



COLORADO
Department of
Regulatory Agencies
Division of Insurance



COLORADO
Department of Health Care
Policy & Financing

Final Report for Colorado's Public Option

November 15, 2019

*Submitted by
the Colorado Division of Insurance, part of the Department of Regulatory Agencies
and
the Department of Health Care Policy & Financing*



COLORADO
Department of
Regulatory Agencies
Division of Insurance



COLORADO
Department of Health Care
Policy & Financing

November 15, 2019

To the Members of the Joint Budget Committee, the House Public Health Care and Human Services Committee, the House Health and Insurance Committee, and the Senate Health and Human Services Committee:

The Division of Insurance (DOI) and the Department of Health Care Policy and Financing (HCPF) are pleased to submit the Final Report for Colorado's Public Option dated November 15, 2019. We have prepared and are submitting this report pursuant to HB19-1004, C.R.S § 25.5-1-129, which directed the DOI and HCPF to develop an affordable health care coverage option for Coloradans.

The recommended plan will save money for Coloradans who purchase health insurance on the individual market, and soon, the small group market. On average, premiums will be reduced by 10%; in many parts of the state, Coloradans will save more than 15%. Premium savings are achieved through reductions in the underlying costs of care. In addition, the plan will offer high value, pre-deductible services such as behavioral health and primary care, so consumers can readily access these services.

As described more fully in the final report, the DOI and HCPF recommend that the public option is structured as a public-private partnership. This new plan will increase consumer choice and result in every county having at least two carriers in the individual market. The plan will be administered by private-sector carriers, available statewide to any resident seeking coverage in the individual market, and provide access to federal subsidies, if applicable. This plan will result in very low costs to the State - both start-up and ongoing - and savings for Coloradans.

The recommendations are based on extensive stakeholder engagement over the past six months. Our agencies hosted 20 public listening sessions in Alamosa, Aurora, Boulder, Burlington, Denver, Durango, Edwards, Glenwood Springs, Grand Junction, Greeley, Hugo, Keystone, and Pueblo. We received 260 written comments, conducted three focus groups, released a draft for comment, and publicly posted all materials. Our recommendation responds to the innovative ideas and thoughtful input raised during this process.

Everything in this recommendation is targeted at making health care more affordable for Coloradans, and it asks for collaboration from everyone - hospitals, insurance companies, the pharmaceutical industry - to achieve this goal. We are pleased to submit this recommendation and look forward to partnering with the General Assembly and presenting this report at the annual joint meeting of the House and Senate committees. In the meantime, we are available to answer any questions you have.

Regards,

Michael Conway



Commissioner
Division of Insurance

Kim Bimestefer



Executive Director
Department of Health Care Policy and Financing

Table of Contents

Executive Summary	3
Introduction	5
Overview of HB19-1004 Legislation	8
Stakeholder Outreach and Feedback	8
What is the Public Option?	9
Who Can Enroll in the Public Option?	9
What Benefits Will Be Covered?	10
How Will the Public Option Be More Affordable?	11
How Will the Advisory Board Work?	15
How Will the Public Option Fit In With Other Health Care Initiatives?	15
How Will This Impact Costs for Employers?	16
How Will This Impact the State Budget?	17
Why is Medicaid Buy-In an Alternative?	18
What is the Role of the Division of Insurance?	18
What is the Role of Health Care Policy and Financing?	19
What is the Role of Connect for Health Colorado?	19
Will Hospitals and Carriers be Required to Participate?	20
What Other Policy Considerations Influenced This Report?	21
Does This Proposal Require a 1332 Waiver?	23
What Legislation is Required to Implement the Public Option?	24
Timeline for Next Steps	24
Conclusion	25

Appendix I: Actuarial Analysis

Appendix II: Stakeholder Engagement Summary

Appendix III: Summary of Public Option

Appendix IV: Presentation from Draft Rollout Stakeholder Sessions

Appendix V: Public Comments

(due to the large size of Appendix V, it is not attached but instead linked online at <https://www.colorado.gov/pacific/hcpf/proposal-affordable-health-coverage-option>)

Executive Summary

Ensuring all people have access to affordable health care is a challenge that has vexed public officials and policy experts for decades, despite seemingly constant efforts to address the costs of coverage and care. The Affordable Care Act made great strides in increasing coverage, but it did not address the underlying cost of care. For many - in Colorado and nationally - even the subsidies provided by the federal government are not enough to keep insurance affordable.

HB19-1004 was passed and signed into law in May of 2019 in response to this important and persistent problem. It directed the Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Division of Insurance (DOI) to make a recommendation to the Legislature on the design of a public option that would be more affordable than current options available to Coloradans seeking care through the Individual and Small Group markets.

In order to ensure that we received input from every corner of the state, we undertook a major outreach and feedback process. Insurance Commissioner Michael Conway, HCPF Executive Director Kim Bimestefer, and Lieutenant Governor Primavera hosted 20 public listening sessions in Alamosa, Aurora, Boulder, Burlington, Denver, Durango, Edwards, Glenwood Springs, Grand Junction, Greeley, Hugo, Keystone, and Pueblo. We received 260 written comments, and conducted three focus groups. To maximize Colorado's collaborative nature, we went beyond what was asked in HB19-1004 and took the additional step of releasing a draft report for public comment so that all stakeholders had the opportunity to further improve the recommendation.

This recommendation directly draws from and responds to the innovative ideas, thoughtful questions, and important concerns raised throughout this process. It asks all of the stakeholders — health care providers, insurance carriers, prescription drug manufacturers, brokers, and Coloradans — to come to the table to do their part to help make care more affordable. It represents a carefully balanced approach that strengthens market competition, while giving State leaders tools to increase affordability. It recognizes the vital role that hospitals play in our community while also acknowledging that hospital costs are one of the leading drivers of the overall rising cost of health care. It initiates a new platform that continues to transform our health care system to one that pays for value, not volume. It provides thoughtful pathways to protect and strengthen our independent, rural, and critical-access hospitals - pathways crafted in collaboration with the hospitals themselves. It recommends a majority of federal savings be used to provide further premium assistance and cost-reductions for currently subsidized Coloradans struggling with affordability. Finally, and most importantly, it reflects our obligation to Coloradans to ensure that individuals, and ultimately small and medium employers, can afford insurance to access needed care. In short, this recommendation draws from an extensive, expansive, multi-stakeholder collaborative process to offer a proposal that will take us one very important step closer to achieving universal coverage for Colorado.

In accordance with HB19-1004, we recommend that Colorado establish a public option that is structured as a public-private partnership and initially sold in the individual market, both on and

off the exchange, starting in the 2022 plan year. In the draft report, our actuaries estimated the proposal would result in plans available in 2022 that are about 9-18 percent less expensive than otherwise available plans. This final recommendation is aligned with that target. We recommend the plan be administered by private-sector carriers, be available statewide to any resident seeking coverage in the individual market, and that people can utilize federal subsidies, if applicable. We recommend it be offered in the catastrophic, bronze, silver, and gold metal tiers, and that it promote quality through standardized benefit designs.

Through an innovative partnership between State government and private carriers, the public option will increase consumer choice and result in every county having at least two carriers in the individual market, solving the troublesome problem of a growing number of single-carrier counties in Colorado - 22 as of January 2020 - where people only have only one carrier option for coverage.

Finally, we recommend that an Advisory Board be established, composed of diverse stakeholders that will make ongoing recommendations to DOI and HCPF on ways to lower costs, increase access, and promote quality through the public option.

To hit the savings targets outlined by our actuarial analysis, savings will be achieved through three primary strategies. First, we recommend raising the carrier medical loss ratio (MLR) for the public option from 80 percent to 85 percent, matching the MLR in the large group market. This would mean that an additional 5 cents of every premium dollar will be required to go towards patient care rather than administration and other non-care expenses.

Second, we recommend that hospital reimbursement rates be set through a public and transparent formula that ensures sustainability and helps to stabilize our rural hospitals, while preventing the price inflation currently taking place in some markets. This formula would be applied on a hospital-by-hospital basis, resulting in reimbursement rates that can be expressed as a percentage of Medicare, just as reimbursement rates from private carriers can also be expressed as a percentage of Medicare. This will drive more rational pricing and hospital accountability to the communities served, while assisting policy makers in comparing reimbursement rates across markets.

Third, we recommend that carriers be required to ensure that all compensation from prescription drug manufacturers (like rebates) paid to insurance carriers or their pharmacy benefit managers (PBMs) are passed through to consumers. This will help to deter misaligned incentives between manufacturers and carriers that encourages the use of the highest cost drugs.

Colorado has historically been at the forefront of designing and implementing strategies to improve health care access and quality. We are pleased to submit this recommendation that represents the next bold step forward for the state. The details of how these pieces will work, the data and feedback we used to inform this recommendation, and descriptions of what legislation we believe is required for successful implementation are described below.

The public option is an innovative approach that will make a tangible difference for Coloradans -- and eventually the state's small employers. It will accelerate delivering affordable health care by working in tandem with other existing and proposed policies to expand access and lower costs. While similar debates are happening in other states and at the national level, we believe this public-private solution — designed by and for Colorado — is the right one for our state, and can serve as a leading national model. Everything in this recommendation is targeted at making high quality health care more affordable for Coloradans.

We look forward to partnering with the General Assembly and the greater health community as you consider this recommendation and continue to take steps to make health care more affordable for Coloradans.

Introduction

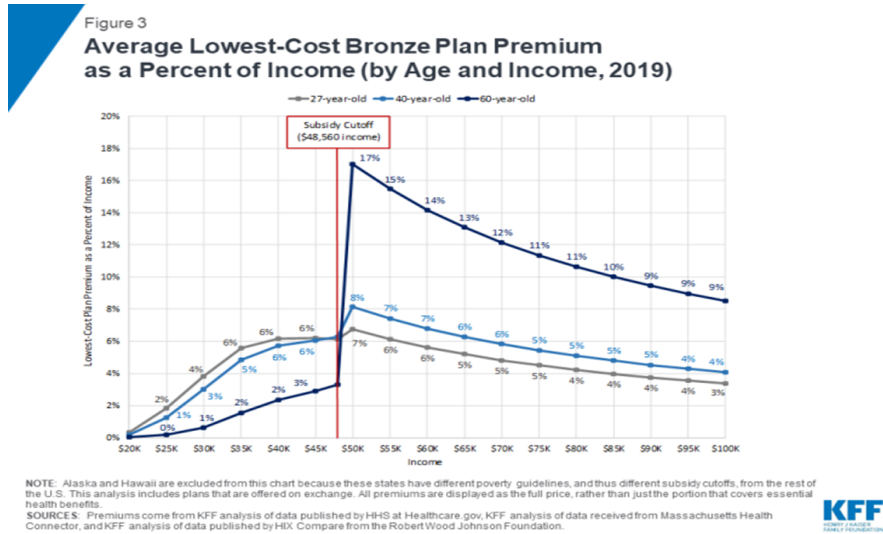
Recognizing that affordability is one of the largest barriers to accessing health care, Governor Polis and the Colorado General Assembly have taken a number of steps to improve affordability, including establishing the Office of Saving People Money on Health Care, passing a reinsurance program, supporting community purchasing alliances, rolling out a Health Care Affordability Roadmap in communities around the state, creating new incentives for hospitals to transform their practices to better meet the needs of their communities, and designing and recommending a public insurance option.

Affordability is a critical and persistent problem across the state. New data from the 2019 Colorado Health Access Survey (CHAS) show that 90 percent of uninsured Coloradans cite “cost” as the reason they are not covered.¹ Even those *with* health insurance coverage are concerned about affordability. Stakeholders in every single meeting we held raised serious concerns about their inability to afford their out-of-pocket costs - their deductibles, co-insurance and co-pays.

Coloradans are paying a hefty percentage of their incomes on health care, and this is especially true for people who are not eligible for federal subsidies. As demonstrated in the image below, the portion of income spent on health insurance skyrockets for individuals making more than \$48,560 a year — about 400 percent of the federal poverty line, or the threshold where subsidies stop.

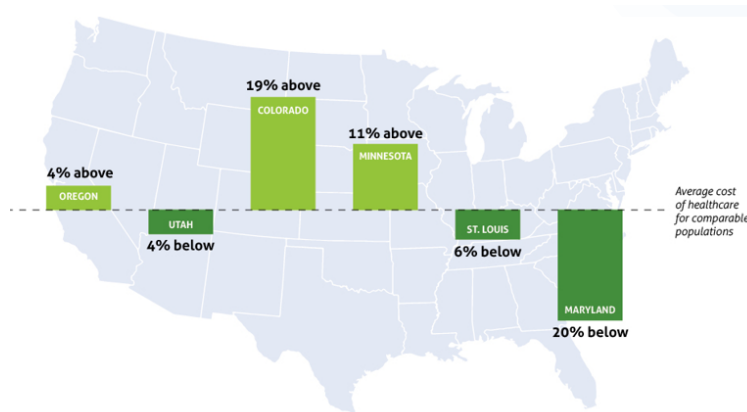
¹Colorado Health Institute (2019). 2019 Colorado Health Access Survey: Progress in Peril. Available from The CHAS Launch Powerpoint at coloradohealthinstitute.org/research/CHAS. See also Ingold, J. (2019, Sep. 25). Colorado's Uninsured Rate is Holding Steady, but a New Study Shows Troubling Trends in the State's Health Care Market. The Colorado Sun. Available from <https://coloradosun.com/2019/09/25/colorado-health-access-survey-results/>.

Image 1.



There are many drivers of health care costs. But, at its core, cost is a two-part equation: the combination of the price you are charged and how much care you use. Numerous studies show that Americans do not use more care than the rest of the world.² In fact, Colorado ranks as one of the healthiest states, favorably impacting how much care Coloradans need. Still, our overall costs are significantly higher than in other states.³ To get at the root of the problem — something stakeholders resoundingly asked — we have to get a grip on the high price of care.

Image 2.



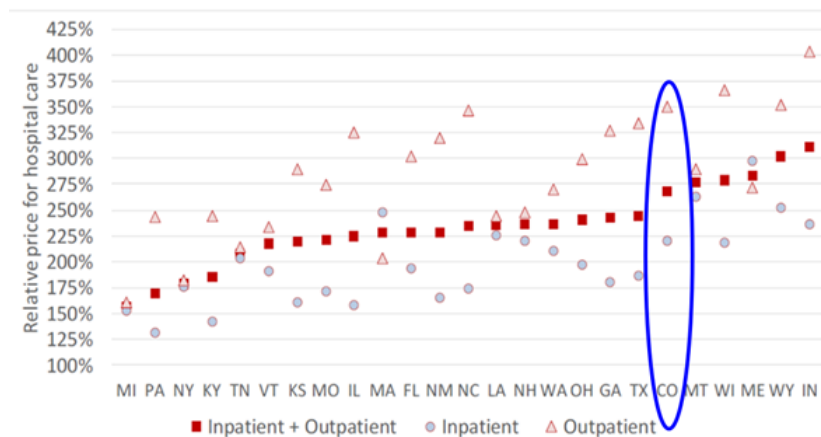
In this regard, it is clear that Colorado is ripe for positive change. According to a recent report by the RAND Corporation and as seen in Image 3 below, Colorado ranks as one of the highest

² See, e.g., Papanicolas I., Woskie, L.R., & Jha A.K. (2018). Health Care Spending in the United States and Other High-Income Countries. *JAMA*. 319(10):1024–1039. Available from <https://doi.org/10.1001/jama.2018.1150>.

³ Center for Improving Value in Health Care (2019, Nov. 8). Colorado’s Health Care Costs Continue to Rise Above Other States. Available from <https://www.civhc.org/2018/11/08/colorados-health-care-costs-continue-to-rise-above-other-states/>.

states for hospital prices in the nation.⁴ Indeed, hospitals in most other states charge individuals and employers lower prices than are charged in Colorado, and they do so successfully, without disruptions.

Image 3.



There are also wild variations for hospital pricing across our state. A recent report published by the Center for Improving Value in Health Care (CIVHC) showed variation of more than 400 percent across Colorado for the same group of services.⁵ For example, delivering a baby in Routt County costs an average of \$17,160 versus \$6,000 at a Denver area hospital.⁶

Alongside these unjustifiable price variations, Coloradans in many parts of our state only have one carrier as an option. In single-carrier counties, Coloradans have limited choice without the benefit of competition to drive prices down.

Costs are also high when looking at the costs of prescription drugs. In a 2019 report, the Kaiser Family Foundation found that nearly 8 in 10 Americans believe prescription drugs costs are unreasonable and that 1 in 4 Americans who are taking medications are struggling to afford them.⁷ Unfortunately, the high cost of prescription drugs also has a direct impact on patient compliance with their medications: 29 percent of all adults either did not fill a prescription or did not take their medicine as prescribed in order to save money, which often costs both the individual and the system more in the long run.⁸

⁴ White, C. & Whaley, C. (2019). Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation. Available from https://www.rand.org/pubs/research_reports/RR3033.html.

⁵ Center for Improving Value in Health Care (2019, Sept. 5). Regional Price Information as a Percent of Medicare Now Available. Available from <https://www.civhc.org/2019/09/05/regional-price-information-as-a-percent-of-medicare-now-available/>.

⁶ Data extracted using the Center for Improving Value in Health Care Shop for Care Tool. Center for Improving Value in Health Care (undated). Shop for Care. Available from <http://www.civhc.org/shop-for-care/>.

⁷ Kirzinger, A., Lopes, L., Wu, B., & Brodie, M. (2019, Mar. 1). KFF Health Tracking Poll - February 2019: Prescription Drugs. Available from <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>. Kaiser Family Foundation (2019, Mar. 1). Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including Larger Shares Among Those with Health Issues, with Low Incomes and Nearing Medicare Age. Available from <https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/>.

⁸ Kirzinger, A., Lopes, L., Wu, B., & Brodie, M. (2019, Mar. 1). KFF Health Tracking Poll - February 2019: Prescription Drugs. Available from <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>.

We consistently heard in stakeholder meetings and comments that people want the public option to make health care more affordable, but this must be carefully balanced with preserving and expanding access to care, and with recognizing that our hospitals play important economic and public health roles in our communities. It is within this context that we developed this recommendation to reduce costs, increase competition, leverage our state's existing infrastructure, and create a model for affordable health insurance.

Overview of HB 19-1004

The Department of Insurance (DOI) and Department of Health Care Policy and Financing (HCPF) were charged with developing a proposal that identifies the most effective implementation of a public option that accomplishes the goals of:

- Developing an innovative, proactive, and Colorado-specific, approach to increasing consumer access to affordable, high-quality health care coverage;
- Providing an additional health care coverage option for those living in one of the now 22 counties in the state that have only one health insurance carrier offering individual plans;
- Increasing competition in the state among health insurance carriers to put downward pressure on health insurance premiums and increase consumer choice;
- Considering the feasibility and costs of implementing a public option for health care coverage that leverages current state infrastructure; and
- Utilizing the expertise of HCPF – which manages Colorado Medicaid, also known as Health First Colorado - the DOI, and various experts in health care and health care policy.

