A Promising Strategy for an Affordable Medicaid Buy-In Option in Colorado

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An Initial Study of a Medicaid Buy-In Plan

Contents

Executive Summary ... 2
Introduction ... 4
Design of the Initial Buy-In Approach Modeled in This Analysis ... 6
Buy-In Participation Assumptions ... 9
Approach to Modeling ... 9
Modeling Results for the Initial Buy-In ... 10
Opportunities to Use State Savings and Refine the Buy-In Design ... 11
State Funding Considerations ... 13
Waiver Considerations for Instituting a Buy-In Program ... 13
Broader Insurance Market Considerations ... 14
Conclusion ... 14
Authorship ... 15
Appendix: Detailed Analysis Considerations ... 16
Variations on the Illustrative Scenario ... 16
Data and Methodology ... 16
Reliances and Caveats ... 19
Disclosures and Limitations ... 20

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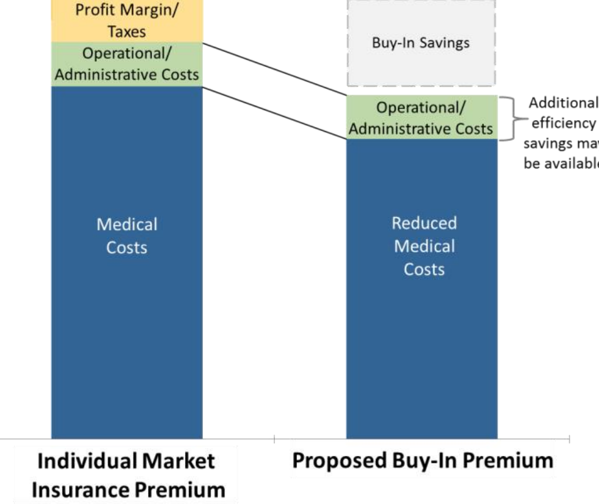
Executive Summary

In order to address rising costs and continued uncertainty in the individual insurance market, states are beginning to explore offering alternative coverage options to residents in need of premium and cost-sharing relief. One option under consideration is a state-initiated product that allows people above current Medicaid eligibility levels (i.e., 138 percent of the federal poverty level (FPL) for most adults in expansion states) to pay a premium to receive healthcare coverage through a plan built on the state's existing Medicaid program.

In Colorado, where average Affordable Care Act (ACA) benchmark premiums[1] have increased 71 percent since 2014, advocates and stakeholders initiated an analysis to evaluate the feasibility and potential impact of a newly introduced Medicaid "buy-in" product, offered outside the individual ACA market, with access to Advanced Premium Tax Credit (APTC) funding under an ACA Section 1332 State Innovation Waiver. The product would be offered statewide, leverage the current Medicaid infrastructure, provide the same benefits and range of cost sharing as coverage on the state Marketplace (Connect for Health Colorado), and reimburse providers at Medicare rates. The analysis evaluated expected premiums for the buy-in product, the impact of its introduction on existing individual market premiums, and the potential for state savings under this program design. The effort was led by a coalition of Colorado health policy advocates, represented by the Colorado Center on Law and Policy, the Colorado Consumer Health Initiative and the Bell Policy Center. Manatt Health Strategies provided the policy and technical support and Wakely Consulting Group, LLC conducted the analytical modeling of the proposed program design and scenario alternatives.

Based on this preliminary review, it appears that the buy-in option holds significant potential for the state of Colorado and warrants further debate and analysis. The initial results suggest that a buy-in could:



- **Offer consumers access to a more affordable plan.** Results from an illustrative scenario show a 28 percent decrease in premiums for the buy-in product, relative to projected individual market premiums in 2020. A buy-in option with greater affordability would be particularly helpful for Colorado residents above 400 percent of the FPL, who do not qualify for premium tax credits. The premium reduction relative to current individual market pricing comes from a combination of savings that includes (1) reduced non-benefit expenses (that is, administrative costs such as taxes and margin for profit); (2) provider

[1] The benchmark premium is the second-lowest-cost Silver plan (SLCSP) available on the Marketplace, which is used to determine tax credit eligibility.

reimbursement rates that lower the premiums for the buy-in product by, on average, 15 percent; and (3) reduced medical costs from a healthier population. The analysis assumes the plan will have some administrative costs for establishing the buy-in.

- **Generate savings that the state could use to improve coverage more broadly, subject to federal approval.** The results of this initial model suggest that—after covering the cost of providing coverage and subsidizing APTC-eligible enrollees—the state could still realize an estimated $5.7 million in savings annually (which reflects federal "pass-through" funds that remain after accounting for the costs of an initial buy-in). If sanctioned to do so by the federal government under a waiver, the state could use these savings to invest in a variety of alternative buy-in design options or pay for any additional operating costs. For example, Colorado could reduce premiums for those seeking coverage through Connect for Health Colorado (Connect) or other ACA-compliant individual market plans (particularly for those who do not qualify for premium tax credits); offer lower deductibles and copayments; or offer additional benefits, such as dental, under the buy-in product.

- **Ensure a stable plan option throughout the state.** The buy-in option could ensure that each area of Colorado has at least one plan year-over-year, regardless of what decisions private insurers make about participation in Connect. And, depending on the market response, the new buy-in could generate additional choices for Colorado residents.

- **Impact on the individual market.** Under the illustrative scenario modeled for this analysis, there was relatively little impact on the premiums for those who opt to remain in the individual market. However, any increase in individual market premiums is a source of concern and would need to be monitored carefully, especially because estimates of the impact on the individual market are highly sensitive to assumptions about the health status of individuals who opt into the buy-in. Insurer reaction to the buy-in is also an important consideration for Colorado and will depend on the specifics of the buy-in design.

In sum, this analysis is an important first step in understanding the feasibility of a Medicaid buy-in for Colorado. The estimates reveal that lower non-benefit expenses and provider reimbursement costs could drive premium decreases and that, subject to federal approval, the resulting state savings could be used to further improve coverage for Colorado residents. At the same time, it is important to highlight that these results are preliminary and that other key decisions—such as making the buy-in available more broadly (e.g., to small businesses), marketing it particularly to those currently uninsured and/or offering it as an individual market option through Connect—could lead to different results. It should also be noted that this analysis does not include state implementation planning, such as agency oversight and program operations. More work, including a more detailed analysis and additional administrative considerations, is needed to determine the best design decisions for a Colorado buy-in.

This document has been prepared for the sole use of the noted entities. This document contains the results, data, assumptions and methods used in Wakely's analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate. This document should be distributed to parties in its entirety and should be evaluated only by qualified users.

