

FY 2020-21 JOINT BUDGET COMMITTEE HEARING AGENDA

DIVISION OF INSURANCE (DEPARTMENT OF REGULATORY AGENCIES) AND
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Friday, January 24, 2020

PUBLIC OPTION
1:30 pm – 3:10 pm

1:30 - 1:40 Introductions and Opening Comments

Presenter: Kim Bimestefer, Executive Director, Department of Health Care Policy and Financing

1:40 - 3:10 Responses to JBC Public Option Questions

Presenters: Kim Bimestefer, Executive Director, Department of Health Care Policy and Financing
Michael Conway, Commissioner, Division of Insurance

BREAK
3:10 pm – 3:20 pm

REINSURANCE
3:20 pm – 5:00 pm

3:20 - 3:30 Introductions and Opening Comments

Presenter: Michael Conway, Commissioner, Division of Insurance

3:30 - 5:00 Responses to JBC Reinsurance Questions

Presenter: Michael Conway, Commissioner, Division of Insurance

DIVISION OF INSURANCE (DEPARTMENT OF REGULATORY AGENCIES) AND
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

PUBLIC OPTION

Friday, January 24, 2020
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NAMES AND TITLES OF PRESENTERS

Kim Bimestefer, Executive Director, Department of Health Care Policy and Financing
Michael Conway, Commissioner, Division of Insurance

- 1 Please clarify the figure of 5,700 new people participating in the individual market. Are these people all previously uninsured?**

The 5,700 people who are projected to purchase the public option plan in the first year are assumed to be previously uninsured individuals. We expect this number to grow in future years, especially if the public option extends to the small group market. We would also anticipate that some currently insured individuals may purchase this product because of the additional benefits of the public option plan, such as first dollar coverage for high value services like primary care and behavioral health services.

It's important to note that establishing a public option would help every Coloradan. With a public option, insurance companies will have incentives to compete and improve the quality and affordability of their plans compared to the public option. Larger businesses will be able to use the published hospital reimbursement rates and standards of the public option to negotiate better hospital reimbursements for themselves. We've already heard anecdotes from Washington state, which is establishing a public option where all hospitals are reimbursed at 160% of Medicare, that the business community is using this rate to strengthen their own negotiations. Having a state standard will help all privately-covered Coloradans, not only the people directly enrolled.

- 2 Are there projections on the number of people who would participate in the public option who were uninsured as compared to those who would shift over from another plan?**

The Wakely analysis, which is included in the November 15, 2019 Final Report on the Public Option, made projections only about the number of uninsured individuals who would purchase the public option. However, as insurance rates come down, more people will be able to afford insurance, which will directly and favorably impact Colorado's uninsured rate.

3 Please discuss the projected public option participation rate. What are some reasons people are expected, or are not expected, to choose a public option plan?

The plans will save people money including by creating access to preventive care and behavioral health care before the deductible. One of the principal reasons people can't afford health care is out-of-pocket costs. What we heard was that those costs can be so high that people don't think it is worth their while to buy insurance.

The actuarial analysis projects that 5,717 uninsured individuals would enroll in the public option plan in the first year. That number will increase as the public option becomes established, and as it expands to the small group market.

While premium cost is often the primary reason why individuals in the individual market choose a health insurance plan, other factors that influence purchasing decisions include whether their doctor is in the provider network, whether their prescription drugs are covered on the formulary, and what services are covered pre-deductible.

4 How do bundled payments affect insurance premiums if the provider's costs exceed the target rate?

The Recommendation does not specifically propose the use of bundled payments. However, the Recommendation does propose that the Advisory Board identify ways to improve quality and reduce costs looking forward. Bundled payments, or other value based payments, could be strategies that the Advisory Board explores. In that case, the specifics of how a bundled payment would impact premiums if a provider's costs exceed the target rates would depend on how the original agreement between the provider and carrier was structured.

5 Is there a potential outcome that includes the dilution of access to care or quality of care that could happen as providers adjust to a new reality? Please describe.

No, we do not think that the public option will lead to a dilution of access. On the contrary, we believe it will expand access by providing a more affordable health insurance option, because one of the current barriers to care is the high cost. We already know that 1 in 5 Coloradans

aren't getting needed medical care or filling prescriptions because they can't afford to.¹ If we bring down the cost of care appropriately, access will improve.

We know that the prices charged to Coloradans are national outliers. Many Colorado hospitals have affiliated hospitals in other states where they charge much lower prices. For example, Colorado's two largest systems are Centura and HCA. Centura is part of the nation's largest tax-exempt system. HCA is the nation's largest for profit system. Both have hospitals all across the country that are charging lower prices. I don't think those systems would say that their other, non-Colorado, hospitals are providing substandard quality; they are just charging lower prices.

However, it is impossible to foresee all of the potential impacts of any new policy. That is why we encourage the Legislature to adopt mechanisms that address any unforeseen impacts by establishing an Advisory Board that can make ongoing recommendations to continue to improve the public option.

6 Bundled payments may decrease quality. What types of value based payments are the departments considering implementing through the public option plans? What evidence is there that they would be effective?

While carriers may move to bundled payment models, there is nothing in the Recommendation suggesting or requiring them to do that. With respect to future cost savings mechanisms that may be adopted by plans offering public option plans, reducing the price paid for care does not mean reducing quality. A central tenet of bundled payments, and all value-based payment models, is ensuring that patients have access to high quality care. As there are several types of value based payments, the departments would work with the Advisory Board, including carrier input, to consider the evidence and which types of value based payments might be included in the public option plans.

7 How will the proposed plan involve individual providers and clinics?

The Recommendation did not propose setting reimbursement rates for individual providers or independent clinics. Those rates will be established through carrier negotiations, as they currently are today.

8 Please compare and contrast the public option model with the previous health co-op from 2014. What lessons were learned from the health co-op and why is the public option plan expected to work where the co-op did not?

¹ Colorado Health Access Survey 2019, Colorado Health Institute

The public option is fundamentally different from the HealthOp. One of the very first things that we said at our initial stakeholder meeting was that we would be very careful to learn the lessons from the Colorado HealthOp to ensure that the issues that ultimately led to the HealthOp's demise would not be repeated in the public option.

