www.wakely.com

State of Colorado

Actuarial Analysis of a Colorado Health Insurance Option in 2022

February 21, 2020

Prepared by:
Wakely Consulting Group, LLC

Aree Bly, FSA, MAAA
Senior Consulting Actuary

Brittney Phillips, ASA, MAAA
Consulting Actuary

TABLE OF CONTENTS

Introduction

As required in House Bill 19-1004, the Colorado Insurance Commissioner, along with the Department of Health Care Policy and Financing (HCPF), developed a report that was submitted to the General Assembly in November 2019 on potential options for a Colorado Health Insurance Option.[1] The Colorado Division of Insurance (DOI) within the Department of Regulatory Agencies (DORA) retained Wakely Consulting Group, LLC (Wakely) to provide additional analysis on new structures of the Colorado Health Insurance Option beyond what was described in the initial report.

The DOI requested that Wakely analyze how a Colorado Health Insurance Option might impact the Colorado Affordable Care Act (ACA) individual market for the 2022 benefit year. In particular, Wakely focused on the potential impact to enrollment, premiums, and Premium Tax Credits (PTCs), as well as potential Federal pass-through savings. It is expected that a Colorado Health Insurance Option would benefit the current individual market by offering additional plan choices and lower premiums. This may also encourage current uninsured individuals to enroll in a health care plan.

This report expands on the November 14, 2019, report that Wakely provided in support of the submission to the General Assembly. This version updates the reimbursement methodology for facilities under the Colorado Health Insurance Option and explores funding a premium wrap to reduce premiums for subsidized members. The analysis reviews the impact for each rating area separately.

This document has been prepared for the sole use of DOI. This document contains the results, data, assumptions, and methods used in our 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.

Summary

Colorado is considering a Colorado Health Insurance Option that would provide health care options for individuals across the state at potentially lower premiums than currently offered. The goals of the Colorado Health Insurance Option include increased choice in health insurance plans, improved affordability, and increased competition in the individual health insurance market. The following is the structure of the Colorado Health Insurance Option that was analyzed:

1. The issuers will offer the plans on and off the Exchange in the individual market.

[1] http://www.leg.colorado.gov/bills/hb19-1004

2. The issuers will offer qualified health plans (QHPs) at Bronze, Silver, and Gold metal tiers.

3. The premiums of the plans will reflect facility reimbursement levels that vary by facility. The formula for determining facility-specific reimbursement levels was provided by DOI, utilizing hospital specific financial information provided by HCPF. Maximum reimbursement levels by facility are set between 155% and 218% of Medicare payment rates.

4. The plans will be offered beginning in calendar year 2022.

5. The state intends to apply for a 1332 waiver and use Federal pass-through savings for additional benefits or expanded coverage.[2] The Baseline scenario presented below reflects the current federal and state regulatory market, including a state-based reinsurance program. The second scenario reflects the results of offering a Colorado Health Insurance Option with additional benefits, a premium wrap and a cost-sharing wrap. The premium wrap would decrease the required contribution of income between 0.7 and 1.2 percentage points for enrollees below 400% of the federal poverty level (FPL). The cost-sharing wrap will reduce expenses through lower deductibles, copays, and/or coinsurance rates for on-Exchange Silver plan enrollees between 200% and 400% FPL. This would be achieved through a new CSR plan for enrollees between 200%-249% FPL with a 77% actuarial value (members currently eligible for 73% AV CSR plan) and expanding eligibility for the 73% AV CSR plan to members between 250%-400% FPL (members currently not eligible for CSRs).

   Comparing the two scenarios shows the differences in enrollment and premiums, as well as the total pass-through amounts available. The comparison further analyzes the cost of the additional premium and cost-sharing subsidies, and how much of the pass-through funding would be used to pay for these additional benefits.

   The estimates presented throughout this report assume both the premium wrap and cost-sharing wrap are included. However, we did evaluate the impact of offering each of these benefits on their own. The results of those scenarios are shown below in the “Pass-Through Savings and New Benefit Program Scenarios” section.

   The initial analysis also included an evaluation of including adult dental benefits. These benefits were found to be a material cost and could not be offered simultaneously with the premium and cost-sharing wraps using the Federal pass-through savings available. As such, adult dental benefits are not included in this revised version.

The key findings of the analysis include:

[2] Section 1332 of the Affordable Care Act allows states to waive key provisions of the ACA in order to pursue innovative health coverage models. 1332 waivers allow states to receive federal funds “pass-through amounts” if the Secretaries of HHS and Treasury both approve the waiver and estimate federal savings. This report assumes a successful 1332 waiver and should not be seen as commenting on the likelihood of a 1332 waiver being approved.

1. The Colorado Health Insurance Option with premium and cost-sharing wraps is estimated to reduce average premiums by 12.0% statewide, with reductions varying from 7.1% in Rating Area 2 – Colorado Springs to 19.8% in Rating Area 4 – Fort Collins, compared to the expected rates in 2022 based on current policies and regulations.

2. Total enrollment in the Colorado individual market is estimated to increase by approximately 18,100 members. The new members are expected to be individuals who were previously uninsured, and are a combination of unsubsidized and subsidized individuals. This is a significant increase over the assumed take-up in the previous version of the report, and is due to the addition of the premium wrap program. We are estimating a greater take-up among the uninsured as individuals tend to be sensitive to premium changes. An increase in subsidized enrollment due to decreases in net premiums from the premium wrap could lower pass-through savings. Wakely further assumed no change in employer coverage as a result of the Colorado Health Insurance Option for the initial year.

3. Our best estimate of the total reduction in Premium Tax Credits in 2022, as a result of the Colorado Health Insurance Option, will be approximately $42.7 million under the assumptions outlined in this report. These amounts reflect the potential Federal pass-through savings and would be used to fund the premium wrap and cost-sharing wrap benefits.

   This estimate is lower than the previous version due to the increased take-up of subsidized members with the premium wrap program.

The ultimate structure of the Colorado Health Insurance Option, as determined by the legislature, will define the impact that the program has on the individual market. Changes to the structure of the program, federal regulations, or the underlying market could alter the results. The assumptions underlying the analysis in this report include the following:

1. Issuers will offer plans that adhere to the Colorado Health Insurance Option requirements using their current provider networks and infrastructure.

2. Issuers will be required to offer Colorado Health Insurance Options and these options will become the second lowest cost silver plan (SLCSP) in every service area in the state.

3. There will be limits to reimbursement for facility services. The limits will set the maximum reimbursement for facility services by facility. These are modeled to range from 155% to 218% of Medicare. Professional and prescription drug reimbursement will not be impacted under the Colorado Health Insurance Option.

4. The benefits and actuarial value of the plans will align with ACA individual market requirements (i.e., Essential Health Benefits, metallic actuarial values (AV)). The Silver Colorado Health Insurance Option plan will reflect a target AV of 71.5%, while Gold and

Bronze Colorado Health Insurance Option plans will reflect AVs in line with current individual market plans.

5. Wakely assumed the effects of the reinsurance program are unaffected by the introduction of the Colorado Health Insurance Option and that the reinsurance program will continue into 2022.

