Urban Institute. The analysis assumed the distribution of consumers by metal level and the percentage receiving PTCs for PY 2024–2033 mirrors the distribution for PY 2022 and 2023, but it accounts for an expected loss of consumers from the On-Exchange market due to the reduction in premium tax credits beginning 2026. New consumers with incomes of 200–250% of the FPL joining the market starting in PY 2024 were assumed to be at the same health status as PY 2022

[22] After reviewing 2023 URRTs insurers included in the rate filing process, it was determined the information in the URRTs contained accurate premium information on a plan and metal level basis, but projected 2023 enrollment for On- and Off-Exchange status was likely misrepresented in the URRTs. Current 2022 enrollment provided by the Exchange indicates roughly 19% of consumers are enrolled in Off-Exchange plans, while 2023 URRTs projected roughly 3% of consumers would be enrolled in Off-Exchange plans, a migration of roughly 40,000 consumers. DFS communicated that data insurers supplied in Exhibit 18 of rate filings projected Off-Exchange enrollment in 2023 to remain relatively steady compared to 2022, prompting a detailed investigation of the information supplied in the 2023 URRTs. After further review, it was determined there were likely inconsistencies in the On/Off-Exchange indicator insurers inputted into Field # 1.9 'Exchange Plan?' from the 'Wksh 2 – Plan Product Info' tab of the URRTs. Based on the outcomes of the investigation combined with conversations with DFS, it was determined that using the total projected enrollment figures from insurer URRTs would be accurate, but applying 2022 distributions for On/Off-Exchange by Metal Level would be a more accurate representation of expected 2023 enrollment.

and 2023 consumers with incomes of 200–250% of the FPL. Therefore, no adjustments were made to QHP premiums based on these new consumers joining the market.

For Scenario A, it was assumed that Off-Exchange enrollment for 2026 would generally be consistent with 2025 enrollment. Changes in enrollment due to the sunsetting of the expanded premium tax credits under the Inflation Reduction Act in 2025 were reflected in reductions to On-Exchange enrollment. No adjustments were made to premiums or metal level distributions from the reductions in On-Exchange enrollment in PY 2026–2033. Although the risk profile of enrollees may potentially change when the subsidies expire, it would be difficult to determine the extent of the risk profile change, and any incremental changes to premiums resulting from associated changes to population morbidity accounted for by insurers.

4.2 Baseline Federal Spend for the Essential Plan

Baseline federal spend for the Essential Plan was calculated using the BHP payment methodology and relevant trend factors. Section 1331(d)(3) defines the amount of the federal payment for the BHP to be equal to 95 percent of the premium tax credits (PTCs) (under section 36B of the Internal Revenue Code) and cost-sharing reductions (CSRs) (under section 1402 of the ACA) that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals had been allowed to enroll in qualified health plans through an Exchange. The payment is determined on a per enrollee basis and takes into account all relevant factors necessary to determine the value of the PTCs and CSRs that would have been provided to eligible individuals, including (i) whether the enrollment is for self-only or family coverage, (ii) geographic differences in average spending for health care across rating areas, (iii) an optional health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange (note, New York has never taken advantage of this factor for the calculations), and (iv) whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled. The following factors are used in the calculation of federal BHP payments:

- Reference premiums
- Premium trend factor
- Federal poverty level
- Premium tax credit formula percentages
- Income reconciliation factor
- Premium adjustment factor

Estimated federal spend for the Essential Plan beginning PY 2023 is based on the actual average federal spend per eligible member from Quarter 4 of PY 2022, trended forward. Since federal spend for the Essential Plan is tied to the premium growth in the QHP market and associated increases in premium tax credits, the QHP premium growth trend factors were used to estimate federal spend for the Essential Plan for PY 2024–2033. Federal spend was calculated specific to income distribution using the current BHP methodology for consumers with incomes up to 200%

of the FPL and then trended forward for PY 2024 using the 6.2% premium growth rate trend and for PY 2025–2033 using the 4.8% premium growth rate trend projected by OACT.

4.3 Baseline Federal Spend for QHPs

Federal spend for the QHP market is based on expected PTC spend per member per month (PMPM). The PY 2022 APTC PMPMs were summarized from the actual PY 2022 APTC data received from the Exchange by metal level. The net member premium in PY 2022 was calculated as the difference between gross member premium and APTC.

The change in net member premium from PY 2022 to 2023 was estimated by indexing at an annual wage inflation rate of 6.0%, developed from New York-specific data from the Bureau of Labor Statistics (BLS), reflecting economic inflation pressure. The change in net member premium from PY 2023 to 2024 was estimated by indexing at an annual wage inflation rate of 4.0%. The change in net member premium in PY 2024–2033 was estimated by indexing at an annual wage inflation rate of 2.0%, developed from New York-specific data from the Bureau of Labor Statistics (BLS). For Scenario A, the average estimated APTC spend by income threshold for PY 2026 was recalculated based on what the affordability thresholds were for PY 2021, prior to the American Rescue Plan Act. This was then trended by 4.8% per year for PY 2027–2033 for all consumers with incomes above 200–400% of the FPL. For Scenario B, the 4.8% QHP premium growth factor was also applied to the estimated APTC spend for PY 2024 – 2033. For the purposes of converting APTC data to PTC spend, a reconciliation factor of 0.933 was used. The reconciliation factor of 0.933 is reflective of the ratio of the sum of total APTC and net PTC, less excess APTC compared to the total APTC. All figures are for PY 2019, the most recent year for which they are available[23].

4.4 With-Waiver Development

Under the Waiver, DOH is seeking to suspend the Essential Plan as a BHP under Section 1331 and implement an identical Essential Plan (referred to as the "With-Waiver Essential Plan") under Section 1332 beginning PY 2024. Current Essential Plan enrollees are assumed to shift to the With-Waiver Essential Plan. This eliminates the current BHP payment and uses resulting pass-through to pay for the same coverage on the With-Waiver Essential Plan.

From the baseline scenario, the projected enrollment for On-Exchange consumers with incomes 200–250% of the FPL age 64 or younger were migrated to the Essential Plan beginning in PY 2024. Consumers age 65 or older were projected to remain in the market based on current state policy which New York is requesting to maintain under the Waiver. Federal spend for consumers 200–250% of the FPL was subtracted from the total federal spend for the individual market. To account for the migration of consumers 200–250% of the FPL out of the QHP market, a 2.2% premium adjustment was added to the 4.8% QHP premium trend for PY 2024. This factor is based on an analysis of metal-level enrollment and loss-ratios based on sensitivity testing. *See Section 5.3 for more details.* A price elasticity adjustment was applied to non-group

[23] https://www.irs.gov/statistics/soi-tax-stats-historic-table-2-2015-2019

enrollment.[24] Federal PTC spend for consumers over 250% of the FPL was also increased by 2.2% per consumer.

Essential Plan premiums were adjusted for this new 200–250% of the FPL population based on the actual demographic differences observed for PY 2022 between the new population and Essential Plan enrollees 150–200% of the FPL, which was assumed to continue under the Waiver, and to take a conservative approach to model the impact of this migration on the current Essential Plan. *See Section 5.3 for more details.*

4.5 Essential Plan Pregnancy Choice Policy Provision

In State Fiscal Year 2022-2023, New York proposed a change that would allow individuals who report being pregnant in the Essential Plan the choice of staying in the Essential Plan rather than moving to Medicaid, which has eligibility rules that overlap with Essential Plan eligibility. The State is seeking approval to implement this policy under the State's 1332 Waiver, once the authority of the Essential Plan changes to Section 1332 of the Affordable Care Act. New York intends to allow 12-months postpartum coverage in the With-Waiver Essential Plan and to align cost-sharing between Medicaid and the Essential Plan for pregnant individuals.

Projected enrollment for the number of pregnant individuals expected to remain in the Essential Plan beginning in 2024 is based on historical administrative data and enrollment growth assumptions from Urban Institute. The federal government is expected to generate savings in Medicaid spend with the reduction in expenditures for individuals who elect to remain in the With-Waiver Essential Plan. The results of the analysis for the proposed pregnancy provision on the Waiver may be found in Appendix C.

4.6 Essential Plan Quality Incentive Pool

New York operates a Quality Incentive Pool for the Essential Plan under BHP. The program awards participating EP insurers based on the results of their health plan quality data submissions. The State plans to continue to operate the program under the 1332 Waiver, and $225M per year has been allocated by the Board of Trustees for the program. This program cost has been added to both the Baseline Without-Waiver and With-Waiver scenarios.

4.7 Essential Plan Provider Rate Adjustments

The Essential Plan Board of Trustees voted on April 21, 2023 to increase provider reimbursement for the EP 3 and EP 4 tiers to be consistent with EP 1 and EP 2. The goal of this adjustment is to bring greater equity across the EP tiers by improving access to providers. This change will occur with or without the implementation of the 1332 Waiver. The Board has voted

[24] Enrollment projections provided by Urban Institute assume a negligible (+/- 1.0%) increase to premiums in the QHP market, instead of the moderate 2.2% increase accounted for in the With-Waiver development. Accordingly, an additional price elasticity adjustment was made to projected enrollment for Off-Exchange, and On-Exchange subsidy ineligible consumers. Enrollment was adjusted to decrease by 2.6% for each year of the Waiver, to account for the number of consumers who would choose different health coverage in response to premium changes. A mildly elastic cross-price elasticity factor of -1.18 was applied based on estimates developed by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) in January 2019: https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf

to increase the provider reimbursements up to a maximum of $800M per year. The cost for the provider rate adjustment has been added to the baseline Without-Waiver and With-Waiver analysis.

4.8 Essential Plan Investments

The Essential Plan Board of Trustees has voted to enrich the package of benefits for EP members. These include providing a grant program for Social Determinants of Health (SDoH) and Behavioral Health (BH), adding coverage for Long Term Services and Supports (LTSS), and reducing the cost-sharing burden on members. The State is investing in these areas under BHP authority and plans to provide these benefits under 1332 Waiver.

SDoH and BH

The Essential Plan Board of Trustees has allocated a total of $25M per year for the SDoH and BH grant programs. These program costs have been added to both the Baseline Without-Waiver and With-Waiver scenarios.

LTSS

The covered community based LTSS services and premium impact for the EP have not been finalized, however, the State anticipates these services to begin in PY 2025. A preliminary analysis was conducted to estimate the number of utilizers and potential cost for the EP population. Actual experience among the Medicaid population was used to estimate the cost for the EP population with incomes at or below 138% of FPL. The same utilization assumption with an acuity adjustment that assumed slightly lower utilization of LTSS among higher income individuals was used to estimate the cost for the population above 138% of FPL.

The State's preliminary budget estimate for PY 2025 was added to the Baseline Without-Waiver and With Waiver scenarios and trended forward based on the estimated aggregate increase in enrollment and premiums.

Reductions in Member Cost-Sharing

The Essential Plan Board of Trustees is considering several potential options to reduce member cost sharing under the Essential Plan for the EP1 population. An analysis was conducted which included several scenarios for reducing member cost sharing starting in PY 2023. The analysis estimated the impact of changing the cost sharing requirements for the EP1 population by increasing the actuarial value.

The Board of Trustees has not yet voted on the options. It is expected to be voted upon and implemented starting in PY 2024, with or without the 1332 Waiver. There is strong support for a proposed scenario that reduces cost sharing by 50% for EP1 which will result in approximately $100M of additional program costs starting in PY 2024. This program cost was added to the

Baseline Without-Waiver and With Waiver scenarios and trended based on estimated aggregated premium increases for the EP 1 cohort.

Section 5: Sensitivity Testing

5.1 Essential Plan Enrollment Growth

For purposes of the 5- and 10-year estimates, it was assumed 100% of consumers with incomes 200–250% of the FPL who bought health insurance on the individual marketplace for PY 2023 would move to the Essential Plan starting in 2024 and there would be additional enrollment from those who are otherwise uninsured in the Baseline Without-Waiver scenario. If more consumers enroll than estimated, it will increase the overall cost of the program. This will not impact the federal deficit as the State bears the financial risk for the program.

The following table includes the summary results from the sensitivity analysis for Scenario A. The top row is modeled in Scenario A With-Waiver 5-year estimates. The subsequent sensitivity analyses demonstrate the estimated impact to the Essential Plan premiums if enrollment growth differs from the With-Waiver scenario.

Table 5.1.1: Essential Plan Enrollment Sensitive Analysis and WW 5 Year Premium Estimates for Scenario A

Sensitivity Analysis for EP Population Growth						
Waiver Modeled Scenario	2024	2025	2026	2027	2028	5-Year Total
Essential Plan With Waiver (With Waiver Enrollment)						
Enrollment[1]	1,139,016	1,175,895	1,196,324	1,219,287	1,241,677	1,194,440
Average Premium PMPM	$569	$592	$615	$640	$665	$617
Aggregate Premiums (millions)	$7,774	$8,354	$8,830	$9,358	$9,909	$44,226
Increased EP Enrollment						
+10% EP Enrollment Increase	2024	2025	2026	2027	2028	5-Year Total
Essential Plan With Waiver (+10%)						
Enrollment[1]	1,252,918	1,293,485	1,315,956	1,341,216	1,365,845	1,313,884
Average Premium PMPM	$569	$592	$615	$640	$665	$617
Aggregate Premiums (millions)	$8,551	$9,190	$9,713	$10,294	$10,900	$48,648
Difference (+10%)						
Enrollment[1]	113,902	117,590	119,632	121,929	124,168	119,444
Average Premium PMPM	$0	$0	$0	$0	$0	$0
Aggregate Premiums (millions)	$777	$835	$883	$936	$991	$4,423

5.2 Essential Plan Premium Growth

For purposes of the 5- and 10-year estimates, it was assumed that the Essential Plan premium growth under the Baseline Without-Waiver scenario grows at an average annual trend of 4.0% for PY 2023 onwards. If the Essential Plan capitation payments grow at a higher rate, it will not have an impact on the federal deficit as the State bears the financial risk for increased capitation rates.

To test the sensitivity of the premium growth assumption on potential future costs to the State, we adjusted the Essential Plan premium growth trend by 1.5% in both directions.

The following table includes the summary results from the sensitivity analysis for Scenario A. The top row is modeled in Scenario A With-Waiver 5-year estimates. The subsequent sensitivity analyses demonstrate the estimated impact to the Essential Plan premiums if the premium growth differs from the With-Waiver scenario.

Table 5.2.1: Essential Plan Premium Growth Sensitivity Analysis and WW 5 Year Premium Estimates for Scenario A

Sensitivity Analysis for EP Premium Growth						
Waiver Modeled Scenario	2024	2025	2026	2027	2028	5-Year Total
Essential Plan With Waiver (4.0% Trend)						
Average Premium PMPM	$569	$592	$615	$640	$665	$617
Aggregate Premiums (millions)	$7,774	$8,354	$8,830	$9,358	$9,909	$44,226
Increased Essential Plan Premium Trend						
Trend +1.5%	2024	2025	2026	2027	2028	5-Year Total
Essential Plan With Waiver (5.5% Trend)						
Average Premium PMPM	$577	$609	$642	$677	$714	$645
Aggregate Premiums (millions)	$7,886	$8,597	$9,218	$9,910	$10,645	$46,255
Difference (+1.5% Trend)						
Average Premium PMPM	$8	$17	$27	$38	$49	$28
Aggregate Premiums (millions)	$112	$243	$388	$552	$736	$2,030
Decreased Essential Plan Premium Trend						
Trend -1.5%	2024	2025	2026	2027	2028	5-Year Total
Essential Plan With Waiver (2.5% Trend)						
Enrollment	1,139,016	1,175,895	1,196,324	1,219,287	1,241,677	1,194,440
Aggregate Premiums (millions)	$7,662	$8,115	$8,453	$8,830	$9,215	$42,275
Difference (-1.5% Trend)						
Average Premium PMPM	($8)	($17)	($26)	($36)	($47)	($27)
Aggregate Premiums (millions)	($112)	($239)	($377)	($528)	($694)	($1,951)

5.3 Relative Health Status of Consumers 200 – 250% of the FPL

For purposes of the 5- and 10-year estimates for the baseline and With-Waiver analysis, it was estimated that the 200–250% of the FPL cohort currently buying on the marketplace for PY 2023 is slightly healthier than the rest of the QHP market. The Waiver analysis assumes the migration of the 200–250% of the FPL consumers from the QHP market to the Essential Plan will cause the QHP premiums in the market to increase for PY 2024. A 2.2% premium impact was used to model the 5- and 10-year With-Waiver scenario and is based on estimates using the medical loss ratio methodology and age/gender methodology described below.

QHP Market Impact Using Medical Loss Ratio Methodology

One unique aspect of the State's individual Exchange market is the State's market-wide risk adjustments in addition to insurer-wide and high-cost risk adjustments facilitated by the Federal government. In an effort to stabilize the State's market-wide risk adjustment program, insurers are instructed to include state-specific components during the rate-setting and rate-filing process. These components include induced demand by metal tier, and a standardization of the slopes (or relative cost difference) across metal levels, from platinum to catastrophic. The inclusion of these provisions effectively compresses the premium ranges between metal levels, and creates an

environment where catastrophic, bronze, and silver plans have more favorable experience for claims in relation to premiums (as premiums for lower-level plans are artificially inflated). If members migrating out of the market were more likely to be enrolled in catastrophic, bronze, and silver plans, there could be an impact on future premiums as insurers attempt to maintain similar claims-to-premium ratios (also known as medical loss ratios) across all of their plans offered.

In 2022, consumers with FPLs between 200–250% were generally concentrated in silver plans which were slightly lower on the metal level slope in comparison to consumers with FPLs outside this range. Consumers with FPLs between 200% and 250% were roughly half as likely to select platinum and gold level plans, and about 25% less likely to select bronze or catastrophic plans.

Medical loss ratio (MLR) data was received for each of the QHP plans in the marketplace from DFS for PY 2022. MLR accounts for both the estimated claims experience of members and premiums. The MLR for consumers 200–250% of the FPL is 79.2% compared to a MLR of 94.6% for the rest of the market. Based on the MLR analysis, the migration of this group out of the QHP market could increase premiums in the rest of the market by 0 – 4% for PY 2024 as insurers will no longer have significant enrollment in these more profitable plans and may account for risk adjustment dollars potentially exiting the QHP market by increasing premiums in other parts of the market.

To test the sensitivity of the assumed premium impact in the individual market from the migration of the 200%–250% of the FPL population on changes to federal deficit neutrality, the assumed loss ratio of the 200%–250% population was adjusted by 10% in both directions. The top row is what is modeled in Scenario A With-Waiver 5- and 10- year estimates. It assumes the MLR of the QHPs consumers between 200–250% of the FPL would have otherwise been enrolled in the same plan selections in MLR for the market for 2022. The average MLR is assumed to be 79.2% in the Baseline Without-Waiver, so it is assumed insurers will adjust premiums in the rest of the QHP by 2.2% due to this loss of these profitable plans in the With-Waiver scenario. The subsequent sensitivity analyses demonstrate the estimated impact to the QHP premiums if the MLR of this group differs from the With-Waiver scenario. The Improved 200–250% of the FPL Loss Ratio Assumption shows the resulting average premium PMPM increase by 3.8%, as opposed to the 2.2% estimated increase, resulting in increased federal spend for years 2024 – 2028 if the average MLR of the QHPs for the migrating 200–250% of the FPL population is lower than what is modeled in the Waiver. A lower MLR means the enrolled individuals are more profitable for insurers than estimated with the Waiver. Insurers would be expected to respond to the loss of these consumers by shifting more costs to the remaining QHP market by increasing premiums to maintain profitability. The decrease in MLR would be expected to result in an increase in the average premiums and estimated federal spend on PTCs.

The Worse 200–250% of the FPL Loss Ratio Assumption shows the resulting average premium PMPM and the estimated decrease in federal spend for PY 2024–2028 if the average MLR of the QHPs for the migrating 200–250% of the FPL population is higher than what is modeled in the Waiver. A higher MLR means the enrolled individuals are less profitable for insurers than estimated with the Waiver. Insurers would be expected to respond to the loss of these consumers

by shifting fewer costs to the remaining QHP market. The increase in MLR would be expected to result in a lower premium impact and estimated federal spend on PTCs than what is modeled in the Waiver as insurers would not need to raise premiums as high in the QHP market to maintain the same level of profitability. An improved loss ratio for the exiting 200 – 250% of the FPL population would also lead to larger increases to premiums in the QHP market, lowering expected enrollment for subsidy-ineligible consumers.

Table 5.3.1: 200 – 250% of the FPL Health Status and Potential Impact on QHP Market Using MLR Methodology

Sensitivity Analysis for Individual Premium/APTC Impact from 200-250% Market Exit						
Waiver Modeled Scenario	2024	2025	2026	2027	2028	5-Year Total
Total Individual Market (79.2% MLR 200-250%)						
Subsidized Premium PMPM	$728	$763	$799	$838	$878	$786
Subsidized APTCs PMPM	$273	$299	$273	$301	$330	$293
Projected Federal Spend	$516,932,667	$570,242,426	$267,228,542	$296,412,593	$327,586,018	$1,978,402,246
Improved 200-250% Loss Ratio						
Loss Ratio -10%	2024	2025	2026	2027	2028	5-Year Total
Total Individual Market (69.2% MLR 200-250%)						
Subsidized Premium PMPM	$739	$775	$812	$851	$892	$798
Subsidized APTCs PMPM	$285	$311	$286	$314	$344	$305
Projected Federal Spend	$538,659,672	$593,190,402	$279,575,799	$309,437,507	$341,325,781	$2,062,189,161
Difference (-10% MLR)						
Subsidized Premium PMPM	$11	$12	$13	$13	$14	$12
Subsidized APTCs PMPM	$11	$12	$13	$13	$14	$12
Projected Federal Spend	$21,727,005	$22,947,976	$12,347,257	$13,024,913	$13,739,764	$83,786,914
Worse 200-250% Loss Ratio						
Loss Ratio +10%	2024	2025	2026	2027	2028	5-Year Total
Total Individual Market (89.2% MLR 200-250%)						
Subsidized Premium PMPM	$716	$751	$787	$824	$864	$774
Subsidized APTCs PMPM	$262	$287	$260	$288	$316	$280
Projected Federal Spend	$495,205,663	$547,294,451	$254,881,285	$283,387,680	$313,846,254	$1,894,615,332
Difference (+10% MLR)						
Subsidized Premium PMPM	($11)	($12)	($13)	($13)	($14)	($12)
Subsidized APTCs PMPM	($11)	($12)	($13)	($13)	($14)	($12)
Projected Federal Spend	($21,727,005)	($22,947,976)	($12,347,257)	($13,024,913)	($13,739,764)	($83,786,914)

Essential Plan Premium Cost Impact Using Age & Gender Methodology

Alternative methods were assessed to determine the sensitivity of the impact on premiums from the migration of the 200 – 250% of the FPL population. After weighing multiple options, it was determined that a viable approach for comparing relative risk across populations would be to use an age/gender risk factor that combined population-specific demographic information with a publicly available[25], accredited study that calculated cost relativities for age groupings, split by gender.

