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Quantitative Evaluation of a Targeted Medicaid Buy-In for New Mexico

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Wakely Consulting Group, LLC, are actuaries and consultants who specialize in healthcare financing. Wakely has considerable experience carrying out complex projects, yet our size and structure allow us 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.

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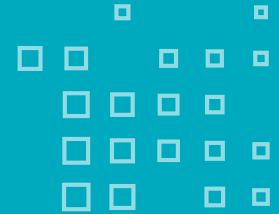


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Executive Summary

Similar to a number of other states, New Mexico is exploring a Medicaid buy-in as part of a broader strategy to expand coverage and affordability of health insurance to residents. Health Action New Mexico and the New Mexico Center on Law and Poverty engaged Manatt Health with the support of the Laura and John Arnold Foundation to complete a legislatively authorized study “exploring the policy and fiscal implications of offering a Medicaid buy-in coverage option to New Mexico residents...” The study involves two phases designed to inform state decision makers with regard to pursuing a Medicaid buy-in: a Phase 1 paper released in December 2018 that provides a qualitative assessment of several Medicaid buy-in options for New Mexico, and a Phase 2 actuarial assessment of the Targeted Medicaid Buy-In. This Phase 2 report is the culmination of the legislative study.

Phase 2 modeled the impacts of implementing a Targeted Medicaid Buy-In, where the state offers buy-in coverage—with financial assistance for lower-income individuals—outside of the Affordable Care Act (ACA) individual market (including coverage sold both on and off the beWellnm Marketplace) to those currently ineligible for Marketplace or other coverage assistance. The analysis, led by Manatt Health and Wakely Consulting Group, its actuarial partner, evaluated expected premiums for the buy-in product, its estimated enrollment and the state costs of providing financial assistance for individuals earning below 200 percent of the federal poverty level (FPL) who are impacted by immigration status or the family glitch.

The initial results suggest that a Targeted Medicaid Buy-In would have positive premium and enrollment impacts for individuals who lack access to affordable coverage by:

- **Reducing premiums by 15-28 percent relative to the average and lowest-cost premiums in the individual market.** Specifically, the buy-in monthly premium would range from \$377 to \$403 depending on the buy-in enrollment scenarios, compared to an average premium of \$521 and an estimated lowest-cost premium of \$475 in the ACA individual market in 2020.
- **Enrolling a significant number of individuals.** Projected total enrollment for the populations impacted by immigration status and the family glitch earning up to 200 percent FPL and the unsubsidized population ranges from 7,000 to 16,000.

Phase 2 modeling results estimate state costs of providing financial assistance to target groups earning below 200 percent FPL ranging from \$12 million to \$48 million.

This analysis is an important first step in understanding the feasibility of a Medicaid buy-in for New Mexico, and should be evaluated as part of a longer-term, comprehensive plan that considers its relationship to other buy-in options, as well as additional state strategies to expand coverage and increase affordability.

Introduction

New Mexico is considering a Medicaid buy-in solution in the context of rising costs for health coverage, uncertainty regarding the stability of the individual market and the state's persistently high uninsured rate of more than 9 percent. Against this backdrop, New Mexico is contemplating new ways to leverage its Medicaid program—the largest payer in the state, covering more than 40 percent of the state population—to increase affordability, expand coverage and improve access to care. Specifically, the state is exploring a state-sponsored coverage option that uses the Medicaid program—via its “purchasing power” as the state's largest payer, its well-established Medicaid managed care plans, its Medicaid provider network and provider reimbursement rates—to offer a more accessible and affordable statewide coverage option.