6. Wakely assumed that current Federal and state laws pertaining to the ACA are unchanged. The requirement for 85% MLR would apply to the issuer as a whole. Wakely assumed that the recent regulations impacting Association Health Plans and Health Reimbursement Accounts would not impact enrollment.

Results

Premium Impact of Colorado Health Insurance Option

To estimate the impact of a Colorado Health Insurance Option, Wakely first estimated the enrollment and premiums in the individual market in 2022 under current state and Federal regulations, which is the baseline estimate. To develop the baseline, Wakely analyzed Colorado rate filings, publicly available information, rates submitted by issuers for 2019 and 2020, and the analysis performed by Lewis and Ellis for the reinsurance program that will be effective in 2020 in Colorado.[3] We developed our analysis to reflect geographic differences based on the nine rating areas established for the ACA markets in Colorado. The prior analysis only utilized three high-level regions which were established to align with the regions defined in the analysis of the reinsurance program development. The "Urban" region reflected rating areas 1, 2, and 3. The "Rural West" region reflected rating areas 5 and 9. And the "Rural East" region reflected rating areas 4, 6, 7, and 8.

Once the baseline 2022 premiums were estimated and through discussions with the DOI, Wakely adjusted the current individual market premiums for the Colorado Health Insurance Option. The adjustments reflect various facility payment rates as an average of Medicare and also an expected increase in AV for Silver plans to reflect the targeted 71.5% AV[4] of the Colorado Health Insurance Option.

A key result of the modeling is the premium difference between the baseline 2022 ACA products and the Colorado Health Insurance Option in 2022. To the extent provider behavior, individual market carrier behavior, or the Colorado Health Insurance Option pricing differ from expected, the

[3] Colorado Reinsurance Program Analysis, March 2019, https://drive.google.com/file/d/1nREYicKQsB3zprlPLR9ztP_HSyFtIvEu/view

[4] As measured by the 2020 Actuarial Value Calculator

results may differ. Table 1 shows the weighted average premiums of the Colorado Health Insurance Option for each of the regions as well as the statewide average premiums, assuming no change in the distribution of members by age and metal level. The premium changes are assumed to similarly impact the benchmark plans for calculation of the PTC.

Table 1: Difference between 2022 Baseline Average ACA Premiums and the Colorado Health Insurance Option by Rating Area

Region	Rating Area	Baseline Projected 2022 ACA Premium	Colorado Health Insurance Option Estimated 2022 ACA Premium	Premium Impact
Urban	1 - Boulder	$504	$462	-8.4%
Urban	2 - Colorado Springs	$525	$488	-7.1%
Urban	3 - Denver Metro	$498	$445	-10.7%
Rural East	4 - Fort Collins	$535	$429	-19.8%
Rural West	5 - Grand Junction	$636	$516	-18.8%
Rural East	6 - Greeley	$541	$445	-17.7%
Rural East	7 - Pueblo	$587	$532	-9.3%
Rural East	8 - East	$638	$558	-12.6%
Rural West	9 - West	$679	$570	-16.0%
Statewide Average		**$536**	**$472**	**-12.0%**

Premium Tax Credit Pass-Through Savings of Colorado Health Insurance Option Program

Premium tax credits are influenced by the cost of the benchmark, or second lowest cost silver plan. We are assuming that more than one Colorado Health Insurance Option plan will be available in all regions, so the Colorado Health Insurance Option plan will become the new benchmark plan for purposes of calculating the PTCs. The current subsidized population will be impacted by the new lower benchmark plan.

The Federal PTC costs associated with the subsidized population are essentially the difference between the unsubsidized premium and the required contribution level for subsidized individuals. Wakely assumed that the 2022 contribution rate would equal the 2020 estimated contribution rate based on 2020 filed rates, trended at 2% to 3% annually. The unsubsidized premiums per member per month (PMPM) are as reflected in Table 1, adjusted to reflect differences in demographics and plan mix between the total market and subsidized population. Federal costs under the baseline and Colorado Health Insurance Option with premium and cost-sharing wrap programs are shown in Table 2 below. Note that actual pass-through savings will be calculated by the Office of Tax Analysis (OTA) and could differ from that shown below due to differences in methodology, actual premiums filed by carriers, actual level of take-up by the uninsured, etc.

Table 2: Subsidy Estimates after Introduction of a Colorado Health Insurance Option

Region	Rating Area	Baseline Scenario 2022 PTCs	PTCs with Colorado Health Insurance Option and Wrap Programs	Pass-Through Savings
Urban	1 - Boulder	$40,300,000	$39,400,000	$900,000
Urban	2 - Colorado Springs	$46,100,000	$45,000,000	$1,100,000
Urban	3 - Denver Metro	$247,900,000	$232,800,000	$15,100,000
Rural East	4 - Fort Collins	$40,500,000	$32,200,000	$8,300,000
Rural West	5 - Grand Junction	$19,500,000	$16,600,000	$2,900,000
Rural East	6 - Greeley	$23,000,000	$19,400,000	$3,600,000
Rural East	7 - Pueblo	$9,200,000	$8,900,000	$300,000
Rural East	8 - East	$40,600,000	$41,300,000	-$700,000
Rural West	9 - West	$124,100,000	$112,900,000	$11,200,000
	Statewide Average	**$591,200,000**	**$548,500,000**	**$42,700,000**

A key assumption underlying the results above are the baseline reimbursement rates in the individual market. As described below, the current reimbursement rates in the individual market are estimated to be approximately 280% of Medicare rates, though this varies by facility and area. This estimate is based on a summary of average reimbursement levels by facility using the Colorado All Payer Claims Database (APCD) for claim payments from 2015-2017[5] and was adjusted to reflect the individual market based on the results of a study performed by Lewis & Ellis using 2017 individual market claim payments provided to Wakely by DOI. The data underlying the APCD analysis includes all commercial claim payments, including the individual market as well as group markets.

The pass-through savings will be used to provide additional benefits to enrollees. Wakely reviewed the potential cost for a premium wrap and a cost-sharing wrap. Subsidized members who are not currently enrolled in their benchmark plan could pay higher premiums under the Colorado Health Insurance Option as the reduction in their premium subsidy reduces their buying power. The premium wrap could partially or fully offset this loss of buying power by decreasing the required contribution for enrollees below 400% FPL. The cost-sharing wrap will reduce expenses through lower deductibles, copays, and/or coinsurance rates for on-Exchange Silver plan enrollees between 200% and 400% FPL.

We estimate that the total cost to add both a premium wrap for enrollees below 400% FPL and cost-sharing wrap for enrollees between 200% and 400% FPL is approximately $42.1 million in

[5] https://www.civhc.org/get-data/public-data/interactive-data/reference-pricing/

2022. These estimated amounts are below the expected Federal pass-through amounts. Colorado would adjust the program, as needed, to align with deficit neutrality requirements.

