COLORADO
Department of Regulatory Agencies
Division of Insurance

Impact of Reinsurance on Colorado's Subsidized Enrollee Population

The Colorado Division of Insurance is pleased to share this report on the impacts of Colorado's reinsurance program on low-income consumers who are eligible for federal assistance to purchase health insurance. While this study, required under Colorado House Bill 19-1168, is not due until 2022, the Division recognized the importance of understanding the program's impact on subsidized enrollees, and expedited the study to begin in 2020. We contracted with the Colorado Health Institute (CHI) and actuarial consulting firm Lewis & Ellis to complete the study. CHI produced the final report, and the Lewis & Ellis actuarial findings are included as an appendix.

In its first year (2020), the reinsurance program lowered premiums by 20% on average statewide for the roughly 200,000 consumers who buy their own health insurance on Colorado's individual market. The program reduced premiums more in parts of the state that historically had the highest health care and insurance costs, thus reducing the significant variation in cost between regions. The program continues to reduce premiums by nearly 21% on average throughout the State in 2021.

The CHI report explains how federal policy changes led to insurer pricing decisions that caused silver plan prices (including the silver benchmark plan) to decrease more in relation to bronze or gold plans. CHI and Lewis & Ellis identified these plan pricing decisions and consumer purchasing decisions as the main reasons why some subsidized consumers saw net premium price increases in 2020. CHI's report includes recommendations for addressing those issues in order to help maximize the subsidies available to consumers. We look forward to continued evaluation of those recommendations along with their potential implementation.

The Division of Insurance remains committed to making health insurance more affordable for Coloradans, giving more people improved access to necessary health care - preventive, diagnostic, chronic, and emergency. We will take advantage of every tool available to improve affordability, including the report's recommendations for the reinsurance program, as well as the many improvements to health insurance markets that are part of the American Rescue Plan Act.

Sincerely,

Michael Conway
Commissioner of Insurance

Reinsurance and Affordability

Maximizing the Buying Power of Subsidized Consumers in Colorado's Individual Health Insurance Market

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Informing Policy. Advancing Health.

Reinsurance and Affordability

Maximizing the Buying Power of Subsidized Consumers in Colorado's Individual Health Insurance Market

This research was conducted in partnership with the Colorado Division of Insurance in response to House Bill 19-1168.

Introduction

Reinsurance is designed to lower insurance premiums on the individual market by covering a portion of the most expensive claims, thereby reducing the risk for insurance carriers. In its first two years, Colorado's reinsurance program has succeeded in driving down premiums.

Some consumers who qualify for advance premium tax credits (APTCs) to subsidize the cost of insurance saw price increases that coincided with the launch of the reinsurance program.

The primary reason that occurred was because insurance carriers increased the price of their gold and bronze plans relative to silver plans. Consumer behavior also had a large effect: Consumers often chose a more expensive plan when they shopped for 2020 coverage. Reinsurance was not the primary driver of price increases. In some cases, differences in how insurers estimated reinsurance-driven premium reductions also caused prices to go up for some subsidized consumers. This is due to the way subsidy amounts are calculated. All of these factors are explored in detail in this report.

The Colorado Division of Insurance (DOI) commissioned the actuarial firm Lewis & Ellis to conduct data analysis on Colorado's individual market open enrollment for 2020 and evaluate the impact of reinsurance on the enrollee population eligible for APTCs. DOI commissioned the Colorado Health Institute (CHI) to identify and evaluate policy options that address the specific issues and findings identified in the actuarial report. This policy options report was developed by CHI in consultation with DOI.

CHI performed research on the experience of other states with reinsurance programs, conducted key informant interviews with insurance policy experts and health coverage guides, and hosted focus groups to gather consumer input on priorities for their insurance coverage and on different policy options that aim to reduce costs for subsidized consumers. These policy options are detailed beginning on Page 10.

Key Takeaways

- The reinsurance program lowered the price of insurance on Colorado's individual market by an average of 20% in 2020, and maintained the 20% premium reduction in 2021.
- However, the average Coloradan receiving financial assistance to purchase coverage experienced a $9 increase in their monthly premium. The primary reason for that increase was due not to reinsurance, but to metal tier pricing decisions made by insurance carriers, ultimately in response to federal policy changes. The increase was also the result of consumer decision-making; some people chose to purchase higher-priced plans than they previously had, even when lower-priced plans were available.
- The three policy options considered in this report were assessed on their likelihood of maximizing the buying power of subsidized consumers on the individual market while retaining reinsurance-driven affordability gains for those without subsidies. Two options — new guidance for insurers to price plans based on coverage value, and a requirement that insurers apply reinsurance savings proportionally across different plan levels — should be pursued further. A third option, a potential addition to the auto-enrollment process, is not recommended.

Reinsurance in Colorado

Colorado's reinsurance program was authorized by House Bill (HB) 19-1168, which allowed the Commissioner of Insurance to apply for a federal State Innovation Waiver, through Section 1332 of the Affordable Care Act (ACA), to gain approval and funding for the creation of a state-level reinsurance program. The reinsurance program is intended to reduce individual market insurance premiums by reducing insurers' costs and financial risk. It does so by paying for some of insurers' highest-cost claims. Insurers pass those savings on to consumers in the form of reduced individual market premiums.

Because federal financial support for subsidized consumers is tied to the price of coverage for certain benchmark plans, and because reinsurance reduces the cost of those plans, federal financial support (via APTCs) decreases when the benchmark plan price decreases. Colorado's Section 1332 State Innovation Waiver, approved in July 2019, allows Colorado to use the federal savings from reduced APTCs to partially fund the state's reinsurance program.[1]

HB 19-1168 was passed in May 2019. A year later, Senate Bill (SB) 20-215 extended authorization for the reinsurance program for an additional five years pending additional federal waiver approval.

The Impact of Reinsurance on Affordability

In its first two years, the reinsurance program has been successful at driving down premiums. For the 2020 plan year, Coloradans shopping on the individual market for health insurance saw rates decrease by an average of 20.2% compared to insurance rates from the year before.[2] For the 2021 plan year, premiums were estimated to be 20.8% lower than they would have been without the program.[3]

Reinsurance-driven savings were even larger when looking only at plans consumers actually purchased. Monthly premiums for plans consumers selected for 2020 coverage dropped 23.4%, from $617 to $473, according to analysis from actuaries with Lewis & Ellis. This rate change is specific to consumers who purchased their insurance through Connect for Health Colorado (C4HC), the state's health insurance marketplace, also sometimes referred to as the "exchange." However, Lewis & Ellis found off-exchange rates decreased by a similar percentage.

By design, premium reductions in both years were greatest in higher-cost areas of the state, where relief for consumers was most needed. In areas with more expensive premiums, the reinsurance program pays a larger percentage of each of the high-cost claims that are eligible for the program. This allows insurers to reduce their prices by a larger amount, knowing more of their costs are covered by the program.

Price-sensitive Coloradans who are not eligible for subsidies benefited most from the premium reductions brought about by the reinsurance program. Nearly 5,000 (4,819) additional Coloradans not eligible for subsidies enrolled in coverage during the 2020 open enrollment period compared to 2019, a 16.0% increase.[4]

For the 2020 plan year, some people who receive subsidies enrolled in a plan with a higher net premium (the amount they owe after accounting for their subsidy) than they paid the year before. ***After choosing a plan for 2020, 54% of subsidized consumers experienced a post-subsidy rate increase.[5] The average post-subsidy rate change for subsidized consumers was 6.7%, from $129 to $138.***

Consumers' choice of plan played a role: Before shopping (i.e., if consumers renewed their plans from the previous year), the average consumer received a post-subsidy rate decrease of $27, and only 42% of subsidized members received a post-subsidy rate increase. Consumers had many potential reasons to choose a more expensive plan (known as "shopping up"), including a desire for a higher level of coverage, a lower deductible, or access to a particular provider. Enrollment of subsidized consumers decreased 6.3% during the 2020 open enrollment period compared to 2019, potentially due to reduced subsidies.[6]

However, the reinsurance program was not the primary driver of price increases for subsidized consumers. Actuarial analysis from Lewis & Ellis points to insurer pricing decisions in response to federal policy changes — not reinsurance — as the primary cause of increased prices for subsidized consumers between 2019 and 2020. This dynamic is covered in detail in the following section.

Financial Help Available Through Connect for Health Colorado

There are two sources of financial support available through C4HC.

*APTCs reduce monthly **insurance premiums** for people with incomes between 100% and 400% of the federal poverty level (FPL), or between $34,847 and $104,799 in annual household income for a family of four.[7] The amount of the tax credit varies based on household income and the cost of the benchmark plan, which is the second-lowest-price silver plan available in each geographic area. Those who qualify for an APTC have to pay, at most, about 10% of their annual income for the premium of the benchmark plan — the subsidy covers the rest.[8] The subsidy amount is fixed even if consumers choose a plan other than the benchmark.*

*Cost Sharing Reduction (CSR) payments are an additional form of financial assistance available to people with incomes between 100% and 250% FPL, or between $34,847 and $65,500 in annual household income for a family of four.[9] CSRs lower costs related to **deductibles, copayments, and coinsurance** — costs that are separate from those reduced by APTCs. Consumers must enroll in a silver plan to receive CSRs.*

Actuarial Value and Metal Tiers

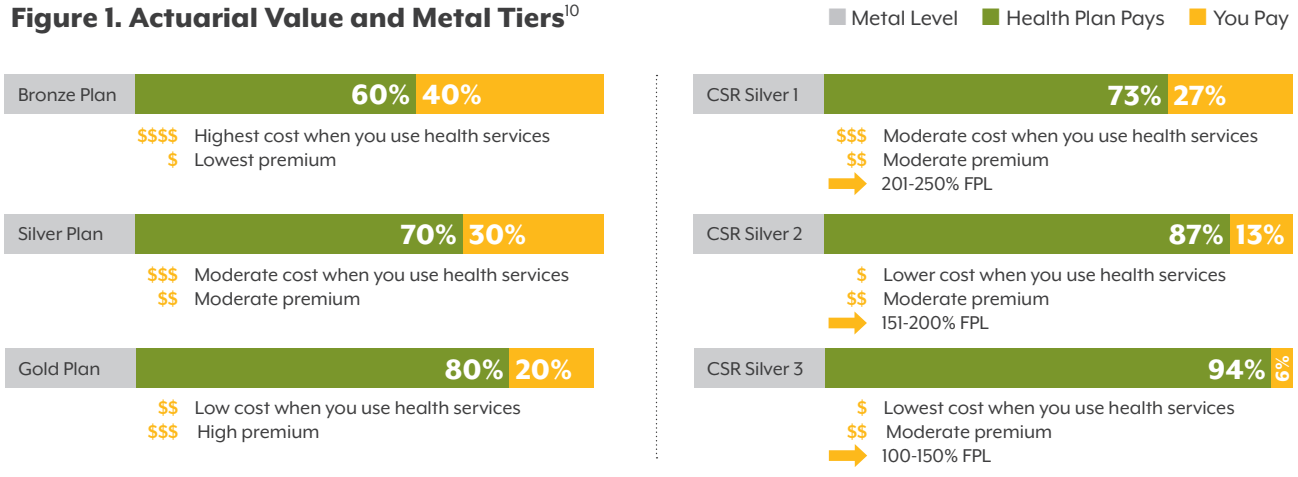
Actuarial value (AV) is the percentage of total health costs a plan will cover on average. Particular individuals could pay more or less than average. The remaining percentage is paid for by the enrollee through premiums and cost sharing such as deductible payments, copayments, and coinsurance.

The ACA sorted plans into four levels based on their AV: bronze, silver, gold, and platinum (see Figure 1), although no platinum plans are offered on the exchange in Colorado. A plan with lower AV, such as a bronze plan, comes with a lower monthly premium than a gold plan, but enrollees will pay more in copayments and coinsurance.

This simple market structure is complicated by CSRs. CSRs are only available to those with incomes between 100% and 250% FPL who enroll in an on-exchange silver plan. The additional financial assistance from CSRs means consumers in those plans have more of their costs covered than those with non-CSR silver plans. This has the effect of raising the AV of CSR silver plans above the standard 70% level for silver plans.

There are three different tiers of CSR payments, meaning there are three different AVs for silver plans for consumers eligible for CSRs. Those AVs range from 73%, or a slight increase in value from the standard silver plan, to 94%, or benefits that are much more generous than gold plans.

Figure 1. Actuarial Value and Metal Tiers[10]



Note: Cost Sharing Reduction (CSR) silver plans are available to those with incomes 100%-250% FPL

Silver Loading, Induced Utilization, and Impacts on Consumer Buying Power

Pursuant to the ACA, the federal government reimburses insurance companies for the CSRs they provide to eligible consumers. In late 2017, the federal government stopped these payments to insurers as part of a larger effort to dismantle the ACA.[11] However, the ACA still required carriers to make reduced cost sharing available to eligible consumers. In order to offset these lost payments, DOI first instructed insurers offering plans in Colorado to increase the cost of plans at every metal tier, a practice known as "broad loading." This meant prices went up for plans at each metal tier, and subsidies for consumers increased proportionally.

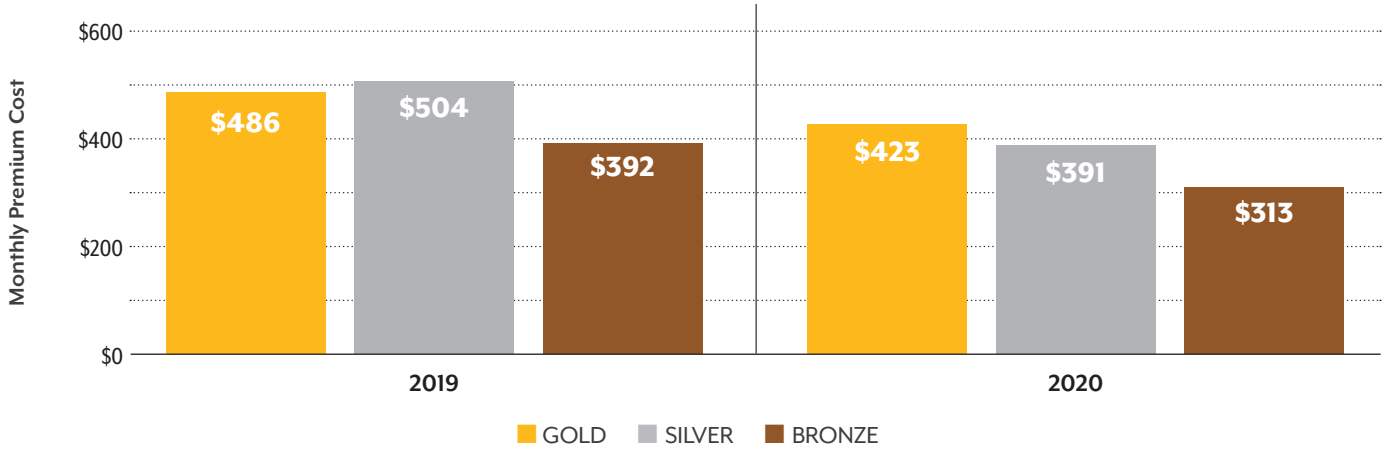
In 2019, with additional clarity from the federal government, DOI instructed insurers to "load," or apply, CSR costs onto on-exchange silver plans only, since CSRs are only available through those plans. This is a practice known as "silver loading."

Because the AV of certain CSR silver plans is significantly higher than standard silver plans (specifically CSR Silver 2 and 3; see Figure 1), this increased the price of silver plans relative to other metal levels, in some cases making silver plans more expensive than gold plans. Because APTC amounts are tied to the benchmark silver plan cost, increasing the cost of silver plans increased the size of APTCs available to subsidized Coloradans. In practice, this meant Coloradans with incomes between 250% and 400% FPL, who were eligible for APTCs but not for CSRs, got a better deal than in previous years on bronze or gold plans, but some silver plans became more expensive. Coloradans with incomes between 100% and 250% FPL (especially those between 100% and 200%, who are eligible for the higher-value version of the CSR Silver 2 and 3 plans; see Figure 1) could also benefit from the cheaper bronze and gold plans but still get the best value in terms of price relative to benefits by enrolling in a silver plan to receive the reduced cost sharing.

In 2020, the second year of silver loading and, incidentally, the first year of reinsurance in Colorado, insurers adjusted a pricing lever known as "induced utilization" to increase the relative price of gold plans, with the goal of reestablishing a clear pricing structure where gold plans are the most expensive.[12] However, when insurers pursue this goal, the side effect is an increase in prices paid by subsidized consumers.

The reinsurance program, which went into effect in the same year as this induced utilization change, caused the prices of plans at all metal levels to go down. But because of the induced utilization changes for the 2020 plan year, gold and bronze plan prices dropped less than silver plan prices (see Figure 2). The average gold price dropped by 13.0%, while the average silver price dropped by 22.4%. APTC subsidies are tied to the price of a silver plan, so when silver plans drop in price relative to other plans, the subsidies become less valuable to consumers who choose a gold or bronze plan.

Figure 2. Example Metal Tier Monthly Premium Cost by Year [13]



Insurers made this pricing adjustment because they were concerned about consumers migrating out of silver plans, which had become more expensive because of silver loading. According to the actuarial analysis, insurers generally want to attract non-CSR enrollees into silver plans because they are less costly to cover than enrollees who are eligible for CSRs. Having enough non-CSR enrollees helps keep the price of those silver plans down, which in turn helps attract more people to enroll in the plans. Conversely, insurers do not want to have the lowest-price gold plan available on the market for fear of attracting large numbers of more costly enrollees, as they are likely to have higher health needs.

The phrase "induced utilization" refers to how the plan's AV affects the use of medical services. The basic principle is that, on average, someone with a more generous plan (meaning one with a higher AV) is likely to use more medical care than someone with the same health status who has a less generous plan. Customers who use more medical care are more costly to the insurer, so insurers charge higher prices for more generous plans.

Policies that affect the price of a silver plan differently than other metal tiers can affect the buying power of subsidized consumers. The result can be to the consumer's benefit, as with silver loading, or to the subsidized consumer's detriment, as with induced utilization. Per the Lewis & Ellis report: "In general, any time the silver plan rates change in a way that is different from the rest of the plan rates in the market, the subsidized population will be impacted. From 2019 to 2020, this occurred because of the adjustments made [by insurance companies] to counteract silver-loading. These adjustments led to rate increases for some subsidized members."

The relative increase in gold and bronze plan prices has caused the value of subsidies to decrease because subsidy amounts are benchmarked to the price of silver plans. If gold or bronze plans get more expensive while silver plan prices stay the same, subsidy amounts also stay the same and cover a smaller share of the costs of a gold or bronze plan.

Figure 3. Reinsurance and Key Insurer Pricing Decisions, 2017 to 2020

Year	Policy Development	Impact
2017	CSR Payments from Federal Government Stop	Insurers and DOI had to determine how to price CSR costs into premiums to offset lost payments from the federal government.
2018	Broad Loading	CSR costs were added on at all plan levels (bronze, silver, and gold), increasing the price of all plans by a similar amount, with a minimal impact on affordability for subsidized consumers because subsidies also increased accordingly.
2019	Silver Loading	CSR costs were shifted to be priced into on-exchange silver plans only, increasing the price of silver plans relative to gold and bronze plans. This significantly increased the value of subsidies for consumers who were enrolled in a bronze or gold plan. On-exchange silver plan prices rose for non-subsidized consumers, but off-exchange silver plan prices did not increase.
2020	Reinsurance and Induced Utilization Changes	Reinsurance reduced rates across the board by an average of 20.2%. But insurer changes to induced utilization factors meant silver plan prices dropped by more than gold plan prices, reducing the size of the average subsidy available to purchase a gold plan. This caused a rate increase for some subsidized consumers.

In summation, the actuarial analysis found silver loading in the 2019 plan year improved the buying power of subsidized consumers by increasing the relative price of on-exchange silver plans and thus increasing subsidy amounts. (Consumers who received no financial assistance saw on-exchange silver prices rise in 2019, though off-exchange silver plan prices did not increase.) Insurer pricing decisions for the 2020 plan year — particularly, use of the induced utilization factor — then reduced the relative price of silver plans, which decreased subsidy amounts and reduced the buying power of consumers.

From the perspective of a subsidized consumer, the result can be a marketplace that feels challenging to navigate. For those not eligible for CSRs, on-exchange silver plans are not a good match based on their price and AV compared to bronze and gold plans. Yet, for those eligible for CSRs, on-exchange silver plans are a great value based on the AV they offer. And because on-exchange silver plans are underpriced compared to the coverage level they provide to the CSR-eligible population, subsidies available to all subsidized consumers are lower than they could be. Finally, because insurers have increased the price of gold plans relative to silver plans, gold plans are overpriced in relation to the level of coverage they provide.

The bottom line: The current pricing structure of on-exchange plans does not maximize buying power for many subsidized consumers.

Reinsurance and the Importance of Relative Price Changes

The actuarial analysis identified insurer pricing decisions as the primary cause of subsidized consumers' net rate increases. Consumers' choice of plan also played a role. However, when insurers come to different conclusions about the value of estimated savings from reinsurance, and thus reduce their rates by different amounts, the margin between those decreases has important implications for the affordability of plans.