In accordance with the directive passed by the New Mexico state legislature to study the implications of offering a state-sponsored Medicaid buy-in to state residents to improve coverage affordability and enrollment, Manatt has collaborated with Representative Deborah Armstrong, chair of the Legislative Health and Human Services Committee, Health Action New Mexico, New Mexico Center on Law and Poverty, Partnership for Community Action and Strong Families New Mexico to complete a two-phased Medicaid buy-in study, with generous support from the Laura and John Arnold Foundation:

- **Phase 1: Qualitative Assessment of Medicaid Buy-In Options.** On December 7, 2018, Manatt released a paper that assessed four potential buy-in options (Targeted Medicaid Buy-In, Qualified Health Plan Public Option, Basic Health Program and Medicaid Buy-In for All) and recommended a quantitative study of the Targeted Medicaid Buy-In during Phase 2.¹
- **Phase 2: Quantitative Evaluation of Targeted Medicaid Buy-In Option.** Manatt and its actuarial partner, Wakely, conducted an analysis that includes estimated enrollment and costs for a Targeted Medicaid Buy-In, with design parameters selected for illustrative purposes in consultation with New Mexico partners noted above. This paper provides the results of that analysis.

Consistent with the Phase 1 recommendation, the Phase 2 analysis focused on a quantitative evaluation of the Targeted Medicaid Buy-In, considering the data that is readily available for analysis, as well as the ability for the state to use the Targeted Medicaid Buy-In as a bridge to or in combination with the other buy-in options that remain under consideration.

Phase 1 Assessment of Medicaid Buy-In Options

During Phase 1, a diverse group of New Mexico stakeholders provided feedback regarding the goals and objectives for a New Mexico Medicaid

buy-in.² There was remarkable consistency in stakeholder points of view related to three core goals:

- Increasing health insurance coverage and reducing the uninsured rate.
- Increasing affordability of coverage and care, while supporting adequate provider reimbursement rates.
- Simplifying healthcare coverage for beneficiaries and families.

Figure 1. Overview of Buy-In Options for New Mexico

Option One	Option Two	Option Three	Option Four
Targeted Medicaid Buy-In	Qualified Health Plan (QHP) Public Option	Basic Health Program (BHP)	Medicaid Buy-In for All
State offers Medicaid-like coverage off the Marketplace to those not eligible for Medicaid, Medicare or subsidized Marketplace coverage. NM could provide financial assistance for those in need.	State offers lower-cost product on the Marketplace to individuals and small employers; would be offered as a QHP, likely in partnership with an existing insurer. NM could capture potential savings under a waiver to further increase affordability.	State offers BHP for individuals with incomes below 200% FPL who are not Medicaid-eligible (including people who would be Medicaid eligible, but for their immigration status). Over time, NM could expand BHP through buy-in.	State offers Medicaid coverage to everyone (except individuals covered by Medicare); would be offered as a lower-cost option off the Marketplace. Individuals eligible for financial assistance could apply their assistance to the cost of coverage.
Off Marketplace	On Marketplace	Off Marketplace, Outside of Individual Market	
No Federal Approval Needed	QHP Certification/ 1332 Waiver	1331 Authority (1332 Waiver for Buy-In)	1332 Waiver
Low Potential Enrollment	Moderate Potential Enrollment	Moderate Potential Enrollment	High Potential Enrollment

With these goals in mind, Manatt, together with its New Mexico partners, outlined four potential buy-in options for assessment and discussion with stakeholders. These proposals vary in their complexity, required federal authority and risks, as well as their “reach” in covering uninsured New Mexicans. Notably, these options are not mutually exclusive and could be implemented separately, sequentially or in combination with one another. Based on Manatt’s assessment, all of these models would help New Mexico make headway in its quest to expand coverage, improve affordability and increase access to care.

Financial Risk and Responsibility. The potential financial impacts to the state vary across these four options. Option 1, Targeted Medicaid Buy-In, and Option 4, Medicaid Buy-In for All, envision coverage of a certain number of low-income individuals who will not qualify for federal assistance even with a 1332 waiver. As a result, New Mexico would need to allocate state funding to provide financial assistance to these populations. Additionally, Option 4, Medicaid Buy-In for All, requires the state to obtain a 1332 waiver in order to repurpose premium tax credits. This option places the state at some financial risk if costs are higher than expected. The Phase 1 report provides additional detail on the potential financial risk to the state generated by the requirement that 1332 waivers must be “deficit neutral” to the federal government (meaning that costs above a certain projected federal spending “cap” are borne by the state).³

Phase 2 Quantitative Evaluation of Targeted Medicaid Buy-In Option

To advance a potential buy-in coverage option in New Mexico, and taking into account the Phase 1 assessment and key considerations, Phase 2 modeling focuses on the Targeted Medicaid Buy-In option. While the other buy-in options are not specifically modeled here, the Phase 2 analysis can help to inform the design of a broader coverage strategy by providing an understanding of the potential costs associated with providing financial assistance for populations ineligible for federal funding, as well as the potential magnitude of per capita savings.

