New York Section 1332 Waiver Application Federal Questions and State Responses

Below are New York's responses to additional information as requested by the U.S. Department of Health and Human Services and the Department of the Treasury during the review of the waiver application.

Questions on the initial application:

Q1. Federal Question (5/18/2023): Does the 0.5% morbidity adjustment in the actuarial certification account for age and how does that works given that New York does not do age adjustments?

A1. State Response (5/23/2023): Yes, the 0.5% figure referenced on page 26 of the actuarial certification reflects the difference in age/gender factors between the on-exchange QHP market without the 200-250% cohort and the on-exchange QHP market with the 200-250% market, using the Society of Actuaries study referenced in the actuarial certification. This means that the QHP market could be ~0.5% more expensive after removing the 200-250% cohort (or in other words, the 200-250% FPL cohort is healthier on average than the remaining population) based on age/gender alone. Even though New York does not charge different premiums based on age, carriers would be expected to raise premiums across the market if a younger and healthier segment were to leave the market.

It is important to note that the 0.5% value is not used in calculating the impacts in the waiver or the assessment of waiver guardrails. Rather, this amount is included as another reference point for estimating potential impacts to premiums in the QHP market in addition to the MLR methodology which was used to estimate a 2.2% estimated premium impact. The 2.2% premium impact is a separate estimate of the premium impact and was used in the waiver since it would have a higher impact on federal spend.

Questions on the addenda:

Q1. Federal Question (8/3/23): **Under the waiver, NY projects that total individual market enrollment will decline by 23% (loss of 70,669 people) in 2024 and by 24% (loss of 65,972 people) in 2028 (PDF pg. 16). Of the 70,669 leaving the individual market in 2024, 3,020 are unsubsidized on-/off-Exchange and 67,648 are subsidized on-Exchange.**

- **Please confirm that the 3,020 is composed of people >600% FPL (1,596 people) and those who do not report their income (1,425 people).**

A1. State Response (8/8/2023): Yes, that is correct. Estimated enrollment from consumers above 600% FPL decreased by 1,596 people from 13,641 to 12,045 in 2024 and those who do not report their income decreased 1,425 people from 52,482 to 51,057 in 2024.

Q2. Federal Question (8/3/23): **Under the waiver in 2024, among the subsidized on-Exchange population, NY projects that 34 people below 150% FPL will lose coverage (33**

people below 139% FPL + 1 person 139-150% FPL), and that 7 people at 151-200% FPL will lose coverage (Tables A8 & A9, PDF pg. 67).

- **Please clarify why these individuals are not assumed to be/move in the BHP and instead are losing coverage?**

A2. State Response (8/8/2023): The slight differences observed are due to the methodology for allocating estimated enrollment by income band and are not reflective of an explicit assumption or expectation that consumers below 200% FPL would lose coverage under the waiver. Consumers buying on-exchange under 250% FPL are those above age 65.

Urban Institute provided with and without waiver total estimated enrollment for the subsidized on-exchange population in NY and the projected 200-250% FPL group migrating to the EP. The projection for total enrollment for the subsidized on-exchange population was split out between FPL bands based on an assumed enrollment distributions from 2022 state exchange data.

When removing the 200-250% FPL group from the individual market under the waiver, the remaining subsidized, on exchange membership was redistributed based on the 2022 distribution of membership across FPL bands, which is why the difference is observed. We have noted that the decrease in membership observed in Tables A8 and A9 for the subsidized on-exchange population <200% FPL (41 total members) is approximately 0.4% of total without-waiver enrollment (9,569 members). Based on the 0.4% difference and the data available when estimates were made, this methodology was determined to be reasonable.

Q3. Federal Question (8/3/23): **NY projects that with-waiver EP enrollment will increase by 9% (89,250 people) in 2024 and by 8% (93,830 people) in 2028; the people in this group are all at 200-250% FPL (Tables A8 & A9). In another part of the application, NY also notes that 21,602 new consumers will gain coverage in 2024 (PDF pg. 19, 43).**

- **To clarify, is the 21,602 referencing previously uninsured consumers who are gaining with-waiver EP coverage? And the difference between 89,250 and 21,602 being 67,648—does this represent the number of people who are migrating from the QHP to the with-waiver EP?**

A3. State Response (8/8/2023): The 21,602 individuals noted were comprised of an estimated 20,240 individuals between 200-250% FPL who gain coverage through the EP in FY 2024. Another 1,361 (33 individuals 300-400% FPL and 1,328 above 400% FPL) are estimated to gain coverage in the individual market in FY 2024.

The 89,250 increase in with-waiver enrollment is comprised of 20,240 individuals who were previously uninsured and 69,010 individuals who are estimated to migrate from the QHP to the with-waiver EP.

Q4. Federal Question (8/3/23): **Over the 5-year waiver, NY projects that the total number of consumers impacted is an average of 93,953 per year, including those migrating from the QHP market and those that enter the market due to the waiver (PDF pg. 41-42). NY projects that an average of 65,109 consumers per year migrating from the QHP market**

will experience a cost savings of $4,200 per year, resulting in $1.4B over the waiver (PDF pg. 19, 42).

- **The difference between 93,953 and 65,109 being 28,844, does this represent the average number of people per year who enter the individual market under the waiver? Isn't the individual market losing enrollment during the waiver?**

A4. State Response (8/8/2023): The 28,844 individuals per year represents the number of individuals who were previously uninsured who gained coverage through the EP from 2024-2028.

Q5. Federal Question (8/3/23): **Please clarify if the 65,109 represents only consumers at 200-250% FPL?**

A5. State Response (8/8/2023): Yes, the 65,109 represents only consumers at 200-250% FPL.