The CO-OPs that were part of the ACA struggled throughout the country. That was the case for a number of reasons, but the three primary reasons were that (1) they were start up insurance companies; (2) they were very dependent on funding from federally run programs; and (3) the funding for one very important program -- the risk corridor program -- was removed as part of a budget compromise. The Colorado HealthOp was extremely dependent on the funding it was going to receive from the risk corridor program and when that funding wasn't available, the HealthOp found itself in an unsustainable financial position.

We made a strategic choice to utilize the existing private sector infrastructure, in part because of the lesson learned from the HealthOp. The Recommendation proposes asking individual companies to also offer this alongside their current plans, which they have extensive experience building. It does not create a new insurance company, as was the case with the CO-OP's around the country. Furthermore, the insurance companies offering the public option product will not be dependent on state or federal funding as was the case with the HealthOp.

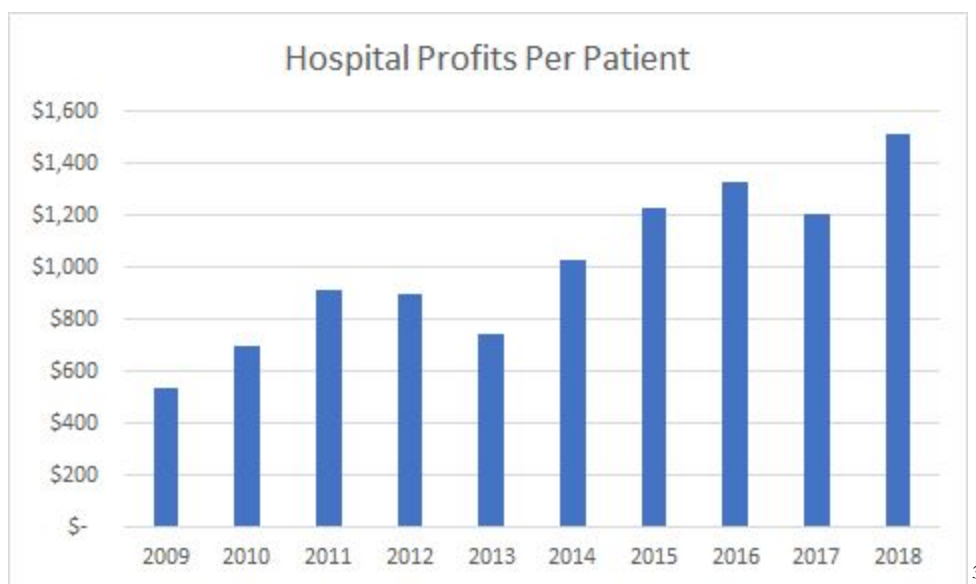
9 If insurance companies are required to offer policies at below current market rates, and they are barred from cost shifting, how would they make up that difference and recoup losses? How would the Commissioner monitor and investigate potential cost shifting?

The Recommendation proposes that private insurance carriers administer the public option plans, and offer them at rates that will cover their administrative and claim costs, as they do today. Because carriers will be able to cover their costs while allowing for profitability, there will be no need to shift costs. That said, premiums will still go down because current insurance rates are based on the underlying cost of health care claims, which in turn are based on payment rates negotiated with hospitals and other providers. Because the underlying costs of care would be reduced in the public option, insurance premiums would also be reduced. In addition, because of the insurer MLR requirements across the fully insured health care markets, insurers effectively cannot shift costs.

We are aware that some questions have also been raised about whether the cost saving mechanisms would result in hospitals shifting costs, and that this is of significant interest given the numerous efforts that have been made by the Legislature to address and prevent cost shifting. The establishment of the Provider Fee in 2009 and the expansion of Medicaid in 2014

were both done to increase Medicaid reimbursement and reduce uncompensated care, and as a result, reduce the need for hospitals to cost shift.

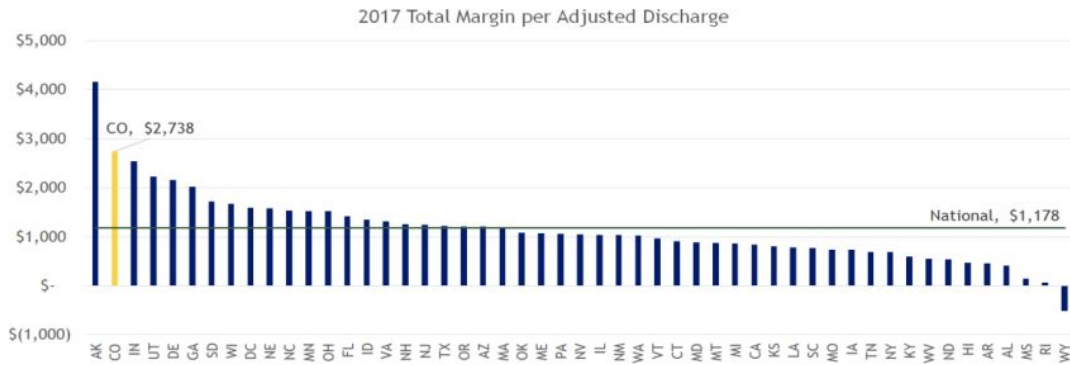
Recent data have found that while these policies have achieved their goals of increasing Medicaid reimbursement and reducing uncompensated care, the prices charged to privately covered Coloradans have still increased, relative to the cost of care. These high prices have resulted in significant profit increases: according to data from the Colorado Hospital Association, between 2009 and 2019, hospital profits have increased by over 280% between 2009 and 2019.²



Colorado hospitals have the 2nd highest profits in the entire country, according to data from the federal Centers for Medicare and Medicaid Services. This is true for both for profit and non-profit hospitals. It is important to note that not all hospitals are seeing significant profits; critical access and rural hospitals often have very thin margins. That makes it even more remarkable that the profits in the Front Range are so high that as a state, we see the 2nd highest profits in the country. This data raise questions as to whether the genesis of hospital cost shifting is truly about the need to cover costs, or simply how hospitals are reaching record profits.