Assessing the age and gender mix of the 200–250% of the FPL On-Exchange consumer group in comparison to other consumers in the QHP market suggests that migration of this population would cause premiums in the QHP market to rise 0.5% due to morbidity adjustments that may potentially be made by insurers during the rate setting process. The 200–250% of the FPL QHP

[25] https://www.soa.org/resources/research-reports/2013/research-health-care-birth-death/

cohort currently buying on the Exchange is slightly younger (43.6 years old) with a higher percentage of females (53.2%) than the rest of the QHP market (43.7 years old, 51.6% female). [26]

For determining the cost differences between the migrating 200–250% of the FPL cohort and the projected 2024 Essential Plan rate for the 150–200% of the FPL group, the medical loss ratio methodology lacked key data components, such as provider fee schedule differences between Essential Plan consumers and individual market consumers. The estimated rate difference using age and gender relativity factors results in a 9.5% difference in comparison to Essential Plan consumers 150–200% of the FPL. To test the sensitivity of this assumption, we adjusted the age/gender relativity factors for the 200–250% of the FPL population by 15% in both directions.

The following table includes the summary results from the sensitivity analysis. The top row is modeled in Scenario A With-Waiver 5-year estimates. The subsequent sensitivity analyses demonstrate the estimated impact to the Essential Plan premiums if health status of the 200 – 250% of the FPL population differs from the With-Waiver scenario.

Table 5.3.2: 200 – 250% of the FPL Health Status and Potential Impact on Essential Plan Rates

Sensitivity Analysis for 200-250% Health Status on Essential Plan Rates						
Waiver Modeled Scenario	2024	2025	2026	2027	2028	5-Year Total
Essential Plan (200-250% A/G 1.095)						
Average Premium PMPM	$569	$592	$615	$640	$665	$617
Aggregate Premiums (millions)	$7,774	$8,354	$8,830	$9,358	$9,909	$44,226
Diminished 200-250% Health Status						
15% Worse Health Status	2024	2025	2026	2027	2028	5-Year Total
Essential Plan (200-250% A/G +15%)						
Average Premium PMPM	$576	$600	$622	$647	$673	$625
Aggregate Premiums (millions)	$7,868	$8,464	$8,936	$9,469	$10,025	$44,763
Difference (A/G +15%)						
Average Premium PMPM	$7	$8	$7	$8	$8	$7
Aggregate Premiums (millions)	$94	$110	$106	$111	$116	$537
Improved 200-250% Health Status						
15% Better Health Status	2024	2025	2026	2027	2028	5-Year Total
Essential Plan (200-250% A/G -15%)						
Average Premium PMPM	$562	$584	$608	$632	$657	$610
Aggregate Premiums (millions)	$7,680	$8,244	$8,724	$9,247	$9,793	$43,688
Difference (A/G -15%)						
Average Premium PMPM	($7)	($8)	($7)	($8)	($8)	($7)
Aggregate Premiums (millions)	($94)	($110)	($106)	($111)	($116)	($537)

[26] The age/gender factor for the 200%–250% group is 1.288, compared to an age/gender factor of 1.332 for other FPLs. The weighted age/gender factor for the entire individual On-Exchange group is 1.325.

Section 6: 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 Section 3. 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 2019–2033. 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

5/12/2023
Date

Appendix A: Scenario A Detailed 10-Year Estimates (Current Law)

The following provides an analysis of the proposed Waiver under current law for expansion to consumers with incomes between 200–250% of the FPL. The analysis estimates that the proposed Waiver meets each of the four guardrails for the five years of the Waiver and 10-year analysis.

Table A1. Scenario A High-Level Guardrail Compliance of 1332 Waiver

Guardrail	Estimated Impact With-Waiver (WW) Compared to Without-Waiver (WoW)
Comprehensiveness	The 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 experience an increase in comprehensiveness. • 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 Waiver is projected to meet the affordability guardrail as the overall affordability across the market is improved compared to the Baseline Without-Waiver Scenario.
	• Affordability for current Essential Plan members 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 $1.4 billion over the 5 years.
	  ○ This is an average annual savings of $4,200 under the Waiver ($2,250 in premiums and $1,950 in out-of-pocket spend), which is approximately 11% 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 expected to decrease slightly as premiums are expected to increase by an additional 2.2% in 2024 under the Waiver.
	  ○ This is an average annual increase of $259 under the Waiver, which falls in the range of 0.1–0.5% of income for subsidy-ineligible On-Exchange consumers above 250% of the FPL and Off-Exchange consumers.

Coverage	The 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 1.4% for PY 2024, 2.1% for PY 2025, 2.0% for PY 2026, 2.0% for PY 2027, and 2.0% for PY 2028.
Deficit Neutrality	The 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 $9.8 billion in PY 2024 and $53.9 billion over the 5-year Waiver period, before pass-through funding. • The net federal spend under the Waiver is estimated to remain the same in PY 2024 and over the 5-year Waiver period, after accounting for pass-through funding.

Table A2. Baseline Without-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

Baseline - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	66,122	64,435	124,043	123,236	122,435	121,639	120,849	120,063	119,283	118,507	100,054	110,061
Average Premium PMPM	$751	$786	$806	$845	$885	$928	$972	$1,019	$1,067	$1,118	$825	$932
Subsidized On-Exchange												
Enrollment[1]	236,570	237,659	149,369	150,356	151,349	152,348	153,354	154,367	155,387	156,413	185,061	169,717
Average Premium PMPM	$712	$746	$782	$820	$859	$900	$944	$989	$1,036	$1,086	$774	$873
Average APTC PMPM	$265	$291	$265	$292	$321	$351	$384	$418	$454	$492	$285	$347
Total Individual Market												
Enrollment[1]	302,692	302,094	273,412	273,592	273,784	273,988	274,203	274,430	274,670	274,920	285,115	279,779
Average Premium PMPM	$721	$755	$793	$831	$871	$913	$956	$1,002	$1,050	$1,100	$792	$896
Aggregate Premiums (millions)	$2,618	$2,737	$2,602	$2,729	$2,861	$3,000	$3,146	$3,299	$3,460	$3,629	$13,546	$30,081
Projected Federal Spend (millions)	$703	$774	$443	$492	$544	$599	$659	$722	$790	$862	$2,956	$6,587
Essential Plan												
Enrollment[1]	1,049,766	1,075,921	1,103,125	1,125,773	1,147,847	1,170,804	1,194,220	1,218,105	1,242,467	1,267,316	1,100,487	1,159,535
Average Premium PMPM	$563	$585	$608	$633	$658	$684	$712	$740	$770	$801	$610	$680
Aggregate Premiums (millions)	$7,086	$7,553	$8,053	$8,547	$9,063	$9,614	$10,199	$10,819	$11,477	$12,174	$40,303	$94,586
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$140	$148	$157	$167	$177	$188	$199	$211	$576	$1,517
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$135	$144	$152	$162	$171	$568	$1,333
Total Program Costs (millions)	$8,236	$8,841	$9,356	$9,866	$10,398	$10,967	$11,569	$12,209	$12,887	$13,607	$46,697	$107,937
Projected Federal Spend (millions)	$9,647	$10,363	$10,241	$10,953	$11,705	$12,513	$13,377	$14,300	$15,287	$16,343	$52,908	$124,729
Employer Shared Responsibility Revenue												
Projected Federal Revenue (millions)	($3)	($3)	($3)	($3)	($4)	($4)	($5)	($6)	($7)	($8)	($16)	($45)
Combined Totals												
Enrollment[1]	1,352,459	1,378,015	1,376,537	1,399,365	1,421,631	1,444,792	1,468,423	1,492,535	1,517,136	1,542,237	1,385,601	1,439,313
Projected Federal Spend (millions)	$10,348	$11,134	$10,681	$11,441	$12,245	$13,108	$14,031	$15,017	$16,070	$17,197	$55,849	$131,271

[1]5 and 10 year totals are straight averages

Table A3. With-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

With Waiver - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592	96,847	106,947
Average Premium PMPM	$772	$809	$827	$866	$908	$951	$997	$1,045	$1,095	$1,147	$847	$956
Subsidized On-Exchange												
Enrollment[1]	168,922	170,243	87,405	87,979	88,556	89,138	89,724	90,313	90,906	91,503	120,621	105,469
Average Premium PMPM	$728	$763	$799	$838	$878	$920	$964	$1,010	$1,059	$1,110	$786	$883
Average APTC PMPM	$273	$299	$273	$301	$330	$361	$394	$429	$466	$505	$293	$352
Total Individual Market												
Enrollment[1]	232,024	231,365	208,157	207,980	207,812	207,651	207,500	207,356	207,222	207,095	217,468	212,416
Average Premium PMPM	$740	$775	$815	$854	$895	$938	$983	$1,030	$1,079	$1,131	$813	$920
Aggregate Premiums (millions)	$2,060	$2,151	$2,036	$2,132	$2,232	$2,337	$2,447	$2,562	$2,683	$2,810	$10,610	$23,449
Projected Federal Spend (millions)	$517	$570	$267	$296	$328	$361	$396	$434	$475	$518	$1,978	$4,162
Essential Plan												
Enrollment[1]	1,139,016	1,175,895	1,196,324	1,219,287	1,241,677	1,264,951	1,288,685	1,312,888	1,337,571	1,362,741	1,194,440	1,253,904
Average Premium PMPM	$569	$592	$615	$640	$665	$692	$719	$748	$778	$808	$617	$687
Aggregate Premiums (millions)	$7,774	$8,354	$8,830	$9,358	$9,909	$10,497	$11,120	$11,780	$12,480	$13,221	$44,226	$103,324
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$138	$147	$155	$165	$174	$185	$196	$207	$571	$1,498
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$135	$144	$152	$162	$171	$568	$1,333
200-250% Member Premiums (millions)	($16)	($18)	($17)	($17)	($17)	($17)	($17)	($17)	($17)	($17)	($85)	($170)
Total Program Costs (millions)	$8,908	$9,624	$10,115	$10,658	$11,226	$11,830	$12,471	$13,150	$13,870	$14,633	$50,531	$116,485
Projected Federal Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employer Shared Responsibility Revenue												
Projected Federal Revenue (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Combined Totals												
Enrollment[1]	1,371,040	1,407,260	1,404,481	1,427,267	1,449,489	1,472,602	1,496,185	1,520,245	1,544,792	1,569,836	1,411,907	1,466,320
Projected Federal Spend (millions)	$517	$570	$267	$296	$328	$361	$396	$434	$475	$518	$1,978	$4,162

[1]5 and 10 year totals are straight averages

Table A4. Baseline Without and With-Waiver Annual Funding Estimates, PY 2024-2033

Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Individual Market										
Without Waiver PTCs	$703,275,446	$773,724,334	$443,099,810	$491,831,155	$543,891,229	$599,480,314	$658,810,162	$722,104,635	$789,600,385	$861,547,570
With Waiver PTCs	$516,932,667	$570,242,426	$267,228,542	$296,412,593	$327,586,018	$360,868,359	$396,386,001	$434,272,546	$474,669,224	$517,725,315
Difference	$186,342,778	$203,481,908	$175,871,268	$195,418,562	$216,305,211	$238,611,955	$262,424,161	$287,832,089	$314,931,162	$343,822,255
Essential Plan										
Without Waiver BHP Funding	$9,647,023,116	$10,362,844,939	$10,240,943,646	$10,952,653,434	$11,704,979,476	$12,512,996,093	$13,376,791,360	$14,300,215,746	$15,287,385,524	$16,342,701,117
With Waiver BHP Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference	$9,647,023,116	$10,362,844,939	$10,240,943,646	$10,952,653,434	$11,704,979,476	$12,512,996,093	$13,376,791,360	$14,300,215,746	$15,287,385,524	$16,342,701,117
Employer Shared Responsibility Revenue										
Employer Penality Loss	($2,592,000)	($2,970,000)	($3,006,000)	($3,258,000)	($3,746,700)	($4,308,705)	($4,955,011)	($5,698,262)	($6,553,002)	($7,535,952)
Combined Totals										
Without Waiver Federal Spend	$10,347,706,562	$11,133,599,273	$10,681,037,456	$11,441,226,589	$12,245,124,005	$13,108,167,702	$14,030,646,511	$15,016,622,119	$16,070,432,908	$17,196,712,735
With Waiver Federal Spend	$516,932,667	$570,242,426	$267,228,542	$296,412,593	$327,586,018	$360,868,359	$396,386,001	$434,272,546	$474,669,224	$517,725,315
Total Federal Savings	**$9,830,773,895**	**$10,563,356,847**	**$10,413,808,914**	**$11,144,813,996**	**$11,917,537,987**	**$12,747,299,343**	**$13,634,260,510**	**$14,582,349,573**	**$15,595,763,684**	**$16,678,987,420**
Requested Pass-through	$9,830,773,895	$10,563,356,847	$10,413,808,914	$11,144,813,996	$11,917,537,987	$12,747,299,343	$13,634,260,510	$14,582,349,573	$15,595,763,684	$16,678,987,420
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	$55,848,693,886	$131,271,275,861
With Waiver Federal Spend	$1,978,402,246	$4,162,323,691
Total Federal Savings	**$53,870,291,639**	**$127,108,952,170**
Requested Pass-through	$53,870,291,639	$127,108,952,170
Net Federal Savings	**$0**	**$0**

Table A5. SLCSP Premium Without and With-Waiver by Rating Area, PY 2024 – 2033

Baseline - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$567	$595	$623	$653	$684	$717	$752	$788	$825	$865
Rating Area 2	$474	$497	$521	$546	$572	$599	$628	$658	$690	$723
Rating Area 3	$641	$672	$704	$738	$773	$810	$849	$890	$932	$977
Rating Area 4	$721	$755	$792	$830	$870	$911	$955	$1,001	$1,049	$1,099
Rating Area 5	$556	$583	$611	$640	$671	$703	$737	$772	$809	$848
Rating Area 6	$615	$645	$676	$708	$742	$778	$815	$854	$895	$938
Rating Area 7	$583	$611	$640	$671	$703	$737	$773	$810	$849	$889
Rating Area 8	$702	$735	$770	$807	$846	$887	$929	$974	$1,021	$1,070

With Waiver - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$580	$607	$637	$667	$699	$733	$768	$805	$843	$884
Rating Area 2	$484	$508	$532	$557	$584	$612	$642	$672	$705	$738
Rating Area 3	$655	$686	$719	$753	$790	$828	$867	$909	$953	$998
Rating Area 4	$736	$772	$809	$848	$888	$931	$976	$1,023	$1,072	$1,123
Rating Area 5	$568	$595	$624	$654	$685	$718	$753	$789	$827	$866
Rating Area 6	$628	$659	$690	$723	$758	$794	$833	$873	$914	$958
Rating Area 7	$596	$624	$654	$686	$719	$753	$789	$827	$867	$909
Rating Area 8	$717	$751	$787	$825	$865	$906	$949	$995	$1,043	$1,093

Table A6. Baseline Without Average Annual Enrollment by Metal Level, PY 2024 – 2033

Baseline - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,352,459**	**1,378,015**	**1,376,537**	**1,399,365**	**1,421,631**	**1,444,792**	**1,468,423**	**1,492,535**	**1,517,136**	**1,542,237**
Unsubsidized On/Off-Exchange Enrollment	66,122	64,435	124,043	123,236	122,435	121,639	120,849	120,063	119,283	118,507
Catastrophic	5,073	5,025	4,739	4,730	4,722	4,714	4,706	4,699	4,691	4,684
Bronze	21,026	20,462	42,758	42,472	42,189	41,907	41,627	41,349	41,072	40,797
Silver	21,525	20,941	45,249	44,945	44,644	44,344	44,046	43,750	43,456	43,164
Gold	10,038	9,771	17,674	17,556	17,439	17,322	17,206	17,091	16,977	16,863
Platinum	8,461	8,236	13,624	13,533	13,442	13,352	13,263	13,174	13,086	12,999
Subsidized On-Exchange Enrollment	236,570	237,659	149,369	150,356	151,349	152,348	153,354	154,367	155,387	156,413
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	88,312	88,718	55,760	56,128	56,499	56,872	57,247	57,625	58,006	58,389
Silver	96,331	96,774	60,823	61,225	61,629	62,036	62,446	62,858	63,273	63,691
Gold	30,993	31,136	19,569	19,698	19,828	19,959	20,091	20,224	20,357	20,492
Platinum	20,934	21,030	13,218	13,305	13,393	13,481	13,570	13,660	13,750	13,841
Essential Plan Enrollment	**1,049,766**	**1,075,921**	**1,103,125**	**1,125,773**	**1,147,847**	**1,170,804**	**1,194,220**	**1,218,105**	**1,242,467**	**1,267,316**
EP1	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697
EP2	106,180	108,884	111,699	114,052	116,351	118,742	121,181	123,671	126,211	128,804
EP3	65,233	66,886	68,675	70,063	71,478	72,922	74,396	75,899	77,432	78,997
EP4	239,324	245,388	251,953	257,044	262,237	267,535	272,940	278,454	284,080	289,819

Table A7. With-Waiver Average Annual Enrollment by Metal Level, PY 2024 – 2033

With Waiver - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,371,040**	**1,407,260**	**1,404,481**	**1,427,267**	**1,449,489**	**1,472,602**	**1,496,185**	**1,520,245**	**1,544,792**	**1,569,836**
Unsubsidized On/Off-Exchange Enrollment	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592
Catastrophic	4,191	4,135	3,949	3,937	3,926	3,914	3,903	3,892	3,881	3,870
Bronze	20,282	19,620	41,845	41,580	41,317	41,056	40,796	40,538	40,281	40,026
Silver	20,815	20,130	44,329	44,047	43,768	43,490	43,214	42,940	42,667	42,396
Gold	9,670	9,356	17,297	17,188	17,079	16,971	16,863	16,757	16,651	16,545
Platinum	8,144	7,880	13,333	13,249	13,165	13,082	12,999	12,917	12,835	12,754
Subsidized On-Exchange Enrollment	168,922	170,243	87,405	87,979	88,556	89,138	89,724	90,313	90,906	91,503
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	63,059	63,552	32,628	32,842	33,058	33,275	33,494	33,714	33,935	34,158
Silver	68,785	69,323	35,591	35,825	36,060	36,297	36,535	36,775	37,017	37,260
Gold	22,131	22,304	11,451	11,526	11,602	11,678	11,755	11,832	11,910	11,988
Platinum	14,948	15,065	7,734	7,785	7,836	7,888	7,940	7,992	8,044	8,097
Essential Plan Enrollment	**1,139,016**	**1,175,895**	**1,196,324**	**1,219,287**	**1,241,677**	**1,264,951**	**1,288,685**	**1,312,888**	**1,337,571**	**1,362,741**
EP1	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697
EP2	106,180	108,884	111,699	114,052	116,351	118,742	121,181	123,671	126,211	128,804
EP3	65,233	66,886	68,675	70,063	71,478	72,922	74,396	75,899	77,432	78,997
EP4	239,324	245,388	251,953	257,044	262,237	267,535	272,940	278,454	284,080	289,819
QHP 200%-250% FPL Population	89,250	99,974	93,199	93,514	93,830	94,147	94,465	94,784	95,104	95,425

Table A8. Baseline Without-Waiver Average Annual Enrollment by FPL, PY 2024 – 2033

Baseline - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,352,459**	**1,378,015**	**1,376,537**	**1,399,365**	**1,421,631**	**1,444,792**	**1,468,423**	**1,492,535**	**1,517,136**	**1,542,237**
Unsubsidized On/Off-Exchange Enrollment	66,122	64,435	124,043	123,236	122,435	121,639	120,849	120,063	119,283	118,507
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	24,239	24,082	23,925	23,770	23,615	23,462	23,309	23,158
501% - 600%	0	0	12,400	12,319	12,239	12,159	12,080	12,002	11,924	11,846
Over 600%	13,641	13,293	15,502	15,401	15,301	15,201	15,103	15,004	14,907	14,810
Do Not Report	52,482	51,142	71,902	71,435	70,970	70,509	70,051	69,595	69,143	68,693
Subsidized On-Exchange Enrollment	236,570	237,659	149,369	150,356	151,349	152,348	153,354	154,367	155,387	156,413
Below 139%	7,523	7,558	4,750	4,782	4,813	4,845	4,877	4,909	4,942	4,974
139% - 150%	288	290	182	183	184	186	187	188	189	191
151% - 200%	1,757	1,765	1,110	1,117	1,124	1,132	1,139	1,147	1,154	1,162
201% - 250%	69,010	69,122	62,093	62,470	62,849	63,230	63,614	64,000	64,388	64,779
251% - 300%	54,227	54,547	36,619	36,876	37,134	37,395	37,657	37,921	38,187	38,455
301% - 350%	40,022	40,258	27,027	27,216	27,407	27,599	27,793	27,988	28,184	28,381
351% - 400%	26,047	26,201	17,589	17,713	17,837	17,962	18,088	18,215	18,342	18,471
401% - 500%	21,502	21,629	0	0	0	0	0	0	0	0
501% - 600%	9,595	9,652	0	0	0	0	0	0	0	0
Over 600%	6,599	6,638	0	0	0	0	0	0	0	0
Essential Plan Enrollment	**1,049,766**	**1,075,921**	**1,103,125**	**1,125,773**	**1,147,847**	**1,170,804**	**1,194,220**	**1,218,105**	**1,242,467**	**1,267,316**
Below 150%	410,737	421,158	432,327	441,159	450,066	459,199	468,517	478,024	487,723	497,620
Over 151%	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697