Q6. Federal Question (8/3/23): **Please clarify if the 65,109 is only being used in reference to the consumers who will realize $4200 savings? Such that there are x number of other consumers who are newly covered under the with-waiver EP, but who will not realize the $4200 savings since they were previously uninsured anyways?**

A6. State Response (8/8/2023): The average annual savings of $4,200 per person is realized by the 65,109 individuals per year. The remaining 28,844 individuals per year are previously uninsured and do not realize savings.

Q7. Federal Question (8/3/23): **Under the waiver, NY projects that an average of 100,054 unsubsidized on- & off-Exchange consumers who are >250% FPL will be impacted by a 2.2% premium increase, which translates to an average cost increase of $259 per person per year from 2024-2028 (PDF pg. 21). Once the IRA expires, NY projects that an average of 123,238 unsubsidized on- & off-Exchange consumers who are >400% FPL will be impacted by an average cost increase of $257 per person per year from 2026-2028 (PDF pg. 42).**

Are the $259 and $257 cost increases representing just the 2.2% premium increase, or do they also include out-of-pocket costs? If they don't include out-of-pocket costs, please provide estimates.

A7. State Response (8/8/2023): The cost increases noted only represent the 2.2% premium increases. Out-of-pocket costs (i.e., copays/coinsurance/deductibles paid by the member) are not expected to change due to the waiver because the benefit structure in the individual market is not expected to change as a result of the waiver.

Q8. Federal Question (8/3/23): **The state notes that the premium increase for the individual market is 2.6-2.8% (pg 16). The application also notes 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. Can the state explain what other factors or impacts they are attributing to the premium increase aside from the 0.5-2.2%?

A8. State Response (8/8/2023): The assumed 2.2% increase was applied to premiums across all metal levels. When weighted for enrollment, the market wide average premium increases 2.6-2.8% because enrollment for the migrating 200 – 250% group is concentrated in lower metal tiers, without the waiver, which have lower premiums.

Q9. Federal Question (8/3/23): **One of the comments noted that the State asserts that it must charge a premium for adults at this income level (200-250%) because children at the same income levels pay a premium in the Child Health Plus (CHP) program. Can the state explain this further?**

A9. State Response (8/8/2023): The State is not required to set premiums for the 200 – 250% of FPL EP group under the waiver equal to CHP premiums. However, from an equity perspective, the State does not want costs to be higher for children than adults at similar income bands. Under CHP, children from 222 – 250% of FPL require a $15/month premium.

Q10. Federal Question (8/3/23): **The State notes that there is more than 95% overlap between existing QHP and EP provider networks, but some commenters expressed that there be ways to mitigate any impact, such as enhanced temporary flexibilities for certain enrollees to continue receiving care at formerly in-network providers who are now out of-network. Did the state consider this suggestion and are there other ways the state plans to mitigate changes in provider networks?**

A10. State Response (8/8/2023): New York State Insurance Law §§ 3217-d(c), 4306-c(c), and 4804(f) and Public Health Law § 4403(6)(f) impose obligations on issuers when a new insured's provider is not a member of the issuer's network. Specifically, these sections require an issuer to permit an insured to continue an ongoing course of treatment with the insured's current provider during a transitional period of up to 60 days from the effective date of enrollment, if: (1) the insured has a life-threatening disease or condition or a degenerative and disabling disease or condition; or (2) the insured has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period must include the provision of post-partum care directly related to the delivery.

In addition to the insurance law provisions listed above, Essential Plan Members are able to change their Health Plan at any point during the year, giving the member the option to move to a plan that does cover their preferred provider. This flexibility should drastically reduce any risk of members being unable to continue receiving care if their provider(s) were in their QHP network, but are not in their new EP network. Lastly, members can always request single case agreements through their insurance companies, in order to continue seeing a provider who is not in-network.

Q11. Federal Question (8/8/23): **Commenters recommended that there should be a plan to mitigate the QHP market impact, including structural changes to ensure that plans remain in the market over time. Has the state considered ways to mitigate the impact to the individual market?**

A11. State Response (8/10/2023): The State has evaluated several options to mitigate the 1332 waiver impact on the individual market with having the 200 – 250% of FPL population transition out of the market to the Essential Plan. These options included a reinsurance program, a state subsidy for consumers, and a retroactive insurer reimbursement. After evaluating the benefits and challenges of each option, the State has decided to use some of the surplus passthrough funding for PY 2024 to provide a reimbursement to insurers in lieu of approving the higher, with waiver individual market rates for PY 2024. Under this scenario DFS will approve insurers' without waiver rates for PY 2024, which has several benefits:

- **Lowers Premiums for Consumers:** Consumers in the individual market will not experience an increase in premiums based on the wavier. This means there is no difference in affordability for consumers in the individual market with and without the waiver. It also means that there is no longer an expected decrease in enrollment in the individual market due to the waiver.

- **Makes Insurers Whole:** Insurers will be provided a reimbursement for the lost revenue under the waiver in lieu of passing along increased costs to consumers in the form of higher premiums.

- **Increases Passthrough for New York:** Expected federal spend on APTC/PTC for consumers is no longer expected to increase due to the waiver (since premiums do not increase because of the waiver), which means there will no longer be an offset to the State's passthrough.

Q12. Federal Question (8/8/23): **For the option to provide carriers with a subsidy retroactively if carriers demonstrate they were impacted by the premium increase, can the State provide more info on how the carriers would demonstrate that impact?**

A12. State Response (8/10/2023):One approach the State is considering is to pay the carriers retrospectively based on actual experience. Using this potential approach, to calculate the insurer reimbursement, the State will require insurers to provide data including member months, paid premiums, allowed claims, and paid claims, for the individual market population and compare those data to 2023 to determine their losses that have resulted from the migration of the 200-250% of FPL population out of the individual market.

