MILLIMAN REPORT

Analysis of Colorado HB 21-1232 Impact on Healthcare Provider Reimbursement and Consumer Premiums

Prepared for Partnership for America's Healthcare Future Action, Inc.

May 26, 2021

Paul Houchens, FSA, MAAA, Principal and Consulting Actuary
Fritz Busch, FSA, MAAA, Consulting Actuary
Lindsy Kotecki, FSA, MAAA, Principal and Consulting Actuary

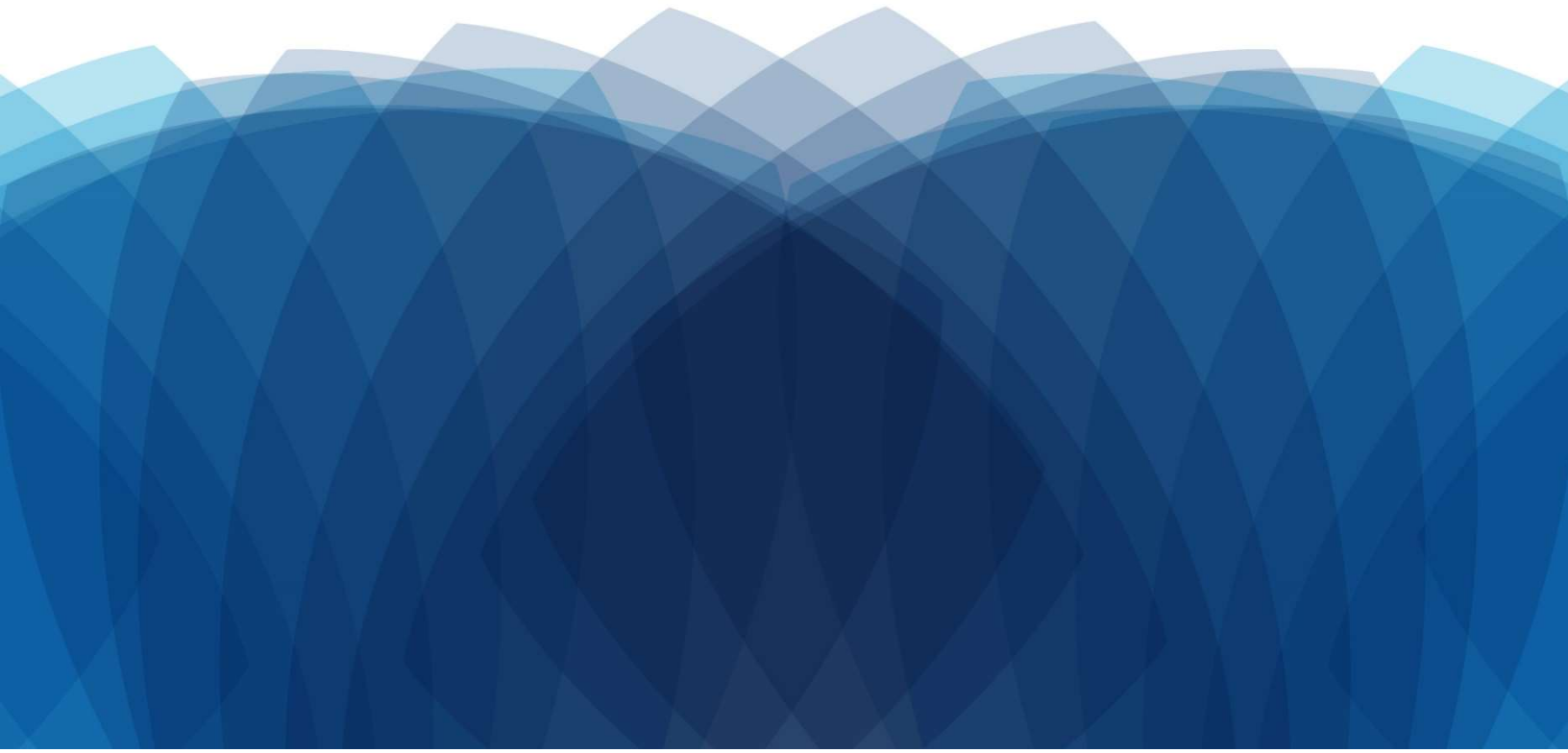


Table of Contents

Executive Summary

Colorado House Bill 21-1232 (HB 21-1232) was introduced on March 18, 2021 to the Colorado General Assembly. This paper was written under the context of the bill as of April 27, 2021. The stated goal of the bill is to ensure that affordable health insurance options are available for Coloradans, particularly those in rural areas and for populations facing barriers to coverage. The mechanism to achieve that goal is the establishment of standardized health insurance plans to be offered by insurers participating in the individual and small group markets in the state. The standardized plans will have prescribed benefits and will be required to be offered with an adequate network and at a premium that is reduced from premiums offered by each insurer in the 2021 individual and small group markets. If an insurer is unable to meet network adequacy or premium rate requirements, it must notify the Division of Insurance (DOI) commissioner of the reasons why in advance of the benefit period. If shortfalls are not resolved, the commissioner may initiate a public hearing. If a shortfall remains at the conclusion of the hearing, the commissioner will have the authority to require hospitals and physicians to accept lower reimbursement rates from that insurer, limited to pre-established minimum reimbursement levels as a percentage of the Medicare fee schedule.

Milliman was engaged to perform an actuarial analysis of the impact of the requirements under HB 21-1232 on various stakeholders in the Colorado market, with a particular emphasis on insurers, providers, and consumers. The key findings from our analysis include.