Stakeholder Outreach and Feedback

HCPF and the DOI gathered input from stakeholders for the development of this Colorado public option by accepting 260 public letters and comments, conducting focus groups, and hosting 20 listening sessions in communities throughout the state.

The stakeholders who participated in the sessions included community representatives, health care providers, hospitals, county health and human services agencies, insurance companies, insurance brokers, consumers, businesses, non-profits, and elected officials. Stakeholders offered their thoughts on populations to be served, cost containment strategies, affordability, needs, gaps, and priorities.

Some common themes identified in these stakeholder meetings included:

- Addressing underlying health care costs, in particular hospital costs;
- Simplifying processes and products;
- Offering a public option statewide to all who want it;
- Utilizing Connect for Health Colorado's infrastructure;
- Reducing costs beyond premiums, e.g. co-pays, deductibles, and out-of-pocket limits;
- Caring for uninsured populations and subsidy-eligible populations;

- Understanding the impacts of participation requirements;
- Balancing reduced rates with the importance of health care access, and,
- Including a dental benefit.

What is the Public Option?

The public option is a new insurance plan maximizing public and private industry strengths, designed by Colorado, for Colorado. The plan will be sold by licensed insurance companies and will cover a comprehensive, standardized set of benefits. The public option will provide Coloradans with more affordable, high-value coverage.

Our latest actuarial modeling estimates that average premium savings statewide will be approximately 10.6 percent. In some areas of the state, they will be significantly higher.

Image 4.

Table 1: Difference between 2022 Baseline Average ACA Premiums and the Public Option by Region

	Statewide	Urban - Rating Areas 1, 2, 3	Rural West - Rating Areas 5, 9	Rural East - Rating Areas 4, 6, 7, 8
Baseline Projected 2022 ACA Premium	\$538.78	\$502.28	\$668.55	\$576.40
State Coverage Option Estimated 2022 ACA Premium	\$481.69	\$463.19	\$566.07	\$479.19
Difference	-10.6%	-7.8%	-15.3%	-16.9%

Who Will Be Able to Enroll in the Public Option?

The public option will be available to all Colorado residents. Any Colorado resident, statewide, will be able to purchase the public option. It should be noted, however, that persons who qualify for Medicare, Medicaid, Tricare, VA and employer-sponsored coverage may be better served by staying in those programs.

The public option will also be available to Coloradans who receive federal subsidies. Given the importance of federal tax credit subsidies to the affordability of coverage for hundreds of thousands of Coloradans, the public option will be offered as a Qualified Health Plan (QHP) through Connect for Health Colorado, the state’s Health Insurance Marketplace (the exchange). Coloradans eligible for tax credits and other subsidies will be able to utilize tax credits to purchase the public option. Licensed brokers will be eligible to be paid under the public option for their services, providing valuable guidance to consumers through the purchasing process.

The public option will be available regardless of eligibility for subsidies. All Coloradans will be able to enroll in the public option. It will be offered both on and off the exchange, although we will encourage consumers to begin the application process on the exchange to ensure that they receive any subsidies that may be available to them.

The public option will be an additional choice, alongside other options in the market. The public option will be offered alongside the plans currently offered for sale, which will increase competition and choice for Coloradans. There will not be a requirement to buy it.

Specifically, there will be a standardized public option offering for each metal tier on the exchange provided by carriers in the individual market. In other words, there will be at least a catastrophic, bronze, silver, and gold public option plan, in addition to the cost-sharing reduction variant levels for the silver plan, offered by each carrier. In practical terms, in many areas this means dozens of additional choices for Coloradans. Consumers will be able to clearly identify the public option on the exchange.

Some stakeholders expressed concerns about a lack of competition. As noted above, this recommendation brings more choice to the individual market, especially in regions where there is only one carrier offering policies now. The public option will simply create more options, not less.

What Benefits Will Be Covered?

The public option will cover Essential Health Benefits. Because the public option will be offered as a QHP, the plan will cover all of the essential health benefits covered by plans sold on Connect for Health Colorado. These benefits include hospital care, prescription drugs, maternity coverage, preventive services and mental health care. As with other plans in the individual market, preventive services such as annual check-ups, well-child visits, cancer screenings and contraceptive options will be provided at no additional cost to patients.

The public option will define more benefits that can be used pre-deductible. Many stakeholders expressed concerns with current plan offerings because high deductibles make it hard for Coloradans to access their benefits. Consumers may delay seeking more routine care due to high cost-sharing requirements. The public option will be designed to provide a greater set of high-value primary and preventive care services that individuals and families can rely on without needing to meet their deductible.

The public option will feature innovative designs. HCPF and DOI will incentivize and reward the provision, reimbursement, and utilization of high-value care, and disincentivize low-value care. For example, value based payments can be used to reward providers and carriers that address social influences of health or deliver effective interventions to prevent diabetes. Bundled payments could be used to incentivize coordination and efficiency. The public option will provide a platform that continues to transform our health care system to one that pays for value, not volume.

The Advisory Board will make recommendations on specific benefit design inclusions, enabling a coordinated, collaborative approach to achieve shared goals across the state. Non-public option plans will remain non-standardized, as carriers have expressed interest in continuing innovations through their unique plan designs.

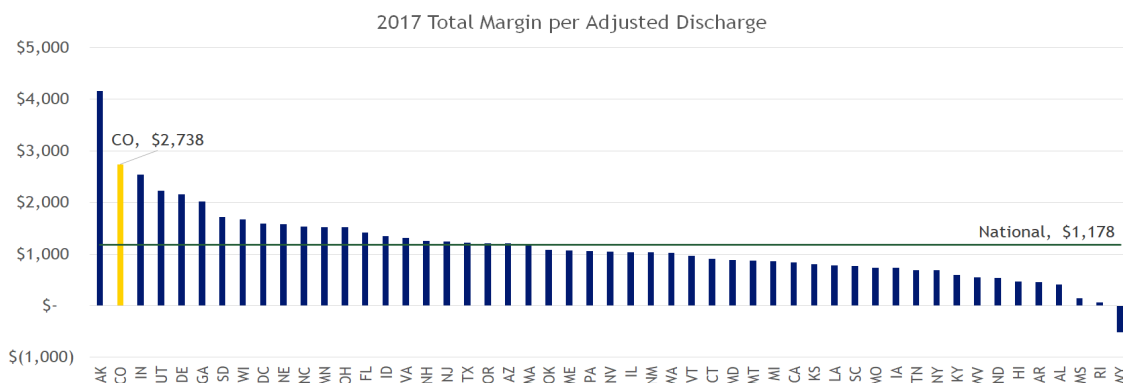
How Will the Public Option Be More Affordable?

The public option will make sure that more premium dollars go toward care. Current federal law requires that a minimum of 80 cents of every dollar collected as premium in the individual market be spent on patient care. The public option plan will increase that requirement to 85 cents, ensuring that more of a person’s premium dollar is going towards their health care. Massachusetts has taken a similar approach by requiring 88 cents of every dollar to go to care in both their combined individual and small group market. The administration is in discussions with the federal government about the increase of the Medical Loss Ratio (MLR) and will update the Legislature as we learn more.

The public option will ensure prescription drug rebates directly benefit consumers. Carriers will be required to ensure that pharmaceutical rebates and all other compensation from prescription drug manufacturers paid to carriers or their PBMs (such as market share allowances, discounts, etc.) are applied to the consumers’ benefit. This means all such compensation must be passed to consumers either through reduced overall premiums or reduced plan design cost shares. This will begin the process of correcting misaligned incentives across the system that reward middlemen for encouraging the use of higher cost drugs.

The public option will create an inpatient and outpatient hospital reimbursement fee schedule that results in savings as well as a more reasonable prices for consumers and soon small and medium employers.⁹ The main reason health insurance is so expensive is that health care itself is expensive. This is particularly true when looking at hospital prices. Hospital expenses are the largest component of health care premiums, representing between 40-50 percent of insurance premium rates.¹⁰ Colorado has some of the highest hospital prices in the nation. We rank 4th for highest administrative expenses, 2nd highest for hospital construction, and 2nd for the highest profits, according to reports filed by hospitals with the federal government.¹¹ As you can see in this chart, Colorado is surpassed only by Alaska in total margins, reflecting the excess of revenues, both patient and nonpatient related, over total operating costs.¹²

Image 5.



⁹ Effective January 1, 2016, Colorado State law defines ‘small employer’ as an employer with up to 100 employees (C.R.S. 10-16-102(61)(b)); however, many consider employers with over 50 employees as medium sized. Therefore, we reference small and medium employers here.

¹⁰ Appendix I, Wakely Actuarial Report.

¹¹ Medicare Cost Reports, data extracted by the Department of Health Care Policy & Financing in 2019

¹² Medicare Cost Reports, data extracted by the Department of Health Care Policy & Financing in 2019.

Further, hospitals spend on average only 54 cents of every dollar on patient care, based on a report released by the Colorado Hospital Association.¹³ Hospitals have an opportunity to improve affordability by increasing efficiency and the amount of money actually spent on care related activities.

This is in part because hospital reimbursement rates are set through private, individual negotiations with health insurance carriers. Hospitals have significant power in these negotiations, particularly because of their size and market share due to the increase in hospital mergers and acquisitions in Colorado over the last several years and regional monopolies and oligopolies.¹⁴ This contributes to price increases as carriers fail to control hospital reimbursements, which ultimately impact premiums or cost shares paid by consumers. The nation’s five largest insurance carriers - all serving Colorado - have failed to prevent Colorado’s hospital prices from reaching some of the highest levels across the country.¹⁵ The public option intervenes to address this problem - bringing affordability first to Coloradans who purchase their own insurance, and soon to small and medium sized businesses.

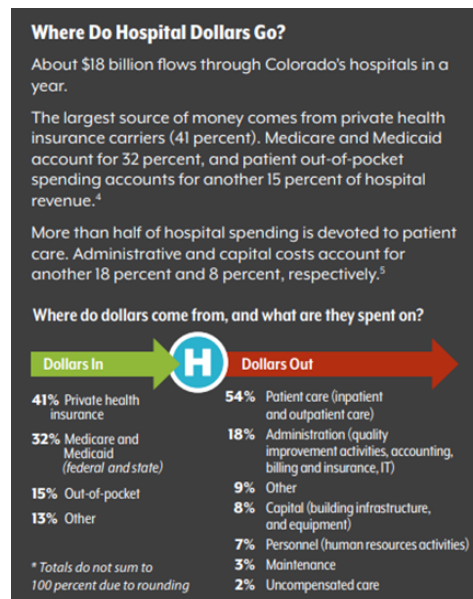


Image 6

We are proposing that the amount a hospital be reimbursed for services to patients covered by the public option be set by a **clear, public, and transparent formula**.

This formula will take into account important variables that reflect the diversity of Colorado hospitals, and will be applied on a hospital-by-hospital basis, resulting in reimbursement rates that can be expressed as a percentage of Medicare, just as reimbursement rates from private carriers can also be expressed as a percentage of Medicare. This will help improve efficiency across the state, and reduce the wild variation in prices across the state, while reining in exorbitant prices, creating savings that can be passed on to Coloradans.

Free-standing Psychiatric Hospitals, Institutions for Mental Disease (IMD), Acute Long Term Hospitals, and those hospitals licensed or certified as rehabilitation hospitals will be excluded from this formula.

The reimbursement formula will be set through a diligent and careful process. This recommendation outlines a structure for how hospital reimbursement rates should be set, and recommends that additional work be completed to ensure the methodology will appropriately

¹³ Colorado Hospital Association & Colorado Health Institute (undated). Affordability In Colorado: Answers About Health Care Costs. Available from <https://cha.com/wp-content/uploads/2018/12/Affordability-in-Colorado-Report.pdf>.

¹⁴ Ingold, J. (2017, July 4). In Colorado’s drumbeat of medical mergers, rural hospitals often trade independence for better care. The Denver Post. Available from <https://www.denverpost.com/2017/07/04/colorado-rural-hospitals-merge-with-big-city-health-economic-concerns/>.

¹⁵ White, C. & Whaley, C. (2019). Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation. Available from https://www.rand.org/pubs/research_reports/RR3033.html.

reduce prices while promoting the financial sustainability of our rural, critical-access and independent hospitals. We have initiated work with experts at Johns Hopkins University who are providing technical assistance in developing methodologies for implementation of the formula.

In our draft report, we proposed setting the benchmark between 175 percent and 225 percent of Medicare. In this final report, we are proposing that reimbursement rates be determined by a clear, public, and transparent formula, which may very well fall in that range, but importantly, will be applied on a hospital-by-hospital basis to incentivize efficiency and results.

This is because we recognize that averages do not tell the whole story, particularly in our state. For example, a rural hospital on the Eastern Plains has a profoundly different business model than larger health systems on the Front Range, which are among the most profitable hospital systems in the state.¹⁶ Many critical access hospitals throughout our state have thin margins, which limit their ability to evolve their services and capabilities in this dynamic health care ecosystem. Similarly our independent hospitals are lifelines to their communities, with missions tied to their independence.

Our goal is to reduce prices where possible, while solidifying the financial sustainability and health of providers, and so a one-size-fits-all approach simply does not fit. That is why we are proposing that we develop a public and transparent formula that takes into account numerous variables and adjusts the rate accordingly to drive market prices toward a more reasonable range over time. This latter point is critical. Hospitals represent the largest part of the health care system; a multi-year approach to achieving more rational market prices will enable the industry to properly plan and adapt.

The reimbursement formula will factor in variables like:

- a hospital's payer mix (how many of its patients are covered by Medicaid, Medicare, commercial insurance, or are uninsured)
- whether the hospital is critical access, rural, urban independent, or part of a larger system
- patient margins, total margins (which take into account investment income and other earnings), and accumulated earnings over time
- administrative expenses compared to national norms

Over the next few months, we will be considering other value-based payment models to drive behaviors that support affordability or increase investments in areas of underserved and needed care.

In addition, HCPF and DOI will conduct in-depth actuarial, cost, and margin analysis, including price modeling on unique hospitals such as critical access hospitals or independents like Denver

¹⁶ Baumgarten, A. (2019, Sept. 12). Colorado Hospitals Post Record Profits; Health Insurers are Profitable Again, Add Members. Available from <https://allanbaumgarten.com/colorado/>.

Health, Boulder Community Health, Grand Junction Community, and Parkview Medical Center to ensure that we have fully accounted for the diversity of all of our hospitals in our methods.¹⁷ Ultimately, the model will address the burdens imposed by high prices charged by some of the Front Range and mountain area hospitals, protect our independent hospitals, and help our rural and critical-access hospitals thrive. This additional analysis is expected to be finalized by early February.

This revised model allows us to achieve these goals, and it reflects stakeholder feedback that emphasized the need to put downward pressure on prices while protecting our state’s more vulnerable hospitals. This process will give us the ability to test our assumptions in partnership with our stakeholders, and avoid unintended consequences that can be identified with further analysis. Further, this process will ensure that we provide significant advance notice of the established reimbursements to allow hospitals to thoughtfully forecast the financial impact, plan, and adapt.¹⁸

We are collaborating with rural and critical access hospitals and their representatives to ensure their financial sustainability through the public option. More than 150 rural hospitals have closed across the country since 2005, according to a recent report by the Cecil G. Sheps Center for Health Services Research.¹⁹ Effectively battling this trend — and helping our rural and critical hospitals thrive — is a key consideration of the public option.

To achieve this goal, we have had numerous meetings and discussions with rural and critical access hospital leadership to better understand their challenges and to address them through the public option. Ensuring sustainability for rural and critical-access hospitals is and will continue to be a priority as we develop the reimbursement formula.

Further, the public plan design is being integrated into other state efforts that intentionally and thoughtfully boost the financial sustainability of rural hospitals. For example, HCPF is establishing a \$12 million Hospital Transformation Rural Support Fund to provide funding for rural and critical access hospitals to hire actuaries and consultants to model and implement new value-based payment methodologies; help with strategic planning to meet the emerging needs of rural communities, including their growing population of older Coloradans; secure federal and other grants; and more. The public option will work in alignment with this and many other strategies to craft solutions that help rural providers thrive, and firmly buck the national trend of rural hospital closings.

¹⁷ This includes independent urban hospitals, defined as a general hospital within an urban county not owned or operated by a health care system.

¹⁸ In the interim, we have provided an attachment of all Colorado hospitals and the variables noted above, with the exception of “accumulated earnings over time”, which is in process. Further, HB1001, Hospital Transparency, was passed into law during the 2019 legislative session. Through that legislation and the approved rules, seven years of financial information on Colorado hospitals will be provided to HCPF in January 2020.

¹⁹ The Cecil G. Sheps Center for Health Services Research, University of North Carolina (undated). 161 Rural Hospital Closures: January 2005 - Present (119 since 2010). Available at <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

How Will the Advisory Board Work?

The Advisory Board will ensure that stakeholder voices continue to inform the ongoing evolution of the public option. The Advisory Board will help continue and maximize the stakeholder talent, insights, and experience that helped craft and refine this public option recommendation, propelling the public option's long term, collaborative success. It is our recommendation that the Advisory Board be established at the DOI in a similar structure as the Primary Care Collaborative established in HB 19-1233.

The Board will advise on significant policy issues throughout the implementation of the public option, including benefits, affordability, cost control methodologies, value-based innovation, plan rates, out-of-pocket costs, and the development of quality metrics. It will ensure that the public option meets its intended goals of increasing access to high-quality, affordable coverage, and will consider how the public option can further promote affordability across the health insurance market.

We recommend that the Board benefit from a wide variety of viewpoints and reflect the diversity of the state. That will ensure that the most important constituents — Coloradans — are well-represented. We also recommend that the Board include a strong focus on diversity of consumers, specifically those who the data show have the highest barriers to accessing affordable, high-quality health care due to income, geographic location, language, race/ethnicity, sexual orientation, gender identity, or disability status.²⁰

For example, it is vital that we recognize that health care markets operate very differently in the Front Range than in many of our rural communities. As such, we need to structure the Advisory Board to grapple with these important differences perhaps through efforts like a Rural Advisory Subcommittee, or other steps. Indeed, our rural communities, rural hospitals, critical access hospitals and frontier communities have unique needs, and such needs must be uniquely addressed.

How Will the Public Option Fit In With Other Health Care Initiatives?

The public option will advance primary care in Colorado. At the same time the public option is being developed, Colorado is embarking on a process to build a modernized primary care system. The Primary Care Collaborative, created by the Legislature in 2019, will support the growth of advanced primary care practices in Colorado by ensuring that the part of the health care system that focuses on keeping people healthy to begin with has the resources it needs. The public option will align with this work by utilizing payment structures that manage chronic conditions, coordinate across providers, and support the physical and emotional health and wellbeing of all enrollees.

²⁰ National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. (2017, Jan. 11). *Communities in Action: Pathways to Health Equity*. The State of Health Disparities in the United States. Washington, D.C.: National Academies Press. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK425844/>.

The public option will leverage value-based payments and innovative delivery models that more effectively control costs. HCPF and DOI are continually working to drive health care innovation, reduce prices, and improve quality and outcomes. The public option will align with this work, particularly when doing so can promote sustainability for rural and critical access hospitals.