Table 3: Approximate Funds Needed in Year 1 (2022) for Wrap Programs

Region	Rating Area	Premium Wrap	Cost-Sharing Wrap	Total Funds Required
Urban	1 - Boulder	*$2,600,000*	*$700,000*	**$3,300,000**
Urban	2 - Colorado Springs	*$2,600,000*	*$700,000*	**$3,300,000**
Urban	3 - Denver Metro	*$16,000,000*	*$4,100,000*	**$20,100,000**
Rural East	4 - Fort Collins	*$2,400,000*	*$500,000*	**$2,900,000**
Rural West	5 - Grand Junction	*$900,000*	*$100,000*	**$1,000,000**
Rural East	6 - Greeley	*$1,300,000*	*$300,000*	**$1,600,000**
Rural East	7 - Pueblo	*$500,000*	*$100,000*	**$600,000**
Rural East	8 - East	*$2,000,000*	*$400,000*	**$2,400,000**
Rural West	9 - West	*$5,500,000*	*$1,400,000*	**$6,900,000**
	Statewide Average	*$33,800,000*	*$8,300,000*	**$42,100,000**

Table 4: Difference between Pass-Through Savings and Funds Required for Wrap Programs

Region	Rating Area	Pass-Through Savings	Funds Required for Added Benefits	Pass-Through Savings Less Funds Required for Added Benefits
Urban	1 - Boulder	$900,000	$3,300,000	-$2,400,000
Urban	2 - Colorado Springs	$1,100,000	$3,300,000	-$2,200,000
Urban	3 - Denver Metro	$15,100,000	$20,100,000	-$5,000,000
Rural East	4 - Fort Collins	$8,300,000	$2,900,000	$5,400,000
Rural West	5 - Grand Junction	$2,900,000	$1,000,000	$1,900,000
Rural East	6 - Greeley	$3,600,000	$1,600,000	$2,000,000
Rural East	7 - Pueblo	$300,000	$600,000	-$300,000
Rural East	8 - East	-$700,000	$2,400,000	-$3,100,000
Rural West	9 - West	$11,200,000	$6,900,000	$4,300,000
	Statewide Average	**$42,700,000**	**$42,100,000**	**$600,000**

Additional Take-up of Uninsured Members

Wakely estimated take-up of the Colorado Health Insurance Option product by currently uninsured individuals. The estimate utilized the non-linear enrollment response function estimated

by the Council of Economic Advisors (CEA take-up function).[6] Uninsured individuals eligible for subsidies are expected to be encouraged to take up coverage due to the potential for lower premiums through the premium wrap and reduced cost-sharing through the cost-sharing wrap. We assumed that additional growth in enrollment will come from uninsured individuals driven by the lower cost of the Colorado Health Insurance Option plan premiums.

The population that is uninsured in the baseline but who are estimated to enroll due to lower premiums are assumed to be motivated primarily by price of the product. Thus, they are expected to have lower relative morbidity, as they are not driven to purchase coverage due to pressing health needs. Wakely estimates that the average cost of the unsubsidized individuals is 73% of the current average ACA market individual. To arrive at this factor we used data from a CEA study on the marginal costs of enrollees.[7]

Final enrollment estimates can be seen in Table 5 below.

Table 5: Total Enrollment Estimates by Rating Area

Region	Rating Area	Baseline 2022 Individual Enrollment	Unsubsidized Individuals - Previously Uninsured	Subsidized Individuals - Previously Uninsured	Estimated Total Individual Enrollment
Urban	1 – Boulder	19,100	600	1,000	20,700
Urban	2 - Colorado Springs	15,900	500	1,000	17,400
Urban	3 - Denver Metro	104,500	3,100	5,600	113,200
Rural East	4 - Fort Collins	14,100	400	700	15,200
Rural West	5 - Grand Junction	4,200	100	300	4,600
Rural East	6 – Greeley	6,700	200	400	7,300
Rural East	7 – Pueblo	2,300	100	200	2,600
Rural East	8 – East	8,500	200	1,100	9,800
Rural West	9 – West	23,800	700	1,900	26,400
	Statewide Average	**199,100**	**5,900**	**12,200**	**217,200**

[6]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[7]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

Data and Methodology

2022 Baseline

The first component of the analysis was to create the 2022 baseline for the individual market's enrollment and premium estimates without consideration of a new Colorado Health Insurance Option. Wakely completed the following steps:

1. Initial 2019 enrollment was estimated using publicly available data and data from Connect for Health Colorado and DOI.

    a. The number of enrollees with PTCs in 2019 was measured based on the reported number of enrollees with an Advanced Premium Tax Credit (APTC) provided by the Exchange, Connect for Health Colorado (C4HCO) as of April 2019. The number of enrollees with PTCs was assumed to be the same as the number of enrollees with APTC.

    b. On and off Exchange enrollment for 2019 was provided by DOI as of April 2019.

2. Overall enrollment in 2020 through 2022 was estimated based on a non-linear enrollment response function estimated by the Council of Economic Advisors (CEA take-up function)[8] based on estimated premium increases in 2020 through 2022. The function computes expected enrollment change based on premium rate increases and the portion of the market that is not receiving subsidies. As the APTC subsidy structure insulates those eligible for subsidies from premium increases, the changes in overall enrollment were distributed pro rata between on-Exchange unsubsidized and off-Exchange by the share of unsubsidized enrollment that the on-Exchange enrollees represent.

    In addition, we assumed some shifting between the on-Exchange subsidized and unsubsidized enrollment through 2022. As the premium rate changes before subsidies differ from the change in required contribution used to determine subsidy eligibility, enrollees on the border of subsidy eligibility may gain or lose eligibility in a given year. Therefore, Wakely assumed members would shift between subsidized and unsubsidized membership, with members shifting to unsubsidized when APTC PMPMs decrease, and shift back to subsidized when APTC PMPMs increase.

[8]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

3. State-wide average premium: Wakely used the 2020 state average premium as identified from 2020 rate filings. This amount was then increased by 2021 and 2022 estimated rate increases of 6% based on Lewis and Ellis report[9] assumptions. The rate increases in 2021 and 2022 are driven by trend and the morbidity assumption.

4. APTC amounts per member per month for 2019 were provided by C4HCO as of June 2019. We assumed the average APTC and premium for the remainder of 2019 would not vary significantly from these values. To estimate the 2020 APTC PMPMs, we increased the required contribution (i.e., net premium) based on an analysis of the impact of the 2020 filed rates for members enrolled in June 2019. The required contribution increase was based on an equal blend of the results of two scenarios described below:

    1. All members auto-renew in 2020 and remain in the same plan as they enrolled in 2019. For members whose plans are being discontinued, if the carriers indicated these members would be cross-walked, the cross-walked plan was assumed.

    2. All members switch to the lowest cost plan offered by their current issuer and in their current metal level. This second option allows members to offset some or all of the net premium increase they may have otherwise experienced.

    This blend resulted in a net premium increase from 2019 to 2020 ranging from approximately -25% in Rating Area 5 to 36% in Rating Area 1.

    To estimate 2021 through 2022 APTC PMPMs, we increased the required contribution to conform to the indexing of the contribution rate. We increased it 2% annually from 2020 to 2022. We then trended gross premiums for APTC enrollees (the 2019 APTC amounts plus net premiums) by the 2020 through 2022 premium increases noted above. This new 2022 gross premium amount is then reduced by the 2022 contribution rate (since APTC enrollees' share of premiums is capped based on their respective household income) to calculate the 2022 APTC PMPM amounts. We assumed that the distribution of subsidized members by FPL would be constant.