- The ability of insurers to achieve target premium rate reductions will vary in ways that may influence competition.
  - Because premium reductions are measured relative to 2021 levels, it may be more difficult for insurers with low or negative margins in 2021 to achieve the required reductions relative to insurers with higher margins in 2021. Insurers with low or negative margins may be at a competitive disadvantage.
  - Our analysis suggests that the minimum hospital reimbursement levels established in the bill may be higher than the contracted arrangements that certain insurers (particularly those insurers with lower cost premiums) currently have in place with at least some of their providers. There may be limited ability for the commissioner to enforce premium rate reductions for those insurers in rating areas where those providers are located.
  - As a result, insurers that have successfully negotiated low reimbursement rates prior to the implementation of the bill may see their competitive advantage eroded as hospitals contracting with higher cost insurers are required to reduce their reimbursement levels to achieve the premium reductions in accordance with the bill.
  - While converging provider reimbursement levels may foster competition by narrowing the range of premiums among insurers and encouraging them to compete on quality, these dynamics may possibly result in some current low-cost insurers exiting the market due to the erosion of their prior competitive advantage, reducing competition and consumer choice.
- HB 21-1232 gives the DOI commissioner authority to reduce hospital and professional reimbursement rates to achieve target premium levels, but does not provide the authority to enforce reductions in pharmacy costs or insurer retention. It is possible that insurers may choose to reduce margin or increase care management protocols to achieve a portion of the reduction, but it is also possible that the entire premium reduction may be borne by hospitals and other healthcare providers. In order to get a sense for the full potential impact of the bill on healthcare providers, we have assumed for purposes of this analysis that pharmacy costs and insurer administrative expenses and margin remain generally constant. If insurers proactively find ways to reduce administrative expenses or if pharmacy costs are reduced, the impact on healthcare providers may be less than our estimates.
  - Generally speaking, the composition of premium in the individual and small group markets is weighted most heavily on inpatient and outpatient hospital services (around 35-50%), followed by physician services and prescription drugs (each around 15-20%), ancillary services (around 5%), and insurer retention (15-25%). If reductions in hospital reimbursement and physician charges are the primary mechanisms for reducing premiums, the reductions in reimbursement rates will need to be larger than the reduction in premium.
  - Physician reimbursement in the individual and small group markets today is most often lower as a percentage of the Medicare fee schedule than inpatient and outpatient hospital services. In Colorado, our analysis suggests that it is near or below the 135% floor enforceable under HB 21-1232. For this reason, we have made the simplifying assumption that physician reimbursement will not be reduced from where it is today. If there are

regions where physician reimbursement rates are higher than the floor, the hospital reductions reported in our analysis may be greater than needed under the bill, albeit not much greater because physician reimbursement rates only influence a relatively small portion of premium.

- HB 21-1232 uses a uniform set of criteria for establishing minimum reimbursement levels for facilities across the state. The use of a uniform set of criteria will, paradoxically, drive non-uniform results by region, because health care costs differ dramatically by region for a multitude of reasons.
  - Hospitals in urban areas that are more densely populated and more likely to have more than one health system are more likely to have narrow network arrangements at reimbursement levels that are already below the minimums established in the bill.
  - Hospitals in rural areas, where there is little to no insurer or provider competition and lower patient volume, may be required to reduce reimbursement by more without the benefit of the increased volume associated with narrow network arrangements in urban areas.
- Premium rate changes under HB 21-1232 will vary by insurer and region, and may not reflect the full reduction prescribed in the bill. This is especially true in urban areas where narrower networks are more prevalent.
  - As noted above, the bill gives the commissioner the authority to set hospital reimbursement rates, but does not explicitly give authority to enforce other premium rate reduction measures. Further, the bill limits year-over-year hospital reimbursement rate reductions and establishes floors for the reimbursement level hospitals are required to accept under the enforcement mechanisms of the bill. These limits effectively translate to diminishing average premium rate reductions each year, as more and more hospitals reach the reimbursement floor.
- Some consumers may experience a rate reduction under HB 21-1232 if they choose to enroll in the standardized plan, but many subsidized individual market consumers will not see any change in the lowest out-of-pocket premium option available to them. It is possible that some consumers in the individual market could experience a rate increase if they choose to keep their current plans.
  - In general, if premium rates for the standardized plans are reduced below current levels, then small group market consumers will realize a reduction in premium if they choose a standardized plan.
  - In the individual market, the impact of any premium reductions will vary depending on an individual's income level (affecting subsidy eligibility) and the second lowest cost silver plan (SLCSP) in the individual's region of residence.
    - Premium rates for higher income individual market consumers who are not subsidized may be reduced if premium rates for the standardized plans fall below current levels. An individual would be required to switch to the standardized plan to capture the premium rate reduction.
    - Many subsidized consumers whose out-of-pocket premiums are already capped at a maximum percentage of income are not likely to see any reduction in premium under HB 21-1232, provided they remain enrolled in a plan with a premium equal to or lower than the SLCSP.
    - To the extent that standardized premiums drop below the SLCSP premium, subsidized consumers may need to switch to the standardized plan to avoid an increase in out-of-pocket (after subsidy) premium. If the reduction in the SLCSP is large enough, consumers with zero-premium bronze plans may no longer have a zero-premium option.
  - In the absence of state action, the savings from any premium reductions for subsidized individuals will be realized by the federal government. HB 21-1232 requires the state of Colorado to file for a section 1332 Waiver in order to capture savings via pass-through funding for use by the state. Should enhanced subsidies under the American Rescue Plan (ARP) continue beyond 2022, the number of consumers eligible for subsidies will be higher, increasing available pass-through funding, but decreasing the number of consumers directly benefiting from premium rate reductions under the bill.
  - Figure 1 provides a numerical demonstration of estimated average reimbursement levels underlying 2021 premium rates in Colorado and estimated premium rate reductions achievable under HB 21-1232 from 2023 to 2025. To reiterate, it is possible that premium rate reductions under the provisions of the bill will diminish in each year relative to the reductions established in the bill. Hospitals in urban areas are less likely to require significant reductions from current reimbursement levels, while hospitals in rural areas may be impacted more. Premium rate

reductions in urban areas are likely to be lower than in rural areas and are unlikely to reach the reductions set in the bill. Note, consistent with how premium rate reductions for the standardized plan will be measured against 2021 premium rates under HB 21-1232, estimated premium rate impacts illustrated in Figure 1 are isolated to the effect of HB 21-1232 and do not consider any interactions with the Colorado reinsurance program.