Introduction

The cost of buying individual market coverage in Colorado has been rising relatively rapidly, especially for residents of rural areas and those who do not qualify for federal subsidies (e.g., because they have incomes above 400 percent of the FPL, referred to hereafter as "unsubsidized" individuals). Statewide average benchmark premiums[2] on Connect rose by 71 percent between 2014 and 2018.[3] Rural areas have been particularly impacted—premiums for unsubsidized individuals rose by up to 38 percent in the West region between 2017 and 2018 alone.[4] For example, an individual on the western slope with an income of $49,000 could need to spend over $7,000 a year on premiums, or more than 15 percent of their income, to purchase an average Silver-level plan that may still require considerable cost sharing in the form of deductibles and copayments.[5] A dearth of competition in key parts of the state may be one factor contributing to rising premiums in Colorado; 14 of 64 Colorado counties (22 percent), mostly in the West region, have only one individual market insurance carrier.[6] Residents in the West region faced Silver plan premiums that were 42 percent higher, on average, than in the Denver region, which had six carriers in 2018.[7] Fortunately, increases in 2019 will be smaller (an average of 6 percent[8]) than in previous years. While this is a welcome reprieve, premiums remain too high,

Key Goals of a Medicaid Buy-In

A Medicaid buy-in product in Colorado could potentially address several key policy goals:

- **Increased Consumer Affordability.** Because Medicaid has lower administrative costs and coverage could be structured to reimburse providers at Medicare (rather than commercial) rates, a buy-in could offer a more affordable option for consumers, particularly unsubsidized individuals who pay the full cost of premiums. Depending on the program design, the product could also potentially offer lower deductibles and other cost sharing.
- **Improved Market Access and Competition.** By offering a statewide product, the buy-in plan could ensure at least one stable plan option in all areas of the state, and could diversify plan offerings in regions (often rural) that currently have only one participating insurer.
- **Strengthened Coverage, Continuity and Alignment.** A statewide plan could improve continuity of coverage for populations moving between Medicaid and the individual market, stabilize the market from year to year, and align with the state's efforts to increase access and strengthen coverage.

[2] The benchmark premium is the second-lowest-cost plan available on the Marketplace, which is used to determine tax credit eligibility.
[3] Kaiser Family Foundation. (2018). Marketplace Average Benchmark Premiums: Colorado. https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/.
[4] Colorado Department of Regulatory Agencies. (2017). 2018 Health Insurance Premiums: Public Forum. https://drive.google.com/file/d/0BwguXutc4vbpVHFWTTN1THRVYms/view.
[5] As noted later in this report, Connect plans are offered in varying "metal tiers" that indicate the average share of total medical expenses that are paid by insurers, with the remainder paid out of pocket by enrollees. The annual calculation is based on 2018 average premiums between all plans in the West region.
[6] Colorado Department of Regulatory Agencies. (2017). 2018 Individual Plan Counts by Area and County (On Exchange). Division of Insurance. https://drive.google.com/drive/folders/0BwguXutc4vbpVFV0azBOT0NoQ2c.
[7] Colorado Department of Regulatory Agencies. (2017). 2018 Individual Approved Rates. Division of Insurance. https://drive.google.com/drive/folders/0BwguXutc4vbpVFV0azBOT0NoQ2c.
[8] Colorado Department of Regulatory Agencies. (2018). Division of Insurance releases preliminary 2019 health insurance information. https://www.colorado.gov/pacific/dora/news/division-insurance-releases-preliminary-2019-health-insurance-information.

especially for unsubsidized individuals—those purchasing coverage on their own— because with incomes just above 400 percent FPL, they are ineligible for tax credits.

In light of these trends, which are not unique to Colorado, states and advocates across the country are exploring a range of strategies to stabilize and strengthen the individual market. One policy under consideration in many states is offering a state-initiated Medicaid buy-in, or public option. Under this approach, people above current Medicaid eligibility levels (i.e., 138 percent of the FPL for most adults in expansion states) could purchase a new healthcare coverage product based on the Medicaid program or could continue to choose among existing individual market plans. While a buy-in can be designed in a number of different ways, its core purpose is to improve coverage options for consumers by leveraging the strengths of Medicaid. Depending on the state, these strengths can include experienced Medicaid managed care plans, an efficient infrastructure for administering Medicaid services, and/or Medicaid provider networks rates.[9]

To explore the potential impact of a buy-in option for Colorado, the Colorado Center on Law and Policy, the Colorado Consumer Health Initiative and the Bell Policy Center commissioned an analysis by Manatt Health Strategies and Wakely on the viability of a buy-in option in the state. The purposes of the analysis were to assess the feasibility of bringing a buy-in to Colorado, to develop high-level estimates of its impact on premiums and participation, and to begin a discussion of whether and how a buy-in product could be designed to contribute to key goals— including increasing coverage affordability (especially for unsubsidized individuals), providing additional plan choices to consumers, and strengthening continuity of coverage (see Key Goals of a Medicaid Buy-In box on page 5 for details).

Based on the preliminary review described in this paper, it appears clear that the buy-in option holds significant promise for the state of Colorado. It could give consumers throughout the state, particularly those who are unsubsidized, a lower-cost plan option, as well as generate savings that the state could use to modify the buy-in design to offer additional services, such as premium reductions, lower deductibles, increased provider reimbursement rates and/or additional benefits. At the same time, it is important to highlight that this preliminary analysis relies on publicly available high-level data and makes several key assumptions, most notably that the state of Colorado will be able to secure a federal State Innovation Waiver under Section 1332 of the ACA, which is needed to give Colorado consumers who are under 400 percent FPL the flexibility to decide to use their federal premium tax credits to purchase the new buy-in product.

In the remainder of this report, we describe in detail the design features of the modeled buy-in option, outline the methodology and assumptions used by Wakely when performing the analysis, summarize the estimated impact of the buy-in option under an illustrative scenario, and discuss opportunities for refining the buy-in design. Since a buy-in product of the scale under consideration in this analysis is unprecedented, it should be noted that the estimates presented here are intended to answer threshold questions, such as whether a buy-in is feasible and how it might affect premiums. If Colorado pursues further work on a buy-in, it will be important to continue to refine design details and the corresponding estimates.

[9] Manatt Health. (2018). Medicaid Buy-In: State Options, Design Considerations and Section 1332 Waiver Implications. State Health and Value Strategies. Robert Wood Johnson Foundation. https://www.shvs.org/wp-content/uploads/2018/05/Medicaid_Buyin_-FINAL.pdf.

Design of the Initial Buy-In Approach Modeled in This Analysis

Based on consultation with a group of Colorado stakeholders, this analysis evaluates an initial buy-in product that is administered and offered outside of Connect—that is, an "off-Marketplace" product that operates outside of the ACA individual market risk pool.[10] The analysis assumes that the Colorado Department of Health Care Policy and Financing would offer the buy-in product on a statewide basis to anyone who is currently eligible to purchase individual market coverage (i.e., no enrollment cap or targeted eligibility criteria). The product would leverage the current Medicaid fee-for-service and behavioral health capitation infrastructure and provider network, with the assistance of a third-party administrator (TPA) for claims processing. Participants would receive the same essential health benefits as those provided to enrollees in Connect coverage[11] and the same level of cost-sharing support provided through Connect at a lower premium (as described below). Specifically, Connect offers products based on "metal tiers" that correspond to various actuarial values (i.e., the percentage that insurance companies will pay on average for the health services consumers use), with cost-sharing subsidies provided to individuals with incomes below 250 percent of the FPL who enroll in a Silver plan. The analysis assumes that anyone who enrolls in the buy-in product would receive coverage that has actuarial value and cost-sharing assistance directly comparable to what they would have received had they opted to obtain coverage through Connect.