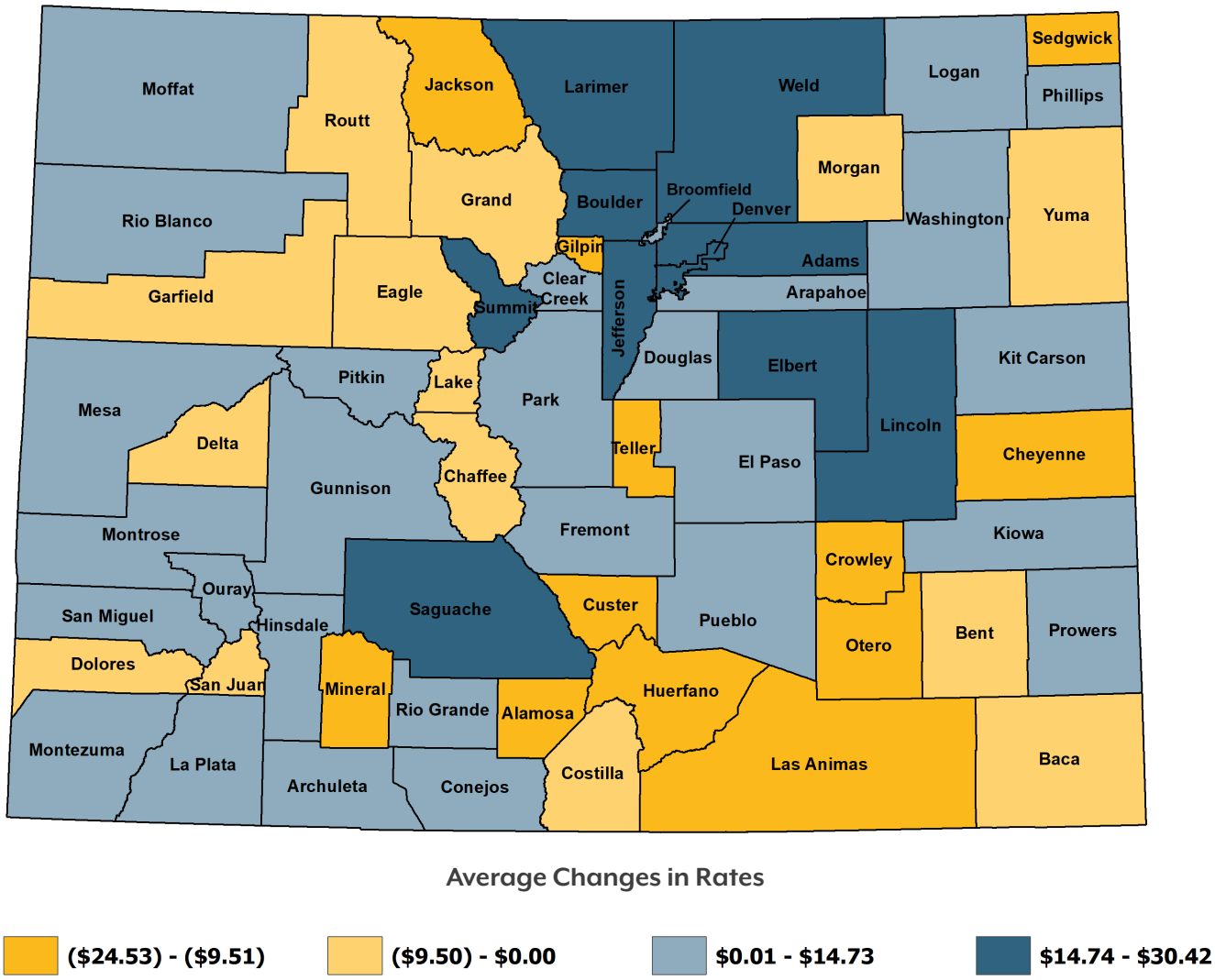
For example, in Weld County in 2019, one insurer reduced its rates on average by 25%, compared to another insurer that cut rates by just 13%. Because the first insurer happens to offer the benchmark plan (the second-lowest-cost on-exchange silver plan) for the county, subsidized consumers enrolled in plans offered by that insurer were not significantly affected — their subsidy went down by an amount roughly equivalent to the average rate decrease, in this case producing savings of 5%. However, consumers enrolled in plans offered by the second insurer were negatively affected because their subsidy amount decreased by much more than their rates (see Figure 4). ***Because of the mismatch between the 25% decrease in the benchmark plan's cost and commensurate decrease in subsidies and the 13% decrease in the plans offered by the second insurer, consumers enrolled in the latter saw a 38% increase in their after-subsidy costs from 2019 to 2020.***

Figure 4. The Importance of Relative Prices for Subsidized Consumers

Example: Weld County Carrier Profile

Carrier	2019 Rate, Before Subsidy	2020 Rate, Before Subsidy, Pre-Shopping	Change in Rate Before Subsidy	2019 Rate, After Subsidy	2020 Rate, After Subsidy, Pre-Shopping	Change in Rate After Subsidy
HMO Colorado	$613	$458	-25%	$126	$120	-5%
Kaiser	$650	$567	-13%	$133	$184	38%

Map 1. Monthly Subsidized Member Premium Rate Change by County, 2019 to 2020[15]



A similar dynamic occurred in Elbert and Lincoln counties, and to a lesser extent in other areas of the state, including the Denver metro area and parts of the Western Slope. This relative price dynamic is not relevant for the 22 counties in 2020 with only one insurer offering plans on the individual market, such as Phillips and Yuma, where subsidized consumers did not see substantial price changes due to reinsurance.[14] However, in some areas, most notably the southeastern part of the state, rates actually decreased for most subsidized consumers (see Map 1). This may be due to a similar relative price dynamic, but in reverse: when the benchmark plan price decreases by less than the prices of plans offered by other insurers, the value of subsidies increases, and many consumers see post-subsidy price decreases.

DOI analyzes insurers' proposed rates every year, and all 2020 rates were determined to meet the applicable standard for reasonable price changes. One insurer may have assumed a healthier population than that of competitors, or that insurer could have more robust care management processes in place that reduce the number of high-dollar claims that would be covered by the reinsurance program.

Other local relative price changes that are unrelated to the reinsurance program, such as the savings generated by Summit County's Peak Health Alliance (a community-driven health care purchasing effort), could have a similar impact by significantly decreasing the price of the benchmark silver plan.

Consumer Shopping Preferences and COVID-19 Special Enrollment Period

Actuarial analysis also identified consumer shopping behavior as a driver of increased post-subsidy rates. Before shopping for a plan for 2020, the average subsidized consumer saw a $27 decrease in their premium after their APTC subsidy was factored in (the median change was a decrease of $5). But after shopping, the average subsidized consumer chose a $12 increase in their post-subsidy premium. ***Before shopping, only 42% of members received a rate increase, compared with 54% after shopping. This analysis indicates that shopping behavior and consumer preference actually drove some of the increase, which may seem counterintuitive.***

One potential driver of the apparent consumer preference for more expensive plans is the COVID-19 pandemic, which could have made higher-value coverage more attractive to consumers during the Special Enrollment Period (SEP) that C4HC opened on March 20, 2020.

But two factors temper the effect the pandemic could have had on overall shopping behavior. First, the vast majority of Coloradans signed up for coverage during the regular Open Enrollment window, which closed before the pandemic hit; fewer than one in 10 (8.6%) subsidized Coloradans in 2020 enrolled during the SEP. Second, returning customers who enrolled during the SEP chose a more expensive plan in similar numbers to those who had enrolled during Open Enrollment. These returning enrollees represented about a quarter (23%) of the roughly 14,300 people who enrolled during the SEP.[16] Generally, it seems that whatever caused this preference for more expensive plans was active during both enrollment periods, and therefore it cannot be fully explained by the impact of COVID-19. Data on new enrollees were not available for this report; those enrollees may or may not have had a significant preference for higher-dollar coverage.

Some consumers choose a higher-price plan because they think the benefits are worth the higher price — for example, access to a certain provider or provider network, coverage for certain prescription medications, or simply more generous coverage (higher AV). Some consumers may have chosen a more expensive plan for 2020 coverage compared to their 2019 coverage because of a new medical condition or a network change that required them to switch plans to keep their existing provider.

CHI conducted focus groups for this work and asked participants if they purchased higher-value coverage for 2020 or 2021. A few people said they purchased higher-value coverage in 2020 than in previous years because it became more affordable to them, either due to a subsidy increase or price decrease because of the reinsurance program, but there was not a clear trend among participants of shopping for a more expensive plan. Most said their insurance costs are affordable due to the APTC they receive, but only two out of 12 (17%) said they had ever purchased a plan that was more expensive than their current coverage. One of those two participants purchased a silver plan for 2021 because of income changes that qualified her for a CSR. The other is an insurance broker who moved from silver to gold to decrease his deductible; his professional experience means his preferences may not be representative of the average consumer.

Policy Options for Consideration

The Trump administration's 2017 decision to stop CSR payments and subsequent guidance to states led Colorado to pursue a policy of silver loading, along with nearly every other state.[17] This policy has increased federal funds flowing to the state in the form of APTCs by increasing the price of the silver benchmark plan used to calculate APTC amounts. In response to silver loading, however, insurers made adjustments for the 2020 plan year to build in price spacing between gold and silver plans, which reversed some of the silver loading effect.

A key choice for the DOI is whether to pursue policies that keep the price of silver plans high relative to other metal tiers, or to allow insurers to continue to reduce the impact of silver loading by increasing the prices of gold plans and reducing prices of silver plans. Silver loading results in larger subsidies and improves affordability for consumers who are eligible for APTCs. But analysis of rate changes from 2019 to 2020 shows a need for policies that protect those affordability

improvements, as they will otherwise be eroded by insurers' pricing decisions.

The following three policy options to improve affordability on the individual market were considered for this report. CHI recommends that DOI consider the first two:

- Align coverage prices with plan value
- Require insurers to apply reinsurance savings proportionally across plan types
- Institute new auto-enrollment rules

Several other states employ the first policy option, and many experts recommend it to maximize the buying power of subsidized consumers. The second policy is being enforced by DOI as of the 2021 plan year and should continue. The third policy option demonstrates one way to assist price-sensitive consumers in choosing the best-value plan, but CHI is not aware of a similar process in place in other states. This third policy is also expected to be challenging to implement, and unlike the other policy options, most of the work would fall to C4HC rather than DOI — therefore, it is not recommended at this time. It has been included here as an example of an innovative response to the complexity of the individual market as designed by the ACA.

CHI analyzed these options independent from other policy changes, including a potential public option at the state or federal level, and the work of the state's Health Insurance Affordability Enterprise. Future changes in these areas could impact the policy options discussed in this report.

Policymakers should install appropriate guardrails to protect the affordability of insurance coverage for the subsidized population. These policy options outline what forms those guardrails might take. Each section includes a description of the policy option, an analysis of the potential impact on consumer buying power and enrollment, consumer feedback on the option, and considerations for how the option might be implemented.

Option 1: Align Coverage Costs with Plan Value

Earlier in this report, CHI described the induced utilization changes insurers applied to increase the price of gold plans relative to silver plans in 2020. These changes run counter to the coverage values of those particular plan tiers. This policy option proposes changes to align premium prices more closely with AV, meaning consumers would be getting what they pay for in the individual market.

There are two levers associated with this policy option. They work in tandem to establish relative pricing that increases the buying power of subsidized consumers:

1. Prevent the inflation of gold plan prices by limiting induced utilization.
2. Require insurers to price silver plans using a weighted average AV based on the projected distribution of CSR-eligible enrollees.

The two levers, along with their impacts and implementation considerations, are explained in more detail here. These policy changes should be implemented together to establish an individual market pricing structure that maximizes the buying power of subsidized consumers. Only implementing one policy change and not the other would not achieve the desired insurance pricing results, and could be actuarially unsound. This approach was also informed and supported by analyses done by Stan Dorn of Families USA and Greg Fann and Daniel Cruz of Axene Health Partners.[18,19]

Prevent the inflation of gold prices by limiting induced utilization

The actuarial analysis found the primary driver of decreased affordability from 2019 to 2020 was insurers increasing the relative price of gold and bronze compared to silver plans. Part of the reason for this shift was through a change in the amount of induced utilization applied to those plans, particularly gold plans. Use of this elevated induced utilization factor is being seen in many states.[20]

To implement Option 1, DOI would limit how much induced utilization insurers can apply to their plan rates. For example, induced utilization could be limited to the factors established by the U.S. Department of Health and Human Services (HHS) as part of the ACA risk adjustment program (see Figure 5).

Figure 5. ACA and Axene Induced Utilization Adjustments for Each Metal Level [21, 22]

Metal Level	ACA Induced Utilization Adjustment	Axene Proposed Induced Utilization Adjustment
Catastrophic	1.00	1.00
Bronze	1.00	1.00
Silver	1.03	1.10
Gold	1.08	1.21
Platinum	1.15	1.33

Sources: Patient Protection and Affordable Care Act (2013) and Axene Health Partners

A less restrictive approach, proposed by Fann and Cruz of Axene Health Partners, would involve a slightly more relaxed cap — allowing an induced utilization adjustment of up to 10% between metal levels, or 1.21 for gold plans. This would likely eliminate the most extreme examples of gold plans being priced far higher than silver plans, which have the greatest negative impact on affordability, but would not be as strict as requiring the HHS values.[23]

DOI could also consider regulating the allowed amount of induced utilization for all metal tiers rather than just gold plans using HHS adjustment amounts or similar values (see Figure 5). Note that induced utilization should be highest for silver plans if they are priced based on the weighted average AV of plans available only to CSR-eligible enrollees; this is explained in the next section. The allowable induced utilization factor for those plans should be around the value allowable for platinum plans, given those plans have similar AV.[24]

Require insurers to price silver plans using a weighted average AV based on the projected distribution of CSR-eligible enrollees

The second component necessary for implementing Option 1 involves silver plan pricing. Aligning coverage cost with plan value while maintaining price differences between metal tiers also requires adjusting how insurers price silver plans. Insurers aim to balance the demand from different enrollee populations that are combined in a single risk pool — by averaging the benefit value and thus the premium cost.

As long as silver loading is in place, these on-exchange silver plans will be a relatively poor deal for those who are eligible for APTCs but not CSRs, even if insurers try to price them competitively. This group of consumers, whose incomes are between 250% and 400% FPL, can buy a gold plan with better coverage at a cheaper price than a silver plan, or they could get a bronze plan for a very low premium or even for free. The explanation of coverage levels on the C4HC website notes silver plans are "good only for those getting Cost-Sharing Reductions."[25]

The second piece of this policy option would involve pricing these plans using a weighted average AV based on projected enrollment among consumers who are eligible for CSRs. This population is expected to include primarily those with incomes between 100% and 200% FPL, as they have the option to select the higher-value CSR Silver 2 and 3 plans, which have an AV of 87% and 94%, respectively (see Figure 1).[26]

Impact on Consumer Buying Power and Enrollment

Option 1 would price plans based on AV. It also would sever the common definitions of gold and silver plans from the value these plans offer in the real world for consumers who get APTCs. Pursuit of this policy could require further consumer education to explain why a silver plan is more valuable than a gold plan for some consumers.

In Colorado, gold plans in 2020 were priced about 8% higher than silver plans despite the fact that the majority of silver enrollees in Colorado were CSR-eligible.[27] Recall from Figure 1 that the CSRs available to many of these enrollees push the AV of their silver plan (CSR Silver 2 and 3) above the 80% AV of a standard gold plan. An analysis by Families USA based on 2020 enrollment in Colorado found that silver plans could be expected to cost about 5% more than gold plans, rather than 8% less.[28] This is likely a slight underestimate — incentivizing additional non-CSR enrollees to shift to more comprehensive gold coverage (or less expensive bronze coverage) would further increase the cost difference between silver and gold plans.

Increasing the cost of the benchmark silver plan would increase the value of subsidies for those eligible for APTCs. Eliminating the padding of

the costs of gold plans and increasing the cost of silver plans would make gold plans more affordable. Both of these changes would reverse the impacts seen in 2020 that worsened affordability for subsidized consumers compared to the year before and would lead to additional improvements in affordability for many consumers.

Analysis by Families USA found these changes would improve affordability for three key populations: [29]

- **Current beneficiaries of APTCs:** Lower net premiums due to increased APTCs and lower gross prices of gold plans, making high-value (gold) coverage more affordable and zero-premium, basic (bronze) coverage more widely available.
- **Currently unsubsidized consumers:** Eliminating inflation of gold plan premiums makes these plans more affordable. Some currently in silver plans could buy up to gold and save on reduced out-of-pocket costs, or they could switch to an off-exchange silver plan (which does not have a silver loading impact because CSRs are not available off-exchange). Greater affordability across plans and populations may increase enrollment of healthier Coloradans, driving down premiums.
- **Currently uninsured consumers:** The combination of increased APTCs and slightly decreased gross prices for gold and bronze coverage would make coverage more attractive to more price-sensitive Coloradans, both eligible and ineligible for subsidies, who currently lack insurance coverage.

Coloradans currently receiving higher-value CSRs (those with incomes between 100% and 200% FPL enrolled in CSR Silver 2 and 3 plans; see Figures 1 and 6) are not expected to benefit from this policy, but are also not expected to experience negative affordability effects. The silver plans this population is enrolled in will increase in price, but premium subsidies will increase by a corresponding amount, meaning affordability should stay the same. This population is eligible for 87% and 94% AV coverage at a relatively low premium cost and minimal out-of-pocket costs due to the CSR.

Affordability challenges are most acutely felt by certain populations. More than one in 10 (10.2%) Hispanic or Latinx Coloradans is uninsured, compared to the state average of 6.5%. The uninsured rate of non-citizen Coloradans, many of whom are immigrants with documentation eligible for APTCs, is even higher — more than one in four (27.1%).[30]

Among Coloradans eligible for APTCs based on income, the uninsured rate is highest among those with incomes between 200% and 300% FPL, at 11.8% (around 87,000 Coloradans).[31] APTCs are scaled to income, with no subsidized individual or household asked to pay more than about 10% of their annual income for benchmark coverage.[32] But those at lower income levels have less money available to spend on insurance premiums and out-of-pocket costs, with other necessities taking up a larger portion of their spending. For Coloradans with incomes below 200% FPL but above the Medicaid eligibility threshold of 138% FPL, this problem is addressed somewhat by the high-value, lower-cost coverage available to them through CSR plans.

Coloradans with incomes between 200% and 300% FPL are a key demographic for improving insurance coverage and affordability. This two-part policy option can improve affordability for this population.

Figure 6. Optimal Enrollment in a Market Where Prices Reflect Actuarial Value

Federal Poverty Level	Metal Tier	Actuarial Value
100-150% FPL* **Most Coloradans under 138% FPL are eligible for Medicaid and should enroll in that program if eligible. 100% FPL is used here because it is the federally defined income floor for APTC eligibility. Additionally, immigrants with documentation between 100% and 138% FPL are eligible for APTCs but must meet additional criteria to be eligible for Medicaid.*	**Recommended:** Silver	94%
	Not Recommended: Bronze *Healthy, cost-conscious Coloradans could buy down to a bronze or catastrophic plan but would expose themselves to large financial liability if they had unexpected health expenses.*	60%
	Strongly Discouraged: Gold *Lower AV for this population for minimal savings or increased cost.*	80%
150-200% FPL	**Recommended:** Silver	87%
	Not Recommended: Bronze *Healthy, cost-conscious Coloradans could buy down to a bronze or catastrophic plan but would expose themselves to large financial liability if they had unexpected health expenses.*	60%
	Strongly Discouraged: Gold *Lower AV for this population for minimal savings or increased cost.*	80%
200-400% FPL	**Recommended:** Gold *For Coloradans who know they will have medical needs, a gold plan offers the most coverage. Under this policy option, gold coverage may also be cheaper than silver coverage.*	80%
	Neutral: Bronze *Healthy, cost-conscious Coloradans could buy down to a bronze or catastrophic plan but would expose themselves to large financial liability if they had unexpected health expenses.*	60%
	Not Recommended: Silver *Some Coloradans in this income bracket are eligible for the lowest-value CSR plan (CSR Silver 1), but in a market where prices reflect AV, the 80% gold plan should be cheaper.*	70% / 73% *(depending on income)*
>400% FPL (not eligible for APTCs)	**Recommended:** Bronze/Off-Exchange Silver/Gold *For Coloradans who know they will have medical needs, a gold plan offers the most coverage. For healthy Coloradans who can afford to pay out of pocket for some care, a bronze plan may be appropriate but would potentially expose them to large financial liability if they have unexpected health expenses.* *Off-exchange silver plans are available at a lower price than on-exchange silver plans that include silver loading costs.*	60% / 70% / 80%
	Strongly Discouraged: On-Exchange Silver *Equivalent off-exchange silver plans should be available at a lower price to Coloradans who want the same level of coverage.*	70%

Consumer Feedback

Focus group participants were asked by CHI about the complementary policy levers described above.

Many focus group participants did not consider a gold plan to be within reach financially, though many of them said they would buy a gold plan, because of the additional benefits, if it were more affordable. Participants reacted similarly to a proposal to price silver plans differently. They expressed confusion at the complicated structure of the individual market but said they would welcome improvements in affordability as long as they were not accompanied by unintended consequences.

One participant speculated that very few people enroll in gold plans and that those who do may not need additional financial help. Others felt that silver plans should be made more affordable, speculating that the majority of Coloradans are middle-class and thus more likely to select a silver plan than a gold plan. These comments implied a perception that metal tiers are correlated with income levels, a sentiment expressed in all three focus groups.