FIGURE 1: SUMMARY OF POTENTIAL IMPACTS TO FACILITY REIMBURSEMENT AND PRE-SUBSIDY MEMBER PREMIUMS UNDER HB 21 1232 (URBAN-RURAL VIEW)

	INDIVIDUAL MARKET REIMBURSEMENTS LEVELS % OF MEDICARE					HOSPITAL REIMBURSEMENT CHANGES				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
REGION	ESTIMATED CURRENT	AVG. FLOOR UNDER HB 21-1232	EFFECTIVE YEAR 1	EFFECTIVE YEAR 2	EFFECTIVE YEAR 3	YEAR 1	YEAR 2	YEAR 3	3-YEAR REIMB. CHANGE	THREE YEAR PREMIUM IMPACT
Urban	237%	180%	205%	184%	180%	-13.5%	-9.0%	-1.7%	-24.1%	**-10.7%**
Rural	375%	178%	325%	274%	225%	-13.5%	-13.5%	-13.2%	-40.2%	**-17.8%**
Total	**259%**	**180%**	**224%**	**198%**	**187%**	**-13.5%**	**-10.0%**	**-4.3%**	**-27.8%**	**-12.4%**
PREMIUM IMPACT						**-6.0%**	**-4.5%**	**-1.9%**	**-12.4%**	

	SMALL GROUP MARKET REIMBURSEMENTS LEVELS % OF MEDICARE					HOSPITAL REIMBURSEMENT CHANGES				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
REGION	ESTIMATED CURRENT	AVG. FLOOR UNDER HB 21-1232	EFFECTIVE YEAR 1	EFFECTIVE YEAR 2	EFFECTIVE YEAR 3	YEAR 1	YEAR 2	YEAR 3	3-YEAR REIMB. CHANGE	3-YEAR PREMIUM IMPACT
Urban	256%	182%	222%	198%	185%	-13.3%	-9.2%	-5.1%	-27.6%	**-12.3%**
Rural	372%	176%	322%	272%	228%	-13.5%	-13.5%	-11.7%	-38.7%	**-17.2%**
Total	**273%**	**181%**	**237%**	**209%**	**191%**	**-13.3%**	**-10.1%**	**-6.4%**	**-29.8%**	**-13.2%**
PREMIUM IMPACT						**-5.9%**	**-4.5%**	**-2.9%**	**-13.2%**	

Notes: Regional definitions are based on rating regions defined under the ACA, where regions 1-4 are considered urban areas and regions 5-9 are considered rural areas (see Figure 13). Hospital reimbursement rates reductions inherently reflect an increase in the Medicare fee schedule. In accepting these reductions, we note that hospitals are also forgoing any additional year-over-year increase in fees they would have typically received in excess of changes in medical inflation underlying the Medicare rates. For purposes of this analysis, we assumed that Medicare rates will increase consistent with the medical inflation allowable under the bill. There is some evidence that Medicare rates increase 0.5% to 1.0% less than CPI.

I. Introduction

Partnership for America's Healthcare Future Action, Inc. engaged Milliman to assist in analyzing the potential impact of Colorado House Bill 21-1232 (HB 21-1232) on healthcare provider reimbursement and premium rate impacts to Colorado's individual and small group markets. In determining the scope, methodology, and assumptions for our analysis, we relied on the policy objectives and parameters written in the text of HB 21-1232 as of April 27, 2021. To the extent the legislation is further amended, conclusions and values stated in this report may need to be updated.

KEY PROVISIONS OF HB 21-1232

Key provisions of HB 21-1232 applicable to the actuarial analysis of individual and small group market premium rates and provider reimbursement levels are summarized below. HB 21-1232 also includes a number of other provisions related to the establishment of an advisory board and other administrative bodies responsible for overseeing the implementation and operation of the bill. Operational and administrative aspects of the bill were not considered in this analysis.

Structure of standardized plans

- The bill establishes, by January 1, 2022, a set of standardized benefit plans at the bronze, silver, and gold levels of coverage that are to be sold in the individual and small group markets by January 1, 2023. Insurers are required to offer the standardized plan in each county in which they are otherwise participating starting on January 1, 2023, and plans must be offered throughout the entire county.
- The standardized plans are to be established through collaboration with various stakeholders and are to be designed such that they improve access and affordability of healthcare coverage. Standardized plans could, for example, include first dollar coverage for certain high-value services, such as primary care and behavioral health care. The standardized plans may be updated annually.
- The standardized plans must have a provider network that is no more narrow than the most restrictive network offered by the insurer in a rating area. Failure to meet network adequacy standards will require an insurer to submit an action plan to the DOI commissioner, explaining the reasons for not meeting the requirements.
- The standardized plans will be subject to the risk adjustment requirements under the Patient Protection and Affordable Care Act (ACA)[1].