² Colorado Hospital Association DATABANK

³ Colorado Hospital Association DATABANK



4

The Legislature has recently increased the tools available to the Division of Insurance (DOI) and the Department of Health Care Policy and Financing (HCPF) to prevent, monitor, and address cost shifting, in partnership with the Legislature. To start, as part of the DOI's standard rate review authority, it reviews rates to ensure they are not excessive, discriminatory, or inadequate. Further, HB19-1233 requires the DOI to review the affordability of health care plans during the rate review process, and as part of that process requires the DOI to promulgate regulations establishing how that process will work. The DOI is currently drafting regulations to in part require insurance companies to file their contractual rates between the hospital and the carrier to monitor what actually occurs in the negotiations between hospitals and insurers. That will ensure that the hospital did not raise the rates offered to one market or product in order to offset lower rates offered to another market or product as outlined in question #10. In addition, this will give the DOI the ability to make sure that pricing concessions provided by hospitals to carriers are passed through to consumers and not retained by carriers in the form of increased profits. Finally, HB19-1001 and HB19-1320 are new laws that require hospitals to report financial information to HCPF. HCPF will use this data to monitor hospital financial performance and behavior, to achieve public option goals, and to prevent unintended consequences.

10 Please describe the authority of the Commissioner of Insurance in HB 19-1233 to prevent cost shifting. Is this authority open to interpretation?

Under HB19-1233, Investments in Primary Care to Reduce Health Care Cost, the Commissioner was given specific requirements, as part of the rate review process, to consider whether a carrier's products are affordable and whether the carrier has implemented effective strategies to enhance affordability of its products.

⁴ Medicare Cost Reports, data extracted by the Department of Health Care Policy & Financing in 2019

HB19-1233 requires the Commissioner to promulgate rules establishing affordability standards. With this authority, the Commissioner will have the ability to review the contracted reimbursement rates between the carriers and the hospitals. If a hospital attempts, and a carrier permits, an attempt to increase prices to other markets (like large employers), the Commissioner has the authority under HB19-1233 to reject a carrier's rate filings, thereby forcing the parties back into negotiations to correct the hospital's attempt to cost shift.

11 If the actuary did not attribute any savings to this the increase in in medical loss ratios, then why should it be included as a financing mechanism for the public option?

The Recommendation proposes that 85 cents from every dollar be dedicated to patient care instead of advertising, administration, and profits, up from the 80 cents currently required to be spent on patient care for the individual market. In other words, it proposes that the Medical Loss Ratio (MLR) be changed from 80% to 85% which matches what is required in the large group market.

This was proposed in part because the public option will be easier for carriers to administer. Because hospital rates will be set through a formula, carriers will have to spend far less time negotiating their rates and their administrative burden will be reduced. In addition, the recommendation proposes that pharmaceutical rebates should be passed through to reduce costs for consumers, whereas currently, those rebates are kept by the carriers as profits. If the administrative burden is reduced and the profits from pharmacy rebates are being passed through to the consumer, then the MLR should be appropriately adjusted to ensure that those benefits are actually reaching patients, as intended.

12 What was the rationale for requiring insurance companies to increase their medical loss ratio from 80 to 85 percent versus some other percentage?

We believe this increase is appropriate because, as stated previously, many aspects of this plan reduce the administrative burden for carriers like the requirement to pass through pharmacy rebates and the reduced need for provider rate negotiations. As such, the portion of each dollar they set aside for administration should be reduced. There is precedence for this: the 85% MLR is already the threshold for the large group market and as many of our carriers operate in that market, they have experience administering products at the more efficient 85% threshold. Other states have similarly explored increasing the MLR; Massachusetts has even raised the MLR to 88%.

13 Provide specific data on the medical loss ratio for insurance carriers as it stands now and the number/percentage of covered lives. Why is the MLR not expected to have an effect on premium reductions?

For the individual market, the MLR is currently 80%. For the large group market, it is already 85%. MLR is a three year average, and it varies by carrier. For the 2018 three year average, which is the most current data available, the following MLR data were reported to CMS:

Insurance Carrier	2018 MLR	Number of Lives
Bright Health	85.2%	21,119
Cigna	89.1%	27,515
Denver Health	69.7%	1,059
Friday Health Plans	87.5%	5,482
HMO Colorado Inc	77.6%	51,000
Kaiser	101.1%	82,207
Rocky Mountain HMO	96.1%	1,637
Rocky Mountain Hospital & Medical Services (Anthem)	93.5%	8,237

By moving the MLR to 85% and by requiring that the carriers pass along rebates and all compensation from prescription drug manufacturers, carriers will spend more of each premium dollar on medical care. While the change in the MLR may not show a premium decrease in the actuarial modeling, it will indeed have an impact on premium rates, as also outlined in question #11.

Source: DOI Statistical Report

14 How does the proposed recommendation account for economics and human behavior over time rather than a single point in time?

The Recommendation was designed to be a uniquely Colorado solution that addresses the needs voiced by Coloradans during the extensive HB1004 stakeholder process. The Recommendation directly draws from and responds to the innovative ideas, thoughtful questions, and important concerns raised throughout this process.

We recommended establishing an Advisory Board to continually improve the public option to respond to the voices and needs of Coloradans, employers, and other stakeholders. We felt like it was important to include this mechanism to continually improve the public option, to account for any changes in either economics, human behavior, the health care market, or our state in general as those changes happen.

15 It appears that the premium reductions in the actuarial analysis were all relating to the setting of hospital rates. Is there a way to balance out the mechanisms so that more levers are used to reduce premiums?

The Recommendation proposed three ways to make the public option more affordable:

- (1) Ensure profitable but fair hospital reimbursement rates that are hospital specific, and take into account unique factors impacting rural, critical access, and independent hospitals in a transparent process;
- (2) Use all pharmacy rebates collected by insurers to reduce the cost of insurance; and,
- (3) Increase the amount insurers must pay out as a percent of every premium dollar they take in (The Medical Loss Ratio, or MLR for short) from 80% to 85%.

16 JBC staff analysis discussed how there was no financial risk for the state. Please discuss the financial risk for both hospitals and insurance carriers. What are some potential unintended consequences and how are the departments preparing to mitigate those consequences?

The Recommendation proposes maximizing existing private sector infrastructure to administer the public option plans. This means that the state can minimize both the financial risk to taxpayers and the expenses required to operate a plan; while preserving the ability for private sector hospitals and insurance carriers to make a profit from selling and accepting the public option.

The Recommendation has taken many steps to minimize financial risk, but still achieve the intentions of HB19-1004. In particular, the Recommendation proposes utilizing a formula to set hospital reimbursement rates that would be clear, public, and transparent, and applied on a hospital by hospital basis. By applying a formula to each individual hospital, it takes into account the unique characteristics and geographic and community context of each hospital, thereby minimizing unintended consequences.