Table A9. With-Waiver PY Average Annual Enrollment by FPL, PY 2024 – 2033

With Waiver - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,371,040**	**1,407,260**	**1,404,481**	**1,427,267**	**1,449,489**	**1,472,602**	**1,496,185**	**1,520,245**	**1,544,792**	**1,569,836**
Unsubsidized On/Off-Exchange Enrollment	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	23,596	23,450	23,304	23,159	23,015	22,872	22,729	22,588
501% - 600%	0	0	12,071	11,996	11,921	11,847	11,773	11,700	11,627	11,555
Over 600%	12,045	13,568	15,091	14,997	14,903	14,811	14,719	14,627	14,536	14,446
Do Not Report	51,057	47,554	69,995	69,560	69,127	68,697	68,270	67,845	67,423	67,003
Subsidized On-Exchange Enrollment	168,922	170,243	87,405	87,979	88,556	89,138	89,724	90,313	90,906	91,503
Below 139%	7,490	7,548	3,875	3,901	3,927	3,952	3,978	4,004	4,031	4,057
139% - 150%	287	289	149	149	150	151	152	153	154	155
151% - 200%	1,750	1,763	905	911	917	923	929	935	942	948
201% - 250%	410	413	212	213	215	216	218	219	220	222
251% - 300%	54,568	54,995	37,083	37,326	37,571	37,818	38,067	38,317	38,568	38,822
301% - 350%	40,274	40,589	27,369	27,548	27,729	27,912	28,095	28,279	28,465	28,652
351% - 400%	26,211	26,416	17,812	17,929	18,047	18,165	18,285	18,405	18,526	18,647
401% - 500%	21,637	21,807	0	0	0	0	0	0	0	0
501% - 600%	9,655	9,731	0	0	0	0	0	0	0	0
Over 600%	6,641	6,693	0	0	0	0	0	0	0	0
Essential Plan Enrollment	**1,139,016**	**1,175,895**	**1,196,324**	**1,219,287**	**1,241,677**	**1,264,951**	**1,288,685**	**1,312,888**	**1,337,571**	**1,362,741**
Below 150%	410,737	421,158	432,327	441,159	450,066	459,199	468,517	478,024	487,723	497,620
151% - 200%	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697
Over 201%	89,250	99,974	93,199	93,514	93,830	94,147	94,465	94,784	95,104	95,425

Table A10. Without and With-Waiver Monthly Federal Funding by Metal Level and Rate Cohort, PY 2024 – 2033

Without Waiver - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$265	$291	$265	$292	$321	$351	$384	$418	$454	$492
Bronze	$252	$272	$260	$281	$304	$329	$354	$381	$410	$440
Silver	$315	$342	$321	$350	$381	$413	$447	$483	$522	$562
Gold	$218	$248	$199	$231	$265	$300	$338	$379	$421	$467
Platinum	$164	$197	$126	$162	$199	$239	$281	$326	$374	$425
Essential Plan BHP Funding	**$766**	**$803**	**$774**	**$811**	**$850**	**$891**	**$933**	**$978**	**$1,025**	**$1,075**
EP1	$623	$653	$597	$625	$655	$687	$720	$754	$790	$828
EP2	$1,051	$1,102	$1,090	$1,142	$1,197	$1,254	$1,314	$1,378	$1,444	$1,513
EP3	$988	$1,036	$1,054	$1,105	$1,158	$1,213	$1,272	$1,333	$1,397	$1,464
EP4	$960	$1,006	$1,028	$1,078	$1,129	$1,184	$1,240	$1,300	$1,362	$1,428

With Waiver - Scenario A	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$273	$299	$273	$301	$330	$361	$394	$429	$466	$505
Bronze	$255	$275	$262	$285	$308	$333	$359	$386	$416	$446
Silver	$323	$350	$329	$358	$390	$423	$458	$495	$534	$575
Gold	$231	$262	$213	$245	$280	$317	$356	$397	$441	$487
Platinum	$186	$220	$151	$187	$226	$267	$310	$357	$406	$458
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
QHP 200%-250% FPL Population	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Table A11. Without and With-Waiver Unsubsidized On-Exchange & Off-Exchange Enrollment and Annual Premium Increases by FPL, PY 2024 – 2033

Without Waiver - Scenario A	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Unsubsidized On-exchange & Off-exchange Enrollment	66,122	64,435	124,043	123,236	122,435	121,639	120,849	120,063	119,283	118,507
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	24,239	24,082	23,925	23,770	23,615	23,462	23,309	23,158
501% - 600%	0	0	12,400	12,319	12,239	12,159	12,080	12,002	11,924	11,846
Over 600%	13,641	13,293	15,502	15,401	15,301	15,201	15,103	15,004	14,907	14,810
Do Not Report	52,482	51,142	71,902	71,435	70,970	70,509	70,051	69,595	69,143	68,693
Unsubsidized On-exchange Enrollment	16,531	16,109	74,426	73,942	73,461	72,984	72,509	72,038	71,570	71,104
Off-exchange Enrollment	49,592	48,326	49,617	49,295	48,974	48,656	48,339	48,025	47,713	47,403
With Waiver - Scenario A	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Unsubsidized On-exchange & Off-exchange Enrollment	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	23,596	23,450	23,304	23,159	23,015	22,872	22,729	22,588
501% - 600%	0	0	12,071	11,996	11,921	11,847	11,773	11,700	11,627	11,555
Over 600%	12,045	13,568	15,091	14,997	14,903	14,811	14,719	14,627	14,536	14,446
Do Not Report	51,057	47,554	69,995	69,560	69,127	68,697	68,270	67,845	67,423	67,003
Unsubsidized On-exchange & Off-exchange Premium Increase (Annual)	$256	$268	$245	$257	$270	$284	$298	$313	$328	$345
Unsubsidized On-exchange Enrollment	15,775	15,280	72,452	72,001	71,553	71,108	70,666	70,226	69,789	69,355
Unsubsidized On-exchange Premium Increase (Annual)	$408	$427	$258	$271	$285	$300	$315	$331	$348	$366
Off-exchange Enrollment	47,326	45,841	48,301	48,001	47,702	47,405	47,110	46,817	46,526	46,237
Off-exchange Premium Increase (Annual)	$205	$215	$226	$237	$248	$260	$272	$285	$299	$313

Table A12. Without and With-Waiver Annual Out-of-Pocket Expenses by FPL, PY 2024 – 2033

Without Waiver - Scenario A - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,294	$2,405	$2,520	$2,641	$2,768	$2,901	$3,040	$3,186	$3,339	$3,499	$2,516	$2,850
251% - 300%	$2,204	$2,310	$2,421	$2,537	$2,659	$2,787	$2,920	$3,060	$3,207	$3,361	$2,400	$2,710
301% - 350%	$2,205	$2,311	$2,422	$2,539	$2,660	$2,788	$2,922	$3,062	$3,209	$3,363	$2,401	$2,712
351% - 400%	$2,221	$2,328	$2,440	$2,557	$2,679	$2,808	$2,943	$3,084	$3,232	$3,387	$2,418	$2,731
401% - 500%	$2,240	$2,347	$2,460	$2,578	$2,702	$2,832	$2,967	$3,110	$3,259	$3,416	$2,473	$2,796
501% - 600%	$2,258	$2,366	$2,480	$2,599	$2,724	$2,854	$2,991	$3,135	$3,286	$3,443	$2,502	$2,831
Over 600%/Do Not Report	$2,321	$2,433	$2,550	$2,672	$2,800	$2,935	$3,075	$3,223	$3,378	$3,540	$2,568	$2,905
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$129	$134	$140	$145	$151	$157	$163	$170	$177	$184	$140	$156
Over 151%	$546	$568	$591	$614	$639	$664	$691	$719	$747	$777	$593	$660

With Waiver - Scenario A - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,347	$2,460	$2,578	$2,702	$2,831	$2,967	$3,110	$3,259	$3,415	$3,579	$2,535	$2,849
251% - 300%	$2,254	$2,362	$2,476	$2,595	$2,719	$2,850	$2,987	$3,130	$3,280	$3,438	$2,454	$2,772
301% - 350%	$2,255	$2,364	$2,477	$2,596	$2,721	$2,851	$2,988	$3,132	$3,282	$3,439	$2,456	$2,773
351% - 400%	$2,271	$2,380	$2,495	$2,614	$2,740	$2,872	$3,009	$3,154	$3,305	$3,464	$2,473	$2,793
401% - 500%	$2,291	$2,400	$2,516	$2,636	$2,763	$2,896	$3,035	$3,180	$3,333	$3,493	$2,526	$2,857
501% - 600%	$2,309	$2,420	$2,536	$2,658	$2,785	$2,919	$3,059	$3,206	$3,360	$3,521	$2,556	$2,893
Over 600%/Do Not Report	$2,374	$2,488	$2,607	$2,732	$2,863	$3,001	$3,145	$3,296	$3,454	$3,620	$2,627	$2,973
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$129	$134	$140	$145	$151	$157	$163	$170	$177	$184	$140	$156
151% - 200%	$546	$568	$591	$614	$639	$664	$691	$719	$747	$777	$593	$660
Over 201%	$598	$622	$647	$673	$699	$727	$756	$787	$818	$851	$648	$718

Table A13. Without and With-Waiver Annual Out-of-Pocket Expenses by Age, PY 2024 – 2033

Without Waiver - Scenario A - 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	$948	$993	$1,041	$1,091	$1,143	$1,198	$1,256	$1,316	$1,379	$1,446	$1,043	$1,181
21 - 25 Years	$943	$989	$1,036	$1,086	$1,138	$1,192	$1,250	$1,310	$1,372	$1,438	$1,038	$1,175
26 - 30 Years	$1,222	$1,281	$1,342	$1,407	$1,474	$1,545	$1,619	$1,697	$1,779	$1,864	$1,345	$1,523
31 - 35 Years	$1,494	$1,566	$1,641	$1,720	$1,802	$1,889	$1,979	$2,074	$2,174	$2,278	$1,645	$1,862
36 - 40 Years	$1,643	$1,721	$1,804	$1,891	$1,981	$2,077	$2,176	$2,281	$2,390	$2,505	$1,808	$2,047
41 - 45 Years	$1,832	$1,919	$2,012	$2,108	$2,209	$2,315	$2,427	$2,543	$2,665	$2,793	$2,016	$2,282
46 - 50 Years	$2,160	$2,264	$2,373	$2,487	$2,606	$2,731	$2,862	$2,999	$3,143	$3,294	$2,378	$2,692
51 - 55 Years	$2,665	$2,793	$2,927	$3,067	$3,215	$3,369	$3,531	$3,700	$3,878	$4,064	$2,933	$3,321
56 - 60 Years	$3,265	$3,421	$3,585	$3,758	$3,938	$4,127	$4,325	$4,533	$4,750	$4,978	$3,593	$4,068
61 - 65 Years	$4,024	$4,217	$4,420	$4,632	$4,854	$5,087	$5,331	$5,587	$5,855	$6,136	$4,429	$5,014
Essential Plan - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$178	$186	$193	$201	$209	$217	$226	$235	$244	$254	$193	$214
21 - 25 Years	$178	$185	$192	$200	$208	$216	$225	$234	$243	$253	$192	$213
26 - 30 Years	$230	$239	$249	$259	$269	$280	$291	$303	$315	$328	$249	$276
31 - 35 Years	$281	$293	$304	$316	$329	$342	$356	$370	$385	$400	$305	$338
36 - 40 Years	$309	$322	$335	$348	$362	$376	$391	$407	$423	$440	$335	$371
41 - 45 Years	$345	$359	$373	$388	$403	$420	$436	$454	$472	$491	$374	$414
46 - 50 Years	$407	$423	$440	$458	$476	$495	$515	$535	$557	$579	$441	$488
51 - 55 Years	$502	$522	$543	$564	$587	$610	$635	$660	$687	$714	$544	$602
56 - 60 Years	$615	$639	$665	$691	$719	$748	$778	$809	$841	$875	$666	$738
61 - 65 Years	$758	$788	$820	$852	$886	$922	$959	$997	$1,037	$1,078	$821	$910

With Waiver - Scenario A - 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	$965	$1,011	$1,060	$1,111	$1,164	$1,220	$1,278	$1,340	$1,404	$1,471	$1,062	$1,202
21 - 25 Years	$960	$1,006	$1,054	$1,105	$1,158	$1,214	$1,272	$1,333	$1,397	$1,464	$1,057	$1,196
26 - 30 Years	$1,244	$1,304	$1,366	$1,432	$1,501	$1,573	$1,648	$1,727	$1,810	$1,897	$1,369	$1,550
31 - 35 Years	$1,521	$1,594	$1,670	$1,750	$1,834	$1,922	$2,015	$2,111	$2,213	$2,319	$1,674	$1,895
36 - 40 Years	$1,672	$1,752	$1,836	$1,924	$2,017	$2,114	$2,215	$2,321	$2,433	$2,550	$1,840	$2,083
41 - 45 Years	$1,864	$1,954	$2,047	$2,146	$2,249	$2,357	$2,470	$2,588	$2,713	$2,843	$2,052	$2,323
46 - 50 Years	$2,199	$2,304	$2,415	$2,531	$2,652	$2,780	$2,913	$3,053	$3,199	$3,353	$2,420	$2,740
51 - 55 Years	$2,712	$2,843	$2,979	$3,122	$3,272	$3,429	$3,594	$3,766	$3,947	$4,136	$2,986	$3,380
56 - 60 Years	$3,323	$3,482	$3,649	$3,825	$4,008	$4,201	$4,402	$4,613	$4,835	$5,067	$3,657	$4,140
61 - 65 Years	$4,096	$4,292	$4,498	$4,714	$4,941	$5,178	$5,426	$5,687	$5,960	$6,246	$4,508	$5,104
Essential Plan - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$187	$194	$202	$210	$218	$227	$236	$246	$255	$266	$202	$224
21 - 25 Years	$186	$193	$201	$209	$217	$226	$235	$244	$254	$264	$201	$223
26 - 30 Years	$241	$250	$260	$271	$281	$293	$304	$317	$329	$342	$261	$289
31 - 35 Years	$294	$306	$318	$331	$344	$358	$372	$387	$402	$419	$319	$353
36 - 40 Years	$323	$336	$350	$364	$378	$393	$409	$425	$442	$460	$350	$388
41 - 45 Years	$360	$375	$390	$406	$422	$439	$456	$474	$493	$513	$391	$433
46 - 50 Years	$425	$442	$460	$478	$497	$517	$538	$560	$582	$605	$461	$510
51 - 55 Years	$525	$545	$567	$590	$614	$638	$664	$690	$718	$747	$568	$630
56 - 60 Years	$643	$668	$695	$723	$752	$782	$813	$846	$879	$915	$696	$771
61 - 65 Years	$792	$824	$857	$891	$927	$964	$1,002	$1,042	$1,084	$1,127	$858	$951

Appendix B: Scenario B Detailed 10-Year Estimates (IRA Subsidies Are Extended)

The following provides an analysis of the proposed Waiver under current law for the expansion to consumers with incomes between 200 – 250% of the FPL. The analysis estimates that the proposed Waiver meets each of the four guardrails for the five years of the Waiver and 10-year analysis.

Table B1. Scenario B High-Level Guardrail Compliance of 1332 Waiver

Guardrail	Estimated Impact With-Waiver (WW) Compared to Without-Waiver (WoW)
Comprehensiveness	The 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 experience an increase in comprehensiveness. • 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 Waiver is projected to meet the affordability guardrail as the overall affordability across the market is improved compared to the Baseline Without-Waiver Scenario.
	• Affordability for current Essential Plan members 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 $1.3 billion over the 5 years.
	  ○ This is an average annual savings of $4,050 under the Waiver ($2,100 in premiums and $1,950 in out-of-pocket spend), which is approximately 11% 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 expected to decrease slightly as premiums are expected to increase by an additional 2.2% in 2024 under the Waiver.
	  ○ This is an average annual increase of $285 under the Waiver, which falls in the range of 0.1–0.5% of income for subsidy-ineligible On-Exchange consumers above 250% of the FPL and Off-Exchange consumers.

Coverage	The 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 1.4% for PY 2024, 2.1% for PY 2025, 2.1% for PY 2026, 2.0% for PY 2027, and 2.0% for PY 2028.
Deficit Neutrality	The 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 $9.8 billion in PY 2024 and $56.9 billion over the 5-year Waiver period, before pass-through funding. • The net federal spend under the Waiver is estimated to remain the same in PY 2024 and over the 5-year Waiver period, after accounting for pass-through funding.

Table B2. Baseline Without-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

Baseline - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	66,122	64,435	62,609	60,248	57,976	55,790	53,686	51,662	49,714	47,839	62,278	57,008
Average Premium PMPM	$751	$786	$823	$861	$901	$943	$987	$1,032	$1,080	$1,130	$822	$917
Subsidized On-Exchange												
Enrollment[1]	236,570	237,659	239,503	241,952	244,435	246,953	249,506	252,095	254,721	257,385	240,024	246,078
Average Premium PMPM	$712	$746	$782	$820	$859	$900	$944	$989	$1,036	$1,086	$785	$891
Average APTC PMPM	$265	$291	$317	$346	$376	$407	$440	$476	$513	$552	$319	$401
Total Individual Market												
Enrollment[1]	302,692	302,094	302,112	302,200	302,411	302,743	303,192	303,757	304,435	305,224	302,302	303,086
Average Premium PMPM	$721	$755	$791	$828	$867	$908	$951	$996	$1,043	$1,093	$792	$896
Aggregate Premiums (millions)	$2,618	$2,737	$2,867	$3,003	$3,147	$3,300	$3,461	$3,632	$3,812	$4,003	$14,371	$32,578
Projected Federal Spend (millions)	$703	$774	$851	$937	$1,028	$1,126	$1,231	$1,343	$1,463	$1,592	$4,293	$11,048
Essential Plan												
Enrollment[1]	1,049,766	1,075,921	1,103,125	1,125,773	1,147,847	1,170,804	1,194,220	1,218,105	1,242,467	1,267,316	1,100,487	1,159,535
Average Premium PMPM	$563	$585	$608	$633	$658	$684	$712	$740	$770	$801	$610	$680
Aggregate Premiums (millions)	$7,086	$7,553	$8,053	$8,547	$9,063	$9,614	$10,199	$10,819	$11,477	$12,174	$40,303	$94,586
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$140	$148	$157	$167	$177	$188	$199	$211	$576	$1,517
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$135	$144	$152	$162	$171	$568	$1,333
Total Program Costs (millions)	$8,236	$8,841	$9,356	$9,866	$10,398	$10,967	$11,569	$12,209	$12,887	$13,607	$46,697	$107,937
Projected Federal Spend (millions)	$9,647	$10,363	$11,137	$11,911	$12,729	$13,608	$14,547	$15,551	$16,624	$17,772	$55,788	$133,890
Employer Shared Responsibility Revenue												
Projected Federal Revenue (millions)	($3)	($3)	($3)	($3)	($4)	($4)	($5)	($6)	($7)	($8)	($16)	($45)
Combined Totals												
Enrollment[1]	1,352,459	1,378,015	1,405,237	1,427,973	1,450,259	1,473,547	1,497,413	1,521,862	1,546,902	1,572,540	1,402,789	1,462,621
Projected Federal Spend (millions)	$10,348	$11,134	$11,986	$12,845	$13,754	$14,729	$15,773	$16,888	$18,081	$19,356	$60,065	$144,893

[1]5 and 10 year totals are straight averages

Table B3. With-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

With Waiver - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	63,102	61,122	58,865	57,449	56,068	54,719	53,403	52,119	50,865	49,642	59,321	55,735
Average Premium PMPM	$772	$809	$846	$886	$928	$972	$1,018	$1,066	$1,116	$1,169	$846	$949
Subsidized On-Exchange												
Enrollment[1]	168,922	170,243	172,199	173,370	174,549	175,736	176,932	178,135	179,347	180,567	171,857	175,000
Average Premium PMPM	$728	$763	$799	$838	$878	$920	$964	$1,010	$1,059	$1,110	$802	$909
Average APTC PMPM	$273	$299	$326	$355	$386	$418	$452	$488	$526	$567	$328	$411
Total Individual Market												
Enrollment[1]	232,024	231,365	231,064	230,819	230,617	230,455	230,335	230,254	230,212	230,209	231,178	230,735
Average Premium PMPM	$740	$775	$811	$850	$890	$932	$977	$1,023	$1,072	$1,122	$813	$919
Aggregate Premiums (millions)	$2,060	$2,151	$2,249	$2,354	$2,463	$2,578	$2,699	$2,826	$2,960	$3,101	$11,276	$25,441
Projected Federal Spend (millions)	$517	$570	$630	$690	$754	$823	$896	$974	$1,057	$1,146	$3,161	$8,058
Essential Plan												
Enrollment[1]	1,139,016	1,175,895	1,203,416	1,226,374	1,248,758	1,272,026	1,295,754	1,319,951	1,344,627	1,369,791	1,198,692	1,259,561
Average Premium PMPM	$569	$592	$616	$640	$666	$692	$720	$748	$778	$809	$617	$687
Aggregate Premiums (millions)	$7,774	$8,354	$8,889	$9,420	$9,973	$10,563	$11,189	$11,852	$12,554	$13,298	$44,410	$103,867
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$139	$148	$156	$166	$175	$186	$197	$208	$574	$1,506
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$135	$144	$152	$162	$171	$568	$1,333
200-250% Member Premiums (millions)	($16)	($18)	($18)	($18)	($18)	($18)	($18)	($18)	($18)	($18)	($88)	($180)
Total Program Costs (millions)	$8,908	$9,624	$10,174	$10,720	$11,289	$11,896	$12,540	$13,222	$13,944	$14,710	$50,714	$117,026
Projected Federal Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employer Shared Responsibility Revenue												
Projected Federal Revenue (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Combined Totals												
Enrollment[1]	1,371,040	1,407,260	1,434,481	1,457,193	1,479,375	1,502,481	1,526,088	1,550,205	1,574,839	1,600,000	1,429,870	1,490,296
Projected Federal Spend (millions)	$517	$570	$630	$690	$754	$823	$896	$974	$1,057	$1,146	$3,161	$8,058