Colorado Health Insurance Option Premiums

To create the estimated 2022 Colorado Health Insurance Option product rates, Wakely completed the following steps:

[9] https://drive.google.com/open?id=1gWS-ovi7pCeccXQT1vOckti6_SVwdPbx

1. Started with 2020 Individual market rates – These rates were blended across the rating areas based on the total 2019 enrollment.

2. Adjusted Reimbursement Rates. Current facility reimbursement averages for the individual market are estimated to be approximately 280% of Medicare rates. This average was estimated based on a summary of average reimbursement levels by facility using the Colorado All Payer Claims Database for claim payments from 2015-2017.[10] The overall reimbursement rate was estimated to be 294% for facilities for commercial plans. This was reduced to reflect an individual market average of 280% based on a study by Lewis & Ellis using 2017 individual market claim payments, provided by DOI.

   The projected reimbursement rates vary by facility and range from 155% to 218% of the Medicare reimbursement rate. The reimbursement for each facility was provided by DOI.

   Hospital reimbursement rates were set on a facility by facility basis via a formula that pays hospitals more when they meet certain criteria. Hospital specific financial data used to calculate reimbursement rates were provided by HCPF. Starting at a base rate of 155% of Medicare payments, a hospital's reimbursement rate was increased by additional percentage points of Medicare payments based on the type of hospital, a hospital's payer mix, and a hospital's efficiency. Below are the criteria used to increase the reimbursement rate:

   - Critical Access hospital received an additional 20 percentage points above the base rate.
   - Independent hospitals (i.e. those not owned by a system larger than 2 hospitals) also received 20 additional percentage points.
   - Hospitals who had more than 65% of their adjusted discharges from Medicare and Medicaid patients (the statewide average) received up to an additional 30 percentage points. Hospitals that exceeded this statewide payer mix average by a larger amount received more of the maximum 30 additional percentage points.
   - Hospitals received up to 10 additional percentage points for each of the following: having net patient revenue per adjusted discharge lower than the state average of $15,618, and having hospital only operating expenses per adjusted discharge lower than the statewide average of $11,790.
   - Hospitals received up to 20 additional percentage points for having net income per adjusted discharge of less than $2,149.

[10] https://www.civhc.org/get-data/public-data/interactive-data/reference-pricing/

The baseline and resulting reimbursement rates as a percent of Medicare are shown below for the different areas.

Table 6: Assumed Reimbursement Rates as a Percent of Medicare Payments by Area

Region	Rating Area	Baseline	Colorado Health Insurance Option
Urban	1 - Boulder	265%	174%
Urban	2 - Colorado Springs	247%	172%
Urban	3 - Denver Metro	265%	164%
Rural East	4 - Fort Collins	369%	161%
Rural West	5 - Grand Junction	313%	175%
Rural East	6 - Greeley	328%	166%
Rural East	7 - Pueblo	261%	196%
Rural East	8 - East	275%	180%
Rural West	9 - West	285%	174%
	Statewide Average	**280%**	**168%**

3. This version of the analysis incorporates an outmigration report, provided by the Center for Improving Value in Health Care (CIVHC). It summarizes the historical inpatient and outpatient utilization and medical claims by facility and the member's county. The report was based on commercial members and claims data for 2016-2018. We assumed the utilization mix by facility in the individual market would be similar to the total commercial market.

   The report was used to estimate the impact of outmigration on the claims payment rates under the Colorado Health Insurance Option. For example, members in rural counties, particularly rating areas 8 and 9, may travel to the urban areas such as Denver and Boulder to receive treatment. The medical claims for these members and the impact of the change in reimbursement rates under the Colorado Health Insurance Option will be influenced by the change in the rates for facilities in the urban areas as well as facilities located within rating areas 8 and 9. The claims and premium impact for each rating area is based on the average change in reimbursement rates for each facility. These were weighted separately for each rating area, based on the mix of utilization for members in those areas.

   There are several facilities in the CIVHC report which were not included in the facility reimbursement changes received from DOI. This appears to be primarily outpatient facility claims, including rehabilitation centers, ambulatory surgery centers. For facilities which we were not able to match to the reimbursement change file, we assumed the facility would not be impacted and the reimbursement level under the Colorado Health Insurance Option would not change from the current reimbursement.

4. Adjusted Silver plan AV. It is DOI's expectation that the Silver Colorado Health Insurance Option plan will reflect richer benefits than that reflected by the current average Silver plan AV of 69.4%. The analysis reflects an increase to 71.5% AV. It is our understanding that this change in AV will be driven by reductions in member cost-sharing relative to the current plan offerings and that there are no changes to the benefits considered EHB for purposes of calculating the APTCs.

5. Blended metal level rates.

    a. Gold, Silver, and Bronze rates were then blended based on the 2019 distribution of individuals in the individual market. We are assuming that there will not be any material shifting of enrollment between metal levels.

    b. Administrative items were generally held constant from the 2020 blended individual market rates. These items were found in the 2020 rate filings, and include:

        i. Exchange fee – The Colorado Health Insurance Option product is assumed to be offered by carriers on and off the Exchange for the individual market. We are assuming no change from the 2020 exchange fee as a percent of revenue.

        ii. Commissions – Commissions will be paid at a comparable level to baseline average commissions as a percent of premium. No impact to premium is assumed for commission levels in the Colorado Health Insurance Option relative to the current market average.

        iii. Profit and Risk Load – Colorado Health Insurance Option rate is estimated to include a load for profit or margin consistent with the margin included in current rate filings.

    c. Additionally, 50% of the remaining administrative expenses in the rate filings was estimated to be variable. As rates decrease, the amount of variable administrative expenses included in the rates also decreases.

6. Trend 2020 final rates to 2022 – Wakely increased gross premium rates by 6%, annually, to account for the estimated changes in Colorado's market between 2020 and 2022.

7. Morbidity impact of the new enrollees was estimated using a Morbidity/Utilization factor calculated for Unsubsidized Individuals previously uninsured using data from a CEA study on the marginal costs of enrollees.

Final Pass-Through Savings Estimates

The pass-through savings estimate is calculated as the difference between the estimated PTC in 2022 under the baseline scenario without the Colorado Health Insurance Option and the estimated PTC with the Colorado Health Insurance Option in place. To calculate the estimated savings produced by the Colorado Health Insurance Option product's premium subsidies, Wakely completed the following steps:

1. As discussed above, inherent in our baseline scenario development is an estimate of the APTC based on the 2019 individual market enrollment. The APTC and actual PTC are reconciled after the end of the year through enrollee's tax returns. The PTC has historically been slightly lower than the APTCs reported. The baseline total PTC was calculated by taking the average APTC multiplied by a ratio of 0.979. This ratio was developed based on a review of the difference between APTC and PTC in Colorado's total tax returns for 2016 as measured by data from the IRS.[11] The extent to which this ratio differs in future years, the final PTC savings amount could also differ. Wakely assumed no material change in the APTC and PTC ratio in future years.