This is reflected in 2019 and 2020 enrollment data: the vast majority of non-CSR exchange enrollees purchase bronze coverage.[33] It was also a trend among focus group participants: Of the eight focus group participants who specified the metal tier of their 2020 coverage, seven were enrolled in a bronze plan.

Participants expressed reservations about improving affordability for gold plans for that reason: Since gold plans would likely still be out of reach financially even if their prices were reduced, some participants felt that affordability improvements would be better applied to bronze plans. This is despite at least one participant sharing that their family had to take out a loan to pay for care because the bronze plan did not cover many costs.

Considerations for Implementation

Several states have already implemented policies similar to those described here. For the 2020 plan year, for example, Pennsylvania began requesting that all insurers price silver exchange plans using a uniform adjustment factor established by the state, which has the effect of pricing the plans based on the AV available to CSR enrollees.[34] For the 2021 plan year, Pennsylvania instituted the other piece of this proposed approach, requiring insurers to base induced utilization factors on those used in the HHS risk adjustment program.[35] New for the 2021 plan year, Pennsylvania has implemented a modest reinsurance program, the state's share of which is financed by fees insurers pay to operate on the newly implemented state-based insurance exchange.[36,37,38] Premiums in Pennsylvania are down slightly for 2021, largely due to the reinsurance program.

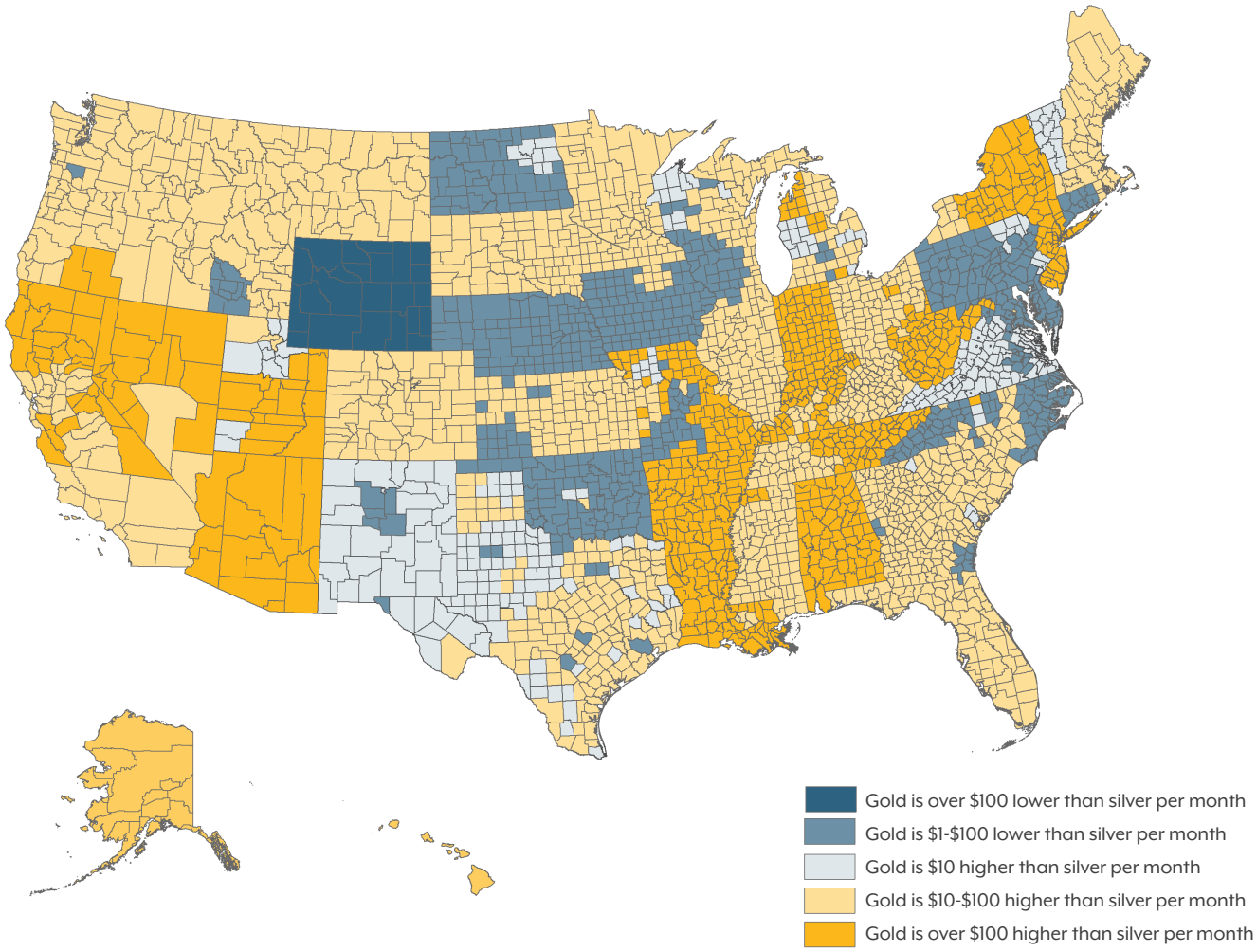
Further analysis is needed to understand how the induced utilization and silver plan pricing changes have affected affordability for the subsidized population in Pennsylvania, but initial analyses show affordability improvements for gold and bronze plans available to subsidized consumers in both 2020 and 2021.[39]

Analysis by county shows a decrease in post-subsidy premiums across the state (in most but not every county) for the 2020 plan year for a hypothetical 40 year old with income at 240% FPL shopping for a bronze plan. That same hypothetical person shopping for a gold plan for 2020 coverage also would have seen affordability improvements in most counties, though on average a smaller percentage reduction.[40] Post-subsidy premium reductions in 2021 for that same hypothetical person — an individual who fits squarely in the 200% to 300% FPL population previously highlighted — were even more dramatic for both bronze and gold plans.[41]

Similar regulations or policies are in place in Maryland and Virginia. As in Pennsylvania, Virginia permits the use of only induced demand factors associated with the HHS risk adjustment program.[42]

Maryland, which operates a state-based insurance exchange and has had a reinsurance program since 2019, has pushed insurers to price plans based on value. For several years Maryland has required insurers to submit values from the HHS AV calculator, and beginning with the 2021 plan year, the state requires insurers to provide screen captures of the values output from the calculator to verify plan pricing is consistent with AV.[43] (Pennsylvania also requires the use of this calculator.) In Maryland, gold enrollment as a percentage of total plan enrollment (among bronze, silver, and gold plans) rose from only 5% in 2017 to 36% in 2020.[44] In Colorado, gold enrollment as a percentage of total on-exchange plan enrollment was around 6% in 2020.[45]

Map 2. Lowest-Cost Gold and Silver Plan Pricing Dynamics by County, 2021 (Before Tax Credits)[46]



The cost for implementing this combination of policy changes is minimal. In the case of Pennsylvania, the changes were accomplished by updating regulations governing insurer rate submissions. States that use the HHS-created AV calculator and induced demand factors did not need to develop their own tools or benchmarks, and they have the benefit of using vetted and widely accepted standards.

Additional research is needed to assess whether these policy changes have had any material negative impact on insurer participation. Some rural parts of Virginia, Pennsylvania, and Maryland have only one insurer offering plans on the individual market. But insurer participation in those states is similar to Colorado, which has only one insurer operating statewide and has 10 counties with only that carrier offering plans on the exchange in 2021.[47]

However, analysis by actuaries with Axene Health Partners and Stan Dorn of Families USA suggests insurers stand to benefit from these policies as well, assuming they are applied uniformly to all carriers. Lower-cost coverage will entice additional, healthier consumers to enroll, which in turn will improve insurers' risk pools.[48] Insurers may further benefit from increased revenues as healthier consumers upgrade to gold-level coverage as those plans become more affordable.

These changes should create more pricing stability in the individual market by clarifying pricing rules for insurers. However, DOI should continue to monitor how insurers respond to new pricing rules to assess whether estimated affordability gains

are realized and whether adjustments need to be made to ensure consumers continue to benefit in future years. DOI already has the authority to implement these changes.[49]

If these changes were to be implemented, some consumers would need to act to shift to the plan that is most optimal given their income and health status. (Optimal enrollment is discussed on page 14 in Figure 6.)

Option 2: Require Insurers to Apply Reinsurance Savings Proportionally Across Plan Types

The reinsurance program is designed to target high-cost insurance rating areas for larger premium decreases. The target premium reduction statewide is 20%, but the target reduction varies based on geographic tier defined by the reinsurance program. In Tier 1, the Denver metro area, the target reduction is 15-20%. In Tier 2, the Eastern Plains, the target is slightly higher: 20-25%. In Tier 3, the Western Slope, the target reduction is highest: 30-35%. Insurers operating in a tier with a higher target reduction have a greater portion of their costs (known as a coinsurance percentage) covered by the reinsurance program, which allows them to reduce their premium rates more than those in other tiers.[50]

During the review process for 2021 plan year rates, the actuarial firm Lewis & Ellis found that most insurers projected the impact they expected reinsurance to have on their premiums to vary based on geographic factors. Lewis & Ellis found this to be a reasonable practice, given the structure of the reinsurance program and how relative enrollment by geography can affect an insurer's expected reimbursement from the program.

However, one carrier proposed applying further adjustments at a plan level, which DOI did not allow. In addition to geography, this insurer proposed applying reinsurance savings differently (meaning a higher or lower percentage discount) based on whether the plan was a gold, silver, or bronze plan. This could involve, for example, an insurer choosing to apply a larger reinsurance-driven premium reduction to silver and bronze plans than to gold plans in an effort to discourage enrollment in gold plans, which cover a larger portion of costs and draw enrollees who may have higher health needs.

This policy option aligns with how DOI has responded to the one prior instance of an insurer applying reinsurance savings disproportionately across plan types. It is simply to recommend that response as DOI policy going forward. It would entail restricting insurers from applying varying amounts of reinsurance-driven price reductions by plan type, and allow variation in reinsurance pricing only by geography, as defined by the three tiers. While the practice of distributing reinsurance savings disproportionately (meaning a larger percentage discount applied to silver plans compared to gold, for example) among a carrier's plans has not been widespread to date, this change would prevent insurers from making such pricing decisions in future years.

Impact on Consumer Buying Power and Enrollment

Additional data are needed to assess the specific impacts of this option. Because uneven distribution of reinsurance dollars based on non-geographic factors has not been allowed by DOI, it is unclear how the practice might impact subsidy amounts or enrollment by the subsidized population. But it is plausible that it might further exacerbate existing challenges related to inflated gold prices, especially if it were to become a more common practice.

Using savings accrued through the reinsurance program to change the relative cost of certain plans could increase existing affordability issues. For example, using reinsurance savings to reduce the cost of silver and bronze plans by a greater percentage than the cost of gold plans means that gold plans become more expensive relative to silver and bronze plans. Because subsidy amounts are tied to the benchmark silver plan, this means that gold plans could become more expensive for subsidized consumers, not just in relative terms but as measured by the dollars they pay each month because their available subsidy has decreased disproportionately.

Consumer Feedback

The majority of consumers in CHI's focus groups liked the idea of potential regulations requiring insurance companies to use the reinsurance program to reduce the cost of all types of plans (gold, silver, and bronze) equally. This policy option was popular with participants partially because it seemed intuitive as a way to improve affordability, and partially because it appealed to a commitment to fairness expressed by consumers. This was rooted in the concept of reducing costs proportionally across all metal tiers. Participants did have questions about the specifics of how this option would work in practice.

Considerations for Implementation

Existing regulations give the DOI authority to enforce this change through the rate review process.

CRS 10-16-107 gives the Commissioner of Insurance authority to review rates to determine if they are excessive, inadequate, or unfairly discriminatory. In considering whether rates are excessive, the Commissioner may consider whether a carrier's products are affordable. The Commissioner may also adopt rules to ensure that premium pricing complies with the requirements of the ACA for modified community rating, meaning insurers cannot vary premiums based on enrollees' health status.[51]

There are no implementation costs related to this policy, since DOI already has authority to deny rates that apply reinsurance dollars inappropriately and has done so in the past.

No action would be required from consumers in order for them to benefit from the policy change.

Option 3: Institute New Auto-Enrollment Rules

For this analysis, CHI also explored a theoretical addition to individual marketplace auto-enrollment rules that would steer customers into the plan with the highest AV relative to premium cost (in other words, the most cost-effective plan). Because auto-enrollment rules are implemented by C4HC, which operates the exchange, any potential implementation of this policy is not within the purview of this report. Further, neither CHI nor DOI are recommending that this option be pursued at this time. Unlike the previous policies, this policy has not been tested by other states and therefore the potential challenges are less clear due to a lack of real-world evidence. Further, consumers participating in focus groups conducted for this analysis consistently expressed reservations about this policy because of concern it might reduce their control over selecting the plan that is best for them.

However, there is some reason to explore ideas that either increase consumer engagement with selecting a health plan or simplify the process. Many consumers do not shop for their insurance coverage every year, although doing so is recommended to ensure the best coverage and price. Almost half (43%) of all continuing consumers with subsidies enrolled on the individual market in 2020 were auto-enrolled in their coverage, based on their 2019 plan, without logging into the system to review their plan or shop for a new one. Another 30% of subsidized consumers logged into the exchange, reviewed their plan, and decided to auto-enroll in that plan. Only 13% of consumers shopped and selected a new plan for 2020. (The remaining group of continuing subsidized consumers either opted out or were not part of the auto-enroll process for 2020 coverage.)[52]

For some consumers, particularly those with known health concerns and existing provider relationships, it is critical to review plan specifics such as provider networks and prescription drug coverage to make sure the services they need continue to be covered. But there is another group of consumers that simply shops for coverage based on premium prices. For this population, an addition to existing auto-enrollment rules could help ensure their dollars go furthest.

This proposed policy option would allow consumers who know they are searching for the most cost-effective coverage available to opt into a new auto-enrollment flow that would place them in the most cost-effective coverage, which may be different than the plan they had the prior year. Requiring participants to opt into this process is key. It is not for everyone — only consumers who know they are shopping

for the most cost-effective coverage would participate. Consumers who want to make sure a particular provider is in network, or that a particular prescription drug is covered, would not opt into this process, which does not account for those factors.

Impact on Consumer Buying Power and Enrollment

This theoretical auto-enrollment process could benefit some subsidized consumers. Based on an analysis of 2020 individual market enrollment by Lewis & Ellis, nearly 8,700 Coloradans who receive APTCs but not CSRs were enrolled in on-exchange silver plans. These plans are overpriced relative to their AV for this group of consumers. Almost 5,700 other Coloradans who are not eligible for either APTCs or CSRs are enrolled in on-exchange silver plans.[53] These consumers would likely receive better value if they bought up to a gold plan for more generous coverage at a better coverage-to-cost ratio; bought down to bronze coverage for a more affordable plan; or purchased an equivalent silver plan off-exchange, which does not have silver loading costs built into the price. In short, nearly 15,000 Coloradans could be receiving better value on a different plan.

Consumer Feedback

Many consumers are wary of auto-enrollment functions because they prize a sense of choice. The participants in the three focus groups conducted by CHI represent a group of particularly engaged consumers: 100% (14 of 14) of participants said they actively shop for coverage every year. They valued autonomy, especially those who have complex health conditions or are particularly connected to their health care providers, and said personal choice, a sense of control, and the ability to advocate for themselves were important.

Considerations for Implementation

This option was explored in this analysis as a potential method for maximizing buying power of subsidized consumers. For several reasons, CHI does not recommend that it be pursued at this time.

Active Shopping Improves Coverage Quality and Affordability

According to the analysis by Lewis & Ellis, younger Coloradans were more likely than older people to auto-enroll in their 2020 coverage. Older consumers were more likely to review their plan choices and shop around, perhaps due to their higher use of enrollment assistance sites or more significant health needs. The analysis also found that enrollees in higher-cost regions, such as the Western Slope and Eastern Plains, were more likely to be active shoppers. Enrollees closer to the 400% FPL cutoff for APTCs were also more likely to actively shop, likely because their subsidies cover less of the cost of their coverage, which may make them more price sensitive.

Because of the many variables at play in the individual market, all consumers would benefit from actively reviewing their options and choosing the best plan for themselves or their family each year. This report does not make recommendations related to marketing and outreach, but it does note some important factors for policymakers and stakeholders to consider and includes some general findings from research conducted for this work.

The policy options recommended in this report would improve affordability for many subsidized consumers. However, without corresponding marketing and education campaigns, they could potentially add confusion to an already complicated market. For example, on-exchange silver plans are currently the best value only for those who are eligible for CSRs. These policies would increase the cost of silver plans and the subsidies associated with them, meaning subsidized consumers would see cheaper gold and bronze plans. But on-exchange silver plans would continue to offer poor value for non-CSR consumers.

As a potential alternative to the theorized auto-enrollment process discussed in this report, the state of Maryland has the ability to perform targeted outreach to segments of enrollees by categories such as metal level enrollment and income. This has allowed the state to reach out to enrollees not eligible for APTCs who were enrolled in silver plans when silver loading began. Those enrollees were

notified they could likely get a better deal on a silver plan by purchasing it off-exchange.[54] This capability would allow outreach to exchange enrollees who could get a better deal on a different plan. However, it might also involve directing some people away from the exchange — a drawback, considering the state's efforts to bring Coloradans onto C4HC's platform.

This targeted outreach approach would likely be easier to implement than the modified auto-enrollment option and has less potential for unintended consequences for consumers, but because it requires consumers to act, it may be less effective in steering them to comparable and more cost-effective plans.

A 2016 report from RAND on best practices for consumer decision-making recommended listing optimal choices, when they can be identified, more prominently than others (for example, putting them first in a list). This and other more moderate steering strategies, such as enhanced training for coverage guides, could also improve the likelihood of helping more enrollees enroll in optimal plans.[55] Many states, including Maryland, have become increasingly creative in their outreach strategies, exploring new channels such as Twitch, an online streaming platform, and working with popular local social media figures to reach consumers. These channels tend to reach a younger audience. Maryland recently worked with Hispanic and Black social media figures to target their message to those populations.[56]

California, which has a large budget for insurance marketing and outreach, partnered with social media figures to create content that generated more than 3 million social media impressions. California's strong individual market enrollment is also credited to additional state subsidies that improve affordability for consumers, as well as a state-level individual mandate for purchasing insurance coverage.[57]

Conclusion

Colorado continues to be a leader among states in identifying and implementing solutions to improve health care affordability. Investments in primary care and value-based care arrangements are driving dollars toward where they will have the most impact. State-based subsidies will be made available to eligible individual market consumers in 2022 to further improve the affordability of insurance.

This report examines dynamics affecting costs since the state implemented its reinsurance program in 2020. The reinsurance program has reduced individual market premium prices by just over 20% in both 2020 and 2021. Despite this, many consumers have not been reaping the full benefits of the cost savings from reinsurance and other price reductions because of various actions from insurers and the complicated structure of APTCs and the individual market.

DOI should continue to take action to protect the buying power of subsidized consumers by implementing policies that maximize federal dollars flowing into the state via APTCs. DOI has a further opportunity to bolster subsidized consumer buying power by implementing policies that encourage insurers to price coverage based on AV and to explore other potential solutions, such as new auto-enrollment processes or targeted outreach and marketing.

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STATE OF COLORADO
SUBSIDIZED POPULATION STUDY
INDIVIDUAL HEALTH INSURANCE MARKET, 2019 TO 2020
OCTOBER 2020

Prepared by
Lewis & Ellis, Inc.

Andrea Huckaba Rome, FSA, CERA, MAAA, Vice President

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Executive Summary

This report explores the changes that occurred in the Health Insurance Individual Market in Colorado from 2019 to 2020, due to the introduction of a State Reinsurance program, made possible through an ACA Section 1332 Waiver and Colorado House Bill 19-1168. The report focuses on impacts to the ACA Subsidy-eligible enrollee population and fulfills the statutory requirement in HB 19-1168 for the Commissioner of Insurance to evaluate the Reinsurance program's effects on this population.

The following are the key conclusions from the analysis.

1. **The reinsurance program worked as intended**. Monthly rates were significantly lowered for all enrollees (before subsidy). Individuals in areas with higher healthcare costs and rates received the most rate relief from the program. Enrollment increased significantly for unsubsidized individuals, and moderately for subsidized individuals. *[See Section 2 for more detail.]*

2. **Silver-loading the Cost Sharing Reduction (CSR) Plans and subsequent actions taken by carriers have impacted subsidies.** In 2019, Silver-loading to cover the cost of unfunded CSR plans increased Silver plan rates to the same level as Gold plan rates. In 2020, many carriers seem to be re-adjusting: lowering Silver plan rates and raising Gold plan rates to put distance between the metal levels. This shifting down of Silver rates has lowered premium subsidy amounts. *[See Section 3 for more detail.]*

3. **Subsidized members may or may not have benefited, depending on location.** Monthly rates for subsidized members decreased for half of the subsidized population and increased for the other half. The subsidized members receiving increases most likely live in areas where the change in silver plans was substantially different from the change in all rates; their subsidy may have decreased more than their plan rate, leading to a rate increase. This was highly dependent on location and insurance carrier. *[See Section 4 for more detail.]*

4. **Members have different motivations when shopping for a plan, but have much greater control over their costs when they choose to shop.** The members most likely to shop are older, healthier, likely to use assistance when enrolling, and live in rural areas of the state. The members least likely to shop are younger, live in more populated areas of the state, and have a low current premium rate. *[See Section 5 for more detail.]*

Colorado continues to make health insurance more affordable for its citizens. The reinsurance program has been effective in providing rate relief to thousands of Individual Health Insurance Market enrollees, and has made health insurance rates more level across the varying areas of the state. The Division will continuing pursuing policies that reduce the cost of insurance for Coloradans, particularly those experiencing the greatest financial need.