[1]5 and 10 year totals are straight averages

Table B4. Baseline Without and With-Waiver Annual Funding Estimates, PY 2024-2033

Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Individual Market										
Without Waiver PTCs	$703,275,446	$773,724,334	$851,386,865	$936,647,677	$1,028,026,838	$1,125,925,285	$1,230,769,465	$1,343,012,949	$1,463,138,144	$1,591,658,119
With Waiver PTCs	$516,932,667	$570,242,426	$629,510,716	$689,917,231	$754,346,627	$823,039,437	$896,249,968	$974,247,072	$1,057,314,967	$1,145,754,096
Difference	$186,342,778	$203,481,908	$221,876,148	$246,730,446	$273,680,211	$302,885,848	$334,519,497	$368,765,876	$405,823,177	$445,904,024
Essential Plan										
Without Waiver BHP Funding	$9,647,023,116	$10,362,844,939	$11,137,277,703	$11,911,359,670	$12,729,231,176	$13,607,803,918	$14,547,015,601	$15,551,051,498	$16,624,385,747	$17,771,801,289
With Waiver BHP Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference	$9,647,023,116	$10,362,844,939	$11,137,277,703	$11,911,359,670	$12,729,231,176	$13,607,803,918	$14,547,015,601	$15,551,051,498	$16,624,385,747	$17,771,801,289
Employer Shared Responsibility Revenue										
Employer Penality Loss	($2,592,000)	($2,970,000)	($3,006,000)	($3,258,000)	($3,746,700)	($4,308,705)	($4,955,011)	($5,698,262)	($6,553,002)	($7,535,952)
Combined Totals										
Without Waiver Federal Spend	$10,347,706,562	$11,133,599,273	$11,985,658,568	$12,844,749,347	$13,753,511,314	$14,729,420,498	$15,772,830,055	$16,888,366,184	$18,080,970,889	$19,355,923,456
With Waiver Federal Spend	$516,932,667	$570,242,426	$629,510,716	$689,917,231	$754,346,627	$823,039,437	$896,249,968	$974,247,072	$1,057,314,967	$1,145,754,096
Total Federal Savings	**$9,830,773,895**	**$10,563,356,847**	**$11,356,147,852**	**$12,154,832,116**	**$12,999,164,687**	**$13,906,381,061**	**$14,876,580,087**	**$15,914,119,112**	**$17,023,655,922**	**$18,210,169,361**
Requested Pass-through	$9,830,773,895	$10,563,356,847	$11,356,147,852	$12,154,832,116	$12,999,164,687	$13,906,381,061	$14,876,580,087	$15,914,119,112	$17,023,655,922	$18,210,169,361
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	$60,065,225,064	$144,892,736,147
With Waiver Federal Spend	$3,160,949,668	$8,057,555,208
Total Federal Savings	**$56,904,275,396**	**$136,835,180,939**
Requested Pass-through	$56,904,275,396	$136,835,180,939
Net Federal Savings	**$0**	**$0**

Table B5. SLCSP Premium Without and With-Waiver by Rating Area, PY 2024 – 2033

Baseline - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$567	$595	$623	$653	$684	$717	$752	$788	$825	$865
Rating Area 2	$474	$497	$521	$546	$572	$599	$628	$658	$690	$723
Rating Area 3	$641	$672	$704	$738	$773	$810	$849	$890	$932	$977
Rating Area 4	$721	$755	$792	$830	$870	$911	$955	$1,001	$1,049	$1,099
Rating Area 5	$556	$583	$611	$640	$671	$703	$737	$772	$809	$848
Rating Area 6	$615	$645	$676	$708	$742	$778	$815	$854	$895	$938
Rating Area 7	$583	$611	$640	$671	$703	$737	$773	$810	$849	$889
Rating Area 8	$702	$735	$770	$807	$846	$887	$929	$974	$1,021	$1,070

With Waiver - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$580	$607	$637	$667	$699	$733	$768	$805	$843	$884
Rating Area 2	$484	$508	$532	$557	$584	$612	$642	$672	$705	$738
Rating Area 3	$655	$686	$719	$753	$790	$828	$867	$909	$953	$998
Rating Area 4	$736	$772	$809	$848	$888	$931	$976	$1,023	$1,072	$1,123
Rating Area 5	$568	$595	$624	$654	$685	$718	$753	$789	$827	$866
Rating Area 6	$628	$659	$690	$723	$758	$794	$833	$873	$914	$958
Rating Area 7	$596	$624	$654	$686	$719	$753	$789	$827	$867	$909
Rating Area 8	$717	$751	$787	$825	$865	$906	$949	$995	$1,043	$1,093

Table B6. Baseline Without Average Annual Enrollment by Metal Level, PY 2024 – 2033

Baseline - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,352,459**	**1,378,015**	**1,405,237**	**1,427,973**	**1,450,259**	**1,473,547**	**1,497,413**	**1,521,862**	**1,546,902**	**1,572,540**
Unsubsidized On/Off-Exchange Enrollment	66,122	64,435	62,609	60,248	57,976	55,790	53,686	51,662	49,714	47,839
Catastrophic	5,073	5,025	4,981	4,924	4,871	4,822	4,776	4,733	4,694	4,657
Bronze	21,026	20,462	19,850	19,057	18,295	17,560	16,853	16,171	15,515	14,884
Silver	21,525	20,941	20,307	19,485	18,695	17,933	17,200	16,493	15,813	15,158
Gold	10,038	9,771	9,480	9,105	8,743	8,395	8,059	7,736	7,425	7,126
Platinum	8,461	8,236	7,992	7,677	7,373	7,080	6,799	6,528	6,267	6,015
Subsidized On-Exchange Enrollment	236,570	237,659	239,503	241,952	244,435	246,953	249,506	252,095	254,721	257,385
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	88,312	88,718	89,407	90,321	91,248	92,187	93,141	94,107	95,088	96,082
Silver	96,331	96,774	97,525	98,522	99,533	100,559	101,598	102,653	103,722	104,807
Gold	30,993	31,136	31,378	31,698	32,024	32,353	32,688	33,027	33,371	33,720
Platinum	20,934	21,030	21,194	21,410	21,630	21,853	22,079	22,308	22,540	22,776
Essential Plan Enrollment	**1,049,766**	**1,075,921**	**1,103,125**	**1,125,773**	**1,147,847**	**1,170,804**	**1,194,220**	**1,218,105**	**1,242,467**	**1,267,316**
EP1	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697
EP2	106,180	108,884	111,699	114,052	116,351	118,742	121,181	123,671	126,211	128,804
EP3	65,233	66,886	68,675	70,063	71,478	72,922	74,396	75,899	77,432	78,997
EP4	239,324	245,388	251,953	257,044	262,237	267,535	272,940	278,454	284,080	289,819

Table B7. With-Waiver Average Annual Enrollment by Metal Level, PY 2024 – 2033

With Waiver - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,371,040**	**1,407,260**	**1,434,481**	**1,457,193**	**1,479,375**	**1,502,481**	**1,526,088**	**1,550,205**	**1,574,839**	**1,600,000**
Unsubsidized On/Off-Exchange Enrollment	63,102	61,122	58,865	57,449	56,068	54,719	53,403	52,119	50,865	49,642
Catastrophic	4,191	4,135	4,077	4,039	4,003	3,969	3,935	3,903	3,872	3,842
Bronze	20,282	19,620	18,865	18,391	17,928	17,476	17,035	16,605	16,184	15,774
Silver	20,815	20,130	19,348	18,857	18,377	17,909	17,452	17,006	16,571	16,146
Gold	9,670	9,356	8,997	8,773	8,553	8,339	8,130	7,925	7,726	7,532
Platinum	8,144	7,880	7,579	7,390	7,206	7,026	6,851	6,679	6,512	6,348
Subsidized On-Exchange Enrollment	168,922	170,243	172,199	173,370	174,549	175,736	176,932	178,135	179,347	180,567
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	63,059	63,552	64,282	64,719	65,159	65,602	66,049	66,498	66,950	67,406
Silver	68,785	69,323	70,119	70,596	71,076	71,560	72,046	72,536	73,030	73,527
Gold	22,131	22,304	22,560	22,713	22,868	23,023	23,180	23,338	23,496	23,656
Platinum	14,948	15,065	15,238	15,342	15,446	15,551	15,657	15,763	15,870	15,978
Essential Plan Enrollment	**1,139,016**	**1,175,895**	**1,203,416**	**1,226,374**	**1,248,758**	**1,272,026**	**1,295,754**	**1,319,951**	**1,344,627**	**1,369,791**
EP1	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697
EP2	106,180	108,884	111,699	114,052	116,351	118,742	121,181	123,671	126,211	128,804
EP3	65,233	66,886	68,675	70,063	71,478	72,922	74,396	75,899	77,432	78,997
EP4	239,324	245,388	251,953	257,044	262,237	267,535	272,940	278,454	284,080	289,819
QHP 200%-250% FPL Population	89,250	99,974	100,291	100,600	100,910	101,221	101,533	101,846	102,160	102,475

Table B8. Baseline Without-Waiver Average Annual Enrollment by FPL, PY 2024 – 2033

Baseline - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,352,459**	**1,378,015**	**1,405,237**	**1,427,973**	**1,450,259**	**1,473,547**	**1,497,413**	**1,521,862**	**1,546,902**	**1,572,540**
Unsubsidized On/Off-Exchange Enrollment	66,122	64,435	62,609	60,248	57,976	55,790	53,686	51,662	49,714	47,839
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	0	0	0	0	0	0	0	0
501% - 600%	0	0	0	0	0	0	0	0	0	0
Over 600%	7,685	7,755	7,824	7,529	7,245	6,972	6,709	6,456	6,213	5,979
Do Not Report	58,437	56,680	54,785	52,719	50,731	48,818	46,977	45,206	43,501	41,861
Subsidized On-Exchange Enrollment	236,570	237,659	239,503	241,952	244,435	246,953	249,506	252,095	254,721	257,385
Below 139%	7,523	7,558	7,617	7,694	7,773	7,853	7,935	8,017	8,101	8,185
139% - 150%	288	290	292	295	298	301	304	307	310	314
151% - 200%	1,757	1,765	1,779	1,797	1,816	1,834	1,853	1,873	1,892	1,912
201% - 250%	69,010	69,122	69,500	69,870	70,241	70,615	70,990	71,368	71,748	72,129
251% - 300%	54,227	54,547	55,024	55,704	56,394	57,095	57,807	58,530	59,265	60,011
301% - 350%	40,022	40,258	40,610	41,112	41,621	42,139	42,664	43,198	43,740	44,291
351% - 400%	26,047	26,201	26,430	26,756	27,088	27,425	27,767	28,114	28,467	28,825
401% - 500%	21,502	21,629	21,818	22,088	22,362	22,640	22,922	23,209	23,500	23,796
501% - 600%	9,595	9,652	9,736	9,856	9,978	10,102	10,228	10,356	10,486	10,618
Over 600%	6,599	6,638	6,696	6,779	6,863	6,948	7,035	7,123	7,213	7,303
Essential Plan Enrollment	**1,049,766**	**1,075,921**	**1,103,125**	**1,125,773**	**1,147,847**	**1,170,804**	**1,194,220**	**1,218,105**	**1,242,467**	**1,267,316**
Below 150%	410,737	421,158	432,327	441,159	450,066	459,199	468,517	478,024	487,723	497,620
Over 151%	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697

Table B9. With-Waiver PY Average Annual Enrollment by FPL, PY 2024 – 2033

With Waiver - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,371,040**	**1,407,260**	**1,434,481**	**1,457,193**	**1,479,375**	**1,502,481**	**1,526,088**	**1,550,205**	**1,574,839**	**1,600,000**
Unsubsidized On/Off-Exchange Enrollment	63,102	61,122	58,865	57,449	56,068	54,719	53,403	52,119	50,865	49,642
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	0	0	0	0	0	0	0	0
501% - 600%	0	0	0	0	0	0	0	0	0	0
Over 600%	7,404	7,380	7,356	7,179	7,007	6,838	6,674	6,513	6,357	6,204
Do Not Report	55,698	53,741	51,509	50,270	49,061	47,881	46,729	45,605	44,508	43,438
Subsidized On-Exchange Enrollment	168,922	170,243	172,199	173,370	174,549	175,736	176,932	178,135	179,347	180,567
Below 139%	7,490	7,548	7,635	7,687	7,739	7,792	7,845	7,898	7,952	8,006
139% - 150%	287	289	293	295	297	299	301	303	305	307
151% - 200%	1,750	1,763	1,783	1,796	1,808	1,820	1,832	1,845	1,857	1,870
201% - 250%	410	413	418	420	423	426	429	432	435	438
251% - 300%	54,568	54,995	55,627	56,005	56,386	56,769	57,155	57,544	57,936	58,330
301% - 350%	40,274	40,589	41,055	41,334	41,615	41,898	42,183	42,470	42,759	43,050
351% - 400%	26,211	26,416	26,719	26,901	27,084	27,268	27,454	27,640	27,828	28,018
401% - 500%	21,637	21,807	22,057	22,207	22,358	22,510	22,663	22,818	22,973	23,129
501% - 600%	9,655	9,731	9,843	9,910	9,977	10,045	10,113	10,182	10,251	10,321
Over 600%	6,641	6,693	6,770	6,816	6,862	6,909	6,956	7,003	7,051	7,099
Essential Plan Enrollment	**1,139,016**	**1,175,895**	**1,203,416**	**1,226,374**	**1,248,758**	**1,272,026**	**1,295,754**	**1,319,951**	**1,344,627**	**1,369,791**
Below 150%	410,737	421,158	432,327	441,159	450,066	459,199	468,517	478,024	487,723	497,620
151% - 200%	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697
Over 201%	89,250	99,974	100,291	100,600	100,910	101,221	101,533	101,846	102,160	102,475

Table B10. Without and With-Waiver Monthly Federal Funding by Metal Level and Rate Cohort

Without Waiver - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$265	$291	$317	$346	$376	$407	$440	$476	$513	$552
Bronze	$252	$272	$293	$316	$339	$364	$391	$418	$448	$479
Silver	$315	$342	$370	$400	$432	$465	$501	$538	$577	$619
Gold	$218	$248	$280	$313	$348	$386	$426	$468	$512	$559
Platinum	$164	$197	$232	$269	$309	$351	$395	$443	$493	$546
Essential Plan BHP Funding	**$766**	**$803**	**$841**	**$882**	**$924**	**$969**	**$1,015**	**$1,064**	**$1,115**	**$1,169**
EP1	$623	$653	$684	$717	$751	$787	$825	$865	$906	$950
EP2	$1,051	$1,102	$1,154	$1,210	$1,268	$1,329	$1,393	$1,459	$1,529	$1,603
EP3	$988	$1,036	$1,086	$1,138	$1,192	$1,250	$1,310	$1,372	$1,438	$1,507
EP4	$960	$1,006	$1,054	$1,105	$1,158	$1,214	$1,272	$1,333	$1,397	$1,464

With Waiver - Scenario B	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$273	$299	$326	$355	$386	$418	$452	$488	$526	$567
Bronze	$255	$275	$297	$320	$344	$370	$396	$425	$455	$486
Silver	$323	$350	$379	$410	$442	$476	$512	$550	$590	$633
Gold	$231	$262	$294	$328	$365	$403	$444	$487	$533	$581
Platinum	$186	$220	$256	$295	$335	$379	$425	$473	$525	$580
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
QHP 200%-250% FPL Population	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Table B11. Without and With-Waiver Unsubsidized On-Exchange & Off-Exchange Enrollment and Annual Premium Increases by FPL, PY 2024 – 2033

Without Waiver - Scenario B	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Unsubsidized On-exchange & Off-exchange Enrollment	66,122	64,435	62,609	60,248	57,976	55,790	53,686	51,662	49,714	47,839
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	0	0	0	0	0	0	0	0
501% - 600%	0	0	0	0	0	0	0	0	0	0
Over 600%	7,685	7,755	7,824	7,529	7,245	6,972	6,709	6,456	6,213	5,979
Do Not Report	58,437	56,680	54,785	52,719	50,731	48,818	46,977	45,206	43,501	41,861
Unsubsidized On-exchange Enrollment	16,531	16,109	15,652	15,062	14,494	13,948	13,422	12,915	12,428	11,960
Off-exchange Enrollment	49,592	48,326	46,957	45,186	43,482	41,843	40,265	38,746	37,285	35,879
With Waiver - Scenario B	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Unsubsidized On-exchange & Off-exchange Enrollment	63,102	61,122	58,865	57,449	56,068	54,719	53,403	52,119	50,865	49,642
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	0	0	0	0	0	0	0	0
501% - 600%	0	0	0	0	0	0	0	0	0	0
Over 600%	7,404	7,380	7,356	7,179	7,007	6,838	6,674	6,513	6,357	6,204
Do Not Report	55,698	53,741	51,509	50,270	49,061	47,881	46,729	45,605	44,508	43,438
Unsubsidized On-exchange & Off-exchange Premium Increase (Annual)	$256	$268	$281	$302	$324	$349	$376	$406	$438	$474
Unsubsidized On-exchange Enrollment	15,775	15,280	14,716	14,362	14,017	13,680	13,351	13,030	12,716	12,410
Unsubsidized On-exchange Premium Increase (Annual)	$408	$427	$446	$497	$553	$617	$688	$767	$856	$955
Off-exchange Enrollment	47,326	45,841	44,149	43,087	42,051	41,039	40,052	39,089	38,149	37,231
Off-exchange Premium Increase (Annual)	$205	$215	$226	$237	$248	$260	$272	$285	$299	$313

Table B12. Without and With-Waiver Annual Out-of-Pocket Expenses by FPL, PY 2024 – 2033

Without Waiver - Scenario B - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,294	$2,405	$2,518	$2,637	$2,763	$2,894	$3,031	$3,175	$3,326	$3,484	$2,525	$2,859
251% - 300%	$2,204	$2,310	$2,419	$2,534	$2,654	$2,780	$2,912	$3,050	$3,195	$3,347	$2,426	$2,753
301% - 350%	$2,205	$2,311	$2,420	$2,535	$2,655	$2,782	$2,914	$3,052	$3,197	$3,349	$2,428	$2,754
351% - 400%	$2,221	$2,328	$2,438	$2,553	$2,674	$2,801	$2,934	$3,074	$3,220	$3,373	$2,445	$2,774
401% - 500%	$2,240	$2,347	$2,458	$2,575	$2,697	$2,825	$2,959	$3,100	$3,247	$3,401	$2,466	$2,797
501% - 600%	$2,258	$2,366	$2,478	$2,595	$2,719	$2,848	$2,983	$3,125	$3,273	$3,428	$2,486	$2,820
Over 600%/Do Not Report	$2,321	$2,433	$2,547	$2,668	$2,795	$2,928	$3,067	$3,212	$3,365	$3,525	$2,546	$2,852
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$129	$134	$140	$145	$151	$157	$163	$170	$177	$184	$140	$156
Over 151%	$546	$568	$591	$614	$639	$664	$691	$719	$747	$777	$593	$660

With Waiver - Scenario B - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,347	$2,460	$2,576	$2,698	$2,826	$2,960	$3,101	$3,248	$3,402	$3,564	$2,583	$2,926
251% - 300%	$2,254	$2,362	$2,474	$2,591	$2,714	$2,843	$2,978	$3,119	$3,268	$3,423	$2,481	$2,810
301% - 350%	$2,255	$2,364	$2,475	$2,593	$2,716	$2,845	$2,980	$3,121	$3,269	$3,425	$2,482	$2,812
351% - 400%	$2,271	$2,380	$2,493	$2,611	$2,735	$2,865	$3,001	$3,143	$3,293	$3,449	$2,500	$2,832
401% - 500%	$2,291	$2,400	$2,514	$2,633	$2,758	$2,889	$3,026	$3,170	$3,320	$3,478	$2,521	$2,856
501% - 600%	$2,309	$2,420	$2,534	$2,654	$2,780	$2,912	$3,050	$3,195	$3,347	$3,506	$2,541	$2,879
Over 600%/Do Not Report	$2,374	$2,488	$2,605	$2,729	$2,858	$2,994	$3,136	$3,285	$3,441	$3,604	$2,604	$2,926
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$129	$134	$140	$145	$151	$157	$163	$170	$177	$184	$140	$156
151% - 200%	$546	$568	$591	$614	$639	$664	$691	$719	$747	$777	$593	$660
Over 201%	$598	$622	$647	$673	$699	$727	$756	$787	$818	$851	$649	$720

Table B13. Without and With-Waiver Annual Out-of-Pocket Expenses by Age, PY 2024 – 2033