A Targeted Medicaid Buy-In represents an incremental approach to expanding coverage and affordability for populations that currently do not and will not have access to federally subsidized healthcare coverage—Medicaid or Marketplace premium tax credits—using state authority and funding for financial assistance. As it evaluates Phase 2 modeling results, New Mexico can consider a longer-term, comprehensive plan that also addresses, for example:

- Additional buy-in options that New Mexico might pursue, leveraging a “data call” request sent to insurers to inform its decision-making process and an examination of how various options might interact.

- Other strategies that will expand coverage and increase affordability (Figure 2), with goals that ultimately include increasing access to care and the functioning of the healthcare system overall. These initiatives could increase federal funding available to the state and its residents, and positively impact “baseline” Marketplace

enrollment, which will be to the state’s advantage if it ultimately decides to apply for a 1332 waiver that includes a buy-in option. Increases in enrollment of individuals receiving premium tax credits can raise the amount of federal funding available through a 1332 waiver.

Figure 2. Other State Strategies to Expand Coverage and Increase Affordability



Increasing outreach and education efforts to reach and employing other strategies to retain those eligible and un-enrolled for Medicaid and Marketplace coverage



Requiring more standardization of individual market plans, such as requiring certain benefits to be covered without a deductible



Establishing a reinsurance program—lower premiums for individual market insurance coverage



Implementing a state-based coverage mandate



Supplementing ACA cost-sharing assistance to lower deductibles and premiums for health care services



Exerting an active purchaser role when the state transitions to a state-based marketplace (SBM)

Basic Design Parameters of Targeted Medicaid Buy-In

This Phase 2 quantitative analysis evaluates the scenario where the state offers buy-in coverage outside of the ACA individual market (including coverage sold both on and off the beWellnm Marketplace); targets the coverage to certain individuals who are currently ineligible for Marketplace or other coverage assistance; and provides state-funded financial assistance in

a manner consistent with the ACA. The plan’s specific design elements (Figure 3) focus on balancing desires to provide an affordable coverage option (benefiting New Mexico residents who are currently uninsured and others who struggle to pay for their current coverage) and to minimize disruptions to the existing individual market.

Figure 3. Basic Design Parameters of Targeted Medicaid Buy-In Modeled for Phase 2

Eligibility		
Immigration Status	Family Glitch	State Assistance
Individuals ineligible for the Marketplace due to immigration status earning less than 200% FPL	Spouses and children affected by family glitch earning between 138 and 200% FPL	State-funded premiums and cost-sharing assistance for those with incomes below 200% FPL at levels equivalent to those in the ACA
Unsubsidized	Benefits	Additional estimates include cost of premium assistance for family glitch between 200 and 400% FPL
Those impacted by immigration status or family glitch earning more than 200% FPL and all others with incomes above 400% FPL	Essential health benefits, mirroring beWellnm coverage	

Individuals affected by the family glitch are those where the family is offered employer insurance and the employee’s premium amount is “affordable” (i.e., less than 9.56 percent of

income), which prevents other members from receiving assistance, regardless of the additional premium cost of family coverage.

Modeling Approach

Using a variety of data sources, Wakely compiled baseline (i.e., current law without a Medicaid buy-in) estimates that serve as key inputs for modeling impacts of the Targeted Medicaid Buy-In, including:

- Enrollment, premiums and premium tax credits for coverage in the ACA individual market (on and off the beWellnm Marketplace) as of 2020.
- The number of individuals falling into each of the Targeted Medicaid Buy-In groups, including

those below 200 percent FPL who are otherwise ineligible for coverage assistance due to their immigration status; those up to 200 percent and 400 percent FPL who are affected by the family glitch; and other unsubsidized individuals, including those above 400 percent FPL and immigrants otherwise ineligible for assistance between 200 percent and 400 percent FPL.