The reimbursement formula will factor in variables like:

- a hospital's payer mix (how many of its patients are covered by Medicaid, Medicare, commercial insurance, or are uninsured)

- whether the hospital is critical access, rural, urban independent, or part of a larger system
- patient margins, total margins (which take into account investment income and other earnings), and accumulated earnings over time
- administrative expenses compared to national norms.

Currently, the formula is being modeled in partnership with data collected directly from rural hospitals, independent hospitals, and Front Range hospitals so that we can test assumptions and ensure the formula achieves its goals of lowering costs while promoting sustainability for rural and critical access hospitals. The Advisory Board can provide ongoing monitoring and evaluation, and make recommendations on how to improve the formula as the public option becomes established.

17 What kind of mechanisms does the current proposal include that allow for an appeal from insurance carriers, hospitals, and providers? What are some potential models for what an appeals process might look like?

The final report did not specify an appeal process. If included in legislation, the Advisory Board could consider this issue as part of their charge to make recommendations related to the public option plan.

Rates for hospitals will be established according to a clear, transparent, and public formula. As contemplated by the report, the formula will be subject to a rulemaking process at DOI -- a public process to where all APA standards apply. The Recommendation does not propose setting rates for non-hospital providers.

18 What sort of regulatory tools do the departments have to utilize if a hospital or hospital system says no to accepting the public option plan? How could Medicaid be leveraged in this scenario?

The report recommends the legislature establish the regulatory authority in statute to require hospitals to accept public option insurance if we see hospitals declining patients with this coverage. The proposal depends on lowering our outlier hospital prices and without that authority, it will be hard to realize substantial cost savings for Coloradans and our employers.

19 What sort of regulatory tools do the departments have to utilize if an insurance company says no to administering a public option plan? What about if an insurance company refuses to expand to a new market with only one carrier?

The report recommends the legislature establish this authority in statute.

DIVISION OF INSURANCE (DEPARTMENT OF REGULATORY AGENCIES)

REINSURANCE

Friday, January 24, 2020

3:20 pm – 5:00 pm

NAME AND TITLE OF PRESENTER

Michael Conway, Commissioner, Division of Insurance

1 Describe the magnitude of the cliff effect on out of pocket expenses when a person earns too much to qualify for federal tax credits.

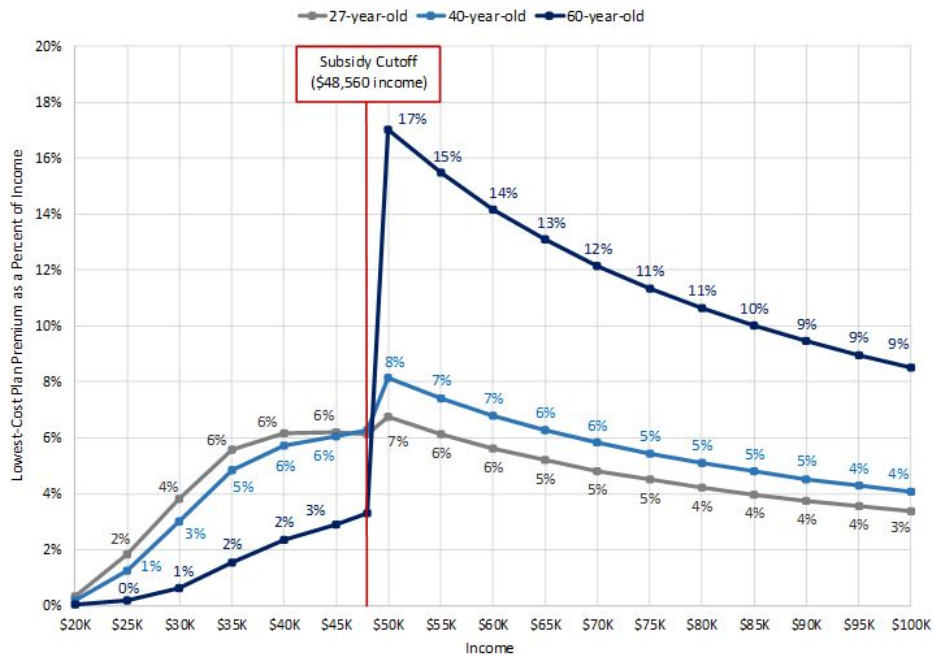
Consumers who earn more than 400% FPL and purchase their own insurance are the *only* consumer group that receives no financial assistance to purchase health insurance. This group does not receive premium assistance from the federal government in the form of advance premium tax credits (APTC) or employer assistance to help reduce premium costs, nor are they covered by Medicaid or Medicare (unless they are 65 or older).

Consequently, consumers earning more than 400% FPL pay significantly more for insurance than other consumers, including those earning less than 400% FPL. The “cliff” occurs at 401% FPL, the point at which a consumer no longer receives premium assistance and must cover the entire premium amount without financial assistance. While the premium assistance amount for consumers earning less than 400% FPL uses a sliding scale based on income, with higher earners receiving less premium assistance, there is still a significant difference or “cliff” between the average premium after premium assistance for someone earning 400% FPL and the unsubsidized premium for someone earning 401% FPL.

The 20% average premium reduction the reinsurance program was able to provide helps people impacted by the subsidy “cliff” described here. A 60 year old consumer who makes \$48,560 (401% FPL) would pay almost 20% of their income on their insurance premium, compared to a consumer who makes \$48,559 (400% FPL) who would only pay 5% of their income. As shown in the chart below, premium prices increase dramatically at 401% FPL because that is the point at which consumers no longer receive subsidies. And although it is not represented in this chart, the cliff effect is even more prevalent in Colorado’s rural areas because premiums there are higher.

Figure 3

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



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

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



Source: Kaiser Family Foundation

The average premium reduction of 20% in the individual market due to reinsurance has huge impacts for those over 400% of FPL. In our 1332 waiver application to the federal government, we estimated that population to exceed 86,000 Coloradans in 2020. Those people will save thousands of dollars this year as a direct result of the reinsurance program.

- 2 **One of the goals of reinsurance is to stabilize the market, making it more attractive for retaining and recruiting insurers and encouraging competition. How has reinsurance affected the number of insurers and available insurance products in the individual market? How many insurers and products have entered and left the market by region?**

All insurers have remained in the state from 2019 to 2020, and one new insurer (Oscar Health) entered the market.