Without Waiver - Scenario B - 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	$948	$993	$1,040	$1,090	$1,141	$1,196	$1,252	$1,312	$1,374	$1,439	$1,043	$1,179
21 - 25 Years	$943	$989	$1,035	$1,084	$1,136	$1,190	$1,246	$1,305	$1,367	$1,432	$1,037	$1,173
26 - 30 Years	$1,222	$1,281	$1,341	$1,405	$1,472	$1,542	$1,615	$1,691	$1,772	$1,856	$1,344	$1,520
31 - 35 Years	$1,494	$1,566	$1,640	$1,717	$1,799	$1,884	$1,974	$2,067	$2,166	$2,269	$1,643	$1,858
36 - 40 Years	$1,643	$1,721	$1,803	$1,888	$1,978	$2,072	$2,170	$2,273	$2,381	$2,494	$1,807	$2,042
41 - 45 Years	$1,832	$1,919	$2,010	$2,105	$2,205	$2,310	$2,420	$2,534	$2,655	$2,781	$2,014	$2,277
46 - 50 Years	$2,160	$2,264	$2,371	$2,483	$2,601	$2,725	$2,854	$2,989	$3,131	$3,280	$2,376	$2,686
51 - 55 Years	$2,665	$2,793	$2,924	$3,063	$3,209	$3,361	$3,521	$3,688	$3,863	$4,046	$2,931	$3,313
56 - 60 Years	$3,265	$3,421	$3,582	$3,752	$3,931	$4,117	$4,313	$4,517	$4,732	$4,957	$3,590	$4,059
61 - 65 Years	$4,024	$4,217	$4,416	$4,626	$4,845	$5,075	$5,316	$5,569	$5,833	$6,110	$4,426	$5,003
Essential Plan - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$178	$186	$193	$201	$209	$217	$226	$235	$244	$254	$193	$214
21 - 25 Years	$178	$185	$192	$200	$208	$216	$225	$234	$243	$253	$192	$213
26 - 30 Years	$230	$239	$249	$259	$269	$280	$291	$303	$315	$328	$249	$276
31 - 35 Years	$281	$293	$304	$316	$329	$342	$356	$370	$385	$400	$305	$338
36 - 40 Years	$309	$322	$335	$348	$362	$376	$391	$407	$423	$440	$335	$371
41 - 45 Years	$345	$359	$373	$388	$403	$420	$436	$454	$472	$491	$374	$414
46 - 50 Years	$407	$423	$440	$458	$476	$495	$515	$535	$557	$579	$441	$488
51 - 55 Years	$502	$522	$543	$564	$587	$610	$635	$660	$687	$714	$544	$602
56 - 60 Years	$615	$639	$665	$691	$719	$748	$778	$809	$841	$875	$666	$738
61 - 65 Years	$758	$788	$820	$852	$886	$922	$959	$997	$1,037	$1,078	$821	$910

With Waiver - Scenario B - 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	$965	$1,011	$1,059	$1,109	$1,162	$1,217	$1,275	$1,335	$1,399	$1,465	$1,061	$1,200
21 - 25 Years	$960	$1,006	$1,054	$1,104	$1,156	$1,211	$1,268	$1,329	$1,392	$1,458	$1,056	$1,194
26 - 30 Years	$1,244	$1,304	$1,365	$1,430	$1,498	$1,569	$1,644	$1,722	$1,803	$1,889	$1,368	$1,547
31 - 35 Years	$1,521	$1,594	$1,669	$1,748	$1,831	$1,918	$2,009	$2,104	$2,204	$2,309	$1,672	$1,891
36 - 40 Years	$1,672	$1,752	$1,835	$1,922	$2,013	$2,109	$2,209	$2,314	$2,424	$2,539	$1,839	$2,079
41 - 45 Years	$1,864	$1,954	$2,046	$2,143	$2,245	$2,351	$2,463	$2,580	$2,702	$2,831	$2,050	$2,318
46 - 50 Years	$2,199	$2,304	$2,413	$2,527	$2,647	$2,773	$2,905	$3,043	$3,187	$3,339	$2,418	$2,734
51 - 55 Years	$2,712	$2,843	$2,977	$3,118	$3,266	$3,421	$3,583	$3,753	$3,932	$4,119	$2,983	$3,372
56 - 60 Years	$3,323	$3,482	$3,646	$3,819	$4,001	$4,191	$4,390	$4,598	$4,816	$5,045	$3,654	$4,131
61 - 65 Years	$4,096	$4,292	$4,495	$4,708	$4,932	$5,166	$5,411	$5,668	$5,937	$6,219	$4,505	$5,092
Essential Plan - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$187	$194	$202	$210	$218	$227	$236	$246	$255	$266	$202	$224
21 - 25 Years	$186	$193	$201	$209	$217	$226	$235	$244	$254	$264	$201	$223
26 - 30 Years	$241	$250	$260	$271	$281	$293	$304	$317	$329	$342	$261	$289
31 - 35 Years	$294	$306	$318	$331	$344	$358	$372	$387	$402	$419	$319	$353
36 - 40 Years	$323	$336	$350	$364	$378	$393	$409	$425	$442	$460	$350	$388
41 - 45 Years	$360	$375	$390	$406	$422	$439	$456	$474	$493	$513	$391	$433
46 - 50 Years	$425	$442	$460	$478	$497	$517	$538	$560	$582	$605	$461	$510
51 - 55 Years	$525	$545	$567	$590	$614	$638	$664	$690	$718	$747	$568	$630
56 - 60 Years	$643	$668	$695	$723	$752	$782	$813	$846	$879	$915	$696	$771
61 - 65 Years	$792	$824	$857	$891	$927	$964	$1,002	$1,042	$1,084	$1,127	$858	$951

Appendix C: Scenario C Detailed 10-Year Estimates (Pregnancy Choice, Current Law)

The following provides an analysis of the proposed Waiver under current law for expansion to consumers with incomes between 200 – 250% of the FPL and with the policy allowing pregnant individuals the choice to remain in the With-Waiver Essential Plan. The analysis estimates that the proposed Waiver meets each of the four guardrails for the five years of the Waiver and 10-year analysis.

Table C1. Scenario C High-Level Guardrail Compliance of 1332 Waiver

Guardrail	Estimated Impact With-Waiver (WW) Compared to Without-Waiver (WoW)
Comprehensiveness	The 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 experience an increase in comprehensiveness. • 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 Waiver is projected to meet the affordability guardrail as the overall affordability across the market is improved compared to the Baseline Without-Waiver Scenario.
	• Affordability for current Essential Plan members 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 $1.4 billion over the 5 years.
	  ○ This is an average annual savings of $4,200 under the Waiver ($2,250 in premiums and $1,950 in out-of-pocket spend), which is approximately 11% 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 expected to decrease slightly as premiums are expected to increase by an additional 2.2% in 2024 under the Waiver.
	  ○ This is an average annual increase of $259 under the Waiver, which falls in the range of 0.1–0.5% of income for subsidy-ineligible On-Exchange consumers above 250% of the FPL and Off-Exchange consumers.

Coverage	The 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 1.9% for PY 2024, 3.1% for PY 2025, 3.1% for PY 2026, 3.0% for PY 2027, and 3.0% for PY 2028. • Individuals who become pregnant may opt to remain in the Essential Plan, this is estimated to increase enrollment by 7,583 for 2024, 14,151 for 2025, 14,434 for 2026, 14,723 for 2027, and 15,017 for 2028.
Deficit Neutrality	The 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 $9.9 billion in PY 2024 and $54.2 billion over the 5-year Waiver period, before pass-through funding. • The net federal spend under the waiver is estimated to decrease by $36.7 million in PY 2024 and $325.7 million over the 5-year waiver period, after accounting for pass-through funding.

Table C2. Baseline Without-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

Baseline - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	66,122	64,435	124,043	123,236	122,435	121,639	120,849	120,063	119,283	118,507	100,054	110,061
Average Premium PMPM	$751	$786	$806	$845	$885	$928	$972	$1,019	$1,067	$1,118	$825	$932
Subsidized On-Exchange												
Enrollment[1]	236,570	237,659	149,369	150,356	151,349	152,348	153,354	154,367	155,387	156,413	185,061	169,717
Average Premium PMPM	$712	$746	$782	$820	$859	$900	$944	$989	$1,036	$1,086	$774	$873
Average APTC PMPM	$265	$291	$265	$292	$321	$351	$384	$418	$454	$492	$285	$347
Total Individual Market												
Enrollment[1]	302,692	302,094	273,412	273,592	273,784	273,988	274,203	274,430	274,670	274,920	285,115	279,779
Average Premium PMPM	$721	$755	$793	$831	$871	$913	$956	$1,002	$1,050	$1,100	$792	$896
Aggregate Premiums (millions)	$2,618	$2,737	$2,602	$2,729	$2,861	$3,000	$3,146	$3,299	$3,460	$3,629	$13,546	$30,081
Projected Federal Spend (millions)	$703	$774	$443	$492	$544	$599	$659	$722	$790	$862	$2,956	$6,587
Essential Plan												
Enrollment[1]	1,049,766	1,075,921	1,103,125	1,125,773	1,147,847	1,170,804	1,194,220	1,218,105	1,242,467	1,267,316	1,100,487	1,159,535
Average Premium PMPM	$563	$585	$608	$633	$658	$684	$712	$740	$770	$801	$610	$680
Aggregate Premiums (millions)	$7,086	$7,553	$8,053	$8,547	$9,063	$9,614	$10,199	$10,819	$11,477	$12,174	$40,303	$94,586
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$140	$148	$157	$167	$177	$188	$199	$211	$576	$1,517
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$135	$144	$152	$162	$171	$568	$1,333
Total Program Costs (millions)	$8,236	$8,841	$9,356	$9,866	$10,398	$10,967	$11,569	$12,209	$12,887	$13,607	$46,697	$107,937
Projected Federal Spend (millions)	$9,647	$10,363	$10,241	$10,953	$11,705	$12,513	$13,377	$14,300	$15,287	$16,343	$52,908	$124,729
Other Federal Spend/Revenue												
Pregnancy Medicaid Spend (millions)	$39	$73	$75	$76	$78	$79	$81	$83	$84	$86	$341	$754
ESRP Revenue (millions)	($3)	($3)	($3)	($3)	($4)	($4)	($5)	($6)	($7)	($8)	($16)	($45)
Combined Totals												
Enrollment[1]	1,352,459	1,378,015	1,376,537	1,399,365	1,421,631	1,444,792	1,468,423	1,492,535	1,517,136	1,542,237	1,385,601	1,439,313
Projected Federal Spend (millions)	$10,387	$11,207	$10,756	$11,517	$12,323	$13,187	$14,112	$15,099	$16,155	$17,283	$56,190	$132,025

[1]5 and 10 year totals are straight averages

Table C3. With-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

With Waiver - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592	96,847	106,947
Average Premium PMPM	$772	$809	$827	$866	$908	$951	$997	$1,045	$1,095	$1,147	$847	$956
Subsidized On-Exchange												
Enrollment[1]	168,922	170,243	87,405	87,979	88,556	89,138	89,724	90,313	90,906	91,503	120,621	105,469
Average Premium PMPM	$728	$763	$799	$838	$878	$920	$964	$1,010	$1,059	$1,110	$786	$883
Average APTC PMPM	$273	$299	$273	$301	$330	$361	$394	$429	$466	$505	$293	$352
Total Individual Market												
Enrollment[1]	232,024	231,365	208,157	207,980	207,812	207,651	207,500	207,356	207,222	207,095	217,468	212,416
Average Premium PMPM	$740	$775	$815	$854	$895	$938	$983	$1,030	$1,079	$1,131	$813	$920
Aggregate Premiums (millions)	$2,060	$2,151	$2,036	$2,132	$2,232	$2,337	$2,447	$2,562	$2,683	$2,810	$10,610	$23,449
Projected Federal Spend (millions)	$517	$570	$267	$296	$328	$361	$396	$434	$475	$518	$1,978	$4,162
Essential Plan												
Enrollment[1]	1,146,600	1,190,046	1,210,758	1,234,010	1,256,694	1,280,269	1,304,309	1,328,825	1,353,826	1,379,321	1,207,622	1,268,466
Average Premium PMPM	$569	$592	$615	$640	$665	$691	$719	$748	$777	$808	$617	$687
Aggregate Premiums (millions)	$7,825	$8,454	$8,935	$9,470	$10,028	$10,623	$11,253	$11,922	$12,630	$13,380	$44,712	$104,520
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$138	$147	$155	$165	$174	$185	$196	$207	$571	$1,498
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$136	$145	$153	$163	$172	$571	$1,340
200-250% Member Premiums (millions)	($16)	($18)	($17)	($17)	($17)	($17)	($17)	($17)	($17)	($17)	($85)	($170)
Total Program Costs (millions)	$8,959	$9,724	$10,221	$10,771	$11,345	$11,957	$12,605	$13,293	$14,021	$14,793	$51,020	$117,688
Projected Federal Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Federal Spend/Revenue												
Pregnancy Medicaid Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ESRP Revenue (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Combined Totals												
Enrollment[1]	1,378,623	1,421,411	1,418,916	1,441,990	1,464,506	1,487,920	1,511,809	1,536,181	1,561,047	1,586,417	1,425,089	1,480,882
Projected Federal Spend (millions)	$517	$570	$267	$296	$328	$361	$396	$434	$475	$518	$1,978	$4,162

[1]5 and 10 year totals are straight averages

Table C4. Baseline Without and With-Waiver Annual Funding Estimates, PY 2024-2033

Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Individual Market										
Without Waiver PTCs	$703,275,446	$773,724,334	$443,099,810	$491,831,155	$543,891,229	$599,480,314	$658,810,162	$722,104,635	$789,600,385	$861,547,570
With Waiver PTCs	$516,932,667	$570,242,426	$267,228,542	$296,412,593	$327,586,018	$360,868,359	$396,386,001	$434,272,546	$474,669,224	$517,725,315
Difference	$186,342,778	$203,481,908	$175,871,268	$195,418,562	$216,305,211	$238,611,955	$262,424,161	$287,832,089	$314,931,162	$343,822,255
Essential Plan										
Without Waiver BHP Funding	$9,647,023,116	$10,362,844,939	$10,240,943,646	$10,952,653,434	$11,704,979,476	$12,512,996,093	$13,376,791,360	$14,300,215,746	$15,287,385,524	$16,342,701,117
With Waiver BHP Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Difference	$9,647,023,116	$10,362,844,939	$10,240,943,646	$10,952,653,434	$11,704,979,476	$12,512,996,093	$13,376,791,360	$14,300,215,746	$15,287,385,524	$16,342,701,117
Other Federal Spend/Savings										
Pregnancy Medicaid Reduction	$39,270,833	$73,283,040	$74,748,701	$76,243,675	$77,768,549	$79,323,920	$80,910,398	$82,528,606	$84,179,178	$85,862,762
Employer Penality Loss	($2,592,000)	($2,970,000)	($3,006,000)	($3,258,000)	($3,746,700)	($4,308,705)	($4,955,011)	($5,698,262)	($6,553,002)	($7,535,952)
Combined Totals										
Without Waiver Federal Spend	$10,386,977,395	$11,206,882,313	$10,755,786,158	$11,517,470,265	$12,322,892,554	$13,187,491,622	$14,111,556,909	$15,099,150,725	$16,154,612,086	$17,282,575,497
With Waiver Federal Spend	$516,932,667	$570,242,426	$267,228,542	$296,412,593	$327,586,018	$360,868,359	$396,386,001	$434,272,546	$474,669,224	$517,725,315
Total Federal Savings	**$9,870,044,728**	**$10,636,639,887**	**$10,488,557,616**	**$11,221,057,672**	**$11,995,306,536**	**$12,826,623,263**	**$13,715,170,908**	**$14,664,878,179**	**$15,679,942,863**	**$16,764,850,182**
Requested Pass-through	$9,833,365,895	$10,566,326,847	$10,416,814,914	$11,148,071,996	$11,921,284,687	$12,751,608,048	$13,639,215,521	$14,588,047,835	$15,602,316,686	$16,686,523,372
Net Federal Savings	**$36,678,833**	**$70,313,040**	**$71,742,701**	**$72,985,675**	**$74,021,849**	**$75,015,215**	**$75,955,387**	**$76,830,344**	**$77,626,177**	**$78,326,810**

Combined Totals	5-Year Total	10-Year Total
Without Waiver Federal Spend	$56,190,008,685	$132,025,395,524
With Waiver Federal Spend	$1,978,402,246	$4,162,323,691
Total Federal Savings	**$54,211,606,439**	**$127,863,071,833**
Requested Pass-through	$53,885,864,339	$127,153,575,801
Net Federal Savings	**$325,742,099**	**$709,496,032**

Table C5. SLCSP Premium Without and With-Waiver by Rating Area, PY 2024 – 2033

Baseline - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$567	$595	$623	$653	$684	$717	$752	$788	$825	$865
Rating Area 2	$474	$497	$521	$546	$572	$599	$628	$658	$690	$723
Rating Area 3	$641	$672	$704	$738	$773	$810	$849	$890	$932	$977
Rating Area 4	$721	$755	$792	$830	$870	$911	$955	$1,001	$1,049	$1,099
Rating Area 5	$556	$583	$611	$640	$671	$703	$737	$772	$809	$848
Rating Area 6	$615	$645	$676	$708	$742	$778	$815	$854	$895	$938
Rating Area 7	$583	$611	$640	$671	$703	$737	$773	$810	$849	$889
Rating Area 8	$702	$735	$770	$807	$846	$887	$929	$974	$1,021	$1,070

With Waiver - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Second Lowest Cost Silver Plans (SLCSP) Monthly Premiums										
Rating Area 1	$580	$607	$637	$667	$699	$733	$768	$805	$843	$884
Rating Area 2	$484	$508	$532	$557	$584	$612	$642	$672	$705	$738
Rating Area 3	$655	$686	$719	$753	$790	$828	$867	$909	$953	$998
Rating Area 4	$736	$772	$809	$848	$888	$931	$976	$1,023	$1,072	$1,123
Rating Area 5	$568	$595	$624	$654	$685	$718	$753	$789	$827	$866
Rating Area 6	$628	$659	$690	$723	$758	$794	$833	$873	$914	$958
Rating Area 7	$596	$624	$654	$686	$719	$753	$789	$827	$867	$909
Rating Area 8	$717	$751	$787	$825	$865	$906	$949	$995	$1,043	$1,093

Table C6. Baseline Without Average Annual Enrollment by Metal Level, PY 2024 – 2033

Baseline - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,352,459**	**1,378,015**	**1,376,537**	**1,399,365**	**1,421,631**	**1,444,792**	**1,468,423**	**1,492,535**	**1,517,136**	**1,542,237**
Unsubsidized On/Off-Exchange Enrollment	66,122	64,435	124,043	123,236	122,435	121,639	120,849	120,063	119,283	118,507
Catastrophic	5,073	5,025	4,739	4,730	4,722	4,714	4,706	4,699	4,691	4,684
Bronze	21,026	20,462	42,758	42,472	42,189	41,907	41,627	41,349	41,072	40,797
Silver	21,525	20,941	45,249	44,945	44,644	44,344	44,046	43,750	43,456	43,164
Gold	10,038	9,771	17,674	17,556	17,439	17,322	17,206	17,091	16,977	16,863
Platinum	8,461	8,236	13,624	13,533	13,442	13,352	13,263	13,174	13,086	12,999
Subsidized On-Exchange Enrollment	236,570	237,659	149,369	150,356	151,349	152,348	153,354	154,367	155,387	156,413
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	88,312	88,718	55,760	56,128	56,499	56,872	57,247	57,625	58,006	58,389
Silver	96,331	96,774	60,823	61,225	61,629	62,036	62,446	62,858	63,273	63,691
Gold	30,993	31,136	19,569	19,698	19,828	19,959	20,091	20,224	20,357	20,492
Platinum	20,934	21,030	13,218	13,305	13,393	13,481	13,570	13,660	13,750	13,841
Essential Plan Enrollment	**1,049,766**	**1,075,921**	**1,103,125**	**1,125,773**	**1,147,847**	**1,170,804**	**1,194,220**	**1,218,105**	**1,242,467**	**1,267,316**
EP1	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697
EP2	106,180	108,884	111,699	114,052	116,351	118,742	121,181	123,671	126,211	128,804
EP3	65,233	66,886	68,675	70,063	71,478	72,922	74,396	75,899	77,432	78,997
EP4	239,324	245,388	251,953	257,044	262,237	267,535	272,940	278,454	284,080	289,819

Table C7. With-Waiver Average Annual Enrollment by Metal Level, PY 2024 – 2033

With Waiver - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,378,623**	**1,421,411**	**1,418,916**	**1,441,990**	**1,464,506**	**1,487,920**	**1,511,809**	**1,536,181**	**1,561,047**	**1,586,417**
Unsubsidized On/Off-Exchange Enrollment	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592
Catastrophic	4,191	4,135	3,949	3,937	3,926	3,914	3,903	3,892	3,881	3,870
Bronze	20,282	19,620	41,845	41,580	41,317	41,056	40,796	40,538	40,281	40,026
Silver	20,815	20,130	44,329	44,047	43,768	43,490	43,214	42,940	42,667	42,396
Gold	9,670	9,356	17,297	17,188	17,079	16,971	16,863	16,757	16,651	16,545
Platinum	8,144	7,880	13,333	13,249	13,165	13,082	12,999	12,917	12,835	12,754
Subsidized On-Exchange Enrollment	168,922	170,243	87,405	87,979	88,556	89,138	89,724	90,313	90,906	91,503
Catastrophic	0	0	0	0	0	0	0	0	0	0
Bronze	63,059	63,552	32,628	32,842	33,058	33,275	33,494	33,714	33,935	34,158
Silver	68,785	69,323	35,591	35,825	36,060	36,297	36,535	36,775	37,017	37,260
Gold	22,131	22,304	11,451	11,526	11,602	11,678	11,755	11,832	11,910	11,988
Platinum	14,948	15,065	7,734	7,785	7,836	7,888	7,940	7,992	8,044	8,097
Essential Plan Enrollment	**1,146,600**	**1,190,046**	**1,210,758**	**1,234,010**	**1,256,694**	**1,280,269**	**1,304,309**	**1,328,825**	**1,353,826**	**1,379,321**
EP1	643,645	663,375	679,575	693,568	706,910	720,915	735,198	749,764	764,618	779,767
EP2	106,947	110,316	113,160	115,544	117,873	120,295	122,767	125,289	127,862	130,489
EP3	65,704	67,766	69,574	70,979	72,414	73,876	75,369	76,892	78,445	80,030
EP4	241,053	248,616	255,250	260,405	265,668	271,035	276,511	282,097	287,797	293,611
QHP 200%-250% FPL Population	89,250	99,974	93,199	93,514	93,830	94,147	94,465	94,784	95,104	95,425