Q13. Federal Question (8/8/23): **How much is the State estimating this option would cost for PY 2024?**

A13. State Response (8/10/2023): Based on the 1332 waiver actuarial and economic analysis, the State estimates the total insurer reimbursement for PY 2024 will be approximately $43.6M. This assumes a 6.2% growth in premiums in the market from 2023 to 2024 without waiver. However, actual rate filings from insurers for 2024 were higher than waiver projections. Rates have not yet been finalized by DFS, but based on preliminary data, the State is estimating the reimbursement to be between $46.0 and $58.8M for 2024 based on the approved with and without waiver rate increases and enrollment.

Q14. Federal Question (8/11/23): **For the group of subsidized on-Exchange individuals <150% FPL who are projected to lose coverage under the waiver, please further clarify that the model produced this output based on income projections (not eligibility), and include a footnote as an update to the application to clarify.**

A14 State Response (8/15/2023): This will be addressed as a footnote in the updated actuarial analysis. Please see the updated language below for a revised response to question #2 which was asked on 8/3/2023.

Q15. Federal Question (8/11/23): **For the following EP investments that NY plans to continue under the waiver and spend pass-through funding on (with the exception of LTSS being a new program investment under the waiver), is there some fungibility with how much the state would allocate across these programs under the waiver?**

- **Reduction in member cost sharing (affordability for with-waiver EP enrollees) – $100-$128M annually in 2024-2028**
- **Quality Incentive Pool for issuers – $225M annually in 2024-2028**
- **Community-based LTSS - $0 in 2024 and $131-$155M annually in 2025-2028**
- **Provider rate adjustments (provider reimbursements) – $800M annually in 2024-2028**
- **SDoH/BH grant program – $25M annually in 2024-2028**

A15. State Response (8/15/2023): The amounts included in the waiver application for the EP investments listed above were allocated and approved by the EP Board of Trustees. The EP Trustees' intention is to disburse/incur the amounts as budgeted, however, the Trustees may change the amounts in the future based on changes to the Essential Plan or external factors.

In terms of the allocation across years of the waiver, the amounts shown across years are the same for the Quality Incentive Pool, Provider Rate Adjustments, and SDoH/BH, as these programs were approved for funding by the EP Trustees at a consistent level year-over-year. Amounts for the LTSS program and reductions in member cost sharing were trended forward to future years, as noted in Section 4.8 of the waiver actuarial analysis.

Q16. Federal Question (8/11/23): **If the State approves without-waiver rates, the Departments will want a concrete way to validate whether the waiver did not, in fact, impact premiums. Will there be a way for insurers to prove to the State and for the Departments to verify that rates were set based on a risk pool that would include individuals 200 to 250% of FPL (i.e., a without-waiver risk pool)? What information will be available to verify that the rates are in fact not impacted by the waiver, and what approach would be used to do so?**

A16. State Response (8/15/2023): This question will be addressed as part of the 1332 waiver addendum implementation plan.

Q17. Federal Question (8/3/23) **State Updates to Question #2 Asked on 8/3/2023: Under the waiver in 2024, among the subsidized on-Exchange population, NY projects that 34 people**

below 150% FPL will lose coverage (33 people below 139% FPL + 1 person 139-150% FPL), and that 7 people at 151-200% FPL will lose coverage (Tables A8 & A9, PDF pg. 67).

- **Please clarify why these individuals are not assumed to be/move in the BHP and instead are losing coverage?**

A17. State Response (8/15/2023): The slight differences observed are due to the methodology for allocating estimated enrollment by income, and do not reflect any changes in eligibility for this population that would cause consumers below 200% of FPL to lose coverage. Consumers with income below 250% FPL who are projected to buy on-exchange QHP coverage are those above age 65.

Urban Institute provided with and without waiver total estimated enrollment for the subsidized on-exchange population in NY and the projected 200-250% FPL group migrating to the EP. The projection for total enrollment for the subsidized on-exchange population was split out between FPL bands based on an assumed enrollment distributions from 2022 state exchange data.

When removing the 200-250% FPL group from the individual market under the waiver, the remaining subsidized, on exchange membership was redistributed based on the 2022 distribution of membership across FPL bands, which is why the difference is observed. We have noted that the decrease in membership observed in Tables A8 and A9 for the subsidized on-exchange population <200% FPL (41 total members) is approximately 0.4% of total without-waiver enrollment (9,569 members). Based on the 0.4% difference and the data available when estimates were made, this methodology was determined to be reasonable.

Q18. Federal Question (8/14/23): **For the 200-250% population: NY projects an average of 65,109 consumers per year who will each see an average savings of $4,200 ($2,250 in premiums and $1,950 in out-of-pocket spend). Is the $2,250 in premiums in terms of *gross premiums* (total premium paid by a combo of APTC and enrollee contributions)? If so, then the per enrollee's savings are much smaller than $2,250, and what would the projection be instead?**

A18. State Response (8/18/2023): **State Response:** The $2,250 in premiums savings reflects the average annual premium savings from the enrollee contribution portion of the gross premiums.