For example, HCPF is developing a model, in partnership with hospitals, to promote “Centers of Excellence” or “CoE,” which are concentrations of expertise and resources that support consolidated, interdisciplinary care. In rural areas, CoE is intended to help increase access to care by expanding coordinated services offered, which also propels sustainability. In areas of excess capacity and price variation, CoE can increase patient volume at the higher quality, lower cost sites, while reducing utilization of the higher cost, lower quality sites. In short, insurance premiums go down, patient outcomes improve, and hospitals that perform better grow their business. HCPF and DOI will collaborate with a variety of stakeholders to craft quality target metrics each year and related value-based payments that create the right incentives across the health care system.

The public option builds on reinsurance savings. In the 2019 Legislative session, lawmakers passed HB 19-1168, establishing a two-year reinsurance program for plan years 2020 and 2021. For 2020, the program reduced premiums 20.2 percent on average in the individual market. The State may choose to further extend the reinsurance program beyond 2021. While the public option is anticipated to go into effect in 2022, the federal waivers for both programs will take each other into account.

While no one thinks they are paying too little for health insurance, some stakeholders have asked if individual consumers need further savings through a public option, given the favorable reinsurance impact. Given that the cumulative family premium increases over the last four years on the Individual market totaled more than 80 percent (2009: \$11,952 compared to 2017: \$19,339), it is important that we continue to bring affordability solutions to Coloradans who purchase insurance in the individual market.

How Will This Impact Costs for Employers?

Special efforts will be undertaken to monitor and prevent cost shifting. Some stakeholders voiced a fear of cost shifting by hospitals onto the small and large group markets, if lower rates were established for the public option. This is because while empirical evidence in economic studies show that there is little or no relationship between the rates charges to private carriers and what hospitals receive from Medicare and Medicaid, it is superficially thought that those programs reimburse below cost, and hospitals recover that difference through increased negotiated rates with private insurance.

While this issue is raised whenever there are attempts to improve health care markets, it is important to recognize a few things. First, HB19-1004 calls for the public option to respond to both the individual and small group markets, and this report outlines a pathway to enter the

small group market as soon as possible, which helps prevent cost shifting and helps small and mid-sized businesses save money on health care.

Second, the initial impact to hospitals — over the first few years — will be quite measured. The individual market only serves about 7 percent of the state’s population at the time of this report. The transition of membership into the public option will be gradual as will the transition of reimbursement rates to the ultimate targets.

Further, by creating a public and transparent formula, employers will have an additional model to utilize in their negotiated rates. We believe that this offers employers a new tool to decrease costs.

It is important that concerns about cost shifting do not prevent us from spearheading meaningful change. In some cases where the concern is legitimate, we have policy tools to address it. But often cost shifting is raised as a way to stall efforts to disrupt the status quo — even when doing so will benefit Coloradans. We must recognize that cost shifting only happens if we let it. We invite hospitals and carriers to work intentionally and methodically to avoid cost shifting. They have partners in HCPF and DOI in doing so.

The Insurance Commissioner has additional tools to prevent cost-shifting. By publishing the public option rates, we are giving carriers, employers, business associations, and communities an important data point in their negotiations. For example, we expect that efforts like the Peak Health Alliance and other purchasing cooperatives will use this information to help lower their costs too.²¹

However, if we see cost-shifting as a result of the public option, the Commissioner has the authority to intervene. HB19-1233 provides new authority for the Commissioner to analyze the total underlying costs of care. In doing so, DOI will be able to better assess and respond to any cost-shifting attempts.

How Will This Impact the State Budget?

The public option will not put the State budget at risk. Insurance companies - not the State - will bear the risk for the payment of health claims, as they currently do in the existing Individual market.²²

The public option will require minimal State funding. It will cost about \$750,000 to launch over two fiscal years, and then less than \$1 million annually for agencies to oversee and manage the public option -- a tiny fraction of the projected savings for consumers. The public option does not require the State of Colorado to cover any costs of care, unless the Legislature specifically

²¹ Tozzi, J. & Recht, H. (2019, June 21). Colorado’s Ski Towns Could Fix the High Cost of American Health Care. Bloomberg. Available from <https://www.bloomberg.com/graphics/2019-colorado-new-healthcare-cost-plan/>.

²² Insurance carriers in Colorado are required to maintain financial reserves to ensure that all claims can be paid; their financial strength and reserve adequacy is audited and monitored by the DOI.

chooses to fund new benefits above and beyond the required Essential Health Benefits and the benefits covered by the State's benchmark plan. Minor additional funding may be required to complete the State's application for a 1332 waiver related to the public option.

Why is Medicaid Buy-In an Alternative?

Building the public option as a public private partnership is an innovative path to universal coverage. Some stakeholders suggested that the public option be built upon Medicaid's infrastructure. Specifically, it was suggested that HCPF should expand and evolve its infrastructure to administer the public option in addition to Medicaid, the Child Health Plan Plus (CHP+) program, and other safety net programs. HCPF and DOI did consider this opportunity, but ultimately decided not to pursue it at this stage because of the unique benefits of the innovative public-private partnership model.

However, building upon the strengths of our Medicaid program is a viable path forward towards universal coverage, if this recommended plan is not implemented. Indeed, HB19-1176's Health Care Cost Savings Analysis Task Force, initiated last month, could logically consider this as a back-up option. There are about 13 other states also considering some form of a Medicaid buy-in that we can learn from if this plan does not garner the required support.

The recommended approach reduces financial risks to the state budget. For HCPF to administer the State plan, the State would have to fund the start up expenses, the initial and growing reserves associated with a health plan and bear the financial risk associated with the evolving public option. This may challenge the annual State budgeting process.

What is the Role of the Division of Insurance?

DOI will maintain regulatory authority. As the primary agency responsible for regulating the private health insurance market in Colorado, DOI will continue to approve rates and plan designs of carriers and plans, including public option plans. DOI will be responsible for ensuring that the public option plans meet the benefits and rate requirements of Colorado law and regulation, while protecting the interests of consumers.

DOI currently reviews the rates that health insurance plans wish to charge on the individual market to ensure that they are justified based on the cost of providing health care and other factors. We recommend that DOI, as part of the rate review process discussed above, ensure that public option plans are complying with the established payment benchmarks - by hospital - to ensure program compliance as well as the affordability benchmark. Further, DOI will publicly report annually on and act to prevent any cost-shift through the rate review process, including cost-shifting to the large group market. This provider behavior can then be addressed through the affordability standards rulemaking process as defined in HB 19-1233.

What is the Role of the Department of Health Care Policy and Financing?

HCPF will partner with DOI to chart the goals, operational requirements, plan designs, reimbursement benchmarks, reporting and monitoring of the public option. Commercial insurers will be empowered to administer the public option.

In addition, HCPF can partner with the public option to leverage its membership volume, expertise, and resources to impact Colorado's emerging best practices in cost control strategy, alternate payment methodologies, delivery system influence, rural insights, evolving transparency reporting, and technology innovations. The public option will also benefit from HCPF expertise and best practices in hospital performance reporting, as well as claim and utilization analytics that identify carrier inefficiencies and gaps to best practices, driving carrier accountability and lower premiums to the benefit of consumers. Ultimately, this partnership between HCPF, especially Medicaid, and the public option is intended to benefit the public option, employers and all Coloradans.

What is the Role of Connect for Health Colorado?

Connect For Health will utilize its infrastructure for enrollment. Because the public option will be sold as a QHP in the individual market, Connect for Health Colorado will play a pivotal role in connecting Coloradans to the public option. Leveraging Connect for Health Colorado for eligibility and enrollment makes the best use of the state's existing marketplace, an established and known distribution channel for affordable health coverage in the state. By offering the public option, Connect for Health Colorado will further the original purpose in creating a state-based exchange – to fit the unique needs of Colorado, seek Colorado-specific solutions, and explore the maximum number of options available to the state of Colorado.

Offering the public option through Connect for Health Colorado enables the State to use the consumer-friendly shopping platform already established. Additionally, Connect for Health Colorado can more easily and quickly adapt to support the initial rollout of the public option and any future improvements to the program. Importantly, using Connect for Health Colorado ensures that those Coloradans who qualify for federal tax subsidies and cost-sharing assistance can continue to access those affordability programs.

Connect for Health will conduct outreach and marketing. Connect for Health Colorado has a State and federal mission to conduct outreach and assistance to consumers – efforts that continue throughout the year. Connect for Health Colorado works to encourage active shopping to ensure customers are finding the best coverage options available for their needs. Adding the public option to the products on the marketplace will provide the Marketplace a new opportunity to offer consumers a plan that is more affordable and designed with them in mind.

Connect for Health Colorado's outreach is achieved via multiple channels. Connect for Health Colorado partners with trusted community-based organizations to raise awareness, encourage enrollment and answer questions – an effort that includes over 400 assisters, 600 brokers, and

176 partner organizations. During Open Enrollment, Connect for Health Colorado deploys a paid and earned media plan to amplify these messages online, in the news, and via social media.

The public option will be a core element of this outreach and marketing effort, highlighting both the affordability and the new choices in current single-carrier counties. Individuals shopping for coverage on Connect for Health will be able to identify the public option plans through co-branding that includes both the brand of the public option and the carrier's brand. Licensed brokers will be eligible to be paid under the public option for their services, providing valuable guidance to consumers through the purchasing process.

Will Hospitals and Carriers Be Required to Participate?

The public option will ensure access and network adequacy. A key concern with all policies that focus on coverage affordability is ensuring a robust network of providers willing to participate. There are limited numbers of providers in certain parts of the state, and if those providers choose not to participate in the public option, the insurance carrier administering the public option may not be able to offer a product.

A successful public option will require that all stakeholders come to the table to do their part to deliver affordable health care to Coloradans. We are hopeful that providers will recognize their important role and partner with carriers to ensure adequate networks. However, if there are areas where networks are not adequate, the State could implement measures to ensure that health systems participate and provide cost effective, quality care to covered individuals. HCPF and DOI seek an open dialogue with providers and carriers in order to achieve this goal. We believe that our formula which recognizes the unique needs of independent, rural, and critical access hospitals should significantly reduce the risk of hospital disengagement.

The public option will increase statewide access and competition. Insurance carriers are a key component of the public option plan. Further, HB19-1004 instructs HCPF and DOI to consider how to increase competition through the public option. Our goal is to ensure that the public option is available statewide, and that each county has at least two carriers to ensure consumer choice as well as the competition among carriers that is necessary to drive down insurance premiums.

In the draft proposal, we recommended carriers over a certain market share be required to offer the public option. After considering stakeholder feedback, our final report recommends carriers operating in the individual market will be required to offer the public option alongside their other offerings. If the public option is available statewide and there are at least two carriers in every county, we do not believe any further action needs to be taken.

But, if this goal is not achieved, we recommend that the Commissioner be given the authority to ensure at least two carriers offer the public option in single-carrier counties. We recognize that not all carriers (for example, Denver Health) are in a position to cover all areas of the state.

Such carrier limitations will also be considered as the Commissioner decides how to best respond if there are not at least two carriers competing in each county, each year. Ultimately, the public option will increase competition between plans and provide greater choice to more Coloradans.

What Other Policy Considerations Influenced This Report?

The public option considers affordability standards. The authorizing legislation instructs us to determine a definition of affordability to guide the development and implementation of the option. Our affordability considerations included the following:

- Total out-of-pocket costs, including premiums, co-pays, co-insurance, deductibles, and out-of-pocket-maximums in the product.
- Ability to be purchased without sacrificing other budgetary priorities required for basic self-sufficiency taking into account family size, location, income level or degree of illness.

While this affordability standard acknowledges the broad goals of accessible coverage for all Coloradans, it is important to note that meeting this standard may ultimately require reliance on a variety of new funding sources such as federal waiver dollars, State funds, or other levers to realize cost savings for consumers.

The affordability standard above will align with the Division of Insurance’s affordability standards as described in HB19-1233 and developed through rulemaking throughout 2019-2020.

The public option will expand to the small group market. The cost of health insurance for small and medium-sized businesses continues to rise at unsustainable rates, placing a burden on small businesses and their employees, and reducing the number of small businesses that offer benefits. According to a recent survey administered by the Grand Junction Chamber of Commerce, 32 percent of employers do not offer health insurance coverage to their employees, and 10 percent have had to drop coverage in the last year or are considering dropping coverage.²³

While we believe the public option should be available for the small group market, we also believe it is prudent to expand the public option into the small group market after it is successfully implemented in the individual market. Fortunately, employees of businesses of any size that don’t offer health insurance will be able to purchase the public option plan sooner on the individual market regardless of income or geography. We anticipate similar carrier participation requirements that we are recommending for the individual market will also apply to the small group market as we expand into it.

²³ Grand Junction Area Chamber of Commerce (2019). 2019 Health Care Survey of Businesses. Available from <https://www.surveymonkey.com/results/SM-VLYGY93J7/>.

We also recommend allowing employers who are self-funded, preferring stop-loss protection to traditional insurance, to opt-in to the public option. This would enable them to retain the advantages of self-funding, while benefiting from the public option affordability measures. Given that carriers are administering the public option, this alternative can be readily accommodated to the benefit of all small employers and their employees.

The public option focuses on vulnerable populations. The individual insurance market is structured to ensure that all who need coverage are able to purchase a plan they can trust and can use to access coverage. However, certain populations still have challenges getting the care they need. The public option will support these groups as they seek to enroll in coverage, including low-income Coloradans, individuals with chronic diseases, persons with limited English proficiency and families with children on Child Health Plan Plus. Connect for Health Colorado's consumer assistance staff will be available to answer questions and help Coloradans navigate their coverage.

The public option will have comprehensive benefits to help patients with chronic diseases manage their care - building a more comprehensive primary care system to support the needs of patients. The public option will also recognize that as personal circumstances change, so too do coverage needs. As Coloradans move between programs, the public option will support continuity of care and the needs of Coloradans as they work to get and stay healthy.

The public option will reduce the number of uninsured and underinsured, resulting in increased coverage and reduced uncompensated care to the benefit of providers. Some stakeholders were concerned that the public option does not address the needs of the uninsured. On the contrary, it is designed to do just that.

Currently, one of the biggest reasons Coloradans are uninsured is because of the cost of insurance. Many people receive financial assistance to purchase insurance: lower income individuals have access to Medicaid, and those over 65 have access to Medicare. Employers that offer health insurance often contribute to some or all of the employee's premium. Individuals who don't qualify for Medicaid but make less than 400 percent of the federal poverty level (FPL) may be eligible to receive financial assistance through Connect for Health Colorado and federal subsidies.

Still, we have a major affordability gap for people seeking to buy health insurance on the individual market. The public option is in part crafted to lower the percent of income required to pay for individual insurance premiums for those who are not eligible for federal subsidies or financial support (earning over 400 percent of the FPL).

But we also recognize that those below 400 percent of the FPL continue to struggle to afford health insurance. In fact, the uninsured rate for portions of that population exceeds 11 percent

according to the most recent CHAS report.²⁴ Even those who can afford premiums often go without care because of high deductibles and out-of-pocket costs. As explained in more detail below, we recommend that we apply for a 1332 waiver as part of the public option program in part to target more help for that portion of the population.

Does This Proposal Require a Federal 1332 Waiver?

A 1332 waiver would result in additional cost savings, but is not necessary in order to implement the recommendation. In order to maximize affordability for Coloradans, DOI and HCPF recommend applying for a 1332 waiver to draw down federal savings that would otherwise be spent on tax credits for higher-premium QHPs absent the lower-cost public option. The lower-cost public option will reduce the amount the federal government spends on tax credits. If a state mechanism results in lower federal spending, those savings can be drawn down to the State through a 1332 waiver. Colorado took advantage of this option for its reinsurance program as well.

Colorado could then utilize these federal dollars for a variety of options that will have direct, positive impact such as:

- Lowering deductibles and out-of-pocket costs;
- Funding additional plan high-value benefits, such as dental coverage; or
- Increasing premium subsidies available to consumers.

It is our strong recommendation that upwards of 80-90% of waiver funds be applied to benefit the subsidized population. According to the most recent CHAS report, the uninsured rate in the population eligible for subsidies reaches as high as 11.8%. Stakeholders urged us to recognize that the pass through funding could be utilized to target that population to help address that problem.

As such, we recommend most of the waiver funds be directed to this population. One option includes increasing cost-sharing reductions for those between 200 and 250 percent of FPL and extending new cost-sharing reductions to the 250 and 400 percent of FPL.²⁵ Maximizing federal dollars will benefit subsidized consumers who are still struggling with high deductibles and out-of-pocket costs.

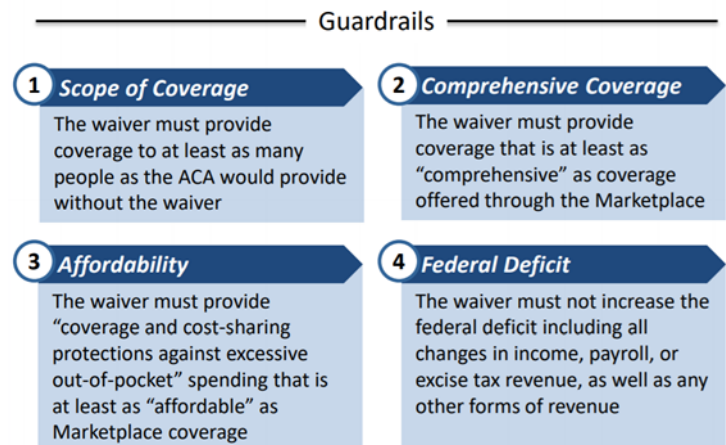


Image 7

²⁴ Colorado Health Institute (2019). 2019 Colorado Health Access Survey: Progress in Peril. Available from The CHAS Launch Powerpoint at coloradohealthinstitute.org/research/CHAS.

²⁵ Appendix I, Wakely Actuarial Report

With any remaining funds, we recommend applying it to additional rate decreases or to help with out of pocket costs for middle-class consumers above the current subsidy cliff. Alternatively, some remaining funds could potentially be utilized to fund enrollment assistance to help everyone in the individual market find coverage.

We estimate that Colorado will receive approximately \$89 million. The attached actuarial report (Appendix I) shows initial modeling for various uses of the federal dollars. Over the coming months, we will perform more modeling for the legislature's review.

What Legislation is Required to Implement the Public Option?

HB19-1004 gave HCPF and DOI the broad ability to implement a proposal for a public option. However, it is likely that the General Assembly will need to make adjustments to existing statutory authority in this upcoming legislative session to successfully implement key pieces of this proposal, including provider and carrier participation, hospital reimbursements, plan standardization, and potentially medical loss ratio adjustments and the advisory board.

We look forward to partnering closely with state legislators and the broader stakeholder community to ensure the public option proposal's success.

Timeline for Next Steps

The Administration acknowledges the need for continued robust stakeholder engagement throughout the coming years in order to implement the most effective, cost-savings public option possible for consumers -- and subsequently, for small businesses. Expected next steps are as follows.