Table C8. Baseline Without-Waiver Average Annual Enrollment by FPL, PY 2024 – 2033

Baseline - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,352,459**	**1,378,015**	**1,376,537**	**1,399,365**	**1,421,631**	**1,444,792**	**1,468,423**	**1,492,535**	**1,517,136**	**1,542,237**
Unsubsidized On/Off-Exchange Enrollment	66,122	64,435	124,043	123,236	122,435	121,639	120,849	120,063	119,283	118,507
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	24,239	24,082	23,925	23,770	23,615	23,462	23,309	23,158
501% - 600%	0	0	12,400	12,319	12,239	12,159	12,080	12,002	11,924	11,846
Over 600%	13,641	13,293	15,502	15,401	15,301	15,201	15,103	15,004	14,907	14,810
Do Not Report	52,482	51,142	71,902	71,435	70,970	70,509	70,051	69,595	69,143	68,693
Subsidized On-Exchange Enrollment	236,570	237,659	149,369	150,356	151,349	152,348	153,354	154,367	155,387	156,413
Below 139%	7,523	7,558	4,750	4,782	4,813	4,845	4,877	4,909	4,942	4,974
139% - 150%	288	290	182	183	184	186	187	188	189	191
151% - 200%	1,757	1,765	1,110	1,117	1,124	1,132	1,139	1,147	1,154	1,162
201% - 250%	69,010	69,122	62,093	62,470	62,849	63,230	63,614	64,000	64,388	64,779
251% - 300%	54,227	54,547	36,619	36,876	37,134	37,395	37,657	37,921	38,187	38,455
301% - 350%	40,022	40,258	27,027	27,216	27,407	27,599	27,793	27,988	28,184	28,381
351% - 400%	26,047	26,201	17,589	17,713	17,837	17,962	18,088	18,215	18,342	18,471
401% - 500%	21,502	21,629	0	0	0	0	0	0	0	0
501% - 600%	9,595	9,652	0	0	0	0	0	0	0	0
Over 600%	6,599	6,638	0	0	0	0	0	0	0	0
Essential Plan Enrollment	**1,049,766**	**1,075,921**	**1,103,125**	**1,125,773**	**1,147,847**	**1,170,804**	**1,194,220**	**1,218,105**	**1,242,467**	**1,267,316**
Below 150%	410,737	421,158	432,327	441,159	450,066	459,199	468,517	478,024	487,723	497,620
Over 151%	639,029	654,763	670,797	684,614	697,781	711,605	725,704	740,081	754,744	769,697

Table C9. With-Waiver PY Average Annual Enrollment by FPL, PY 2024 – 2033

With Waiver - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Total Combined Enrollment	**1,378,623**	**1,421,411**	**1,418,916**	**1,441,990**	**1,464,506**	**1,487,920**	**1,511,809**	**1,536,181**	**1,561,047**	**1,586,417**
Unsubsidized On/Off-Exchange Enrollment	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	23,596	23,450	23,304	23,159	23,015	22,872	22,729	22,588
501% - 600%	0	0	12,071	11,996	11,921	11,847	11,773	11,700	11,627	11,555
Over 600%	12,045	13,568	15,091	14,997	14,903	14,811	14,719	14,627	14,536	14,446
Do Not Report	51,057	47,554	69,995	69,560	69,127	68,697	68,270	67,845	67,423	67,003
Subsidized On-Exchange Enrollment	168,922	170,243	87,405	87,979	88,556	89,138	89,724	90,313	90,906	91,503
Below 139%	7,490	7,548	3,875	3,901	3,927	3,952	3,978	4,004	4,031	4,057
139% - 150%	287	289	149	149	150	151	152	153	154	155
151% - 200%	1,750	1,763	905	911	917	923	929	935	942	948
201% - 250%	410	413	212	213	215	216	218	219	220	222
251% - 300%	54,568	54,995	37,083	37,326	37,571	37,818	38,067	38,317	38,568	38,822
301% - 350%	40,274	40,589	27,369	27,548	27,729	27,912	28,095	28,279	28,465	28,652
351% - 400%	26,211	26,416	17,812	17,929	18,047	18,165	18,285	18,405	18,526	18,647
401% - 500%	21,637	21,807	0	0	0	0	0	0	0	0
501% - 600%	9,655	9,731	0	0	0	0	0	0	0	0
Over 600%	6,641	6,693	0	0	0	0	0	0	0	0
Essential Plan Enrollment	**1,146,600**	**1,190,046**	**1,210,758**	**1,234,010**	**1,256,694**	**1,280,269**	**1,304,309**	**1,328,825**	**1,353,826**	**1,379,321**
Below 150%	413,704	426,697	437,984	446,928	455,955	465,207	474,646	484,278	494,104	504,130
151% - 200%	643,645	663,375	679,575	693,568	706,910	720,915	735,198	749,764	764,618	779,767
Over 201%	89,250	99,974	93,199	93,514	93,830	94,147	94,465	94,784	95,104	95,425

Table C10. Without and With-Waiver Monthly Federal Funding by Metal Level and Rate Cohort, PY 2024 – 2033

Without Waiver - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$265	$291	$265	$292	$321	$351	$384	$418	$454	$492
Bronze	$252	$272	$260	$281	$304	$329	$354	$381	$410	$440
Silver	$315	$342	$321	$350	$381	$413	$447	$483	$522	$562
Gold	$218	$248	$199	$231	$265	$300	$338	$379	$421	$467
Platinum	$164	$197	$126	$162	$199	$239	$281	$326	$374	$425
Essential Plan BHP Funding	**$766**	**$803**	**$774**	**$811**	**$850**	**$891**	**$933**	**$978**	**$1,025**	**$1,075**
EP1	$623	$653	$597	$625	$655	$687	$720	$754	$790	$828
EP2	$1,051	$1,102	$1,090	$1,142	$1,197	$1,254	$1,314	$1,378	$1,444	$1,513
EP3	$988	$1,036	$1,054	$1,105	$1,158	$1,213	$1,272	$1,333	$1,397	$1,464
EP4	$960	$1,006	$1,028	$1,078	$1,129	$1,184	$1,240	$1,300	$1,362	$1,428

With Waiver - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Exchange Subsidized APTCs	$273	$299	$273	$301	$330	$361	$394	$429	$466	$505
Bronze	$255	$275	$262	$285	$308	$333	$359	$386	$416	$446
Silver	$323	$350	$329	$358	$390	$423	$458	$495	$534	$575
Gold	$231	$262	$213	$245	$280	$317	$356	$397	$441	$487
Platinum	$186	$220	$151	$187	$226	$267	$310	$357	$406	$458
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
QHP 200%-250% FPL Population	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Table C11. Without and With-Waiver Unsubsidized On-Exchange & Off-Exchange Enrollment and Annual Premium Increases by FPL, PY 2024 – 2033

Without Waiver - Scenario C	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Unsubsidized On-exchange & Off-exchange Enrollment	66,122	64,435	124,043	123,236	122,435	121,639	120,849	120,063	119,283	118,507
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	24,239	24,082	23,925	23,770	23,615	23,462	23,309	23,158
501% - 600%	0	0	12,400	12,319	12,239	12,159	12,080	12,002	11,924	11,846
Over 600%	13,641	13,293	15,502	15,401	15,301	15,201	15,103	15,004	14,907	14,810
Do Not Report	52,482	51,142	71,902	71,435	70,970	70,509	70,051	69,595	69,143	68,693
Unsubsidized On-exchange Enrollment	16,531	16,109	74,426	73,942	73,461	72,984	72,509	72,038	71,570	71,104
Off-exchange Enrollment	49,592	48,326	49,617	49,295	48,974	48,656	48,339	48,025	47,713	47,403
With Waiver - Scenario C	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**
Unsubsidized On-exchange & Off-exchange Enrollment	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592
Below 400%	0	0	0	0	0	0	0	0	0	0
401% - 500%	0	0	23,596	23,450	23,304	23,159	23,015	22,872	22,729	22,588
501% - 600%	0	0	12,071	11,996	11,921	11,847	11,773	11,700	11,627	11,555
Over 600%	12,045	13,568	15,091	14,997	14,903	14,811	14,719	14,627	14,536	14,446
Do Not Report	51,057	47,554	69,995	69,560	69,127	68,697	68,270	67,845	67,423	67,003
Unsubsidized On-exchange & Off-exchange Premium Increase (Annual)	$256	$268	$245	$257	$270	$284	$298	$313	$328	$345
Unsubsidized On-exchange Enrollment	15,775	15,280	72,452	72,001	71,553	71,108	70,666	70,226	69,789	69,355
Unsubsidized On-exchange Premium Increase (Annual)	$408	$427	$258	$271	$285	$300	$315	$331	$348	$366
Off-exchange Enrollment	47,326	45,841	48,301	48,001	47,702	47,405	47,110	46,817	46,526	46,237
Off-exchange Premium Increase (Annual)	$205	$215	$226	$237	$248	$260	$272	$285	$299	$313

Table C12. Without and With-Waiver Annual Out-of-Pocket Expenses by FPL, PY 2024 – 2033

Without Waiver - Scenario C - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,294	$2,405	$2,520	$2,641	$2,768	$2,901	$3,040	$3,186	$3,339	$3,499	$2,516	$2,850
251% - 300%	$2,204	$2,310	$2,421	$2,537	$2,659	$2,787	$2,920	$3,060	$3,207	$3,361	$2,400	$2,710
301% - 350%	$2,205	$2,311	$2,422	$2,539	$2,660	$2,788	$2,922	$3,062	$3,209	$3,363	$2,401	$2,712
351% - 400%	$2,221	$2,328	$2,440	$2,557	$2,679	$2,808	$2,943	$3,084	$3,232	$3,387	$2,418	$2,731
401% - 500%	$2,240	$2,347	$2,460	$2,578	$2,702	$2,832	$2,967	$3,110	$3,259	$3,416	$2,473	$2,796
501% - 600%	$2,258	$2,366	$2,480	$2,599	$2,724	$2,854	$2,991	$3,135	$3,286	$3,443	$2,502	$2,831
Over 600%/Do Not Report	$2,321	$2,433	$2,550	$2,672	$2,800	$2,935	$3,075	$3,223	$3,378	$3,540	$2,568	$2,905
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$129	$134	$140	$145	$151	$157	$163	$170	$177	$184	$140	$156
Over 151%	$546	$568	$591	$614	$639	$664	$691	$719	$747	$777	$593	$660

With Waiver - Scenario C - FPL	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5 Year	10 Year
Exchange - Annual Out-of-Pocket Expenses - FPL												
Below 250%	$2,347	$2,460	$2,578	$2,702	$2,831	$2,967	$3,110	$3,259	$3,415	$3,579	$2,535	$2,849
251% - 300%	$2,254	$2,362	$2,476	$2,595	$2,719	$2,850	$2,987	$3,130	$3,280	$3,438	$2,454	$2,772
301% - 350%	$2,255	$2,364	$2,477	$2,596	$2,721	$2,851	$2,988	$3,132	$3,282	$3,439	$2,456	$2,773
351% - 400%	$2,271	$2,380	$2,495	$2,614	$2,740	$2,872	$3,009	$3,154	$3,305	$3,464	$2,473	$2,793
401% - 500%	$2,291	$2,400	$2,516	$2,636	$2,763	$2,896	$3,035	$3,180	$3,333	$3,493	$2,526	$2,857
501% - 600%	$2,309	$2,420	$2,536	$2,658	$2,785	$2,919	$3,059	$3,206	$3,360	$3,521	$2,556	$2,893
Over 600%/Do Not Report	$2,374	$2,488	$2,607	$2,732	$2,863	$3,001	$3,145	$3,296	$3,454	$3,620	$2,627	$2,973
Essential Plan - Annual Out-of-Pocket Expenses - FPL												
Below 150%	$129	$134	$140	$145	$151	$157	$163	$170	$177	$184	$140	$156
151% - 200%	$546	$568	$591	$614	$639	$664	$691	$719	$747	$777	$593	$660
Over 201%	$598	$622	$647	$673	$699	$727	$756	$787	$818	$851	$648	$718

Table C13. Without and With-Waiver Annual Out-of-Pocket Expenses by Age, PY 2024 – 2033

Without Waiver - Scenario C - 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	$948	$993	$1,041	$1,091	$1,143	$1,198	$1,256	$1,316	$1,379	$1,446	$1,043	$1,181
21 - 25 Years	$943	$989	$1,036	$1,086	$1,138	$1,192	$1,250	$1,310	$1,372	$1,438	$1,038	$1,175
26 - 30 Years	$1,222	$1,281	$1,342	$1,407	$1,474	$1,545	$1,619	$1,697	$1,779	$1,864	$1,345	$1,523
31 - 35 Years	$1,494	$1,566	$1,641	$1,720	$1,802	$1,889	$1,979	$2,074	$2,174	$2,278	$1,645	$1,862
36 - 40 Years	$1,643	$1,721	$1,804	$1,891	$1,981	$2,077	$2,176	$2,281	$2,390	$2,505	$1,808	$2,047
41 - 45 Years	$1,832	$1,919	$2,012	$2,108	$2,209	$2,315	$2,427	$2,543	$2,665	$2,793	$2,016	$2,282
46 - 50 Years	$2,160	$2,264	$2,373	$2,487	$2,606	$2,731	$2,862	$2,999	$3,143	$3,294	$2,378	$2,692
51 - 55 Years	$2,665	$2,793	$2,927	$3,067	$3,215	$3,369	$3,531	$3,700	$3,878	$4,064	$2,933	$3,321
56 - 60 Years	$3,265	$3,421	$3,585	$3,758	$3,938	$4,127	$4,325	$4,533	$4,750	$4,978	$3,593	$4,068
61 - 65 Years	$4,024	$4,217	$4,420	$4,632	$4,854	$5,087	$5,331	$5,587	$5,855	$6,136	$4,429	$5,014
Essential Plan - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$178	$186	$193	$201	$209	$217	$226	$235	$244	$254	$193	$214
21 - 25 Years	$178	$185	$192	$200	$208	$216	$225	$234	$243	$253	$192	$213
26 - 30 Years	$230	$239	$249	$259	$269	$280	$291	$303	$315	$328	$249	$276
31 - 35 Years	$281	$293	$304	$316	$329	$342	$356	$370	$385	$400	$305	$338
36 - 40 Years	$309	$322	$335	$348	$362	$376	$391	$407	$423	$440	$335	$371
41 - 45 Years	$345	$359	$373	$388	$403	$420	$436	$454	$472	$491	$374	$414
46 - 50 Years	$407	$423	$440	$458	$476	$495	$515	$535	$557	$579	$441	$488
51 - 55 Years	$502	$522	$543	$564	$587	$610	$635	$660	$687	$714	$544	$602
56 - 60 Years	$615	$639	$665	$691	$719	$748	$778	$809	$841	$875	$666	$738
61 - 65 Years	$758	$788	$820	$852	$886	$922	$959	$997	$1,037	$1,078	$821	$910

With Waiver - Scenario C - 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	$965	$1,011	$1,060	$1,111	$1,164	$1,220	$1,278	$1,340	$1,404	$1,471	$1,062	$1,202
21 - 25 Years	$960	$1,006	$1,054	$1,105	$1,158	$1,214	$1,272	$1,333	$1,397	$1,464	$1,057	$1,196
26 - 30 Years	$1,244	$1,304	$1,366	$1,432	$1,501	$1,573	$1,648	$1,727	$1,810	$1,897	$1,369	$1,550
31 - 35 Years	$1,521	$1,594	$1,670	$1,750	$1,834	$1,922	$2,015	$2,111	$2,213	$2,319	$1,674	$1,895
36 - 40 Years	$1,672	$1,752	$1,836	$1,924	$2,017	$2,114	$2,215	$2,321	$2,433	$2,550	$1,840	$2,083
41 - 45 Years	$1,864	$1,954	$2,047	$2,146	$2,249	$2,357	$2,470	$2,588	$2,713	$2,843	$2,052	$2,323
46 - 50 Years	$2,199	$2,304	$2,415	$2,531	$2,652	$2,780	$2,913	$3,053	$3,199	$3,353	$2,420	$2,740
51 - 55 Years	$2,712	$2,843	$2,979	$3,122	$3,272	$3,429	$3,594	$3,766	$3,947	$4,136	$2,986	$3,380
56 - 60 Years	$3,323	$3,482	$3,649	$3,825	$4,008	$4,201	$4,402	$4,613	$4,835	$5,067	$3,657	$4,140
61 - 65 Years	$4,096	$4,292	$4,498	$4,714	$4,941	$5,178	$5,426	$5,687	$5,960	$6,246	$4,508	$5,104
Essential Plan - Annual Out-of-Pocket Expenses - Age												
00 - 20 Years	$187	$194	$202	$210	$218	$227	$236	$246	$255	$266	$202	$224
21 - 25 Years	$186	$193	$201	$209	$217	$226	$235	$244	$254	$264	$201	$223
26 - 30 Years	$241	$250	$260	$271	$281	$293	$304	$317	$329	$342	$261	$289
31 - 35 Years	$294	$306	$318	$331	$344	$358	$372	$387	$402	$419	$319	$353
36 - 40 Years	$323	$336	$350	$364	$378	$393	$409	$425	$442	$460	$350	$388
41 - 45 Years	$360	$375	$390	$406	$422	$439	$456	$474	$493	$513	$391	$433
46 - 50 Years	$425	$442	$460	$478	$497	$517	$538	$560	$582	$605	$461	$510
51 - 55 Years	$525	$545	$567	$590	$614	$638	$664	$690	$718	$747	$568	$630
56 - 60 Years	$643	$668	$695	$723	$752	$782	$813	$846	$879	$915	$696	$771
61 - 65 Years	$792	$824	$857	$891	$927	$964	$1,002	$1,042	$1,084	$1,127	$858	$951

Appendix D: Essential Plan and QHP Regions

Table D1. Essential Plan Regions and Counties

Region 1	Region 2	Region 3
Bronx Kings New York Queens Richmond	Nassau Suffolk	Putnam Rockland Westchester
Region 4	**Region 5**	**Region 6**
Dutchess Orange Sullivan Ulster	Albany Fulton Montgomery Rensselaer Saratoga Schenectady Warren Washington	Clinton Essex Franklin Hamilton Herkimer Jefferson Lewis Oneida Oswego St. Lawrence
Region 7	**Region 8**	**Region 9**
Cayuga Chenango Columbia Cortland Greene Madison Onondaga Otsego Schoharie Schuyler Tompkins	Allegany Broome Cattaraugus Chautauqua Chemung Livingston Onondaga Ontario Seneca Steuben Tioga Wayne Yates	Erie Genesee Monroe Niagara Orleans Wyoming

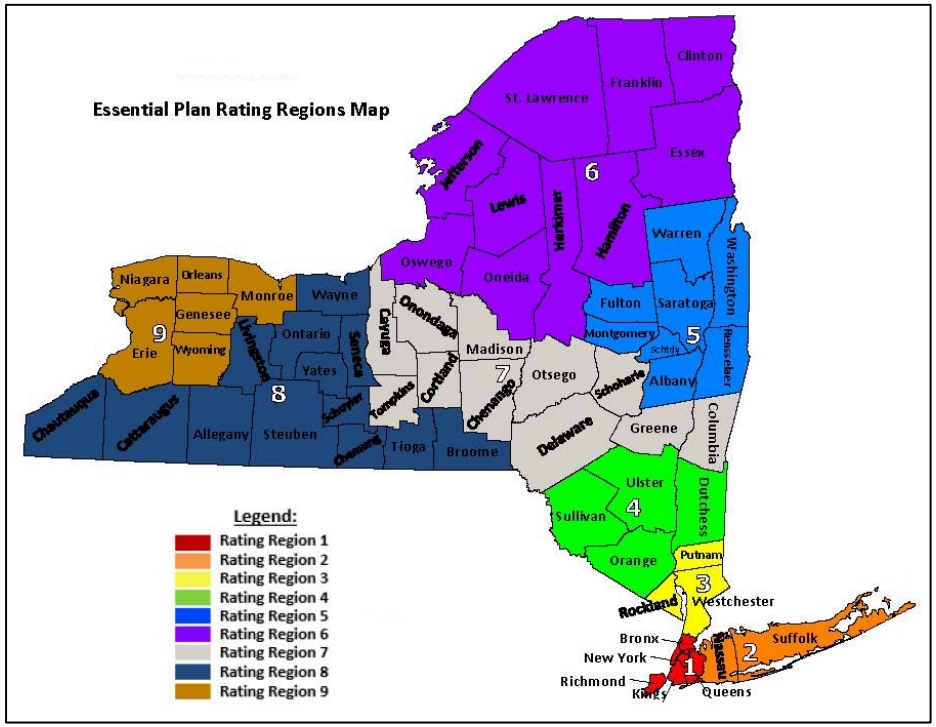
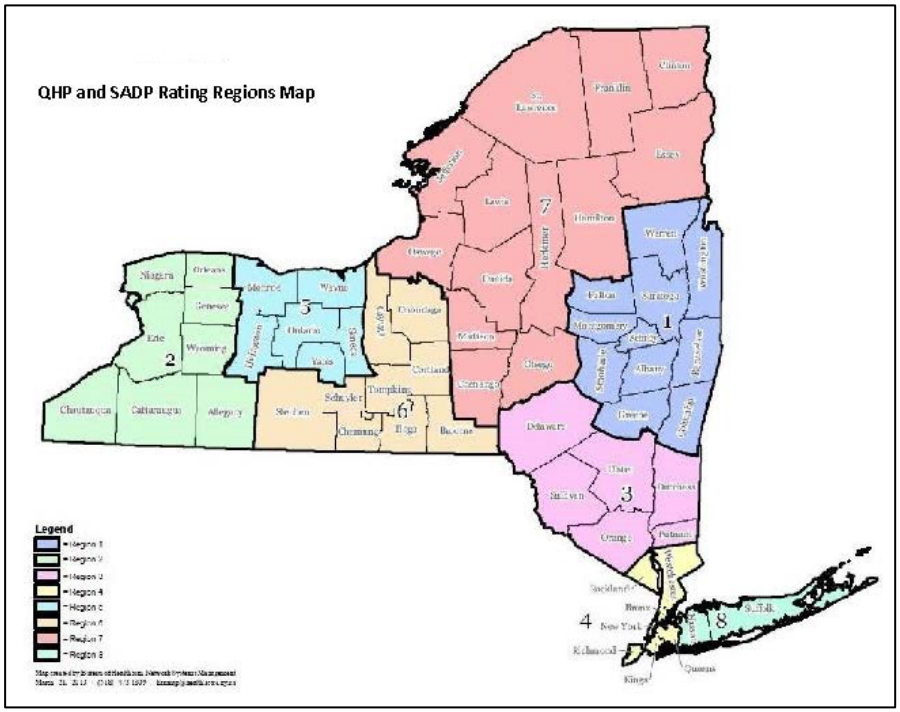


Table D2. QHP and SADP Rating Regions and Counties

Region 1 (Albany)	Region 2 (Buffalo)	Region 3 (Mid-Hudson)
Albany Columbia Fulton Greene Montgomery Rensselaer Saratoga Schenectady Schoharie Warren Washington	Allegany Cattaraugus Chautauqua Erie Genesee Niagara Orleans Wyoming	Delaware Dutchess Orange Putnam Sullivan Ulster
Region 4 (NYC)	**Region 5 (Rochester)**	**Region 6 (Syracuse)**
Bronx Kings New York Queens Richmond Rockland Westchester	Livingston Monroe Ontario Seneca Wayne Yates	Broome Cayuga Chemung Cortland Onondaga Schuyler Steuben Tioga Tompkins
Region 7 (Utica / Waterton)		**Region 8 (Long Island)**
Chenango Clinton Essex Franklin Hamilton Herkimer Jefferson	Lewis Madison Oneida Oswego Otsego St. Lawrence	Nassau Suffolk



Section 7: Attached Materials

Chapter 56 of the Laws of 2022

exceeds one hundred thirty-three percent of the federal poverty line for the applicable family size;

(ii) are not otherwise eligible for medical assistance under this title; and

(iii) are enrolled in a standard health plan in the silver level, as defined in 42 U.S.C. 18022.