Premium rate requirements for standardized plans

- Starting with the 2023 plan year, premium rates for the standardized plan must be at least 6% less than health benefit plans offered in 2021 in the individual or small group markets, adjusted for medical inflation[2] and any differences in the actuarial value of the standardized plan. The 6% is measured against an insurer's own plan offerings in a county. If an insurer did not offer benefit plans in a county in 2021, but does so in 2023, the 6% reduction is measured against the average of the benefit plans offered in that county in 2021. The achievement of premium rate reductions will be measured against 2021 premium rates adjusted to remove premium rate reductions resulting from the Colorado reinsurance program (individual market only).
- For plan years 2024 and 2025, the reduction parameters move to 12% and 18%, respectively.
- Starting in plan year 2026, premium increases for the standardized plans will be no more than medical inflation[2].
- Rate filings that reflect cost shifting between the standardized plan offered by the insurer and the plan for which a rate approval is being sought will not have the requested rate increase approved.

Commissioner authority for plans that do not meet premium rate requirements

- If an insurer is unable to meet network adequacy or premium rate requirements, it must notify the DOI commissioner of the reasons why, far in advance of the benefit period, by the deadlines established in the bill.

[1] The relevant section of the ACA is available at https://ecfr.io/Title-45/Part-153.

[2] HB 21-1232 defines "medical inflation" as the annual percentage change in the medical care index component of the U.S. Department of Labor's Bureau of Labor Statistics Consumer Price Index for medical care services and medical care commodities, or its applicable predecessor or successor index, based on the average change in the medical care index over the previous 10 years.

- If by January 1, 2023 an insurer is unable to offer standardized plans at the premium rate levels required in the bill, the DOI will hold a public hearing. Based on evidence presented in the hearing, the commissioner may establish fixed hospital and / or physician reimbursement rates for the standardized plan to meet the premium rate requirements. Rates set by the commissioner are subject to parameters and constraints established in the bill, as outlined in Figure 11 of Section III in this report below.
- Reimbursement rates shall only be set by the commissioner for hospitals or healthcare providers who prevented an insurer from meeting its premium rate requirements.
- The commissioner may require a healthcare provider to participate in a standardized plan and accept set reimbursement rates.
- The commissioner may require health insurers to offer the standardized plan in specific counties where no standardized plan is offered in the individual or small group markets.

Federal waiver

- The implementation and operation of the premium rate requirements for standardized plans is contingent on the approval of a Section 1332 waiver application and the receipt of federal funds.

ANALYSIS SCOPE

Milliman's analysis scope was to review the impact of Colorado HB 21-1232 on healthcare insurers, healthcare providers, and consumers in the individual and small group markets, including:

- An overview of the current Colorado individual and small group market landscape, including enrollment, insurer financial experience, and estimated provider reimbursement rates as a percentage of the Medicare fee schedule.
- An analysis of the potential impact of HB 21-1232 on provider reimbursement rates in the individual and small group markets in 2023, 2024, and 2025 under the authority and constraints established in the bill.
- A discussion of the potential implications of HB 21-1232 on aggregate federal subsidy outlays in Colorado, before any pass-through funding from a Section 1332 waiver, and with consideration given to the potential impact of the American Rescue Plan (ARP) should the ARP continue beyond 2022.
- A discussion of the implications of premium rate reductions prescribed by the bill on consumer premiums net of federal Advanced Premium Tax Credits (APTCs, also known as premium subsidies).
- A discussion of considerations related to insurer participation, provider outmigration, and the effects of the bill on other stakeholders.

II. Summary of Colorado's individual and small group health insurance market

To provide a foundation for understanding potential impacts of HB 21-1232 to Colorado's individual and small group markets, we have summarized features of both markets including their expense structure and composite financial results, the variability of market share and financial results among insurers, and the competitiveness of each market relative to national measures.

INDIVIDUAL AND SMALL GROUP MARKET FINANCIAL RESULTS

As stated previously, HB 21-1232 requires insurers participating in Colorado's individual and small group markets to offer the standardized plan at a premium rate that is at least 6% (2023), 12% (2024), and 18% (2025) below calendar year 2021 rates after adjusting for medical inflation and the Colorado state-based reinsurance program (individual market only). To assess the potential sources of premium rate reductions available to insurers, we have summarized financial experience from 2018 and 2019 for insurers offering coverage in Colorado's individual and small group markets from the Centers for Medicare and Medicaid Services (CMS) commercial medical loss ratio (MLR) form data and calculated the following financial indicators: MLR, administrative loss ratio (ALR), and underwriting ratio. Note that MLR data for the calendar year (CY) 2020 coverage year is not available at the time of this report.

FIGURE 2: COLORADO INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKET FINANCIAL SUMMARY (VALUES SHOWN ON PER MEMBER PER MONTH BASIS)

	INDIVIDUAL		SMALL GROUP	
	2018	2019	2018	2019
Average Monthly Enrollment	222,131	210,940	262,896	260,361
Earned Premium	$ 557.94	$ 584.84	$ 442.28	$ 462.69
Taxes and Fees	(42.44)	(31.25)	(18.37)	(15.22)
Net Ceded Reinsurance Premiums and Other Revenue Adjustments	(1.06)	(20.22)	(1.26)	(0.04)
Net Adjusted Premiums After Reinsurance	**514.43**	**533.37**	**422.65**	**$ 447.43**
Net Prescription Drugs	67.56	73.33	49.56	52.71
Other Benefit Expense	355.51	366.91	303.69	309.82
Reinsurance Recoveries	(1.49)	(14.34)	(2.97)	(0.16)
MLR Rebates and Other Claims Expense Adjustments	4.26	7.81	1.48	1.45
Total Benefit Expense	**425.84**	**433.71**	**351.77**	**363.81**
Administrative Expenses	**54.88**	**49.16**	**59.39**	**57.62**
Underwriting Gain/(Loss)	**$ 33.71**	**$ 50.50**	**$ 11.48**	**$ 25.99**
Medical Loss Ratio	82.8%	81.3%	83.2%	81.3%
Administrative Loss Ratio	10.7%	9.2%	14.1%	12.9%
Underwriting Ratio	6.6%	9.5%	2.7%	5.8%

Notes:
1. Medical loss ratio = total benefit expense divided by net adjusted premiums after reinsurance.
2. Administrative loss ratio = administrative expenses divided by net adjusted premiums after reinsurance.
3. Underwriting ratio = underwriting gain/(loss) divided by net adjusted premiums after reinsurance.
4. Net prescription drugs reflect paid prescription drug cost less pharmacy rebates received by insurers.