Fall 2019

- Support legislators in developing legislation necessary to implement the public option
- Initiate actuarial analysis needed for the 1332 waiver process

Winter-Spring 2020

- Finalize Hospital Reimbursement formula
- Prepare 1332 waiver for submission
- Support legislative efforts to implement public option
- Engage stakeholders in benefit design process

Fall 2020

- Continue benefit design process
- Establish the public option Advisory Board

Winter 2021

- Submit federal 1332 waiver to the federal government
- Initiate rulemaking process for plan designs and cost-savings approaches

Spring- Summer 2021

- Carriers submit public option plans and rates for 2022 to DOI for review
- DOI completes review of public option plans and rates

Fall 2021

- Release public option plans and rates
- Begin Open Enrollment for 2022 on Connect for Health Colorado

January 2022

- Begin Public option plans coverage

June 2024

- Submit comprehensive evaluation of the first two years of the public option due to the General Assembly

Conclusion

A public option plan for affordable coverage can be achieved in Colorado through a strategic public-private partnership approach to reducing costs, aligning incentives, designing high-value benefit plans, and ensuring quality access to care for Coloradans.

This plan will use existing infrastructure for coverage - Connect for Health Colorado - and will not require the State to carry risk as a health insurer, relying instead on licensed insurance carriers to administer the plans, hold the financial risk and manage provider contracting.

Key to the plan will be a range of cost saving measures including hospital reimbursements determined by a clear, public, and transparent formula calculated on a hospital-by-hospital basis, innovations in care delivery, and increasing the amount of each premium dollar that is required to be paid out for patient care. Overall, HCPF and DOI will work together for plan administration, creating an advisory board to garner advice from stakeholders.

Throughout implementation and plan administration, the State is committed to working with the provider, carrier, and stakeholder communities across Colorado to move forward with a public option that prioritizes affordability, improves quality care, and saves Coloradans money on health care.

Appendices

Appendix I – Actuarial Analysis

Appendix II—Stakeholder Engagement Summary

Appendix III—Summary of Public Option

Appendix IV – Presentation from Draft Rollout Stakeholder Sessions

[Appendix V – Public Comments](#) (due to the large size of this appendix, at over 700 pages, it is linked online)

Appendix I – Actuarial Analysis

State of Colorado, 2022 State Coverage Option (Wakely)

Repricing of Non-Group Commercial ACA Market to Medicare Reimbursement Levels (Wakely)

State of Colorado Facility Breakeven Analysis (Wakely)

State of Colorado

2022 Public Option

November 14, 2019

Prepared by:
Wakely Consulting Group, LLC

Aree Bly, FSA, MAAA
Senior Consulting Actuary

Brittney Phillips, ASA, MAAA
Consulting Actuary

TABLE OF CONTENTS

Introduction	2
Summary	2
Results.....	3
Premium Impact of Public Option	4
Additional Take-up of Unsubsidized Members.....	5
Premium Tax Credit Pass-Through Savings of Public Option Program.....	6
Data and Methodology	8
2022 Baseline.....	8
Public Option Premiums	9
Final Pass-Through Savings Estimates	11
Adult Dental Cost Estimates	12
Cost-Sharing Wrap Estimates.....	13
Assumptions	17
Reliances and Caveats	19
Disclosures and Limitations.....	21

Introduction

As required in House Bill 19-1004, the Colorado Insurance Commissioner, along with the Department of Health Care Policy and Financing (HCPF), is developing a report to be submitted to the General Assembly in November 2019 on potential options for a public option for Colorado.¹ The Colorado Division of Insurance (DOI) within the Department of Regulatory Agencies (DORA) retained Wakely Consulting Group, LLC (Wakely) to analyze the potential effects of introducing a public option in Colorado. The report will include an analysis of a public option with estimated impacts to enrollment and premiums.

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

This document has been prepared for the sole use of DOI in conjunction with the final policy proposal that will be delivered to the General Assembly in November. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

Summary

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

1. The issuers will offer the plans on and off the Exchange in the individual market.
2. The issuers will offer qualified health plans (QHPS) at Bronze, Silver, and Gold metal tiers.
3. The premiums of the plans will reflect facility reimbursement levels that vary by facility, depending on the proportion of Medicare and Medicaid services provided by facility. Maximum reimbursement levels by facility are set at between 160% and 210% of Medicare payment rates.

¹ <http://www.leg.colorado.gov/bills/hb19-1004>

4. The plans will be offered beginning in calendar year 2022.
5. The state intends to apply for a 1332 waiver and use Federal pass-through savings for additional benefits or expanded coverage.²

The key findings of the analysis include:

1. The public option is estimated to reduce average premiums by 10.6% statewide, with reductions varying from 7.8% in urban areas to 16.9% in rural areas in the East, compared to the expected rates in 2022 based on current policies and regulations.
2. Total enrollment in the Colorado individual market is estimated to increase by approximately 5,700 members. The new members are expected to be individuals that were previously uninsured, and are a combination of unsubsidized and subsidized individuals. Changes in subsidized enrollment due to changes in APTC could impact pass-through savings. Wakely further assumed no change in employer coverage as a result of the public option for the initial year.
3. If the state follows the current ACA premium subsidy structure, we estimate that the total reduction in Premium Tax Credits in 2022 as a result of the public option, will be approximately \$88.8M under the assumptions outlined below. These amounts reflect the potential Federal pass-through savings.

Results

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

1. Issuers will offer plans that adhere to the public option requirements using their current provider networks and infrastructure.
2. Issuers will be required to offer public options and these options will become the second lowest cost silver plan (SLCSP) in every service area in the state.
3. There will be limits to reimbursement for facility services. The limits will set the maximum reimbursement for facility services by facility. These are modeled to range from 160% to

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

210% of Medicare. Professional and prescription drug reimbursement will not be impacted under the public option.

4. The benefits and actuarial value of the plans will align with ACA individual market requirements (i.e., Essential Health Benefits, metallic actuarial values (AV)). The Silver public option plan will reflect a target AV of 71.5%, while Gold and Bronze public option plans will reflect AVs in line with current individual market plans.
5. Wakely assumed the effects of the reinsurance program are unaffected by the introduction of the public option and that the reinsurance program will continue into 2022.
6. Wakely assumed that current Federal and state laws pertaining to the ACA are unchanged. The requirement for 85% MLR would apply to the issuer as a whole. Wakely assumed that the recent regulations impacting Association Health Plans and Health Reimbursement Accounts would not impact enrollment.

Premium Impact of Public Option

To estimate the impact of a public option, Wakely first estimated the enrollment and premiums in the individual market in 2022 under current state and Federal regulations. To develop the baseline, Wakely analyzed Colorado rate filings, publicly available information, rates submitted by issuers for 2019 and 2020, and the analysis performed by Lewis and Ellis for the reinsurance program that will be effective in 2020 in Colorado.³ We developed our analysis to reflect regional differences in three regions in Colorado. These regions were established to align with the regions utilized in the analysis of the reinsurance program development. The “Urban” region reflects rating areas 1, 2, and 3. The “Rural West” region reflects rating areas 5 and 9. And the “Rural East” region reflects rating areas 4, 6, 7, and 8. Once the baseline 2022 premiums were estimated and through discussions with DOI, Wakely adjusted the current individual market premiums for the public option. The adjustments reflect various facility payment rates as a percentage of Medicare and also an expected increase in AV for Silver plans to reflect the targeted 71.5% AV⁴ of the public option.

A key result of the modeling is the premium difference between the baseline 2022 ACA products and the Colorado public option in 2022. To the extent which provider behavior, individual market carrier behavior, or the public option pricing differ from expected, the results may differ. Table 1 shows the weighted average premiums of the public option for each of the regions as well as the statewide average based on the estimated distribution of members by age, rating area, and metal

³ Colorado Reinsurance Program Analysis, March 2019,
https://drive.google.com/file/d/1nREYicKQsB3zprlPLR9ztP_HSyFtlvEu/view

⁴ As measured by the 2019 Actuarial Value Calculator

level. The premium changes are assumed to similarly impact the benchmark plans for calculation of the PTC.

Table 1: Difference between 2022 Baseline Average ACA Premiums and the Public Option by Region

	Statewide	Urban - Rating Areas 1, 2, 3	Rural West - Rating Areas 5, 9	Rural East - Rating Areas 4, 6, 7, 8
Baseline Projected 2022 ACA Premium	\$538.78	\$502.28	\$668.55	\$576.40
State Coverage Option Estimated 2022 ACA Premium	\$481.69	\$463.19	\$566.07	\$479.19
Difference	-10.6%	-7.8%	-15.3%	-16.9%

Additional Take-up of Uninsured Members

Wakely estimated take-up of the public option product by currently uninsured individuals. The estimate utilized the non-linear enrollment response function estimated by the Council of Economic Advisors (CEA take-up function).⁵ We assumed that all of the growth in enrollment will come from uninsured individuals driven by the lower cost of the public option plan premiums. Additional uninsured individuals eligible for subsidies will be encouraged to take up coverage due to the potential for lower cost sharing through the cost-sharing wrap.

The population that are uninsured in the baseline but who are estimated to enroll due to lower premiums are assumed to be motivated primarily by price of the product. Thus, they are expected to have lower relative morbidity, as they are not driven to purchase coverage due to pressing health needs. Wakely estimates that the average cost of the unsubsidized individuals is 73% of the current average ACA market individual. To arrive at this factor we used data from a CEA study on the marginal costs of enrollees.⁶

⁵https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

⁶ibid

Final enrollment estimates can be seen in Table 2 below.

Table 2: Total Enrollment Estimates by Region

	Statewide	Urban - Rating Areas 1, 2, 3	Rural West - Rating Areas 5, 9	Rural East - Rating Areas 4, 6, 7, 8
Baseline Individual Enrollment	197,603	138,365	30,637	28,602
Unsubsidized Individuals - Previously Uninsured	4,711	2,437	1,117	1,157
Subsidized Individuals – Previously Uninsured	1,006	705	156	146
Estimated Total Individual Enrollment	203,320	141,506	31,909	29,905
Morbidity Impact of Previously Uninsured	-0.7%	-0.7%	-0.7%	-0.7%

Premium Tax Credit Pass-Through Savings of Public Option Program

Premium tax credits are influenced by the cost of the benchmark, or second lowest cost silver plan. We are assuming that more than one public option plan will be available in all regions, so the public option plan will become the new benchmark plan for purposes of calculating the PTCs. Although the new enrollment will not be subsidized, the current subsidized population will be impacted by the new lower benchmark plan.

The Federal PTC costs associated with the subsidized population are essentially the difference between the unsubsidized premium and the required contribution level for subsidized individuals. Wakely assumed that the 2022 contribution rate would equal the 2020 contribution rate estimated based on 2020 filed rates, trended at 2% to 3% annually. The unsubsidized premiums PMPM are as reflected in Table 1. Federal costs under the baseline and public option program are shown in Table 3 below.

Table 3: Subsidy Estimates after Introduction of a Public Option

	Statewide	Urban - Rating Areas 1, 2, 3	Rural West - Rating Areas 5, 9	Rural East - Rating Areas 4, 6, 7, 8
Baseline Scenario PTC	\$591,900,000	\$334,300,000	\$143,800,000	\$113,900,000
PTC with State Coverage Option	\$503,100,000	\$296,500,000	\$117,500,000	\$89,100,000
Pass-Through Savings	\$88,800,000	\$37,800,000	\$26,300,000	\$24,800,000

A key assumption underlying the results above are the baseline reimbursement rates in the individual market. As described below, the current reimbursement rates in the individual market

are estimated to be approximately 254% of Medicare rates, though this varies by facility and area. This estimate is based on a summary of average reimbursement levels by facility using the Colorado All Payer Claims Database (APCD) for claim payments from 2015-2017⁷ and was adjusted to reflect the individual market based on the results of a study performed by Lewis & Ellis using 2017 individual market claim payments provided to Wakely by DOI. The data underlying the APCD analysis includes all commercial claim payments, including the individual market as well as group markets.

The pass-through savings will be used to provide additional benefits to enrollees. Wakely reviewed the potential cost for adding adult dental benefits to covered benefits as well as a cost-sharing wrap that will reduce enrollees' expenses through lower deductibles, copays, and/or coinsurances. We estimate that the total cost to add both a low coverage option for adult dental and cost-sharing wrap for enrollees between 200% and 400% of the federal poverty level (FPL) is approximately \$72 million in 2022. These estimated amounts are below the expected Federal pass-through amounts. Colorado would adjust the program, as needed, to align with deficit neutrality requirements.

Table 4: Approximate Funds Needed in Year 1 (2022) for Additional Benefits

	Statewide Average	Urban - Rating Areas 1, 2, 3	Rural West - Rating Areas 5, 9	Rural East - Rating Areas 4, 6, 7, 8
Pass-Through Savings	\$88,800,000	\$37,800,000	\$26,300,000	\$24,800,000
Funds Required for Added Benefits				
<i>Adult Dental</i>	<i>\$64,690,000</i>	<i>\$45,280,000</i>	<i>\$10,020,000</i>	<i>\$9,390,000</i>
<i>Cost-Sharing Wrap</i>	<i>\$7,390,000</i>	<i>\$4,850,000</i>	<i>\$1,370,000</i>	<i>\$1,170,000</i>
Total Funds Required	\$72,080,000	\$50,130,000	\$11,390,000	\$10,560,000
Pass-Through Savings Less Funds Required for Added Benefits	\$16,720,000	-\$12,330,000	\$14,910,000	\$14,240,000

⁷ <https://www.civhc.org/get-data/public-data/interactive-data/reference-pricing/>

Data and Methodology

2022 Baseline

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

1. Initial 2019 enrollment was estimated using publicly available data and data from Connect for Health Colorado and DOI.
 - a. The number of enrollees with PTCs in 2019 was measured based on the reported number of enrollees with an Advanced Premium Tax Credit (APTC) provided by the Exchange, Connect for Health Colorado (C4HCO) as of April 2019. The number of enrollees with PTCs was assumed to be the same as the number of enrollees with APTC.
 - b. On and off Exchange enrollment for 2019 was provided by DOI as of April 2019.
2. Overall enrollment in 2020 through 2022 was estimated based on a non-linear enrollment response function estimated by the Council of Economic Advisors (CEA take-up function)⁸ based on estimated premium increases in 2020 through 2022. The function computes expected enrollment change based on premium rate increases and the portion of the market that is not receiving subsidies. As the APTC subsidy structure insulates those eligible for subsidies from premium increases, the changes in overall enrollment were distributed pro rata between on Exchange unsubsidized and off Exchange by the share of unsubsidized enrollment that the on Exchange enrollees represent.

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

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

3. State-wide average premium: Wakely used the 2020 state average premium as identified from 2020 rate filings. This amount was then increased by 2021 and 2022 estimated rate increases of 6% based on Lewis and Ellis report⁹ assumptions. The rate increases in 2021 and 2022 are driven by trend and the morbidity assumption.
4. APTC amounts per member per month for 2019 were provided by C4HCO as of June 2019. We assumed the average APTC and premium for the remainder of 2019 would not vary significantly from these values. To estimate the 2020 APTC PMPMs, we increased the required contribution (i.e., net premium) based on an analysis of the impact of the 2020 filed rates for members enrolled in June 2019. The required contribution increase was based on an equal blend of the results of two scenarios described below:
 1. All members auto-renew in 2020 and remain in the same plan as they enrolled in 2019. For members whose plans are being discontinued, if the carriers indicated these members would be cross-walked, the cross-walked plan was assumed.
 2. All members switch to the lowest cost plan offered by their current issuer and in their current metal level. This second option allows members to offset some or all of the net premium increase they may have otherwise experienced.

This blend resulted in a net premium increase from 2019 to 2020 of approximately 23% in the Urban area, -16% in the Rural West, and 6% in the Rural East.

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

Public Option Premiums

To create the estimated 2022 public option product rates, Wakely completed the following steps:

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

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

2. Adjusted Reimbursement Rates. Current facility reimbursement averages for the individual market are estimated to be approximately 254% of Medicare rates. This average was estimated based on a summary of average reimbursement levels by facility using the Colorado All Payer Claims Database for claim payments from 2015-2017.¹⁰ The overall reimbursement rate was estimated to be 268% for facilities for commercial plans. This was reduced to reflect an individual market average of 254% based on a study by Lewis & Ellis using 2017 individual market claim payments, provided by DOI.

The projected reimbursement rates vary by facility and range from 160% to 210% of the Medicare reimbursement rate. The reimbursement for each facility was determined based on the portion of inpatient days paid under the Medicare and Medicaid programs. Facilities with less than 50% Medicare/Medicaid services receive a maximum reimbursement rate of 160% of Medicare. Facilities with more than 85% Medicare/Medicaid services receive a maximum reimbursement rate of 210% of Medicare. Reimbursement rates in between 50% and 85% varied linearly in 5% increments. The baseline and resulting reimbursement rates as a percent of Medicare are shown below for the different areas.

Table 5: Assumed Reimbursement Rates as a Percent of Medicare Payments by Area

	Statewide	Urban - Rating Areas 1, 2, 3	Rural West - Rating Areas 5, 9	Rural East - Rating Areas 4, 6, 7, 8
Baseline	254%	236%	261%	317%
Public Option	175%	171%	172%	194%

3. Adjusted Silver plan AV. It is DOI’s expectation that the Silver public option plan will reflect richer benefits than that reflected by the current average Silver plan AV of 69.4%. The analysis reflects an increase to 71.5% AV. It is our understanding that this change in AV will be driven by reductions in member cost sharing relative to the current plan offerings and that there are no changes to the benefits considered EHB for purposes of calculating the APTCs.
4. Blended the metal level rates.
 - a. Gold, Silver, and Bronze rates were then blended based on the 2019 distribution of individuals in the individual market. We are assuming that there will not be any material shifting of enrollment between metal levels.

¹⁰ <https://www.civhc.org/get-data/public-data/interactive-data/reference-pricing/>

- b. Administrative items were generally held constant from the 2020 blended individual market rates. These items were found in the 2020 rate filings, and include:
 - i. Exchange fee – The public option product is assumed to be offered by carriers on and off the Exchange for the individual market. We are assuming no change from the 2020 exchange fee as a percent of revenue.
 - ii. Commissions – Commissions will be paid at a comparable level to baseline average commissions as a percent of premium. No impact to premium is assumed for commission levels in the public option relative to the current market average.
 - iii. Profit and Risk Load – Public option rate is estimated to include a load for profit or margin consistent with the margin included in current rate filings.
 - c. Additionally, 50% of the remaining administrative expenses in the rate filings was estimated to be variable. As rates decrease, the amount of variable administrative expenses included in the rates also decreases.
5. Trend 2020 final rates to 2022 – Wakely increased gross premium rates by 6%, annually, to account for the estimated changes in Colorado’s market between 2020 and 2022.
 6. Morbidity impact of the new enrollees was estimated using a Morbidity/Utilization factor calculated for Unsubsidized Individuals previously uninsured using data from a CEA study on the marginal costs of enrollees.