2. We are assuming that all carriers On-Exchange will be required to offer the Colorado Health Insurance Option. Therefore the second-lowest cost silver (SLCS) plan, which is used to determine the APTC in each area will be based on the premium of the Colorado Health Insurance Option as there will be at least two Colorado Health Insurance Options available and are anticipated to have a lower premium than other non-Colorado Health Insurance Option plans in the current market.

    a. The estimated APTC was calculated as the difference between the projected gross premiums of the Colorado Health Insurance Option plans less the projected contribution rate for 2022.

        i. The projected gross premiums with the Colorado Health Insurance Option plans were calculated by taking the baseline scenario gross premium estimate for subsidy-eligible members in the 2022 baseline multiplied by the estimated premium reduction for the Colorado Health Insurance Option plans in each reimbursement scenario. As the premium reductions vary by metal level, the estimated premium reduction was weighted based on the distribution of subsidy-eligible membership by metal level in 2019.

        ii. While it does not impact the estimate of the pass-through savings, we assumed that 50% of subsidized enrollees would remain in their current plan offering, rather than switching to the Colorado Health Insurance

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

Option plans. Therefore, the contribution rate in 2022 was increased relative to the difference in the baseline gross premium and the Colorado Health Insurance Option plan gross premium. This reflects that subsidized members who choose to remain in their current plan, rather than switching to the Colorado Health Insurance Option would see an increase in their net premium after subsidy.

b. Inherent in this calculation is the assumption that the subsidized member's metal level selection is not impacted by the Colorado Health Insurance Option and there is not significant migration by metal level and net premium is similar between both scenarios. Similarly, Wakely assumes that there is no change in the income distribution of those currently subsidized as a result of the introduction of the Colorado Health Insurance Option.

3. Total APTC payments are the product of the estimated APTC PMPM in each scenario (before and after introduction of the Colorado Health Insurance Option) and the estimated membership below 400% FPL.

4. The estimated total PTC with the Colorado Health Insurance Option and wrap programs was calculated by taking the average APTC multiplied by a ratio of 0.979 as discussed in item #1 above.

5. The pass-through is the difference between the total subsidy estimates.

Premium Wrap Estimates

A premium wrap would provide state premium assistance to a subset of enrollees, paid in addition to the current federal program that provides premium subsidy assistance via APTC dollars to Coloradans who have incomes between 138% and 400% FPL and are enrolled in a non-catastrophic plan on the Exchange.

Wakely analyzed a premium wrap program as follows:

- Enrollees on the Exchange under 400 percent FPL would be eligible to receive this benefit. This could encourage current off-Exchange enrollees to migrate to an on-Exchange plan in 2022.

- The benefit would be offered through a reduction in the required contribution percentage used to determine enrollee's premium tax credit. The applicable percentages are updated each year. We assumed that the applicable percentage applicable in 2022 would equal the 2020 percentages. The actual percentage in 2022 may be higher as the rates typically increase annually. This would have a negligible impact on the funding estimate as the funding is tied to the decrease in contribution requirement rather than the actual

contribution percentage. The state's premium wrap required contribution percentage, and how they compare to the federal percentages, by FPL are as follows:

Table 7: Premium Wrap – Required Contribution Percentage by FPL

	133%	150%	200%	250%	300%	350%
Federal Contribution Percentage	4.12%	6.49%	8.29%	9.78%	9.78%	9.78%
State Contribution Percentage	2.92%	5.39%	7.29%	8.88%	9.08%	9.08%
Decrease in Contribution Requirement for Household	**1.20%**	**1.10%**	**1.00%**	**0.90%**	**0.70%**	**0.70%**

For example, for a member in single household at 175% FPL, the 1.20% decrease in contribution requirement would reduce their net premium approximately $21 PMPM. Similarly, member in single household at 325% FPL, the 0.70% decrease in contribution requirement would reduce their net premium approximately $25 PMPM.

- The 2019 enrollment reports available did not contain household size or detailed income as a percent of FPL information for members. Therefore, in estimating the cost of the premium wrap, we assumed that all members were in single households. This is a conservative assumption, as the PMPM cost for a single household is greater than that for households of two or more. Additionally, enrollment information was provided in 50 percentage point groupings by FPL (Under 150%, 150%-199%, 200%-249%, 250%-299%, 300%-349%, 350%-399%, and Over 400%). As the required contribution level varies within each of these groupings, we assumed that the average income and required contribution percentage for the members in each FPL grouping were equal to the mid-point. For example, for the 150%-199% FPL group, we assumed that the average member had an FPL of 175% and would have a required contribution of 7.39% under the federal program and 6.29% under the premium wrap.

Key takeaways include:

- **Funding Needed:** The estimated funds needed for year 1 (assumed to be 2022) of the program, excluding operational costs, are approximately $33.8 million based on Wakely's best estimate. The program benefits do not vary based on geographic location.
- **Consumer Savings**: The estimated annual premium savings for the targeted population is $280 per eligible member.
- **Consumers Impacted:** We estimate this would affect 54% of the current enrollees and result in an increase in market enrollment of 6% due to uninsured taking up coverage.

Table 8: Premium Wrap - Summary of Consumers Impacted and Costs by Rating Area

Region	Rating Area	Consumers Positively Impacted	From Currently Enrolled	From Currently Uninsured	Cost of Premium Wrap
Urban	1 - Boulder	9,400	8,400	1,000	$2,600,000
Urban	2 - Colorado Springs	9,500	8,500	1,000	$2,600,000
Urban	3 - Denver Metro	57,600	52,000	5,600	$16,000,000
Rural East	4 - Fort Collins	8,600	7,900	700	$2,400,000
Rural West	5 - Grand Junction	3,100	2,800	300	$900,000
Rural East	6 - Greeley	4,600	4,200	400	$1,300,000
Rural East	7 - Pueblo	1,800	1,600	200	$500,000
Rural East	8 - East	7,000	5,900	1,100	$2,000,000
Rural West	9 - West	18,900	17,000	1,900	$5,500,000
	Statewide Average	**120,500**	**108,300**	**12,200**	**$33,800,000**

Migration of Off-Exchange Enrollees to On-Exchange

As we do not have detailed information regarding the off-Exchange enrollment, we assumed these enrollees were not eligible for subsidies. Therefore, we assumed there would be no migration of the off-Exchange enrollees into on-Exchange plans due to the additional subsidies created by the premium wrap. The extent to which migration would occur would decrease the Pass-Through amount and increase premium wrap costs.

Uninsured Taking Up Coverage

Enrollment with the premium wrap is expected to increase due to currently uninsured individuals taking up coverage on the Exchange. We applied the aforementioned CEA enrollment function to the pool of uninsured individuals in Colorado, as estimated, based on the member premium decrease. The underlying assumption in this modeling is that the uninsured members enrolling in the on-Exchange plans would have similar demographics as the current on-Exchange members in the same income bracket, with slight morbidity adjustments noted below. The modeling resulted in an estimated 12,200 uninsured members taking up coverage on the Exchange.

Wakely estimated the market-wide impact to morbidity due to uninsured enrollees taking up coverage for the premium wrap program. Based on the aforementioned CEA study, new market entrants are estimated to have 27% lower morbidity than those already enrolled. This resulted in a 2.1% reduction in market average costs due to the improved morbidity of the covered population from the lower cost-sharing.