Section 1: Introduction and Purpose

Colorado House Bill 19-1168 instructs the Commissioner of Insurance to evaluate the effect of the reinsurance program on access to affordable, high-value health insurance for consumers who are eligible for premium tax credit subsidies and cost sharing reductions and minimize any potential negative effects on those consumers.

This report was developed to comply with those requirements and to analyze the following:

1. Analyze changes from 2019 to 2020 for the Colorado ACA Individual Market. Determine if the State Reinsurance Program was effective in both lowering rates for consumers and in reducing the difference in rates between low and high cost areas of the state. **See Section 2.**

2. Analyze changes from 2019 to 2020 for the Colorado ACA Individual Market, subsidized population. Determine how the state reinsurance program and other factors like Silver-loading may have impacted these populations. **See Sections 3 and 4.**

3. Analyze Colorado ACA Individual Market shopping. Determine which members utilized the auto-enroll function when renewing their plans for 2020, and which members decided to shop for a new plan. Identify characteristics of the the "shoppers". **See Section 5.**

Section 2: Market Changes from 2019 to 2020

This section is a review of impacts to ACA Individual Market unsubsidized rates from 2019 to 2020. The results include the COVID-19 Special Enrollment Period members. Section 4 reviews the impacts to rates after a subsidy is factored in.

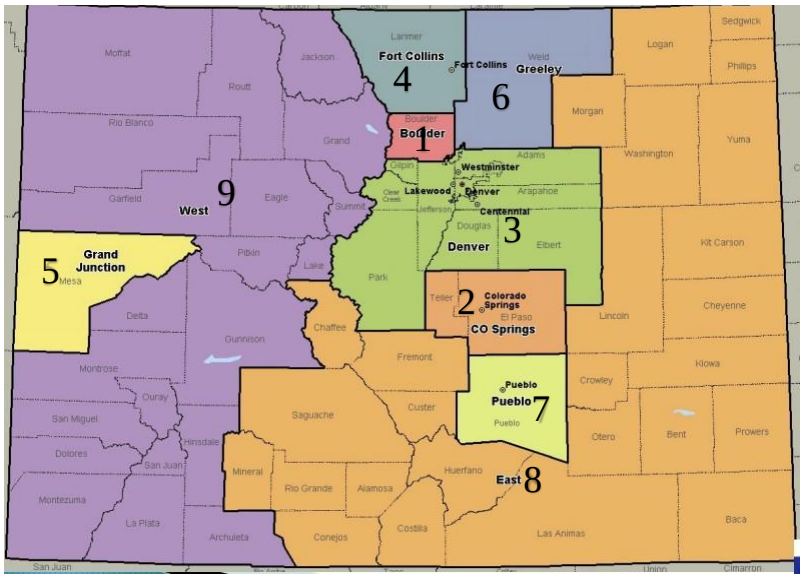
Open Enrollment in the Colorado Individual Health Insurance Marketplace for calendar year 2020 began November 1, 2019. Enrollees from across the state logged in to discover that rates had dropped substantially from the prior year. This drop in costs was due to the implementation of a state-based reinsurance program, made possible through an ACA Section 1332 Waiver and HB 19-1168.

The program is designed to reimburse insurers for any individual enrollee's annual paid dollars that exceeded an attachment point of $30,000 up to a cap of $400,000. Between the attachment point and cap, a portion of per member annual dollars would be covered based on a coinsurance percentage, which corresponded to the member's location. See below for the coinsurances by tier, and a map of Colorado's rating areas.

Figure 1: Colorado State Reinsurance Program Parameters, 2020

	Tier 1	**Tier 2**	**Tier 3**
	Areas 1, 2 and 3	***Areas 4, 6, 7 and 8***	***Areas 5 and 9***
Attachment Point	$30,000	$30,000	$30,000
Cap	$400,000	$400,000	$400,000
Coinsurance	45%	50%	85%

Figure 2: Colorado Allowable Rating Regions, ACA Market



Since the program covers a portion of expenses that typically would be paid by the insurance companies, rates could be lowered to reflect the lower cost-obligation of the insurers. Rates were, on average, lowered by 20.2% from 2019 to 2020, as reported by the Colorado Division of Insurance at the time of rate filings, primarily due to the impact of reinsurance.

This program is seamless to the consumer; all Colorado ACA Individual Market members automatically benefit from this program, and the only public-facing difference is the change in rates they experience.

After actual enrollment and shopping, 2020 rates for people who purchased coverage *on the exchange*[1] went down by an average of 23.4% compared to those members' 2019 rates. Off-exchange rates experienced a similar decrease over 2019. The chart below summarizes rate changes on the exchange.

Figure 3: Colorado Individual Market, On-Exchange Change in Rates from 2019 to 2020

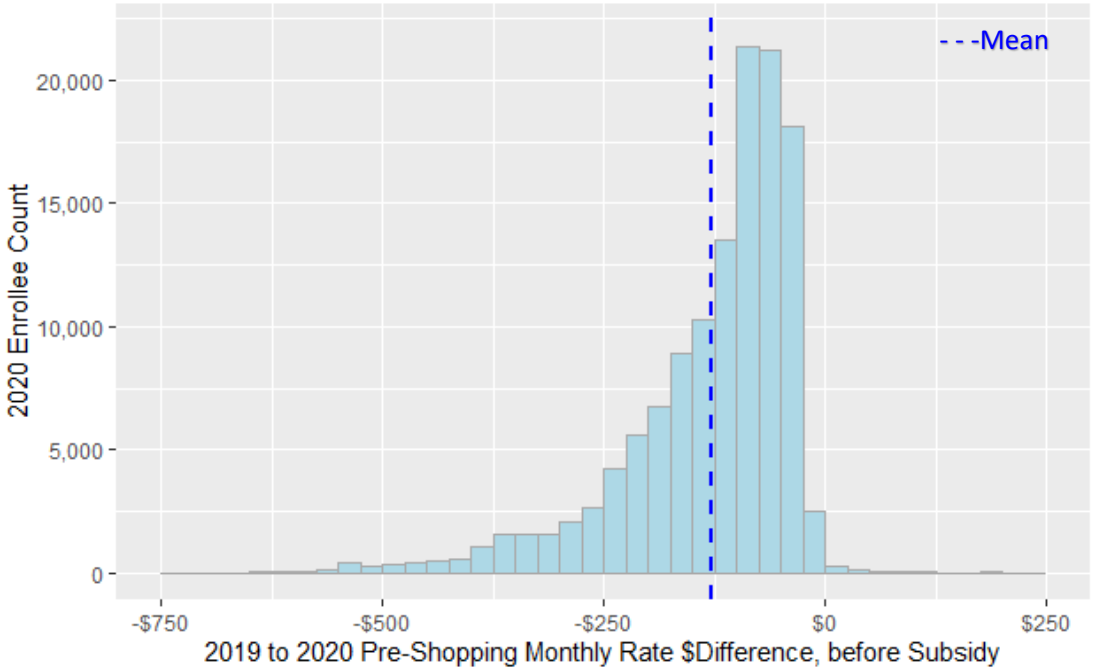
	2019	2020	Δ from 2019
Total On-Exchange Rate	$617	$473	-23.4%
Members not eligible for Subsidy, final rate	$508	$400	-21.2%
Members eligible for Subsidy, rate ***before*** subsidy	$648	$499	-23.0%

The above figure shows the average rate change of members on the exchange. On average, members received a significant rate decrease due to the impact of reinsurance. Subsidized members had a significant decrease before the subsidy impact was included. This section reviews these member's rate changes before subsidies, and Section 4 will review the subsidy impact.

[1] This report focuses on On-Exchange members because all subsidized members are contained within that subset. Members must enroll On-Exchange to receive a premium subsidy and/or a CSR plan. Detailed and quality enrollment data was available for tracking On-Exchange members through 2019 and 2020 courtesy of Connect for Health Colorado. Comprehensive data that allows for member tracking is not available for Off-Exchange members.

Below is a distribution of all members' monthly rate change, in dollars. This distribution shows the rate before members make any shopping decisions, and before a subsidy is applied.

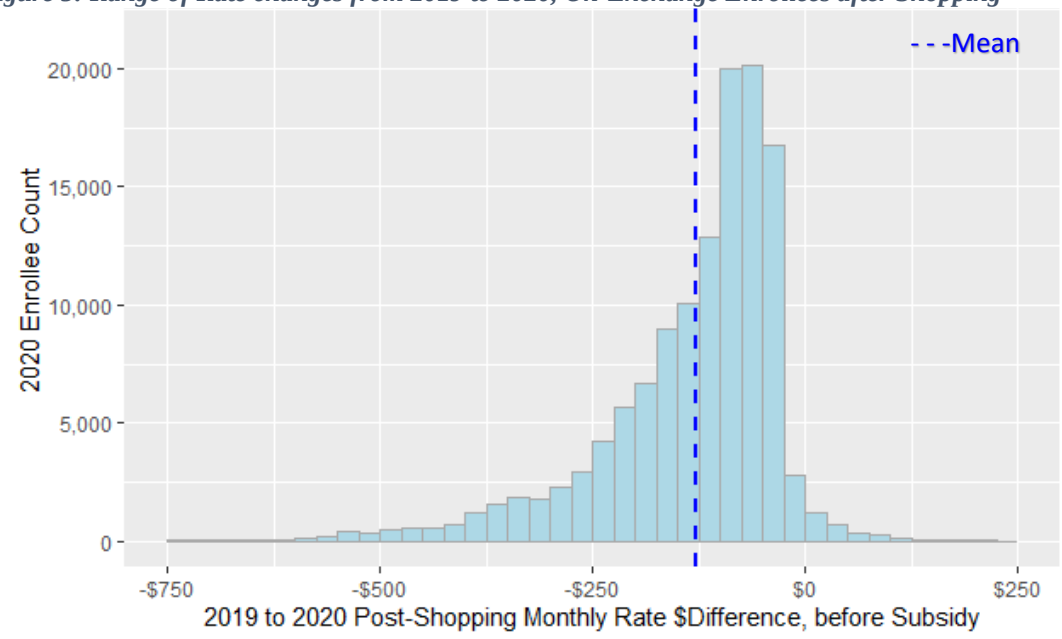
Figure 4: Range of Rate changes from 2019 to 2020, On-Exchange Enrollees before Shopping



The distribution peaks around a $50 to $100 savings from 2019 to 2020, with almost all members receiving a savings. The mean of the distribution is -$129. The median is -$100. Nearly all members received a rate decrease (before subsidies) from 2019 to 2020.

After members shop for coverage, we see a few enrollees opt for a small increase, and more members shop for a greater decrease, spreading out the curve a small amount.

Figure 5: Range of Rate changes from 2019 to 2020, On-Exchange Enrollees after Shopping

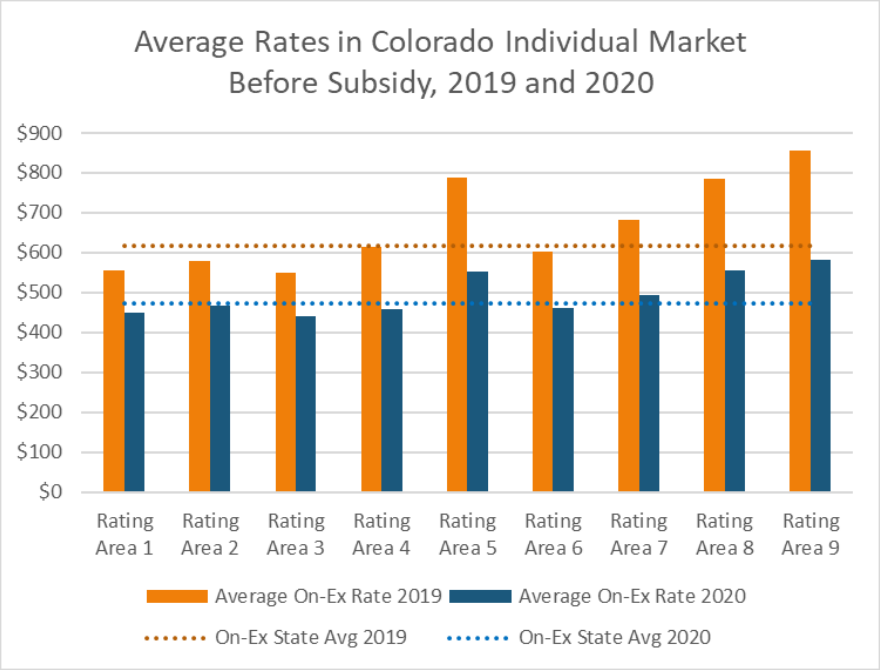


The distribution above (prior page) peaks in the same place. Mean has decreased to -$132. The median remains at -$100. There is a slight impact for 1 year of aging, which the pre-shop rates do not include.

Both pre- and post- shopping charts are shown, indicating that there is significant savings to members both before and after plan selections are made. This significant savings is not being driven by consumer activity, but by an actual, significant decrease in the rates themselves. For a distribution of rate changes after a premium subsidy is applied, please see Section 4.

The bar graph below illustrates the average changes in rates by rating region. The dollars shown reflect the monthly rates for all individual market enrollees on the exchange, before taking into account any premium subsidies.

Figure 6: Rates by Rating Area, 2019 and 2020, On-Exchange Enrollees



The reinsurance program appears to have done an excellent job of lowering unsubsidized rates in all areas, and providing larger rate relief to those areas that had higher rates in 2019 due to higher claims cost: Areas 5, 8 and 9.

Below is the change in enrollment from 2019 to 2020 for the ACA Individual Market. These numbers include both Open Enrollment and Special Enrollment Period counts:

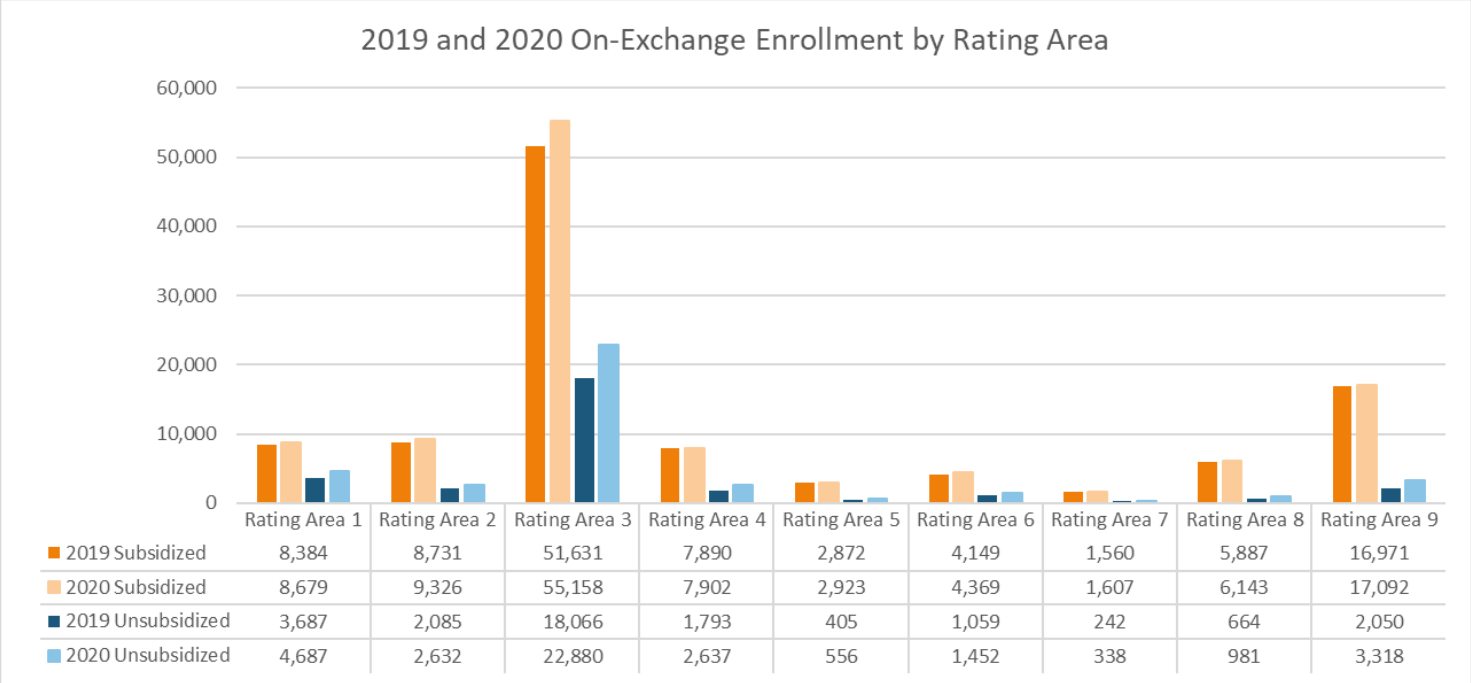
Figure 7: Enrollment in 2019 and 2020, ACA Individual Market

	2019	2020	Δ from 2019
On-Exchange	138,125	152,679	10.5%
Subsidy + CSR Plan	41,488	45,404	9.4%
Subsidy Only	66,587	67,796	1.8%
No Subsidy	30,050	39,479	31.4%
Off-Exchange*	56,483	59,820	5.9%
Total Individual ACA	194,608	212,499	9.2%

*Estimated from URRT Experience Period and Current Member Months

Additionally, after including both open enrollment members and special enrollment period members (for COVID-19), we see increases in membership across all rating areas. These increases are more significant for the unsubsidized population. See the chart below:

Figure 8:Enrollment by Subsidy and Rating Area, On-Exchange 2019 and 2020



	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7	Rating Area 8	Rating Area 9
2019 Subsidized	8,384	8,731	51,631	7,890	2,872	4,149	1,560	5,887	16,971
2020 Subsidized	8,679	9,326	55,158	7,902	2,923	4,369	1,607	6,143	17,092
2019 Unsubsidized	3,687	2,085	18,066	1,793	405	1,059	242	664	2,050
2020 Unsubsidized	4,687	2,632	22,880	2,637	556	1,452	338	981	3,318

Overall, subsidized members increased by roughly 5,100 and unsubsidized members increased by roughly 9,400. Note that these enrollment counts include enrollees who took advantage of the Special Enrollment Period in April 2020, due to the onset of the COVID-19 pandemic.

To summarize, the above information tells us that the reinsurance program worked as intended. It reduced rates for members in the individual market, and increased enrollment for unsubsidized members. Further, it reduced the difference in rates between the highest cost areas and the lowest cost areas, making coverage more affordable for members in high cost areas, and more level across the state of Colorado.

Observations about Diversity by %FPL

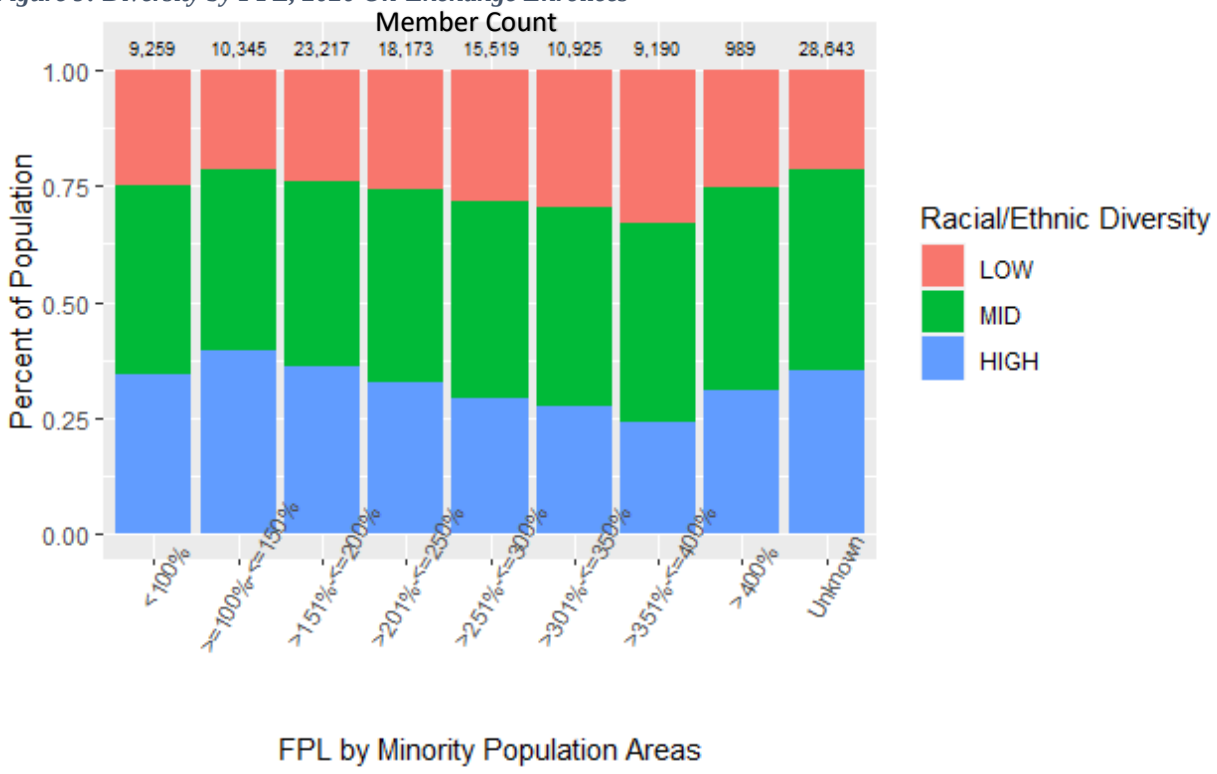
Diversity data was largely not available for the on-exchange enrollees, but the US Census allows us to consider the locations of our enrollees and provide some broad insights around race and ethnicity in the context of the individual market.

