COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

COLORADO DEPARTMENT OF REGULATORY AGENCIES DIVISION OF INSURANCE

FINAL REPORT TO THE JOINT HOUSE AND SENATE HEALTH AND HUMAN SERVICE COMMITTEE

CENTENNIAL CARE CHOICES/ SB 08-217

March 2, 2009

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1. Executive Summary

Senate Bill 08-217 created a framework for developing the Centennial Care Choices Program, which would provide options for uninsured Coloradoans through new health insurance products known as value benefit plans (VBPs).

On June 24, 2008, Governor Ritter appointed 19 members to an expert panel to assist the Department of Health Care Policy and Financing (the Department) and the Colorado Department of Regulatory Agencies – Division of Insurance (the Division) in seeking information from the health insurance industry about the development of value benefit plans. From July through December, the Panel met and provided input on a Request for Information (RFI) and review process. The RFI was released on October 7, 2008, and eight responses were received by the Department on December 2. Along with the expert panel, staff and consultants from the Department, the Division, and the Governor's Policy Office have assessed the RFI responses to provide this report to the Legislature describing findings about the uninsured Coloradoans who could be covered by VBPs, the cost of providing subsidies to make VBPs affordable for low income individuals and families, and cost savings that could be achieved by reducing Colorado's uninsured population. The report also provides recommendations about a premium subsidy program and an individual mandate that would be needed in support of the Centennial Care Choices Program.

The Centennial Care Choices Panel, the Department and the Division consider the RFI a success having received meaningful cooperation from private sector companies in the form of a number of interesting value benefit plan (VBP) designs. Proposed plans have attractive primary and preventive benefits; however, for the lowest income uninsured residents of our state, none of the VBPs would be affordable without an individual mandate, guaranteed issue requirements and a significant state subsidy. Recognizing today's economic realities, it is clearly a difficult time to ask the Legislature to introduce a costly new subsidy program to support Centennial Care Choices.

Despite the current economic situation, and in fact, in some part, due to the current economic situation, it is important to address the need to provide insurance coverage and health care services to uninsured Coloradoans; in this environment, the demand is higher than ever. Opportunities exist for the Legislature to take interim steps toward implementing Centennial Care Choices that will prepare the State for actions that can be taken when the economy improves.

2. Introduction

Colorado faces an enormous challenge in assuring access to health care for all of its citizens. There are now familiar problems of cost, quality and access. Of particular concern are the estimated 792,000 Coloradoans without health insurance.[1] It is well documented that people without insurance do not receive appropriate health care.

Last year, the 208 Commission reported on the results of their yearlong process trying to understand and address these issues. Senate Bill 08-217 built on the 208 Commission's recommendations by studying practical steps to provide coverage to some of Colorado's uninsured residents through low cost, State-subsidized value benefit plans as part of "Centennial Care Choices."

The Centennial Care Choices Panel has worked for over six months to evaluate the potential impact of this solution. It is not the Panel's responsibility to weigh in on whether value benefit plans themselves are good public policy; the Colorado Legislature determined that these plans represent a strategy worth exploring when it passed Senate Bill 08-217. Instead, the Panel has endeavored to provide expert opinion on what policy changes would be needed to enable the introduction of value benefit plans (VBPs) to reduce the number of uninsured Coloradoans, and comment on additional strategies that may provide partial or interim solutions to providing access to health coverage and health care to all citizens of our state.

[1] Blue Ribbon Commission for Health Care Reform, Blue Ribbon Commission for Health Care Reform: Final Report to the General Assembly, Rep., <www.colorado.gov>.

This report is respectfully submitted to the House and Senate Health and Human Services committees of the Colorado General Assembly by the Department of Health Care Policy and Financing and the Department of Regulatory Agencies, Division of Insurance, as required by SB 08-217. Senate Bill 08-217 created a framework for developing the Centennial Care Choices Program, requiring the Department of Health Care Policy and Financing, in coordination with the Division of Insurance and a panel of experts, to acquire actuarial projections, research potential cost savings, and develop a Request for Information from health insurance companies for a new health insurance product known as a value benefit plan (VBP). The purpose of this report is to detail the results of the Request for Information process and the actuarial and cost savings research, including a detailed summary of the information submitted by health insurance carriers and other interested parties, along with the Department's and Division's evaluation and analysis. The report also includes information regarding policy considerations should the General Assembly proceed to implement the Centennial Care Choices Program.

3. Change in Colorado's environment since SB 08- 217 was passed

When Senate Bill 08-217 was proposed in March 2008, and even signed in June 2008, Colorado was not yet feeling the severe negative effects of the current economic environment. While Colorado did not experience job losses until September 2008,[2] according to the National Bureau of Economic Research, the U.S. economy has been in recession since December 2007.

When people lose their jobs, they also lose their health insurance. Colorado's unemployment rate grew by a half point to 5.7 percent in October, the highest in nearly five years. With every one percentage point increase in Colorado's unemployment rate, 19,000 adults and more than 800 children enter the ranks of the uninsured.[3] A positive development is that the 65 percent subsidy for COBRA continuation coverage included in the recently passed American and Reinvestment

[2] Colorado Department of Labor & Employment, Colorado LMI Data Overview for May 2008 - September 2008, 13 Feb. 2009 <http://lmigateway.coworkforce.com/lmigateway/default.asp>.

[3] Unpublished data from the Urban Institute provided to The Colorado Health Foundation, 2008.

Act will weaken the link between job loss and becoming uninsured, so this trend will be somewhat mitigated in coming months.

Some newly unemployed people will become eligible for public health insurance programs like Medicaid and the State Children's Health Insurance Program, while others will rely on safety net clinics that serve the uninsured, or simply go without needed health care. Colorado experienced a 12 percent Medicaid caseload increase in 2008, driven by enrollment of non-disabled, non-elderly clients who would typically be able to afford and access a private insurance product. At the same time, the State is seeing significant revenue shortfalls that are forcing lawmakers to make tough choices. Governor Ritter presented the legislature's Joint Budget Committee with recommended budget cuts on January 15, after directing his department heads and Budget Director Todd Saliman to prepare plans for a 10 percent, or nearly $800 million, reduction through a combination of programmatic cuts, cash-fund transfers and utilizing the State's emergency reserve.

This is an obviously a difficult environment in which to advocate for new programs, particularly something as significant and costly as a massive premium subsidy program. However, as Anne Warhover, Executive Director of The Colorado Health Foundation wrote in a recent Denver Business Journal editorial:

> *"Though it is counterintuitive, the economic meltdown may be the catalyst for meaningful health care reform. It's time to change the way health care is delivered in this country to make it more efficient. Health information technology and care coordination hold potential to both increase quality and drive down costs. Changing the way we pay for health care is also an important component of reforming the system. And finally, we must tackle the problem of the growing number of people without health insurance. There are powerful ethical and moral arguments for a health care system in which everyone has access to health care. But there is a strong economic case as well. The cost to reform our*

health care system will be significant. But the cost of doing nothing could be even greater, in both financial and human terms. We simply can't afford to do nothing." [4]

Ms. Warhover's conclusions are consistent with the view of the Centennial Care Choices Panel. The rising number of uninsured Coloradoans emphasizes the need for meaningful healthcare reform, of which the Centennial Care Choices Program may be a part. The Centennial Care Choices Panel agrees that there is a cost to doing nothing; the consequences of the lack of health insurance are serious and cannot be ignored.

4. Key Findings

While none of the experts on the Panel believe that Centennial Care Choices is "the" answer to health care reform in our state, it could provide a partial solution to some people who are currently uninsured. Following are the key findings from the Value Benefits Plan Request for Information process:

- **The private health insurance sector cooperated with the State in this attempt to cover uninsured residents of Colorado.**
- **To be an appropriate solution for the uninsured, value benefit plans must strike a balance that is both adequate and affordable.**
- **A series of policy changes need to happen together to make value benefit plans viable.**
- **The price of the subsidies that would make Centennial Care Choices value benefit plans affordable to uninsured Coloradoans is a barrier to implementing the program.**
- **There is not a single program solution that will provide insurance to all of Colorado's uninsured residents.**

[4] Anne Warhover, "The time is right to fix our health care system," Denver Business Journal: pg. #, 20 Jan. 2009, <http://denver.bizjournals.com/denver/stories/2009/01/19/editorial2.html>.

Below, each of these findings is discussed in more detail.

The private health insurance sector cooperated with the State in this attempt to cover uninsured residents of Colorado.

The following companies participated in a response to the Request for Information:

- Celtic Insurance Company (subsidiary of Centene Corporation)
- Colorado Access
- Colorado Choice Health Plans (dba San Luis Valley)
- CoverColorado (in conjunction with Pinnacol Assurance)
- Delta Dental (in conjunction with Kaiser Permanente and Rocky Mountain Health Plans)
- Kaiser Permanente
- Pinnacol Assurance
- Rocky Mountain Health Plans
- United Health Group

Complete RFI responses are included in Appendix 2.

Anthem BCBS also submitted a response to the RFI, which was not considered in the analysis and evaluation process, because it did not comply with the requirement of SB 08-217 to limit the characteristics used in determining premium rates exclusively to the age of individuals to be covered under the VBP and the geographic location of the policyholder. Rates for Anthem's SmartSense 1500 VBP were determined by age, gender, geographic location and initial health status.

Panel members, staff and other observers initially had doubts about whether health plans and other interested entities would participate in the RFI process due to concerns about making proprietary information and strategies part of a public record. That was not the case for the ten organizations that shared in developing responses for the Panel. Their proposals show that the insurance industry can develop health insurance products that provide primary and preventive benefit coverage without large out of pocket costs. However, there were clearly tradeoffs in

terms of other benefit categories, and cost-sharing requirements (deductibles, co-pays and coinsurance) that make the proposed value benefit plans too costly for many of Centennial Care Choices' potential clients. More detail from the RFI responses is discussed in Section 7.

The RFI process was important in terms of creating a dialogue and understanding roles, information needs, and the concessions that some of the health insurers are willing to make in the development of a public private partnership.

To be part of a solution for the uninsured, value benefit plans must strike a balance that is both adequate and affordable.

According to a recent national survey, among the uninsured, 76 percent said that someone in their family did not see a doctor during the past year when they were sick because of cost, and 57 percent of the uninsured said they had to choose between paying medical costs or their rent, mortgage or utilities.[5] Low cost limited benefit plans can offer a solution for uninsured citizens struggling with these tradeoffs. Of the seven VBPs analyzed through the RFI process, five offered access to primary and preventive care with very low, or no out of pocket costs. For example, proposed benefit designs included:

- no deductible on office visits, lab, drugs
- no deductible on preventive office visits
- no cost sharing on preventive services
- no cost sharing on prevention or primary care physician visits for evaluation and management
- no charge for appropriate physicals, lab work, immunization, and prenatal care

[5] Steven Reinberg, "High Costs Force Third of Americans to Skip Needed Health Care," Health News Articles - US News Health, 25 Mar. 2008, 10 Feb. 2009 <http://health.usnews.com/usnews/health/healthday/080325/high-costs-force-third-of-americans-to-skip-needed-health-care.htm>.

While the Panel and the companies that responded to the RFI understand that for many people, low cost primary and preventive care will not meet all their needs, it can, in some cases, keep currently uninsured patients out of the Emergency Department or operating room.

In providing these basic level of services in an affordable manner, VBPs make other benefit categories expensive through deductibles, copayments, and coinsurance, making participants gamble that they will not need higher cost services, and putting at financial risk the citizens that can least afford such uncertainty. This "underinsurance" could cause lower-income consumers to face catastrophic costs, medical debt or even bankruptcy. As described in a 2002 Commonwealth Fund report, "Although stripped-down policies are meant to make insurance more affordable for low-income consumers, they do so only with enormous risks."[6]

Nationally, this high level of risk has led to low enrollment in basic benefit plans. In most states that permit the sale of limited-benefit plans, enrollment has fallen far short of expectations. For example, during the first year of Montana's mandate-lite health plan, the administrator received 400 requests for applications, but only 53 individuals enrolled. The program, which provided office-based care but no inpatient coverage, could serve up to 1,000 Montanans. According to the Director of Health Care Access for the plan, "After individuals reviewed the plan, they realized that the package didn't cover enough to be of value to them." In 2007, the plan administrator discontinued the program due to low enrollment.[7]

As panel members reviewed proposed value benefit plans, a central concern was the trade-off among cost-sharing (particularly deductibles), benefit levels and premiums. Some of the responses explicitly stated they designed their plans, including cost sharing, to bring down premiums. Examples of benefit limits proposed included:

- inpatient benefits limited to an annual max of $35,000 or $50,000
- $200,000 annual benefit maximum and a $1,000,000 lifetime max
- exclusion for pregnancy
- $50,000 annual benefit max

[6] Families USA 2008.

[7] Families USA 2008.

Panel members were divided as to whether the benefits justified the cost and the risk to consumers.

A series of policy changes need to happen together to make value benefit plans viable.

Most respondents (in addition to the Panel and staff) believe that the value benefit plans would work only in the context of state subsidies and an individual mandate. Subsidies would use state funding to reduce the cost of the value benefit plan premium to the consumer. The Centennial Care Choices Panel and staff developed RFI questions assuming that state funds would subsidize premiums for value benefit plans to make them affordable for low-income individuals and families. But the design of the resulting plans and suggestions from respondents led the reviewers to question whether subsidies have to provide support for premiums only; perhaps there is a way to subsidize the cost-sharing provisions (deductibles, copayments, coinsurance) of VBPs, to truly make accessing health care affordable. Respondents and reviewers agree that subsidy dollars should be restricted to the VBP market, and not be made available to products in the broader individual market to reduce adverse selection in VBPs.

An individual mandate requires that individuals have health insurance, through an employer, an individual plan or a public insurance program (such as Medicaid). In the absence of an individual mandate, many question the viability of VBPs as guaranteed issue, community rated products that would exist "alongside" underwritten products in the individual market. Without a mandate, most respondents believe that VBPs would be subject to significant adverse selection (in which only those who are sick purchase health coverage). With a mandate in place, insurers would likely be less concerned about the occurrence of adverse selection, enabling the purchasing pools to work as designed.

A guaranteed issue requirement would ensure that no one would be turned away from a VBP due to health conditions, but it would also make VBPs more costly. If VBPs are guaranteed issue, they will compete with medically underwritten products and will generally attract the less healthy individuals, especially without a mandate in place. Lessons from other states confirm that guaranteed issue plans can be much more costly. For example, up until 2008, the individual market in New Jersey was guaranteed issue and used community rating in its purest form.

Individual insurance carriers were not allowed to rate by age, gender, or any other rating characteristic. However, health insurance rates in New Jersey are more than twice as high as neighboring states.

In a pure community-rating environment, the younger healthier individuals subsidize those that are older and less healthy. The younger more healthy individuals will be more likely to seek less expensive coverage elsewhere, if it can be found. The older, sicker individuals will remain in the community rated or guaranteed issue environment. Thus, the older, sicker individuals "adversely select" the products, driving up the cost for the remaining members.

In a guaranteed issue environment, there are ways that adverse selection can be significantly reduced or even eliminated. One way to reduce adverse selection is to impose an individual mandate. Another would be to allow limitations on pre-existing conditions or specify waiting periods to enroll or annual enrollment periods.

Several respondents noted that VBPs would have a significant disadvantage when competing with other products in the individual market. Carriers offering individual products are currently allowed to rate by gender, smoking status and health status, but VBPs are limited to setting rates based on age and region. If the same restrictions were placed on all products offered in the individual as well as small group markets, the potential for adverse selection would be significantly reduced.

The price of the subsidies that would make Centennial Care Choices Value Benefit Plans affordable is a barrier to implementing the program.