The CEA enrollment function used to estimate the uninsured taking up coverage was designed to model shifts in enrollment of the unsubsidized population for the Exchange. Therefore, the take-

up of members who are eligible for subsidies may react differently. We have muted the enrollment function 50% in our best estimate to reflect that these individuals may have different sensitivity than the members the enrollment function was designed to model. The estimated pass-through savings and funds required are very sensitive to the assumed take-up of members and the actual results could vary significantly from the best estimate shown here. In the table below, we reviewed the sensitivity of the take-up function on the pass-through savings and program costs by increasing and decreasing the muting factor 25%. Under the increased elasticity (assuming members are more sensitive to premium changes), there is an increase in the take-up from uninsured, that results in the costs of funding the premium and cost-sharing wrap programs exceeding the estimated pass-through savings. While, we believe that the best estimate reflects a conservative assumption and actual take-up between the best estimate and decreased elasticity scenario is more likely, estimates should be revisited if a full actuarial and economic analysis is submitted as part of a 1332 waiver.[12]

Table 9: Sensitivity of Elasticity Function and Uninsured Take-Up

	Best Estimate	Increased Elasticity	Decreased Elasticity
Enrollment Take-up from Previously Uninsured	18,100	24,800	11,400
Pass-Through Savings	**$42,700,000**	**$20,000,000**	**$65,200,000**
Funds Required for Added Benefits			
Premium Wrap	$33,800,000	$35,700,000	$32,200,000
Cost-Sharing Wrap	$8,300,000	$8,500,000	$7,700,000
Total Funds Required	**$42,100,000**	**$44,200,000**	**$39,900,000**
Pass-Through Savings Less Funds Required for Added Benefits	**$600,000**	**-$24,200,000**	**$25,300,000**

Cost-Sharing Wrap Estimates

A cost-sharing wrap pays for a portion of an enrollee's expenses that they incur for medical care, through lower copays, coinsurance, and deductibles. While premiums are fixed and known at the time of enrolling in coverage, cost-sharing amounts are incurred at the time of receiving medical care and may be more difficult to predict and budget for (e.g., particularly for coinsurance). Under the ACA, there is a federal program that provides cost-sharing assistance to members who meet certain income or tribal affiliation requirements. For example, eligible individuals in Colorado between 138% and 250% FPL, can enroll in CSR variant silver plans that offer cost-sharing protections. Under the proposed 1332 program, the new program would not cover CSR related costs currently provided by carriers under the federal program, but instead would supplement the federal program with additional cost-sharing subsidies. As a result of the state paying for a portion

[12] There is limited information on how the Office of Tax Analysis (OTA) may estimate such changes in subsidies. As ultimately the Federal government estimates of the policy will determine if the waiver meets the 1332 guardrails, further analysis may be warranted.

of consumer costs, individuals may have greater access to services needed or may avoid forgoing medical care.

The state cost-sharing wrap is designed to provide assistance to individuals who enroll in a silver metal level plan on the Exchange. The program would cover additional cost-sharing for members between 200 and 250 percent FPL and would also provide cost-sharing assistance for members between 250 and 400 percent FPL. The percentage of cost-sharing costs covered by the state would vary based on the household's FPL.

Wakely analyzed a cost-sharing wrap program as follows:

- Enrollees on the Exchange under 400 percent FPL would be eligible to receive this benefit. The member must enroll in a silver plan. This could encourage current off-Exchange or on-Exchange enrollees in other plans to migrate to a silver on-Exchange plan in 2022.
- The benefit would be offered through a richer plan design with lower cost-sharing (copays, deductible, coinsurance) based on varying actuarial value requirements. This is similar to the federal program which requires silver plan variants with 73 percent, 87 percent, and 94 percent actuarial values. The plan designs would be offered through different silver plan variants, which vary by FPL level. The state's cost-sharing wrap actuarial values, and how they compare to the federal cost-sharing program, by FPL are as follows:

Table 10: Cost-Sharing – Actuarial Value Benefit Structure by FPL

	Less than 150%	150%-199%	200%-249%	250%-399%
Federal Program Actuarial Value	94%	87%	73%	70%
State Benefit Actuarial Value	94%	87%	77%	73%
Increase in State Benefit Actuarial Value	0%	0%	4%	3%

Key takeaways include:

- **Funding Needed:** The estimated funds needed for year 1 (assumed to be 2022) of the program, excluding operational costs, are approximately $8.3 million based on Wakely's best estimate. This is in addition to the premium wrap funding required above. The program benefits do not vary based on geographic location.
- **Consumer Savings**: The estimated annual cost-sharing savings for the targeted population is $376 per eligible member between 200-399% FPL. For members between 200-249% FPL enrolled in a Silver plan, we estimate they will save approximately $32 PMPM in reduced cost sharing. For members between 250-399% FPL enrolled in a Silver plan, we estimate they will save approximately $30 PMPM in reduced cost sharing. Note that the actual impact for consumers will depend on their specific utilization of services and could vary significantly from one member to the next.

- **Consumers Impacted:** We estimate this would affect 26% of the current enrollees.
- There could be an increase in utilization of services because of decreased cost-sharing. This would increase claim costs and, therefore, plan liability. As discussed above, issuers cover the costs incurred under the federal program. The cost-sharing wrap is estimated to have a negligible increase to the costs that issuers would incur under the federal program.

Table 11: Cost-Sharing Wrap - Summary of Consumers Impacted and Costs by Rating Area

Region	Rating Area	Consumers Enrolled in CSRs	From Currently Enrolled	From Currently Uninsured	Cost of CSR Wrap
Urban	1 - Boulder	4,700	4,000	700	$700,000
Urban	2 - Colorado Springs	5,100	4,400	700	$700,000
Urban	3 - Denver Metro	31,100	26,400	4,700	$4,100,000
Rural East	4 - Fort Collins	3,900	3,300	600	$500,000
Rural West	5 - Grand Junction	1,100	1,000	100	$100,000
Rural East	6 - Greeley	2,200	1,800	400	$300,000
Rural East	7 - Pueblo	1,000	900	100	$100,000
Rural East	8 - East	3,000	2,600	400	$400,000
Rural West	9 - West	7,600	6,400	1,200	$1,400,000
	Statewide Average	**59,700**	**50,800**	**8,900**	**$8,300,000**

Migration of On-Exchange Enrollees into Silver Plans On-Exchange

Migration of the on-Exchange enrollees into silver plans was modeled based on an elasticity function that measures consumers' elasticity of demand for insurance generosity, or actuarial value. The change in out-of-pocket costs considered both differences in the expected average cost-sharing and average premium from switching to a silver plan on-Exchange. This calculation was done by metal level and FPL range. The difference in out-of-pocket expenditures for premiums and cost-sharing was then converted into an average actuarial value change.

Once the average actuarial value change was estimated, we applied an elasticity function to determine the ultimate migration of enrollees to silver on-Exchange plans. The elasticity function is based on the published research literature – "we find the consumers' elasticity of demand for insurance generosity (AV) to be near unit elastic, with estimates of -0.90 at 150% FPL, -0.86 at 200 percent FPL, and -1.3 at 250% FPL."[13] We assumed a flat elasticity of -1.3 for incomes above 250 percent of FPL. Further, we included muting adjustments within the migration calculations

[13] Do Individuals Respond to Cost-Sharing Subsidies in their Selections of Marketplace Health Insurance Plans? DeLeire, T. et al. Available at http://terramedica.hsinetwork.com/DeLeire_CHES_Dec16.pdf.

that varied by FPL level and Exchange status to reflect a range of reasonable results. Muting adjustments differed to account for lack of awareness of the cost-sharing wrap subsidies (which would depend on the level of advertisement and member education provided by the state) and the general level of inertia associated with changing a health insurance plan, among other reasons. Also, utilizers of services are more likely to be incentivized by a cost-sharing benefit subsidy compared to non-utilizers, and studies show enrollees may be more premium sensitive versus cost-sharing sensitive, which further decreases potential migration of members.