Q19. Federal Question (8/15/23): **In 2024, an individual at 250% of FPL will have an annual expected contribution of $1,458 under the PTC subsidy schedule (i.e., 4% of $36,450). An individual at 201% of FPL will only have an annual expected contribution of $597.84 (2.04% of $29,305.80). Under the waiver, these individuals will be required to pay premiums totaling $180 annually. This means that an individual who would otherwise purchase the SLCSP would save ~$417 to ~$1,278 annually on premiums. Individuals in bronze plans would save much less. Unless everyone in this income bracket is purchasing up to gold, for example, it doesn't seem possible that each of these consumers will save $2,250 in annual enrollee contributions on average.**

A19. State Response (8/18/2023): The $2,250 reflects the estimated weighted average member premium savings for the 200-250% population across the 5-year waiver period for Scenario A. Please see the table below for an illustration of this figure:

Annual Amounts for 200-250% Population	**2024**	**2025**	**2026**	**2027**	**2028**
WoW Estimated QHP Member Premium	$2,191	$2,235	$2,538	$2,588	$2,640
WW EP Member Premium	$180	$180	$180	$180	$180
Savings (WoW Minus WW)	$2,011	$2,055	$2,358	$2,408	$2,460
Projected WoW Enrollment	69,010	69,122	62,093	62,470	62,849
Weighted Avg. Savings (Rounded):					**$2,250**

The amounts for the WoW Estimated QHP Member Premium (the first row in the table above) were developed using actual 2022 detailed QHP enrollment and premium data, which was provided by NYSoH. The amounts reflect the difference between the average gross premium amount (across all plans and metal levels) and the average premium subsidy amount (across all plans and metal levels). This amount was then trended forward to 2024 and beyond based on the growth in estimated member premiums for each year.

While this savings figure is larger than the numbers referenced in your question, it includes the impact of savings for members who would have chosen plans more expensive than the SLCSP without the waiver (including gold, platinum, and other silver plans more expensive than SLCSP). In 2022, ~59% of the 200-250% QHP population enrolled in Silver plans, ~8% enrolled in Gold plans, and ~4% enrolled in Platinum plans.

Q20. Federal Question (8/16/23): **Under the waiver, the OOP max is $2,000 for individuals 200-250% of FPL. The application also indicates that the average OOP spend will be $600 for this population in the waiver scenario (table A12). Please clarify is $1,950 the OOP cost savings that these individuals will experience on average?**

A20. State Response (8/18/2023): Yes, the $1,950 is the estimated weighted average OOP cost savings for the 200-250% population across the 5-year waiver period for Scenario A. This weighted average calculation was done similarly to the calculation for premium savings above, with the WoW QHP cost sharing compared to the WW EP cost sharing.

Q21. Federal Question (8/17/23): **How was the 11% of income figure calculated (Appendix Table A1)?**

A21. State Response (8/18/2023): The 11% figure is calculated by taking the $4,200 total average estimated savings ($2,250 premium + $1,950 out-of-pocket spend) divided by the projected income for 250% of the FPL, ($37,908) which equals $14,580 (2023 100% FPL level) times 1.04 (assumed income growth for 2024) times 250%.

Q22. Federal Question (8/22/23): **The adjustment factor the state displays for use in the estimated reimbursement for effects of the waiver are developed in aggregate across all issuers in the individual market. Will the state apply a single factor to all issuers when they calculate the reimbursement payment?**

A22. State Response (8/24/2023): The state will use company specific factors that represent the difference between each company's 2024 DFS approved "with" and "without" waiver premium rates to calculate the reimbursement payment.

Q23. Federal Question (8/22/23): **Is the state directing insurers to account for the issuer reimbursements? Or to set rates that reflect the inclusion of those 200 to 250% of FPL even though they are moving to the EP? Is this something you have thought about?**

A23. State Response (8/24/2023): The state has already accounted for the issuer reimbursements by having approved 2024 premium rates that do not reflect the impact of the waiver (i.e., the 2024 approved premium rates assume that the 200-250 FPL population will remain in the individual market as opposed to migrating to the EP).

Q24. Federal Question (8/23/23): **Does the EP reimburse premiums and cost sharing separately? OR is it just that the plan design just includes low cost-sharing), so I've added "if applicable" throughout.**

A24. State Response (8/24/2023): The State pays the full premium amount to EP carriers for all EP populations except for the 200-250% expansion population, which has a $15 monthly member premium. The cost-sharing levels are part of the plan design for EP and the monthly capitation rates paid to insurers take the cost sharing levels into account. Issuers are not separately reimbursed for cost-sharing.

Q25. Federal Question (8/23/23): **We wanted to confirm the with-waiver OOP max for the 200-250% population? It seems like the state says the OOP max is $2,000 in the waiver scenario and New York also says the average OOP spend will be $600 for this population in the waiver scenario (table A12). Is $1,950 the OOP cost savings that these individuals will experience on average?**

A25. State Response (8/24/2023): Yes, the 200-250% expansion cohort will have a $2,000 OOP max in EP under the waiver. The $1,950 reflects the estimated weighted average member out-of-pocket savings for the 200-250% population across the 5-year waiver period for Scenario A. Please see the table below for an illustration of this figure:

Annual Amounts for 200-250% Population	**2024**	**2025**	**2026**	**2027**	**2028**
WoW Estimated QHP Member OOP Costs	*$2,540*	$2,661	$2,789	$2,923	$3,063
WW EP Member OOP Costs	*$741*	$776	$814	$853	$893

Savings (WoW Minus WW)	$1,799	$1,885	$1,976	$2,071	$2,170
Projected WoW Enrollment	69,010	69,122	62,093	62,470	62,849
				Weighted Avg. Savings (Rounded):	$1,950

The amounts for the estimated out-of-pocket costs under the QHP (WoW) and EP (WW) were developed using actual 2022 detailed QHP enrollment and premium data, which was provided by NYSoH, along with assumptions for the estimated Medical Loss Ratio for the 200-250% population and the estimated actuarial value (paid claims / allowed claims) for the QHP market (WoW) vs. the EP (WW). These amounts were applied to the estimated gross premium amounts (consistent with our response detailing the development of the $2,250 savings figure on 8/18) and trended forward to 2024 and beyond based on the growth in estimated member premiums for each year.