Colorado Medicaid Buy-In Model Design Elements

Eligibility	Benefits	Cost-Sharing	Provider Network
All Coloradans eligible for individual market coverage	Essential health benefits, mirroring Connect for Health Colorado coverage	Metal levels (actuarial value) and cost sharing assistance mirroring Connect for Health Colorado coverage	Medicaid network, reimbursed at Medicare rates

Administration	Delivery System	Financing
Medicaid fee-for-service infrastructure with TPA claims processing	Fee-for-service and behavioral health capitation	Enrollee premiums Pass-through funds from APTC

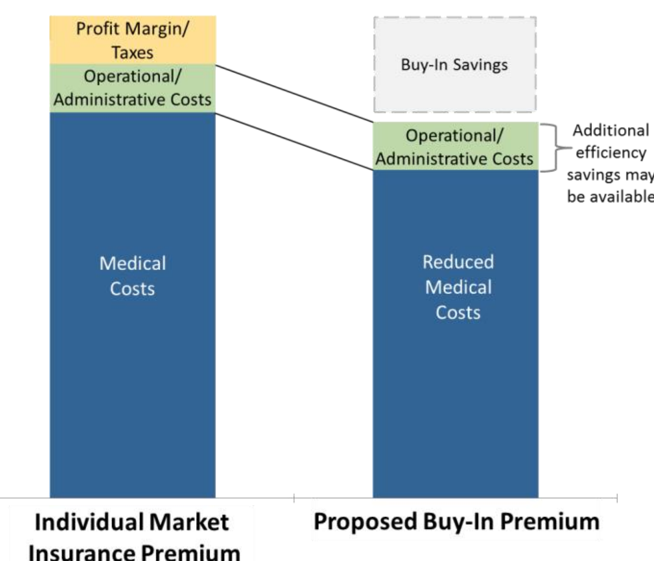
In addition to the lower premiums realized for unsubsidized buy-in participants, subsidized consumers who elect the buy-in product would receive a 5 percent discount on their out-of-pocket premiums (that is, net after APTCs) to encourage them to enroll in the buy-in option. Since APTCs essentially insulate subsidized consumers from changes in underlying premium costs,[12] they would have little incentive to select the lower-cost buy-in product in the absence of the 5 percent discount.

[10] Plans in the ACA individual market include those that comply with insurance requirements of the ACA and exclude other plans such as "grandfathered" plans.

[11] Essential health benefits required for all Connect plans include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and management of chronic diseases; and pediatric services, including oral and vision care. Buy-in participants would receive all of these essential health benefits, but unlike Medicaid beneficiaries, they would not receive specialized Medicaid services such as long-term care services and supports.

[12] APTCs are set at a level that allows individuals to purchase coverage based on a percentage of their income. As a result, if underlying premium costs increase or decrease, APTC amounts adjust but an individual's out-of-pocket costs remain the same.

Lower premiums would be achieved in part by reimbursing providers at Medicare rates, a level intended to encourage sufficient network participation while still providing savings relative to current individual market rates. Based on an analysis of Colorado-specific data, Wakely estimates that Medicare rates are 15 percent lower on average relative to the individual market, with variation by provider type. No difference in prescription drug payment rates is assumed. Because of the lower payment rates, the analysis also assumes that the provider network for the buy-in product is narrower compared with the individual market, which in turn affects the risk profile of people who may be willing to take up the buy-in option.



Additional premium reductions would be driven by lower administrative costs compared with commercial plans,[13] with an estimated 6 percent savings attributable to two factors—taxes and margin. First, the state would not pay the same taxes faced by existing individual market plans. This includes the federal health insurance tax typically assessed on insurers in the individual market because the TPA used to process claims is not a risk-bearing entity (and therefore not considered an insurer under ACA regulations) and government entities are exempted.[14] Fees are assessed on insurers based on premium revenue and market share and are ultimately passed on to consumers in the form of an average premium rate increase of approximately 3 percent.[15] The state's insurance tax would likely be waived for a state-initiated buy-in product as well. A second source of savings arises from the fact that, unlike in commercial insurance plans, no profit margin is built into the buy-in premium. Overall, 6 percent represents a moderate savings estimate for taxes and margin. In practice, the elimination of such fees could produce savings of up to 10 percent.[16] In addition, while the state may be able to achieve further administrative efficiencies that would lower premiums based on the implementation structure, our preliminary analysis assumes that administering the buy-in product would incur ongoing operational costs similar to those of other individual market plans.[17]

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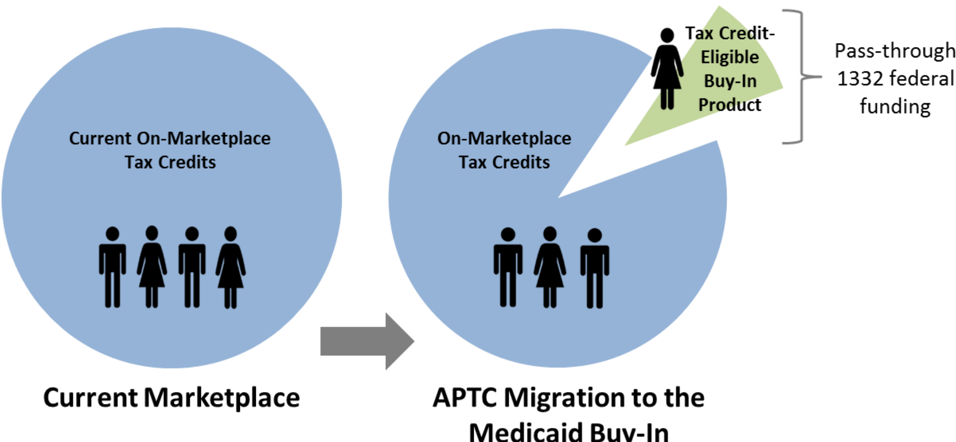
[13] According to America's Health Insurance Plans, average commercial insurance administrative/operating costs were approximately 17 percent of spending between 2014 and 2016. For more information, see America's Health Insurance Plans. (2018.) Where Does Your Health Care Dollar Go? https://www.ahip.org/health-care-dollar/.

[14] Health Insurance Providers Fee, 26 C.F.R. § 57 (2018). https://www.federalregister.gov/documents/2018/02/26/2018-03884/health-insurance-providers-fee.

[15] Carlson, C., Giese, G., and Armstrong, A. (2017). New Analysis: How the ACA's HIT Will Impact 2018 Premiums. Oliver Wyman Health. http://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August2017/HIT_Impact_Report_Revised.pdf.

[16] Savings from taxes and margin may vary depending on buy-in design and regulations upon implementation, and on market conditions.