Final Pass-Through Savings Estimates

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

1. As discussed above, inherent in our baseline scenario development is an estimate of the APTC based on the 2019 individual market enrollment. The APTC and actual PTC are reconciled after the end of the year through enrollee’s tax returns. The PTC has historically been slightly lower than the APTCs reported. The baseline total PTC was calculated by taking the average APTC multiplied by a ratio of 0.979. This ratio was developed based on a review of the difference between APTC and PTC in Colorado’s total tax returns for 2016 as measured by data from the IRS.¹¹ The extent to which this ratio differs in future

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

years, the final PTC savings amount could also differ. Wakely assumed no material change in the APTC and PTC ratio in future years.

2. We are assuming that all carriers On-Exchange will be required to offer the public option. Therefore the second-lowest cost silver (SLCS) plan, which is used to determine the APTC in each area will be based on the premium of the public option as there will be at least two public options available and are anticipated to have a lower premium than other non-public option plans in the current market.
 - a. The estimated APTC was calculated as the difference between the projected gross premiums of the public option plans less the projected contribution rate for 2022.
 - i. The projected gross premiums with the public option plans were calculated by taking the baseline scenario gross premium estimate for subsidy-eligible members in the 2022 baseline multiplied by the estimated premium reduction for the public option plans in each reimbursement scenario. As the premium reductions vary by metal level, the estimated premium reduction was weighted based on the distribution of subsidy-eligible membership by metal level in 2019.
 - ii. While it does not impact the estimate of the pass-through savings, we assumed that 50% of subsidized enrollees would remain in their current plan offering, rather than switching to the public option plans. Therefore, the contribution rate in 2022 was increased relative to the difference in the baseline gross premium and the public option plan gross premium. This reflects that subsidized members who choose to remain in their current plan, rather than switching to the public option would see an increase in their net premium after subsidy.
 - b. Inherent in this calculation is the assumption that the subsidized member's metal level selection is not impacted by the public option and there is not significant migration by metal level and net premium is similar between both scenarios. Similarly, Wakely assumes that there is no change in the income distribution of those currently subsidized as a result of the introduction of the public option.
3. Total PTC payments are the product of the estimated PTC PMPM in each scenario (before and after introduction of the public option) and the estimated membership below 400% FPL. The pass-through is the difference between the total subsidy estimates.

Adult Dental Cost Estimates

The estimated cost for adding adult dental coverage to the individual plans was developed based on the 2020 premiums for standalone dental plans offered in Colorado. There were two coverage

levels offered in 2020, low and high, and we assume that the plans to be added will be low coverage options. Due to pent up demand that may increase utilization in the early years of the benefit, we utilized the maximum premium for each region as the base premium estimate. Premiums were trended to 2022 at 5% annual trend assumption. We estimated the total number of adults in the individual on Exchange population by applying the proportion of adults (age 19 and above) to the estimated total individual population in 2022. The table below shows the estimated PMPM costs and total costs by area for adult dental coverage by region.

Table 6: Estimated Costs for Adult Dental (Low) Coverage by Area

	Statewide	Urban - Rating Areas 1, 2, 3	Rural West - Rating Areas 5, 9	Rural East - Rating Areas 4, 6, 7, 8
Adult Dental Total \$	\$64,690,000	\$45,280,000	\$10,020,000	\$9,390,000
Adult Dental PMPM	\$29.60	\$29.77	\$29.22	\$29.22

Cost-Sharing Wrap Estimates

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

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

Wakely analyzed a cost-sharing wrap program as follows:

- Enrollees on the Exchange under 400 percent FPL would be eligible to receive this benefit. The member must enroll in a silver plan. This could encourage current off-Exchange or on-Exchange enrollees in other plans to migrate to a silver on-Exchange plan in 2022.

- The benefit would be offered through a richer plan design with lower cost-sharing (copays, deductible, coinsurance) based on varying actuarial value requirements. This is similar to the federal program which requires silver plan variants with 73 percent, 87 percent, and 94 percent actuarial values. The plan designs would be offered through different silver plan variants, which vary by FPL level. The state’s cost-sharing wrap actuarial values, and how they compare to the federal cost-sharing program, by FPL are as follows:

Table 7: Cost-Sharing – Actuarial Value Benefit Structure by FPL

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

Key takeaways include:

- **State Costs:** The estimated state funds needed for year 1 (assumed to be 2022) of the program, excluding operational costs, are approximately \$7.4 million based on Wakely’s best estimate. The program benefits do not vary based on geographic location.
- **Consumer Savings:** The estimated annual cost-sharing savings for the targeted population is \$360.
- **Consumers Impacted:** We estimate this would affect 10% of the current enrollees and result in an increase in market enrollment of 0.5% due to uninsured taking up coverage.
- There is an anticipated increase in utilization of services because of decreased cost-sharing. This would increase claim costs and, therefore, plan liability. As discussed above, issuers cover the costs incurred under the federal program. The cost-sharing wrap is estimated to increase the costs that issuers would incur under the federal program by \$100,000. Therefore, an increase to on-Exchange silver premiums may occur.

Table 8: Cost-Sharing Wrap - Summary of Consumers Impacted and Costs By Rating Area

	Statewide Total	Urban - Rating Areas 1, 2, 3	Rural West - Rating Areas 5, 9	Rural East - Rating Areas 4, 6, 7, 8
Consumers Positively Impacted	20,300	13,700	3,100	3,500
From Currently Enrolled	19,300	13,000	2,900	3,400
From Currently Uninsured	1,000	700	200	100
Cost of CSR Wrap	\$7,390,000	\$4,850,000	\$1,370,000	\$1,170,000

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

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

Once the average actuarial value change was estimated, we applied an elasticity function to determine the ultimate migration of enrollees to silver on-Exchange plans. The elasticity function is based on the published research literature – “we find the consumers' elasticity of demand for insurance generosity (AV) to be near unit elastic, with estimates of -0.90 at 150% FPL, -0.86 at 200 percent FPL, and -1.3 at 250% FPL.”¹² We assumed a flat elasticity of -1.3 for incomes above 250 percent of FPL. Further, we included muting adjustments within the migration calculations that varied by FPL level and Exchange status to reflect a range of reasonable results. Muting adjustments differed to account for lack of awareness of the cost-sharing wrap subsidies (which would depend on the level of advertisement and member education provided by the state) and the general level of inertia associated with changing a health insurance plan, among other reasons. Also, utilizers of services are more likely to be incentivized by a cost-sharing benefit subsidy compared to non-utilizers, and studies show enrollees may be more premium sensitive versus cost-sharing sensitive, which further decreases potential migration of members.

Uninsured Taking Up Coverage

The second source of the cost-sharing wrap enrollment increase is from currently uninsured individuals taking up coverage in silver plans on the Exchange. We applied the aforementioned CEA enrollment function to the pool of uninsured individuals in Colorado, as estimated, based on the member cost-sharing benefit decrease. The underlying assumption in this modeling is that the uninsured members enrolling in the on-Exchange silver plans would have similar demographics as the current silver on-Exchange members in the same income bracket, with slight morbidity adjustments noted below. The modeling resulted in an estimated 1,000 uninsured members taking up coverage on the Exchange in silver plans. This is a conservative assumption, in regards to pass-through amounts, as uninsured take-up tends to be more influenced by premiums than cost-sharing.

¹² Do Individuals Respond to Cost-Sharing Subsidies in their Selections of Marketplace Health Insurance Plans? DeLeire, T. et al. Available at http://terramedica.hsinet.com/DeLeire_CHES_Dec16.pdf.

Impact on Allowed Cost Levels

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

- Allowed claim costs were estimated based on the net premiums increased by the average federal actuarial value at the various metal levels reported in the 2020 rate filings.
- Adjustments were applied to allowed claims based on the implied morbidity of members migrating from another plan on the individual market to the silver on-Exchange plans. It's likely that, on average, more members who are higher utilizers of services may migrate for the new benefit compared to non-utilizing, healthier members. The implied morbidity was estimated based on Exchange status, FPL, and benefit richness of the cost-sharing wrap. We assumed members who migrate are less healthy than the average cohort of members in which they are migrating from; said another way, allowed claims would be X percent higher (based on varying assumptions) for a bronze member migrating to a silver on-Exchange plan compared to the allowed claims for an average bronze member.
- Then, induced demand adjustments were applied. The increased utilization factors were derived from Wakely's proprietary 2016 national ACA individual database (WACA). They were applied to allowed claims to reflect a change from the member's base period plan actuarial value, prior to any migration, to the state cost-sharing benefit actuarial value. For example, if a member migrated from a bronze plan to a silver plan and has a FPL of 340 percent (thus in the 300 to 350 percent FPL bucket), the induced demand factor would reflect a shift from an average bronze actuarial value of 60 percent to an average silver actuarial value of 70. Then, an additional 3 percent induced utilization would be assumed due to the state cost-sharing wrap which would cover 73 percent of the member's cost-sharing.
- Wakely estimated the marketwide impact to morbidity due to uninsured enrollees taking up coverage for the cost-sharing wrap program. Based on the aforementioned CEA study, new market entrants are estimated to have 27% lower morbidity than those already enrolled. This resulted in a 0.1% reduction in market average costs due to the improved morbidity of the covered population from the lower cost-sharing. Further, silver allowed claims, by FPL, and estimated cost-sharing were reduced to account for the improved morbidity.

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

As noted above, the cost-sharing wrap also impacts the overall individual market enrollment and premiums, therefore the pass-through savings calculated also depend on the cost-sharing wrap. Therefore, the table below shows the impact on the pass-through savings should only the adult dental benefit be offered. These estimated amounts are below the expected Federal pass-through amounts. Colorado would adjust the program, as needed, to align with deficit neutrality requirements.

Table 9: Summary of Pass-Through Savings and New Benefit Costs

	Include Both Adult Dental and Cost-Sharing Wrap	Include Only Adult Dental	Include Only Cost-Sharing Wrap
Pass-Through Savings	\$88,800,000	\$92,500,000	\$88,800,000
Funds Required for Added Benefits			
<i>Adult Dental</i>	<i>\$64,690,000</i>	<i>\$64,380,000</i>	<i>\$0</i>
<i>Cost-Sharing Wrap</i>	<i>\$7,390,000</i>	<i>\$0</i>	<i>\$7,390,000</i>
Total Funds Required	\$72,080,000	\$64,380,000	\$7,390,000
Pass-Through Savings Less Funds Required for Added Benefits	\$16,720,000	\$28,120,000	\$81,410,000

Assumptions

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

- Calculation of the Change in Premiums: The impact of premium changes due to a change in claims has been calculated as the estimated change in claims times 94%. This is due to the presence of fixed administrative costs.
- Average morbidity: New enrollees coming from uninsured population are assumed to be at a 0.73 relative morbidity compared to the currently insured individual population. These healthier individuals have opted out of coverage prior to the availability of a lower cost plan such as the public option.
- Percent of Claims in a Facility: Wakely used 2017 National Wakely Individual ACA data¹³ to find the percentage of total paid claims in the individual market that are facility claims. Approximately 50% of total claims are facility. Wakely assumed that this ratio would be accurate in 2022. This is lower than the 60% reflected in the Lewis & Ellis analysis. Using a higher assumption will result in higher estimated pass-through.
- Percent of Admin that is Variable: Assuming 50% of administrative expenses are variable and 50% are fixed.

¹³ <https://www.wakely.com/services/product/wakely-aca-database-waca>

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

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

Reliances and Caveats

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

- The 2018, 2019 Open Enrollment Report PUF produced by HHS^{14 15}
- Effectuated Enrollment Reports released by CMS^{16 17}
- 2020 Rate Templates and Plan Benefit Templates
- Estimated March 2018, 2019 Enrollment^{18 19}
- 2019 Enrollment, Premium, and APTC data provided by Connect for Health Colorado

¹⁴ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

¹⁵ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html

¹⁶ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf>

¹⁷ <https://www.cms.gov/sites/default/files/2019-08/08-12-2019%20TABLE%20Early-2019-2018-Average-Effectuated-Enrollment.pdf>

¹⁸ <https://www.markfarrah.com/mfa-briefs/a-brief-analysis-of-the-individual-health-insurance-market/>

¹⁹ <https://www.markfarrah.com/mfa-briefs/current-trends-in-individual-segment-enrollment/>

- Lewis and Ellis Colorado Reinsurance Program Analysis²⁰
- 2020 Issuer Rate Filings
- 2017 Wakely ACA Data
- Colorado Hospitals Reimbursement Levels by County²¹
- Summary of 2017 Inpatient Facility Days by Facility and Payer Type (Medicare/Medicaid/Other) provided by DOI
- Lewis & Ellis study of Repricing of Non-Group Commercial ACA Market to Medicare Reimbursement Levels, provided by DOI.

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

- **Data Limitations.** As discussed above, Wakely relied on high level data in Colorado. We reviewed the data for reasonability but did not perform an independent audit. Any errors in the data may materially impact the results of our analysis.
- **Political Uncertainty.** There is significant policy uncertainty. Future federal actions or requirements in regards to, income verification, silver-loading, reinsurance, or other administrative actions could dramatically change premiums and enrollment in 2022.
- **Enrollment Uncertainty.** At the time of producing this report, April 2019 enrollment data was available. To the extent 2019 attrition at the end of year varies significantly from historical rates, the estimates for 2022 will not be accurate. Individual enrollee responses to policy changes also has uncertainty. All of these factors result in uncertainty for the impacts of a 1332 waiver.
- **Premium Uncertainty.** There is uncertainty in 2022 ACA premiums and the enrollment and uncertainty on the number of uninsured. These uncertainties result in limitations in providing point estimates.
- **Medical Claim Cost Uncertainty.** Medical claims cost, especially with smaller populations, have an inherent level of unpredictability.

²⁰ https://drive.google.com/open?id=1gWS-ovi7pCeccXQT1vOckti6_SVwdPbx

²¹ <https://www.civhc.org/wp-content/uploads/2019/09/Colorado-Hospitals-with-county-and-DOI-estimated-reference-20190722.xlsx>

Disclosures and Limitations

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

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

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

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. The uncertainty is amplified given that in most instances Colorado specific data was not available. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Colorado will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of the Colorado Department of Regulatory Agencies of the Division of Insurance.

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

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. Material changes as a result of federal or state regulations may also have a material impact on the results. Changes to current Colorado practice of loading CSR amounts to Silver plans only could also impact the results. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

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

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

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

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

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication



To: Colorado Division of Insurance

From: Andrea Huckaba Rome, FSA, CERA, MAAA and Mike Brown, FSA, MAAA
Lewis & Ellis, Inc.

Re: Repricing of Non-Group Commercial ACA Market to Medicare Reimbursement Levels

1. Introduction

The Colorado Division of Insurance (DOI) within the Department of Regulatory Agencies (DORA), and the State of Colorado has retained Lewis & Ellis, Inc. (L&E) to calculate how payments to providers in the non-group commercial healthcare ACA market compare with what Medicare would reimburse providers. In other words, what “percent of Medicare” are providers being paid for the non-group ACA health insurance market?

The most expedient way to determine what the non-group market is currently paying providers is to review actual total non-group market claims and reprice these actual claims to Medicare levels. The following describes the results of this exercise, the data used, and the methodology followed.

2. Summary of Results

The table below describes the medical claims, from the All Payer Claims Database, repriced to Medicare by L&E. The results are in the last two columns. L&E recommends using the Trended % of Medicare as the most correct ratio. Since 2017 claims were repriced to 2019 Medicare levels (including using 2019 Medicare fee schedules), it is crucial to take that time difference into account. See section 3.2.3 for more detail on trending.

Using trended numbers, facility claims (inpatient + outpatient) are being reimbursed at 254% of Medicare. Total medical claims (inpatient + outpatient + professional & FFS) are being reimbursed at 227% of Medicare.

Non-Group ACA Dollars Repriced to Medicare					
	Total Allowed Dollars (2017)	Total Trended Allowed Dollars (2019)	Total Repriced Allowed Dollars (2019)	% of Medicare	% of Medicare Trended
Inpatient	\$284.9M	\$317.7M	\$142.4M	200%	223%
Outpatient	\$400.7M	\$446.8M	\$158.8M	252%	281%
Professional & FFS	\$446.4M	\$497.8M	\$254.6M	175%	196%
Total Facility	\$685.6M	\$764.5M	\$301.1M	228%	254%
Total Medical	\$1.13B	\$1.26B	\$0.56B	204%	227%

3. Data and Methodology

3.1 Data

For this repricing, the following data sources were used:

- 2017 Non-Group Market claims and demographics in the Colorado All Payer Claims Database (APCD), provided by the Center for Improving Value in Healthcare (CIVHC)
- Carrier 2019 rate filings submitted in 2018
- Medicare FFS, OPSS, and IPPS reimbursement details, from CMS

3.2 Methodology

3.2.1 Claims

Repricing focused on claims incurred in 2017, that is those with service start dates between January 1, 2017 and December 31, 2017 and paid through November 30, 2018. Claims Data were provided by the Center for Improving Value in Health Care (CIVHC). Data included claims with service dates from January 1, 2016 through October 31, 2018 and paid through November 30, 2018. CIVHC provided claims filtered on the non-group market in Colorado.

L&E further filtered the data by removing any commercial Medicare non-group market data. After validation, they removed claims associated with members with a Market Category Code not equal to "IND", for all carriers but Cigna and Kaiser. The market category code did not align with member months for these two carriers. In addition, we removed any member that was listed as being enrolled in a Grandfathered plan in 2017.

L&E also filtered our report to include only those carriers providing coverage in the ACA non-group market. That is, we limited our claims to include only Anthem, Bright Health Plan, Cigna, Denver Health, Friday Health Plans, Kaiser, and Rocky Mountain HMO. After repricing, Denver Health was also removed, as their claims did not contain the necessary fields to properly reprice for outpatient and professional claims. Denver Health's medical claims were less than 0.3% of the total medical claims in 2017. Removing this carrier will not have a material impact on the total result.

We did not apply claims completion factors to the data in order to capture claims run-out. The data used has eleven months of hindsight, that is, claims incurred through December 2017 and paid through November 2018. In other words, the last service month is December 2017 while the last paid date is eleven months later, November 2018. Annual Medical and Pharmacy claims, based on a sampling of L&E commercial carriers, are on average 99.9% complete after eleven months and therefore, estimating claims without completion factors does not have a material impact on this study.

The total allowed claims reported from the CIVHC data, as filtered above, amounted to \$1.391B. The total allowed claims filed by the carriers noted above (including pharmacy claims) amounted to \$1.371B, a difference of 1.5%. The amount filed by the carrier was taken from the 2019 Unified Rate Review Template (URRT) section 1 claims which represents 2017 experience. There could be various reasons why these amounts do not reconcile such as: claims run-out (completion), URRT filed reported on various bases (with or without risk adjustment for example), or CIVHC data capturing other non-group commercial medical coverage. This data uncertainty may lead to a non-material variation in results.

3.2.2 Claims Repricing

All Medical Claims incurred in 2017 were repriced. Pharmacy claims were not repriced. CIVHC 2017 facility and professional claims were repriced using 2019 Medicare pricing models developed by L&E. The L&E model is developed using software, tables and documentation publicly available on the CMS website. L&E models are validated against a CMS 5% limited data set filtered on Colorado providers (this set is available for purchase through CMS).