The number of plan options in 2020 is increasing in most parts of the state. The total number of plans offered on the individual market in 2019 was 252 (124 on-exchange and 128

off-exchange), and the total number in 2020 is 264 (130 on-exchange and 134 off-exchange). On average, insurers are offering more products than before. And those products are being offered at lower premiums thanks to the reinsurance program. Further, Colorado’s new health care purchasing alliances, such as Peak Health in Summit County, are helping to increase coverage choices and affordability for consumers across the state.

Changes in Number of Plans from 2019 to 2020 by Rating Area

Rating Area	Name	2019 on-exchange	2020 on-exchange	Change	2019 off-exchange	2020 off-exchange	Change
1	Boulder	55	59	4	58	61	3
2	Colo. Springs	60	64	4	62	65	3
3	Denver*	73	87	14	75	88	13
4	Fort Collins	40	42	2	41	43	2
5	Gr. Junction	29	37	8	30	39	9
6	Greeley	40	42	2	41	43	2
7	Pueblo	40	42	2	41	43	2
8	East **	59	64	4	60	66	6
9	West *** ¹	44	40	-4	46	40	-6

* Oscar Health is new carrier to area 3 for 2020

** Bright Health is new carrier to area 8 for 2020

*** Rocky Mountain HMO is new carrier to area 9 for 2020

¹ Kaiser left area 9 for 2020

Regarding the number of insurers and products entering or leaving the market by region for 2020, all regions except 9 (Western Slope) saw an increase in the number of products available both on- and off-exchange. However, while region 9 had a small decrease in plans, it also had an insurer new to the area offering products, as did area 8 (Eastern plains) and area 3 (Denver).

Rating areas 3 (Denver) and 5 (Grand Junction) both had significant increases in the number of plans for 2020. Area 3 had 14 more plans available on-exchange, and 13 off-exchange, with most of that increase driven by a new insurer in the market, Oscar Health, which offered 10 plans each in both the on- and off-exchange markets. Anthem (HMO Colorado) and Bright Health also increased the number of plans. Area 5 had an increase of eight plans on-exchange and nine plans off-exchange. These were due to increased offerings from Anthem (HMO Colorado) and Rocky Mountain HMO.

Rating areas 1 (Boulder) and 2 (Colorado Springs) saw a modest increase in plan counts for 2020, with each area growing by four plans on-exchange and three plans off-exchange. In both areas, the increases were from Anthem (HMO Colorado) and Bright Health.

Rating areas 4 (Fort Collins), 6 (Greeley) and 7 (Pueblo) all had increases in 2020 of two plans each on- and off-exchange. These were all increases from Anthem (HMO Colorado).

In rating area 8 (East), Bright Health was a new insurer for this region, making 10 on-exchange plans and 11 off-exchange plans available to consumers. Anthem (HMO Colorado) also increased its offerings with two plans each on- and off-exchange. Friday Health offered fewer plans, going from 14 in 2019 to seven plans in 2020 both on- and off-exchange.

Rating area 9 (Western slope) was the only area to have an insurer leave the rating area, as Kaiser pulled all of its plans (12 each both on- and off-exchange). However, a carrier new to this area for 2020, Rocky Mountain HMO, stepped in and offered five plans on-exchange and six plans off-exchange. Anthem (HMO Colorado) added four plans each on- and off-exchange for 2020. Bright Health also slightly reduced its footprint in this area, going from eight on-exchange plans in 2019 to seven plans in 2020, and from 10 off-exchange plans in 2019 to six in 2020.

3 With reinsurance how many people would have to pay more after tax credits to purchase the same plan? How much more would they have to pay?

Consumers who don't qualify for premium assistance and are hit by the previously discussed "subsidy cliff" saw an average reduction in their premiums of 20% - the first decrease since the establishment of the ACA.

The amount of premium assistance that the subsidized population receives is primarily calculated based on the cost of a benchmark plan in the person's area and on their income. If the premium of that benchmark plan goes down, making the plan more affordable overall, the tax credit amount also goes down.

As a result, premium reductions in the individual market may have the impact of reducing the amount of premium assistance a subsidized individual receives from the federal government. Plan choice also impacts the amount of premium assistance subsidized consumers receive.

For example, early data shows that consumers receiving premium assistance in three rating areas actually chose to purchase more expensive plans on average, when they could have remained in the plan they had in 2019 and paid less.⁵

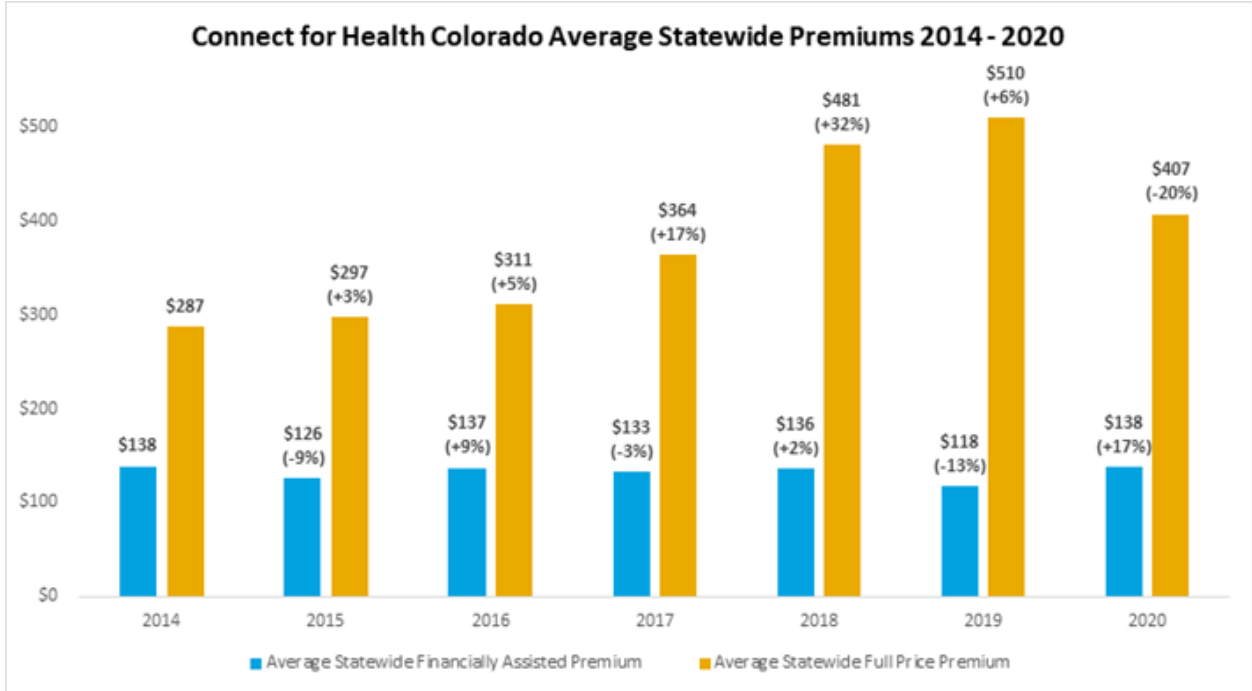
⁵ It's important to note that the numbers laid out above are preliminary. This data will change once we have the complete data from open enrollment.