[17] The design of the initial buy-in approach modeled here assumes the state may need to contract with a TPA or otherwise alter its existing Medicaid claims processing procedures (e.g., to accommodate Medicare payment rates). There may be additional state expenditures such as income or eligibility verification for the buy-in or other



The initial buy-in design modeled in this report assumes that the state of Colorado could secure a Section 1332 waiver from the federal government to repurpose APTCs for the buy-in. Under standard federal rules and regulations, APTCs are available only to eligible consumers who buy a Marketplace plan. If such a waiver were granted, the federal government would in effect be "passing through" to Colorado the premium tax credit amounts for beneficiaries who opt for the buy-in. The state would use these funds to finance the buy-in product.[18] To the extent that the pass-through funds are more than sufficient to cover the costs of the cheaper buy-in product, the savings could be used for additional programs to improve the affordability of health coverage for Colorado residents (see discussion later in this report).

The Trump Administration has granted a number of Section 1332 waivers to states to establish reinsurance initiatives, but it is not yet clear how it would respond to a request to allow pass-through funds to support a Medicaid buy-in option.

Summary of Key Features of the Off-Marketplace Buy-In Option

The proposed buy-in product analyzed in this paper:

- Is available statewide to any individual eligible for individual market coverage, without an enrollment cap
- Is offered outside Connect and the ACA individual market risk pool as a separate product
- Is administered by the Colorado Department of Health Care Policy and Financing, with a TPA for claim processing
- Offers essential health benefits mirroring Connect and other individual ACA market plans
- Pays providers within the Medicaid network at Medicare rates for the buy-in population
- Allows enrollees to utilize their federal premium tax credits to purchase the buy-in product, and uses federal/state savings for program funding

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activities associated with administering premiums and subsidies. Finally, outreach and marketing, especially in the initial years, will be important. This administrative strategy will take time to implement and will require state expenditures.

[18] Specifically, Colorado would first need to use the pass-through funds to offer subsidized products comparable to what buy-in beneficiaries would have received for Connect coverage, given their particular income levels. In addition, a design feature of this buy-in option assumes that some of the pass-through funds are dedicated to providing those who would have received APTCs with an additional 5 percent discount on their out-of-pocket premium.

Buy-In Participation Assumptions

For the initial buy-in design, the modeled scenario includes key assumptions about buy-in participation and the risk profile of those who enroll. For illustrative purposes, Wakely assumed a modest number of individual market participants (10 percent of the unsubsidized and 5 percent of the subsidized population, or 7.7 percent of the total individual market) would transfer their coverage to the new buy-in product. If more subsidized individuals took advantage of the buy-in option under a Section 1332 waiver, federal pass-through funding available to the state would increase.

In addition to the number of participants, one of the most critical issues to address when modeling the impact of the buy-in is the health risk of those who would enroll. A large body of research suggests that healthier people are willing to accept a narrower network if it lowers their premiums, while sicker people will pay more in premiums for a stronger network.[19] In addition, young, healthy individuals are more sensitive to price[20] and, therefore, more likely to move to a cheaper coverage option. Since the Medicaid buy-in network would likely be narrower (even with Medicare rates) than those offered by Connect plans, Wakely assumed that the buy-in participants would be modestly healthier than consumers who remain in the individual market (i.e., that the buy-in population has an average morbidity of 0.9 compared with 1.0 for the overall individual market, meaning that buy-in customers are 10 percent healthier). This impacts premiums in the individual market because the change in morbidity from potentially healthier people migrating out of the ACA single risk pool to the buy-in changes the composition of the risk pool that remains for individual market plans.

Approach to Modeling

To complete the initial buy-in model, Wakely used an analysis based on 2017 data on Connect insurance premiums and enrollment to estimate figures for benefit year 2020 that assume continuation of the 2017 policy environment (e.g., excluding potential effects of individual mandate repeal). Wakely also estimated the likely cost of a Medicaid buy-in product in 2020 using available data and assumptions about provider reimbursement rates and non-benefit expenses.[21] Drawing on the extensive research available on consumer responses to premiums, Wakely incorporated an estimate of the number of individual market enrollees who might choose the buy-in option, the resulting state savings and the impact on premiums in the remaining individual market. Specifically, the analysis evaluates potential behavior change for individuals currently enrolled in Connect and other ACA individual market coverage; it does not take into account the possible migration of uninsured, small-group or employer-sponsored insurance populations to the buy-in product. It is important to note that this product may also be attractive to small employers and, perhaps, individuals who currently have employer-sponsored insurance from larger employers. This product could also be attractive to the currently uninsured—indeed, increasing coverage is a goal of buy-in supporters. While this analysis does not model the impact of adding those individuals to the buy-in, including them would increase the number of participants and could affect the risk pool. We discuss these populations more in a later section on opportunities to refine the buy-in design, and additional information is provided in the appendix.

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[19] Shepard, M. (2016). Hospital network competition and adverse selection: Evidence from the Massachusetts health insurance exchange (No. w22600). National Bureau of Economic Research. http://www.nber.org/papers/w22600.

[20] Hackmann, M.B., Kolstad, J.T., and Kowalski, A.E. (2015). Adverse selection and an individual mandate: When theory meets practice. American Economic Review, 105(3), 1030–66. http://faculty.haas.berkeley.edu/jkolstad/hackmann_kolstad_kowalski_2015.pdf.

[21] This analysis focuses on estimated impacts for 2020; however, multiyear effects would need to be estimated for full consideration of a Section 1332 waiver.

Given the proposal's novelty, it is important to highlight that the estimates in this paper are designed to present an illustrative scenario of how a buy-in might work in Colorado, reflecting a set of reasonable assumptions. For the scenario presented in this report, Wakely assumed that a modest number of current individual market participants—with a somewhat healthier-than-average risk profile—would purchase buy-in coverage. Additional estimates that assume varying buy-in participation and risk profiles were also examined. The final section of the paper briefly explores how alternative choices for buy-in design (e.g., with regard to cost sharing) could change the estimated impacts of a buy-in (e.g., mitigating premium impacts on the remaining individual market) while still providing an affordable alternative option.

Modeling Results for the Initial Buy-In

Results of the initial buy-in product analysis indicate that by 2020, consumers would have a more affordable product among their choices if a buy-in were implemented. Specifically, for the illustrative scenario reflected in this report, the buy-in premium would average $475 per month, compared with $661 for an average individual market plan before the buy-in plan. This is a 28 percent reduction that would add up to, on average, $2,228 in annual savings for an unsubsidized individual. This lower premium would be particularly helpful for unsubsidized residents of Colorado, but even APTC-eligible individuals are assured a 5 percent out-of-pocket premium discount under the initial buy-in design. Under this illustrative scenario, Wakely assumes some 7.7 percent of individual market enrollees (17,300 individuals) would take up the buy-in option.

Example Premiums Paid by Individuals at Varying Income Levels for Current Individual Market Versus Buy-In Coverage

	Individual Market Premium Without Buy-In	Buy-In Premium	Annual Savings
250% FPL $30,350/year Subsidized with APTC	$2,460	$2,340	$120
400% FPL (and above) $48,560/year No Access to APTC	$7,932	$5,704	$2,228

Note: Premiums reflect out-of-pocket costs and are for the average market premium in the individual ACA market. The FPL reflects 2018 guidelines for an individual.