Non-pharmacy benefit expenses ("Other Benefit Expense") are approximately 60% to 65% of earned premium in the individual market and 65% to 70% of earned premium in the fully insured small group market. To the extent an insurer is unable to reduce pharmacy benefit expense, administrative expenses, or risk margin assumptions, the reduction to non-pharmacy benefit expense necessary to achieve the premium rate reduction targets in HB 21-1232 would be greater than the premium reduction percentages of 6% (2023), 12% (2024), and 18% (2025).

For example, if an insurer's non-pharmacy benefit expense was 70% of earned premium, then a nearly 26% (0.18 / 0.70) reduction to hospital and physician benefit expenses would be necessary to achieve the 18% premium reduction (holding the other expense components constant[3]).

For the three key financial measures (MLR, ALR, Underwriting Ratio), Figure 3 compares Colorado's individual market to national financial results. Figure 4 provides the same comparison for the small group insurance market.

FIGURE 3: COLORADO VS. NATIONAL INDIVIDUAL MARKET FINANCIAL INDICATORS

	COLORADO		NATIONAL		DIFFERENCE	
	2018	2019	2018	2019	2018	2019
Medical Loss Ratio	82.8%	81.3%	79.0%	79.8%	3.7%	1.5%
Administrative Loss Ratio	10.7%	9.2%	10.3%	10.6%	0.3%	-1.4%
Underwriting Ratio	6.6%	9.5%	10.6%	9.6%	-4.1%	-0.2%

FIGURE 4: COLORADO VS. NATIONAL SMALL GROUP MARKET FINANCIAL INDICATORS

	COLORADO		NATIONAL		DIFFERENCE	
	2018	2019	2018	2019	2018	2019
Medical Loss Ratio	83.2%	81.3%	82.5%	83.1%	0.7%	-1.8%
Administrative Loss Ratio	14.1%	12.9%	12.8%	12.6%	1.2%	0.3%
Underwriting Ratio	2.7%	5.8%	4.7%	4.3%	-2.0%	1.5%

Source: 2018 and 2019 values for Figures 3 and 4 summarized from CMS commercial medical loss ratio submissions.

In Colorado's individual market, MLR percentages for 2018 and 2019 were higher than the national composite by 3.7% in 2018 and 1.5% in 2019. Consistent with the MLR percentages, the underwriting ratios in Colorado's individual market were (4.1%) and (0.2%) less than the national composite results for 2018 and 2019, respectively.

Small group financial results for Colorado relative to the national composite values did not vary materially. While Colorado's small group MLR was higher (and underwriting ratio lower) than the national composite in 2018, the relationship between Colorado and national values reversed itself in 2019.

Based on these figures, the insurers in the Colorado individual and small group markets do not appear to be generating outsized underwriting margins relative to the nation as a whole. This may be important as insurers might be able to contribute towards meeting the 6% annual premium reduction target in 2023 by reducing margins.

VARIABILITY OF INDIVIDUAL AND SMALL GROUP MARKET FINANCIAL RESULTS

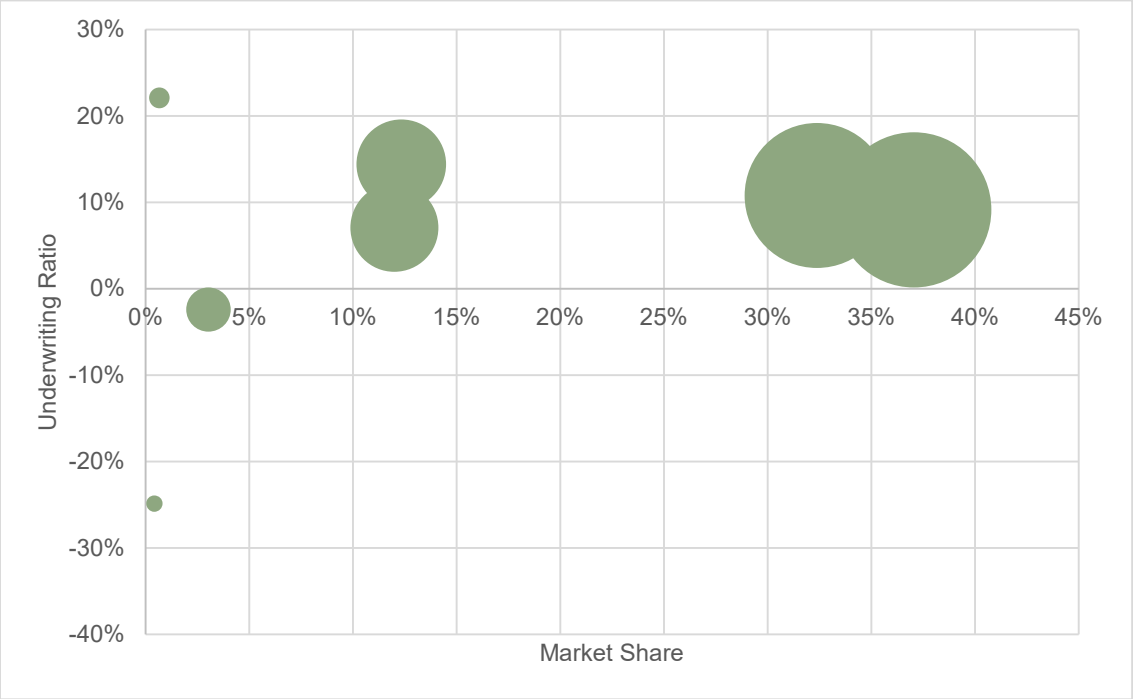
HB 21-1232 requires an insurer to offer the standardized plan in 2023 through 2025 at specified percentage rates lower than plans offered by the insurer in 2021 (in counties where the insurer offered coverage in 2021). As the target premium rate reduction is not based on a market average across insurers, the ability for an insurer to meet this target may be influenced by the insurer's premium rate levels and profitability in 2021, as noted above.