Uninsured Taking Up Coverage

The second source of the cost-sharing wrap enrollment increase is from currently uninsured individuals taking up coverage in silver plans on the Exchange. The modeling resulted in an estimated 8,900 uninsured members taking up coverage on the Exchange in silver plans. Note, that this increase in enrollment was included in the uninsured taking up coverage due to the premium wrap and reflects a subset of those members as cost-sharing reductions tend to have a much smaller impact on take-up of the uninsured compared to the impact of premiums. The underlying assumption in this modeling is that the uninsured members enrolling in the on-Exchange silver plans would have similar demographics as the current silver on-Exchange members in the same income bracket, with slight morbidity adjustments noted below.

Impact on Allowed Cost Levels

Allowed costs are expected to change due to the migration of current enrollees to silver plans on the Exchange, increased utilization of services due to the increased richness in cost-sharing benefits, and improved morbidity due to uninsured taking up coverage.

- Allowed claim costs were estimated based on the net premiums increased by the average federal actuarial value at the various metal levels reported in the 2020 rate filings.
- Adjustments were applied to allowed claims based on the implied morbidity of members migrating from another plan on the individual market to the silver on-Exchange plans. It's likely that, on average, more members who are higher utilizers of services may migrate for the new benefit compared to non-utilizing, healthier members. The implied morbidity was estimated based on Exchange status, FPL, and benefit richness of the cost-sharing wrap. We assumed members who migrate are less healthy then the average cohort of members in which they are migrating from; said another way, allowed claims would be X percent higher (based on varying assumptions) for a bronze member migrating to a silver on-Exchange plan compared to the allowed claims for an average bronze member.
- Then, induced demand adjustments were applied. The increased utilization factors were derived from Wakely's proprietary 2016 national ACA individual database (WACA). They were applied to allowed claims to reflect a change from the member's base period plan actuarial value, prior to any migration, to the state cost-sharing benefit actuarial value. For

example, if a member migrated from a bronze plan to a silver plan and has a FPL of 340 percent (thus in the 300 to 350 percent FPL bucket), the induced demand factor would reflect a shift from an average bronze actuarial value of 60 percent to an average silver actuarial value of 70. Then, an additional 3 percent induced utilization would be assumed due to the state cost-sharing wrap which would cover 73 percent of the member's cost-sharing.

- As noted above, the increased take-up of uninsured enrollees was captured in the premium wrap estimate. Therefore, no additional morbidity adjustment was made specific to the cost-sharing wrap program. In scenarios below, we did reflect the impact of including only a cost-sharing wrap without a premium wrap. In these scenarios, Wakely estimated the market-wide impact to morbidity due to uninsured enrollees taking up coverage for the cost-sharing wrap program. Based on the aforementioned CEA study, new market entrants are estimated to have 27% lower morbidity than those already enrolled. This resulted in minimal impact to the morbidity of the market.

  Silver allowed claims, by FPL, and estimated cost-sharing were reduced to account for the improved morbidity across both the premium and cost-sharing wrap.

The increase in the allowed cost levels and enrollment in the cost-sharing wrap also translates to an increase in the federal CSRs, which are funded by carriers through silver premium loading on the Exchange. This may warrant a shift in the carriers' silver loading on the Exchange premium rates.

Pass-Through Savings and New Benefit Program Scenarios

As noted above, the premium and cost-sharing wraps impact the overall individual market enrollment and premiums, therefore the pass-through savings calculated also depend on the premium and cost-sharing wrap and take-up of the uninsured. Table 9 below shows the impact on the pass-through savings under various combinations of added benefits (premium wrap, cost-sharing wrap and adult dental coverage). These estimated amounts are below the expected Federal pass-through amounts. Colorado would adjust the program, as needed, to align with deficit neutrality requirements.

Table 12: Summary of Pass-Through Savings and New Benefit Costs

	Include Both Premium and Cost-Sharing Wrap	Include Premium Wrap Only	Include Cost-Sharing Wrap Only
Pass-Through Savings[14]	**$42,700,000**	**$47,400,000**	**$84,100,000**
Funds Required for Added Benefits			
Premium Wrap	*$33,800,000*	*$33,500,000*	*$0*
Cost-Sharing Wrap	*$8,300,000*	*$0*	*$7,700,000*
Total Funds Required	**$42,100,000**	**$33,500,000**	**$7,700,000**
Pass-Through Savings Less Funds Required for Added Benefits	**$600,000**	**$13,900,000**	**$76,400,000**

Assumptions

The estimates in this report are point estimates based on a certain set of assumptions. In reality, there is a range of reasonable assumptions and ranges of results based on differences such as market conditions, regulatory changes, the ultimate structure of the policy, and other factors. In addition, some high level assumptions were made. Users of the estimates should recognize that the actual results may vary, potentially significantly, from those included in the report.

See below for additional relevant assumptions and methodologies used throughout Wakely's calculations.

- Calculation of the Change in Premiums: The impact of premium changes due to a change in claims has been calculated as the estimated change in claims times 94%. This is due to the presence of fixed administrative costs.
- Average morbidity: New enrollees coming from uninsured population are assumed to be at a 0.73 relative morbidity compared to the currently insured individual population. These healthier individuals have opted out of coverage prior to the availability of a lower cost plan such as the Colorado Health Insurance Option.
- Percent of Claims in a Facility: Wakely used 2017 National Wakely Individual ACA data[15] to find the percentage of total paid claims in the individual market that are facility claims. Approximately 50% of total claims are facility. Wakely assumed that this ratio would be accurate in 2022. This is lower than the 60% reflected in the Lewis & Ellis analysis. Using a higher assumption will result in higher estimated pass-through.

[14] Pass-through savings are impacted by both changes in the benchmark plan premium and take-up of uninsured due to premium and cost-sharing wrap programs. Therefore, the pass-through savings are significantly lower under the scenarios that include the premium wrap compared to the cost-sharing wrap only scenario.