As noted earlier, the primary reasons for the lower premium are the buy-in's reduced non-benefit expenses (6 percent lower than individual ACA plans) and lower reimbursement rates (15 percent lower than the individual market). After accounting for the presumed health status of the buy-in population, these factors would reduce medical expenditures by $18 million among buy-in participants, and lower non-benefit expenses would generate an additional $7 million in savings. Among unsubsidized individuals, the savings from lower premiums go directly into their pockets.

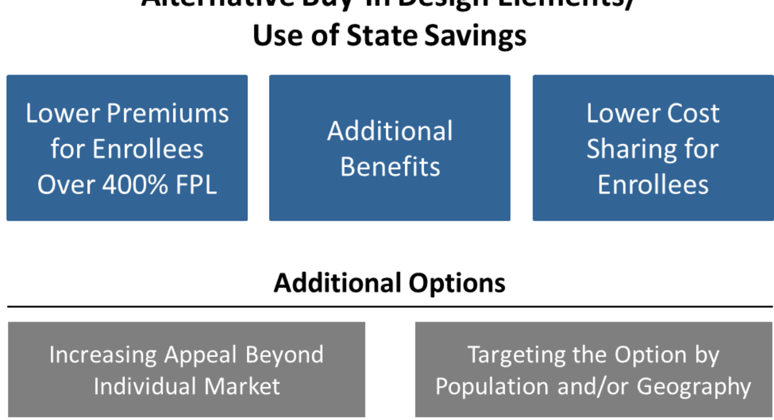
On behalf of the 5,100 tax-credit-eligible individuals who are assumed to take up the buy-in product, the state would receive an estimated $27.9 million in 2020 federal pass-through funding from reduced premium tax credits through Connect, assuming a Section 1332 waiver is granted. The state would need to use the bulk of this money to provide subsidies to APTC-eligible individuals that are comparable to, if

not greater than, what they would have received through Connect coverage. As a result, the state would ultimately have $5.7 million in remaining pass-through funds under this illustrative scenario. These state funds could be invested in the buy-in program in a variety of ways, including to further reduce premiums, to lower cost sharing or to fund operations. (As part of a Section 1332 waiver agreement, it is possible that the federal government could limit the uses of pass-through funding.)

The modeling results also indicate that the buy-in option has an impact on the remaining individual market, albeit a modest one. When relatively healthy people leave the existing individual market, as the illustrative scenario assumes would happen under the modeled initial buy-in approach, the premiums of those who remain are potentially impacted, because individuals who remain in the individual market are somewhat less healthy than the average member before the buy-in. Under the scenario modeled for this analysis, the effect on the premiums of people who remain in the individual market is a less than 1 percent (0.8 percent) increase. This reflects the facts that 7.7 percent of individuals are assumed to take up the buy-in option and that these individuals are modestly healthier than those who remain. If, however, an even healthier population were to enroll in the buy-in, the result could be a larger impact on individual market premiums. Since the goal of the buy-in is to make coverage more affordable—whether through Connect or the buy-in—the buy-in design should consider the potential for unintended consequences. Additionally, an increase in individual market premiums would likely need to be addressed before a Section 1332 waiver would be granted. One option, as discussed further below, is to use some of the federal pass-through funds that remain available as state savings to further improve coverage for individuals above 400 percent of the FPL who remain in Connect or other individual market coverage.

Opportunities to Use State Savings and Refine the Buy-In Design

Modeling of the illustrative scenario suggests that the initial buy-in approach outlined earlier would generate $5.7 million in savings for the state of Colorado in 2020. These funds could be used to further improve coverage options and to reduce impacts on the existing market. A variety of alternative uses of state savings and buy-in designs can be explored, including:



- **Lower premiums for those over 400 percent FPL.** Colorado could use buy-in savings to mitigate the impact of a somewhat healthier population opting into the buy-in product by subsidizing individual market coverage for those who are currently ineligible for subsidies (e.g., those with incomes over 400 percent FPL). Colorado, for example, could lower premiums directly for those above 400 percent FPL through a state tax credit or subsidy. Alternatively, it could consider

using the state savings for a reinsurance program, which would lower premiums across the individual market.[22]

- **Add benefits to buy-in.** The savings could also be used for a buy-in design that includes more benefits, such as dental and/or vision coverage, to the extent funds are available. Additional benefits would make the buy-in coverage more attractive to a broader population, including those with greater health needs.

- **Lower cost sharing.** A buy-in that offers lower deductibles and other cost sharing (i.e., a higher minimum AV) could provide additional benefits to Coloradans who enroll in the buy-in product. It could also attract less-healthy members and therefore mitigate premium increases within the remaining individual market.

While this initial analysis indicates that a buy-in can successfully lower premiums for participating beneficiaries and simultaneously generate savings for the state that could be reinvested in health coverage, it is important to highlight that the savings estimates are highly sensitive to design decisions. If stakeholders in Colorado continue to explore the buy-in option, it will be essential to update estimates to reflect the design and ultimately ensure that the model continues to offer benefits to buy-in consumers and other Colorado residents.

Colorado could also consider other options to influence the population that chooses to participate in the buy-in. For example:

- **Target the option.** Since the buy-in effect on the individual market is very dependent on who enrolls, options to mitigate risk would include targeting enrollment to those with potentially greater health needs, those who are older (e.g., the 45–64 age group), those in particular regions or those with certain incomes. The buy-in could also be limited to non-APTC-eligible individuals, or premiums for APTC-eligible enrollees could be held constant. While the buy-in model was structured to attract APTC enrollees by lowering the premium in order to achieve federal pass-through funding, focusing on the unsubsidized would limit the need for a Section 1332 waiver (discussed in more detail below).

- **Broaden the buy-in appeal.** The fact that the buy-in offers lower premiums relative to the current individual market, and under certain designs could offer lower cost sharing at a similar or even reduced price point, may prompt greater enrollment from populations not currently engaged in the individual market. This includes the uninsured, many of whom have forgone participation in the individual market because of unaffordable prices—particularly individuals in high-cost regions of Colorado, where premiums to date have been higher than those in other regions. Lower premiums and cost sharing may also hold appeal for individuals with access to employer-sponsored plans. Depending on their risk profile, new groups that bolster buy-in enrollment could potentially be introduced, driving down average costs and further reinforcing the buy-in as an attractive coverage option.

- **Offer the buy-in as an additional plan through Connect.** Another buy-in strategy for future consideration is to offer the product as an individual market product through Connect, thereby

[22] America's Health Insurance Plans. (2018). Factors Influencing 2019 Premiums in the Individual Market. https://www.ahip.org/wp-content/uploads/2018/05/2019Premiums_IssueBrief_FINAL.pdf.

avoiding the need to obtain a Section 1332 waiver. In that instance, the impact of the buy-in on the individual market would be very different, as the buy-in product would be part of the calculation for all APTCs, assuming it was one of the two least-expensive Silver plan options available through Connect.[23] Many of the implementation challenges and risks to the existing individual market of an off-Marketplace buy-in could be mitigated by offering the buy-in product on Connect. Risks to the state would be lower and applying for a Section 1332 waiver would not be necessary. This type of buy-in would likely require coordination with an existing insurer (e.g., to ensure that reserve and other requirements that apply to individual market plans are met), and Colorado would have some administrative costs of contracting with a managed care plan, as the state does not have a statewide managed care infrastructure. A buy-in plan offered through Connect would also pay insurer taxes, so it is possible that buy-in premiums would be higher and savings would be lower than they would be under the initial buy-in approach (i.e., an option outside of the individual market) modeled for this report.