High are counties with non-white population above 35%
33% of members live in these 16 counties
Mid are counties with non-white population between 20% and 35%
42% of members live in these 20 counties
Low are counties with non-white population below 20%
25% of members live in these 28 counties

Although we cannot draw conclusions about the racial/ethnic makeup of the exchange population, Colorado can use the census information to better reach potential enrollees.

The data below indicates that our enrollees with lower Federal Poverty Level (FPL)% are more likely to live in places where the non-white population is higher.

Figure 9: Diversity by FPL, 2020 On-Exchange Enrollees[2]



For reference, below (next page) is the measure of county diversity, by rating area. Some areas are only one color if the area consists of a single county.

[2] The "Unknown" category includes 2,349 members in 2020 with subsidies where their FPL was not loaded into Connect for Health Colorado data from the state eligibility system. The other 26,294 members with "Unknown" FPL did not receive a subsidy.

Figure 10: Diversity of member counties by Rating Area

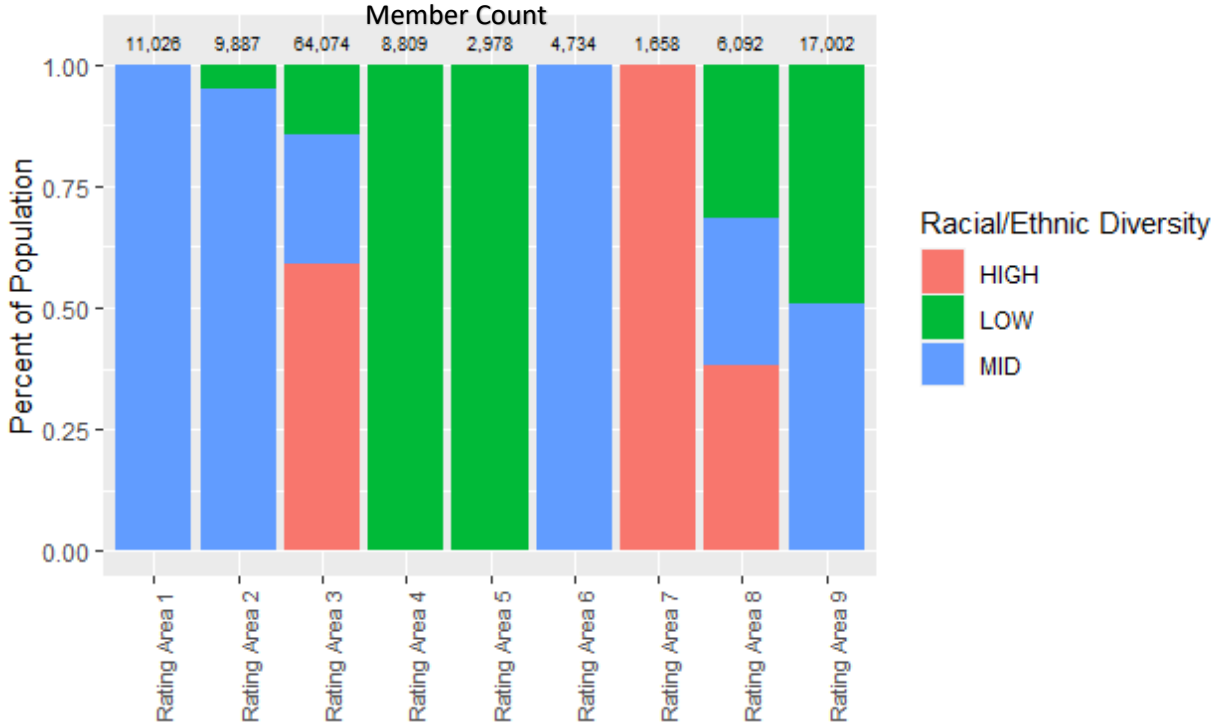
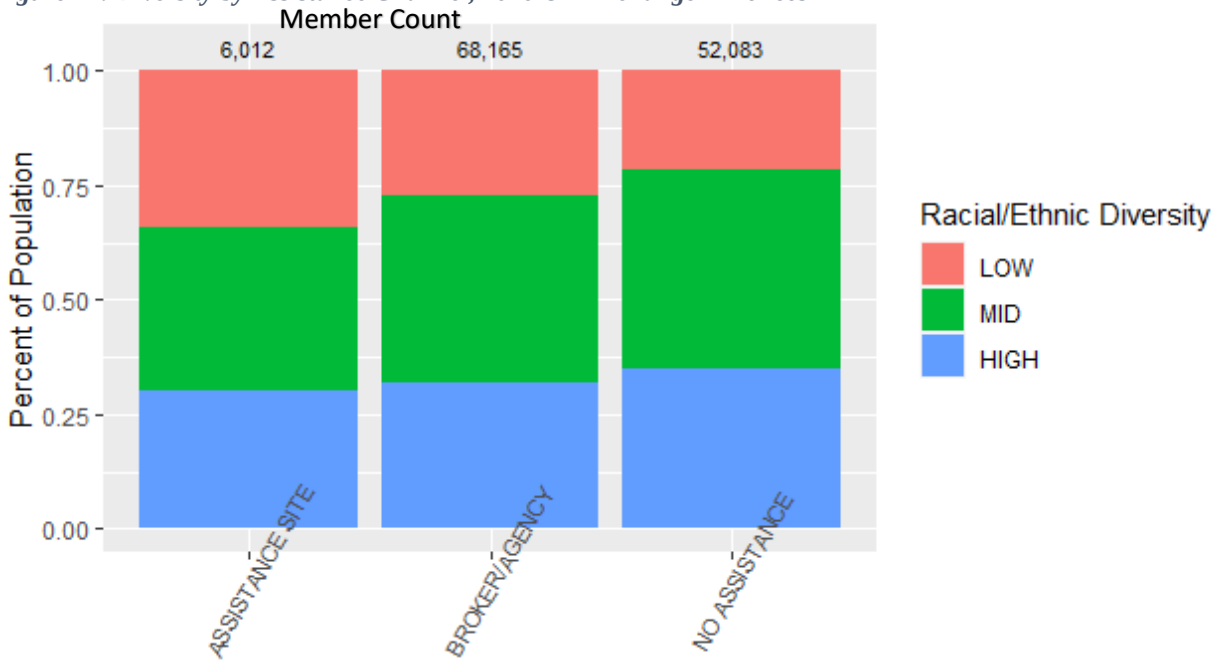


Figure 11: Diversity by Assistance Channel, 2020 On-Exchange Enrollees



Members living in higher-diversity counties are slightly less likely to seek assistance when enrolling. This may also be related to age, as more densely populated areas tend to be younger and more diverse.

Section 3: Impact of Unfunded CSRs, Detail

Key market changes outside of Colorado's reinsurance program occurred leading up to 2020. These factors also impacted the 2020 net rate changes for subsidized enrollees. This section details the impact of Silver loading and subsequent adjustments that impacted premium subsidies.

Cost Sharing Reduction (CSR) is a discount that lowers the amount a member may pay for deductibles, copayments and coinsurance. It was a function of the Patient Protection and Affordable Care Act (PPACA or ACA) that further defrayed the cost of health insurance coverage for lower income populations. Members with incomes under 250% FPL, as well as federally recognized tribes are eligible for cost sharing reductions, but they must enroll on a silver plan to get the savings.

The federal government originally agreed to reimburse insurance carriers for these CSR plans by paying the difference between the standard silver plan cost sharing and the reduced cost sharing for these members. In late 2017, the federal government declined to fund the CSR costs. This led the carriers to consider various methods to increase the rates to cover the extra cost of funding the CSR portion.

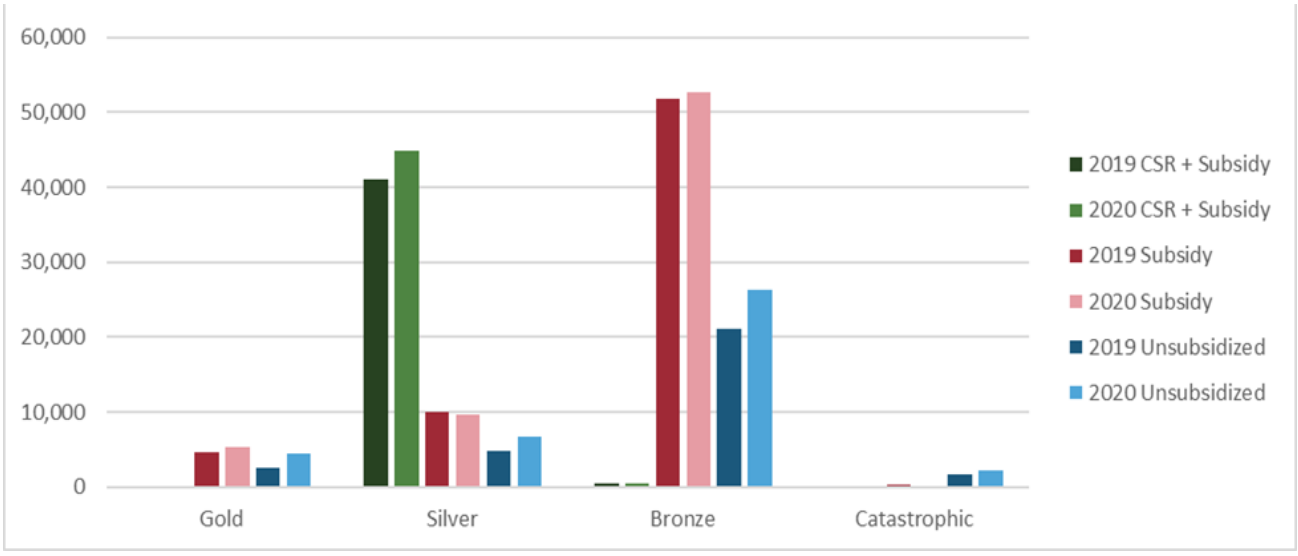
These methods include:

- Broad-loading. Increase all metallic rates by an equal amount to cover the cost.
- Silver-loading. Increase only the silver plans to cover the cost.

In 2018, Colorado allowed Broad-loading. The following year in 2019, Colorado required Silver-loading. This increased rates for only silver plans, which increased the premium tax credits. The premium tax credit is based on the Second Lowest Cost Silver Plan (SLCSP) in each area.

The other major result of silver-loading is that, due to silver plan costs increasing significantly, silver and gold plans end up being roughly the same price. Any member who does not have to enroll in a silver plan (for the CSR benefits) will either buy down to a bronze plan, or select a gold plan where they can get better benefits for the same price. We see this migration clearly in the following graph. The majority of silver enrollees are CSR recipients; subsidy only enrollees are more likely to choose a bronze plan.

Figure 12: Subsidy by Metal Level, 2019 and 2020 On-Exchange Enrollees

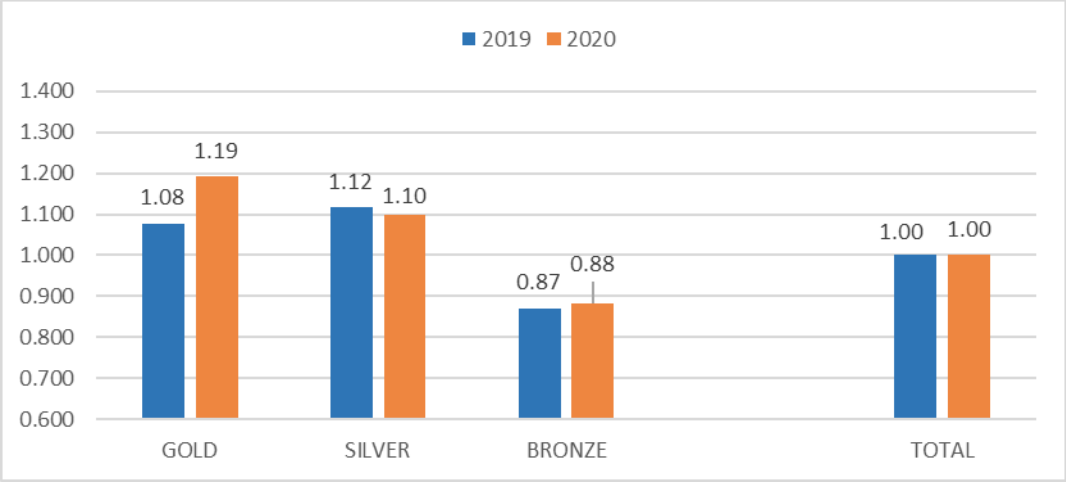


This matters, because members are changing their insurance plan based on logical comparisons and good shopping sense. This also matters because health insurance companies in this market are concerned about the migration away from Silver.
Insurers are allowed to adjust their plan pricing ratios by:

1. The pure Actuarial Value (AV), the ratio of expected insurance-paid claims based on member cost-sharing
2. Expected changes in use of medical services due to member cost-sharing levels, independent of health status (also called induced utilization).
3. Other factors including member network and adjustments for catastrophic plans.

In 2020, we see insurers in Colorado attempting to course correct by adjusting the balance between the metal levels. They are building in some space between gold and silver plans. They cannot do this through the pure AV if the plan designs haven't changed significantly. The carriers instead adjust induced utilization to build in space between the metals. See the graph below of ACA Individual Market normalized pricing ratios for on-exchange plans:

Figure 13: Marketwide Metal Pricing Ratios, before Shopping, 2019 to 2020



As stated, the gold plans have pricing ratios that are slightly below the silver plan pricing ratios for 2019. In 2020, the gold plans increase, so there is now a roughly 10% difference between gold and silver, and the silver- bronze relationship narrows from 29% higher to 25% higher.

See the impact these shifting ratios from above have on actual rates:

Figure 14: Example: Impact of changing price ratios by Metal Level

Example: Change in Pricing Ratios

	2019		2020		
	Ratio	Rate	Ratio	Rate	Rate change
Gold	1.08	$486	1.19	$423	-13.0%
Silver	1.12	$504	1.10	$391	-22.4%
Bronze	0.87	$392	0.88	$313	-20.1%
Total	1.00	$450	1.00	$356	-21.0%

Although the overall rate change is -21% in this case, the rate change varies by metal level. Silver is reduced by more than Bronze, and noticeably more than Gold. The Silver plan had the largest decrease and the tax subsidy is based on the Second Lowest Cost Silver Plan. These pricing ratios lead to a result where the subsidy drops more than the rate. This leads to a rate increase for the subsidized. We observe this impact in the Colorado Individual market in 2020.

Why is this happening? The carriers are making these AV adjustments for the following reasons:

1. Cost sharing differences between Gold and Silver plans should be reflected in price.
2. Competitors were doing it (and no carrier wants to have the lowest price Gold plan in the market)
3. Entice more non-CSR members to stay on the silver plans, (as there is less incentive to move to Gold plans). Non-CSR members are less expensive than CSR members because of cost-sharing, so they will help keep the silver price lower.

The downside of this rebalance of metal levels is that the silver plan costs will decrease. In a normal economic market, this would be a positive, but in the healthcare marketplace, any gains from a lower cost silver plan are negated by a lower premium tax subsidy available to individuals. See **Figure 15** below.

Figure 15: Example of Silver Decrease → Subsidy Decrease

Example: Silver Plan Decreases, Subsidy Decreases			
	2019	**2020**	**Rate Change**
Second Lowest Cost Silver Plan (SLCSP)			
Silver	$438	$349	-$89
Subsidy			
Maximum Paid for 250% FPL	$305	$309	
Subsidy = [SLCSP - Max Paid]	$133	$40	-$93

In the above example, the enrollee's rate decreased by more than his or her premium from 2019 to 2020. The enrollee in this example experienced a 2020 rate increase of +$4.

In general, any time the silver plan rates change in a way that is different from the rest of the plan rates in the market, the subsidized population will be impacted. From 2019 to 2020, this occurred because of the adjustments made to counteract silver-loading. These adjustments led to rate increases for some subsidized members, as we will see in the next section. To the extent that carriers continue to put space between metal levels, the subsidies will continue to be impacted in the future.

Section 4: Subsidized Population Changes from 2019 to 2020

Before the subsidy, most members experienced significant savings in their 2020 rate, compared to 2019. However, most of these savings were neutralized for members receiving a subsidy. See the table below:

Figure 16:Colorado Individual Market, On-Exchange Subsidized Change in Rates from 2019

	2019	2020	Δ from 2019
Members eligible for Subsidy, rate ***before*** subsidy	$648	$499	-23.0%
Members eligible for Subsidy, rate ***after*** subsidy	$129	$138	6.7%

Referring back to the number of enrollees shown in **Figure 7**, subsidized individuals in 2020 accounted for just over 113,000 members, or 74% of the on-exchange enrollees.

The primary reason for the savings being neutralized is the reason stated in Section 3; namely, the shifting of pricing ratios lowers the cost of silver plans more than the other metals, which in turn decreases the premium subsidies.

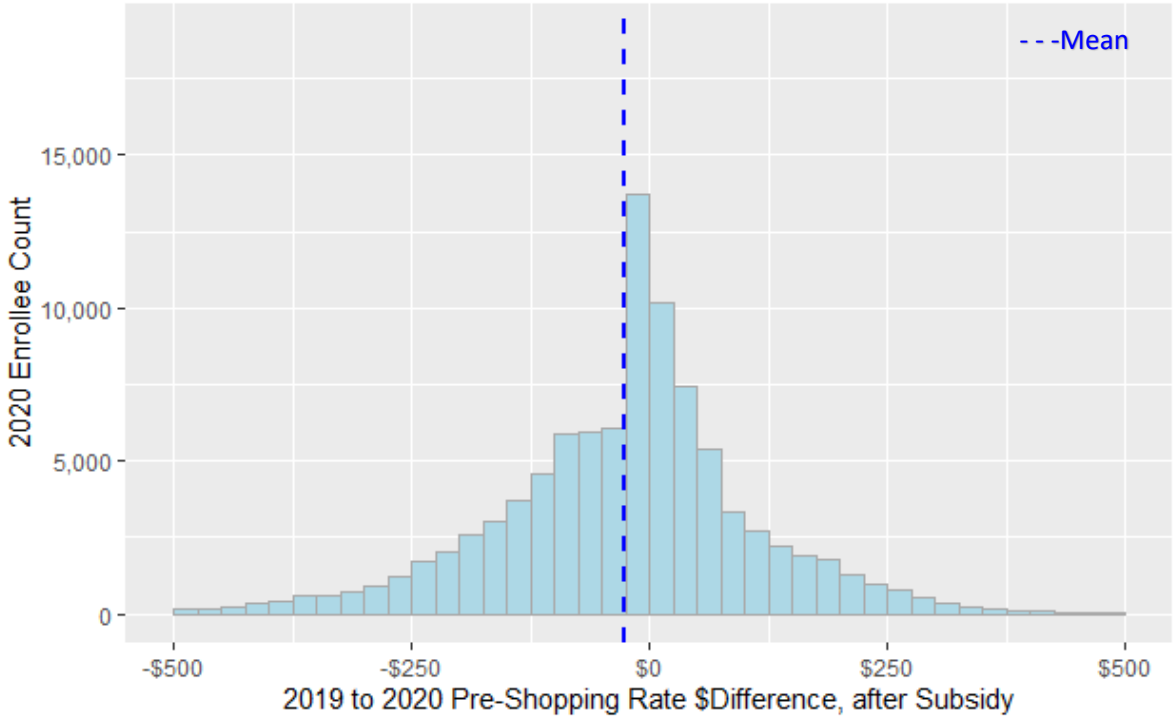
Here is an example of how this decrease in silver plan pricing and the Second Lowest Cost Silver Plan (SLCSP) would impact the total rate:

Figure 17:Example, Change in SLCSP

Example: Change in SLCSP and Subsidy			
Plan Selected	**2019 Price**	**2020 Price**	**Rate Change**
Bronze	$350	$291	-17.0%
Second Lowest Cost Silver Plan (SLCSP)			
Silver	$438	$349	-20.3%
Subsidy			
Maximum Paid for 250% FPL	$305	$309	
Subsidy = [SLCSP - Max Paid]	$133	$40	
Final Cost			
Plan Rate = [Plan Rate - Subsidy]	$217	$250	15.4%

In general, the distribution below (next page) shows the range of rate increases and decreases for the subsidized enrollees, including the impact of subsidies. The distribution is fairly normally distributed, with a mean value (blue dotted line) just below zero at -$27 and a Median of -$5. The distribution shows 42% of Subsidized members received a rate increase, and 58% received a rate decrease, before shopping.