According to data analyzed for the 208 Commission, 75 percent of the uninsured in our state have incomes of $50,000 per year or less. A July 2000 study commissioned by the Colorado Coalition for the Medically Underserved (CCMU) showed that very few low-income individuals could afford to pay *any amount* for health insurance after spending for essentials. Survey data showed that on average, all groups with incomes less than $50,000 per year spent more than their income. The very lowest income groups, those most likely to be uninsured, had the greatest excess of expenditures over income. Even when categories of expenditure not usually considered

essential were subtracted from each group's expenditures, only seven of 28 household size/income categories with incomes under 300 percent of the federal poverty level (FPL) had, on average, any disposable income. This makes decisions about reasonable levels of contribution that can be required of low-income families extremely difficult.[8]

The Colorado Center on Law and Policy is due to release a new study on the affordability of health care in March 2009, using 2008 data that is generally consistent with the earlier CCMU findings. They took a different approach to affordability and showed that families spending higher percentages of their total income on health care (including health insurance) spent less on basic necessities such as housing, transportation and childcare, and reduced their savings levels and educational expenditures.

Based on both of these analyses, the State will need to fund the vast majority, if not all, premium costs to encourage enrollment in value benefit plans for people with incomes under 300 percent FPL.

The following table presents the proposed monthly premiums for each VBP and the percent of family income that would be required to purchase these plans in the absence of a subsidy:

[8] Judith Glazner, Prices and Affordability of Health Insurance for Colorado's Uninsured Population, Rep. July 2000 (The Colorado Coalition for the Medically Underserved).

Table 1: VBP Affordability Summary

VBP	percent of FPL and monthly family income	Avg monthly premium with mandate	Premium as % of monthly family income	Annual deductible	Co-pays or co-insurance for non-preventive care	Out of pocket max
Celtic VBP	100% = $867 per month 200% = $1,734 per month 300% = $2,601 per month	$211.36	24.4% 12.2% 8.1%	$3,000	$25 Spec.	$3,000
Colorado Access VBP Option 1	100% = $867 per month 200% = $1,734 per month 300% = $2,601 per month	$224.61	25.9% 13.0% 8.6%	$1,000	$10 PCP $35 Spec.	None given
Colorado Choice Plan	100% = $867 per month 200% = $1,734 per month 300% = $2,601 per month	$308.35	35.6% 17.8% 11.9%	$250 $500 for PL	$10 PCP, $20 Spec. $15 PCP, $20 Spec.	$2,500 $4,000
Kaiser - Option 1	100% = $867 per month 200% = $1,734 per month 300% = $2,601 per month	$407.63	47.0% 23.5% 15.7%	$2,500	Subject to Deductible and 30% coinsurance	$5,000
Kaiser Option 2	100% = $867 per month 200% = $1,734 per month 300% = $2,601 per month	$416.13	48.0% 24.0% 16.0%	$2,500	Subject to Deductible and 30% coinsurance	$5,000
Pinnacol Assurance Assured Care VBP	100% = $867 per month 200% = $1,734 per month 300% = $2,601 per month	$190.14	21.9% 11.0% 7.3%	$0	$15 PCP $25 Spec	$5,000
RMHP Value Plan	100% = $867 per month 200% = $1,734 per month 300% = $2,601 per month	$252.82	29.2% 14.6% 9.7%	$3,000	$45 PCP $65 Spec	$8,000
United Health Group VBP	100% = $867 per month 200% = $1,734 per month 300% = $2,601 per month	$260.37	30.0% 15.0% 10.0%	$2,500	Subject to Deductible and 20% coinsurance	$5,500

There is not a single program solution that will provide insurance to all of Colorado's uninsured residents.

Limited benefits plans will never serve the total needs of a population with known, multiple, chronic illnesses. Cost sharing provisions and benefit limits quickly make value benefit plans unaffordable for Coloradoans with ongoing needs. The Centennial Care Choices RFI process considered the role of VBPs within the existing paradigm of employer sponsored health insurance, and in this context, VBPs are not an appropriate option for the high needs population.

5. Making Value Benefit Plans Work

Addressing Crowd-Out

Limited-benefit plans that are touted as an option for covering the uninsured do not necessarily reach only their intended audience. Instead, limited-benefit plans can lead individuals or employers who previously offered comprehensive health insurance to reduce the breadth of their benefits to take advantage of the lower premiums. This erosion of benefits in the existing individual, small group, and large group markets is commonly called "crowd out." To minimize crowd out, RFI Respondents' suggested the establishment of specific annual enrollment periods or waiting periods for VBPs ranging from 120 days to 12 months. Another suggestion would require administering a means test through the Colorado Benefits Management System.

Lessons from other states confirm that crowd out can be a real issue. For example, in 2006, only 11 percent of enrollees in Texas' limited-benefit plan were previously uninsured. Limited-benefit plans can be much more appealing to young and healthy individuals than they are to older people or those with health care needs who have greater risk of large out of pocket expenditures under the plans. In fact, some policy makers have proposed limited-benefit plans specifically targeted at young adults. These plans may draw low-cost enrollees out of comprehensive coverage, leaving behind only older and sicker enrollees in plans with comprehensive benefits. With fewer

young and healthy enrollees to spread the financial risk of illness, the price of comprehensive plans in a state's insurance market may increase.[9]

Lessons from the RFI

In addition to the policy considerations including subsidies, mandates, and crowd out, there are operational decisions about value benefit plans that must be addressed before a successful Centennial Care Choices Program could be implemented. Specific operational decisions were highlighted in one or more VBP proposals, including:

- **Requirement for statewide vs. regional plans**

  SB 08-217 explicitly states that VBPs will, at a minimum, "Be offered statewide and issued to any Colorado resident eligible pursuant to the terms of the approved VBP who agrees to make the premium payments required for that person." In developing the RFI, Panel members and staff assumed that the requirement for statewide operation of VBPs was to assure that plans could not participate in "cherry picking," or offering coverage only to the most attractive (low cost) clients in the areas of the state that are the least costly within which to operate. Therefore, the RFI required each respondent to describe in which regions of the State they could offer their proposed VBP, and if necessary, describe how they would partner with another entity to create a statewide program.

  However, this requirement creates a barrier for regional plans that provide appropriate health care coverage in specific areas of the state. If VBPs are implemented, the same protection against cherry picking could be addressed by requiring plans to offer their VBP anywhere they are licensed to provide any health insurance products, instead of requiring each VBP to itself be a statewide plan.

[9] Families USA 2008.

- **Decision on health mart, brokers, and payment of commissions**

  Based on the language in SB 08-217, the RFI instructed respondents to assume that the Legislature could establish "health marts" through which an individual may select a VBP that best meets his or her needs. More details around this process of marketing and enrolling clients into VBPs is needed, as differences in assumptions led to differences in pricing the value benefit plans (i.e. some health plans included broker commission in their cost for operating a VBP while some did not).

- **80 percent actuarial equivalence with state employees PPO benchmark**
  Because SB 08-217 required development of VBPs with a benchmark standard that was approximately 80 percent of the actuarial value of a state employees' PPO plan, benefits were automatically starting from a place that is inferior to typical commercial products. While this was consistent with the concept of minimum or value benefit plans, it does raise adequacy concerns, as discussed above (Section 5).

- **Limit the allowable cost sharing in value benefit plans**
  As discussed in detail on pages 12-13 of this report, Panel members had significant concerns about the affordability of the out of pocket costs related to Value Benefit Plans. These concerns could potentially be addressed by imposing maximum out of pocket costs in the Centennial Care Choices Program.

- **Develop explicit rules or mechanisms for those who exceed VBP benefit limits**
  As the panel discussed in its key findings, VBPs will not provide a solution to all uninsured Coloradoans. They are particularly unsuited for people with high medical needs, including those who have chronic conditions. One respondent explored an explicit partnership with Cover Colorado as a vehicle for providing coverage for potential enrollees with chronic and ongoing health care needs, who would not be well served by the other VBP options. The Centennial Care Choices Panel recommends that the Legislature make specific decisions about a potential role for Cover Colorado for VBP

enrollees who exceed their benefit maximums each year. As an alternative, a State reinsurance program for value benefit plans could be explored.

6. Detailed Results from the Request for Information: VBP Benefits

As described in Section 5, the following companies participated in a response to the Request for Information:

- Celtic Insurance Company (subsidiary of Centene Corporation)
- Colorado Access
- Colorado Choice Health Plans (dba San Luis Valley)
- Cover Colorado
- Delta Dental
- Kaiser Permanente
- Pinnacol Assurance
- Rocky Mountain Health Plans
- United Health Group

Anthem BCBS also submitted a response, which was not considered in the analysis and evaluation because it did not comply with the requirement of SB08-217 to limit the characteristics used in determining premium rates exclusively to the age of individuals to be covered under the VBP and the geographic location of the policyholder. Rates for Anthem's SmartSense 1500 VBP were determined by age, gender, geographic location and initial health status.

Copies of each response are included in Appendix B. Key characteristics of the value benefit plans are summarized in three tables to follow, with narrative descriptions of important themes.

Panel members were asked to submit worksheets describing their reactions to each value benefit plan proposal including a recommendation on whether they would support offering the plan to

uninsured Coloradoans. Ten panelists provided written feedback on some or all plans (members abstained from commenting on health plans with which they had a relationship):

Table 2: Reviewer Feedback Summary

	Panel Votes			
Value Benefit Plan	***"Yes"***	***"Maybe"***	***"No"***	***Comments***
Celtic	4	3	3	• Medicaid and SCHIP experience in other states • Maternity benefits excluded • Broad PPO network – not cost-effective
Colorado Access	7	3		• Safety net provider with experience in Medicaid and SCHIP • Strong systems for managing uninsured/Medicaid enrollees
Colorado Choice	1	3	5	• Regional plan • Consumer education focuses on web access
Kaiser Permanente	3	3	2	• Proven model • Good use of HIT • Don't have safety net relationships • Recognizes association between oral health and overall health
Pinnacol Assurance	3	2	4	• No safety net relationships • Innovative • Discusses 24-hour coverage • Interesting partnership with CoverColorado
Rocky Mountain Health Plans	7	1	1	• Extremely successful in managing Medicaid • Focus on prevention and wellness • Good use of HIT
United Health Care	2	2	6	• Good national systems • Focused on underwriting

The Panel specifically noted that the two value benefit plans with the greatest level of support ("yes" votes) are non-profit, Colorado-based companies (highlighted above) with extensive experience in public programs. Plans that had the least support were most often criticized for higher costs, for lack of knowledge of the population, or for perceived "cherry picking."

The Request for Information was designed to gather information on specific plan requirements included in SB 08-217. Highlights from this information are described below.

Table 3: Benefits Summary

	Prevention	Hospital Benefits	Drug Benefits	Primary Care Benefits	Provider Network
Celtic VBP	$0 copay	20% coinsurance after deductible	$0 generic $50 brand	$0 copay	Multiplan
Colorado Access VBP Option 1	$0 copay	in patient admission charge of $1000 + $100/day	$5 generic 50% brand $10,000 annual max	$10 copay	CHCs, Children's Hospital, University Hospital
Colorado Choice Plan <250% FPL	$0 copay for children $5 copay for adults	$15 per day copay up to 5 days, then 40% coinsurance	$5 generic $15 brand	$10 copay	Colorado Choice provider network
Colorado Choice Plan 250-300% FPL	$0 copay for children $10 copay for adults	$15 per day copay up to 5 days, then 40% coinsurance	$10 generic $20 brand	$15 copay	Colorado Choice provider network
Colorado Choice Plan >300% FPL	$0 copay for children $15 copay for adults	$15 per day copay up to 5 days, then 40% coinsurance	$15 generic $40 brand	$25 copay	Colorado Choice provider network
Kaiser Foundation VBP- Option 1	$15 copay	30% coinsurance after deductible	$20/$40/$60 retail $40/$80/$120 mail	subject to deducible and 30% coinsurance	Colorado Permanente Medical Group
Kaiser Foundation VBP- Option 2	$10 copay	30% coinsurance after deductible	$15/$40/$60 retail $40/$80/$120 mail	$20 copay	Colorado Permanente Medical Group
Pinnacol Assurance: Assured Care VBP	$0 copay	$75 per day copay up to 5 days per year	$5 generic $25 brand $1,000 annual max	$15 copay	Cor Care PPO Ascent Benefits Co
Pinnacol Assurance: Cover Colorado VBP	$0 copay	$75 per day copay up to 10 days per year	$5 generic $25 brand $1,000 annual max	$15 copay	Cor Care PPO Ascent Benefits Co
RMHP Value Plan	$0 copay	30% coinsurance after deductible	$15/$45/$55/ 20% for > $150 30% for > $250	$45 copay	In Colorado: Rocky Mountain HCO Network Outside Colorado: MultiPlan/PHCS Network Behavioral Health: Life Strategies
United Health Group VBP	15% coinsurance for children and 25% coinsurance for adults, not subject to deductible	20% coinsurance after deductible	20% coinsurance	Subject to deductible and 20% coinsurance	United Health Care Choice Plus

Primary care and preventive benefits

As described in Section 5 and detailed above, the value benefit plans offer low cost access to primary care and preventive services. Five carriers offered zero copays on prevention (one offered zero dollars for children's services and low costs for adults). None of the preventive services were subject to deductibles.

Wellness benefits and incentive

The majority of value benefit plans would encourage members to take Health Risk Assessments (HRAs) and offer coaching. Incentives to participate in HRAs, health education and preventive services included reward points that could be redeemed for prizes, premium reductions, cash, gifts, drawings, and reduced fees and /or premiums for completing HRAs or participating in interventions. One plan suggested using subsidy dollars to incent positive behavior in VBP clients.

Provider Networks

Each respondent promised a statewide provider network, though in reality, several plans currently only serve regions of the state. Only one plan discussed strong network adequacy standards, though several offered to use mapping to monitor "an appropriate set of standards." The RFI specifically asked plans to discuss inclusion of safety net providers in their networks. Some plans have experience with Colorado's safety net through Medicaid or the Child Health Plan Plus, while other companies described experience with safety net providers and public programs in other states. Only one plan had neither, and one plan was actually founded by Colorado safety net providers. Reimbursement levels depend on current provider arrangements and are based on everything from Medicaid to Medicare and commercial contracts.

Pay for Performance

Respondents cited a November 2005 Robert Wood Johnson study that confirmed that pay for performance can improve medical care and quality of life. However, according to respondents, pay for performance reimbursement is not currently in wide use in

Colorado. Several responses discussed the principles (collaboration with providers, using evidence-based guidelines and practices, focusing on outcomes, etc.) that are important in implementing pay for performance programs, and others talked about pilot programs. All except one indicated a willingness to develop pay for performance programs in the future as part of their value benefit plans.

Optional coverage choices

Respondents offered a variety of optional or "buy up" coverage including: vision, dental, prescription coverage, short-term disability, and accidental death and dismemberment insurance. Several carriers also offered plans with lower cost sharing for a higher premium.

Health Outcomes

Other than increasing access to primary and preventive care, for the most part, plans did not offer specific goals for health outcomes. Instead, they provided a general discussion of performance measurement and quality improvement processes including the Healthcare Effectiveness Data and Information Set (HEDIS), which includes measures such as immunization rates, cancer screenings, and follow up after hospitalization for mental illness.

HIT offerings

Respondents discussed collaborative health information networks (Colorado Regional Health Information Exchange or CORHIO, Quality Health Network or QHN), personal health records and e-prescribing under Health Information Technology (HIT) initiatives. Some are also working on web-based practices for the future, such as information exchange, web consultations and the Colorado Telehealth Network initiative. One plan said it is currently using telemedicine, particularly for regions without access to specialty physicians. Another plan is working to develop this capability.

Consumer Education

Responses mentioned fairly typical member handbook and web-based educational opportunities, in addition to phone outreach and mailed reminders for annual preventive services. While plans discussed the low-literacy needs of this population, there was not much discussion of the particular communication channels that would be most effective (for example, primary care physician efforts) for the currently uninsured (low income, minority).