-
- Medicaid spending on emergency and maternity services for certain immigrants who are otherwise ineligible for coverage assistance, which would continue to be paid by Medicaid and is therefore excluded from buy-in coverage costs.

Premiums for the Targeted Medicaid Buy-In were calculated in a series of steps:

- Starting with ACA individual market figures, premiums were adjusted to best align with Medicaid payment rates and blended across rating areas based on historical enrollment.
- Premiums were adjusted to exclude “Silver loading” impacts.⁴
- Buy-in premiums were assumed to exclude Marketplace fees, insurance broker commissions and profit margin.
- The premiums were also adjusted to reflect spending differences of each buy-in population relative to the individual market average, based on a variety of assumptions. Because the buy-in product is outside of the ACA individual market

and has its own separate risk pool, buy-in premiums depend heavily on the actual profile of the expected buy-in population.

- Premiums were reduced to account for the fact that the cost of emergency and maternity services for some buy-in enrollees would continue to be covered by Medicaid, as noted above.

To calculate total buy-in costs, Wakely estimated enrollment using a range of high, medium, low and very low take-up assumptions and multiplied enrollment by the buy-in premiums as calculated above. The state funding required for buy-in assistance (for premiums and cost-sharing reductions) was estimated as follows: for the immigrant population, assistance funding calculations reflect the gross cost of their buy-in coverage, minus enrollee premium contributions required at their income levels; for the family glitch population, calculations were based in part on published studies that use microsimulation modeling to estimate ACA assistance levels for these individuals.

Modeling Results

Premiums

Modeling results indicate that the premium cost of the Targeted Medicaid Buy-In would be more affordable than premiums for both the average and estimated lowest-cost offerings on the ACA individual market. Specifically, the buy-in monthly premium would range from \$377 to \$403 depending on the buy-in enrollment scenarios, compared to an average premium of \$521 and an estimated lowest-cost premium of \$475 in the ACA individual market in 2020. Reductions range from 23 percent to 28 percent compared to the individual market average

and from 15 percent to 21 percent compared to the estimated lowest-cost premium. Compared to the average individual market premium, the Targeted Medicaid Buy-In would result in an annual savings of between \$1,409 and \$1,726 for someone paying the premium entirely on their own (i.e., an individual who does not receive premium assistance).

Financial Assistance

Phase 2 includes modeling of state-funded premium and cost-sharing assistance for those with incomes below 200 percent FPL at ACA equivalent levels. Below are the costs that

individuals would pay in premiums and an estimate of their deductibles based on 2019 averages (Figure 5).

Enrollment Scenarios

Phase 2 estimates different high, medium, low and very low buy-in enrollment scenarios across the three buy-in target groups. Projected total enrollment

for the populations impacted by immigration status and family glitch earning up to 200 percent FPL and the unsubsidized population ranges from 7,000 to 16,000. The cost of providing financial assistance to target groups earning below 200 percent FPL ranges from \$12 million to \$48 million.

Figure 4. Premium Comparisons for Current Individual Market vs. Targeted Medicaid Buy-In

Comparison Plan	Monthly Premium	Buy-In Premium	Percent Savings	Annual Premium Savings
Individual Market Average Plan	\$521	\$377-\$403	23-28%	\$1,409-\$1,726
Estimated Lowest-Cost Premium Plan	\$475	\$377-\$403	15-21%	\$860-\$1,178

Figure 5. Illustrative Premium Contributions and Out-of-Pocket Amounts for Targeted Medicaid Buy-In Coverage for Individual

Income % FPL	Annual Income	Premium Cap as a % of Income	Monthly Premium Individuals Pay	Median Tier 1 In-Network Deductible (Annual)	Median Tier 1 In-Network Out-of-Pocket Limit (Annual)
Under 100%	<\$12,140	2.08%	<\$21	\$125	\$750
100-133%	\$12,140-\$16,146	2.08%	\$21-\$42	\$125	\$750
133-150%	\$16,146-\$18,210	3.11-4.15%	\$42-\$63	\$125	\$750
150-200%	\$18,210-\$24,280	4.15-6.54%	\$63-\$132	\$150	\$2,600