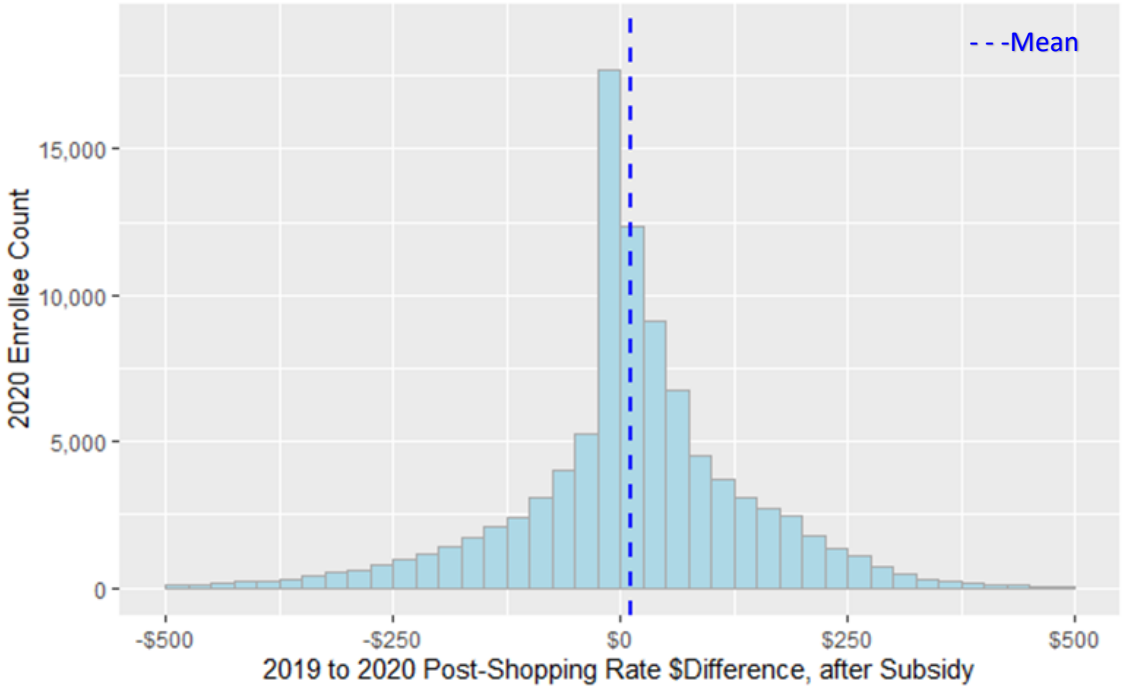
Figure 18: Range of Rate changes from 2019 to 2020, On-Exchange Subsidized Enrollees before Shopping



Subsidized Members Before Shopping…	
...receiving Rate Increase	42%
...receiving Rate Decrease	58%

After shopping, a greater percent of members received increases (54%). The mean is just above zero at $12; this is similar to our $129 to $138 increase calculated for all subsidized members in **Figure 16**.

Figure 19:Range of Rate changes from 2019 to 2020, On-Exchange Subsidized Enrollees after Shopping

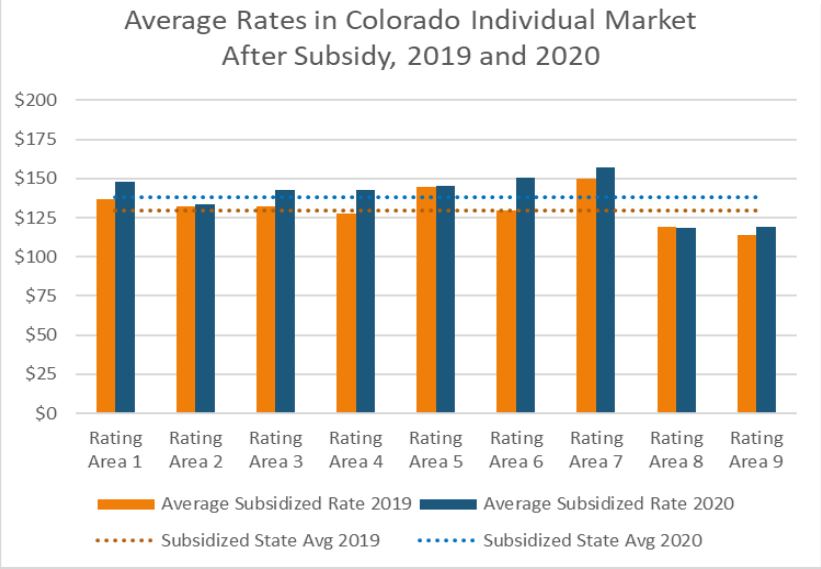


Subsidized Members After Shopping…	
...receiving Rate Increase	54%
...receiving Rate Decrease	46%

The figure above shows a notable finding. The distribution is shifting right after shopping, which indicates a number of subsidized shoppers selected **more expensive** plans.

Not all areas experienced the same curve however. There are particular areas where higher increases are more likely. See below for subsidized rate changes by Rating Areas.

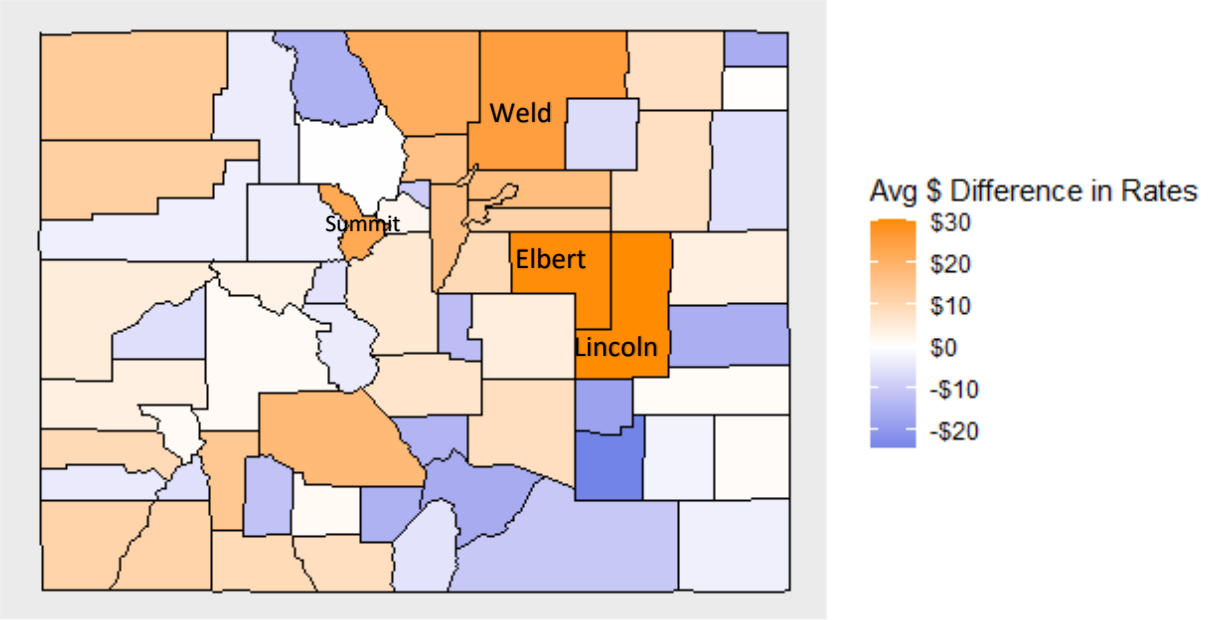
Figure 20: Rates by Rating Area, 2019 and 2020, Subsidized Enrollees



In the county-by-county view below, Elbert (part of Area 3), Lincoln (part of Area 8) and Weld (Area 6) seem to have some of the highest average increases. Summit County (part of Area 9) also stands out from the area around it. We will review some of these counties' experience with examples.

See the map below:

Figure 21: Monthly Subsidized Member Rate Differences by County, 2019 to 2020



Example 1: Second Lowest Silver Mismatch in Weld County

A mismatch occurs when the Second Lowest Silver Plan (SLCSP) decreases much more than the plan a member is enrolled on. See **Figure 22** below for an example.

Figure 22: Weld County (Rating Area 6) Carrier Profile

County	Carrier	2019 Rate, Before subsidy	2020 Rate, Before subsidy, Pre-Shopping	Change in Rate Before subsidy	2019 Rate, After subsidy	2020 Rate, After subsidy, Pre-Shopping	Change in Rate After subsidy
WELD	HMO COLORADO	$613	$458	-25%	$126	$120	-5%
WELD	KAISER	$650	$567	-13%	$133	$184	38%

SLCSP Carrier 2019 -> 2020	Change in SLCSP	% Membership
HMO CO -> HMO CO	-28%	59%
HMO CO -> HMO CO	-28%	41%

In this county, we have two carriers offering service in a 60/40 split to the individual members who live there. HMO Colorado members receive, on average, a -25% rate change before the subsidy. Since the subsidy goes down by a roughly equivalent amount (SLCSP belongs to HMO Colorado in this area), they don't realize any large gains or losses.

Kaiser members, on the other hand, only receive a 13% decrease in rates, which is a mismatch with the SLCSP. Their subsidy goes down significantly more than their rates, leading to a large increase for these members.

Example 2: Health Purchasing Alliance + Second Lowest Silver Mismatch in Summit County

Figure 23: Summit County (Rating Area 9) Carrier Profile

County	Carrier	2019 Rate, Before subsidy	2020 Rate, Before subsidy, Pre-Shopping	Change in Rate Before subsidy	2019 Rate, After subsidy	2020 Rate, After subsidy, Pre-Shopping	Change in Rate After subsidy
SUMMIT	HMO COLORADO	$801	$504	-37%	$194	$200	3%
SUMMIT	BRIGHT	$612	$230	-62%	$119	$72	-39%

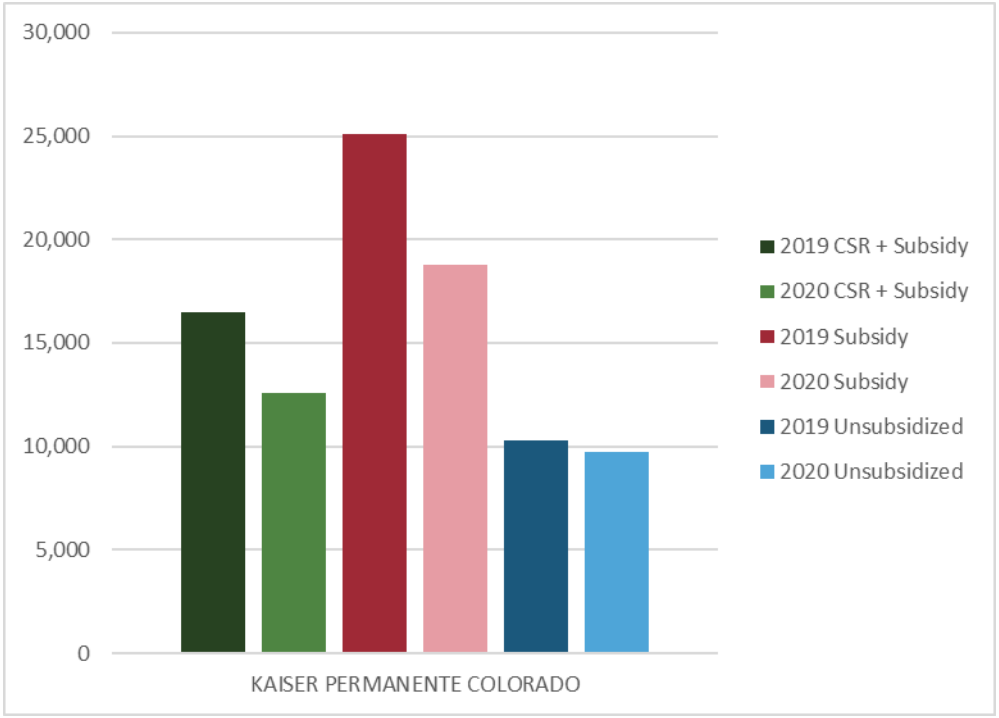
SLCSP Carrier	Change in SLCSP	% Membership
KAISER -> BRIGHT	-44%	29%
KAISER -> BRIGHT	-44%	71%

In Summit County, there is an additional factor of the consumer purchasing alliance, Peak Health Alliance, which has lowered rates significantly for its members in Summit County. Peak is partnered with Bright Health Plan. This has led to a large decrease in the second lowest silver plan, which aligns well with the rate decreases experienced by Bright members, but is a larger decrease than HMO Colorado Plans. Ultimately, subsidized members with Bright in Summit County were more likely to receive a decrease, while HMO Colorado members were more likely to receive an increase.

Example 3: Carrier Rating Mismatches in Elbert County, Lincoln County, etc.

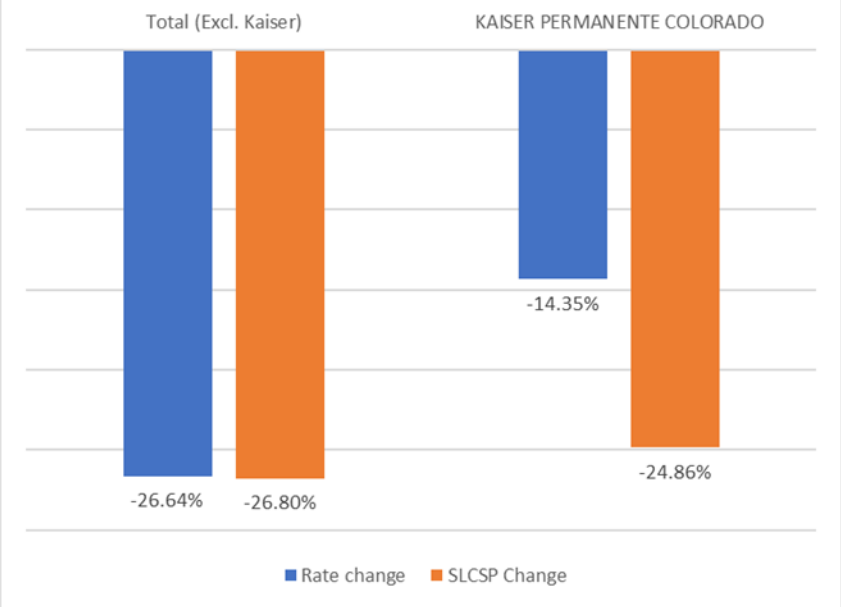
See below for a Kaiser enrollment chart by subsidy:

Figure 24: Change in Enrollment, Kaiser Individual Enrollment, On-Exchange



This chart shows a large drop in subsidized enrollees in Kaiser plans. The reason for this is the rate decrease Kaiser assumed was smaller than other carriers in the same areas. See the chart below.

Figure 25: Carrier Rate Change vs Change in SLCSP, Weighted by Premium and Member



In areas where Kaiser does not have the Second Lowest Cost Silver Plan, their subsidized members' premium subsidies are decreasing much more than their rates are. Therefore, Kaiser subsidized members were most likely to receive a rate increase after subsidies were taken into account.

To summarize, we can explain the rate changes experienced by subsidized members with two key facts:

- In a perfect pricing environment, the decrease in subsidy would offset the decrease in rate, leading to a zero rate change for these members.
- Pricing mismatches between the SLCSP and the member's rate contributed to net rate changes that were not zero.

Section 5: Impact of Enrollment Choices

Most on-exchange members enrolled at the end of the prior year are given an option to auto-enroll for the upcoming plan year. This means the member may continue their enrollment in a current plan, or they are crosswalked to a similar plan if their current plan is no longer available.

Members may make the following decisions:

Active Auto-Enroll: The member logs into the exchange, reviews their plan, and determines that they would like to be auto-enrolled in the suggested plan.

Passive Auto-Enroll: The member does nothing, and is automatically re-enrolled in the suggested plan.

Opt-Out: The member logs into the exchange, reviews their plan, and declines the suggested auto-enroll for the upcoming year. The members who are included in the shopping below decided to log back in later and select coverage.

New Plan: The member logs into the exchange, reviews their plan, and opts for a different plan than the one suggested to them.

No Part of Auto-Enroll: These members are not a part of the auto-enroll system, because their plan is ineligible or terminated and not crosswalked to a continuing plan. The other reason a member might fall in this category is they enrolled outside of the open enrollment period.

Figure 26: Percent of Enrollees by Subsidy and 2020 Auto-Enroll Action

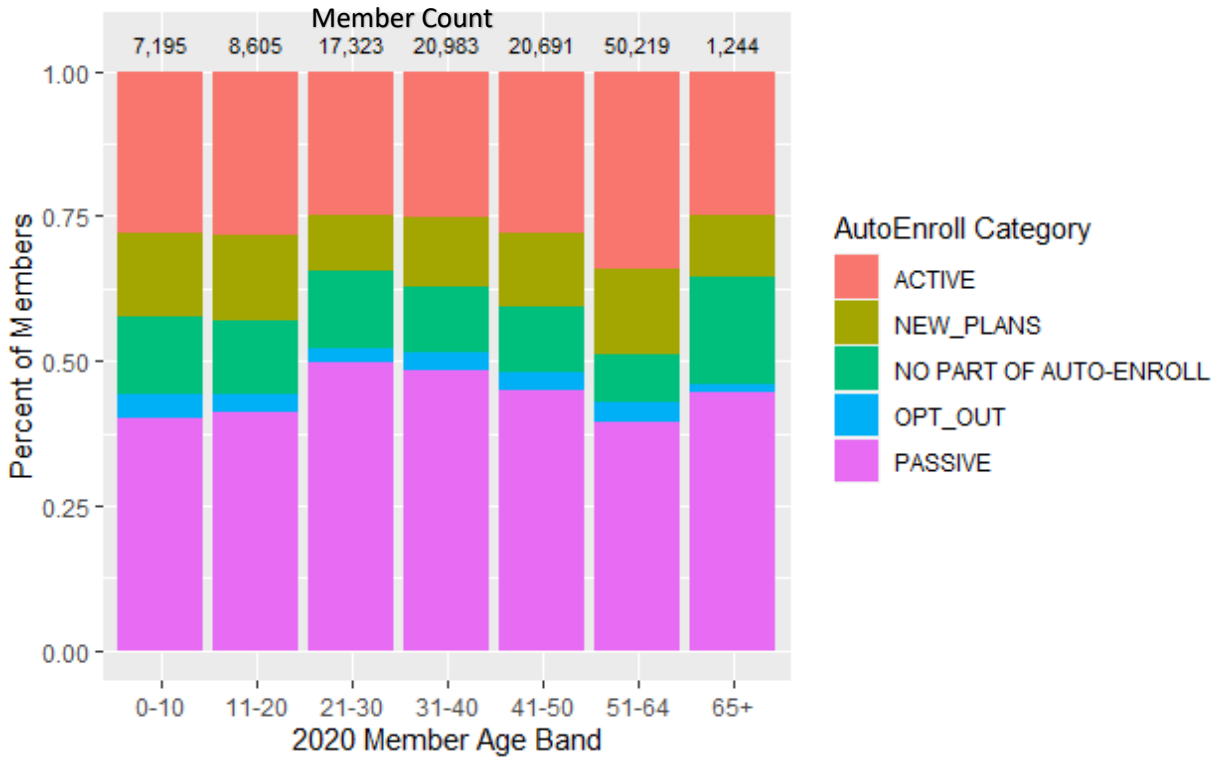
Continuing On-Exchange Members	Active	Passive	New Plan	Opt-Out	No Part of Auto-Enroll
Unsubsidized	28%	44%	13%	2%	12%
Subsidized	30%	43%	13%	3%	10%

The proportion of members utilizing each option is similar between subsidized and unsubsidized populations. Over 70% of continuing on-exchange enrollees auto-enroll in the suggested plan, either actively or passively. Only 13% (plus some of the Opt-Out members) end up chosing another option.

In an ideal marketplace, all members would be actively involved in selecting their health plan each year, whether to shop for a better rate, or to verify they are satisfied with their current plan. This does not occur for all members, resulting in members missing opportunities to select the best plan for their circumstances.

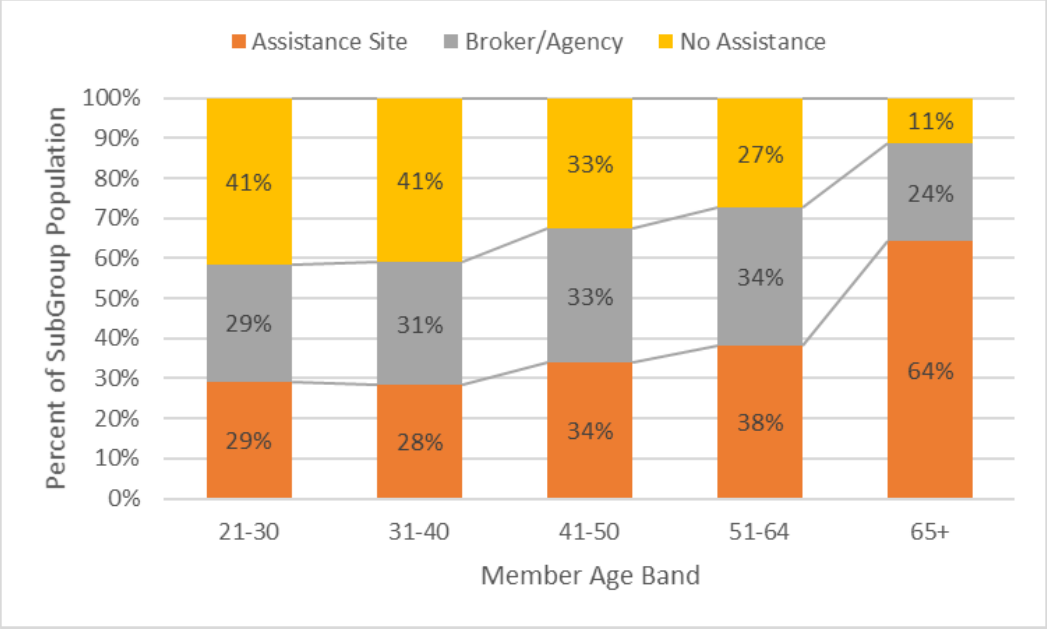
What follows is a description of characteristics that define member auto-enroll actions.