- **Offering the buy-in as an unsubsidized plan.** Finally, while this report modeled a buy-in that is available to anyone eligible for individual market coverage, including those eligible for tax credits, Colorado could also make a buy-in available only for those who choose to purchase their own coverage, regardless of tax credits. In that case, obtaining a Section 1332 waiver also would not be necessary.

State Funding Considerations

As noted throughout this paper, the impacts of a buy-in program are largely dependent on who chooses to participate. Any state engaging in a Medicaid buy-in will need to anticipate the risks associated with an unknown risk pool for the new product[24] and/or the risk that more people than expected will enroll. The illustrative scenario presented here assumes enrollee premium contributions and federal pass-through funding amounts are sufficient to cover program costs. However, for either of the reasons above, medical expenses could outpace federal funding and enrollee premium contributions, resulting in costs to the state. Additionally, offering the buy-in product outside of the ACA individual market means that participation in risk mitigation programs, such as risk adjustment, presumably would not apply. For these reasons, Colorado would likely want to establish a reserve fund to cover premiums in the event of unexpectedly higher costs.

Waiver Considerations for Instituting a Buy-In Program

Because the initial buy-in approach assumes the use of premium tax credits outside of Connect, a Section 1332 waiver would be necessary for implementation. Under a Section 1332 waiver, the state could repurpose premium tax credits (and cost-sharing reductions, if provided) to fund the product and increase the affordability of coverage for enrollees, assuming the waiver meets certain requirements.[25]

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[23] Regardless of the qualified health plan selected, SLCSP in each area is used as a benchmark to determine the amount of premium tax credits a Marketplace enrollee will receive, by determining the difference between the SLCSP premium and predetermined maximum percentages of income (which varies from 2 percent to 9.5 percent) an enrollee can contribute to health insurance premiums.

[24] If the product attracts higher than expected risk, the impact could be different than what was modeled here. Under that scenario, the buy-in would work more like a high-risk pool, resulting in lower premiums in Connect and additional federal pass-through funds.

[25] For more information on Section 1332 waiver requirements, please see Medicaid Buy-In: State Options, Design Considerations and Section 1332 Waiver Implications. State Health and Value Strategies. Robert Wood Johnson Foundation. https://www.shvs.org/wp-content/uploads/2018/05/Medicaid_Buyin_-FINAL.pdf.

However, the Section 1332 authority is the newest of the federal waiver authorities, having started in 2016, so there is limited precedent with respect to what types of initiatives will be approved under this authority, and waivers are always granted at the discretion of the Department of the Treasury (Treasury) and the Department of Health and Human Services (HHS). To date, the Trump Administration has approved only reinsurance Section 1332 waivers, and states that have proposed other types of waivers have encountered various objections from those departments. Some state officials are requesting that the Centers for Medicare & Medicaid Services (CMS) issue new guidance that would increase state flexibility for Section 1332 waiver applicability and streamline the process for receiving approval.

Under the initial buy-in approach in which the product is offered outside of the individual market, HHS and Treasury would likely require Colorado to address any increase in individual market premiums to meet Section 1332 requirements. Under Section 1332 waiver rules, the increase in individual market premiums could result in a waiver not being approved, as it may violate one of these requirements. The buy-in design changes suggested in this paper may mitigate the program's effect on Marketplace plans and meet Section 1332 waiver requirements, as well as strengthen affordability and choice for Coloradans seeking individual market coverage. However, changes in relative premiums between the individual market and the buy-in program could also affect both the number of individuals transitioning and the average health of those transitioning. Further analysis should focus on how to encourage less-healthy members to migrate to the buy-in product.

Broader Insurance Market Considerations

A new buy-in product targeting current individual market participants will impact the existing carriers on Connect by introducing competition at a lower overall price point. Current commercial insurer reaction will be largely influenced by how the product is designed and its popularity. An offering outside of the individual market may elicit less of a reaction from insurance carriers. However, as demonstrated in the analysis, if a large number of healthy individuals leave the individual market in favor of the buy-in product, premium increases and deterioration of the risk pool for individual market carriers could result. Due to administrative and tax requirements for individual market insurers, they would likely be unable to achieve a lower premium relative to a state-initiated buy-in product. A statewide buy-in product may also prompt insurers with dominance in certain geographic regions to leave the market, resulting in the buy-in option being the only source of coverage. State officials will need to work closely with insurance carriers to ensure the buy-in product introduces healthy competition without prompting exits from the individual market.

Conclusion

In sum, this analysis is an important first step in understanding the feasibility of a Medicaid buy-in for Colorado. The estimates reveal that lower administrative and provider reimbursement costs could drive premium decreases and that, subject to federal approval, resulting state savings could be used to further strengthen coverage for Colorado residents. At the same time, it is important to highlight that these results are preliminary and that other key decisions—such as making the buy-in available more broadly (e.g., to small businesses), marketing it particularly to those who are currently uninsured, and/or offering it as an individual market option through Connect—could lead to different results. More work is needed to determine the best design decisions for a Colorado Medicaid buy-in.

Authorship

Several Colorado provider and consumer advocacy organizations worked together on this project. The following nonpartisan, not-for-profit organizations worked directly with Manatt and Wakely on the report.

Colorado Center on Law and Policy
CCLP advances the health, economic security and well-being of low-income Coloradans through research, education, advocacy and litigation.

Colorado Consumer Health Initiative
CCHI advances the consumer voice to improve access to healthcare for all Coloradans by working statewide for progress toward equity, access, affordability and quality.

The Bell Policy Center works to ensure economic mobility for every Coloradan.

Manatt Health Strategies
This white paper was prepared by Chiquita Brooks-LaSure, Jocelyn Guyer, April Grady, and Kyla Ellis.

Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system.

Combining legal excellence, first-hand experience in shaping public policy, sophisticated strategy insight, and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players.

Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future. For more information, visit https://www.manatt.com/Health.

Wakely Consulting Group
Wakely Consulting Group, LLC, are actuaries and consultants who specialize in healthcare financing. Wakely has considerable experience carrying out complex projects, yet its size and structure allow it to be nimbler and more responsive than larger firms. We are a team of diverse professionals with a comprehensive understanding of the entire spectrum of healthcare, including substantive experience working with state agencies, health insurance carriers, boards of directors, advocacy groups, hospitals and physicians. Wakely has approximately 100 employees, including 50 credentialed actuaries, in seven offices across the country.

For more information, visit https://www.wakely.com.

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Appendix: Detailed Analysis Considerations

Variations on the Illustrative Scenario

In addition to the illustrative scenario described for the initial buy-in approach, we examined alternative scenarios with more risk selection (i.e., an even healthier population moving to the buy-in) and larger numbers of Connect participants with APTCs moving to the buy-in.