Table 4: Cost Summary

	Deductible	Coinsurance	Copayments	Out of Pocket Max	Benefit Maximums
Celtic VBP	$3,000 individual $6,000 family		$0 PCP $25 specialist	$3,000 individual $6,000 family	$7,000,000 lifetime
Colorado Access VBP Option 1		50% for DME	$10 PCP $35 Specialist $50 chemo/dialysis $300 ER $25 home health $100 SNF (per day)		Annual maximum of $35,000 inpatient hospital and $10,000 outpatient hospital
Colorado Choice Plan <250% FPL	$250	40%	$10 PCP $20 specialist	$2,500 (does not include copayments)	$200,000 annual maximum and $1,000,000 lifetime maximum
Colorado Choice Plan 250-300% FPL	$500	40%	$15 PCP $30 specialist	$4,000 (does not include copayments)	$200,000 annual maximum and $1,000,000 lifetime maximum
Colorado Choice Plan >300% FPL	$750	40%	$25 PCP $50 specialist	$6,000 (does not include copayments)	$200,000 annual maximum and $1,000,000 lifetime maximum
Kaiser Foundation VBP- Option 1	$2,500 individual $5,000 family	30%	Non preventative office visits subject to deductible	$5,000 individual $10,000 family	
Kaiser Foundation VBP- Option 2	$2,500 individual $5,000 family	30%	Non preventive office visits are not subject to deductible PCP = $20 Specialist = $40	$5,000 individual $10,000 family	
Pinnacol Assurance: Assured Care VBP	none	30% for medical professional services other than office visits	$15 PCP $25 for first three specialist visits, then $40 each	$5,000	$50,000 per year

	Deductible	Coinsurance	Copayments	Out of Pocket Max	Benefit Maximums
Pinnacol Assurance: Cover Colorado VBP (for acute-ongoing/qualifying conditions)	$250	30% for medical professional services other than office visits	$15 PCP $25 for first three specialist visits, then $40 each	$7,500	$50,000 per year
RMHP Value Plan	$3,000/ individual - In-network and out-of-network deductible combined	30% for maternity, hospital, home health, DME, hospice, and skilled nursing	$45 PCP and vision $65 specialist, urgent care $30 lab and $55 x-ray Copays do not count toward out of pocket max	$8,000	$2 million per member per lifetime (in-network and out-of-network benefits combined)
United Health Group VBP	$2,500 individual $5,000 family (separate in and out of network deductibles)	20% for medical, prescription, hospital, lab, x-ray, home health, hospice, physical and occupational therapy	Office visit subject to deductible and coinsurance	$5,000 individual $11,000 family	$3 million lifetime

As described in Section 5, while RFI respondents endeavored to create plans with low premiums, the cost sharing requirements were significant. As detailed above, deductibles ranged from $0 to $6,000, depending largely on benefit maximums (that is, lower deductibles were seen in plans where benefits had caps on hospital, prescription drugs, or overall health benefits). Copayments were generally low for prevention and primary care services, but hospitalization would range in cost from 20 to 30 percent, often after meeting the deductible. With these high cost sharing requirements and benefit limits, plans were able to price value benefit plans with premiums ranging from $190 to $416 (excluding the CoverColorado plan).

Table 5: Pricing Summary

	Average Premium (with mandate)	Administrative Expenses and Profit	Provider Reimbursement	Suggested Subsidy
Celtic VBP	$211.36	11.50%	Medicare	Assume enrollee pays 6% of income toward premiums.
Colorado Access VBP Option 1	224.61	20%	Medicaid	Due to high cost-sharing, strongly suggest zero or near-zero premium for subsidized folks, to avoid adverse selection.
Colorado Choice Plan 250-300% FPL	$308.35	27.50%	Medicare	Subsidies s/b sliding-scale. Assumes enrollee pays 7-10% of income toward premiums. If no mandate, subsidies needed above 300% FPL.
Kaiser Foundation VBP- Option 1	$407.63	9.62%	not specified	Sliding-scale subsidies s/b based on premium only. Expects people to pay about $100 pmpm OOP at 225% FPL (5% of income).
Kaiser Foundation VBP- Option 2	$416.13	9.26%	not specified	Sliding-scale subsidies s/b based on premium only. Expects people to pay about $100 pmpm OOP at 225% FPL (5% of income).
Pinnacol Assurance: Assured Care VBP	$190.14	23.90%	PPO (130% of Medicare)	Assumed 5% of household income per person for premiums. Less for kids>225% FPL.
Pinnacol Assurance: Cover Colorado VBP (for acute-ongoing/qualifying conditions)	$989.80	5.30%	PPO (130% of Medicare)	Assumed 5% of household income per person for premiums. Less for kids >225% FPL
RMHP Value Plan	$252.86	16%	Commercial	Family should spend no more than 5% of income for premium and cost-sharing.
United Health Group VBP	$260.37	22%	Commercial	Adjust subsidies for health status and age (to allow use of those as rating factors).

7. Detailed Results from the Request for Information: Actuarial Analysis

A. Number of plans that met 80 percent benchmark

The benefit relativity of a plan design is the overall difference in covered benefits as compared to a status quo or benchmark set of benefits. As specified in the RFI, the VBPs were required to have a benefit relativity equal to 80 percent of the State PPO benchmark. Since the relativity of the plan design can vary depending on the methodology used, any

plan designs ranging from 75 percent to 85 percent were considered acceptable. In other words, if the average medical cost of covering the State PPO plan is $100 per member per month (PMPM), the VBP is expected to cost between $75 and $85 PMPM (assuming all other things being equal i.e. the same demographics, provider network, reimbursement, etc).

In order to review the benefit relativities of each of the plan designs, a pricing model was used to determine the net paid amount (expected medical care less any member cost sharing) for the benchmark as well as each submitted plan design. The VBPs were then compared against the benchmark to determine if the plan design fell within the 75 percent to 85 percent range.

Seven carriers submitted a total of 14 plan designs for review. Two of the carriers included plans that they designed to be outside of the acceptable range, but for the sake of analysis, they were included either as “buy ups” or as part of a package of plans where the average value was within the stated range.

Of the 12 plans stated by the respondents to be within the 75 percent to 85 percent range, an independent estimate found eight plans (from four carriers) fell within the 75 percent to 85 percent range and four plans (from three carriers) were estimated to be higher than the upper bound. The decision was made not to follow up with the carriers and clarify their calculations that led to the higher than expected relativity due to time constraints and the reality that a formal RFP process is not imminent. Since benefit relativities can vary depending on the methodology and assumptions used, the staff and consultants agreed that the intent of the proposal was met by each of the carriers.

B. VBP Pricing

In addition to comparing the population and pricing assumptions, the overall cohesiveness of the assumptions was reviewed to make sure all of the pricing assumptions aligned with the intent of the proposal. Variations across plans included:

Ratio of mandate to "no mandate" rates: Two carriers assumed that the premium rates would actually be lower under a "no mandate" scenario, with one of these plans assuming carriers would be able to medically underwrite under a no mandate scenario. The remaining plans had higher rates under the "no mandate scenario," but the increase in rates was from 13 percent to over 200 percent higher. The main driver in the differences in the "no mandate" premium rates is the variation in health status assumptions.

Subsidy: For the most part, the subsidy assumptions were consistent. Most plans assumed a subsidy so that premium rates would represent no more than 5 to 10 percent of income. One plan, however, assumed a subsidy that would result in zero or near zero premiums.

Provider Reimbursement: Carriers had various assumptions for the level of provider reimbursement for the VBPs. Several carriers assumed the use of Medicare rates or a multiple of Medicare payment rates, another assumed Medicaid rates and two assumed their current commercial provider reimbursement rates.

Non-Medical Expense Assumptions:

- *Broker Commissions:* Carriers assumed anywhere from no broker commissions to up to 10 percent of premiums for broker commissions.
- *Profit and contingencies:* Profit and contingencies ranged from 0 to 5 percent.
- *Premium Tax:* Most carriers did not stipulate whether premium tax was included in their rates. For those that did, the premium tax ranged from 1 to 2 percent.

- *Overall Non-Medical Expense:* The amount of premium allocated to expenses other than medical care ranged from 9.3 percent to 27.5 percent.

In summary, while the pricing assumptions and the resulting premium amounts varied widely, all assumptions were considered reasonable given the context of the responses and the actuarial judgment used in the pricing.

C. Potential costs and savings from Centennial Choices

Two areas of potential cost savings often cited when describing the impact of universal health care coverage (or individual mandate) are cost shifting and total health care spend (as it relates to potential savings). Even with a detailed health care reform plan, cost savings are, at best, difficult to predict. Thus, given the still undefined parameters of the Centennial Care Choices program, cost savings estimates are impossible to predict with any confidence.

Cost Shifting

Cost shifting occurs when someone with no insurance and a low income receives care for which they cannot pay. "It is commonly argued that the privately insured pay for uncompensated care through cost shifting—that is, health care providers offset uncompensated care "losses" by charging higher prices to privately insured patients." [10] One estimate puts the percent of uncompensated care for hospitals at 6 percent of costs. [11] It is thus reasonable to assume that if everyone were insured, the higher prices passed along to the privately insured would decrease.

While quantifying the cost shifting impact of uncompensated care is complex, Hadley et al estimate that on a national level, "the amount potentially associated with cost shifting

[10] Jack Hadley, John Holahan, Teresa Coughlin and Dawn Miller. 2008. "Covering The Uninsured In 2008: Current Costs, Sources of Payment, And Incremental Costs," *Health Affairs*, 27, no. 5 (2008): w406.

[11] Hadley, Holahan, Coughlin and Miller. 27.

represents at most 1.7 percent of private health insurance costs."[12] It seems reasonable to assume that the cost shifting impact would have a marginal impact to those currently enrolled in private health insurance. Savings would first accrue to health care providers and it is unknown if the providers would pass along any or all of these savings to carriers or patients.

Total Health Care Spending and Potential Cost Savings

There is a great deal of literature arguing both for and against savings related to prevention and improved health. On one hand, studies show that "the uninsured delay seeking care for treatable conditions that often require more costly care when they progress to an advanced state.[13]" As a result, there are potential savings from receiving immediate care. On the other hand, there are studies indicating that the vast majority of preventive interventions add more to medical spending than they save.[14]

The uninsured pay for a significantly higher percent of their medical care out of pocket but also receive significantly less services than their insured counterparts receive. Given the potential for both cost savings and increased costs due to prevention and improved health, combined with the lack of Colorado-specific data, estimating this impact is not possible at this time. Potential cost savings aside, it is fair to assume that providing coverage for all uninsured would increase total health care spend.

8. Detailed Results from the Request for Information: Target Markets

During the RFI process, Centennial Care Choices staff and consultants provided estimates of the number of uninsured in Colorado by federal poverty levels, by state-defined age increments, and by nine regions currently used in the Colorado small group market. Most

[12] Hadley, Holahan, Coughlin and Miller. 27.

[13] Hadley, Holahan, Coughlin and Miller. 27.

[14] Louise Russell, January/February issue of Health Affairs.

respondents appear to have considered the entire uninsured population within each region targeted by their proposed VBP product. Several respondents noted, "care would most likely be unaffordable for those under 300 percent FPL without a subsidy." Perhaps for this reason, at least one respondent appears to restrict its VBP enrollment assumptions to only the subsidy-eligible population (e.g., 100-300 percent FPL).

While not able to explicitly exclude enrollees with chronic illness, one plan commented that "individuals requiring immediate financial assistance as a result of existing chronic health conditions of the most severe nature such as cancer, AIDS or dementia" would not be well served by a VBP. Another plan suggested that VBPs would not be appropriate for individuals "not eligible for insurance," presumably due to medical underwriting, which was explicitly prohibited for the value benefit plans. In addition, three plans excluded maternity coverage altogether, and another excluded maternity benefits in at least one version of their value benefit plan.

Plans did not provide detailed enrollment projections for their VBPs.

9. Next Steps

In spite of mixed feelings about the specific plans proposed during the RFI process, the Centennial Care Choices Panel found value in the process of learning about value benefit plans and keeping discussions about reform options moving forward. The following recommendations provide a path for moving ahead with two major areas of focus: to expand state insurance programs to cover as many uninsured, low income Coloradoans as possible, and to find ways to pilot value benefit plans to continue learning how they can meet the needs of uninsured Colorado residents.

Colorado has two specific opportunities to expand eligibility for Medicaid and the Child Health Plan Plus.

A. 100 percent Medicaid

SB 08-217 states:

IN RESPONDING TO THE REQUEST FOR INFORMATION, A HEALTH INSURANCE CARRIER OR OTHER INTERESTED PARTY SHALL ASSUME THE FOLLOWING:

THAT THE STATE WILL AMEND THE STATE PLAN TO EXPAND ELIGIBILITY FOR THE COLORADO MEDICAL ASSISTANCE PROGRAM TO ADULTS WHOSE FAMILY INCOME DOES NOT EXCEED ONE HUNDRED PERCENT OF THE FEDERAL POVERTY LEVEL, ADJUSTED FOR FAMILY SIZE;

This Medicaid eligibility expansion is critical for providing coverage to the poorest Coloradoans who will not be able to afford VBPs no matter what the subsidy, due to cost-sharing requirements. The Panel supports such Medicaid expansion as long as it can be achieved without harmful reductions in current services, or limitations on current Medicaid beneficiary categories.

One commonly used source of revenue to fund health initiatives in other states is provider fees. Provider fees are a legal funding source eligible for federal matching funds when used to reimburse Medicaid covered services. More than 40 states have imposed some provider fee, including more than 15 states that have imposed hospital provider fees. Colorado approved a nursing home provider fee in the 2008 session (HB 08-1114).

Last spring, the Governor's Office and the Department of Health Care Policy and Financing entered into collaborative discussions with the Colorado Hospital Association about the establishment of a hospital provider fee in Colorado. The parties have been working together for seven months to develop a proposal. As currently modeled, a hospital fee based on patient days will generate new revenue to:

- Increase hospital reimbursement rates under Medicaid and CICP, which will help reduce uncompensated care and cost shifting; and

- Cover the uninsured by increasing eligibility for Medicaid and CHP+.

The hospital provider fee will also create an opportunity for the state to reform and modernize the way payment rates are set for various hospital services. This will allow for a more rational and transparent hospital payment structure.

B. SCHIP Expansion

On February 4, 2009, President Obama signed legislation that reauthorized the State Children's Health Insurance Program (SCHIP). The law provides state's with $35 billion over the next four and half years, funded by a 61-cent-per-pack increase in the federal tax on cigarettes and other tobacco products.

The legislation increases Colorado's SCHIP funding by 36 percent to $97.5 million in the 2009 federal fiscal year. The funding split for the Colorado SCHIP program, marketed as the Child Health Plan *Plus* (CHP+) program is 65 percent federal funds and 35 percent state funds. The increased funding will help Colorado ensure that all children who meet the program's eligibility requirements can be covered by the program. Currently, there are as many as 40,000 children and pregnant women who are eligible for CHP+ but not enrolled in the program. The reauthorization allows Colorado to continue enrolling eligible but not enrolled children and pregnant women in the CHP+ program. The increased match will also allow the expansion of the CHP+ program if other funding sources are identified for the state's match.

Provisions of the SCHIP reauthorization bill, called CHIPRA 2009/ H.R. 2, include:

- Funds SCHIP through fiscal year 2013 with approximately $32.8 billion to expand coverage to 4 million more children. The funding is primarily financed by a $0.61 increase in the federal excise tax on cigarettes.

- Preserves state flexibility to decide income eligibility level for children that need assistance in each State. However, populations above 300 percent of FPL will not receive the SCHIP enhanced match, and will instead receive the Medicaid match.
- Provides states with the option to lift the current five year waiting period for immigrant children and pregnant women to become eligible for SCHIP coverage.
- Dedicates $225 million for a nationwide SCHIP quality initiative. The initiative will include the development of new child-specific health quality measures (which will be published by HHS no later than 1/1/2010), along with a standardized reporting format for States.
- Extends Medicaid citizenship documentation requirement (as established by the Deficit Reduction Act) to SCHIP. The bills also provide the option for states to use information gathered by the Social Security Administration as a potential way to decrease administrative barriers to coverage.