Rating Area	2019 Premium After Subsidy	2020 Premium After Subsidy - Auto Renew (Same Plan)	2020 Premium After Subsidy - Switch to Lowest Cost Plan	2020 Premium - Actual Chosen Plan*
5 - Grand Junction	\$163	\$142	\$71	\$171
8 - East	\$121	\$102	\$83	\$127
9 - West	\$122	\$118	\$82	\$142

*Based on preliminary data. Final data may be different.

We’ve provided an additional chart below that lists the yearly average premiums for the unsubsidized population and the yearly average payments for the subsidized population after premium assistance is applied.

As the chart shows, reinsurance resulted in the first premium savings since the establishment of the ACA. The chart also shows that a subsidized consumer’s after-subsidy payment increased from \$118/month to \$138/month between 2019 and 2020. At \$138/month, subsidized consumers will be paying approximately the same amount that they have paid every year since 2014 with the exceptions of 2015 and 2019.

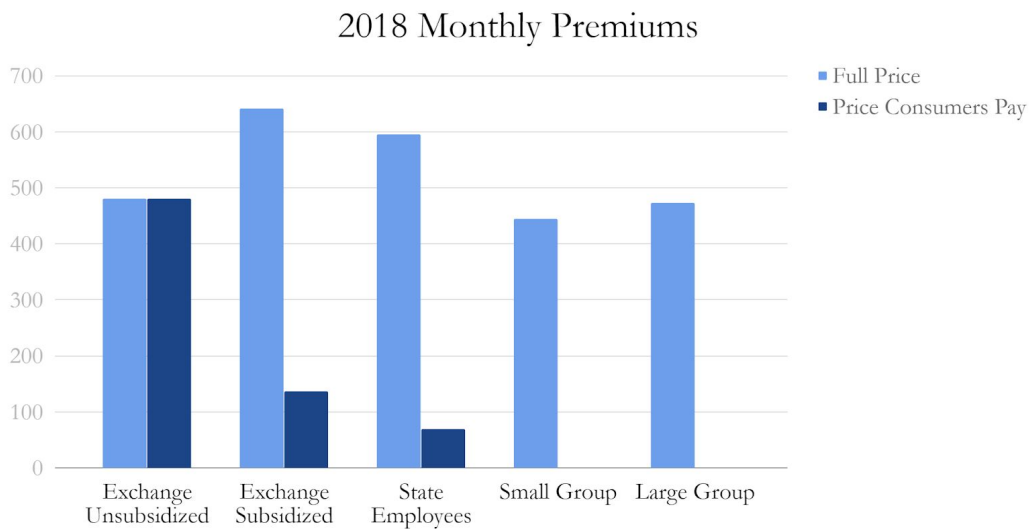


While we will always continue to find ways to reduce premiums in our health care markets, we are also committed to finding ways to help subsidized consumers. A key component of doing that will be understanding why consumers make certain choices. Consumers may have preferred the benefit design of one plan over another, despite the increased premium. Or, the total cost-sharing structure in a plan with a higher premium may have been preferable to that of a plan with a lower premium.

The reinsurance legislation required the Division of Insurance to conduct a study after the second year of the program to evaluate health plan affordability with a special focus on the subsidized population. We have committed to expediting that study and we will be completing it this year. That study will help us provide answers to the questions raised above. However, we hope this initial information will help the JBC members understand what occurred in the individual market for the subsidized population this year.

4 How do premiums and net costs after tax credits for people on the individual market compare to premiums and net costs after employer subsidies for the group markets? How does the individual market compare to state employee premiums and net costs?

The chart below shows average monthly premiums for the groups noted in the question. The “Price Consumers Pay” is the full price minus any financial assistance received (i.e. subsidy or employer contribution). The DOI does not collect employer contribution data for the small and large group markets because those vary based on the amount the employer chooses to pay. So the price consumers pay in those markets is not included in the chart.



Source: Colorado Division of Insurance; Colorado Department of Personnel & Administration

5 Does reinsurance or the public option do anything to help people in the group markets? Why do the departments put so much emphasis on the individual market when concerns about health insurance affordability are more widespread?

Yes, the public option can help lower prices in the small group market. It can also have a positive impact on prices in the large group market because large employers will be able to cite the public option rates in their negotiations as a standard of affordability.

The burden that rising health care costs place on employers and their employees is unsustainable just as it is unsustainable for the individual market. We recommended starting with the individual market because so many people who purchase insurance in that market were being priced out of coverage. Consumers in the individual market who are not eligible for federal tax credits pay the full price of health insurance and are essentially the only group in all of our health care markets that pay the full cost of their health insurance without any assistance.

Coloradans, especially on the Western slope and the Eastern plains, were being asked to pay the equivalent of a mortgage for health insurance. Savings from the Reinsurance program have been life changing throughout the State and in particular in our rural areas.

With that said, insurance premiums, deductibles, and other out-of-pocket expenses are a challenge for all Coloradans that have private insurance, so we are developing additional strategies to reduce health care prices more broadly.

For example, the alliance model that the Division created and that Peak Health Alliance launched is in many ways focused on the employer market. In addition, the affordability standards the Division will be implementing pursuant to HB19-1233 in the coming months will be designed to assist the employer markets with affordability by building more transparency into the system and giving employers more tools to impact the affordability of their health insurance. HCPF's work on hospital price transparency and profits is helping employers understand what they are paying and how prices in Colorado compare to the rest of the country.