If Medicare pricing produced a \$0 allowed amount, or the model was unable to price the claim due to a noneligible provider, then the allowed amount used was the actual. For inpatient claims, this represented 2.4% of claims. For outpatient and professional claims, the percent was negligible. Providers that were out of state were not repriced and allowed amount remained unchanged. For inpatient, this represented 4.4% of claims. For outpatient and professional, this was negligible. This method of allowed dollars “passing through” is conservative; repriced dollars in this study might be larger than actual Medicare-level costs. This conservatism may cause the actual “percent of Medicare” to be slightly higher than what is presented here.

For DRGs that were in the 2017 data set and retired by 2019, we replaced the DRG with an appropriate, yet higher cost 2019 DRG. The replaced DRGs are listed below.

2017 DRG	2019 DRG
765	783
766	788
767	796
774	805
775	806
777	760
778	761
780	761
781	811
782	833

3.2.3 Trending

2017 allowed claims are trended to 2019 using the average annual trend factor used in the carrier rate filings reduced by 1%, that is we assume actual trend is 1% lower and this is a margin/PAD component. The resulting trend is 5.6% allowed medical claims trend. L&E considered trending, because the most recent Medicare reimbursement parameters include fee schedules on a 2019 basis. If a trend is not included, the Medicare reimbursement will be higher, compared to the commercial market, than it would be on a same-year basis. We have shown results with and without trend for comparison.

3.2.4 Final Calculation

Resulting total repriced Medicare level claim dollars for each carrier were compared to total allowed dollar amounts (that is, the negotiated discounted rate paid by the carrier, before adjusting for member cost-sharing). The “percent of Medicare” value was calculated as:

$$[\text{Total Allowed Dollars}] \div [\text{Total Medicare Level Allowed Dollars}] = \text{Percent of Medicare}$$

These results varied between carrier.

For inpatient facility claims, trended reimbursement ranged from 197% of Medicare to 306% of Medicare. For outpatient facility claims, trended reimbursement ranged from 194% of Medicare to 340% of Medicare. For Fee-for-Service and all other Professional claims, trended reimbursement ranged from 153% to 241% of Medicare.

4. Disclosures

4.1 Intended Users, Scope, and Purpose

This information has been prepared for the Colorado Division of Insurance (DOI) within the Department of Regulatory Agencies (DORA), and the State of Colorado to support analysis of provider payments and investigate the possibility of a public option. The report should be reviewed in its entirety by qualified individuals. Parties reviewing this information should retain their own actuarial experts when interpreting results. It should not be used for any other purpose.

4.2 Qualifications

Andrea Huckaba Rome and Mike Brown are the actuaries responsible for this communication. They are Fellows of the Society of Actuaries (FSA) and Members of the American Academy of Actuaries (MAAA) in good standing. They meet the Qualification Standards required to issue this report.

4.3 Risk/Uncertainty

The assumptions and results outlined in this report are inherently uncertain.

The data repriced was 2017 claims, which may vary from claims that will occur in 2020 and beyond, for which these numbers are being used.

Data was submitted by all non-group commercial insurance carriers to the All Payer Claims Database (APCD). This data was validated against 2017 experience claims and membership submitted by carriers in their 2019 URRTs. The data was reviewed adhering to the principles of Actuarial Standard of Practice (ASOP) 23 on Data Quality. To the extent that fields within the APCD (including unit counts, DRG groupings, procedure codes, etc.) are incorrect, they may affect the overall result of this analysis. The actuary has outlined any uncertainties discovered in the methodology section and does not believe they have a material impact on results.

L&E used an internal set of models to reprice commercial claims to Medicare. These models have been validated and peer reviewed but may not capture every nuance of Medicare reimbursement. These small details do not have a material impact on results. The models may also make conservative adjustments when claims do not translate to Medicare reimbursement. Please review the methodology section to understand these adjustments.

Actual results may vary for future Commercial to Medicare ratios, and L&E does not guarantee that predicted results will be realized. Any review an application of this report should be done with care by qualified professionals.

4.4 Conflicts of Interest

The responsible actuaries list above are financially independent and free from conflict related to this report and the supporting analysis performed for this study.

4.5 Data Reliance

L&E relied upon data provided by the Colorado Division of Insurance, the non-group ACA market carriers in Colorado, the Center for Improving Value in Healthcare (CIVHC), and several US Federal Government data sources, listed in our data section. L&E has reviewed the data and assumptions for reasonableness but has not performed an independent audit. To the extent that information provided is inaccurate or incomplete, the analysis could be materially impacted. For a list of data sources, please see Section 3.1 of the report. Key assumptions are outlined in the methodology section.

4.6 Dates Applicable

This report was prepared in November 2019 and reprices the ACA non-group marketplace 2017 claims experience to a 2019 Medicare reimbursement level, using the most recent Medicare parameters. The data is useful for predicting the next few years of “percent of Medicare”. The timeframes used should be carefully considered by qualified experts before applying to any new analysis.

4.7 Subsequent Events

This report and the analysis provide herein are based on conditions specific to the ACA non-group marketplace in Colorado, as of 2017, and the CMS Medicare pricing factors, as of November 2019. The repricing assumes no changes to the population, the mix of services, mix of payers, mix of providers, or Medicare payment factors. These subsequent events are not included in this report and should be carefully considered by qualified experts before applying the findings contained within this report.

STATE OF COLORADO
FACILITY BREAKEVEN ANALYSIS

NOVEMBER 2019

Prepared by
Lewis & Ellis, Inc.

Table of Contents

Section 1: Introduction..... 3
Section 2: Summary 4
Section 3: Facility Profit Margins, Reasonableness Checks and Observations 6
Section 4: Disclosures and Limitations..... 9

Section 1: Introduction

The Colorado Division of Insurance (DOI) within the Department of Regulatory Agencies has retained Lewis & Ellis, Inc (L&E) to calculate the payment rate for commercial payers that would be necessary for a facility to “break even” given various payer mixes. What follows is an explanation of the analysis performed.

Facilities receive payments from three major sources: Medicare; Medicaid and Other, where the majority of this last category is commercial payers. The results will be illustrated based on this assumed mix of payers.

Payments will be shown as a percentage of what Medicare would have paid for that service. It is common that Medicare and Medicaid payments do not cover facility cost and therefore commercial payments are higher, in relation to Medicare, in order to cover all cost and margin. For example, it is not uncommon for facility payment for commercial products to be 2.5 times what Medicare would pay, or 250% of Medicare.

Payment to cost ratio is a term that represents the ratio of the payment a facility receives from a payer compared to the cost of offering the healthcare product or service. So, for example, if Medicare pays \$89 for a service that costs the provider \$100 to offer, then the Payment to Cost Ratio is 0.89. For a facility to break even, they must receive payments equal to 100% of their costs, or a payment to cost ratio of 1.00.

Exhibit 1 provides a sample illustration of what the break-even point would be given a particular mix of revenue and payment to cost ratios. If we assume a facility revenue mix of Medicare, Medicaid and Commercial/Other is 30%/30%/40% respectively and the payment to cost ratio for Medicare and Medicaid is 0.89 and 0.88. Then the payment to cost ratio required to breakeven is 1.17¹ and the estimated payment as a percent of Medicare for commercial is 131.7%².

Exhibit 1: Hypothetical Facility Breakeven Example

Payer	Percent of Revenue	Payment as a % of Medicare	Payment to Cost Ratio
Medicare	30.0%	100.0%	0.89
Medicaid	30.0%	99.0%	0.88
Commercial/Other	40.0%	131.7%	1.17
Breakeven Total	100.0%	112.4%	1.00

Therefore, in order to determine a commercial payment (as a percent of Medicare) that will allow the facilities to break even, this study will have to determine:

- The appropriate payment to cost ratios for each payer
- The appropriate mix of revenue from each payer

¹ Breakeven payment to cost of 1.17 determined such that weighted average of revenue and payment to cost by payer is 1.00 overall

² In this hypothetical example Medicare covers \$0.89 for every \$1.00 cost. L&E estimation in this paper assumes other payers would also cover the same Medicare cost (in this case \$0.89) for every \$1.00 cost if priced to Medicare, so Commercial/Other would cover $\$1.17 / \$0.89 = 131.7\%$ as a % of Medicare. Reasonableness of this assumption is illustrated in section 4.

Section 2: Summary

Exhibit 2 illustrates payment to cost ratios for Colorado facilities compared to the national average. The Medicare national average is 0.89 and Colorado is 0.69. On average, this indicates Medicare pays 20% more of facility cost across the nation, compared to Colorado. There are various reasons why Medicare covers less for Colorado than the rest of the nation. This could include:

- Newly constructed facilities or technology driving higher expenses
- New and older facilities not filling bed days
- More facilities per capita creating higher overhead
- Integration through acquisition can increase overhead cost (and increase bargaining power)
- Mix and or severity of services due to population dynamics not captured in the Medicare PPS
- Hospital employee count, distribution by job type and salaries

Exhibit 2: Colorado Facility Payment to Cost Ratios

Payer	Colorado	National Average
Medicare	0.69 ³	0.89 ⁴
Medicaid	0.69 ³	0.88 ⁵
Commercial/Other	1.56 ³	1.45 ⁵
Commercial/Other as a % Medicare	226% ³	163%

The State of Colorado asked L&E to perform a breakeven analysis assuming Colorado facilities could achieve the national average for Medicare reimbursement.

We reviewed 2018 payer mix by inpatient bed days for facilities⁶. L&E used payment to cost ratios to translate the ranges of inpatient days mix to ranges of revenue by payer mix. These results indicate that if facilities operated at national average payment to cost ratios for Medicare and Medicaid, then the breakeven percent of Medicare would range from approximately 116% to 142% for Commercial/Other payers. Exhibit 3 illustrates the range for various hypothetical payer mixes by facility.

³ Summary of 2017 calendar year Colorado Hospital information provided to the Department of Health Care Policy and Financing by the Colorado Hospital Association (CHA). Originally published in Cost Shift Analysis Report, January 2019 – DRAFT, Colorado Healthcare Affordability and Sustainability Enterprise. In the Colorado example we assume other payers would also cover the same Medicare cost (in this case \$0.69) for every \$1.00 cost if priced to Medicare, so Commercial/Other would cover $\$1.56 / \$0.69 = 226\%$ as a % of Medicare. Other payers include indigent care, self pay/uninsured and government programs (Tricare for example). Other represents 18.9% of the total cost in the Commercial/Other category and estimated payment is 165% of Medicare.

⁴ March 2019 Report to the Congress, Medicare Payment Policy, MedPAC. Report estimates Medicare margin will decline from 9.9% to 11% in 2019. This translates to 0.89 payment to cost ratio <http://medpac.gov/-documents-reports>

⁵ 2016 values from Appendix 4. https://www.aha.org/system/files/2018-05/2018-AHA-Chartbook_0.pdf

⁶ Colorado Health Market Review 2019, Allan Baumgarten, <https://allanbaumgarten.com/product-category/colorado/>

Exhibit 3: Commercial Breakeven - Traditional Hospitals

Facility Scenario ->	1	2	3	4	5	6	7	8	9	10
Percent Revenue from Medicare	10%	15%	20%	25%	20%	30%	20%	30%	40%	45%
Percent Revenue from Medicaid	10%	10%	10%	10%	20%	20%	30%	30%	20%	25%
Percent Revenue from Commercial/Other	80%	75%	70%	65%	60%	50%	50%	40%	40%	30%
Commercial/Other Breakeven as a % of Medicare	116%	117%	118%	119%	121%	125%	125%	132%	131%	142%

In addition, L&E analyzed a breakeven analysis for Critical Access Hospitals (CAH). CAHs typically are smaller rural hospitals that require higher payments to cover a larger per capita overhead. CAHs are reimbursed at 99% of allowable cost (101% less 2% sequestration)^{4,7}. As noted earlier, we reviewed 2018 payer mix by inpatient bed days for particular CAHs⁶ and used payment to cost ratios to translate the ranges of inpatient days mix to ranges of revenue by payer mix. These results indicate that if CAHs operated at 0.99 payment to cost ratio for Medicare and national average for Medicaid, then the breakeven percent of Medicare would range from approximately 102% to 126% for Commercial/Other payers. Exhibit 4 illustrates the range for various hypothetical payer mixes by facility.

Exhibit 4: Commercial Breakeven - Critical Access Hospital

CAH Scenario ->	1	2	3	4	5	6	7	8	9	10
Percent Revenue from Medicare	20%	30%	50%	45%	65%	65%	60%	15%	80%	25%
Percent Revenue from Medicaid	5%	10%	5%	10%	5%	5%	10%	45%	10%	50%
Percent Revenue from Commercial/Other	75%	60%	45%	45%	30%	30%	30%	40%	10%	25%
Commercial/Other Breakeven as a % of Medicare	102%	104%	103%	105%	105%	105%	107%	115%	121%	126%

⁷ Critical Access Hospitals Payment System, Revised October 2019 http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_cah_final_sec.pdf?sfvrsn=0

Section 3: Facility Profit Margins, Reasonableness Checks and Observations

Given the various sources of data used in this report, it is prudent to review for reasonableness. This section provides alternate data points and explanations to provide such a check. As Exhibit 5 illustrates, Colorado facility margins have been 15.9% and 16.7% in 2017 and 2018⁶.

Exhibit 5: Facility Net Income as a Percent of Revenue

Location	2016	2017	2018	2018 Net Income
Denver	13.6%	16.1%	18.4%	\$2,104,296,024
Other		11.7%	13.6%	\$822,775,731
Combined		15.9%	16.7%	\$2,927,071,755

L&E priced 2017 Individual ACA market on a Medicare basis using the Colorado All Payers Claims Database⁸. We estimated this using 2019 Medicare fee schedules and PPS models⁹. We estimated this using 2017 claims trended at 0% to 2019 and claims trended at expected trends per 2019 rate filings (5.6%).

The results yield an individual payment between 228% and 254% of Medicare as summarized in Exhibit 6. L&E expects the non-zero trended results to be more reasonable, and therefore commercial claims are expected to be closer to payments at 254% of Medicare.

Exhibit 6: Individual Insurance - Facility Net Income as a Percent of Revenue

Non-Group ACA Dollars Repriced to Medicare					
	Total Allowed Dollars (2017)	Total Trended Allowed Dollars (2019)	Total Repriced Allowed Dollars (2019)	% of Medicare	% of Medicare Trended
Inpatient	\$284.9M	\$317.7M	\$142.4M	200%	223%
Outpatient	\$400.7M	\$446.8M	\$158.8M	252%	281%
Total Facility	\$685.6M	\$764.5M	\$301.1M	228%	254%

In addition, we reviewed employer sponsored insurance (ESI) payments from the Rand study¹⁰. See comparisons in Exhibit 7.

⁸ Colorado All Payers Claims Database administered by the Center for Improving Value in Health Care (CIVHC) <https://www.civhc.org>

⁹ Lewis & Ellis report to Colorado DOI, Repricing of Non-Group Commercial ACA Market to Medicare Reimbursement Levels

¹⁰ 2015-2017 Calendar years. Rand Corporation Research Report, Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely

Exhibit 7: Hospital Revenue as a Percent of Medicare, Colorado Commercial Insurance

Location	2019 Colorado Individual Market (0% trend)	2019 Colorado Individual Market (5.5% trend)	Colorado Employer Sponsored Insurance	Colorado Employer Sponsored Insurance (Non-CAH)	Colorado Employer Sponsored Insurance (CAH)
Facility Inpatient	200%	223%	219%	222%	199%
Facility Outpatient	252%	281%	336%	345%	296%
Total Facility	228%	254%	262%	265%	247%

There are a few observations worth noting from Exhibit 7. First, we see that Individual insurance is expected to pay less than ESI for total facility. This makes sense, considering individual insurance has a higher portion of narrow networks and HMO products which reimburse at lower rates. Compare this to PPO products, which are more prevalent in ESI. Also note that Non-CAH facilities reimburse 23% higher and 49% higher, as a percent of Medicare, for inpatient and outpatient respectively. This is reasonable given the higher payment levels for CAH Medicare that CAH ESI would be able to charge less.

If revenue distribution remains the same between 2017 and 2018; and Medicare and Medicaid payment to cost ratios remain the same; then Commercial/Other would need to be paid at 254.1% of Medicare to reach a 2018 profit level of 16.7% as noted from exhibit 5. When considering the ranges in exhibit 7, the profit margins and percent of Medicare payments discussed in this section are reasonable.

Exhibit 8: Colorado Percent of Medicare Check

Payer	Percent of Revenue ³	Payment as a % of Medicare	Payment to Cost Ratio
Medicare	33.5%	100.0%	0.69
Medicaid	21.6%	100.0%	0.69
Commercial/Other	44.9%	254.1%	1.75
Total	100.0%	169.1%	1.167

As noted in Section 2, Colorado facilities are reimbursed a much lower portion of their expense compared to the national average (20%). There are many reasons for this. As Exhibit 9³ illustrates, Colorado facility operating expenses per discharge are 15.1% higher than the national average, which aligns with higher payment to cost ratio.

From Section 2, integration through acquisition can increase bargaining power, leading to increased profits. It does stand to reason that the illustrated profits and growth in Exhibit 5 and Exhibit 10³ may be attributable to this phenomenon. Exhibit 10 also indicates that Colorado facilities have grown profits at a much faster pace than the national average. As a point of reference, given the values in Exhibit 8, if average facility margin were close to recent historical averages of 7.8%, then commercial payments would be lowered approximately 11.5%⁴.