Note: This table uses current 2019 assistance ranges and cost-sharing limits for the ACA individual market. The median tier 1 network deductible of \$125 and \$150 reflects the median combined medical and drug tier 1 deductible for 94 percent and 87 percent actuarial value (AV) Silver cost-sharing reduction (CSR) plans reporting these figures, respectively. The median tier 1 in-network out-of-pocket limits of \$750 and \$2,600 reflect the median combined medical and drug tier 1 in-network out-of-pocket limits for 94 percent and 87 percent AV plans reporting these figures. While amounts for a Targeted Medicaid Buy-In could be similar, amounts provided here are for illustrative purposes only.

Source: Manatt analysis of CMS Plan Attributes Health Insurance Exchange Public Use Files, updated December 5, 2018, available at <http://download.cms.gov/marketplace-puf/2019/plan-attributes-puf.zip>, to determine the combined medical and drug deductibles and combined in- and out-of-network out-of-pocket limits for 2019 in New Mexico.

Figure 6. Estimated Enrollment and Assistance Costs for Targeted Medicaid Buy-In

Projected First-Year Enrollment and Costs for Providing Assistance to Target Groups in 2020				
Enrollment Take-up Scenarios	High	Medium	Low	Very Low
Immigration Status: Individuals ineligible for the Marketplace due to immigration status, earning less than 200% FPL (Take-up of 5-40%)	7,100	3,200	1,600	800
Family Glitch: Spouses and children affected by family glitch earning between 138% and 200% FPL* (Take-up of 53-55%)	3,000	3,000	2,100	2,100
State Costs of Providing Financial Assistance up to 200% FPL	\$48,000,000	\$29,000,000	\$17,000,000	\$12,000,000
Family Glitch: Earning between 138% and 400% FPL (Take-up of 53-55%)	13,000	13,000	9,000	9,000
State Costs of Providing Financial Assistance for Immigration Status up to 200% FPL and Family Glitch up to 400% FPL	\$71,000,000	\$50,000,000	\$32,000,000	\$27,000,000
Projected First-Year Enrollment for Unsubsidized Individuals				
Enrollment Take-up Scenarios	High	Medium	Low	Very Low
Unsubsidized: Individuals ineligible for Marketplace financial assistance earning more than 200% FPL and those with incomes above 400% FPL	6,000	4,500	4,400	4,100

Note: Phase 2 estimated projected enrollment scenarios across all three target groups and costs of providing financial assistance to individuals affected by immigration status and family glitch up to 200 percent FPL. Additionally, Phase 2 also estimated the projected enrollment and cost of providing premium tax credits to individuals affected by family glitch up to 400 percent FPL.

* Please see Appendix for additional modeling details and key caveats for the family glitch population.

Source: Estimates provided by Wakely Consulting Group.

Considerations

There are several key considerations related to evaluating the costs of implementing the Targeted Medicaid Buy-In, including:

- Expanding Coverage to the Uninsured Versus Increasing Coverage Affordability.** The Targeted Medicaid Buy-In is focused on individuals who do not qualify for Medicaid, Marketplace or other coverage assistance. Under a scenario where financial assistance is provided up to 200 percent FPL and there is high take-up, the modeling assumes that the currently uninsured comprise most of the enrollment. However, unsubsidized individuals who are currently insured but struggle with costs may also find the buy-in attractive, as premiums are estimated to be lower than those available in the existing individual market.
- Strategies to Mitigate Costs to the State.** There are several unknowns that will affect the state costs of providing premium and cost sharing assistance. If enrollment exceeds the model's estimates, New Mexico could mitigate costs by limiting enrollment, more aggressively negotiating prescription drug prices or changing financial assistance structures. Additionally, New Mexico may want to reserve funding if average premium costs per enrollee are higher than anticipated.
- Impact on beWellnm and the Overall Individual Market.** Because the Targeted Medicaid Buy-In is expected to have lower premiums (driven in part by its risk pool that is separate from the individual market and not subject to user fees or risk adjustment), buy-in enrollment estimates do assume some migration of unsubsidized individuals from the current individual market. As modeled, this migration is not expected to have a substantial impact on premiums in the remaining individual market. However, results could differ if the shift of currently enrolled individuals significantly exceeds estimates and their health risk and utilization profile differs substantially from the average. If less-healthy individuals choose the buy-in, rates in the remaining individual market would likely decrease; if healthier individuals choose the buy-in, rates in the remaining individual market would likely increase.
- Administrative Entity.** An entity would need to perform eligibility determinations and enroll individuals into the buy-in. Whether the state uses an existing state agency or a new agency to perform the determinations, New Mexico would need to allocate administrative costs to modify current systems, as well as conduct outreach for this particular program.

Conclusion

There are several key considerations with which New Mexico must grapple in order to design and implement one or more of the models outlined in Phase 1. These include:

- Reimbursement Rates.** All of the options assume that the buy-in will cost less than

existing individual market coverage, in large part due to anticipated reduced medical costs. This assumption is based in part on the notion that the state (or its health plan contractor) will negotiate lower provider reimbursement levels under the buy-in program than in commercial

coverage. Providers in New Mexico have concerns regarding the level of buy-in reimbursement and the extent to which a buy-in has the potential to cause people with commercial coverage today (for whom providers receive commercial rates) to switch to lower-cost buy-in coverage (under which providers may receive lower rates). Balancing the desire for a more affordable coverage option that attracts currently uninsured New Mexicans against ensuring adequate provider reimbursement is a central design consideration for all buy-in options under consideration. According to data compiled by the Urban Institute, New Mexico Medicaid reimburses 89 percent of what Medicare pays across selected physician services, compared to a national average of 72 percent of Medicare reimbursement.⁵ This is consistent with other findings regarding New Mexico's Medicaid payment rates.⁶ For uninsured individuals who are expected to enroll, the Targeted Medicaid Buy-In could improve reimbursement to providers.

- **Market Stability.** The buy-in could have positive, negative or neutral impacts on the current individual and employer markets. Stakeholders, particularly insurers, have concerns about the effect of certain buy-in options (i.e., the Basic Health Program and Medicaid Buy-In for All) in segmenting the current market. To the extent that the population that moves out of the current markets is healthier, these concerns increase. Further analysis is needed to model the potential market impacts of these options.
- **Data Limitations.** As part of Phase 1, and in preparation for Phase 2, Manatt has reviewed current data available to New Mexico to analyze the effects of a buy-in program. Today, there is insufficient data to fully assess these models; this is particularly the case for the Basic Health

Program and Medicaid Buy-In for All options. As noted in the Phase 1 report, Manatt and its partners recommend that New Mexico collect necessary data through a data request of insurers by the Office of the Superintendent of Insurance, to help inform the state's decision making and the design and implementation of a potential buy-in program. This data will be necessary to model the QHP Public Option or the more expansive options, including the Basic Health Program and the Medicaid Buy-In for All options.

Considerations for Phasing In Other Buy-In Options.

The Targeted Medicaid Buy-In estimates serve as a first step to informing the design of a broader coverage strategy and help to establish a framework for understanding and evaluating the other buy-in options under consideration. The state can use the Phase 2 results to inform its long-term, comprehensive coverage strategy:

- **Option 2, QHP Public Option.** New Mexico could consider implementing the QHP Public Option in conjunction with the Targeted Medicaid Buy-In. If the state wishes to proceed and seek a 1332 waiver, it should consider increasing enrollment in the Marketplace first to increase the baseline enrollment and available funding through a 1332 waiver. In order to increase enrollment, the state could conduct additional outreach and provide state-based premium assistance and/or cost-sharing assistance to encourage enrollment of uninsured individuals. Manatt notes that if New Mexico intended to pair the Targeted Medicaid Buy-In with the QHP Public Option, it would be easier to implement and less disruptive to administer both buy-in products in the same risk pool, so it might be better for the Targeted Medicaid Buy-In to be implemented in, rather than outside of, the individual market risk pool.