Administratively, the SCHIP reauthorization bill includes two options that will allow for more efficiency within the Colorado CHP+ program, as well as one requirement that will call for additional resources in order to comply:

- A new statutory option offers coverage of pregnant women through a State Plan Amendment (SPA). Previously, pregnant women were covered through the application of a waiver.
- Premium Assistance, also referred to as Employer Sponsored Insurance, can also be offered through a SPA, rather than a waiver.
- Requires the application of a prospective payment system for services provided at FQHCs and rural health clinics. There is $5 million available in the form of grants to states with separate SCHIPs to assist in the expenditures related to transitions to comply with the change to prospective payment systems.

C. Continue Policy Work Needed to Support VBPs

VBPs could offer a partial solution to covering some of the remaining uninsured Coloradoans. However, there is still much to learn about how the programs can be implemented and how they will be received in the marketplace. Two major questions need additional consideration by the legislature, the Department, and the Division before value benefit plans can be implemented:

1. Explore what a mandate means and how to implement it

When economic conditions allow for provision of subsidies, considerations about how to implement the accompanying individual mandate should be fully researched and ready to implement. According to SB 08-217, value benefit plans would become minimum creditable coverage under an individual mandate, but more analysis is required to determine what this means in terms of existing health insurance products in Colorado's market. While the primary and preventive benefits of some VBPs are attractive, most do not provide protection against catastrophic expenses, so the proposed VBPs might not provide an adequate benchmark for "minimum creditable coverage."

Enforcement is necessary to achieve gains in coverage under an individual mandate, but it is also important as a matter of fairness to the overwhelming majority of those who already have coverage or who voluntarily comply. The first and most important step to enforcing an individual mandate is to make it easy for people to comply with it and to enroll in qualifying insurance coverage. Substantial amounts need to be spent on outreach and education. Enforcement mechanisms that include financial penalties to low income citizens are not supported by the Panel; other options should be examined. In Massachusetts, the first year's penalty for noncompliance with the individual mandate was the loss of the state income tax exemption (about $200). The penalty in subsequent years will

be up to 50 percent the premium an individual would otherwise have had to pay.[15] The Urban Institute says that:

> *"Ultimately, penalties are needed to ensure compliance. However, our preferred approach is that the states deem all residents to be covered and that the tax penalty serves as a way of collecting unpaid premiums. Initially, penalties should be modest as the system is put in place, initial implementation difficulties are resolved and educational and outreach efforts take effect. Later, those not complying with the mandate could be required to pay the premium that they would have paid had they enrolled in coverage. Low-income individuals who would have been eligible for fully subsidized premiums would therefore incur no penalty, and those who would have been eligible for partial subsidized overage would have only modest penalties."* [16]

2. **Market Research with Target Population**

   The State, in conjunction with the respondents to the RFI, should continue its exploration of what would make a limited benefit plan attractive to the target market, and what people who currently do not have insurance want in terms of access to health care. This would necessarily include exploration of how the intended clients prioritize various benefit options, but also could focus on how they currently access care (safety net providers) and identification of their greatest needs.

3. Select a community in which to pilot value benefit plans in the individual market using private (community or foundation) dollars for the subsidy.

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[15] "RAND: Health COMPARE: Policy Options: Overview of Individual Mandate," RAND, 27 Jan. 2009 <http://randompare.org/options/mechanism/individual_mandate>.

[16] Linda J. Blumberg and John Holahan, "Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues," Urban Institute Jan. 2008.

4. Pilot value benefit plans through an environment that does not require expensive state subsidies – the small group market, where employers could share in the cost of premiums. The pilot could target employers with existing small group health plan who have uninsured low-income workers who cannot afford the cost-sharing attached to the employer's current plan. These workers could purchase a lower-cost VBP, which the employer would subsidize at the same rate they contribute for other employees in the existing small group plan. Under this scenario, employers would keep the group plan that a majority of their workers desire, but still could extend coverage to those who cannot enroll because of cost. The pilot also could target small employers who have no current health care plan at all because of cost. A waiting period or other provisions would need to be developed to address concerns about crowd out.

   The value benefit plans can be sold as individual products in this version of a pilot; if changes to HB94-1210 allowed VBPs under a pilot project to be marketed through employers, and removed the prohibition for employers to contribute to the premiums of employees with individual policies.

5. Work with respondents to the RFI to determine if there are additional ways to structure a pilot of the value benefit plans. When invited to make comments at a Panel Meeting, at least one private company indicated an interest in expanding upon their current business model to make a pilot possible, even under the current economic and regulatory environment.

D. Monitor Pueblo process and see if there is applicability in other regions of the state

Finally, the Centennial Care Choices Panel recognizes that an insurance-based solution to offering health care to uninsured Coloradoans is not the only option, and recommends that the legislature continue to consider additional alternatives.

In 2007, the Colorado General Assembly passed HB 07-1022, authorizing the Board of County Commissioners in Pueblo County to create a pilot program to provide access to health care services to individuals employed in Pueblo County. Health Access Pueblo (HAP) was officially chartered in October 2007 to provide a value benefit plan to small, local employers whose employees and dependents were uninsured but did not qualify for other government assistance programs. HAP contracts with approximately 200 local physicians, including 50 primary care providers. The two Pueblo hospitals receive Medicaid-equivalent reimbursement and the participating physicians/allied health professionals receive Medicare-equivalent reimbursement.

Initially funded by financial contributions/pledges from St. Mary-Corwin and Parkview Medical Center and several regional foundations, HAP generates monthly operating revenue from shared employer/employee paid premiums, currently $120 per month per covered life. HAP is still in its early developmental stage, having enrolled ten employers and their combined 35 covered lives since August 2008. HAP's future viability is highly dependent upon continued enrollment growth, beneficiary compliance with wellness promotion and illness prevention programs, moderate claims experience and voluntary participation by local healthcare providers. HAP has been modeled after a similar type organization in Muskegon, Michigan.

Interest in this tri-share approach has spread and HB 09-1252, which would authorize the San Luis Valley to create a similar pilot program, is currently under consideration by the Colorado General Assembly.

10. Conclusion

The Centennial Care Choices Panel, the Department of Health Care Policy and Financing, and the Division of Insurance consider the RFI a success based on meaningful cooperation from private sector companies, which resulted in a number of interesting value benefit plan designs. Some proposed plans have attractive primary and preventive benefits; however, for the lowest income uninsured residents of our state, none of the VBPs would be affordable without an individual mandate, guaranteed issue requirements and a significant state subsidy. Recognizing today's economic realities, it is a difficult time to ask the Legislature to introduce a costly new subsidy program. However, it is important to provide insurance coverage and health care services to uninsured Coloradoans; in this environment, the demand is higher than ever. Opportunities exist for the Legislature to take interim steps toward implementing Centennial Care Choices that will allow for implementation when the economy improves.

11. Appendices

A. December 15 Report

B. RFI Responses

1. Celtic Insurance Company (subsidiary of Centene Corporation)
2. Colorado Access
3. Colorado Choice Health Plans (dba San Luis Valley)
4. Kaiser Permanente
5. Pinnacol Assurance
6. Rocky Mountain Health Plans
7. United Health Group

C. Response summary grid/side by side

D. Demographic/Uninsured Data Report

E. Suggested Statutory Changes

Appendix A. December 15 Report

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

COLORADO DEPARTMENT OF REGULATORY AGENCIES DIVISION OF INSURANCE

REPORT TO THE JOINT HOUSE AND SENATE HEALTH AND HUMAN SERVICE COMMITTEE

CENTENNIAL CARE CHOICES/ SB 08-217

December 15, 2008

Table of Contents

Executive Summary

Senate Bill 08-217 created a framework for developing the Centennial Care Choices Program, which would provide options for uninsured Coloradoans through new health insurance products known as Value Benefit Plans (VBPs).

On June 24, 2008, Governor Ritter appointed 19 members to an expert panel to assist the Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Regulatory Agencies – Division of Insurance (DOI) in seeking information from the health insurance industry about the development of Value Benefit Plans. From July through December, the panel has met and provided input on a Request for Information (RFI) and review process. The RFI was released on October 7, 2008, and eight responses were received by HCPF on December 2.

Along with the expert panel, staff and consultants from HCPF, the DOI, and the Governor's Policy Office will assess the RFI responses and provide a report to the Legislature by March 1, 2009 describing findings about the number of uninsured Coloradoans who could be covered by VBPs, the cost of providing subsidies to make VBPs affordable for low income individuals and families, and the cost savings that could be achieved by reducing Colorado's uninsured population. The report will also provide recommendations about legislation that would be required to create a premium subsidy program and an individual mandate in support of the Centennial Care Choices program.

Introduction

This report is respectfully submitted to the House and Senate Health and Human Services committees of the Colorado General Assembly by the Department of Health Care Policy and Financing (HCPF) and the Department of Regulatory Agencies, Division of Insurance (DOI), as required by SB 08-217. The law created a framework for developing the Centennial Care Choices Program, requiring the Department of Health Care Policy and Financing, in coordination with the Division of Insurance and a panel of experts, to acquire actuarial projections, research potential cost savings, and develop a request for proposals from health insurance companies for a new health insurance product known as a value benefit plan (VBP). The purpose of this report is to provide an update on the status of the Request for Information process, and to describe the evaluation and analysis process that will result in a final report on or before March 1, 2009. The March 1 report will build on this interim report and detail the results of the Request for Information process and the actuarial and cost savings research, including a detailed summary of the information submitted by health insurance carriers and other interested parties, along with the Department's and Division's evaluation and analysis. The final report will also include information regarding legislation that would be required should the General Assembly proceed to implement the Centennial Care Choices Program, VBPs, and a premium subsidy program, as well as cost projections regarding the funding needed to implement the program.

This report begins with background on the 208 Commission, whose work informed the requirements of SB 08-217, which are explained in the second section. That is followed by a description of the work of the expert panel and staff who implemented SB 08-217, and preliminary results of their work.

Background:

The 208 Commission

The Colorado General Assembly created the Blue Ribbon Commission for Health Care Reform in 2006, to identify strategies to expand health care coverage and reduce health care costs for Coloradans. Legislators took this action because Colorado, like most other states, faces urgent and interconnected problems regarding health care. The cost of health insurance is escalating rapidly, contributing to the growing numbers of Coloradans without insurance – an estimated 792,000 for any given month in 2007, according to the Lewin Group. All Coloradans pay for the uninsured, as premiums continue to rise, in part to cover the cost of care provided to those who cannot pay. The cycle feeds on itself, and in the absence of action will only worsen over time.

The Lewin Group's analysis revealed important details about Colorado's uninsured population:

- Seventy percent of the uninsured are in the workforce or are the dependent of a worker.

- Approximately 37.5 percent of Colorado's uninsured work for firms that do not offer health coverage to their employees.
- Approximately 21 percent are ineligible for their employer's coverage.
- About 11 percent of uninsured workers and dependents are eligible for but do not take the coverage offered by their employer.
- The uninsured are found in all income groups. Rising costs mean that more middle-income families find health insurance premiums unaffordable.
- About 32 percent of the uninsured live in households that earn $20,000 or less annually.
- Approximately 75 percent live in a household with an annual income of $50,000 or less.
- Approximately 13 percent are in households that earn $75,000 or more annually; 6.5 percent earn more than $100,000 annually.
- Young adults are more likely than any other age group to lack insurance: about 40 percent of the uninsured are between the ages of 19 and 34.
- Close to 20 percent of the uninsured are children.
- Nearly 11 percent of the uninsured are eligible for public programs (Medicaid and the Child Health Plan Plus) but not enrolled; most of these are children.
- Approximately 21 percent of the uninsured are not citizens of the United States (either legal non-citizens or undocumented).

Based on these facts, the 208 Commission concluded:

- Many Coloradans can't afford health coverage without some type of assistance.
- The uninsured are a heterogeneous group. If we wish to cover Colorado's uninsured, we must employ a variety of strategies.
- We must look for ways to stabilize rising costs. For example, if we extend health coverage to more people, we can minimize the cost shift from uncompensated care that represents a "hidden tax" and contributes to escalating health insurance premiums. If we bring more healthy people into the insurance pool, we can lower the risk and thereby stabilize costs for everyone.

Addressing each of these points, the Commission submitted a package of 32 recommendations for comprehensive health reform to the General Assembly on January 31, 2008. (Please see Appendix A for the complete set of recommendations.) This package of recommendations was projected to reduce the number of uninsured Coloradans by an estimated 88 percent, extending coverage to 694,500 individuals who currently do not have insurance.

(http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadername2=MDT-Type&blobheadervalue1=inline%3B+filename%3D700%2F832%2FCommission+Final+Report-Executive+Summary.pdf&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobkey=id&blobtable=MungoBlobs&blobwhere=1191379296043&ssbinary=true)

Background:

SB 08-217/Centennial Care Choices

SB 08-217 (Appendix B), Centennial Care Choices, was introduced by Senator Bob Hagedorn and Rep. Anne McGihon, establishing a process to gather information from health insurance carriers and other interested parties about what low cost, limited benefit packages could be offered in the individual market to historically uninsured Coloradans. It was intended to inform health reform efforts. Governor Ritter signed this bill into law on June 3, 2008.

The law created a framework for developing the Centennial Care Choices Program, requiring the Department of Health Care Policy and Financing, in coordination with the Division of Insurance and a panel of experts, to acquire actuarial projections, research potential cost savings, and develop a request for proposals from health insurance companies for a new health insurance product known as a value benefit plan (VBP). VBPs would build on the existing small group and individual insurance markets, Medicaid, and other coverage programs currently available, rather than supplant these programs. A premium subsidy plan could be set up to assist low-income individuals and families in paying health insurance premiums. The law specified the minimum requirements that proposals from insurance companies must include.

http://www.childrensimmunization.org/file.php/178/2008+Legislative+Session+Review.pdf

Based on the information submitted about potential VBPs, the House and Senate Health and Human Services committees will jointly determine whether to recommend that the General Assembly implement the Centennial Care Choices program, including the authorization for the development of VBPs, the creation of a premium subsidy program, and the creation of a funding source. If the funding source is to be created through a new or increased tax, it is to be referred to the general election ballot for voter approval.

http://www.colorado.gov/cs/Satellite?c=Page&cid=1216634433633&pagename=HCPF%2FHCPFLayout

While SB 217 specifically directs development of a Request for Information (RFI) to gather information from the health insurance industry, it states that the RFI could not dictate the benefits or other details of the VBPs to be created. However, the legislation does detail a long list of qualities that an entity responding to the RFI should assume that a VBP must at a minimum meet. Included in the assumed characteristics of a successful VBP are:
1) The inclusion of primary and preventative care benefits,
2) Specification of an adequate network of providers,
3) Rates based only on age and geography, and
4) Guaranteed issue (health plans participating in the individual health insurance market would be required to offer coverage to all applicants).

Other characteristics detailed in the law include:
- Provide the lowest level of benefits that may be offered in the state's individual market

- Encourage the use of health information technology and telemedicine
- Encourage the use of a pay-for-performance system for reimbursing health care providers
- Provide consumers with educational materials on how to access internet-based health care tools
- Encourage the use of regional networks of hospitals, physicians, community health centers and other safety net providers
- Include optional coverage choices for purchase to supplement VBPs and the estimated consumer cost for each particular coverage option
- Specify premium levels for each VBP by age group and region
- Allow for the payment of all or a portion of the covered person's premium from a state-paid premium subsidy
- Not destabilize the existing small group, individual markets, or the CoverColorado program

SB 217 states that if the Committees choose to go forward, legislative recommendations to the rest of the General Assembly should specify:

- Standards that VBPs must meet for certification by HCPF and the DOI and to be authorized to be offered by any health insurance carrier, regardless if it developed the VBP
- Creation of a process for periodic review of VBPs
- Creation of a consumer advisory council for the Centennial Care Choices Program
- A mechanism to encourage the use of evidence-based medicine through the creation of a patient safety council to evaluate patient care with the goals of improving quality of care and minimizing medical care mistakes
- Authorization for HCPF and DOI to establish health marts that individuals eligible for subsidies can choose a VBP

http://www.nclaonline.net/pdf/ncla%20priority%20issue%20areas%20content/2008healthcarereformmemo.pdf

SB 217 incorporates many recommendations of the 208 Commission, including the focus on prevention and guaranteed issue plans (Recommendations 4 and 21), support for Health Information Technology (9), payment for providers based on quality or performance (11), enhanced access through support for safety net providers (27), provision of a premium subsidy (2b), development of a process for periodic review of minimum benefit plans (16a), creation of a Consumer Advocacy Program (28), support for the provision of evidence-based medicine (10), and establishments of health marts ("Connector" – Recommendation 18).