[3] This is a simplifying assumption. It is possible that fixed administrative expenses could increase as a percentage of premium if premiums are reduced from current levels, while other variable expenses could be reduced if premiums are reduced. We do not believe this simplification materially impacts the outcomes of our analysis.

For example, if an insurer's premium rates resulted in poor financial performance in 2021, it may be more difficult for that insurer to achieve the premium rate reductions required under HB 21-1232 relative to an insurer that had strong financial performance in 2021. Given that premium rates are established based on an estimate of future healthcare costs, actual healthcare costs during the coverage year will always vary to some degree relative to forecasts. With the COVID-19 pandemic and its varying impact on healthcare costs, there is additional uncertainty regarding 2021 healthcare costs.[4]

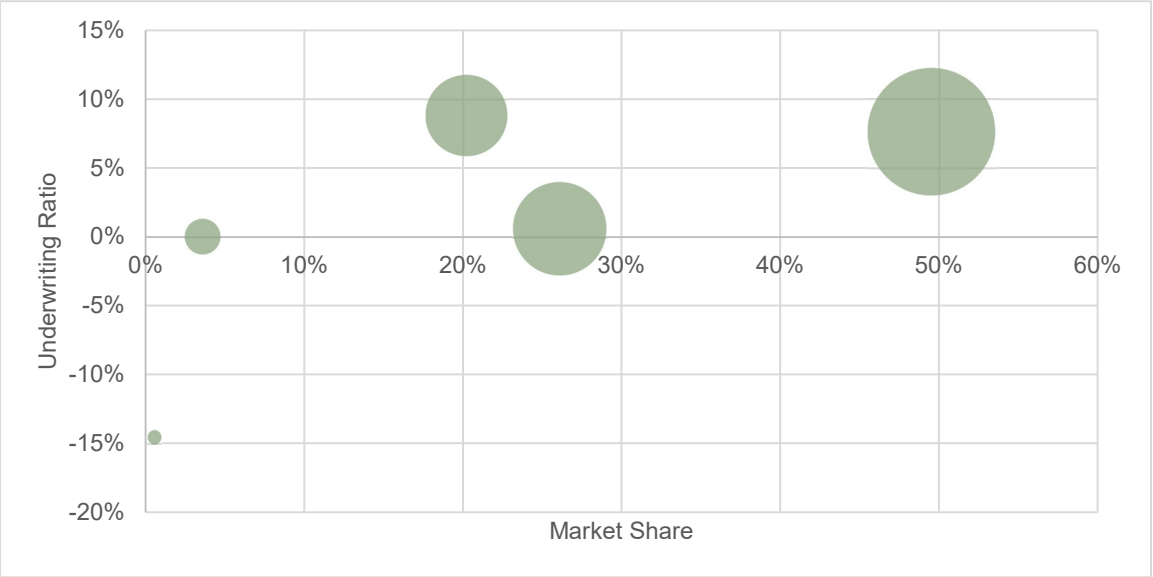
To assess the variability of insurer financial results in a normal year, we have summarized the underwriting ratio financial results at the parent company level for 2019 in Colorado's individual and small group markets by insurer market share in Figures 5 and 6, respectively. The size of each circle is scaled to the insurer's market share in the market. Note that we have excluded insurers that do not offer ACA-compliant coverage from the financial summary.

FIGURE 5: CY 2019 INDIVIDUAL MARKET UNDERWRITING RATIO VARIATION BY PARENT COMPANY MARKET SHARE



[4] American Academy of Actuaries (June 2020). Issue Brief: Drivers of 2021 Health Insurance Premium Changes: The Effects of COVID-19. Retrieved May 23, 2021, from https://www.actuary.org/sites/default/files/2020-06/PremiumDrivers2021.pdf.

FIGURE 6: CY 2019 SMALL GROUP MARKET UNDERWRITING MARGIN VARIATION BY PARENT COMPANY MARKET SHARE



As shown in Figures 5 and 6, there is considerable variability in underwriting ratios among insurers offering coverage in Colorado's individual and small group markets in 2019. While several large insurers had positive underwriting ratios in each market, the financial results for small insurers were mixed, with multiple insurers in each market having underwriting ratios below or near 0%. To the extent similar variability in financial results is observed in 2021, insurers with limited or negative margins for 2021 may have greater difficulty in achieving the premium rate reduction targets in HB 21-1232 relative to insurers with high underwriting margins in 2021.

INDIVIDUAL AND SMALL GROUP MARKET COMPETITION

The following section compares Colorado insurance market competition to national averages using various measures. Based on these measures, Colorado's individual and small group insurance markets offer consumers a larger degree of consumer choice relative to national averages.

Figure 7 illustrates the average number of insurers, weighted by county marketplace enrollment, offering coverage in Colorado's state-based marketplace, Connect for Health Colorado (CFHC), in 2021 relative to national statistics published by Kaiser Family Foundation (KFF).[5,6] Insurer choice is greatest in the Denver metropolitan area, where seven insurers are offering coverage through the marketplace in 2021 in several counties.

[5] McDermott, D. & Cox, C. (November 23, 2020). Insurer Participation on the ACA Marketplaces, 2014-2021. KFF. Retrieved May 23, 2021, from https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/.