Additionally, New Mexico would want to make the buy-in population as large as possible to fully exert the state's purchasing power, and for that reason might also want to keep both buy-in products in the same risk pool.

- **Option 3, Basic Health Program.** The Targeted Medicaid Buy-In modeling estimates that a limited number of individuals will leave the individual market and that their health risk and utilization profile will have a corresponding effect on the individual market premiums. In a similar vein, the Basic Health Program would operate in a different risk pool than the individual market and as a replacement of QHP coverage, and would significantly reduce the number of individuals enrolled in Marketplace coverage, which would have a larger impact on market premiums.⁷ Additional data collection is necessary to understand the implications to beWellnm of establishing the Basic Health Program before implementing this option.
- **Option 4, Medicaid Buy-In for All.** The Targeted Medicaid Buy-In represents an incremental step to Medicaid Buy-In for All. Additional data collection and analysis are necessary to determine the potential impact of the Medicaid Buy-In for All on the individual market, particularly as the coverage

would be an optional choice (unlike the Basic Health Program). Making the Medicaid Buy-In for All optional adds uncertainty regarding the size of the projected enrollment and the corresponding health profile of those who enroll. As with the QHP Public Option, New Mexico could benefit from enrolling additional individuals in Marketplace coverage before seeking a 1332 waiver, which would be necessary to implement this option.

As New Mexico considers whether and when it will pursue a more comprehensive buy-in strategy, it will be important to determine which path it is ultimately inclined to take. The structure of Targeted Medicaid Buy-In today might be influenced by the New Mexico's "future state" buy-in vision.

Finally, the state should consider other solutions that are complementary to the buy-in that will also expand coverage and increase affordability. These strategies include increasing outreach, education, enrollment and retention efforts to reach those who are eligible for Medicaid or Marketplace coverage, but remain uninsured; establishing a reinsurance program; extending financial assistance to those above 400 percent FPL; or providing additional premium and cost-sharing assistance for those eligible for Marketplace financial assistance.

Appendix

As noted earlier, Wakely compiled baseline estimates from a variety of sources to serve as key inputs for modeling impacts of the Targeted Medicaid Buy-In, and calculated buy-in premiums in a series of steps. Because the buy-in product has its own separate risk pool with premiums that

depend heavily on the health risk profile (referred to as "morbidity") of the expected buy-in population, additional information on assumptions about the composition of the buy-in enrollee population is provided here. Additional information on the baseline ACA individual market is also provided.

Figure 7 reflects baseline ACA individual market enrollment and premiums. Some of the historical figures (particularly 2018) are estimates, since only

partial-year enrollment numbers and premiums are available. Wakely's best estimate of 2020 enrollment and premiums is also provided.

Figure 7. Baseline ACA Individual Market Enrollment and Premiums for New Mexico

Baseline	2017	2018	2020
Average Annual Enrollment			
Total Individual Market Enrollment	65,314	63,240	56,327
Marketplace Enrollment	42,474	41,335	38,011
Advance Premium Tax Credit (APTC) Enrollment	31,066	33,909	31,801
Non-APTC Marketplace Enrollment	11,408	7,426	6,209
Off-Marketplace Enrollment	22,840	21,905	18,317
Per Member Per Month (PMPM) Amounts			
Total Individual Market Premium PMPM	\$384	\$530	\$516
APTC PMPM	\$287	\$468	\$415
Total Annual Dollars			
Total Individual Market Premiums	\$301,176,100	\$402,358,124	\$348,538,388
Total APTCs	\$106,879,466	\$190,502,741	\$158,431,006

Note: Premiums shown here include impacts of Silver loading on the Marketplace. Because the second-lowest-cost Silver plan premium is estimated to decrease by 14.3 percent in 2019, Wakely expects a significant enrollment shift into that plan. This shift reduces overall 2019 PMPM amounts for premiums by more than 8.5 percent and for APTCs by 17.4 percent (data not shown). Normal growth is estimated for premiums at 6.3 percent, and for APTCs at 7.3 percent, between 2019 and 2020. As a result, 2020 PMPM amounts remain below 2018 levels.