Q26. Federal Question (9/5/23): **Why is there a slight increase in enrollment in the individual market in Tables E8 and E9m compared to without the waiver for the unsubsidized population?**

A26. State Response (9/5/2023): The slight increase in the enrollment is driven by an increase in unsubsidized on-exchange individuals. This is due to a "woodwork effect" in which the increased awareness and attention with the implementation of the waiver and related state outreach efforts is likely to reach other uninsured individuals aside from those 200-250% of FPL. The health status of these individuals is assumed to be equivalent to those who are unsubsidized buying on-exchange today, thus an adjustment was not made to the premium PMPM. However, aggregate premiums for the market reflect the increased enrollment with and without waiver.

Q27. Federal Question (9/5/23): **Can you also confirm that this is also why there's an increase in subsidized Exchange enrollment?**

A27. State Response (9/5/2023): Yes, it's the same reason why we see a slight increase in those above 250% of FPL buying on exchange with the waiver.

Q28. Federal Question (9/5/23): **Some commenters offered alternative suggestions for addressing potential risk pool impacts of the waiver such as leveraging reinsurance or other methods like risk adjustment to provide stability for issuers using a more established methodology. Is this something the state considered previously or would consider for future years?**

A28. State Response (9/6/2023): The State may consider alternate options in future years to offset the waiver's impact on the individual market, such as a risk adjustment or reinsurance

program. Due to the complexity of implementing those programs, the State decided to include an Insurer Reimbursement Implementation Plan, but plans to explore other options for future waiver updates.

Q29. Federal Question (9/5/23): **Could the state share more information on how it engaged with stakeholders regarding the IRIP? Prior to submission and during the federal comment period?**

A29. State Response (9/6/2023): The State engaged with stakeholders during the federal comment period to discuss and revise the Insurer Reimbursement Implementation Plan (IRIP). This engagement included a series of calls (on August 11, August 17, and August 18) with representatives from the Departments of Health and Financial Services and New York's Health Plan Associations to describe the IRIP with a focus on how the IRIP would impact the premium rates paid to health plans. During the federal comment period, the state notified consumer groups, health plan associations, and health provider associations that the IRIP Addendum to the 1332 waiver had been submitted and that CMS opened a public comment period and encouraged these groups to review and comment on the plan. In addition, the state engaged with representatives from a NYS Provider Association on August 24, from a Consumer Advocacy organization on August 29, and responded to questions from a NYS Senate/Health Committee Office on August 30 about the IRIP.

Q30. Federal Question (12/11/2023): **What are the differences in benefits for pregnant people enrolled in the EP as compared to Medicaid? We understand there is no NEMT benefit for Medicaid-eligible pregnant people enrolled in the EP. Are there any other differences?**

A30. State Response (12/12/2023): All current EP members with incomes at or below 138% of FPL receive Non-Emergency Medical Transportation benefits today. We would continue that coverage and will align the full Medicaid benefit package to pregnant individuals, including the NEMT benefit, to those who are pregnant and in EP. The intent is to align all benefits and cost-sharing. The intent is to also provide a Common Benefit Identification Card (CBIC) card to this group for wraparound benefits.

Q31. Federal Question (12/11/2023): **What are the differences in cost-sharing for pregnant people enrolled in the EP as compared to Medicaid?**

A31. State Response (12/12/2023): Currently there is alignment in cost-sharing for EP levels 2-4, so we would align cost-sharing for the EP 1 and EP 200-250 group.

Q32. Federal Question (12/11/2023): **Would the $2,000, $360, and $200 (Rx only) cost sharing requirements apply to pregnant individuals in households over 138% FPL?**

A32. State Response (12/12/2023): We are adding an identifier to the 834 enrollment transactions to health plans so they know when a EP member is pregnant and would direct them to charge no more than the maximum out-of-pocket cost limits that would have applied had they been in Medicaid. This draft guidance would be disseminated to plans in January, and finalized

when the waiver is approved. All of the EP issuers also participate in Medicaid Managed Care so should be able to handle this change for pregnant members.

Q32. Federal Question (12/11/2023): **Are there any other differences?**

A32. State Response (12/12/2023): No.

Q32. Federal Question (12/11/2023): **What will the enrollment process/hierarchy be for new applicants who are pregnant people in households 138 - 250%FPL (NOT currently enrolled in the EP or Medicaid, but applying for coverage)?**

A32. State Response (12/12/2023): These enrollees will default to Medicaid if their incomes are at or below 223% of FPL. This proposal is only intended for individuals already enrolled in EP who become pregnant.

Q32. Federal Question (12/11/2023): **Will these new enrollees default to Medicaid or the EP?**

A32. State Response (12/12/2023): Medicaid, if their incomes are at or below 223% of FPL.

Q33. Federal Question (12/12/2023): **It is our understanding that EP enrollees in the Aliessa categories/tiers have access to NEMT and other services through the EP. What other benefits are provided to this group that are not available to other coverage categories?**

A33. State Response (12/13/2023): The following benefits are provided as wrap-around to EP coverage for the Aliessa population and would also be provided to the DACA population (with incomes up to 138% of FPL, or 223% of FPL for pregnant individuals): Foot Care Services, Orthopedic Footwear, additional benefits available through the Family Planning Benefit Program and Non-prescription Drugs (Over-the-Counter or OTC) , medical supplies, and hearing aid batteries when ordered by a licensed Provider.