Exhibit 9: Operating Expense per Adjusted Discharge, Colorado and National

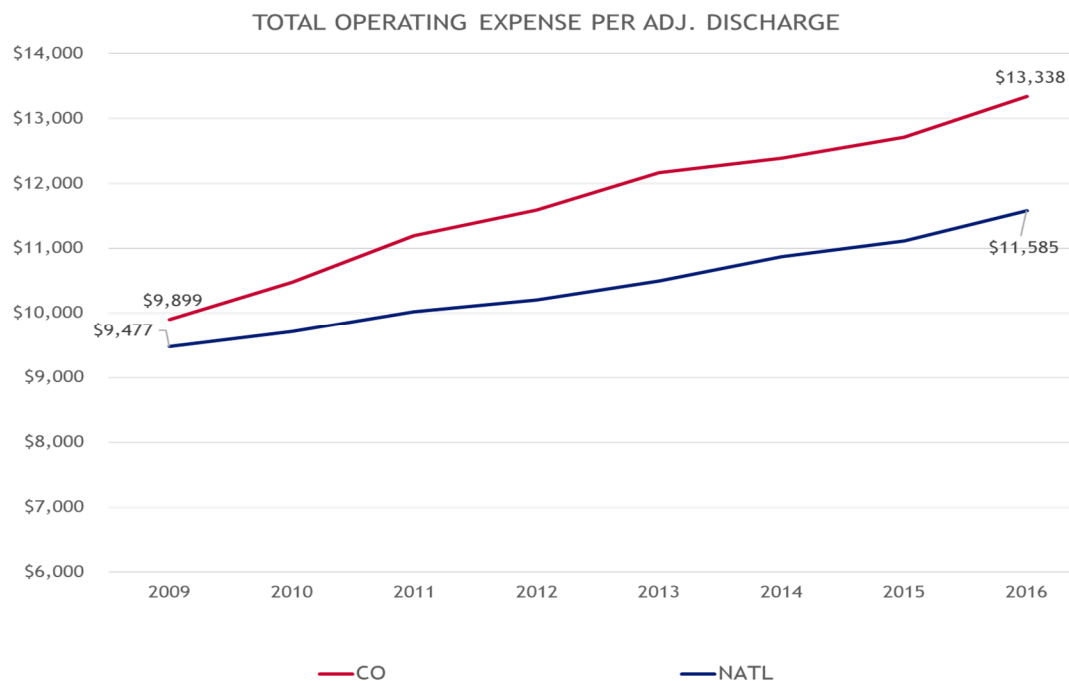
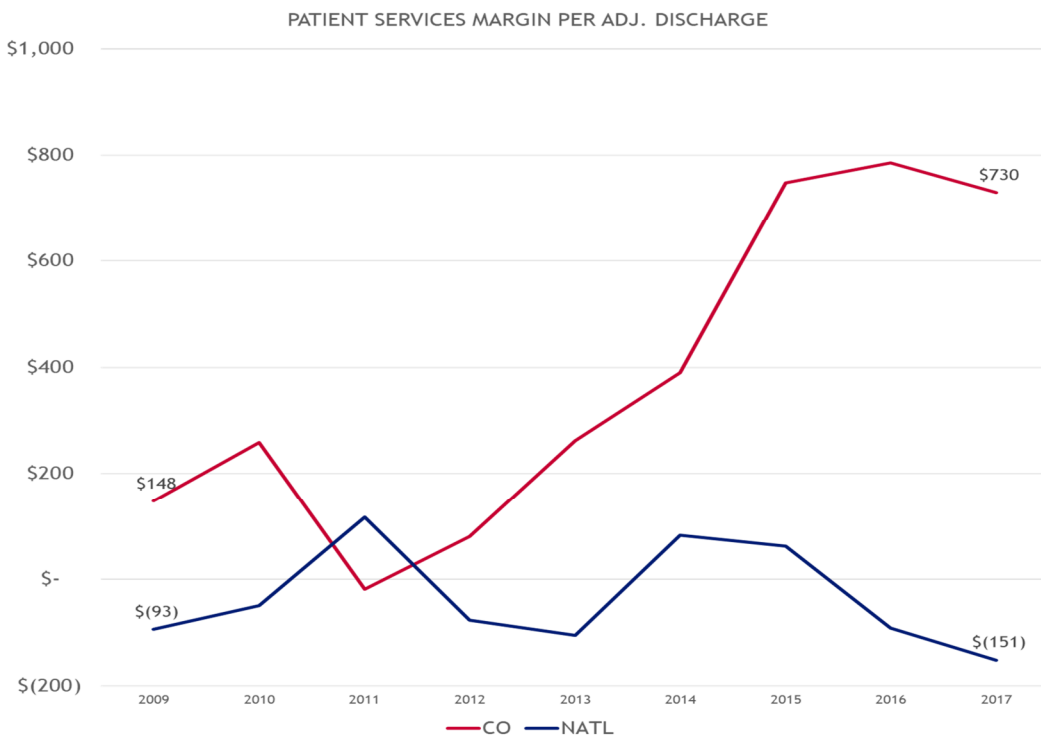


Exhibit 10: Margin Per Discharge, Colorado and National



Section 4: Disclosures and Limitations

4.1 Intended Users, Scope, and Purpose

This information has been prepared for the Colorado Division of Insurance (DOI) within the Department of Regulatory Agencies (DORA). The report should be reviewed in its entirety by qualified individuals. Parties reviewing this information should retain their own actuarial experts when interpreting results. It should not be used for any other purpose.

4.2 Qualifications

Mike Brown and Andrea Huckaba Rome are responsible for this communication. Mike and Andrea are Fellows of the Society of Actuaries (FSA) and a Members of the American Academy of Actuaries (MAAA) in good standing. They meet the Qualification Standards required to issue this report.

4.3 Risk/Uncertainty

The assumptions and results outlined in this report are inherently uncertain. Among other items, change in medical costs over time, changes in facility contracts and percent of Medicare assumptions would require further analysis and more recent experience to price more accurately.

4.4 Conflicts of Interest

The responsible actuaries list above are financially independent and free from conflict related to this report and the supporting analysis performed for this study.

4.5 Data Reliance

L&E relied upon data provided as noted in the body of this report. L&E has reviewed the data and assumptions for reasonableness but has not performed an independent audit. To the extent that information provided is inaccurate or incomplete, the analysis could be materially impacted.

4.6 Dates Applicable and Subsequent Events

This report and the analysis provide herein are based on conditions specific to the health care market in Colorado, specific to the dates from the data sources as noted in this report. The report assumes no uncertain and potential future changes to the Affordable Care Act, the healthcare marketplace, Medicare payments, Medicaid Payments and Facility cost that could materially impact results. There may be future developments that could materially change these results including court rulings, new regulations, using more recent data, updated facility contracts and margins, or a material change to the healthcare markets in general. These subsequent events are not included in this report and should be carefully considered by qualified experts before applying the findings contained within this report.

Appendix II—Stakeholder Engagement Summary

Public Option Stakeholder Engagement Summary

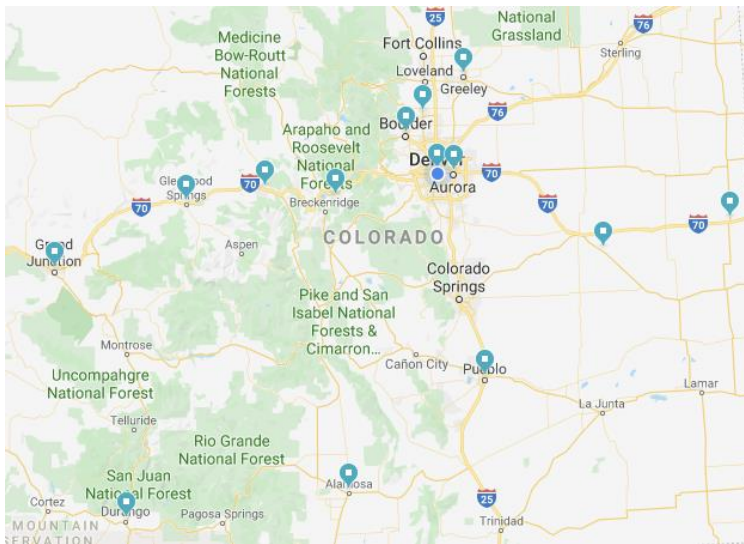
Requirements of the HB 19-1004 Legislation:

In developing the proposal, the State Department and the Division shall consult with the Colorado Health Benefit Exchange and shall engage in a stakeholder process that includes public and private health insurance experts, as well as consumers, consumer advocates, employers, providers, and carriers.

The Colorado Division of Insurance (DOI), Department of Health Care Policy and Financing (HCPF), and the Lieutenant Governor worked diligently to ensure a comprehensive and collaborative stakeholder process. This included holding two comment periods, releasing a draft report, and a number of other stakeholder engagement opportunities:

- 260** Stakeholder Letters Received
- 20** Public Option Stakeholder Meetings
- 3** Uninsured and Underinsured Focus Groups (*Appendix II of Draft Proposal*)

Map of May - November Stakeholder Meetings



Public Information Access

- HCPF and DOI created public-facing websites with all meeting materials posted.
- An email address for public option comment submission was created and monitored.
- A webinar of the draft proposal meeting was recorded for those unable to attend meeting in person.

Language Access

- All public meeting materials, the Draft Proposal, and Final Report were translated to Spanish.
- Two stakeholder meetings held focusing on engaging immigrants and Spanish speakers.

Appendix III—Public Option Overview



Summary of the Public Option Proposal

- The public option plan is initially designed for the individual market, with a later expansion to the small and medium sized business (under 100 employees).
- Coloradans in the individual market are projected to save an average of 10%+ on premiums. In high cost areas of the state, like the Western Slope the savings will be more than 15%.
- This is a public-private partnership model-health plan will offer the plan and bear financial risk, while the state sets the parameters.
- The hospital reimbursement formula will take into account the unique financial models and challenges of many of our hospitals so that we:
 - protect rural and critical access hospitals
 - allow for profitable care delivery on the Front Range
- 80 to 90 percent of any federal pass through funding will be applied to reduce costs for people who are eligible for subsidies.
- An Advisory Board will maximize stakeholder engagement and collaboration.

<u>Colorado’s Public Option for Affordable Coverage: Key Components</u>	
What kind of outreach was done to develop the Public Option?	<ul style="list-style-type: none"> ● 20 public stakeholder meetings were held across Colorado Alamosa, Aurora, Boulder, Burlington, Denver, Durango, Edwards, Glenwood Springs, Grand Junction, Greeley, Hugo, Keystone, and Pueblo ● 260 comment letters received ● Website with all materials posted and email address for inquiries and feedback
Who will oversee the Public Option?	<ul style="list-style-type: none"> ● We are recommending that The Colorado Department of Health Care Policy and Financing and the Colorado Division of Insurance will oversee and set the requirements for the Public Option.
Who will administer the Public Option?	<ul style="list-style-type: none"> ● Licensed insurance carriers will administer the Public Option plans, hold the financial risk and financial reserves, and contract with care providers. ● Every carrier in the individual market -- but not all carriers -- will be required to offer this option, to spread both the opportunity and the risk. The Commissioner will work with carriers to ensure at least two carrier options in each county, to increase competition and choice for consumers. If that is unable to be achieved through collaboration, we recommend that the Commissioner have the authority to mandate carrier participation in single carrier counties.
How much will the Public Option save Coloradans?	<ul style="list-style-type: none"> ● Statewide, people will save an average of 10% on their health insurance premiums. In high-cost areas of the state, like the Western slope the savings will be more than 15%. This is on top of reductions resulting from reinsurance. ● Additional savings on out-of-pocket costs will be achieved through a federal waiver that may bring an additional \$89 million of savings to consumers. We recommend that the additional savings be primarily targeted to help lower costs for the subsidized population.



<p>Why will the Public Option be more affordable?</p>	<ul style="list-style-type: none"> ● Insurance carriers will be required to utilize 85% of the money they collect in premiums to pay for patient care. ● All prescription drug rebates and other compensation paid by drug manufacturers to insurance carriers must be used to reduce the price of individual policies. ● Providers will be reimbursed at a rate set by a hospital-specific formula that takes a number of factors into consideration such as each hospital’s unique payer mix. This rate will continue to allow for profitable delivery of services, while reigning in exorbitant rates. ● There will be a special focus through this process to ensure rural, critical access and urban independent hospital sustainability.
<p>Who can buy these plans?</p>	<ul style="list-style-type: none"> ● Initially, all Colorado residents statewide who buy their own health insurance in the individual market. After a successful implementation in the individual market, we recommend that the product also be made available in the small group market.
<p>Where can Coloradans buy these plans?</p>	<ul style="list-style-type: none"> ● Public Option Plans will be sold through Connect for Health Colorado and in the traditional off-exchange, individual market. ● Eligible consumers will be able to use federal subsidies currently available to them through Connect for Health Colorado to purchase this option. ● Licensed brokers will be able to guide and support consumers in their purchasing decisions.
<p>How will the plans be financed?</p>	<ul style="list-style-type: none"> ● Colorado taxpayers will not fund these plans. ● Plans will be fully insured, offered by private health insurance carriers. ● If the federal government approves Colorado’s application for a 1332 innovation waiver, we will use the funding to make the plans even more affordable for consumers.
<p>What benefits will Public Option plans cover?</p>	<ul style="list-style-type: none"> ● All Essential Health Benefits will be covered. Plans will have standardized benefit designs. ● Many services will be pre-deductible, including preventive care, primary care, and behavioral health care.
<p>How will the plans improve the quality of health care?</p>	<ul style="list-style-type: none"> ● Public Option carriers will collaborate with the state and hospitals to refine and implement Centers of Excellence. They will build high-performing networks and utilize value-based payments to reward providers who achieve quality and pricing targets.
<p>When will the plan be available?</p>	<ul style="list-style-type: none"> ● Open Enrollment Fall 2021, for coverage beginning January 1, 2022.
<p>How will stakeholders continue to share their views?</p>	<ul style="list-style-type: none"> ● HCPF and DOI will create a Public Option Advisory Board, to ensure that all stakeholder voices can continue to inform the ongoing development and implementation of this plan.



COLORADO
Department of
Regulatory Agencies
Division of Insurance



COLORADO
Department of Health Care
Policy & Financing

Appendix IV – Presentation from Draft Rollout Stakeholder Sessions



COLORADO OPTION FOR HEALTH CARE COVERAGE

Presented by: **Kim Bimestefer**, Executive Director, Health Care Policy & Financing;
and **Mike Conway**, Insurance Commissioner, Division of Insurance



Agenda

- Overview of the Process
- Overview of the Proposal
- What's Covered?
- Who's Covered?
- Enhancing Quality
- Maximizing Existing Infrastructure
- Affordability
- Maintaining Engagement
- What We've Achieved
- Timeline
- Feedback Process



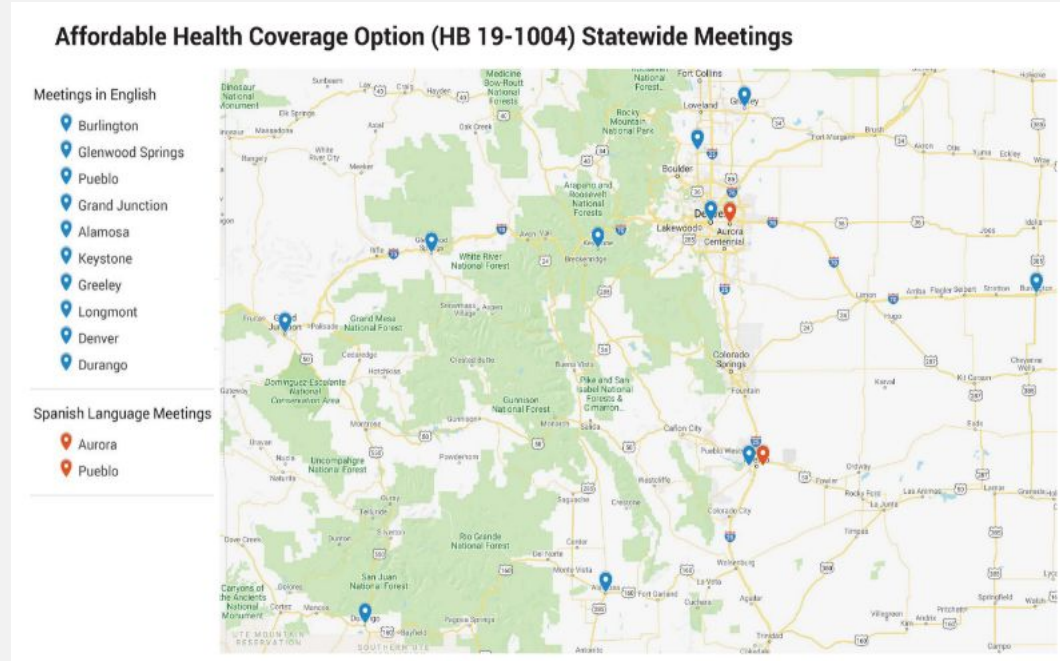
Overview of the Process

Engagement Overview

- 14 statewide public listening sessions
- 42 formal letters received, reviewed
- Significant discussion and thoughtful feedback

Participants who presented ideas:

- Colorado Access
- Colorado Consumer Health Initiative
- Colorado Hospital Association
- Colorado Medical Society
- AJ Ehrle Health Insurance
- Young Invincibles



Key Aspects of the State Option Proposal

- Coloradans across the state are projected to save 9-18%+ on individual premiums
- Plans will be administered by insurance companies and sold on *Connect for Health Colorado*, so people who receive federal subsidies can use them to buy it
- There are very low admin costs and no financial risk to the state or taxpayers
- Reimbursements will be set by the state at a level that
 - protects rural hospitals
 - allows for profitable care delivery
- An Advisory Board will be established to maximize stakeholder collaboration



What's Covered?

- The plan design will include all essential health benefits
- Standardized benefit plan design
- Many services will be pre-deductible, including preventive care, primary care and behavioral health care



Who's Covered?

Initial rollout, effective Jan. 1, 2022:

- Any Colorado resident who seeks to purchase individual coverage

Looking Forward:

- Small groups
- Evaluate over time whether the state option should be made available to the large group market, based in part on any evidence of cost shift (shifting costs of individual plans to the large group plans).



Enhancing Quality

The State Option will:

- Utilize value-based payments to reward providers who achieve quality and pricing targets
- Incentivize the use of high-quality providers by building high-performing networks



Maximizing Existing Infrastructure To Deliver A Public-Private Partnership

- **HCPF and DOI:** chart goals, monitor, and maximize existing public-private functions
- **DOI:** regulatory authority
- **Licensed brokers:** paid commission for services
- **Individual health insurance market:** provide access
- **Connect for Health Colorado:** enable access to federal subsidies
- **Licensed insurance carriers:** administer plans, contract with care providers



Why Not A Medicaid Buy-In?

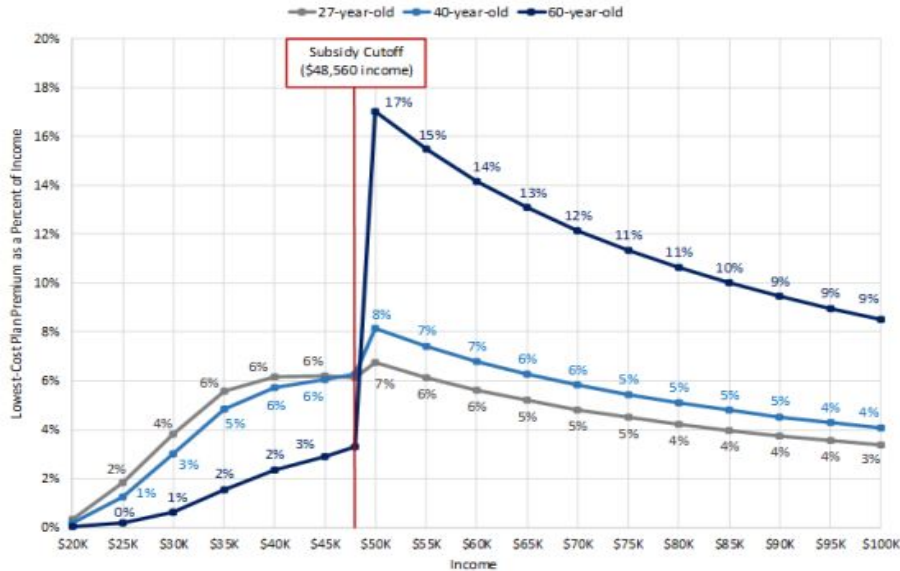
- Colorado Medicaid provides services for low-income, disabled and underserved populations → *need to receive full, focused attention*
- Medicaid serves customers in partnership with Federal government; different from private industry, where state option will compete
- In this proposal, carriers take financial risk, not the state budget.