Figure 27: 2020 Auto-Enroll Action by Age Band



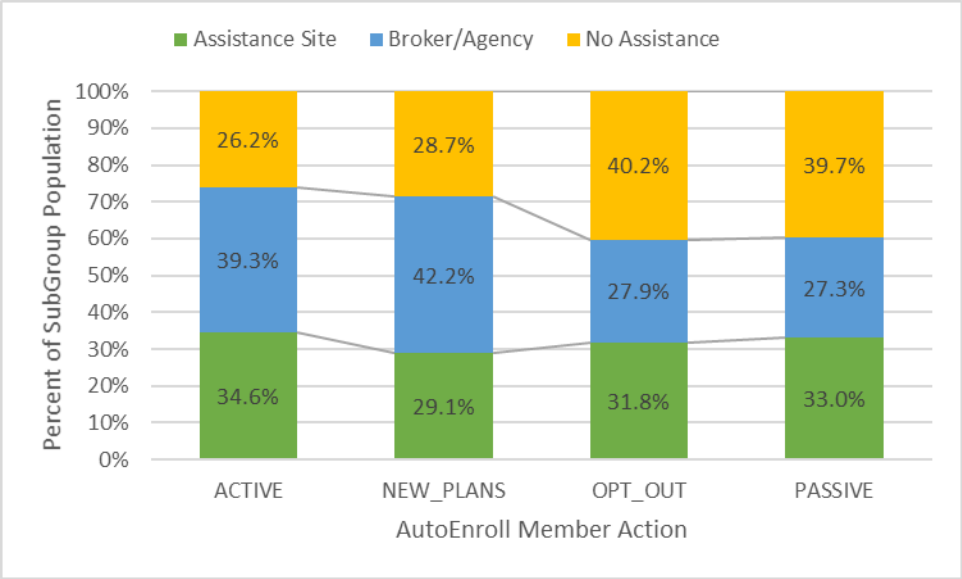
Older members are less likely to passively accept their auto-enroll plan. They are more likely to review their choices, and more likely to shop. This may partially be a result of larger rates as a member ages, or it might be a function of those older members seeking enrollment assistance, as the next two graphs show.

Figure 28: 2020 Assistance Channel by Age Band



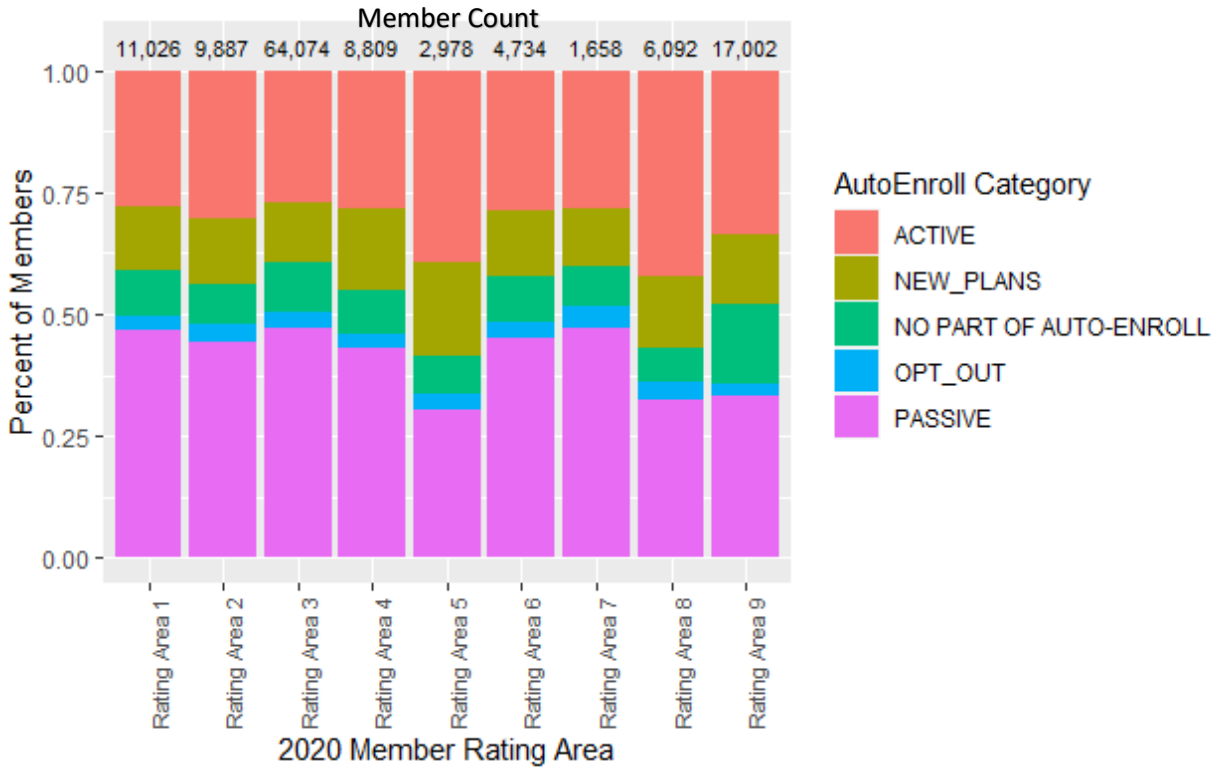
The above chart (prior page) shows that use of enrollment assistance is not propotional by age group. Older members are more likely to utilize the Assistance Site. Younger members are much more likely to enroll without assistance.

Figure 29: 2020 Assistance Channel by 2020 Auto-Enroll Action



The above chart shows that use of enrollment assistance is correlated with Auto-Enroll actions. The chart indicates members who shop or active enroll are much more likely to utilize a Broker or Agency for assistance while enrolling. Passive and Opt-Out enrollees are much less likely to seek assistance.

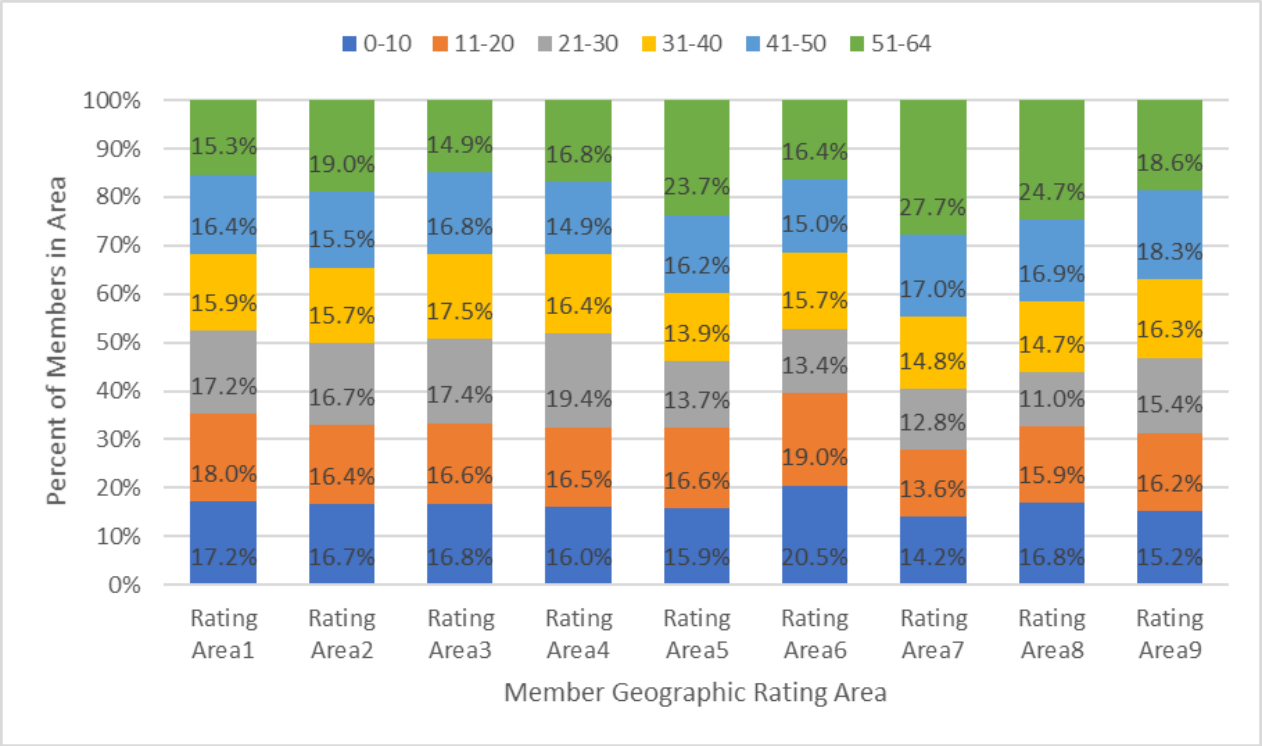
Figure 30: 2020 Auto-Enroll Action by Geographic Rating Area



Rating Areas 5, 8 and 9 have a much lower percent of passive auto-enrollers. This may be a result of consistently larger starting rates in these regions, which has conditioned these members to be more active consumers of health insurance. It might be correlated to ages of members in those areas.

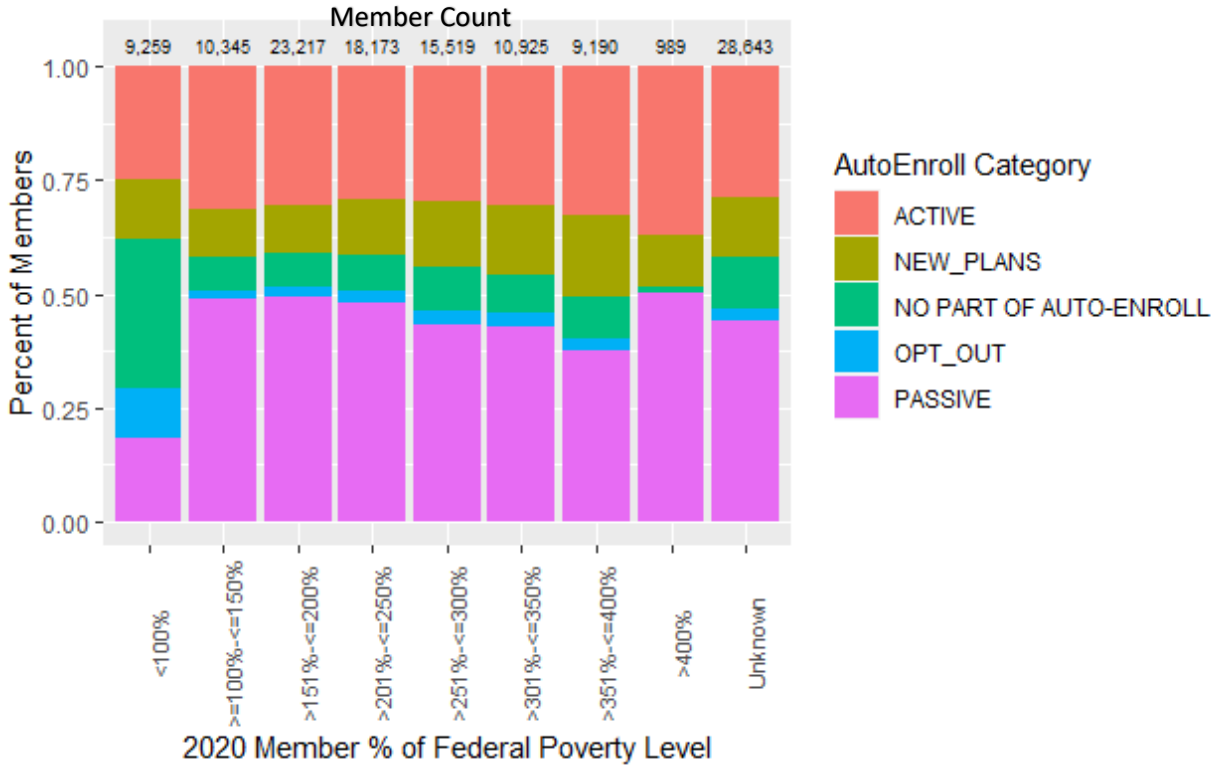
The next chart explores age by rating area:

Figure 31: Age Band by Geographic Rating Area



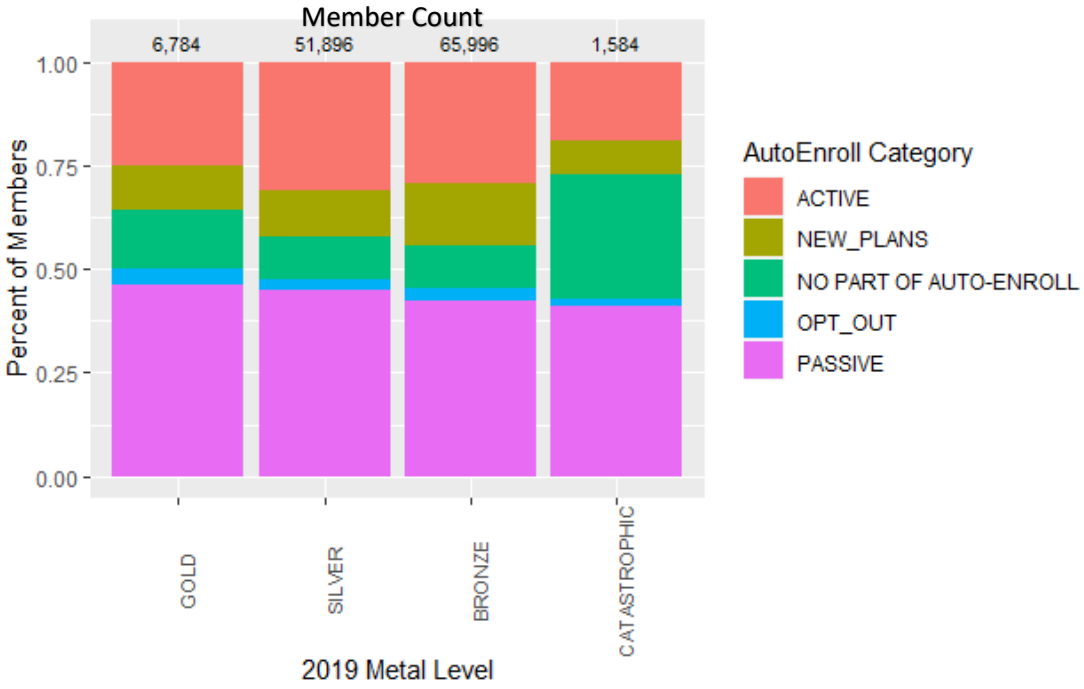
The graph above indicates that members ages 51 to 64 are a smaller portion of members in Rating Area 3, and a larger portion in Rating Areas 5 and 8. The lower passive enrollments in Areas 5 and 8, and higher passive enrollments in Area 3 may be connected to age of the members living in those areas.

Figure 32: 2020 Auto-Enroll Actions by %Federal Poverty Level



As FPL increases, members are less likely to passively accept their auto-enroll choice, and more likely to shop. The effect is seen for members below 400% FPL who are eligible for a subsidy.

Figure 33: 2020 Auto-Enroll Actions by Metal Level



Above (prior page), we see a lower passive acceptance of auto-enroll and a greater inclination to shop among members enrolled in lower metal plans. It is possible these members are healthier and more cost-sensitive than those enrolled in gold plans.

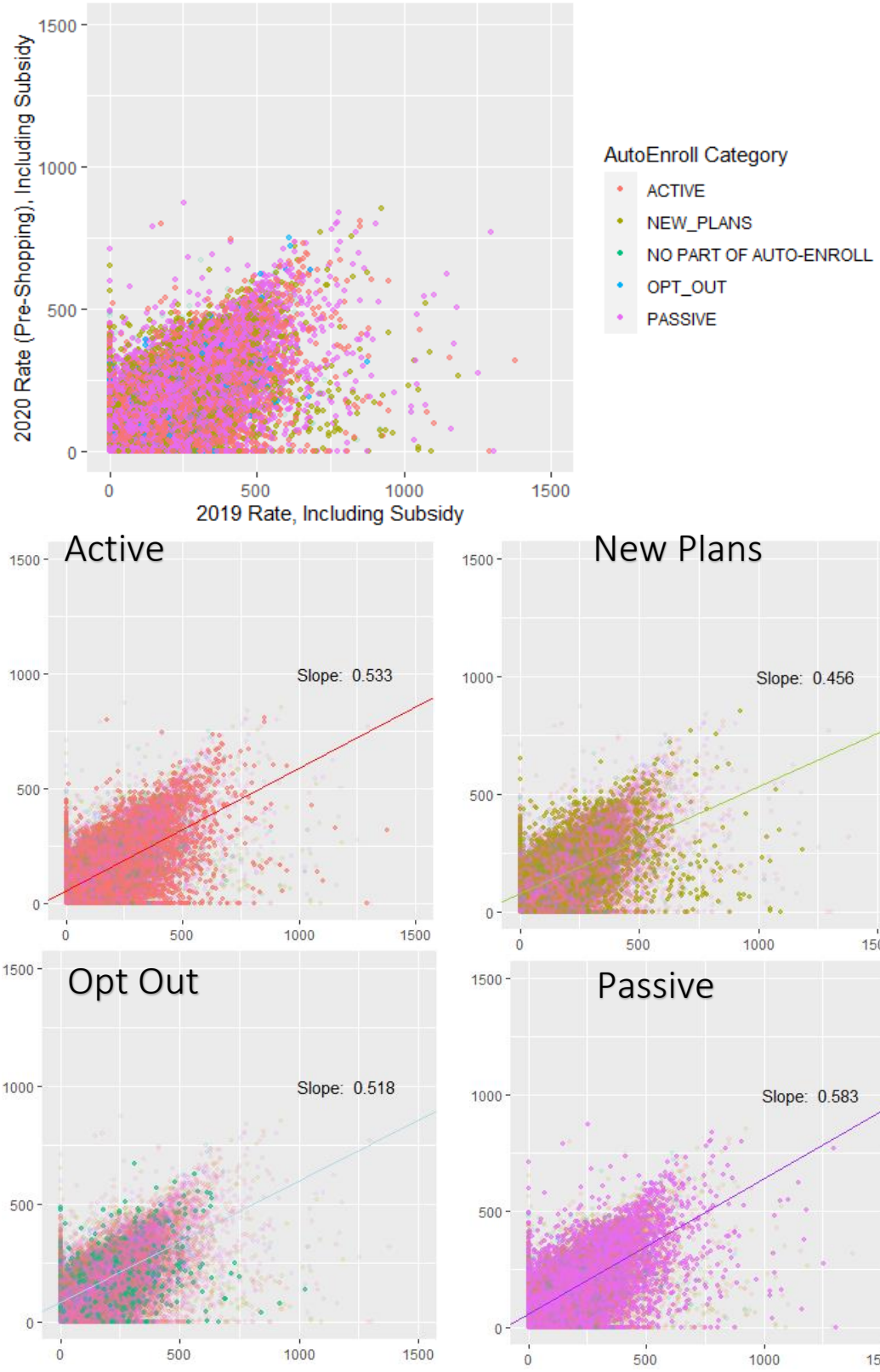
Overall, the common thread driving active auto-enroll decisions is a sensitivity to cost, especially for those paying larger premiums and getting smaller subsidies. It is more likely active enrollment and shopping will occur among older, healthier members, receiving a small subsidy, and dwelling in the rural parts of the state.

As expected, the change in premium, year over year will play a large part in whether the member actively participates in shopping for a plan.

For subsidized enrollees whose income remained consistent from 2019 to 2020 (roughly 74,000 members), the following charts shows their auto-enroll actions against their starting rate, after subsidy, and their auto-enroll rate, after subsidy.

- A majority of enrollees were Passive or Active Auto-Enrollees.
- Members who shopped for new plans appear slightly more spread out (new rate is far apart from old rate) than Active Auto-Enrollees. This suggests a member is more likely to shop for a new plan if their new rate is significantly different from their current rate.
- Members who opted out of auto-enroll, and then ultimately purchased coverage were rare, and more likely in lower premium levels.
- Slope in the graphs below equals the 2020 rate (pre-shop) over the 2019 rate. A lower slope indicates lower 2020 rates compared to 2019.

Figure 34: 2020 Auto-Enroll Actions, Subsidized Members with no Income Change



For unsubsidized enrollees, the following chart shows a different story. Unsubsidized members largely appear to have received a rate that was lower than their current rate. Therefore, auto-enroll actions are more evenly distributed.