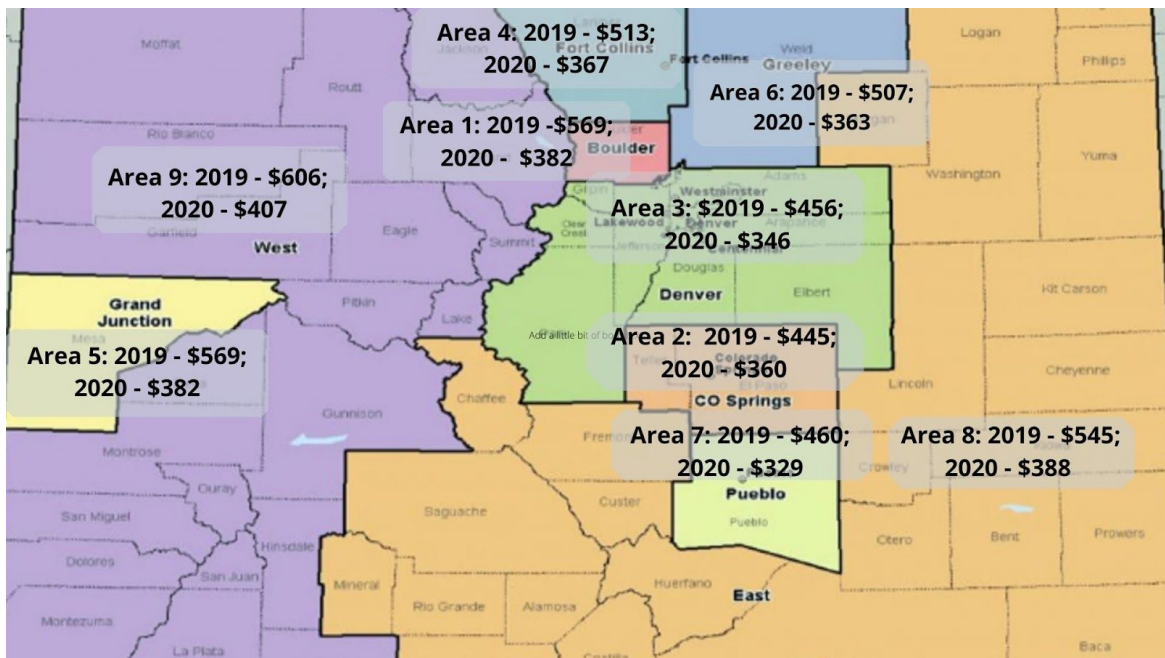
Those are just a few of the initiatives that we are working on to help the employer markets. While reinsurance and the public option have received considerable attention, we are committed to making health care more affordable in the employer markets, as well as the individual market.

Finally, the reinsurance and public option programs will likely have positive spillover effects for other health insurance market sectors in Colorado. Markets are not mutually exclusive, since the same companies typically offer products in multiple markets in a state. The DOI anticipates spillover effects from the reinsurance and public option programs to be in the form of increased overall market stability for carriers, consistent and affordable coverage for consumers, and a reduction in the proportion of uninsured patients for health care providers.

6 How much is reinsurance shifting from urban and suburban counties to rural and frontier counties?⁶

The reinsurance legislation was specifically designed by the sponsors to alleviate the high costs of health care in the rural parts of the state in the individual market. The sponsors did that by building three different tiers of premium relief into the legislation. As the table below with the 2019 premiums compared to the 2020 premiums shows, these tiered savings targets effectively leveled out premiums between areas and across the state. It should also be noted that CMS is promoting the tiering in our Reinsurance program as something other states should emulate in order to address premium discrepancies in their states.

2019 vs. 2020 Projected Premiums - lowest-cost silver plan for non-smoking 40-year-old without tax credits



⁶ https://colorado.gov/pacific/sites/default/files/DC_STI_HIVPrev_Colorado-County-Designations.pdf

Regarding the state share of the funding, of the \$90 million in state reinsurance program funding for 2020, \$68.1 million (75.7%) is expected to reimburse insurers for claims in urban areas, and \$21.9 million (24.3%) will go towards reducing claims in rural areas.

Note: These actuarial projections for reinsurance payments are based on the most current data available at the time the federal 1332 waiver application for Colorado's reinsurance program was submitted. That data was from the 2017 plan benefit year.

Source: Lewis and Ellis; Office of State Planning and Budgeting (OSPB)

7 What is the difference between the amount spent on reinsurance and the decrease in premiums? Why does this difference exist? What is the difference as a percentage of the investment in reinsurance and is the size of the difference appropriate?

Without reinsurance, in our 1332 application we estimated that enrollment for 2020 would have been 216,795 and premiums would have been \$644.91 per member per month.

With reinsurance, our 1332 application estimated that enrollment would increase up to 223,173 and premiums would drop to \$541.81 per member per month. Based on those enrollment projections and per member per month premiums, the total amount of premium collected by insurers in 2020 was estimated to be \$1.46 billion. A portion of the premium reduction is a reflection of a healthier population enrolling.

But, if the same number of people enrolled (223,173) and that the population had the same health characteristics as the pre-reinsurance population, it would be reasonable to assume that the population would pay the premium amount that would have existed without reinsurance (\$644.91 per member per month). That would mean that the total amount of premium that would have been collected would be \$1.73 billion. The difference between \$1.73 billion and \$1.46 billion is \$276 million.

In other words, reinsurance saves a total of \$276 million. That is \$26 million more than the \$250 million in state and federal funds invested in the program. As stated above, that \$26M is largely made up of reduced claims cost due to healthier risk and a reduction in per capita admin expense.

8 How does the cost of reinsurance for the population eligible for federal tax credits compare to the projected federal funds earned? Are we: (1) leveraging federal funds to help pay for premium reductions for people ineligible for tax credits, or (2) earning federal funds roughly equal to the premium reductions for people eligible for tax

credits, or (3) using state funds to help pay for premium reductions for people eligible for tax credits?

The reinsurance program allows us to use federal dollars to reduce premiums for unsubsidized individuals more than would be possible with state dollars alone. In our 1332 application, we projected that the unsubsidized population would make up approximately 40% of the individual market and the subsidized portion of the market would make up the remaining 60%. Based on the latest estimates provided to DOI from the federal government, federal dollars will make up 67% of the total funding for the program while state funding accounts for 33%. Therefore, at a high level, reinsurance leverages federal funds to benefit Coloradans who are not eligible for tax credits.