Q34. Federal Question (12/12/2023): **Will newly eligible enrollees who are ineligible for Medicaid due to their immigration status (e.g. 5-year-bar folks in households earning 200-250%FPL) be eligible for NEMT and other wrap around benefits?**

A34. State Response (12/13/2023): Eligibility for wrap services depends on an individual's income. If they are in the Medicaid eligibility range (typically up to 138% of FPL for most adults), they will receive the wrap benefits through Essential Plan 3 or 4. If their income is above 138% of FPL, they will not receive wrap benefits. Wrap benefits are typically only available to immigrants in the 5-year bar who would otherwise have been Medicaid eligible if not for their immigration status.

Q35. Federal Question (12/12/2023): **Would DACA enrollees (both those currently enrolled in the state-funded Medicaid lookalike program and newly eligible DACA recipients) be eligible for these wrap around benefits?**

A35. State Response (12/13/2023): DACA enrollees who would be otherwise eligible for Medicaid, if not for their immigration status, will be eligible for wraparound benefits. DACA enrollees who would not otherwise be eligible for Medicaid due to their income, for example, would not be eligible for wraparound benefits.

Q36. Federal Question (12/12/2023): **Are pregnant women who are immigrants eligible for these additional benefits if they remain in the EP Expansion? This may overlap with your responses to our questions on the pregnancy choice option. If that's the case, no need to respond twice.**

A36. State Response (12/13/2023): We will align the full Medicaid benefit package for pregnant individuals to those who are pregnant and in EP.

Q37. Federal Question (12/12/2023): **Which cost sharing structure would apply to DACA recipients, pregnant women who are immigrants, and newly eligible immigrants who are not eligible for Medicaid?**

A37. State Response (12/13/2023): Our intent is to align cost-sharing structure for DACA recipients who are not pregnant based on their incomes. They would be enrolled in the EP level that aligns with their incomes. For pregnant individuals, we will direct health plans to align the cost-sharing structure with Medicaid Managed Care for pregnant individuals.

Q38. Federal Question (12/13/2023): **What is meant by "The intent is to align all benefits and cost-sharing." What would prevent this alignment?**

A38. State Response (12/13/2023): EP 3 & 4 are already aligned with Medicaid. For EP 1 & 2, New York will align all benefits and cost-sharing with Medicaid for pregnant individuals. We are still working through the operational details and plan to provide timely guidance to EP health plans so they can make appropriate system updates.

Q39. Federal Question (12/13/2023): **What are the benefits included in the wraparound benefits on the CBIC other than NEMT?**

A39. State Response (12/13/2023): See #38 above.

Q40. Federal Question (12/13/2023): **Any preliminary responses to our questions on coverage for the DACA population**

A40. State Response (12/13/2023): See #38 above.

Q41. Federal Question (12/21/2023): In Appendix Tables C1 and D1, why are you showing only about half the enrollment growth in PY 2024 compared to what you are estimating for PY 2025?

A41. State Response (12/22/2023): Under Scenario D, the overall enrollment for the Essential Plan and individual market is expected to increase by a combined 2.4% for PY 2024, 3.9% for

PY 2025, 4.0% for PY 2026, 3.9% for PY 2027, and 3.9% for PY 2028. These percent increases are based on the average monthly enrollment for the Plan Year after the Waiver is implemented. There are two drivers for the 2.4% difference in PY 2024 compared to the 3.9% different in PY 2025.

1. The pregnancy choice provision is expected to have a 17-month ramp up based on the estimated timing of reported pregnancies after the waiver is effective. In 2026, it is estimated the Essential Plan will reach a steady state with approximately 14,000 individuals in the Essential Plan who would otherwise have been in the Pregnancy Medicaid. This is also what is driving the difference in enrollment growth between 2024 and 2025 in Scenario C.
2. The DACA provision is only in effect for the last four months of 2024. Starting in August, approximately 13,000 DACA recipients will move from Medicaid to the Essential Plan. However, when you take the average monthly enrollment in the Essential Plan under the Waiver for 2024, this is less than it would be in 2025 due to the implementation delay.

Q42. Federal Question (12/21/*2023*): Question: Can you please provide the estimated enrollment growth under the waiver specifically from the uninsured population for Scenario D?

A42. State Response (1/2/2024):

Change in Previously Uninsured With- vs. Without-Waiver

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
On/Off-Exchange	71	104	3	5	6	8	10	11	13	14
Catastrophic	0	0	0	1	1	1	1	1	2	2
Bronze	26	39	1	1	1	2	2	3	3	3
Silver	29	42	0	1	1	1	2	2	2	2
Gold	9	14	1	1	1	2	2	3	3	3
Platinum	6	10	1	1	2	2	2	3	3	4
EP	13,180	20,437	20,516	20,511	20,506	20,501	20,496	20,490	20,484	20,479
EP1	164	592	710	725	740	756	771	787	803	820
EP2	47	169	203	207	211	216	220	225	230	234
EP3	13	13	13	13	14	14	14	15	15	15
EP4	71	72	73	75	76	78	79	81	83	84
EP5	10,546	17,075	17,000	16,974	16,948	16,922	16,894	16,866	16,838	16,809
DACA	2,340	2,516	2,516	2,516	2,516	2,516	2,516	2,516	2,516	2,516
Preg Medicaid	0	0	0	0	0	0	0	0	0	0
Previously Uninsured Covered Under the Waiver:	**13,250**	**20,541**	**20,519**	**20,516**	**20,512**	**20,509**	**20,505**	**20,501**	**20,497**	**20,493**

Q43. Federal Question (12/21/*2023*): In the Scenario D table on PDF p. 41 of the December submission, can NY confirm that the unsubsidized off-Exchange enrollment/premium for DACA recipients is correct? Tables elsewhere (e.g. in Appendix D) in the submission suggest that there are DACA recipients in unsubsidized individual market coverage (both in the baseline and under the waiver).