Implementation of SB 08-217

Expert Panel

On June 24, 2008, Governor Ritter signed Executive Order A 160 08 (see Appendix B) appointing the following expert panel members:

- Penelope Baldwin, Insurance Integrity, Inc.

- Steve Bieringer, American Diabetes Association
- Ned Calonge, Colorado Department of Public Health and Environment
- Douglas Clinkscales, Denver Health and Hospital Authority, Retired
- Judith Glazner, University of Colorado, Denver
- Joan Henneberry, Colorado Department of Health Care Policy and Financing
- Laura Hershey, Self-Employed
- Grant Jones, Center for African American Health
- Elizabeth Leif, Leif Associates, Inc.
- Peter Liebig, Clinica Campesina Family Health Services
- Lorez Meinhold, Colorado Health Foundation
- Carl Miller, Self-Employed
- Marcy Morrison, Colorado Department of Regulatory Agencies – Division of Insurance
- Arnold Salazar, Colorado Health Partnerships, LLC
- Michael Stenger, St. Mary-Corwin Medical Center
- Lucy Trujillo, Self-Employed
- Mark Wallace, North CO Health Alliance/Weld County Department of Public Health and Environment
- Debbie Welle-Powell, Exempla Healthcare
- Robert Wilson, Rocky Mountain Health Management Corporation, Retired

Staff

HCPF Executive Director Joan Henneberry and DOI Commissioner Marcy Morrison serve as co-Chairpersons of the Panel, and each assigned appropriate staff from the Department and the Division to support the Panel's work, including:

- Bill Heller, Child Health Plan, Health Care Policy & Financing
- Jo Donlin, Colorado Department of Regulatory Agencies – Division of Insurance
- Janie Dunckley, Project Management, Health Care Policy & Financing
- Jenny Nate, Health Care Policy & Financing
- Craig Chupp, Colorado Department of Regulatory Agencies – Division of Insurance

In addition, Cody Belzley from the Governor's Policy office attend all panel meetings, participated in development of the RFI and reports, and provided guidance to staff and consultants.

Consultants

Consultants with specific experience and expertise were also contracted to provide support to the Centennial Care Choices Panel:

- Michele Patarino, MBA, MSHA, for Project Management skills, experience with various Requests for Proposal, Technical Writing, and knowledge of health plan operations and product development.
- Tracy Johnson, Ph.D., Technical Advisor to the 208 Commission, for expertise on the uninsured population in Colorado.
- Julie Peper, Actuary, Ingenix Consulting.
- Rick Curtis and Ed Neuschler from the Institute for Health Policy Solutions for implications to the insurance market including crowd out.

The Centennial Care Choices Panel began meeting on July 17, 2008, and have continued throughout the end of December. Agendas for each meeting are included in Appendix C.

Background Information for Expert Panel

Over the course of its first four meetings, the expert panel focused on learning about issues that would contribute to its stated purpose (prepare a request for information to be issued to health insurance carriers and other interested parties regarding the development of the Centennial Care Choices program), including:

- *"Lessons Learned" from the 208 Commission*

  Tracy Johnson, Ph.D., Technical Advisor to the Commission shared an overview of the Commission's work and raised issues for the Centennial Care Choices Panel's consideration, including: benefit pricing drivers, the need for clarity around assumptions, facilitating respondents' access to data, and roles of the Panel and staff.

- *Other States' Limited Benefits Plans*

  Chuck Milligan of The University of Maryland described how several states are attempting to create purchasing pools with a subsidized version of a basic benefit package, but said that large pools don't increase costs – just choice. Rhode Island has developed a state-sanctioned individual benefit plan for private companies to offer. Utah's basic benefit package does not include inpatient benefits. Arkansas and Kentucky have generated cost savings through cost sharing arrangements.

- *Colorado Insurance Market*

  DOI staff explained that in the individual market, approximately 300 companies wrote some individual coverage in 2006. Forty-five companies wrote 90% of the policies. In the small group market, 21 carriers wrote small group coverage in 2006. Ten companies wrote 95% of

the business. In the large group market, 247 companies wrote some large group coverage with 26 companies writing more than 90% of the total.

All small group carriers are required to offer a Basic and a Standard policy in the small group market. Uniform Basic and Standard policy designs are developed through a survey of insurers in the small group market. The Basic plan approximates the lowest level of coverage offered in small group market. Standard coverage approximates the average level of coverage offered in the market.

- *Actuarial Equivalence*

  Expert Panel member and actuary Liz Leif explained that "Actuarial Equivalence" is a general term used for applying some measurement to two benefit plans to see if the resulting values are sufficiently close for the specified purpose. There is no universal definition – the purpose determines the specific method applied. Only rarely will actuarially equivalent plan designs result in the same premiums, because plan premiums reflect expected selection when multiple plan choices are offered, actual negotiated prices, and utilization management techniques.

- *State of Colorado Employee Benefits Program OA 1500 (self-funded PPO Plan)*

  See Appendix D. Vinita Biddle shared the details of a Great West Healthcare Open Access PPO plan for the plan year July 1, 2008 to June 30, 2009. The plan has a $1,500 individual and $3,000 family deductible for in-network services (double that for out of network) with an out of pocket maximum at $3,000 individual and $6,000 family in-network (and double that out of network). Preventive care is not subject to deductible and is paid at 90% in-network (70% out-of-network). Monthly premiums are $379 for employee only, up to $1138 for employee plus spouse and children.

- *CHAT (Choosing Health Plans All Together) Tool*

  The CHAT exercise (Choosing Health plans All Together) is designed to educate users about health care benefits and their cost, and to learn from users about what types of benefits are most important to them individually and to the group of which they are a member. CHAT was created by The National Institutes of Health and The University of Michigan School of Medicine. It has been used locally in the development of Health Access Pueblo benefits. Consultant Chris Adams facilitated a discussion regarding the potential use of CHAT in the Centennial Care Choices process, to possibly inform the process of drafting the RFI or to evaluate the VBPs that are proposed. It was ultimately decided that the panel did not have the time or resources to use the CHAT tool during the timeframe allowed in Senate Bill 217 (before March 1, 2009).

- *Existing Colorado Limited Benefit Plans*

  Colorado Association of Health Plan representatives Vanessa Hanneman and Jerry McElroy told the panel that prior to the passage of SB 217, some Colorado health plans were already offering more modest benefit packages to meet customers' needs, and getting a very positive response. In one carrier's limited product, 50% of enrollees had been uninsured prior to buying the coverage. Another carrier has a young adult product where 70% of enrollees were previously uninsured.

  The Colorado Association of Health Plans warned that guaranteed issue without enforcement of individual mandates is assumed to add 60-80% to the cost of a medically underwritten plan.

- *(Request for Information) RFI vs. (Request for Proposal) RFP process*

  Staff member Bill Heller explained that a Request for Information is different than a Request for Proposal (RFP). It is used to obtain preliminary information about a market, type of available services or product when there is not enough information to write adequate specifications or a Statement of Work. An RFI may ask for vendor input to assist the State in preparing a specification or work statement for a subsequent solicitation and may ask for pricing information only with the provision that such information would be submitted voluntarily. The RFI must clearly state that "No Award Will Result."

- *Colorado DOI statement on loss ratios for commercial plans*

  Staff member Craig Chupp shared a DOI memorandum on loss ratios, which are used to compare and evaluate insurers and managed care organizations in a variety of ways. In Colorado, the term "benefits ratio" has replaced "loss ratio" in the health rate filing regulation, Regulation 4-2-11. The term "benefits ratio" is defined in HB08-1389: "Benefits ratio" means the ratio of policy benefits, not including dividends, to the value of the earned premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. Policy benefits would only include actual benefits paid, and would not include any administrative expenses. Therefore, the benefits ratio would not include any of the expenses associated with managed care plans. Insurance companies, managed care companies, policymakers, regulators, investors, lenders, consumer advocates and others all use loss ratios as a means to evaluate health insurance plans. For example, a regulator may use the loss ratio to determine the reasonableness of benefits provided in relation to premium. A consumer advocate may use the loss ratio as a quality measure of a particular company or health plan. Investors may look at loss ratios when evaluating the future financial possibilities of a company.

- *Detail on the uninsured population in Colorado*

  Consultant Tracey Johnson presented demographic data about Colorado's uninsured population that was developed by Lewin during the 208 Commission process. See the 208 Commission description on page 4 and 5. Lewin estimated that there were 792,000 Coloradans uninsured any month in 2007-2008. They are uninsured because they cannot obtain employer coverage, they do not qualify for public programs, and they cannot afford private coverage.

Development of Centennial Care Choices Panel Values

In its August 21 and September 3 meetings, the Centennial Care Choices Panel discussed a list of values for the health care products developed under the program. The Panel agreed that, to the extent possible, the RFI should encourage:

1. Creativity and innovation around benefit design and delivery system management
2. Customization to meet the varying needs of different uninsured populations
3. Shared responsibility and partnership between providers, payors and patients
4. Practical solutions that are proven to be effective (evidence-based)

In addition, the Panel specified that the evaluation framework used to analyze the responses should reflect the following values:

1. **Affordable and Accessible** – Recognizing that affordability is relative, plans should ensure adequate access to affordable health care.
2. **Targeted and Appropriate** – Recognizing that the uninsured is not homogenous, plans should demonstrate how they meet the basic health care needs of targeted populations and ensure culturally, linguistically and medically appropriate care.
3. **Health and Wellness** – Recognizing that health is not simply the absence of disease, plans should promote healthy living and wellness.
4. **Simple and Transparent –** Recognizing that one of the challenges with health insurance today is the complexity, plans should be easy to understand and coverage and cost information should be readily available to consumers.
5. **Efficient and High Value –** Recognizing that America's health care system is not as efficient as it could / should be, plans should be focused on efficient delivery of high value (high quality, low cost) health care.

Industry Input

The Centennial Care Choices Panel and staff offered several opportunities for health plans and other interested entities (SB 217 defines these as a person or entity that possesses the applicable actuarial experience and has administered or has the capacity to administer a health insurance program) to provide input and expertise on the development of the RFI. Industry representatives have attended all panel meetings, frequently offering public comment when invited. In addition,

at the September 5 Panel meeting, Vanessa Hanneman and Jerry McElroy of the Colorado Association of Health Plans presented the insurance carriers view of current limited benefit plans offered in Colorado (see page 10 and 11), and shared concern over potential regulatory restrictions (specifically for requiring guaranteed issue in the absence of an individual mandate).

In addition, two meetings were planned and promoted directly to health insurers to allow dialogue about the content of the RFI and answer industry questions. Notices appeared on the Centennial Care Choices website and were distributed via e-mail from the Governor's Policy Office and members of the 217 panel. These meetings were on September 11 and September 30. On the 11th, participants were invited to dial in to a toll free conference line. Thirty-nine participants from nineteen organizations participated in addition to Staff. Potential respondents discussed demographic data they would like to see describing the uninsured population and asked about the role of CoverColorado under the Centennial Care Choices program. They also asked for additional clarification on subsidy and mandate provisions, and pointed out that the requirement to provide a statewide program would limit participation of potential respondents in developing VBPs.

On September 30, participants were invited to attend the meeting in person at the Division of Insurance hearing room or dial in via the toll free conference line. Ten companies were represented on the phone and eight at the meeting. Discussion was based on the RFI draft, and included questions about CICP and subsidies. Potential respondents expressed concerns that they were being asked to provide a great deal of detail which seemed more fitting for an RFP than an RFI, including some information they consider proprietary. Staff reviewed the procurement rules associated with RFIs and discussed preliminary plans for the evaluation process. Participants did not respond to a direct question asking how many of them planned on submitting responses to the RFI, so staff discussed the contingency plan to be put into action if no responses were received – to conduct stakeholder interviews to inform a report on what features of SB 217 and the RFI created an unwillingness on behalf of health insurers to participate in Centennial Care Choices.

Development of the RFI

The Request for Information is included in Appendix E. Staff prepared the first draft of the RFI for the September 25 meeting based on requirements found in SB 08-217, the values listed above, and three important themes:

1. The RFI was designed to solicit as many creative responses as possible and focused as much as possible on policy-level questions vs. exact product details, allowing for flexibility whenever possible.
2. The RFI was designed to allow health plans and interested parties to provide solutions instead of having the Panel or staff members specify those solutions.

3. Responses to the RFI would be public, which meant that respondents would be reluctant to provide confidential or proprietary information.

After discussion at the Panel meeting on September 25, changes were made to clarify the intent of the RFI, the requirements of the VBP as described in SB 217, and the Panel's values.

Staff made several assumptions because there was not explicit guidance in SB 217, including:

- Subsidies would be provided to Coloradoans with incomes between 100% and 300% of the FPL who are not eligible for other public programs.
- Role of CoverColorado would remain the same with no requirement for customers with chronic disease or poor health status to join CoverColorado instead of a VBP.

The final version of the RFI was reviewed and approved by the Executive Director of Health Care Policy and Financing (Joan Henneberry) and the Commissioner of Insurance (Marcy Morrison), and posted to the State's Bid Information and Distribution System (BIDS) on October 7, 2008 (see Appendix D). Respondents were not required to be registered with BIDS to access the documents.

Respondents' questions about the RFI were due to the Purchasing office by October 14, and staff posted the responses to fourteen questions on October 28. Question topics included dental benefits, specificity on potential subsidies and the role of a potential health mart, Division of Insurance regulations, and discounts and incentives included in Value Benefit Plans.

Development of the Process for Analysis and Evaluation of RFI Responses

Developing a process to assess the RFI responses was challenging. Staff initially designed a worksheet that gave Panel members an opportunity to select a numerical rating that corresponded with each VBP characteristic. However, after considerable discussion with the Panel at the October 17 meeting, staff realized that SB 217 does not provide specific expectations for characteristics such as "Include benefits for primary and preventive care." Asking Panel members to provide those ratings would be subjective, based on their personal expectations. In addition, the numerical "scores" might imply a "winning" or "losing" proposal, which is not the intent of the RFI.

A second version of the worksheet was posted to the Centennial Care Choices website for Panel member use in reviewing responses on December 4th. (See Appendix F.) Guidance on "best practices" related to important characteristics of VBPs was also provided to the Panel based on research done by the National Business Coalition on Health for its annual eValue8 Request for Information (http://nbch.org/eValue8/index.cfm) see Appendix G.

Results of the RFI

On December 2, the Department of Health Care Policy and Financing received eight responses to the Request for Information describing 17 Value Benefit Plans. Responders included:

Company	Value Benefit Plans
Celtic Insurance	1
Colorado Access	2
Colorado Choice Health Plans dba San Luis Valley HMO	3
Kaiser Permanente with Delta Dental	4
Pinnacol Assurance with Cover Colorado	2
Rocky Mountain Health Plan	3
United Health Group	1
Wellpoint (Anthem)	1

All of these companies offer insurance in Colorado; however, Pinnacol Assurance currently offers workers' comp, not health insurance.

Staff quickly completed an initial assessment of each response relative to four key tests:

1. Provides a statewide plan
2. Proves 80% actuarial equivalence to State employees' PPO
3. Uses only age and region for rating characteristics
4. Identified actuarial expert(s) who contributed to the response

Based on that initial review, one response was not immediately shared with the Panel because the carrier deviated from the direction to limit rating characteristics to age and geographic location. Two responses provided multiple Value Benefit plans did not each meet the test for 80% actuarial equivalence to the State employees' PPO. Finally, in two responses, higher premium rates were proposed under the scenario where Colorado did not impose an individual insurance mandate compared with the scenario that did include an individual mandate, which is inconsistent with industry input to date (see CAHP comments on page 10 and 11). In all of these cases, staff or consultants will make contact and follow up with respondents to resolve misunderstandings and move forward with evaluation.