With that said, a key component of Colorado's reinsurance program is that it is "invisible" to the consumer. Reinsurance dollars may go towards claims for any enrollee who purchased a plan on the individual market, regardless of that person's income, insurance product, or health status. The sole criteria for claims reimbursement for an individual - other than purchasing a plan on the individual market - is that the person's annual claims paid by his or her insurer be above the reinsurance attachment point of \$30,000.

9 Could we use a similar investment of state funds to provide more targeted support to people ineligible for federal tax credits and reduce the cliff effect? What would that look like? What are the pros and cons of these potential alternatives to reinsurance?

Using a more targeted approach to subsidize people that are ineligible for tax credits would result in the loss of the \$169 million dollars the federal government is providing in pass through funding for our program. Furthermore, as we develop policy options to assist the subsidized population, that federal funding could be utilized to in part provide further premium assistance or cost share assistance for the subsidized population. The funding from the federal government that we are able to capture through the reinsurance program provides potential flexibility that simply would not be present in a premium assistance program that only targeted the unsubsidized population.

In addition, reinsurance programs have large positive impacts on markets, without adding burden or paperwork for consumers or carriers. For example:

- Reinsurance stabilizes the insurance market. It mitigates the impact to consumers of high cost claims.
 - Health care expenditures are uncertain by nature.

- o Reinsurance provides insurers with certainty that high cost claims will be covered. Premium assistance targeting the unsubsidized population does not provide such certainty. Greater certainty around claims helps insurers remain in the Colorado market. Certainty is particularly important in rural Colorado, where higher health care costs, and small numbers of people may dissuade insurers from offering coverage.
- o Colorado’s reinsurance program is specifically designed to provide greater financial support and risk mitigation for carriers in rural parts of the state.
- Reinsurance is seamless for the consumer.
 - o It does not require additional income verifications or paperwork requirements.
 - o Individuals can enroll on or off of the exchange and receive the benefit.
 - o Premium assistance would require an entity such as the exchange to administer the program and all consumers would have to enroll through the exchange.
 - o The off-exchange market would effectively cease to exist.
 - o While the impact for consumers that receive subsidies would be minimal because they already enroll through the exchange, the impact for the unsubsidized population could be large.
- The Federal Reinsurance waiver gives Colorado the flexibility to use federal dollars in the way that best meets Coloradans’ needs.
 - o A state premium assistance program would prevent the state from leveraging federal funds to implement a state-specific approach to health care cost reduction.

It is also important to note that, including Colorado, 12 states with political leanings from both sides of the aisle have adopted reinsurance programs throughout the country. These states include Maine, Wisconsin, Minnesota, Alaska, and others. Only one state, California, has taken the approach of a pure premium assistance program.

Finally, it is important to note that the reinsurance program was the result of years of study and debate in Colorado. The legislature first asked the Division to analyze whether a reinsurance program should be established in the 2017 legislative session. We had a robust stakeholder process and ultimately recommended that the legislature establish a reinsurance program as a result of that process. A bill was then introduced in 2018 to establish a reinsurance program and the legislature passed the bill in 2019 establishing our program.

10 **Is reinsurance the most efficient way to reduce premiums?**

Reducing the underlying health care prices that consumers ultimately pay to providers is a more efficient and sustainable way to reduce premiums.

The next best way to reduce premiums is, reinsurance. Colorado's reinsurance program is easy to administer, requires no additional income verification or paperwork for consumers, and includes minimal obligations for insurers. The program also uses a clear and simple formula to leverage Federal dollars, especially in areas of the state where health care costs and consumers' premiums have historically been highest.

Those are many of the reasons that other states continue to adopt reinsurance programs. There are currently 12 states that have approved reinsurance programs and there are others actively considering their own.

11 Why is the Governor proposing to prepay for an extension of reinsurance before an evaluation of the program is complete?

The Governor requested \$18.4 million in the 20-21 fiscal year budget in order to meet the statutory premium reduction goals for the reinsurance program in program year two that were required to be met in year one, and an additional \$41.6 million to insulate the program from uncertainties in federal funding and potentially fund a third program year.

However, in light of the additional \$9 million dollars in federal funding that the program is expected to receive, \$9 million of the Governor's \$18.4 million request in FY 20-21 will no longer be needed. Furthermore, we are no longer requesting the \$41.6 million dollars and will instead work with the legislature on funding sources for an extension of the program.

As set forth in HB 19-1168, the reinsurance program will operate for benefit years 2020 and 2021. The program has successfully reduced premiums by an average of 20% across the state in its first year. By program design, premiums have decreased the most in rural parts of the state that have historically had the highest premiums in the state. The DOI anticipates using similar program payment parameters for the program's second year. As such, the DOI expects premium reductions to remain at lower levels with the additional funding requested by the Governor.

The Governor is prioritizing insurance market stability in planning for an extension of the reinsurance program beyond two years. If the program were to end, cost of care would remain high and premiums would likely increase significantly, back to their pre-reinsurance levels. Consumers who purchased insurance while the reinsurance program was in place would see dramatically higher premiums in many cases, potentially causing major market disruption.

12 Would the extension be for one year, or indefinitely?

Federal waiver programs typically run for five years. If the General Assembly approves an extension of the program, the DOI anticipates requesting a three-year extension for Colorado's reinsurance program, which would implement the program through the end of 2024. HB 19-1168 created a two-year reinsurance program, so this extension request will require new legislation.

13 Is the Governor asking the JBC to extend the reinsurance program, or just to add money for the reinsurance program?

The first year of reinsurance has resulted in significant savings to Coloradans. We want to work with the legislature to extend this successful program.

14 How would reinsurance be impacted by a repeal of the federal Affordable Care Act? Would a repeal impact federal tax credits for people on the individual market?

In the unlikely case that the federal government repeals the ACA, Colorado's reinsurance program, along with the reinsurance programs in eleven other states, would cease to operate. These programs rely on federal premium tax credits created by the ACA.

If the ACA is repealed, the tax credits would not be available. Repeal of the ACA would cause significant disruptions, and in many ways devastation, in all states' health insurance markets, far beyond the scope of reinsurance programs.