[6] CY 2021 county weighting for Colorado based on open enrollment medical enrollments, see: https://c4-media.s3.amazonaws.com/wp-content/uploads/2021/04/07154007/2021-By-the-Numbers-final.pdf, page 21. Metro vs. non-metro classification defined based on Health Resources & Service Administration classifications, see: https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html. https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html

FIGURE 7: CY 2021 INDIVIDUAL MARKETPLACE INSURER COMPETITION: CONNECT FOR HEALTH COLORADO VS. NATIONAL MARKETPLACE

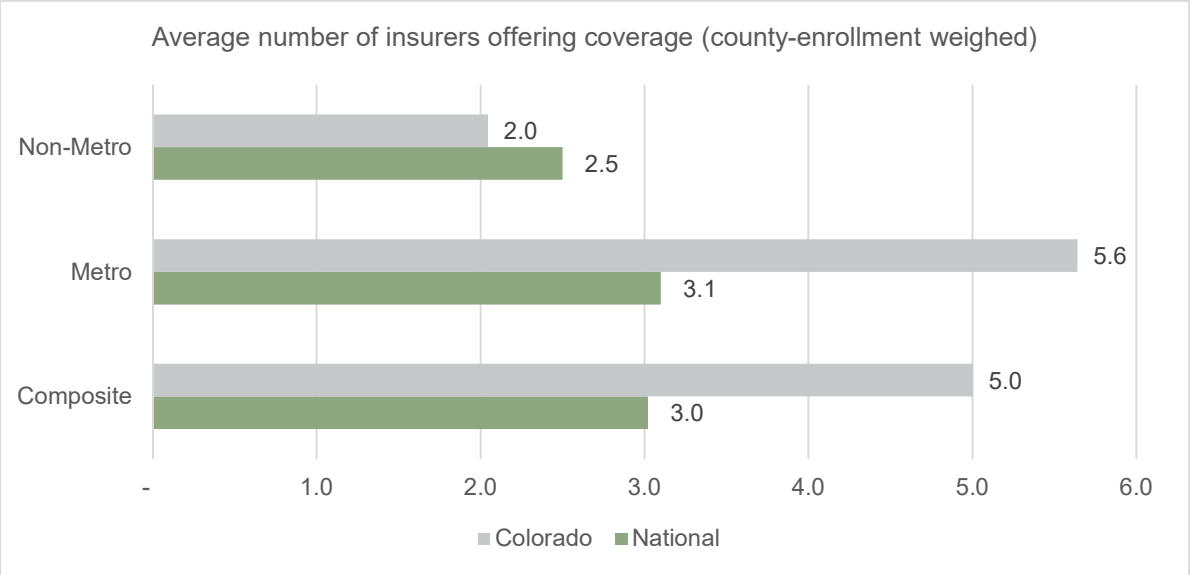


Figure 8 provides additional market competition measures published by KFF for both the individual and small group markets based on 2019 insurer financial data.[7] Using the Herfindahl-Hirschmann Index for market share concentration[8], the analysis indicates that Colorado's individual and small group markets rank among the least concentrated relative to other states and the District of Columbia. Colorado's individual market is the 44th least concentrated, while its small group market is the 39th least concentrated.

FIGURE 8: INDIVIDUAL AND SMALL GROUP MARKET COMPETITVENESS MEASURES

	INDIVIDUAL MARKET		SMALL GROUP MARKET	
	COLORADO	NATIONAL AVERAGE	COLORADO	NATIONAL AVERAGE
Market Concentration Rank Among 50 States and DC	44		39	
Market Share of Largest Insurer	37%	62%	48%	62%
Number of Insurers with Greater than 5% Market Share	4	3	4	3

The effects of HB 21-1232 on insurer competition are uncertain. However, as the DOI commissioner can require healthcare providers to accept reimbursement rates to meet the premium rate reduction requirements, provider reimbursement differences among insurers may be compressed relative to existing reimbursement levels in the individual and small group markets. Insurers may develop price-competitive premium rates through a number of means, including lower provider reimbursement rates relative to competing insurers, more effective utilization and care management, economies of scale that reduce per capita administrative costs, or lower margin requirements. To the extent an insurer is using lower provider reimbursement rates to establish a price competitive premium rate, the insurer may have a reduced ability to effectively compete in the market, which may lead to its withdrawal from the market. Conversely, as the range of provider reimbursements between insurers compresses, this may induce more competition on other fronts such as quality.

[7] KFF. State Health Facts: Insurance Market Competitiveness. Retrieved May 23, 2021, from https://www.kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/.

[8] Please see https://www.justice.gov/atr/herfindahl-hirschman-index for more information.

III. Potential reimbursement impacts for health insurance coverage

To estimate the impact of HB 21-1232 on provider reimbursement and premium rates in the individual and small group markets, we employed a multi-step process that included: 1) estimating CY 2021 provider reimbursement by insurer and rating region separately for the individual and small group markets; 2) applying hospital reimbursement floors as prescribed under HB 21-1232; and 3) assessing the impact to premium rates from 2023 through 2025.

MODELING CY 2021 PROVIDER REIMBURSEMENT IN COLORADO'S INDIVIDUAL AND SMALL GROUP MARKETS

To estimate provider reimbursement and premium rate changes under HB 21-1232, we used a combination of data sources, including Unified Rate Review Template (URRT) and Plan and Benefit Design Template (PBT) data for the 2021 benefit year published by CMS, Milliman's *Health Cost Guidelines*™ rating model (Milliman Guidelines), Milliman's Commercial Percentage of Medicare reimbursement benchmarks, and the RAND Corporation's analysis of commercial hospital reimbursement from 2016 to 2018 contained in Colorado's All-Payer Claim Database (APCD)[9].