Staff and consultants will work together on technical aspects of the assessment including the actuarial/cost savings analysis and analysis of implications to the current individual and small group markets over the next 90 days, while Panel members also review the plans and offer their

assessments. Initial impressions confirm that respondents provided thoughtful, creative benefit plans and advice for the Department, the Division, and the Legislature.

Next Steps

Additional analysis and consideration of the responses submitted on December 2 will progress according to the following schedule:

December 31 – Panel member feedback on RFI Responses due.

January 8 – Staff and consultant meeting. Status report emailed to panel.

January 23 - Panel meeting.

January 30 – Staff and consultant sections of paper due.

February 2 – Draft paper compiled and distributed to Panel.

February 5 – Panel meeting: review paper and recommendations.

February 12 – Second draft paper completed and submitted to department and division.

February 19 – Approval from department/division. Paper ready for clearance/submission.

February 25 – Panel meeting. Distribute copies of final report.

March 1st – Final report due to Legislature.

Appendix B. RFI Responses

Attachments:

1. Celtic Insurance Company (subsidiary of Centene Corporation)
2. Colorado Access
3. Colorado Choice Health Plans (dba San Luis Valley)
4. Kaiser Permanente
5. Pinnacol Assurance
6. Rocky Mountain Health Plans
7. United Health Group

Can also be found at:
http://www.colorado.gov/cs/Satellite?c=Page&cid=1216634433633&pagename=HCPF%2FHCPFLayout

Appendix C. Response summary grid/side by side

Colorado RFI Side-By-Side		
Costs and Market Rules		
-	Rocky Mountain Health Plan	
PRELIMINARY	("Value" Plan Only)	United Health Group
Additional Identifying Info		Golden Rule / Americhoice
Statewide?	Yes	Yes
Premium Savings Appear to Come Primarily From--	Deductible and co-insurance.	High deductible; no maternity; low limits on MH/SA OP. 25% reduction in payment level for OON.
Prevention (not subject to deductible in all cases)	$0 co-pay on preventive.	Scheduled preventive care 25% copay for kids, 15% for adults.
Deductible (Indiv/Family) + Coinsurance	$3,000 ded + 30% coinsurance (50% OON).	$2,500/$5,000 ded (+$2,500/$5,000 OON), 20% coins applies to virtually all services.
Office Visits (OV), etc.	No deductible on OV, lab, drugs. PCP OV $45 co-pay; other OV $65; Lab $30; X-ray $55.	OV subject to ded + coins
Drugs	5-tier drug structure. Retail (31-day) $15/$40/$55/20%<$150/$30%<$250 Mail-Order (90-day) $37.50/$100/$137.50/20%<$375/NA	Drugs subject to ded + coins
Out-of-pocket (OOP) max	ded+$5,000 (+$10,000 OON)	$5,500/$11,000
Guarantee Issue?	Yes	Apparently assumes UW (i.e., no GI) if not mandate. (Also assumes mandate only partially effective.)
Special Treatment for People with Chronic or Known Conditions?		Use "Impact Pro" to ID "indivs who might benefit more from a more intensive model of care than the proposed VBP." (Looks like: Send high users to the risk pool.)
Key Pricing Assumptions		

Colorado RFI Side-By-Side			(VBP Option 2 wd be > 80%)
Costs and Market Rules			
	Kaiser Foundation Health Plan		Colorado Access
PRELIMINARY	Option 1	Option 2	VBP Option 1 (80%)
Additional Identifying Info			CHCs, CMHCs, Chn's Hospital, Univ Colo Hos + Docs
Statewide?	Limited to Denver/Boulder Metro area plus Colorado Springs and Pueblo. Exploring possibilities for statewide.		57/64 counties at present. Believe they can expand.
Premium Savings Appear to Come Primarily From--	Ded/coinsurance, limits on MH/SA.	Ded/coinsurance, limits on MH/SA. No maternity coverage.	No OON except emergency. $35,000 benefit max for inpatient. $10,000 benefit max for hos OPD. Inpatient admission charge of $1,000 + $100 per day.
Prevention (not subject to deductible in all cases)	$15 co-pay on well-baby + physical exams.	$10 co-pay on well-baby + physical exams.	No cost-charing on preventive (not defined).
Deductible (Indiv/Family) + Coinsurance	$2,500/$5,000 ded + 30% coinsurance.		Not mentioned.
Office Visits (OV), etc.	Non-preventive OV subject to deductible. (Per chart. Narrative implies NOT.)	Non-preventive OV NOT subject to ded. PCP/Spec = $20/$40.	$10 PC OV co-pay. $35 spec OV. Others vary. $750 OP surgery. $300 ER.
Drugs	Drug copay = $20/$40/$60.	Drug copay = $15/$40/$60.	$5 generic drug, 50% other drug. $10,000 benefit max on drugs.
Out-of-pocket (OOP) max	$5,000/$10,000		Not mentioned.
Guarantee Issue?	Yes	Yes	Yes.
Special Treatment for People with Chronic or Known Conditions?			CoverColorado would be more appropriate for people with high-cost conditions.
Key Pricing Assumptions			

Colorado RFI Side-By-Side		
Costs and Market Rules		
PRELIMINARY	**Colorado Choice**	**Celtic (Centene Corp.)**
Additional Identifying Info		
Statewide?	14 counties in rural SE Colorado. Hopes to expand or partner.	Yes
Premium Savings Appear to Come Primarily From--	$200,000 annual benefit max. 40% coinsurance. Hefty co-pays for inpa, OPD, ER, specialty services, plus ded + coins. (?) (Modest deductibles.)	**NO**: maternity; OON; non-preferred drugs; anti-psychotics; chiropractic; acupuncture, OT, SpT. Medicare rates.
Prevention (not subject to deductible in all cases)	Deductible waived. No co-pay for kids. $5/$10/$15 for adults.	No cost-sharing on prevention or PCP OV for eval/mgmt.
Deductible (Indiv/Family) + Coinsurance	Modest deductibles vary by income ($250<250% FPL, $500, $750>300% FPL). 40% coins flat.	$3,000/$6,000 ded + 20% coins.
Office Visits (OV), etc.	PCP OV: $10/$!5/$25. Spec OV: $20/$20/$50 after ded.	$25 Spec OV co-pay (prior auth). $250 ER co-pay. Lots of limits.
Drugs	Generic $5/$10/$15, brands $15/$20/$40	Drugs tight except generic. Lots of limits.
Out-of-pocket (OOP) max	Varies by income: $2,500 / $4,000 / $6,000	$3,000/$6,000
Guarantee Issue?	Yes.	GI to "all eligible Colorado residents," as defined by the State.
Special Treatment for People with Chronic or Known Conditions?	Disease mgmt for 35 adult and 6 pediatric conditions. Nurse Case Mgr assigned for complex chronic conditions.	
Key Pricing Assumptions		

Colorado RFI Side-By-Side		
Costs and Market Rules		
-	Pinnacol Assurance	
PRELIMINARY	"Assured Care" VBP	CoverColorado VBP
Additional Identifying Info	Worker's comp carrier	
Statewide?	Yes.	
Premium Savings Appear to Come Primarily From--	$50,000 annual benefit maximum. No OON coverage.	
Prevention (not subject to deductible in all cases)	No charge for age appropriate physicals, lab work, immunizations and prenatal care. $150 "wellness" benefit.	
Deductible (Indiv/Family) + Coinsurance	No deductible.	$250 deductible.
Office Visits (OV), etc.		
Drugs	Drugs limited to $1,000 per year.	Drugs limited to $3,000 per year.
Out-of-pocket (OOP) max	$5,000	$7,500
Guarantee Issue?	See below.	
Special Treatment for People with Chronic or Known Conditions?	Separate VBP for CoverColorado (still $50K max benefit). Sounds like they plan to steer people with heavy needs there.	
Key Pricing Assumptions		

Colorado RFI Side-By-Side		
Costs and Market Rules		
-	**Rocky Mountain Health Plan**	**United Health Group**
PRELIMINARY	**("Value" Plan Only)**	
Baseline Population	Plan's commercial members, 200x. Avg age 35, 50% male. ($ pmpm) Provider reimb exceeds Medicare and Medicaid. $356.08 pmpm.	Current UW individual insurance popn (national). 100% of current commercial rates in Colorado. $126.93 pmpm.
Adjustment for Demographics	Uninsured per RFI. If mandate, -12% or -$43.78 (avg age 33, 58% male). If no mandate, +18% or +$65.46 (avg age 39, 22% male.)	No adjustment.
Adjustment for H Status	If mandate, +10% or $31.23 (assumes some adverse selection). If no mandate, +100% or $421.54 (not quite as bad as CoverColorado due to subsidies).	No adjustment if no mandate (i.e., assumes UW still allowed!) If mandate and GI, +60% or +$76.16. (Would be +100% or more without mandate.)
Adjustment for Utilization	If mandate, +4.5% or $15.50. If no mandate, +9.0% or $76.09. (Due to pent-up demand for routine services: OV, OPD, drugs.)	No adjustment.
Adjustment for Provider Reimbursement Levels	None. Assumes current rates as noted below.	No adjustment.
Other Adjustments	None.	None.
Administrative Costs Profit and Contingencies	16% of premium, of which reserves 3%, taxes 1%. No commissions.	22% of premium, of which: 2% prem taxes. 3% cmsns/mktg/sales (reduced). 5% profit+contingencies.
(Unsubsidized) Premiums With Mandate (Region 2--Denver):		Note: Uses year-by-year age rates, apparently not consistent with RFI.
32-year-old	$202	$176.42
62-year-old	$620	$605.54
Ratio	3.07	3.43

Colorado RFI Side-By-Side			(VBP Option 2 wd be > 80%)
Costs and Market Rules	**Kaiser Foundation Health Plan**		**Colorado Access**
PRELIMINARY	**Option 1**	**Option 2**	**VBP Option 1 (80%)**
Baseline Population	Total uninsured popn for Denver MSA, per RFI.		Plan's own 2005-6 Medicaid managed care experience (mostly AFDC). (No trend forward??) $104.15 pmpm.
Adjustment for Demographics	0.90: 75% from internal Denver popn profile; 25% from "actuarial consulting stnd demographic popn ratio."		Older, more male, lower birth rate. Subsidy-eligible <300% FPL. $214.36 pmpm.
Adjustment for H Status	1.1765. Assumed to be same as stnd popn not subject to medical underwriting.		0.981 no mandate, 0.870 mandate - 7.5% because AFDC-MC popn was sicker than AFDC-FFS population. - 6% if mandate enforced. If no preferential treatment for GI/CR, adjust to CoverColorado levels.
Adjustment for Utilization	1.275 due to GI. Should be almost 2.0, but capped it to maintain affordability. (Does this apply to revised rates, which are higher?)		-25% ER use due to co-pay. -2.5% drug cost due to rebate. (0.964)
Adjustment for Provider Reimbursement Levels	Primarily geographic, due to different provider arrangements. Colorado Springs = 1.215 * Denver.		None. Assumes GME and DSH continue to be paid separately.
Other Adjustments	Limited geog adjustment for Pueblo.		None. ($202.63 / $179.69)
Administrative Costs Profit and Contingencies	9.62% of premium. No cmsn, profit or contingencies.	9.26% of premium. No cmsn, profit or contingencies.	15% (of premium?), of which reserves + profit 1-2%. Assumes payment of premium taxes. ($253.28 / $224.61 includes rewards and bad debt)
(Unsubsidized) Premiums With Mandate (Region 2--Denver):	2009 (From separate Rate Revision document. 2010 rates in main submission were lower.)		2009 (Mkt Reforms, Level Playing Field, with Mandate)
32-year-old	$285	$291	$167.27
62-year-old	$873	$891	$577.91
Ratio	3.06	3.06	3.45

Colorado RFI Side-By-Side Costs and Market Rules			
PRELIMINARY		Pinnacol Assurance	
Baseline Population	**Celtic (Centene Corp.)**	**"Assured Care" VBP**	**CoverColorado VBP**
Adjustment for Demographics	Avg age 35. 58% male. $238.59 pmpm.	Uninsured 100%+ FPL. Avg age 33. 58% male. Fewer children. -9.5% ($322.28)	
Adjustment for H Status	+19% without mandate ($272.11). +8.2% with mandate ($247.37)	94% have no CoverColorado condition: $244.11	6% have a CoverColorado condition: $1,546.94
Adjustment for Utilization	Due to adverse selection, +33% without mandate ($362.72). +10% with mandate ($272.11).	-24% (included above)	+380% (included above)
Adjustment for Provider Reimbursement Levels	Shift from 70% of billed charges to 100% of Medicare yields 31% decrease. ($249.34/$185.05)	Assumes typical commercial reimbursement levels at 130% Medicare. Going to 110% would save 13% on pmpm.	
Other Adjustments	None.	None	
Administrative Costs Profit and Contingencies	11.5% of premium. No UW (costs); no commissions.	23.9% of premium	5.3% of premium
(Unsubsidized) Premiums With Mandate (Region 2--Denver):		(Total premium is $1 less for <300% FPL.)	
32-year-old	$174.81	$177	$897
62-year-old	$538.55	$471	$2,395
Ratio	3.08	2.66	2.67

Colorado RFI Side-By-Side		
Costs and Market Rules		
-	**Rocky Mountain Health Plan**	**United Health Group**
PRELIMINARY	**("Value" Plan Only)**	
(Unsubsidized) Premiums Without Mandate (Region 2):		
32-year-old	$207	$110.26
62-year-old	$636	$378.46
Ratio	3.07	3.43
Health Rating?	NO	Not here, but would prefer
Provider Payment Rates	Cuurent provider reimb under group contracts exceeds Medicare and Medicaid. See also Safety Net Providers, below.	Assume 100% of currently negotiated commercial rates.
Provider Network	Rocky Mtn HCO network in Colorado. Multiplan/PHCS network elsewhere. Says among largest in state.	Will meet any requirement. UHG has extensive contracts in state (including Pacificare "Legacy"). (But apparently anticipates need new contracts for VBP.)
Safety Net Providers	Will be open to all essential cmty providers (ECPs) that don't already participate. Will pay FQHCs, RHCs, ECPs established Medicaid rates or prof fee schedule if they prefer.	AmeriChoice has lots of experience with SNPs in other states. Response expresses commitment to include them. No current Colo specifics.
Target Population	As specified in RFI.	<300% FPL and "eligible" for indiv HI (appears to mean not eligible for CoverColorado). Recommend treat pregnant women separately.
Subsidy Assumptions, Recommendations, Comments	Suggests subsidies for cost-sharing also. Suggests max = 5% of family income, including premium + cost-sharing. (Ref: Medicare Part D low-income subsidy.) If no mandate, subsidies needed above 300% FPL.	Adjust subsidies for health status and age (to allow use of those as rating factors).
Additional Rating Factors Requested	Wants gender rating + smaller geog areas to avoid adverse selcn v. indiv mkt. (Under 55, males cross-subsidize females, even with maternity excluded.)	Tobacco use. Really want all indiv mkt rating factors. Fear "crowd-out" (of current UW indiv coverage?).
	County size not a strong predictor of cost (e.g., resort areas in rural communities).	