(2) Payment pursuant to this paragraph shall be for premium obligations of the individual under the qualified health plan and shall continue only if and for so long as the individual's MAGI household income exceeds one hundred thirty-three percent, but does not exceed one hundred fifty percent, of the federal poverty line for the applicable family size, or, if earlier, until the individual is eligible for enrollment in a standard health plan pursuant to section three hundred sixty-nine-gg of this article.

(3) The commissioner of health shall submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act as may be necessary to receive federal financial participation in the costs of payments made pursuant to this paragraph; provided further, however, that nothing in this subparagraph shall be deemed to affect payments for premiums pursuant to this paragraph if federal financial participation in the costs of such payments is not available.

§ 5. This act shall take effect January 1, 2023, subject to federal financial participation for sections one, three, and four of this act; provided, however that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of federal financial participation in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART BBB

Section 1. Section 268-c of the public health law is amended by adding a new subdivision 25 to read as follows:

25. The commissioner is authorized to submit the appropriate waiver applications to the United States secretary of health and human services and/or the department of the treasury to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148 as amended, or successor provisions, as provided for by 42 U.S.C. 18052, and any other waivers necessary to achieve the purposes of high quality, affordable coverage through NY State of Health, the official health plan marketplace. The commissioner shall implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the secretary of health and human services and/or the secretary of the treasury pursuant to 42 U.S.C. 18052. Copies of such original waiver applications and amendments thereto shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee and the chairs of the senate and assembly health committees simultaneously with their submission to the federal government.

§ 2. Paragraph (d) of subdivision 3 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(d) (i) **except as provided by subparagraph (ii) of this paragraph,** has household income at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and [**(ii)**] has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to [**his or her**] **their** immigration status[**.**];

(ii) subject to federal approval and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, has household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to their immigration status;

(iii) subject to federal approval if required and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, a pregnant individual who is eligible for and receiving coverage for health care services pursuant to this title is eligible to continue to receive health care services pursuant to this title during the pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this title;

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title who would be eligible for coverage pursuant to subparagraphs (2) or (4) of paragraph (b) of subdivision 1 of section three hundred and sixty-six of the social services law shall be deemed to have applied for medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

An applicant who fails to make an applicable premium payment, if any, shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

§ 3. Paragraph (d) of subdivision 3 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(d) (i) **except as provided by subparagraph (ii) of this paragraph,** has household income at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and [**(ii)**]

has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to [his or her] their immigration status[.];

(ii) subject to federal approval and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, has household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to their immigration status;

(iii) subject to federal approval if required and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, a pregnant individual who is eligible for and receiving coverage for health care services pursuant to this title is eligible to continue to receive health care services pursuant to this title during the pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this title;

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title who would be eligible for coverage pursuant to subparagraphs (2) or (4) of paragraph (b) of subdivision 1 of section three hundred and sixty-six of the social services law shall be deemed to have applied for medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

An applicant who fails to make an applicable premium payment shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

§ 4. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, [and] (ii) dental and vision services as defined by the commissioner**, and (iii) as defined by the commissioner and subject to**

federal approval, certain services and supports provided to enrollees eligible pursuant to subparagraph one of paragraph (g) of subdivision one of section three hundred sixty-six of this article who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

§ 5. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(c) "Health care services" means **(i)** the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits**, and (ii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees eligible pursuant to subparagraph one of paragraph (g) of subdivision one of section three hundred sixty-six of this article who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting**;

§ 6. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, [**and**] (ii) dental and vision services as defined by the commissioner**, and (iii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting**;

§ 7. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(c) "Health care services" means **(i)** the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits**, and (ii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the**

setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

§ 7-a. Paragraph (b) of subdivision 5 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval. There shall be no cost-sharing obligations for enrollees for dental and vision services as defined in subparagraph (ii) of paragraph (c) of subdivision one of this section**; services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision one of this section; and health care services authorized under subparagraphs (iii) and (iv) of paragraph (d) of subdivision three of this section**.

§ 7-b. Paragraph (b) of subdivision 5 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval. **There shall be no cost-sharing obligations for services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision one of this section; and health care services authorized under subparagraphs (iii) and (iv) of paragraph (d) of subdivision three of this section.**

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022, provided however:

(a) the amendments to paragraph (d) of subdivision 3 of section 369-gg of the social services law made by section two of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 3 of part H of chapter 57 of the laws of 2021 as amended, when upon such date the provisions of section three of this act shall take effect;

(b) section four of this act shall expire and be deemed repealed December 31, 2024; provided, however, the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by such section of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 2 of part H of chapter 57 of the laws of 2021 when upon such date, the provisions of section five of this act shall take effect; provided, however, the amendments to such paragraph made by section five of this act shall expire and be deemed repealed December 31, 2024;

(c) section six of this act shall take effect January 1, 2025; provided, however, the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by such section of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 2 of part H of chapter 57 of the laws of 2021 when upon such date, the provisions of section seven of this act shall take effect; and

(d) the amendments to paragraph (b) of subdivision 5 of section 369-gg of the social services law made by section seven-a of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 3 of part H of chapter 57 of the laws of 2021 as amended, when upon such date the provisions of section seven-b of this act shall take effect.

PART CCC

Chapter 57 of the Laws of 2023

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PART H

Section 1. Section 5 of part AAA of chapter 56 of the laws of 2022, amending the social services law relating to expanding Medicaid eligibility requirements for seniors and disabled individuals, is amended to read as follows:

§ 5. This act shall take effect January 1, 2023, subject to federal financial participation for sections one, three, and four of this act; provided, however that [~~the~~] **section two of this act shall take effect no later than January 1, 2024. The** commissioner of health shall notify the legislative bill drafting commission upon the occurrence of federal financial participation in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

§ 2. Short title. This act shall be known and may be cited as the "1332 state innovation program".

§ 3. The social services law is amended by adding a new section 369-ii to read as follows:

§ 369-ii. 1332 state innovation program. 1. Authorization. Notwithstanding section three hundred sixty-nine-gg of this title, subject to federal approval, if it is in the financial interest of the state to do so, the commissioner of health is authorized, with the approval of the director of the budget, to establish a 1332 state innovation program pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision twenty-five of section two hundred sixty-eight-c of the public health law. The commissioner of health's authority pursuant to this section is contingent upon obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the treasury based on an application for a waiver for state innovation. The commissioner of health may take all actions necessary to obtain such approvals.

2. Definitions. For the purposes of this section:

(a) "Eligible organization" means an insurer licensed pursuant to article thirty-two or forty-two of the insurance law, a corporation or an organization under article forty-three of the insurance law, or an organization certified under article forty-four of the public health law, including providers certified under section forty-four hundred three-e of the public health law.

(b) "Approved organization" means an eligible organization approved by the commissioner of health to underwrite a 1332 state innovation health insurance plan pursuant to this section.

(c) "Health care services" means:

(i) the services and supplies as defined by the commissioner of health in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner of health for the purposes of defining such benefits, and shall include coverage of and access to the services of any national cancer institute-designated cancer center licensed by the department of health within the service area of the approved organization that is willing to agree to provide cancer-related inpatient, outpatient and medical

services to all enrollees in approved organizations' plans in such
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cancer center's service area under the prevailing terms and conditions that the approved organization requires of other similar providers to be included in the approved organization's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services;

(ii) dental and vision services as defined by the commissioner of health, and

(iii) as defined by the commissioner of health and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting.

(d) "Qualified health plan" means a health plan that meets the criteria for certification described in § 1311(c) of the patient protection and affordable care act (P.L. 111-148), and is offered to individuals through the NY State of Health, the official health Marketplace, or Marketplace, as defined in subdivision two of section two hundred sixty-eight-a of the public health law.

(e) "Basic health insurance plan" means a health plan providing health care services, separate and apart from qualified health plans, that is issued by an approved organization and certified in accordance with section three hundred sixty-nine-gg of this title.

(f) "1332 state innovation plan" means a standard health plan providing health care services, separate and apart from a qualified health plan and a basic health insurance plan, that is issued by an approved organization and certified in accordance with this section.

3. State innovation plan eligible individual. (a) A person is eligible to receive coverage for health care under this section if they:

(i) reside in New York state and are under sixty-five years of age;

(ii) are not eligible for medical assistance under title eleven of this article or for the child health insurance plan described in title one-A of article twenty-five of the public health law;

(iii) are not eligible for minimum essential coverage, as defined in section 5000A(f) of the Internal Revenue Service Code of 1986, or is eligible for an employer-sponsored plan that is not affordable, in accordance with section 5000A(f) of such code; and

(iv) have household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible noncitizens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this section if such noncitizen would be ineligible for medical assistance under title eleven of this article due to their immigration status.

(b) Subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this section who but for their eligibility under this section would be eligi-

ble for coverage pursuant to subparagraphs two or four of paragraph (b) of subdivision one of section three hundred sixty-six of this article,

shall be administratively enrolled, as defined by the commissioner of health, in medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

(c) Subject to federal approval, an individual who is eligible for and receiving coverage for health care services pursuant to this section is eligible to continue to receive health care services pursuant to this section during the individual's pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this section.

(d) For the purposes of this section, 1332 state innovation program eligible individuals are prohibited from being treated as qualified individuals under section 1312 of the Affordable Care Act and as eligible individuals under section 1331 of the ACA and enrolling in qualified health plan through the Marketplace or standard health plan through the Basic Health Program.

4. Enrollment. (a) Subject to federal approval, the commissioner of health is authorized to establish an application and enrollment procedure for prospective enrollees. Such procedure will include a verification system for applicants, which must be consistent with 42 USC § 1320b-7.

(b) Such procedure shall allow for continuous enrollment for enrollees to the 1332 state innovation program where an individual may apply and enroll for coverage at any point.

(c) Upon an applicant's enrollment in a 1332 state innovation plan, coverage for health care services pursuant to the provisions of this section shall be retroactive to the first day of the month in which the individual was determined eligible, except in the case of program transitions within the Marketplace.

(d) A person who has enrolled for coverage pursuant to this section, and who loses eligibility to enroll in the 1332 state innovation program for a reason other than citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage pursuant to this section, or failure to make an applicable premium payment, before the end of a twelve month period beginning on the effective date of the person's initial eligibility for coverage, or before the end of a twelve month period beginning on the date of any subsequent determination of eligibility, shall have their eligibility for coverage continued until the end of such twelve month period, provided that the state receives federal approval for using funds under an approved 1332 waiver.

5. Premiums. Subject to federal approval, the commissioner of health shall establish premium payments enrollees in a 1332 state innovation plan shall pay to approved organizations for coverage of health care services pursuant to this section. Such premium payments shall be established in the following manner:

(a) up to fifteen dollars monthly for an individual with a household income above two hundred percent of the federal poverty line but at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human

services for a household of the same size; and

(b) no payment is required for individuals with a household income at or below two hundred percent of the federal poverty line defined and

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annually revised by the United States department of health and human services for a household of the same size.

6. Cost-sharing. The commissioner of health shall establish cost-sharing obligations for enrollees, subject to federal approval, including childbirth and newborn care consistent with the medical assistance program under title eleven of this article. There shall be no cost-sharing obligations for enrollees for:

(a) dental and vision services as defined in subparagraph (ii) of paragraph (c) of subdivision two of this section; and

(b) services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision two of this section.

7. Rates of payment. (a) The commissioner of health shall select the contract with an independent actuary to study and recommend appropriate reimbursement methodologies for the cost of health care service coverage pursuant to this section. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of reimbursement methodologies, including but not limited to; the adequacy of rates of payment in relation to the population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards.

(b) Upon consultation with the independent actuary and entities representing approved organizations, the commissioner of health shall develop reimbursement methodologies and fee schedules for determining rates of payment, which rates shall be approved by the director of the division of the budget, to be made by the department to approved organizations for the cost of health care services coverage pursuant to this section. Such reimbursement methodologies and fee schedules may include provisions for capitation arrangements.

(c) The commissioner of health shall have the authority to promulgate regulations, including emergency regulations, necessary to effectuate the provisions of this subdivision.

(d) The department of health shall require the independent actuary selected pursuant to paragraph (a) of this subdivision to provide a complete actuarial report, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates for the 1332 state innovation plan authorized under this section. Such report shall be provided annually to the temporary president of the senate and the speaker of the assembly.

8. An individual who is lawfully admitted for permanent residence, permanently residing in the United States under color of law, or who is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15), and who would be ineligible for medical assistance under title eleven of this article due to their immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall be considered to be ineligible for medical assistance for purposes of paragraphs (b) and (c) of subdivision three of this section.

9. Reporting. The commissioner of health shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December thirty-first. The report shall include, at a minimum, an analysis of the 1332 state innovation program and its impact on the financial interest of the state; its impact on the Marketplace including

enrollment and premiums; its impact on the number of uninsured individuals in the state; its impact on the Medicaid global cap; and the demographics of the 1332 state innovation program enrollees including age and immigration status.

10. Severability. If the secretary of health and human services or the secretary of the treasury do not approve any provision of the application for a state innovation waiver, such decision shall in no way affect or impair any other provisions that the secretaries may approve under this section.

§ 4. The state finance law is amended by adding a new section 98-d to read as follows:

§ 98-d. 1332 state innovation program fund. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special fund to be known as the "1332 state innovation program fund".

2. Such fund shall be kept separate and shall not be commingled with any other funds in the custody of the state comptroller and the commissioner of taxation and finance.

3. Such fund shall consist of moneys transferred from the federal government pursuant to 42 U.S.C. 18052 and an approved 1332 state innovation program waiver application for the purpose implementing the state plan under the 1332 state innovation program, established pursuant to section three hundred sixty-nine-ii of the social services law.

4. Upon federal approval, all moneys in such fund shall be used to implement and operate the 1332 state innovation program, pursuant to section three hundred sixty-nine-ii of the social services law, except to the extent that the provisions of such section conflict or are inconsistent with federal law, in which case the provisions of such federal law shall supersede such state law provisions.

§ 5. Subparagraph (1) of paragraph (g) of subdivision 1 of section 366 of the social services law, as amended by section 43 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

(1) Applicants and recipients who are lawfully admitted for permanent residence, or who are permanently residing in the United States under color of law, or who are non-citizens in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15); who are MAGI eligible pursuant to paragraph (b) of this subdivision; and who would be ineligible for medical assistance coverage under subdivisions one and two of section three hundred sixty-five-a of this title solely due to their immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall only be eligible for assistance under this title if enrolled in a standard health plan offered by a basic health program established pursuant to section three hundred sixty-nine-gg of this article **or a standard health plan offered by a 1332 state innovation program established pursuant to section three hundred sixty-nine-ii of this article** if such program is established and operating.

§ 6. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 2023; provided that section three of this act shall be contingent upon the commissioner of health obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the

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treasury based on an application for a waiver for state innovation pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision 25 of section 268-c of the public health law. The department of health shall notify the legislative bill drafting commission upon the occurrence of approval of the waiver program in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART I

FULL PUBLIC NOTICE

Department of Health

New York Essential Plan Expansion

(Section 1332 State Innovation Waiver)

In compliance with 31 CFR 33.112 and 45 CFR 155.1312, notice is hereby provided that the New York State Department of Health (the State) intends to submit a Section 1332 State Innovation Waiver to the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (HHS) and the Department of Treasury (Treasury) for the expansion of the Essential Plan. This notice serves to open the 30-day public comment period on February 9, 2023, which closes on March 11, 2023.

Waiver Summary and Objectives

The State is requesting approval of the 1332 Waiver to expand Essential Plan coverage beyond the current eligible populations to include residents with incomes up to 250% of the FPL. Through this expansion of Essential Plan coverage, the State seeks to reduce the uninsured population in New York by increasing access to high quality, affordable health insurance for low- and moderate-income individuals.

Currently, the Essential Plan is federally designated as a Basic Health Program (BHP) under Section 1331 of the Affordable Care Act (ACA). The Essential Plan provides enrollees with comprehensive coverage with no premiums, no deductibles, and low-cost sharing. Essential Plan eligibility is currently limited to individuals who would have been eligible for state-only Medicaid prior to 2016 and individuals with incomes above the Medicaid ceiling and up to 200% of the FPL, ages 19 – 64, who would otherwise be eligible to purchase Qualified Health Plans (QHPs) and receive premium tax credits (PTCs) on the Exchange (NY State of Health).

Under the Waiver, the State is requesting to establish an identical Essential Plan program for currently eligible populations under Section 1332 Waiver authority, instead of Section 1331 of the ACA, with expanded eligibility to the new population. The Essential Plan under Section 1332 Waiver authority would continue to include coverage of all Essential Health Benefits (EHBs). The State is also requesting continued use of the BHP Trust Fund for the population traditionally eligible for the BHP under Section 1331 of the ACA.

Why is the Waiver Needed?

The State is not legally able to expand eligibility of the Essential Plan to new consumers under Section 1331 of the ACA. The Waiver is required to grant the State the federal authority necessary to expand Essential Plan coverage under Section 1332. To carry out its waiver plan, New York proposes to waive section 36B of the Internal Revenue Code, which creates the ACA's premium tax credit, as permitted under section 1332(a)(2) and will waive any other provisions the Departments deem necessary to implement this waiver plan. Waiving this provision is integral to the waiver plan and to eligibility for pass-through funding.

Waiver Impact

The change in federal authority for the Essential Plan from Section 1331 to Section 1332 will not have administrative or operational impacts for current Essential Plan consumers. All consumers enrolled in the Essential Plan with incomes up to 200% of FPL will continue to have no premiums, no deductibles, and current maximum out-of-pocket contribution levels. New consumers under the Waiver with incomes between 200% and 250% of the FPL will have $15 monthly premiums, no deductibles, and low out-of-pocket costs. These premium and cost sharing requirements are lower than the cost sharing available in the QHP marketplace. Additionally, eligibility and enrollment processes for current Essential Plan consumers will not change under the waiver. Consumers will continue to apply for and enroll in the Essential Plan and QHPs through the NY State of Health. New consumers in the Essential Plan will experience the same eligibility and enrollment processes that current consumers with incomes up to 200% of the FPL currently experience.

New York's 1332 Waiver is expected to generate substantial savings for the State and federal governments, while expanding coverage to additional of New Yorkers. The State is requesting that the BHP funding and the savings from foregone premium tax credits be passed through to the State to continue to fund the Essential Plan for the duration of the Waiver. The State projects that the federal passthrough will fully fund the expansion of the Essential Plan to the new eligibility group with no additional funding required from the State for the duration of the Waiver. The State is requesting continued access to the current Essential Plan Trust Fund balance under the Waiver, which will not increase the federal deficit, but will enhance benefits and lower costs for traditionally BHP eligible individuals.

The 1332 Waiver is projected to meet the four ACA Section 1332 guardrails of scope of coverage, affordability, comprehensiveness of coverage, and federal deficit neutrality.

Essential Plan Expansion 1332 Waiver Submission and Review of Public Comments

A draft of the waiver is available for review on the Department of Health's website at: https://info.nystateofhealth.ny.gov/1332. For individuals with limited online access and/or who require special accommodation, please call (518) 486-9102 to access paper copies.

The State will accept written comments through March 11, 2023. Individuals wishing to provide written comments may submit them online at https://info.nystateofhealth.ny.gov/1332 **or** by mail at:

NY State of Health
Empire State Plaza
Corning Tower
Room 2580
Albany, NY 12237

All comments must be submitted electronically or postmarked by March 11, 2023.