A43. State Response (1/2/2024): As noted, we assume there are some DACA recipients currently in the unsubsidized individual market. Please see the updated Appendix Table D3 below, including the DACA recipient totals split out as such. We assume the same distribution by metal tier for the DACA enrollees in the unsubsidized individual market as the average population.

Table D3. With-Waiver PY 2024 Break-Out

	200-250% FPL	DACA Recipients	All Other FPL	200-250% FPL	DACA Recipients	All Other FPL	200-250% FPL	DACA Recipients	All Other FPL
With Waiver - Scenario D	1/1/24-3/31/24			4/1/24-7/31/24			8/1/24-12/31/24		
Unsubsidized On/Off-Exchange									
Enrollment	0	231	65,891	0	231	65,891	0	137	65,759
Average Premium PMPM	$0	$802	$802	$0	$802	$802	$0	$802	$802
Subsidized On-Exchange									
Enrollment	69,010	0	168,922	410	0	168,512	410	0	168,512
Average Premium PMPM	$756	$0	$761	$756	$0	$761	$756	$0	$761
Average APTC PMPM	$332	$0	$314	$332	$0	$314	$332	$0	$314
Total Individual Market									
Enrollment	69,010	231	234,813	410	231	234,403	410	137	234,271
Average Premium PMPM	$756	$0	$773	$756	$802	$773	$756	$802	$773
Aggregate Premiums (millions)	$156	$0	$544	$3	$1	$725	$3	$1	$905
Projected Federal Spend (millions)	$64	$0	$149	$1	$0	$198	$1	$0	$247
Essential Plan									
Enrollment	0	0	1,369,339	89,922	0	1,369,339	89,922	13,722	1,369,339
Average Premium PMPM	$0	$0	$625	$718	$0	$625	$806	$598	$625
Aggregate Premiums (millions)	$0	$0	$2,567	$258	$0	$3,423	$362	$41	$4,278
IRIP Payment (millions)		$0			$45			$62	
Quality Incentive Pool Costs (millions)		$56			$75			$94	
LTSS Coverage (millions)		$0			$0			$0	
SDoH/BH Grant Program (millions)		$6			$8			$10	
Total Program Costs (millions)		$2,806			$3,741			$4,677	
Projected Federal Spend (millions)		$802			$1,069			$1,336	

Q44. Federal Question (12/21/2023): **Under the pregnancy choice policy, if an EP Expansion enrollee reports a pregnancy and the increase in their household size for the purposes of Medicaid MAGI means that the household income is now below 138% of FPL, will that enrollee be transferred to Medicaid or retained in the EP? In other words, are all enrollees who report a pregnancy retained in the EP or is there an income level at which they would be transferred to Medicaid? For example, suppose a single woman at 150% of FPL becomes pregnant with twins such that her household size is now three and such that her income is now below 138% of FPL. Would she be moved into Medicaid when she reports her change in circumstances? Would she be moved to Medicaid after the postpartum coverage period would typically end?**

A44. State Response (1/2/2024): State Response: Under the pregnancy choice scenario, income changes would not cause a member to move from EP to Medicaid. Under the scenario described, the member would stay in EP through their postpartum period, at the end of which their eligibility would be evaluated and moved into the program for which they were eligible. If they were eligible for Medicaid after the postpartum period ends, they would move to Medicaid. Under the pregnancy choice scenario, the only changes that would cause someone to be moved from EP to Medicaid during a pregnancy is if the member reported information that makes them ineligible for EP, such as being incarcerated or having access to employer sponsored coverage.

Q45. Federal Question (12/21/2023): **Can you please provide additional details about the SDOH and behavioral health grants and the services or supports these programs are likely to include?**

A45. State Response (1/2/2024): The initiatives described below include both social determinants of health and behavioral health investments that plans would be encouraged to pursue, with grant-funded support, as well as related steps the State will take to support improvements in access to behavioral health services.

Focus Area	Intervention	Description	Alignment with New York's 1115 waiver
Food Services	Medically Tailored Meals	As demonstrated in the recently CMS approved programs in Oregon and Massachusetts, issuers can home-deliver a certain number of medically tailored meals per week to patients with chronic conditions. Meals should be customized to nutritionally meet health care needs including high cholesterol, diabetes, etc.	The 1115 waiver will allow up to 6 months of Medically Tailored Meals. The NYS Medicaid program also released a State Identified In Lieu of Service (ILS) for Medically Tailored Meals in 2022. The ILS allows up to two meals a day for 6 months, with the ability to reauthorize if medically necessary.
	Food Pharmacies	Issuers can stand up Food Pharmacies in existing pharmacies, health care clinics, or hospitals to store and dispense healthy food. Food Pharmacies should be staffed with an interprofessional care team (including a nurse, pharmacist, dietician, health coach, etc.) to provide disease management education.	The 1115 waiver will provide up to 6 months of Medically tailored or nutritionally-appropriate food prescriptions (e.g., fruit and vegetable prescriptions, protein box), delivered in various forms such as nutrition vouchers and food boxes, for up to 6 months.
	Personalized Coaching	Provide coaching to enrollees related to healthy eating and physical activity through websites, mobile apps, texts, emails, or one-on-one phone calls.	The 1115 waiver will provide nutrition counseling and education, including on healthy meal preparation.
Preparing for climate change	Air Conditioning	Provide asthmatic enrollees with an air conditioner to protect their health, reduce the number of ED visits, and help communities prepare for extreme weather related to climate-change. Health care providers would have to "prescribe" the purchase, delivery,	The 1115 waiver will provide Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention.