Colorado RFI Side-By-Side			(VBP Option 2 wd be > 80%)
Costs and Market Rules			
-	**Kaiser Foundation Health Plan**		**Colorado Access**
PRELIMINARY	**Option 1**	**Option 2**	**VBP Option 1 (80%)**
(Unsubsidized) Premiums Without Mandate (Region 2):			2009 (Mkt Reforms, Level Playing Field, without Mandate--not realistic)
32-year-old	$248	$253	$188.63
62-year-old	$759	$774	$651.68
Ratio	3.06	3.06	3.45
Health Rating?	NO	NO	NO
Provider Payment Rates	Not specified. Assume current.	Medicaid rates in most cases. Concessions where necessary to obtain adequate network.	
Provider Network	Colorado Permanente Medical Group plus affiliated physicians (primarily specialists).	CHCs, CMHCs, Chn's Hospital, Univ Colo Hos + Docs	
Safety Net Providers	Limited use in current network. Might contract with to expand network to more geographic areas.		Network is essentially composed of safety net providers. But what about hospitals?
Target Population			All uninsured 100-300% FPL.
Subsidy Assumptions, Recommendations, Comments	Sliding-scale subsidies s/b based on premium only. Expects people to pay about $100 pmpm OOP at 225% FPL (5% of income).		Due to high cost-sharing, strongly suggest zero or near-zero premium for subsidized folks, to avoid adverse selection.
Additional Rating Factors Requested	None.	None.	None.

Colorado RFI Side-By-Side		
Costs and Market Rules		
PRELIMINARY	**Colorado Choice**	**Celtic (Centene Corp.)**
(Unsubsidized) Premiums Without Mandate (Region 2):	Rates shown for <250% FPL category (highest rate). 1.05 factor used to show Denver.	
32-year-old	$760.05	$232.50
62-year-old	$1,995.32	$716.27
Ratio	2.63	3.08
Health Rating?	NO	NO
Provider Payment Rates	Uses Medicare RBRVS, negotiates percentage. (Ingenix RVS for 17% of CPTs not in RBRVS.) Several methods for hospitals.	Medicare.
Provider Network	High penetration in current service area.	Now, PHCS/Multiplan PPO. Would seek proprietary, including safety net.
Safety Net Providers	Already contracts with all in its service area.	Centene has extensive experience in other states.
Target Population	Uninsured >100% FPL, not eligible for EBI or other state/federal programs.	All uninsured. But less appropriate for those with existing severe chronic condition.
Subsidy Assumptions, Recommendations, Comments	Subsidies s/b sliding-scale. Assumes enrollee pays 7-10% of income toward premiums. If no mandate, subsidies needed above 300% FPL.	Assume enrollee pays 6% of income toward premiums.
Additional Rating Factors Requested	Apparently subdivided one rating area into four.	None.

Colorado RFI Side-By-Side		
Costs and Market Rules	Pinnacol Assurance	
PRELIMINARY	"Assured Care" VBP	CoverColorado VBP
(Unsubsidized) Premiums Without Mandate (Region 2):		
32-year-old	not viable	not viable
62-year-old	not viable	not viable
Ratio	not viable	not viable
Health Rating?	Between 100%-300% FPL, same premium. Above 300% FPL, ColoradoCare VBP costs 140% of Assured Care VBP.	
Provider Payment Rates	PPO-discounted FFS. Base = 130% Medicare (avg). Up to 140% with pay-for-performance.	
Provider Network	Claim 9,000. CorCare PPO.	
Safety Net Providers	Cite a lot of local initiatives. Will offer contract to safety-net providers.	
Target Population		
Subsidy Assumptions, Recommendations, Comments	Assumed 5% of household income ***per person*** for premiums. Less for kids>225% FPL.	
Additional Rating Factors Requested	Limit UW indiv mkt to same factors used by VBPs.	

Colorado RFI Side-By-Side		
Costs and Market Rules	**Rocky Mountain Health Plan**	
PRELIMINARY	**("Value" Plan Only)**	**United Health Group**
Adverse Selection Issues / Comments	Due to unisex rating and specified geog, Centennial Care plans will be most appealing to younger females, smokers, and residents of higher-cost rural counties. Others will be more inclined to purchase coverage through the medically UW individual health market or to forego coverage entirely. Mandate helps, but doesn't eliminate problem.	
	Strongly warns against adverse selcn if VBP GI and indiv mkt UW.	
"HealthMart" Comments	Wants "HealthMarts" to be "public, neutral source" as for CHP+. (p.21)	
Crowd-Out comments	Worried about adverse selection but not crowd-out of indiv mkt. Possible shift of small group to indiv. Waiting periods could be used to mitigate.	There are risks associated with crowd out. Extent will depend on rating flexibility, level of provider reimbursements, subsidy am't offered, UW flexibility available within VBP plans, and whether indiv covered by non-VBP plans are eligible for subsidies.
Recommended Rule Changes and Other Recommendations	No statutory changes required.	
-- Number of VBP Carriers		
-- Rating Rules		Want rating flexibility, including tobacco use.
-- GI, etc.		Don't require GI. Don't cover uninsurables or pregnant women in VBP.
-- Rel to CoverColorado		(I.e., use CoverColorado for "uninsurables").
-- Statewideness		

Colorado RFI Side-By-Side		
Costs and Market Rules	**Rocky Mountain Health Plan**	
PRELIMINARY	**("Value" Plan Only)**	**United Health Group**
-- Premium Taxes		Don't apply premium tax to VBP.
-- Capital/Surplus Req		
-- Other	More work on targeted cost-sharing to create appropriate utilization incentives.	
-- Financial Incentives and "Wellness"		Suggest personal accounts funded by payments for healthy behaviors (from subsidy $). Could be used toward cost-sharing, perhaps premiums. Debit cards. Strongly recommend indiv incentives aimed at tobacco cessation.
-- Chronic Conditions		Suggest different product for indiv with chronic conditions ~ "more robust care mgmt". Use Impact Pro to target limited care mgmt supports.
-- Pay for Performance (P4P)	P4P: Ultimate goal is to create genuine, outcomes--based reimbursement systems.	Have experience elsewhere with P4P.
-- Other	Suggests (and estimates incorporate) variable reduced cost-sharing based on income, for prenatal and maternity services. Could be expanded to encourage use of cost-eff care.	VBP here well suited for uninsured employed individual capable of maneuvering within commercial health care products. May not be most appropriate for individual with chronic conditions (even if not meet eligibility requirements of Medicaid or CoverColorado).
	Suggest formal, cmty-wide benefit prioritization program for future VBP and subsidy-design efforts. Partner with Kauvar Foundation (evidence-based, value-based)	

Colorado RFI Side-By-Side			(VBP Option 2 wd be > 80%)
Costs and Market Rules	**Kaiser Foundation Health Plan**		**Colorado Access**
PRELIMINARY	**Option 1**	**Option 2**	**VBP Option 1 (80%)**
-- Premium Taxes			
-- Capital/Surplus Req			Modify minimum surplus requirements for Centennial Care.
-- Other			Require hospital participation at <105% Medicaid FFS rate.
			Limit payment to OON providers to Medicare rates.
			Develop State-funded reinsurance or risk adjustment for Centennial Choices.
			Determine eligibility using CBMS (same as Medicaid).
			Limited benefit model is not appropriate for low-inc popn.
			(Especially if no mandate), consider contracts other than full-risk, perhaps ASO.
			Limit subsidies to approved CentChoices programs.
			Financial incentives (premium or cost-sharing reduction) to participate in care management programs or complete preventive screenings on time.
-- Financial Incentives and "Wellness"			
-- Chronic Conditions	Regional Catastrophic Case Mgmt Team; Chronic Care Coordination Program.		
-- Pay for Performance (P4P)			Working on P4P. Has demo operating.
-- Other			Provides premium estimates under several difference mkt-rule scenarios.

Colorado RFI Side-By-Side		
Costs and Market Rules		
PRELIMINARY	Colorado Choice	Celtic (Centene Corp.)
-- Premium Taxes		
-- Capital/Surplus Req		
-- Other	Allow HMOs to offer limited benefit plans.	Encourage additional plan options such as HSAs.
-- Financial Incentives and "Wellness"	"Plan, Coach, Reward" "Reward points" can be redeemed for fitness products.	"Healthy Rewards Account" program, up to $50 per year.
-- Chronic Conditions		
-- Pay for Performance (P4P)	Has modest P4P demo. Planning to expand but sound a bit skeptical.	State P4P principles. No details.
-- Other		

Colorado RFI Side-By-Side	
Costs and Market Rules	Pinnacol Assurance
PRELIMINARY	"Assured Care" VBP CoverColorado VBP
-- Premium Taxes	Exempt VBPs from premium taxes + certain fees.
-- Capital/Surplus Req	Certain Pinnacol-specific changes, including time to build risk-based capital.
-- Other	Allow mktg VBPs through employers. Exempt from small-group rules when ER contributes.
	Exempt VBP-cov individuals from waiving their right to group cov after they've been covered by an individual health policy.
	Allow VBPs to join drug-purchasing pool, if established.
	Adopt a VBP provider fee schedule.
	"24-hour coverage"
-- Financial Incentives and "Wellness"	Incentives for wellness participation. Has Wellness and Care Coordinator (WCC) = personal account manager + services coach.
-- Chronic Conditions	
-- Pay for Performance (P4P)	
-- Other	Dividend-paying mutual?

Appendix D. Demographic/Uninsured Data Report

health policy solutions

DRAFT MEMO

TO: Bill Heller and SB 217 staff/consultants

FROM: Tracy Johnson

DATE: 1/5/08

RE: SB 217 Response: Enrollment-related Issues

In September 2008, the 217 panel asked Health Policy Solutions to provide prospective RFI respondents with demographic information about Coloradoans who are uninsured. Specifically, HPS provided estimates of the uninsured in Colorado by federal poverty levels, by state-defined age increments, and by 9 regions currently used in the Colorado small group market. This memo responds to your request for HPS to evaluate how this data was used in the RFI responses and to provide any other observations about proposed enrollment populations in the RFI responses.

This analysis is based on a review of the following RFI responses from the following respondents:

- CELTIC Insurance Company (CELTIC)
- Colorado Access (CoAc)
- Colorado Choice Health Plans (CCHP)
- Kaiser Permanente/Delta Dental (Kaiser)
- Pinnacol Assurance/Cover Colorado (Pinnacol)
- Rocky Mountain Health Plans (RMHP)
- UnitedHealth Group (United)

It focuses on sections 5 (pricing of VBPs) and 6 (anticipated enrollment) of the RFI response. Because respondents were asked to provide narrative descriptions (and not detailed quantitative tables) on their enrollment assumptions, this memo provides a qualitative and policy analysis and not a quantitative analysis.

The 217 panel made the intentional decision to permit respondents to make different assumptions about key program elements that affect pricing. This decision resulted from lack of precision in the authorizing legislation as well as a desire to encourage creative responses. Many of the respondents' specific program/policy assumptions – especially subsidy levels and the effect of an individual mandate -- directly affect their enrollment projections and pricing assumptions, making apples-to-apples comparisons difficult. Proposed provider reimbursement also varies widely and affects final pricing. Readers of the RFI responses are cautioned to note that their scenario-specific details. As a result, benefits and premium pricing across responses often cannot be directly compared.

Subsidies and individual mandate assumptions affect who enrolls and drive premium prices

Conceptually, most RFP respondents began their pricing exercise with a population that was made to look demographically similar to the currently uninsured population. Several of the respondents noted that the uninsured population is comprised of several subgroups with very different risk profiles and motivations for obtaining coverage.

Premium levels depend on which of the uninsured decide to enroll

For example, the RMHP response notes that there are "three categories of uninsured:

1) those who cannot afford coverage,

2) those who are unable to obtain coverage due to health conditions,
3) those who elect to decline coverage because they are generally healthy."

In general, the respondents agreed that the first and third groups are less expensive to cover than the second group (e.g., those unable to obtain coverage due to health conditions). Respondents' final premium estimates reflect, in part, their predictions about many people with on-going health conditions (group 2) decide to enroll, as compared to the less expensive persons in group 1 and group 3. The tendency for more expensive individuals to enroll in coverage is known as "adverse selection."

Low premiums and/or subsidies are necessary to attract low-cost enrollees

Most of the responses assumed that group 2 is least sensitive to premium price increases. Even if premiums are on the high side of affordable, people with on-going health concerns remain financially motivated to enroll. Other individuals who face higher prices in the traditional individual market are also more likely to enroll, such as women and people who live in high-cost counties. Gender and regional differences in premium pricing can be significant in the individual market, as documented in the responses.

By contrast, healthy young men and those facing affordability issues are most likely to enroll when premiums are very low. Premium subsidies can play an important role in lowering the out-of-pocket portion of the premium, thereby offsetting the tendency toward adverse selection that many respondents view as inherent in the Centennial Cares design.

Most believe that mandates are also required to attract low-cost enrollees

Most respondents appear to believe that competitive pricing for Centennial Cares products needs to be combined with an individual mandate in order to achieve significant enrollment of healthy, low-cost individuals. This is why most respondents assume large subsidies and estimate that average premiums will be lower under the individual mandate scenario. In the context of an individual mandate, respondents appear to assume that most (but not all) uninsured individuals will be compliant with the requirement to obtain coverage. However, most proposals also assume that healthy individuals would weigh the cost of enrolling in Centennial Cares against the cost of obtaining coverage through the "regular" (underwritten) individual market. At least one respondent (Kaiser) believes that individuals would also consider benefit scope.

Respondents disagree on subsidy level necessary to attract low cost enrollees

However, respondents appear to disagree on the level of subsidy necessary to be price-competitive with other (underwritten) products in the individual market.

For example, RMHP and Kaiser make nearly identical assumptions about the level of available subsidies. However, under an individual mandate, RMHP assumes that proposed subsidies would be adequate to attract healthy persons to Centennial Cares products, while Kaiser anticipates that even with significant premium subsidies "a combination of mandated benefits and guaranteed issue may influence those uninsured that are healthy to seek better coverage at a more competitive price through the commercial individual plan offerings. (Kaiser, p 22)" As a result, the RMHP response estimates lower premiums under an individual mandate as compared to the no mandate scenario, whereas Kaiser projects higher premiums. Even among

the majority of responses that assume that adverse selection can be mitigated through a combined subsidy/mandate policy approach, they disagree about whether adverse selection can be eliminated.

In an effort to reduce the amount of variability across the responses and to summarize the above discussion, Table 1 categorizes responses according to their major, underlying program/policy assumptions. The last two columns (on the right side) of the table record respondent assumptions about adverse selection for mandate and non-mandate scenarios. Respondents' policy/program assumptions that drive their enrollment projections are briefly noted.

Table 1:

Summary of Respondent Policy/Program Assumptions that Drive Enrollment Profiles

	Enrollee Share of Premium LESS THAN Individual Market Premium	Enrollee Share of Premium MORE THAN Individual Market Premium	Subsidy targeted to Centennial Care Products?	Individual market rating rules remain same; No guaranteed issue (GI); no community rating (CI)	Enrollment Profile without "individual mandate" assumptions	Enrollment Profile with "individual mandate" assumptions
CELTIC Insurance Company	Unclear; tables and text conflict	Unclear; tables and text conflict	Not addressed	Not addressed	Unclear; tables and text conflict	Unclear; tables and text conflict
Colorado Access **Scenario 1**	√ "Free or almost free"	No	√	No; "Market reform"; All individual products are GI/CR w/ stop loss or risk adjustment	**Some adverse selection;** Even though nearly free, coverage is not compelled and healthy may opt out	**No adverse selection;** Option for healthy to "market shop" eliminated b/c all products are GI/CR and Centennial coverage cheap.
Colorado Access **Scenario 2**	√ Subsidy> Current high risk pool subsidy @ approx. 50% of average individual market price	No	√	√	**Moderate adverse selection;** Subsidies less generous and healthy are not compelled to have coverage	**Moderate adverse selection;** Some healthy individuals are able to find less expensive coverage in individual market
Colorado Access **Scenario 3**	No	√ Subsidy= Current high risk pool subsidy	No; All plans/insurers eligible for subsidies	√	**Significant adverse selection** "Replaces Cover Colorado"; healthy individuals can use subsidies in individual market	**Significant adverse selection** "Replaces Cover Colorado"; healthy individuals can use subsidies in individual market
Colorado Choice Health Plans	√ 7-10% of income (premiums only)	No	√	√	**Significant adverse selection;** 22% male; avg 39 years	**No adverse selection;** Enrolled similar to current uninsured 58% male; avg 33 years
Kaiser Permanente/ **Delta Dental**	No	√ $100/mo (approx.	√	√	**Moderate adverse selection;** Assumes some healthy individuals can find cheaper options in	**Moderate adverse selection;** Assumes some healthy individuals can find cheaper options in

		5% income)			individual market	individual market
Pinnacol Assurance/Cover Colorado	√ Adults: 5% of income per person; Children: 50% premium	No	√	√	**Significant adverse selection;** Not priced b/c not financially viable due to healthy individuals opting out	**No adverse selection;** Enrolled similar to current uninsured 58% male; avg 33 years
Rocky Mountain HMO	√ 5% of income (premiums & cost-sharing)	No	√	√	**Significant adverse selection;** 22% male; avg 39 years	**No adverse selection;** Enrolled similar to current uninsured 58% male; avg 33 years
UnitedHealth Group	Unclear (not modeled?)	Unclear (not modeled?)	√	√	**Significant adverse selection;** Not priced; pricing provided for underwritten alternative	**Significant adverse selection;** Adverse selection partially, but not fully offset by individual mandate.