Source: Estimates provided by Wakely Consulting Group.

With regard to morbidity and expected service utilization, differing assumptions were applied to each buy-in group:

- For the immigrant population, utilization was assumed to be lower than average based on previous research indicating that this population tends to have lower expenditures relative to citizens. However, this low utilization factor was offset to account for the fact that those who choose to enroll in the buy-in are among the most likely within the immigrant population to use services. In determining a final factor for this population, Wakely estimated how lower take-up rates could increase the morbidity of those who enroll (and vice versa), as the sickest individuals are expected seek coverage under any scenario.
- For the family glitch population, differences in utilization were estimated based on a previous study that used microsimulation modeling to estimate the individual market premium effects of fixing the family glitch. Simplifying

assumptions for changes in premiums were applied to the buy-in product estimations that only include financial assistance for 138-200 percent FPL population.

- For unsubsidized individuals who were previously uninsured, the population tends to be motivated primarily on price and is assumed to have lower relative morbidity. Lower morbidity is also assumed for unsubsidized individuals migrating to the buy-in from the ACA individual market, since studies indicate that healthier individuals are more price sensitive.

Figure 8 shows the estimated morbidity and utilization factors for each population and in total across take-up scenarios. The total morbidity and utilization factor reflects a weighted average of the individuals who enroll from each group, and represents the final spending difference factor that is applied to align Medicaid buy-in premiums with the expected spending of the overall buy-in population.

Figure 8. Estimated Morbidity Factors for Targeted Medicaid Buy-In Populations

Enrollment Take-up Scenarios	High	Medium	Low	Very Low
Immigrants	0.90	1.02	1.09	1.25
Family glitch	0.94	0.94	0.94	0.94
Unsubsidized from previously uninsured	0.73	0.73	0.73	0.73
Unsubsidized from ACA individual market	0.95	0.95	0.95	0.95
Total	0.91	0.94	0.94	0.94

Note: Total morbidity factor is weighted by enrollment of each population.

Source: Estimates provided by Wakely Consulting Group.

Additional Caveats

There are still a number of key policy and operational decisions to be finalized that may affect the estimates included in this report. Additionally, changes in the policy environment between now and 2020 may alter estimates. Overall, the lack of sufficient detailed data on

Medicaid rates, uniqueness of the program, operational uncertainties, small data sizes and the price sensitivity of the target populations mean that estimates in this report are inherently uncertain. Results in practice may vary significantly, including varying outside of the range of estimates given within this report.

¹ Manatt Health, Evaluating Medicaid Buy-In Options for New Mexico, December 2018, available at <https://www.manatt.com/Manatt/media/Documents/Articles/Evaluating-Medicaid-Buy-in-Options-for-New-Mexico.pdf>.

² Ibid

³ For background on 1332 waivers, see State Health & Value Strategies, Medicaid Buy-in: State Options, Design Considerations and 1332 Implications, May 2018, available at https://www.shvs.org/wp-content/uploads/2018/05/Medicaid_Buyin_FINAL.pdf.

⁴ Insurers are required to offer cost-sharing reductions (CSRs) that increase the value of Silver plans provided on the Marketplace to subsidized individuals with incomes up to 250 percent FPL, and the cost of these CSRs is loaded onto Silver premiums on the Marketplace. Unsubsidized individuals who purchase off the Marketplace do not pay “Silver loaded” premiums.

⁵ Urban Institute , Medicaid Physician Fees after the ACA Primary Care Fee Bump, March 2017, available at <https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump>.

⁶ Human Services Department, New Mexico Medicaid Access Monitoring Review Plan for Fee For-Service Recipients, October 2016, available at <https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/nm-amrp-16.pdf>.

⁷ In 2018, 45 percent (19,620) of Marketplace enrollees in New Mexico had incomes below 200 percent FPL. Source: Stakeholder Advisory Committee Presentation, July 2018.

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