Key takeaways include:

- The greater the number of APTC enrollees migrating to the buy-in, the higher the federal savings relative to the initial buy-in scenario modeled. Higher savings are the result of fewer APTCs being paid in the Marketplace. For example, a 5 percentage point increase in migration of APTC enrollees increases the federal pass-through amount from approximately $28 million to approximately $61 million.
- The more the state can encourage less-healthy members to migrate to the buy-in, the higher the federal savings. Higher premiums, and therefore higher APTCs, result when higher-risk individuals remain in the individual market. For example, a 10 percent greater risk selection as compared with the individual market relative to the initial buy-in scenario would increase premiums for remaining individual market enrollees by an additional 0.8 percentage points. The federal pass-through amount would be approximately $21 million as opposed to approximately $28 million.

Data and Methodology

To create the enrollment and premium estimates, Wakely completed the following steps:

Estimating Initial Scenario

1. ACA individual market enrollment and premiums were estimated using previous reinsurance analysis for Colorado's individual market (see Reliances and Caveats). This data was estimated for the 2019 benefit year. Wakely then trended the data to 2020. Premiums were trended at 8 percent, and net premiums were trended at 1 percent. Non-APTC enrollment was estimated to decrease by 2 percent, and APTC enrollment was estimated to be the same as the 2019 estimate. Estimates do not include adjustments for policy changes that have occurred since the report, such as individual mandate repeal. The 2019 experience is largely unknown given recent federal changes. Thus, the 2020 baseline should be considered equally unknown. This is just one estimate of 2020 enrollment and premiums.

2. For the baseline scenario, 10 percent of non-APTC enrollees and 5 percent of APTC enrollees were assumed to leave the ACA individual market and enter a Medicaid buy-in program. Given current uncertainties on the program specifications, it is difficult to estimate an exact number, and migration estimates should be treated as illustrative. Nonetheless, Wakely feels the baseline migration estimates are not unreasonable.

3. To estimate the effect of individuals exiting the individual market, Wakely first assumed a morbidity factor of 0.9 for those leaving the market. The healthier population leaving aligns with

previous research that healthier individuals tend to be more price-sensitive and more indifferent to narrower networks.[26,27]

4. Medicaid buy-in premiums were estimated in the following way for the baseline scenario:
    a. Plan characteristics similar to those of the ACA individual market were assumed for the Medicaid buy-in product. In particular, essential health benefits, AV, age rating and other market reform rules were assumed for the Medicaid buy-in plan.
    b. Similarly, we assumed that the distribution of members who migrate to the buy-in product is similar to that of the ACA population with respect to age and metal level.
    c. People choosing Connect or other individual market plans can select from multiple levels of cost sharing, organized by metal levels that represent the plan's actuarial value or by percentage that insurance companies will pay on average for the health services consumers use.[28] On Connect, most individuals select Silver or Bronze coverage plans.[29] This analysis models a state buy-in product that reflects the metal tier of the plans that individuals currently purchase.
    d. The baseline ACA premium estimates were adjusted for the following:
        i. Premiums were reduced by 6 percent to account for lack of inclusion of margin and certain taxes. It is not yet known how the product will be operationalized and what portion, if any, of taxes and fees would apply to the entity administering the program. Based on 2016 Unified Rate Review Template (URRT) data, all margin and roughly half of the taxes/fees were removed to arrive at the 6 percent.
        ii. Premiums were further reduced by 15 percent for provider payment rate savings. This was estimated using a Wakely study using MarketScan data, in which Wakely estimated the unit differences between average Colorado commercial claims and average Colorado Medicare claims. MarketScan data is primarily large-group data, so estimates were made to reduce the variation since it is assumed that the average issuer in the individual ACA market is contracting at lower provider payment rates than in the large group market. Finally, the impact was reduced for prescription drugs (assumed no savings compared with the individual ACA market) and the non-benefit expense portion of premiums.
        iii. Differences in morbidity were incorporated to account for the healthier inflow of enrollees, using the assumption noted previously.

[26] Shepard, M. (2016). Hospital network competition and adverse selection: Evidence from the Massachusetts health insurance exchange (No. w22600). National Bureau of Economic Research.

[27] Hackmann, M.B., Kolstad, J.T., and Kowalski, A.E. (2015). Adverse selection and an individual mandate: When theory meets practice. American Economic Review, 105(3), 1030–66.

[28] Premiums are higher for plans that pay more out-of-pocket medical costs, with options sold in Bronze, Silver, Gold and Platinum tiers. Bronze plans have the lowest premiums but highest out-of-pocket costs. This means the consumer will have to pay a higher share of costs when he/she uses services. People who qualify for cost-sharing reductions must enroll in a Silver plan to receive reduced cost sharing. (1) Platinum: Expected to cover 90 percent of the cost of benefits on average (90 percent AV); (2) Gold: Expected to cover 80 percent of the cost of benefits on average (80 percent AV); (3) Silver: Expected to cover 70 percent of the cost of benefits on average (70 percent AV); (4) Bronze: Expected to cover 60 percent of the cost of benefits on average (60 percent AV).

[29] CMS. (2018). 2018 Marketplace Open Enrollment Period Public Use Files. Accessed from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html.

e. The Medicaid buy-in program was assumed to provide premium subsidies to individuals eligible for premium tax subsidies in a qualified health plan. Given our understanding that Colorado wants enrollees to be able to access premium subsidies and gain Section 1332 waiver approval, the Medicaid buy-in must have some incentive to encourage APTC migration in order for the program to meet the budget neutrality requirements of the Section 1332 waiver. Wakely targeted a reduction of at least 5 percent in net premium amounts for APTC members. The savings may ultimately need to be higher to encourage migration (not as significant a premium change as non-APTC enrollment, as these members are price-sensitive).

5. To calculate a potential federal pass-through, APTC per member per months post-Medicaid buy-in was calculated by increasing the gross premium amounts for those with APTCs by the change in premiums due to a change in morbidity from potentially healthier people migrating out of the ACA single risk pool. The aggregate APTC amount was lower due to the shift in APTC enrollees out of the Marketplace. Net premiums were then subtracted from that amount. (This was calculated assuming the higher the FPL, the greater the probability an APTC enrollee would migrate. In particular, enrollees who did not qualify for cost-sharing reductions were much more likely to shift to the buy-in program. This is because individuals with higher incomes have higher net premiums.) The difference between the estimated total APTCs paid before Medicaid buy-in and the estimated total APTCs paid after Medicaid buy-in is equal to the total federal savings/pass-through amount. Wakely assumed that APTC amounts are equal to the premium tax credit amounts and did not account for differences as a result of tax reconciliation. Wakely notes that under Section 1332 waiver rules, the increase in individual market premiums could result in a waiver not being approved, as it may violate the affordability guardrail. As a result, further analysis should focus on how to encourage less-healthy members to migrate to the buy-in product.