[15] https://www.wakely.com/services/product/wakely-aca-database-waca

- Percent of Admin that is Variable: Assuming 50% of administrative expenses are variable and 50% are fixed.
- Wakely assumed that the ratio of Medicare to Commercial Claims, as reflected currently in the data, is the same ratio in 2022. Wakely reviewed the Office of the Actuaries' National Health Expenditure Data projections and found that historically Medicare spending has grown slower than private insurance spending, and the projections reflect higher spending trends in Medicare.
- Wakely assumed that the impact of the Colorado Health Insurance Option on the second lowest cost silver plan will be similar to the impact of the Colorado Health Insurance Option on the overall market. It is possible that issuers in 2022 that otherwise would have been the second lowest cost silver plan have cheaper cost structures than the market average. However, there are many other factors that also impact premiums and the reimbursement rate may not be the main driver. There are many different carriers that offer the second lowest cost silver plan across the state, implying that no one carrier and reimbursement levels are driving the second lowest cost silver plan. Even in counties with many carriers offering plans, the carrier with the second lowest silver plan is not always the same carrier.
- Assuming no changes to issuers participating on the Exchange.
- Colorado Health Insurance Option Average AV: Wakely has assumed that there will be no impact to the 2020 Average AVs for Bronze and Gold. Silver was set to 71.5% due to the impact of the Colorado Health Insurance Option. We assume that other silver plans will maintain current AV levels.
- Change in Claim Cost due to VBID: The effects of VBID are estimated to be immaterial, with savings and costs offsetting to result in no impact.
- Commissions: The 2020 average commission rate is expected to be 1.4% according to rate filings. Wakely is assuming that the average commission's rate will not change for 2022.
- Change in MLR Requirement: Wakely is assuming immaterial impact since average MLRs for 2015 through 2017 are reported to be above the proposed 85% target.
- Start-up costs: We are not assuming any additional start-up costs to either the state or issuers that may incur in the initial years of the program. Additional advertising and outreach may be needed in the initial years beyond what a plan normally spends.
- Additional expenses: We assume that there will be no additional administrative expenses for the Colorado Health Insurance Option plans for either the state or for issuers.
- Reinsurance program impact: We are assuming no material changes in the premiums due to either changes in the reinsurance program structure or impact in claims experience due to the Colorado Health Insurance Option. We are also assuming that the reinsurance program remains in effect for 2022.

- Enrollment by metal tier: We are assuming no material shifting of enrollment by metal tier, and that new enrollment will be at similar weighting by metal tier.
- We are assuming no material impact to the small group market or employer market more generally.
- Colorado is considering designing a 1332 waiver such that potential Federal pass-through funds would be used to be provide additional benefits or implement policies that improve affordability. Wakely reviewed two potential additional benefits that could be provided in this analysis, although others could be considered.
- We are assuming that there are no material changes or expansion of the Peak Health Alliance initiative that was introduced in Summit County for 2020 plan year. This initiative resulted in lower negotiated reimbursement rates for providers and plan premiums that are 20-25% lower as a result. Should the Peak Health Alliance initiative be expanded to additional counties, the baseline scenario's benchmark premium of the SLCS plan may be lower than the estimate in this report and the pass-through savings may be lower than that reflected in this report.
- We assume the mix of adults will remain consistent through the projection period.
- We assume that pent up demand for dental services will drive premiums to be consistent with the current maximum premiums in the Stand Alone Dental Plans.
- Finally, as with any estimate of future values, there is a significant level of uncertainty to the estimates. Small differences in the assumptions and data used in the analysis can result in changes to the estimates.

Reliances and Caveats

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

- The 2018, 2019 Open Enrollment Report PUF produced by HHS[16] [17]
- Effectuated Enrollment Reports released by CMS[18] [19]

[16] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

[17] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html

[18] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf

[19] https://www.cms.gov/sites/default/files/2019-08/08-12-2019%20TABLE%20Early-2019-2018-Average-Effectuated-Enrollment.pdf

- 2020 Rate Templates and Plan Benefit Templates
- Estimated March 2018, 2019 Enrollment[20] [21]
- 2019 Enrollment, Premium, and APTC data provided by Connect for Health Colorado
- Lewis and Ellis Colorado Reinsurance Program Analysis[22]
- 2020 Issuer Rate Filings
- 2017 Wakely ACA Data
- Colorado Hospitals Reimbursement Levels by County[23]
- Inpatient and Outpatient Facility Outmigration Report, provided by Center for Improving Value in Healthcare (CIVHC)
- Summary of 2017 Inpatient Facility Days by Facility and Payer Type (Medicare/Medicaid/Other) provided by DOI
- Lewis & Ellis study of Repricing of Non-Group Commercial ACA Market to Medicare Reimbursement Levels, provided by DOI.

The following caveats in the analysis should be considered when relying on the results.

- **Data Limitations.** As discussed above, Wakely relied on high-level data in Colorado. We reviewed the data for reasonability but did not perform an independent audit. Any errors in the data may materially impact the results of our analysis.

- **Political Uncertainty.** There is significant policy uncertainty. Future federal actions or requirements in regards to, income verification, silver-loading, reinsurance, or other administrative actions could dramatically change premiums and enrollment in 2022.

- **Enrollment Uncertainty**. At the time of producing this report, April 2019 enrollment data was available. To the extent 2019 attrition at the end of year varies significantly from historical rates and enrollment changes in each of 2020 to 2022 are different than estimated, the estimates for 2022 will not be accurate. Individual enrollee responses to policy changes also has uncertainty. All of these factors result in uncertainty for the impacts of a 1332 waiver.

- **Premium Uncertainty**. There is uncertainty in 2022 ACA premiums and the enrollment and uncertainty on the number of uninsured. These uncertainties result in limitations in providing point estimates.

- **Medical Claim Cost Uncertainty**. Medical claims cost, especially with smaller

[20] https://www.markfarrah.com/mfa-briefs/a-brief-analysis-of-the-individual-health-insurance-market/
[21]https://www.markfarrah.com/mfa-briefs/current-trends-in-individual-segment-enrollment/
[22] https://drive.google.com/open?id=1gWS-ovi7pCeccXQT1vOckti6_SVwdPbx
[23] https://www.civhc.org/wp-content/uploads/2019/09/Colorado-Hospitals-with-county-and-DOI-estimated-reference-20190722.xlsx

populations, have an inherent level of unpredictability.

Disclosures and Limitations

Responsible Actuaries. Aree Bly and Brittney Phillips are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries. Aree is a Fellow of the Society of Actuaries and Brittney is an Associate of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen and Julie Peper are significant contributors to this report.

Scope of Services. Unless otherwise explicitly indicated, Wakely's work is limited to actuarial estimates and related consulting services. Wakely is not providing accounting or legal advice. The users of this report should retain its own experts in these areas. In addition, Colorado is responsible for successful administrative operations of all of its programs, including those which are the subject of Wakely's actuarial work. Further, Wakely strongly recommends that Colorado carefully monitor emerging experience in order to identify and address issues as quickly and completely as possible.

Intended Users. This information has been prepared for the sole use of DOI and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. We do recognize and grant that the report can be used in the development of the broader proposal for Colorado Health Insurance Option that will be submitted to the Colorado Legislature in November 2019. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. The uncertainty is amplified given that in most instances Colorado specific data was not available. Users of the results should be qualified to use it 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 Department of Regulatory Agencies of the Division of Insurance.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. 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 change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. Material changes as a result of federal or state regulations may also have a material impact on the results. Changes to current Colorado practice of loading CSR amounts to Silver plans only could also impact the results. Regulation changes as proposed in the CY2021 Notice of Benefit and Payment Parameters were not included in this analysis as these regulations are still draft and not final. Any impact on enrollment and premiums in the individual market due to the recent HRA regulations was also not incorporated into the baseline or Colorado Health Insurance Option estimates. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Unanticipated events subsequent to the date of this report are beyond the scope of our work, including (but not limited to):

- Differences in risk or utilization of the enrolling population,
- Differences in the assumed contracts, and/or
- Differences in costs of the administration amounts.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede 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