In addition to accepting written comments, the State will be hosting two virtual public hearings during which members of the public may provide verbal comments.

1. Public Hearing Option 1
    a. **Wednesday, February 22, 2023 at 1:00 PM**
    b. Pre-registration by February 20, 2023, is required for anyone wishing to provide verbal comment during the hearing using the following link: https://meetny.webex.com/weblink/register/r9b97d4c0bdb3d30931faaa9c44e913e1.
    c. Individuals who wish to provide comment will need to register with an "SP" in front of their name to indicate they want to speak (ex: SP Jane Doe) when registering for the WebEx meeting.
    d. Individuals will speak in the order of registration. All verbal comments will be limited to five minutes per presenter to ensure that all public comments may be heard.

2. Public Hearing Option 2
    a. **Thursday, February 23, 2023 at 12:00 PM**
    b. Pre-registration by February 21, 2023, is required for anyone wishing to provide verbal comment during the hearing using the following link: https://meetny.webex.com/weblink/register/r3769e6dcad0c4d2f9f27fbeee83e2fe7.
    c. Individuals who wish to provide comment will need to register with an "SP" in front of their name to indicate they want to speak (ex: SP Jane Doe) when registering for the WebEx meeting.
    d. Individuals will speak in the order of registration. All verbal comments will be limited to five minutes per presenter to ensure that all public comments may be heard.

The State will consider all written and verbal comments received and include a summary of the comments in the final 1332 Waiver Application submitted to the Departments.

NEW YORK STATE | Department of Health

New York Draft Section 1332 Waiver Application

Public Hearings on February 22, 2023 & February 23, 2023

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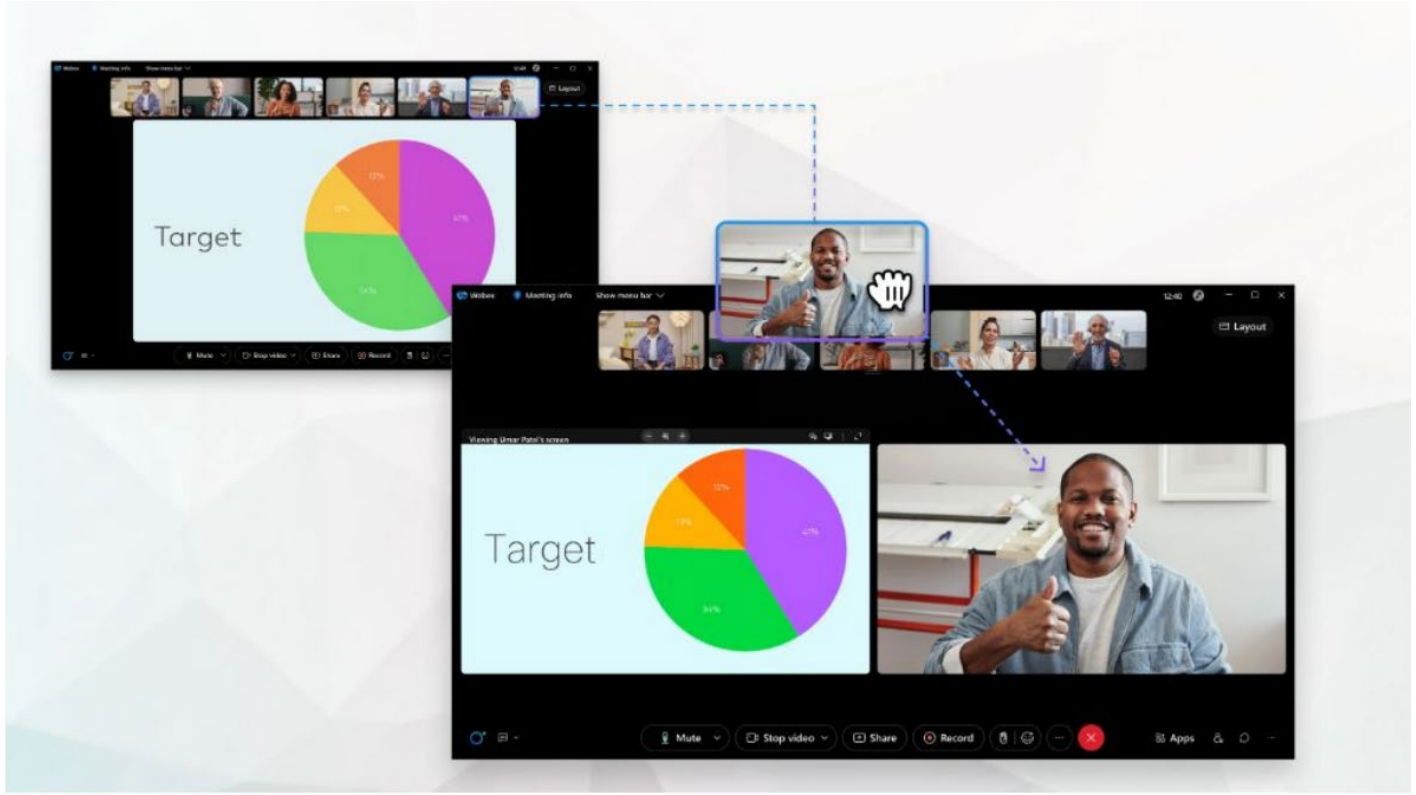
ASL Interpreters Are Available

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."



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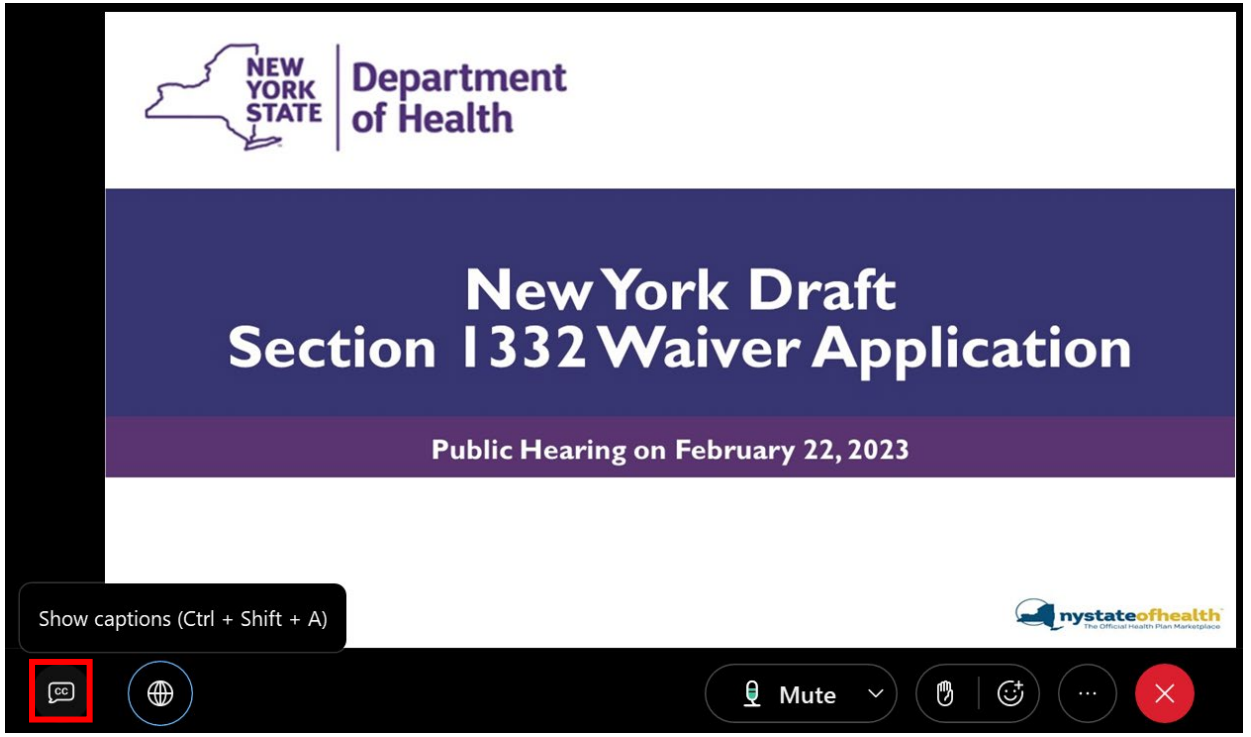
Closed Captions Are Available in English

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."



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Hay Intérpretes de Español en Vivo También

Para escuchar al intérprete de español, por favor:

1. Haga clic en el icono en el parte izquierda de su pantalla.
2. Elige español de la lista.
3. Desliza el círculo en la barra completamenta hacia la derecha.

Today's Agenda

Topic	Presenter
About the Public Hearing & Comment Instructions	Sonia Sekhar
About Section 1332 Waivers	Danielle Holahan
New York Draft 1332 Waiver Application	Sonia Sekhar
Open for Public Comments	Danielle Holahan
Closing Remarks	Danielle Holahan

About the Public Virtual Hearing

In compliance with social distancing guidelines due to COVID-19 and in alignment with approved CMS exceptions to satisfy the public hearing requirements in 42 CFR § 431.420(c), the State is holding two virtual public hearings. The purpose of the public hearings are to solicit comments on New York's Section 1332 Draft Waiver Application.

A recording and transcription of this public hearing will be available on the NY State of Health 1332 Waiver Information website (https://info.nystateofhealth.ny.gov/1332) within 5 – 7 days following this hearing. Language translation will also be available upon request.

The public may submit comments online at https://info.nystateofhealth.ny.gov/1332 or by mail through March 11, 2023. The State will consider all comments received before submitting a final 1332 Waiver Application the U.S. Departments of Health & Human Services and Treasury.

Instructions for Public Comment

1. If you have a question, **type your name and question into the Q&A.**
   - Questions will be answered throughout the presentation.
2. After the presentation, the line will be opened for public comment.
   - During registration, you were asked to indicate if you wished to provide a comment.
   - Registered commenters will be called upon to speak.
   - When your name is called, your line will be unmuted.
   - Commenters will be limited to five minutes to ensure everyone has an opportunity to comment.
3. Time permitting:
   - Registered commenters who were not able to finish their remarks will be granted a second opportunity to speak.
   - The line will be opened for others to provide comment. If you did not register and want to speak, please **enter your name** and affiliated organizations into the Q&A.

About Section 1332 Waivers

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1332 Waiver Overview

- 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.
- States submit 1332 Waiver Applications to the U.S. Department of Health & Human Services and U.S. Department of Treasury for review and approval.
- 1332 Waivers may be authorized for up to 5 years, with options to renew.
- States may request to redirect federal savings from the waiver to the state to administer the program (known as "**passthrough funding**").
- 17 states currently have approved 1332 Waivers (AK, CO, DE, GA, HI, ME, MD, MN, MT, ND, NH, NJ, OR, PA, RI, WA, WI).

Section 1332 Guardrails

For HHS and Treasury to approve a 1332 Waiver, the State must demonstrate that any changes under the waiver comply with the following four statutory guardrails:

- **Comprehensiveness:** The waiver must provide coverage at least as comprehensive as absent the waiver.
- **Affordability:** The waiver must provide protections against excessive out of pocket spending and be at least as affordable for consumers as absent the waiver.
- **Coverage:** The waiver must offer coverage to at least a comparable number of residents as absent the waiver.
- **Deficit Neutrality:** The waiver cannot increase the federal deficit.

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1332 Waiver Application Components

The following must be included as part of the State's 1332 Waiver Application:

1. Comprehensive description of the proposed program.
2. Evidence of enacted legislation and authority to implement the program.
3. List of provision(s) of the law that the State seeks to waive and the reasons.
4. Draft timeline for implementation.
5. An actuarial and economic analysis, including data and assumptions for 5- and 10-year projections which demonstrate compliance with the four statutory guardrails.
6. Additional information pertinent to the waiver.
7. Reporting targets.
8. Evidence of compliance with the public notice, comment, and Tribal consultation requirements.

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New York Draft 1332 Waiver Application

Goals of the 1332 Waiver

1. Expand coverage of the Essential Plan to include residents with **incomes up to 250%** of the federal poverty level (FPL).

2. **Reduce the uninsured population in New York** by increasing access to high quality, affordable health insurance for low- and moderate-income individuals.

3. Be deficit neutral for the federal government with the federal savings from the 1332 Waiver returned to the State to fund the program.

4. Continue to use the Essential Plan Trust Fund surplus to fund the program for consumer benefit.

Legislative Authority for the 1332 Waiver

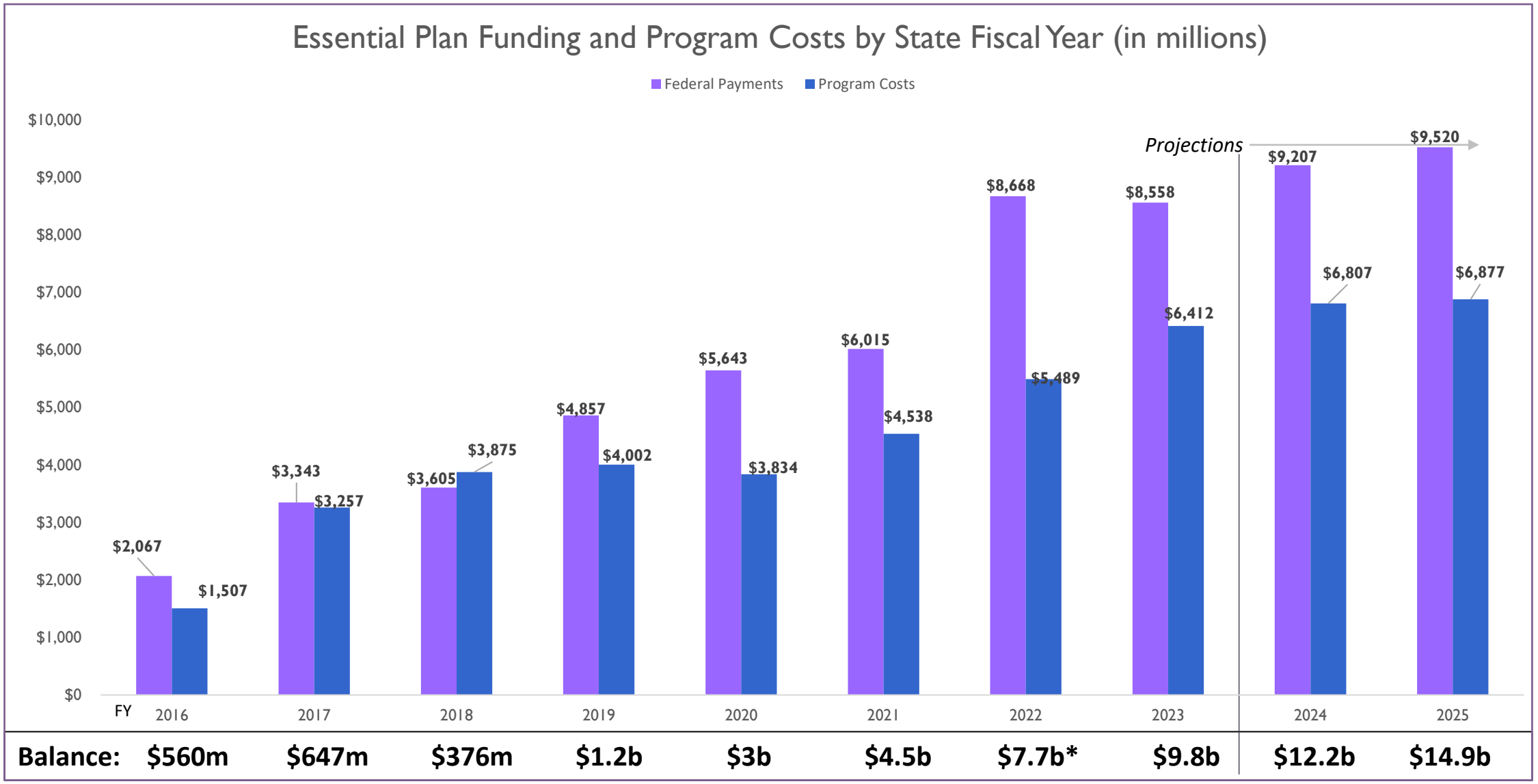
- The SFY 2023 Enacted Budget (passed through the NYS Assembly's Education, Labor and Family Assistance Bill on April 9, 2022) expanded eligibility up to 250% of the FPL, subject to federal approval.

- Legislation was introduced in the NYS SFY 2024 Executive Budget to expand eligibility of the Essential Plan to individuals up to 250% FPL under Section 1332 authority.

Background on the Essential Plan

- Currently, the Essential Plan is health insurance for residents up to 200% of FPL.
- Essential Plan members have comprehensive coverage with no premiums, no deductibles, and low cost-sharing.
- New York's Essential Plan is designated as a Basic Health Program (BHP) under Section 1331 of the Affordable Care Act (ACA); it provides an alternative to Qualified Health Plan (QHP) coverage for eligible consumers.
- As a BHP, New York receives annual federal funding for the program costs of the Essential Plan.
    - The Essential Plan program costs are fully funded by federal dollars through the Trust Fund.

Current Trajectory: Essential Plan Costs vs Funding



Balance:	$560m	$647m	$376m	$1.2b	$3b	$4.5b	$7.7b*	$9.8b	$12.2b	$14.9b

**Not yet certified.*

***Please note SFY 24-25 Program Costs do not reflect Executive Budget Proposals that have not been approved by EP Trustees.*

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Essential Plan Under the Waiver

Current Essential Plan Types (Continuing Under the 1332 Waiver)

Essential Plan 1	151 – 200% of FPL	$0 premium; $0 deductible; $2,000 max out of pocket
Essential Plan 2	139 - 150% of FPL	$0 premium; $0 deductible; $200 max out of pocket
Essential Plan 3	100 - 138% of FPL	$0 premium; $0 deductible; $200 max out of pocket
Essential Plan 4	< 100% of FPL	$0 premium; $0 deductible; $200 max out of pocket

Additional Plan Type (New Under the 1332 Waiver)

Essential Plan 200-250	201 - 250% FPL	$15 monthly premium; $0 deductible; $2,000 max out of pocket

Projected Impact for Consumers

Current Essential Plan Consumers

- No changes for current members.

Consumers Between 201 – 250% of FPL

- Currently, these consumers are eligible to buy Qualified Health Plans (QHPs) on the Exchange. They are eligible for Advance Premium Tax Credits (APTCs) to make premiums more affordable; however, these plans have significant deductibles and large out-of-pocket maximums ($1,625-$6,100+).
- Expected annual savings of $3,400 - $8,900. The average annual savings is $4,183.

Current and New Consumers

- Expected to benefit from a series of program improvements, including Social Determinants of Health interventions, further reductions in cost sharing, and expanded access to services.

Projected Enrollment

- Under the 1332 Waiver, 69,010 consumers between 201 – 250% of FPL who would otherwise enroll in QHPs are expected to enroll in the Essential Plan for 2024.
- Under the 1332 Waiver, 20,087 new consumers who would otherwise be uninsured are expected to gain coverage for 2024.
- Overall, enrollment in the Essential Plan and individual market is expected to increase under the 1332 Waiver compared to without the waiver by:
  - 1.6% for 2024
  - 2.2% for 2025
  - 2.1% for 2026
  - 2.1% for 2027
  - 2.1% for 2028

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Provisions the State is Seeking to Waive

- The State is requesting to suspend the current BHP for the duration of the waiver (2024 – 2028) and establish an identical Essential Plan under ACA Section 1332.
    - This is necessary because the State cannot expand the Essential Plan to new populations under ACA Section 1331.
    - Current Essential Plan consumers will not experience any cost increases or changes in their enrollment experience.
- The State is seeking to waive Section 36B(c)(2)(B) of the Internal Revenue Code (IRC) to allow the State to determine consumers between 0 – 250% of FPL eligible for the Essential Plan instead of for QHPs and APTCs on the Exchange.

Funding

- The State expects the Waiver to **be deficit neutral for the federal government,** while increasing the affordability of coverage and expanding coverage to additional New Yorkers.
- The State is requesting to use federal savings from forgone premium tax credits and federal spending on the current BHP to fund the Essential Plan under the 1332 Waiver.
- The State projects that federal funding will continue to fully fund the Essential Plan with the expanded eligibility for the 5 years of the waiver.
- The State would use any excess pass-through funding for program improvements, including Social Determinants of Health interventions, further reductions in cost sharing and expanded access to services.
- The State is also requesting continued access to the current Trust Fund balance for the Essential Plan.

Timeline

Activity	Date
Public Comment Period Begins	February 9, 2023
Public Hearing #1	February 22, 2023
Public Hearing #2	February 23, 2023
Tribal Consultation	February 28, 2023
Public Comment Period Ends	March 11, 2023
Target Submission of 1332 Waiver Application to HHS/Treasury	~April 7, 2023
Target Federal Waiver Approval	August 31, 2023
Target Implementation	**January 1, 2024**

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Open for Public Comments

Instructions for Public Comment

- Registered commenters will be called upon to speak.
- When your name is called, your line will be unmuted.
- Commenters will be **limited to five minutes** to ensure everyone has an opportunity to comment.
- Time permitting:
  - Commenters who were not able to finish their remarks will be granted a second opportunity to speak.
  - The line will be opened for others to provide comment. If you did not register and want to speak, please **enter your name** and affiliated organizations into the Q&A or **raise your hand** using this icon  .

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Additional Speakers

- If you did not register and want to speak, please **enter your name** and affiliated organizations into the Q&A or **raise your hand** using this icon  .
- When your name is called, your line will be unmuted.
- Commenters will be **limited to five minutes**.

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Closing

Closing

- The Draft 1332 Waiver is available online at https://info.nystateofhealth.ny.gov/1332.
- All comments must be submitted by March 11, 2023 to be considered.
  - Comments may be submitted online at https://info.nystateofhealth.ny.gov/1332.
  - Comment letters and attachments may be emailed to nysoh@health.ny.gov.
  - Comments may be mailed to:

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

Mailed comments must be postmarked by March 11, 2023.