6. Wakely also estimated several additional scenarios to illustrate potential directional effects of different assumptions. These additional scenarios centered on lower provider savings, a greater number of enrollees migrating, a greater number of APTC enrollees migrating and a greater number of non-APTC enrollees migrating.

7. Wakely also provided an illustrative example of potential costs associated with providing cost-sharing protections such that the lowest cost sharing an average consumer would pay would be on par with a Silver or Gold plan. Wakely also estimated the effect of having lower cost sharing for enrollees. This was estimated in such a way that the state would subsidize enrollee premiums in the form of cost-sharing reduction payments (similar to how the federal system used to work). Premiums would be substantially higher, relative to the baseline Medicaid buy-in (especially for Bronze/catastrophic), for enrollees if the reduced cost sharing is included in premiums. However, the state may have insufficient funds if it directly subsidizes. Wakely also estimates the cost of subsidizing enrollees such that all enrollees are guaranteed at minimum a Silver plan. Wakely estimates that while a Gold plan wrap may cost $19.4 million, a Silver wrap may cost $7 million. The analysis assumes static metal-level selection and only accounts for the change in cost sharing and increases in cost due to potential induced demand. Enrollment in the subsidized plans may be static due to eligibility restrictions. However, if enrollees can choose plans freely, subsidies for cost sharing are provided to all enrollees, and no eligibility restrictions are in place, greater migration to lower-priced (i.e., lower-AV) plans is likely. This could greatly increase state costs or premiums.

Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- CMS 2017 and 2018 Open Enrollment Period Public Use Files[30]
- Enrollment data from the Colorado Exchange, received June 25, 2018
- Milliman's 2019 Colorado reinsurance analysis[31]
- 2016 URRT data
- Induced demand as measured by the 2019 Notice of Benefit and Payment Parameters[32]
- Research on individuals' responses to changes in premiums[33] and differences in network breadth[34]

The following are additional reliances and caveats that could have an impact on results:

- The estimates included in this analysis should be considered directionally correct and useful for feasibility purposes but inappropriate for point estimates or budget planning. Further analysis, with detailed data, is warranted.

- Wakely did not adjust Colorado's individual market estimates for changes that are expected for the 2019 or 2020 benefit year, including individual mandate repeal, Silver-loading and introduction of non-ACA products. All of these could influence the estimates in this analysis. Again, this analysis was aimed at isolating key levers to make a Medicaid buy-in feasible rather than producing estimates for budget purposes. Further granular analysis is necessary.

- The estimates were calculated at a market level rather than an individual level. Individual-level data calculations may produce different results. For example, APTC amounts are directly tied to which individuals migrate. Federal savings and subsidies provided by the state in the Medicaid buy-in may differ if individual-level data is used for analysis.

- Wakely also did not include how changes in metal-level composition (e.g., enrollees in a Bronze plan more likely to join a Medicaid buy-in) could affect individual market premiums, risk adjustment transfers or a Section 1332 waiver. In theory, we may be underestimating Silver premium increases for the ACA market if enrollees in lower-tiered metal levels are more likely to shift to a Medicaid buy-in. For example, providing a Gold plan benefit structure to all non-cost-sharing reduction enrollees would increase premiums due to lower cost sharing and higher induced demand. However, it should increase federal pass-through amounts, as less cost sharing should attract relatively less-healthy enrollees. There is inherent uncertainty in estimating the exact morbidity of migrating enrollees to a program in a unique environment of Medicaid buy-in, ACA individual market (i.e., guaranteed issue), and no individual mandate. Wakely cautions

[30] CMS. (2018). 2018 Marketplace Open Enrollment Period Public Use Files. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html.

[31] Colorado Department of Regulatory Agencies. (2017). Colorado High-Risk Health Care Coverage Materials, https://drive.google.com/drive/folders/0B_UoCf17OVmWTUxxOUFuMzRmVGs.

[32] HHS Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019. https://www.gpo.gov/fdsys/pkg/FR-2018-04-17/pdf/2018-07355.pdf.

[33] Hackmann, M.B., Kolstad, J.T., and Kowalski, A.E. (2015). Adverse selection and an individual mandate: When theory meets practice. American Economic Review, 105(3), 1030–66.

[34] Shepard, M. (2016). Hospital network competition and adverse selection: Evidence from the Massachusetts health insurance exchange (No. w22600). National Bureau of Economic Research.

that—especially in the short term, where operational and marketing issues may be especially important—outcomes can vary from what is depicted in these scenarios.

- Wakely did not include additional operational costs that the state may incur that an issuer may not typically process. For example, eligibility/APTC determinations/large marketing effort are administrative expenses that issuers currently do not accrue, or they do so on a far lower level than what might be necessary to implement the buy-in. Such expenses would need to be accounted for via Section 1332 pass-through funds or state funds, which may limit subsidies or the potential of cost-sharing wraps. Wakely also did not account for initial operational startup costs in premium estimates.

- Wakely did not account for any changes a buy-in policy would have on the state Medicaid program or other state expenses.

- Wakely assumed that Marketplace eligibility standards are the same eligibility standards the Medicaid buy-in would use. Relaxation of this assumption could affect estimates.

- Wakely did not include any take-up by the uninsured. In a mandate-less environment, this assumption was not unreasonable; however, it is possible that some uninsured would take up this new product. Future analyses should include scenarios of additional uninsured take-up.

- There is significant political uncertainty around future federal policy actions in regard to the ACA market. Potential federal policies may alter results.

- Future enrollment is inherently uncertain. Beyond changes to potential rates and policy (e.g., mandate repeal, short-term duration plans, association health plans), individual enrollee responses to these changes are also uncertain. All of these factors result in uncertainty for future estimates. Additionally, there is no historical data on which to base the estimates for a Medicaid buy-in; these enrollment estimates are high-level for illustrative purposes.

- Given that several regulations (e.g., short-term duration plans, 2020 Payment Notice) have not been finalized, there is uncertainty in how issuers may respond to their 2020 premiums.

Disclosures and Limitations

Responsible actuaries. Julie Peper is the actuary responsible for this communication. She is a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. She meets the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended users. This information has been prepared for the sole use of the Colorado Center on Law and Policy, the Colorado Consumer Health Initiative and the Bell Policy Center. This report should be distributed to parties in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Users of the results should be qualified to use the report and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Colorado will attain the estimated

values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of the Colorado Center on Law and Policy, the Colorado Consumer Health Initiative and the Bell Policy Center.

Data and reliance. We have relied on others for data and assumptions used in the analysis. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the Data and Methodology and Reliances and Caveats sections identifies the key data and reliances.

Subsequent events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material changes. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results. Material changes to federal or state regulations may also have a material impact on the results. In addition, any changes in issuer actions as well as emerging 2018 enrollment and experience could impact the results. There are unknown impacts of the mandate repeal, association plans and short-term duration plans. This should be considered a feasibility analysis, and further refinement in how the product would be developed and operationalized could impact the results, potentially significantly. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of actuarial report. This document (the report, including appendices) constitutes the entirety of the actuarial report and supersedes any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs, with no known deviations. A summary of ASOP compliance is listed below:

- ASOP No. 23, Data Quality
- ASOP No. 41, Actuarial Communication