State Option Addresses Middle Class Affordability

Figure 3

Average Lowest-Cost Bronze Plan Premium as a Percent of Income (by Age and Income, 2019)



NOTE: Alaska and Hawaii are excluded from this chart because these states have different poverty guidelines, and thus different subsidy cutoffs, from the rest of the U.S. This analysis includes plans that are offered on exchange. All premiums are displayed as the full price, rather than just the portion that covers essential health benefits.

SOURCE: Premiums come from KFF analysis of data published by HHS at Healthcare.gov, KFF analysis of data received from Massachusetts Health Connector, and KFF analysis of data published by HIX. Compare from the Robert Wood Johnson Foundation.



People on the individual market who do not qualify for subsidies are the only people who do not receive help with their premiums

The State Option is especially helpful to these individuals



Affordability - What This Includes

The State Option addresses and influences affordability, including:

- Insurance premiums paid by the consumer
 - Out-of-pocket costs
 - Underlying cost of care
-
- This proposal estimates people will save **9-18%+ savings** on premiums



Affordability - Savings Achieved by Reducing Costs of Care and Admin Expenses

- Reduces Insurance Carrier MLR to 85%, plus commissions
- Hospital inpatient and outpatient at a more efficient level than today with special attention paid to rural and critical access hospitals to ensure sustainability
- Prescription drug manufacturer compensation to carriers must be fully passed through, not retained



Affordability - We Can Save Even More with Federal Approval



Potential federal approval (1332 waiver) to apply any additional savings to:

- Out-of-pocket costs?
- Additional benefits?
- Expanded tax credits?

Why Set Hospital Reimbursements?



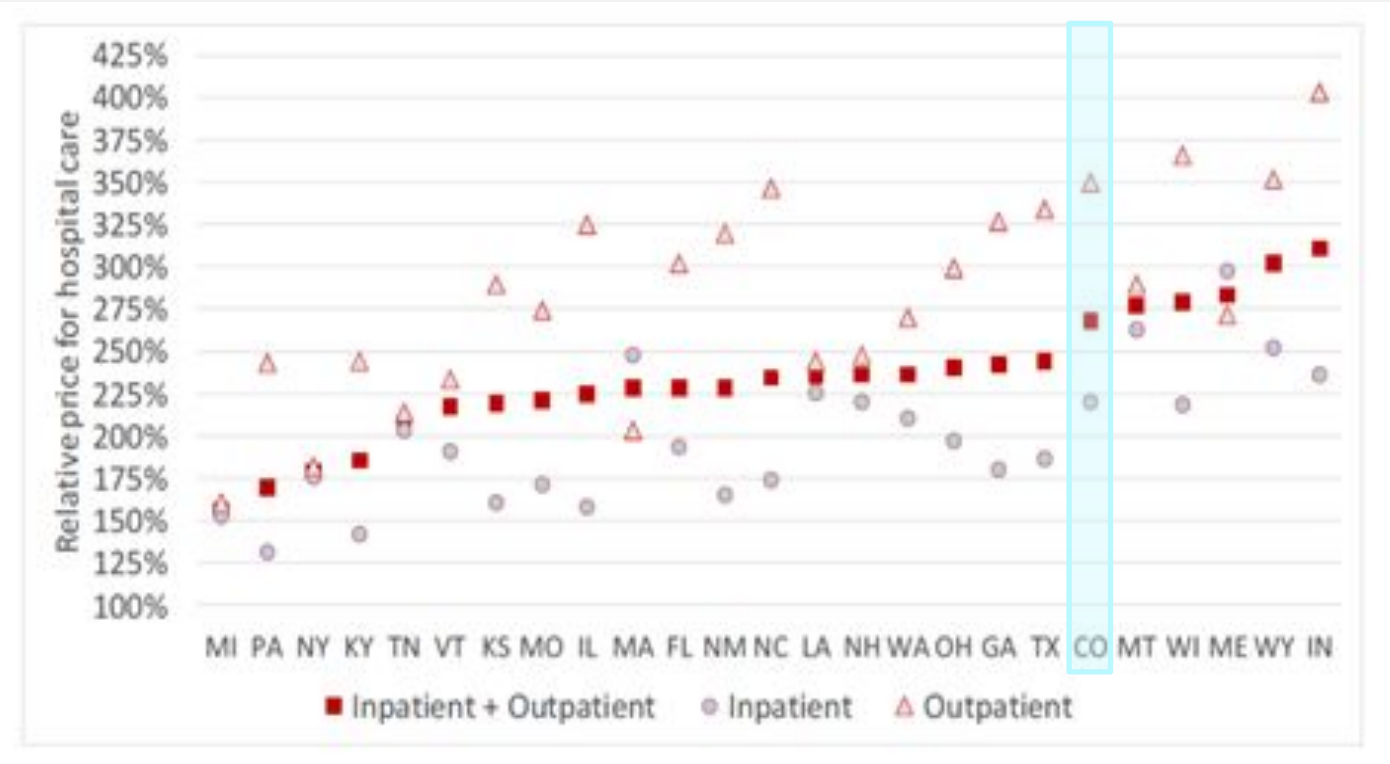
While profits for Denver area hospitals grew by more than 50% in the last two years, **18.1% of Coloradans** reported that they had problems paying medical bills.

That is nearly **1 in 5 residents** of our state.

There Are Big Differences in Prices Statewide

- A recent CIVHC report shows price variations of >400% across Colorado for the same services
- There are no state standards for hospital prices
- Stakeholder feedback urged action to reduce prices
- As hospitals have merged, negotiating leverage has increased prices for both people and business

Colorado Hospital Prices are Higher Than the National Average

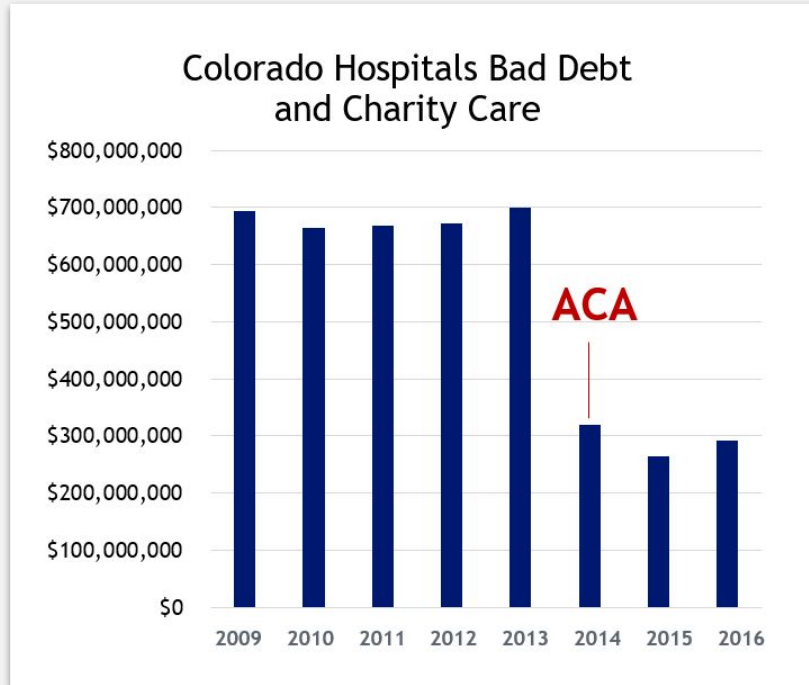


We should be able to compete better with other states, who have lower costs but still maintain sustainability for hospitals and providers



Good News: The ACA Reduced Bad Debt and Charity Care

Bad News: This Hasn't Resulted in Lower Costs



Source: CHASE 2017 Report, CHA DATABANK

Despite charity care going down:

- CO Hospitals' admin costs are increasing at 2x the national rate
- CO ranked in the top three nationally in hospital construction
- Hospital revenues are up 76%
- Hospital margins increased 250%+

According to the Hospital Cost Shift Report, based on the Colorado Hospital Association's Databank, reflecting 2009 to 2017.



This trend is continuing...

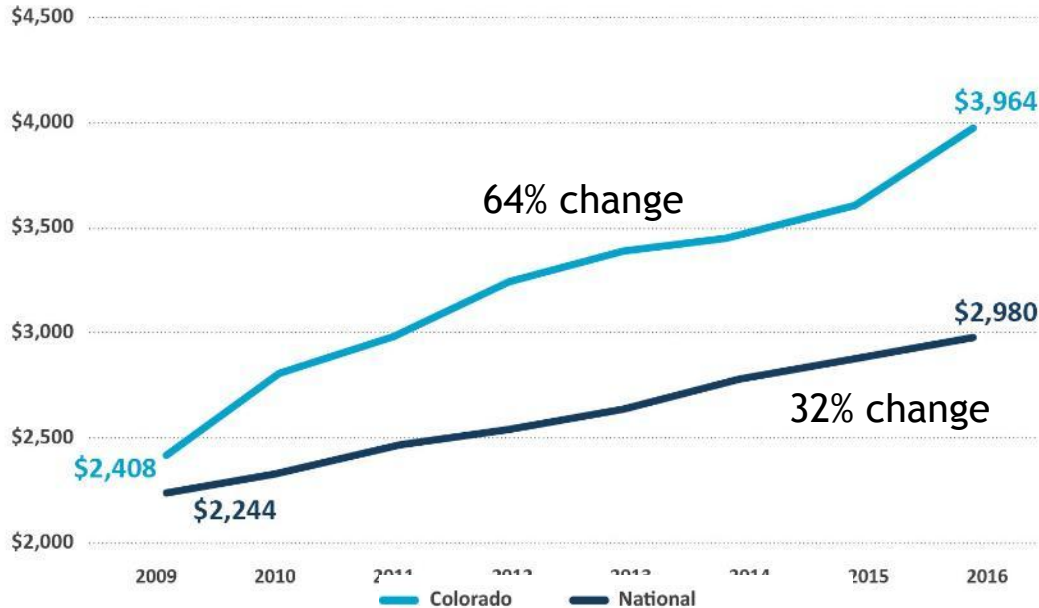
The 2019 Allan Baumgarten Colorado Health Market Review included 27 Denver-area hospitals' profits for 2018. Findings include:

- Hospitals have surpassed \$2 billion in profits for the first time in history
- The \$2 billion in 2018 profits compares with \$1.7 billion in 2017 and \$1.3 billion in 2016 – *that's an increase of ~50%+ in 2 years*
- Hospital prices grew 57% faster than the national average
- 2017 Profit Margin: 18.1% as a percent of net patient revenues
- 2018 Profit Margin: 19.3% as a percent of net patient revenues



Colorado Hospitals are Not Controlling Administrative Expenses

Growth in Overhead Costs per Adjusted Discharge, 2009-16



2009: Six entities owned or were affiliated with 23 hospitals.

2018: Seven entities owned or were affiliated with 41 hospitals.

- UCHHealth grew from 1 to 10
- Centura grew from 10 to 17
- Banner grew from 2 to 3

Overhead Cost per Adjusted Discharge:

CO: 9.2% per year over 7 years

National: 4.7% per year over 7 years

Data Source: Centers for Medicare & Medicaid Services Healthcare Cost Report Information System

We have to transform the system together.

This solution helps us do just that.



Every Stakeholder Needs to Do Its Part

- To provide network access, the state may implement measures to ensure health systems participate and provide cost-effective, quality care to covered individuals
- In order to address only one carrier in the individual market in 22 counties, insurance carriers above a certain market share or membership size (TBD) will be required to offer the state option
- Multiple carriers can offer the State Option in the same county and/or rating area



Protecting Employers from Cost Shifting

- Longer term, proposal expands to small group market
- Alliances enable employers and communities to work together to lower costs, improve quality, and address access issues
- By publishing the State Option reimbursements, employers (or chambers, etc.) can negotiate for the same rates (similar to Peak)
- Primary Care bill (HB19-1233) enables DOI to monitor hospital increases on all commercial business to deter cost shift



Maintaining Collaboration with an Advisory Board

- Advisory Board will provide insights, advice to DOI and HCPF
- Board members will include representatives of stakeholder groups (i.e., providers, carriers, employers, consumers, advocates, brokers)



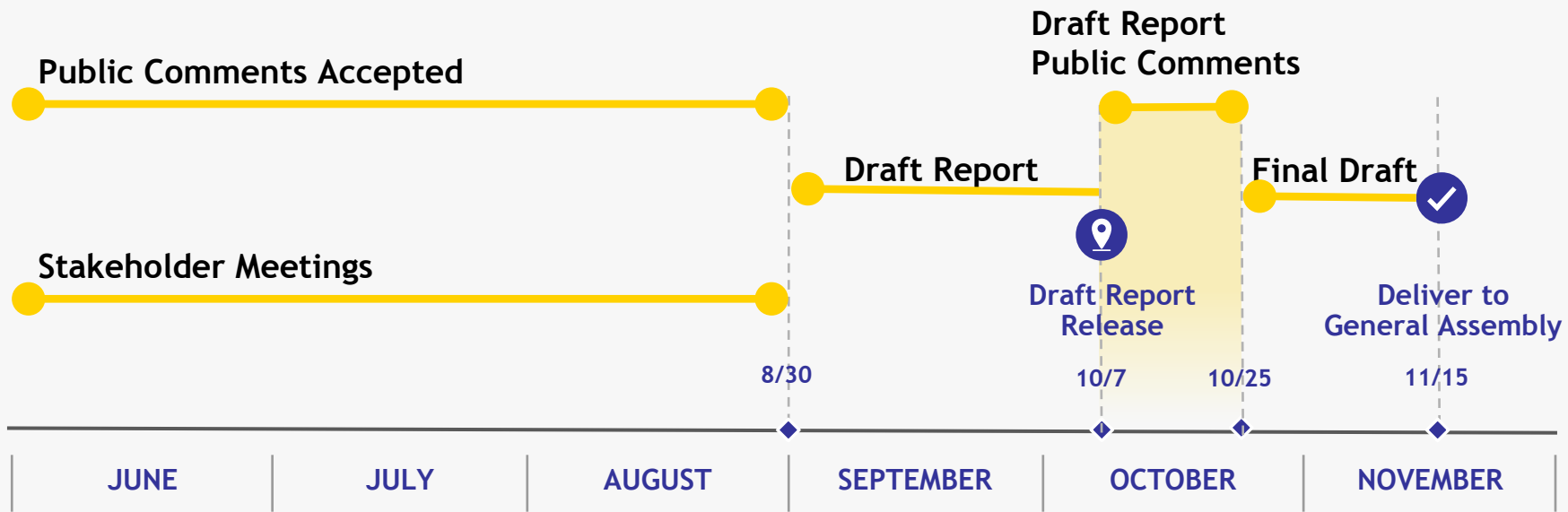
Does This Meet Goals of the Bill?

- ✓ Identify a feasible and cost effective state option
- ✓ Ensure affordability to consumers at various income levels
- ✓ Minimize administrative and financial burden to the State
- ✓ Ease of implementation

More considerations can be found in the legislation:

<https://leg.colorado.gov/bills/hb19-1004>





We look forward to your feedback.

www.colorado.gov/hcpf/proposal-affordable-health-coverage-option

Email: HCPF_1004AffordableOption@state.co.us





APPENDIX

RAND Report Findings Shows Significant Price Variation Across the State

Hospital name	City	Hospital system or, if independent, IPPS/CAH	Relative price for outpatient services	Relative price for inpatient services	Relative price for IP & OP services
Centura Health-St Thomas More Hospital	Canon City	Catholic Health Initiatives	463%	208%	356%
Community Hospital	Grand Junction	QHR	409%	302%	360%
Platte Valley Medical Center	Brighton	SCL Health	467%	256%	368%
Delta County Memorial Hospital	Delta	Independent (IPPS)	437%	283%	381%
The Medical Center Of Aurora	Aurora	HCA Healthcare	630%	283%	385%
Valley View Hospital Association	Glenwood Springs	Independent (IPPS)	478%	301%	399%
Sterling Regional Med Center	Sterling	Banner Health	546%	245%	419%
Medical Center Of The Rockies	Loveland	University of Colorado Health	483%	389%	429%
Poudre Valley Hospital	Fort Collins	University of Colorado Health	575%	331%	430%
Centura Health-St Anthony Hospital	Lakewood	Catholic Health Initiatives	500%	394%	430%
North Suburban Medical Center	Thornton	HCA Healthcare	698%	289%	461%
St Anthony Summit Medical Center	Frisco	Catholic Health Initiatives	697%	336%	503%



RAND Report Findings

Hospital name	City	Hospital system or, if independent, IPPS/CAH	Relative price for outpatient services	Relative price for inpatient services	Relative price for IP & OP services
Centura Health-Littleton Adventist Hospital	Littleton	Adventist Health System Sunbelt Health Care Corp.	352%	280%	311%
St Anthony North Health Campus	Westminster	Catholic Health Initiatives	460%	193%	316%
Mt San Rafael Hospital	Trinidad	Independent (CAH)	347%	159%	316%
Mercy Regional Medical Center	Durango	Catholic Health Initiatives	435%	225%	317%
Mckee Medical Center	Loveland	Banner Health	396%	221%	319%
St Marys Medical Center	Grand Junction	SCL Health	446%	271%	322%
Swedish Medical Center	Englewood	HCA Healthcare	399%	295%	324%
Longmont United Hospital	Longmont	Catholic Health Initiatives	418%	271%	332%
Arkansas Valley Reg. Medical Center	La Junta	QHR	405%	208%	335%
North Colorado Medical Center	Greeley	Banner Health	407%	277%	337%
Animas Surgical Hospital, Llc	Durango	Independent (IPPS)	346%	350%	347%
Parker Adventist Hospital	Parker	Adventist Health System Sunbelt Health Care Corp.	448%	280%	354%

RAND Report Findings

Hospital name	City	Hospital system or, if independent, IPPS/CAH	Relative price for outpatient services	Relative price for inpatient services	Relative price for IP & OP services
Wray Community District Hospital	Wray	Independent (CAH)	139%	93%	121%
Lincoln Community Hospital	Hugo	Independent (CAH)	127%	104%	126%
San Luis Valley Health Conejos County Hospital	La Jara	San Luis Valley Health	141%	68%	131%
Kit Carson County Memorial Hospital	Burlington	Independent (CAH)	157%	137%	150%
Yuma District Hospital	Yuma	Independent (CAH)	158%	125%	154%
Melissa Memorial Hospital	Holyoke	Independent (CAH)	157%	134%	155%
Memorial Hospital, The	Craig	Independent (CAH)	171%	138%	156%
Saint Joseph Hospital	Denver	SCL Health	234%	139%	159%
Pagosa Springs Medical Center	Pagosa Springs	Independent (CAH)	187%	93%	165%
Good Samaritan Medical Center	Lafayette	SCL Health	163%	179%	172%
Sedgwick County Memorial Hospital	Julesburg	Independent (CAH)	216%	116%	172%