In sum, most respondents believe that the Centennial Cares products (as described in SB-217) would work best in the context of large subsidies and an individual mandate. In the absence of an individual mandate, many question the viability of a guaranteed issue/community rated product that exists "alongside" underwritten products in the individual market. Most respondents believe that such a program, even if subsidized, would result in moderate to significant adverse selection. Several responses offered policy alternatives in a non-mandate scenario such as: enhanced subsidies to Cover Colorado and standardizing rating assumptions across the individual market. While the commercial respondents proposed "standardization" in the direction of current rating practices, Colorado Access proposed requiring guarantee issue and community rating for all individual market products. Finally, although respondents did not agree on the ideal level of premium subsidies, most agreed that to avoid/mitigate adverse selection, Centennial Cares products must be price-competitive with products in the individual market.

A more detailed, technical analysis of the individual responses follows.

Using Demographics to Adjust Baseline Pricing Information

In general, the Colorado uninsured data provided to the RFI respondents was younger and more male (58% male) than many of the baseline populations used by respondents' actuaries. Respondents were provided population counts for age groups (rather than for individual ages) and were not given an average age of the Colorado uninsured population. Across the responses, RFI respondents estimated that the average age of uninsured Coloradoans is around 33 to 35 years. Although this uninsured population is younger on average than many

commercial populations, at least one respondent noted that there are fewer uninsured children. This is consistent with uninsured analyses that find that young adults are at an especially high risk of being uninsured.

Most respondents indicated in their pricing descriptions (section 5) that they adjusted their baseline data to reflect differences in age and gender between the baseline population and the uninsured. This adjustment process consists of “reweighting” their analytical database to reflect the age, gender, and regional distributions of the Colorado uninsured populations. As discussed in the next section, many respondents made subsequent adjustments to reflect their assumptions about the demographic profile of uninsured individuals most likely to enroll in their proposed VBP product.

Table 2: Respondent Comparison of Base Population, Proposed Provider Rates, and Initial Demographic Adjustments

	Base Population used in Actuarial Analysis	**Proposed provider rates**	**Demographic Adjustments** **(Re-weighted to CO uninsured age/gender/region data ?)**
CELTIC Insurance Company	Unspecified "commercial population" w/ avg age 38; 56% male	100% Medicare rates	Unclear (probably yes); "Expected demographics have an average age 35; 58% male"
Colorado Access	CoAc's Medicaid (AFDC) managed care experience; Unspecified age; gender	100% Medicaid rates	Yes; Reweighted according to "subsidy eligible population" which is older and more male
Colorado Choice Health Plans	All CCHP commercial members Unspecified age; gender	Unspecified commercial rates	Yes; avg age 33; 58% male
Kaiser Permanente/Delta Dental	Kaiser "Region 2" population Unspecified age; gender	Not disclosed (probably Kaiser commercial rates)	Yes; "standard actuarial consulting age and gender factors were applied"
Pinnacol Assurance/Cover Colorado	Proprietary commercial population, primarily group policies w avg age 35;50% male	130% Medicare (110% Medicare also priced)	Yes; avg age 33; 58% male
Rocky Mountain HMO	RMHP's commercial group members w avg 35; 50% male	RMHP commercial rates or Colorado Medicaid encounter rates (for SNPs)	Yes; avg age 33; 58% male
UnitedHealth Group	National underwritten individual health insurance program Unspecified age; gender	100% existing CO commercial rates	Unclear "no adjustment of demographics was made beyond the Baseline Population assumptions"

Table 2 summarizes and compares the base populations used for the actuarial analysis, proposed provider rates, and demographic adjustments, as described by RFI respondents in sections 5 and 6. (Independent confirmation of their assumptions through analysis of their pricing summary data tables was attempted and discrepancies noted.) Note that respondents used different base populations as the starting place for their actuarial analyses.

Many of the responses did not project enrollment (and therefore provide premium estimates) for all 9 regions (statewide). However, most respondents appear to have considered the entire uninsured population within each region targeted by their proposed VBP product. However, several respondents noted that "care would most likely be unaffordable for those over 300% FPL without a subsidy." (CCHP response, p 20.) Perhaps for this reason, at least one respondent – Colorado Access -- appears to restrict its VBP enrollment assumptions to only the subsidy-eligible population (e.g., 100-300% FPL). Detailed information about VBP enrollment by FPL was not required of respondents and therefore difficult to ascertain in some responses.

Although the enrollment effects on premiums are the focus of this analysis, the reader should note that respondents used different provider rates, which will have a substantial and independent effect on premiums. (To illustrate the pricing implications of different provider reimbursement rates, HPS has attached a Lewin Group analysis of hospital costs, as compared to commercial, Medicare, and Medicaid reimbursement.)

Anticipated VBP Enrollment and Effect on Prices:

Gender, Health Status, and Utilization (Adverse Selection)

As discussed, all of the RFI respondents considered the gender, health status, and utilization of likely VBP enrollees in developing their pricing estimates.

Table 3: Respondent Comparison of Base Population, Gender Adjustments, Health Status Adjustments and Utilization Adjustments

	Base Population used in Actuarial Analysis	**Effect of Gender and Health Status**[17] (no mandate**;mandate)**	**Effect of Utilization** **(**no mandate**;mandate)**
CELTIC Insurance Company	Unspecified "commercial population" w/ avg age 38; 56% male	19% increase **8.2% increase (mandate)** Note: Cannot reconcile numbers from the narrative	33% increase **10% increase (mandate)** Note: Cannot reconcile numbers from the narrative

[17] While many respondents assumed that gender neutral pricing would affect the gender profile of VBP enrollment, some reported these effects under "demographic adjustments" and other reported them under "health status adjustments". Table 2 consolidates all such adjustments under "gender and health status."

		with pricing table p. 17	with pricing table p. 17
Colorado Access	CoAc's Medicaid (AFDC) managed care experience; Unspecified age; gender	Depends on level of subsidy; 3 levels priced	Depends on level of subsidy; 3 levels priced
Colorado Choice Health Plans	All CCHP commercial members	7% increase due to gender 150% increase due to health status increase; **21% decrease due to gender (mandate)** **10% increase due to health status (mandate)**	9.3% increase; **4.2% increase (mandate)**
Kaiser Permanente/Delta Dental	Kaiser "Region 2" population Unexplained difference in mandate vs. no mandate baseline population.	10% decrease due to gender 17.65% increase due to health status **10% decrease due to gender (mandate)** **17.65% increase due to health status (mandate)**	27.5% increase **27.5% increase (mandate)**
Pinnacol Assurance/Cover Colorado ($322.29 avg PMPM)	Proprietary commercial population, primarily group policies W avg age 35;50% male	**9.5% decrease due to gender (mandate)**[18] **0% change (mandate)**[19]	**0% change (mandate)**
Rocky Mountain HMO	RMHP's commercial group members W avg 35; 50% male	18% increase due to gender 200% increase due to health status **12% decrease due to gender (mandate)** **10% increase due to health status (mandate)**	9% increase; **4.5 increase (mandate)**
UnitedHealth Group	National underwritten individual health insurance program	"Without mandate" scenario NOT priced[20] **0% increase (mandate)**	"Without mandate" scenario NOT priced **60% increase (mandate)**

[18] Pinnacle assumes that VBPs without a mandate are unaffordable and unsustainable and does not provide pricing.

[19] Pinnacle provides 2 VBP options, one for healthy enrollees (AssuredCare VBP) and one for people with pre-existing conditions (CoverColorado VBP). Across the two VBPs, Pinnacle assumes the enrolled population will be similar to the base, commercial population. However, the underlying average costs for the two VBPs will be substantially different, given their different enrollment profiles.

[20] "Without individual mandate" pricing provided in the proposal does not assume guarantee issue/community rating. "In the case of a program without an individual mandate, it is assumed that the underwriting selection process between the Baseline Population [a national underwritten individual health insurance program] and the target population will be the same."

Table 3 summarizes and compares the base populations used for the actuarial analysis, as well as any gender adjustments, health status adjustments, and utilization adjustments, as described by RFI respondents in sections 5 and 6. (Independent confirmation of their assumptions through analysis of their pricing summary data tables was attempted and discrepancies noted.)

Note respondents used different base populations as a starting place for their VBP pricing estimates, and adjustments made to pricing (e.g., due to demographics, health status, utilization, or other) are made with reference to this base population. As a result, it is difficult to determine how similar or different the enrollment profiles are across the RFI responses, because it requires detailed knowledge of each respondent's base population. Specifically, it is difficult to infer enrollment assumptions from disclosed changes in PMPM due to health status or other adjustments. For example, Colorado Access used a Medicaid population as its base and projected that a Centennial Cares product would enroll a comparatively healthier population; several of the other responses began with a commercial population and assumed a less healthy enrollment. Despite these differences in pricing methodologies, many respondents drew similar policy conclusions as noted in Table 1 and the related discussion.

Recommendations for a Request for Proposals (RFP)

Recommendation 1: The state should consider funding an analysis of the uninsured aimed at better quantifying the health status of this population. RFI respondents requested information about the health status of the uninsured that the state was unable to provide. Differing assumptions about the underlying health status of the uninsured may be driving some of the differences in pricing, as well as differing assumptions about adverse selection.

Recommendation 2:

In any subsequent RFP, bidders should provide a detailed enrollment profile of for their proposed VBPs by gender, FPL, region, and health status. This enrollment profile should be compared on a side-by-side basis with the underlying uninsured population. A detailed narrative description of enrollment assumptions should be provided.

Recommendation 3: Due to the substantial impact that subsidies have on enrollment, any subsequent RFP should specify precisely the nature of a state-funded sliding fee premium

subsidy program, including the amount of the subsidy and eligibility requirements. The state should expect that bidders will assume moderate to significant adverse selection unless subsidies are price-competitive with underwritten products and large subsidies are paired with an individual mandate to obtain coverage.

Recommendation 4: Due to the substantial impact that an individual mandate has on enrollment, any subsequent RFP should specify precisely the nature and enforcement of a requirement to have health insurance coverage. In the absence of an individual mandate, the state should expect that bidders will assume moderate to significant adverse selection that will be factored into their premium pricing.

Appendix E. Suggested Statutory Changes

SB 217 RFI Responses - Required Statutory Changes and Other Suggestions

The Centennial Care Choices RFI gave respondents two opportunities to suggest changes to the current legal/regulatory environment that would facilitate their operation of a Value Benefit Plans in question 8 (Please identify specific statutory changes (referencing the current citation) that would be needed to implement your proposed VBP) and question 9 (Please describe any other suggestions you have for the Division, the Department, and the Panel relative to implementing VBPs and the Centennial Care Choices Program). The following includes responses to these questions. The Centennial Care Choices Panel did not evaluate the appropriateness of any of these suggested changes, but offers this list for consideration in either pilot programs or a Request for Proposal for Value Benefit Plans.

Required Statutory Changes

Many suggestions were made by the respondents and many respondents listed statutory changes that would be required in order for their VBP plan to be offered. Some of the suggestions were repeated by more than one respondent. Some of the items listed under "required statutory changes" would have been more appropriately placed under "other suggestions." Similarly, some of the responses under "other suggestions" were similar to responses under "required statutory changes." We have tried to sort through all of the suggestions and required changes and list them in the proper category. The following four required statutory changes were repeated by more than one respondent:

1) Establish specific annual enrollment periods or criteria for enrollment in VBPs. Several respondents suggested a waiting period ranging from 60 days to 120 days before an individual would be eligible to enroll. Stable and controlled enrollment is especially important in the absence of an individual mandate to reduce the potential for adverse selection. If there is no mandate, one respondent suggested a waiting period of 12 months before an individual would be eligible to re-enroll if coverage is dropped and no coverage for 12 months for any pre-existing conditions. The respondents were not given any enrollment criteria to use in pricing their VBPs. If specific enrollment criteria were specified, it may reduce the costs of the VBPs.

2) Integrate/coordinate eligibility determination with CoverColorado and other public programs such as CHP+ and Medicaid. One respondent suggested that the exhaustion of VBP benefits would be a qualifying event for CoverColorado enrollment. Another respondent suggested that

the State build on programs already in place and to utilize CoverColorado to offer an array of VBP products, while at the same time improving CoverColorado's care management.

3) Specify same rating standards and structure for individual and small group markets as what is required for VBPs; that is, rating differentials for age and geography only, guaranteed issue and no pre-existing conditions. This would help minimize adverse selection.

4) Except VBPs from premium taxes

Respondents also noted the following additional specific required statutory changes:

- Add VBPs to the list of programs in which a health maintenance organization can engage and be subject to the minimum surplus requirements of §10-16-411(1.5), C.R.S. (Colorado Access)

- Allow the state to establish a risk pooling mechanism, such as stop loss, reinsurance and/or risk adjustment arrangements

- Allow health maintenance organizations to offer limited benefit plans (Colorado Access, Colorado Choice)

- Allow CoverColorado to offer and price VBPs (under Pinnacol's proposal, Pinnacol would also be have to be allowed to offer and price VBPs)

- Modify CoverColorado's premium rating statute, §10-8-512, C.R.S. (Pinnacol)

- Allow VBPs to be marketed through employers, and except VBPs from small group regulations when employer contributes to the cost of the VBP (Pinnacol)

- Except individuals covered by VBPs from waiving their right to group coverage after being covered by an individual policy (Pinnacol)

- Allow carrier offering VBPs to build necessary risk-based capital (Pinnacol)

- Specify permissible marketing and advertising practices

- Require hospitals to accept no more than 105% of the Medicaid fee schedule, and that out-of-network providers be reimbursed at Medicare levels (Colorado Access)

Other Suggestions

The respondents offered a number of suggestions. At least one respondent suggested that there be adequate disincentives for those individuals who do not comply with any mandate and that any individual who does not enroll within a specified grace period be automatically enrolled in a randomly assigned default plan meeting minimum standards.

The following additional suggestions were made:

- Limit the use of subsidies for VBP plans only

- Utilize a sliding-scale of subsidies based on premium only, not out-of pocket costs

- Consider alternative contracting arrangements other than standard capitated risk contracts

- Allow VBPs to join multi-state prescription drug purchasing pools

- Support the development of health marts for the marketing and enrollment of the VBP program

- Expand Medicaid coverage for pregnant women and uninsurable

- Use a variety of mechanisms to provide educational materials

Many suggestions were made regarding the structure and requirements of the VBP themselves:

- Number of available VBP choices should be small enough to allow plans to achieve adequate economies of scale
- Encourage additional more affordable VBP options, such as HSA compatible plans
- VBPs should be more comprehensive in coverage
- Except VBPs from state-wide requirement, at least for carriers who currently are not licensed statewide. (2 respondents)
- Adopt a unique VBP provider fee schedule.
- Allow rating based on gender and tobacco use for VBPs and expand geographic rating to individual counties. One respondent estimated that allowing gender in rating would decrease rates by as much as 20% on average.
- VBPs should not be guaranteed issue
- VBPs should provide preventive dental benefits
- Design VBP cost sharing elements to discourage certain utilizations, such as higher deductibles or co-pays for emergency room visits