		and installation of air conditioners.	
Behavioral Health Services	Mobile Crisis Units	Issuers can standup a mobile crisis unit comprised of a group of behavioral health professionals (such as social workers, peer specialists and family peer advocates) who can provide care and short-term management for people who are experiencing severe behavioral crisis. Units may provide a range of services, including assessment, crisis intervention, supportive counseling, and referrals. (EP issuers have already begun to cover mobile crisis units, but support for increasing mobile crisis units would continue to be supported with waiver funds.)	N/A
	Crisis Diversion Centers	Provide an alternative to emergency department visits for adults experiencing a mental crisis through Crisis Diversion Services. These no-cost, drop-in centers do not require a referral and are typically staffed with a care team including licensed master-level social workers, care managers, and peer counselors. Crisis Diversion centers may partner with local law enforcement acting as first responders for behavioral health crises.	N/A
	Crisis Respite Centers	Provide a short-term safe-haven for individuals experiencing emotional crises through a Crisis Respite Centers. As an alternative to hospitalization, individuals can stay at the center for up to one week and are offered 24/7 support by a care team. Typical care activities include self-advocacy,	N/A

		social support groups, and linkage to medical and psychiatric providers.	
	Credentialing Costs	Cover the cost for the one-time credentialing needed to provide services to EP members, effectively growing the workforce of behavioral health professionals available through EP.	N/A
Accessing Behavioral Health Services	Build and strengthen the behavioral health workforce	Incentivize EP issuers to develop a behavioral health workforce and network of behavioral health providers by: - Issuing capacity-building grants to behavioral health providers for start-up costs (e.g., technology, building, operations) to expand service offerings/ locations; - Investing in the health IT (electronic heath records) and data analytics; - Increasing telehealth offerings to help address access issues; - Convening learning collaboratives for network providers; and - Conducting trainings for behavioral health providers related to contract requirements, including credentialing, billing and documentation	N/A
	Eliminate cost-sharing for all behavioral health services	Eliminate cost-sharing for all behavioral health services, including pharmacy, to remove any barriers to access. Currently, there is cost-sharing in EP 1 (for individuals with incomes above 150% of FPL) for	N/A

		many services (behavioral and other medical services).	
	Clarify prior authorization and referral requirements for behavioral health services.	NY State of Health will: - Clarify for which behavioral health services managed care plans in NY are allowed to impose prior authorization requirements (if any), as well services for which enrollees can self-refer. - Consider applying the current contractual requirements for New York's Medicaid managed care plans to EP. For example, Medicaid managed care plans in New York are explicitly prohibited from imposing prior authorization requirements for behavioral health emergency or crisis services. - Align referral requirements from New York's Medicaid managed care plans across EP and Medicaid. For example, Medicaid managed care enrollees are allowed to make unlimited self-referrals for mental health or substance use disorder assessments from network providers without requiring pre-authorization or referrals from the enrollee's primary care provider with some exceptions.	N/A
	Provide enrollees with information on	Require EP plans to make a list of participating providers offering each covered behavioral health	N/A

	service options available to them.	service available with the intention of allowing enrollees to understand where they can go to access services. Require EP plans to provide information on which providers are currently accepting new patients.[5]	
	Reimburse primary care providers who deliver behavioral health services.	Reimburse for behavioral health services and screenings primary care provider are qualified to deliver, such as treating mild or moderate depression.	N/A
Knowledge Sharing	Provider Training	**Mental health services.** Provide training to assist providers in identifying, understanding, and addressing mental health diagnoses. **Social Determinants of Health**. Administer training on the social determinants of health, such as physical environment and food, and how they can contribute to health disparities and inequities. Provide training models for providers to build skills related to addressing social determinants. **Abortion Access/ Reproductive Rights.** Provide clarification to clinicians and staff regarding what the Reproductive Health Act means for patient care and update NYS law related materials. Train providers on administering feticidal injections and enhanced surgical skills needed for later abortion care. AuthThe 1115	The 1115 authorizes Social Care Networks to develop educational materials and to conduct outreach and stakeholder convenings to educate providers on screening and referral for health related social need (i.e., social determinant of health) services.
Other	Community Health Workers	Build and train a workforce of Community Health Workers (CHWs), building on the lessons of the Medicaid program, with the goal of improving the health of	Medicaid State Plan Amendment 23-02 covers community health worker services to NYS Medicaid fee-for-service

		the population, enhancing the patient experience, and reducing the cost of healthcare. CHWs may play multiple roles, including cultural liaisons, health navigators, health and wellness promoters, and advocates when working with EP enrollees.	(FFS) and Medicaid Managed Care (MMC) members including: a. Children under 21 years of age; b. Pregnant and postpartum individuals during pregnancy, and up to 12 months after pregnancy ends, regardless of the pregnancy outcome; c. Adults with chronic conditions; d. Individuals with justice system involvement within the past 12 months; e. Adults with an unmet health-related social need in the domains of housing, nutrition, transportation, or interpersonal safety; f. Individuals who have been exposed to community violence or have a personal history of injury sustained as a result of an act of community violence, or who are at an elevated risk of violent injury or retaliation

			resulting from another act of community violence The 1115 waiver will support CHW training through the Career Pathways Training Program.