Figure 35: 2020 Auto-Enroll Actions, Unsubsidized Members with no Income Change

Just over 25,000 on-exchange enrollees were unsubsidized and did not experience a change in income over the prior year. Of these members:

- Most enrollees are either Active or Passive.
- Members who shopped for New Plans were more likely to be those with larger decreases.
- Members who opted out, and then ultimately purchased coverage were rare, and more likely in lower premium levels.

Next, continuing members who are shopping for coverage have some characteristics that drive their behavior.

Of the continuing members (those present in both 2019 and 2020), roughly 40% (or 58,000 members) actively reviewed other plans (Active + Opt Out (but present in 2020) + New Plans). Over one third of these shoppers (21,600) selected a new plan. This next section reviews these member's choices.

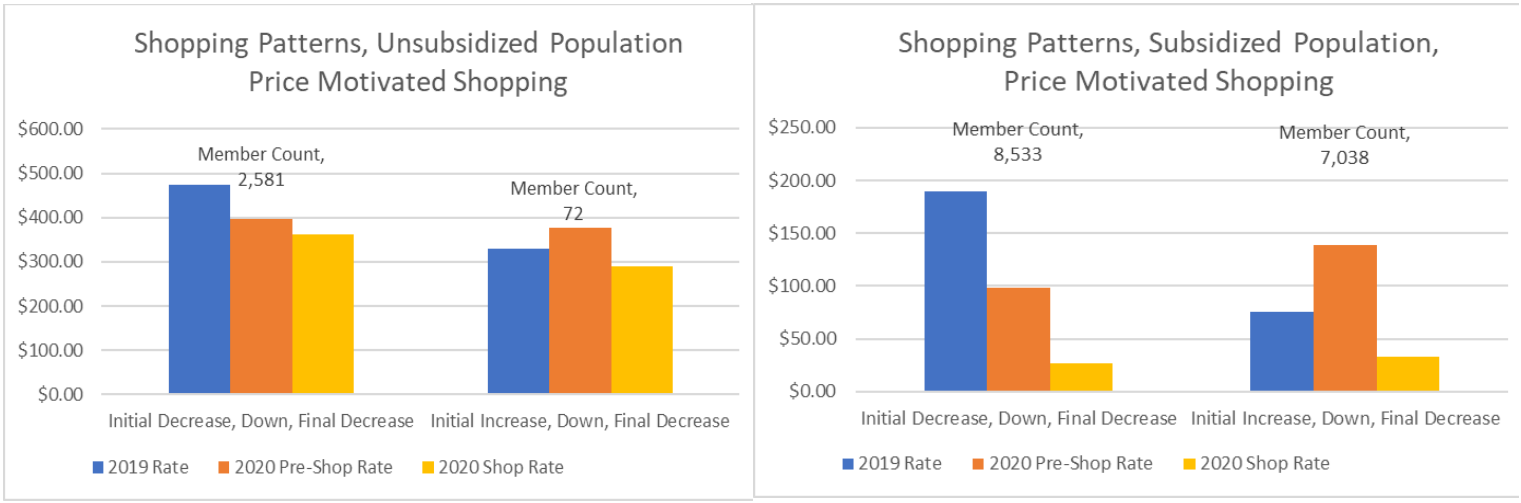
Of these:

- 18,200 were Price Motivated shoppers- selecting a plan that was lower cost than their current coverage.
- 19,800 were Status Quo shoppers- selecting a plan near to their own in cost, but changing some characteristics. Unsubsidized members were more likely to fall in this category.
- 19,800 were Upgrade shoppers- selecting a plan more expensive than their current plan.

The graphs below, for each subgroup, show the starting 2019 average rate (in blue), the initial average rate presented to the member for 2020 (in orange), and the final average rate selected by the member for 2020 (in yellow).

Price Motivated Shoppers:

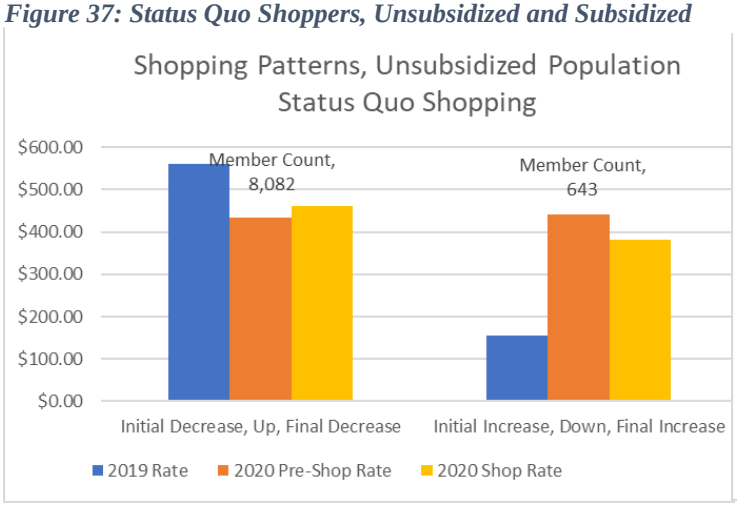
Figure 36: Price Motivated Shoppers, Unsubsidized and Subsidized

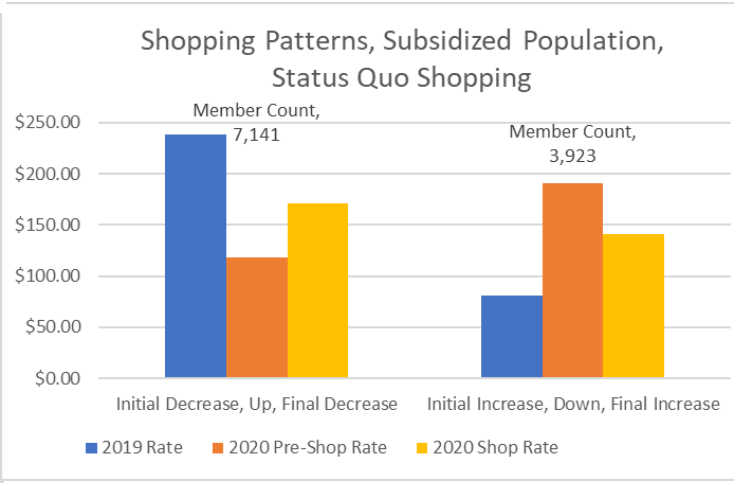


No matter what initial rate is presented, these members will shop for a lower price and this is more likely to occur for subsidized members. Between 15% and 20% of these members dropped to a lower metal level in pursuit of a cheaper plan.

Status Quo Shoppers:

Figure 37: Status Quo Shoppers, Unsubsidized and Subsidized

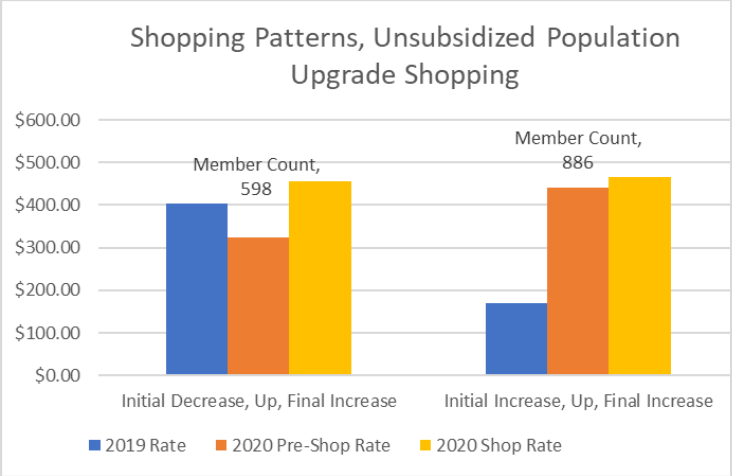


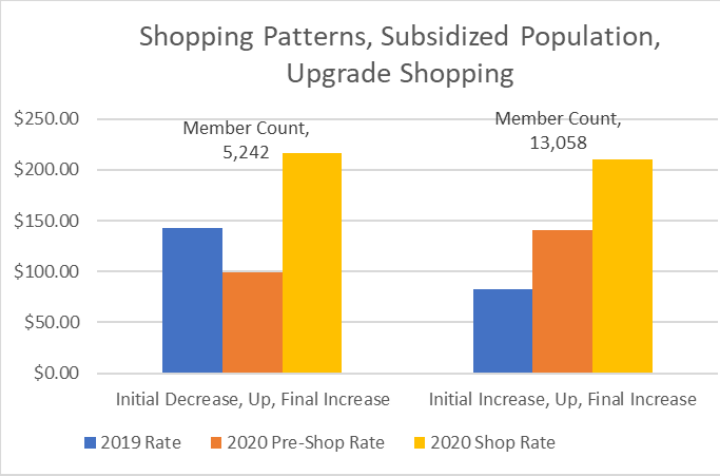


Status Quo Shoppers is the largest group for the unsubsidized population and the smallest group for the subsidized. These members are trying to keep their costs consistent with the prior year. 26% had a change in income that made shopping necessary. 30% of this category moved to another insurance carrier while shopping.

Upgrade Shoppers:

Figure 38: Upgrade Shoppers, Unsubsidized and Subsidized

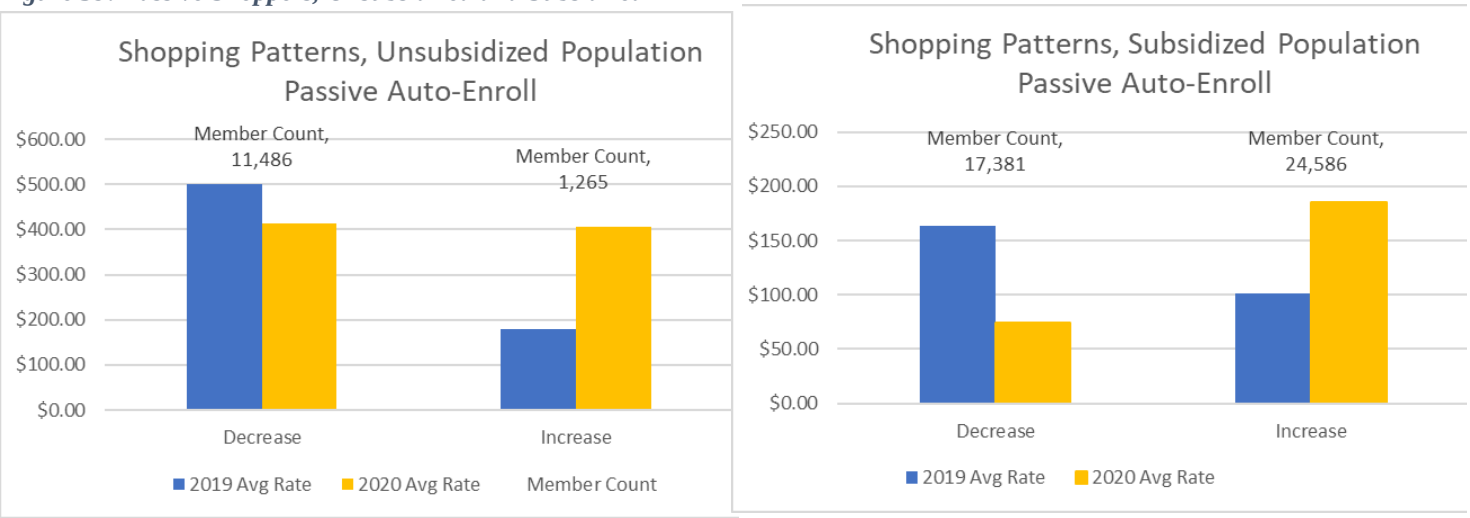




Upgrade shoppers are the largest group for subsidized members; these shoppers are selecting a more expensive plan than what they were presented, and more expensive than current. Roughly 28% had a change in income that would motivate the switch. Of the unsubsidized, roughly 53% of the Upgrade shoppers increased their metal level. It is possible that these members had a change in health circumstance driving them to choose a more expensive plan.

Passive Shoppers:

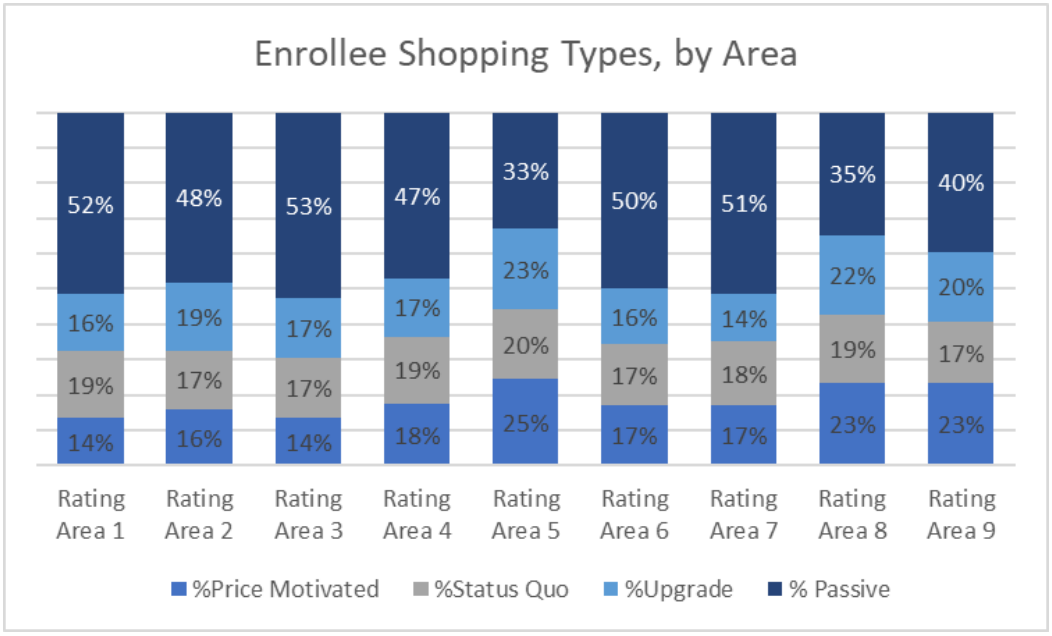
Figure 39: Passive Shoppers, Unsubsidized and Subsidized



Passive shoppers are members who do not review plan options available to them, and allow the rate changes of their current or crosswalked plan to flow through. For the unsubsidized who received a decrease, the members were not adversely affected by their inactivity. The small subgroup of unsubsidized who received an increase were subsidized in 2019, had a change in income, and lost their subsidy for 2020. These members might have benefited from shopping.

The subsidized population who passively enrolled had a 40% chance of a decrease and 60% chance of an increase. Note that the average rates shown above were not experienced by all members, and the reader is referred back to the distribution of rate changes in Section 4, **Figure 18** and **Figure 19**. The drivers of these changes were explained in Sections 3 and 4 above.

Figure 40: 2020 Shopping Type by Rating Area



The ultimate lesson of this section is that members have different motivations when shopping for a plan, but have much greater control over their costs when they choose to shop. The members most likely to shop are older, likely to use assistance when enrolling, and live in rural areas of the state. The members least likely to shop are younger, live in more populated areas of the state, and have a lower 2019 Rate.

Section 6: Data and Methodology

6.1 Data Used

For this study, the following data sources were used:

- 2019 and 2020 Enrollment, Subsidy and Premium data for On-Exchange population, Provided by Connect for Health Colorado
- 2019 and 2020 Enrollment counts by requested split-outs, provided by Colorado insurance carriers
- Carrier 2019 and 2020 rate filings, including Unified Rate Review Template (URRT) information and rate tables.
- Publicly available Summary of Benefits and Coverage (SBC) for select plan designs
- 2014-2018 American Community Survey data by County, Publicly available, US Census Bureau

6.2 Methodology

2019 and 2020 data from Connect for Health Colorado (C4HCO) was requested, received, and used for this study. The following steps were taken to review/modify the dataset:

1. Data was reviewed per requirements of Actuarial Standards of Practice (ASOP) #23. Each field was reviewed for clear understanding of what was being represented, range of values, and management of any missing data. When questions arose, C4HCO was able to provide answers and insight.
2. Data was rearranged to represent a unique member on each line with all information for 2019 and 2020 on a signle row of the dataset. If the member was not present for either 2019 or 2020, those fields remained blank and were excluded from analysis of that year. Throughout the study, if members are stated as “continuous”, then they had enrollment data present for both 2019 and 2020.
3. Member detail data was joined with US Census data. The census data, on a county basis, was aligned with the member’s county for each year they were enrolled. If a member changed location mid-year, the most recent county designation was used. Census data included Race and Ethnicity data. Limitations with this data are noted in Section 2.
4. Member detail data was joined with Actuarial Value data from public rate filings. These were linked based on PlanID, Carrier, and Year.
5. Similarly, member detail data was joined with plan cost-sharing parameters gathered from plan SBCs. These were linked based on PlanID, Carrier and Year.
6. A pre-shopping pre-subsidy rate was calculated for every member who was present in both years. The pre-subsidy rate was determined by identifying the same PlanID and Carrier as the prior year, and using the filed rate tables for both years to: A) Match the prior rate B) Look up the new rate for the same age and Rating Area. Therefore the “shopping” rates (what the member actually chose) will differ by a 1-year age factor, and by any changes in the member’s geographic area, tobacco status, and plan selection. If a plan was discontinued between 2019 and 2020, the crosswalked plan identified by the carrier in their rate filing was used. If no crosswalked plan was available, no “pre-shopping” rate was calculated and the actual rate was used.
7. A pre-shopping rate after subsidies was calculated using the pre-subsidy rate, and the subsidy the member was eligible for in 2020. These subsidies were applied on a household basis in

C4HCO's data, and were assigned by L&E to each member in a household proportionally, based on each member's pre-subsidy rate as a percent of the total household rate. This is a departure on how the subsidies were apportioned by C4HCO in 2019 member data, and may produce some discrepancies in Post-subsidy rate changes, especially for younger members of a household. This issue was considered and is not expected to materially alter the overall conclusions of this report.

8. Differences in rates between 2019 and 2020 were calculated by subtracting the 2020 rate from the 2019 rate. A rate change calculation was also reviewed ([2020 rate]/[2019 rate] -1), but this calculation becomes largely uninformative when some members have a $0 post-subsidy rate. A dollar difference is therefore the preferred method of this report. The rates are on a monthly basis, so the dollar differences in rate are also a monthly representation.

The above data was summarized and subsetted in various ways to produce the detail in this report. Tools used include Microsoft Excel, Microsoft Access, and R with various statistical and visualization packages. The most common review included univariate and bivariate review to understand relationships between various parameters in the data. Apart from the transformations described above, no further adjustments were made to the data provided.

Section 7: Disclosures and Limitations

7.1 Intended Users, Scope, and Purpose

This report was developed to comply with Colorado House Bill 19-1168. This legislation instructs the Commissioner of Insurance to evaluate the effect of the reinsurance program on access to affordable, high-value health insurance for consumers who are eligible for premium tax credit subsidies and cost sharing reductions and minimize any potential negative effects on those consumers.

The report encompasses changes in ACA Individual Market between 2019 and 2020 in Colorado, focusing specifically on subsidized populations. The members who enrolled during the Special Enrollment Period occasioned by the COVID-19 pandemic were also included in this study. However, for most of the population, enrollment decisions were made before the pandemic was widespread, or arguably present in the US. Therefore, it is assumed that enrollment decisions were made independently of the public health crisis.

The Colorado Division of Insurance is the primary intended user of this report, with the understanding that it will be shared with the legislature and the public to inform healthcare policy in Colorado. It should not be applied to other populations, locations, or timeframes, and the information herein should not be used for other purposes.

7.2 Qualifications

Andrea Huckaba Rome is the actuary responsible for this communication. She is a Fellow of the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA) in good standing. She meets the Qualification Standards required to issue this report.

7.3 Risk/Uncertainty

The majority of this report is based on data provided by Connect for Health Colorado. The data has been reviewed for reasonableness but has not been audited. If it is materially incorrect, the data could impact results and conclusions of this report.

Because the report is primarily a review of Subsidized members, the results are based on the On-Exchange population, where subsidized members must enroll to receive CSR plans and premium tax credits. Off-Exchange enrollees were not analyzed, and their behavior may differ from the unsubsidized On-Exchange enrollees in this report.

Some results, where stated, are based on census data by county. It important to carefully interpret this data, as county data does not always align with the characteristics of members enrolled on the exchange.

7.4 Conflicts of Interest

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

7.5 Data Reliance

L&E relied upon data provided by the Colorado Division of Insurance, the non-group ACA market carriers in Colorado, Connect for Health Colorado, 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 6.1 of the report. Key assumptions are outlined in the methodology section.

7.6 Dates Applicable

This report was prepared in September and October 2020 and is intended to reflect the change from Calendar year 2019 to Calendar year 2020 for the Colorado ACA Individual Health Insurance Market, primarily on-exchange and subsidized members. These findings should be carefully reviewed by qualified individuals and considered in light of the timeframe and population to which they apply, and should not be generalized to other populations.

7.7 Subsequent Events

This report was finalized on October 31, 2020. The report assumes no uncertain and potential future changes to the Affordable Care Act or the Colorado health care marketplace that could materially impact how results should be interpreted or acted upon. There are many future developments that could materially change these results including court rulings, new regulations, additional allowed ACA exemptions, a continuation of the COVID-19 pandemic that could impact enrollment decisions, or a material change to the health care markets in general. In addition, any changes made to the parameters or structure of the reinsurance program could have a material impact on the outcomes outlined above. 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.