Our process for estimating provider reimbursement rates in the individual and small group markets was as follows:

- Using the URRT, we identified each participating insurer's lowest cost plan in the individual and small group markets in the bronze, silver, and gold metallic tiers and in each of the nine geographic regions.
- For the individual market, we adjusted these rates for the impact of the reinsurance program by geographic area and insurer[10] and the load on silver plans for unfunded cost-sharing reduction subsidy payments.
- The URRT was also used to identify assumptions by insurer and rating region for administrative loads, and allowances for taxes and fees, and risk margins.
- We calculated implied claims expense from premium rates by adjusting actual insurer premium rates for the items noted above.
- Next, we used plan design information from each insurer's PBT and the Milliman Guidelines to estimate each insurer's claims costs by plan and region at a reimbursement rate equivalent to 100% of Medicare for both facility and professional costs. We adjusted the Milliman Guidelines claim costs (which are based predominantly on large employer experience) for the morbidity levels observed in the individual and small group markets. We used information found in Appendix A of the 2019 Risk Adjustment Transfers Report published by CMS[11].
- The ratio between the implied URRT claim costs and the Milliman Guidelines-calculated claim costs reflects the total (hospital and professional) reimbursement ratio or percentage of Medicare.
- Milliman's Percent of Medicare commercial reimbursement benchmarks (reflective of primarily large employer health insurance plan data) indicated professional reimbursement was approximately 130% to 140% of Medicare for each rating area except areas 8 and 9 (where it was about 170%). For the individual market, we assumed professional reimbursement would be approximately 10 percentage points below these benchmarks, reflecting the possibility of narrow networks involving professional providers.
- The implied reimbursement for facilities, expressed as a percentage of Medicare, was then solved for by backing out the physician reimbursement, assuming prescription drug claims for each insurer were proportional to overall costs and assuming industry-average claims weighting by facility, professional, and Rx from Milliman's benchmarks.

[9] https://www.rand.org/pubs/research_reports/RR4394.html

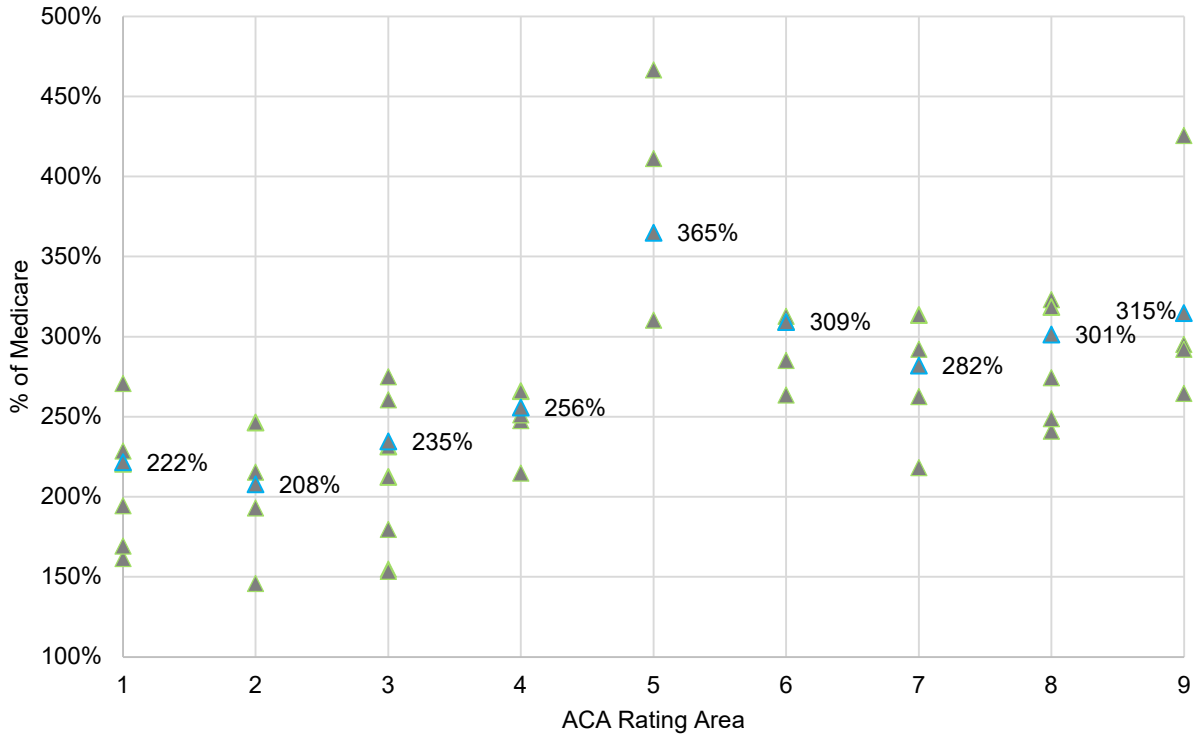
[10] https://doi.colorado.gov/for-consumers/consumer-resources/insurance-plan-filings-approved-plans

[11] https://www.cms.gov/files/document/appendixahhs-operated-risk-adjustment-program-state-specific-data.xlsx

RESULTS - ESTIMATED CY 2021 INDIVIDUAL MARKET HOSPITAL REIMBURSEMENT VARIATION BY RATING AREA

The results of the process described above can be seen in Figures 9 and 10 for the individual and small group markets, respectively. Figure 9 illustrates the estimated hospital reimbursement by insurer and rating area in Colorado's individual market for 2021. Estimated average hospital reimbursement in each rating area is also illustrated and labeled.

FIGURE 9: COMPOSITE HOSPITAL REIMBURSEMENT (% OF MEDICARE) BY INSURER AND RATING AREA – CY 2021 INDIVIDUAL



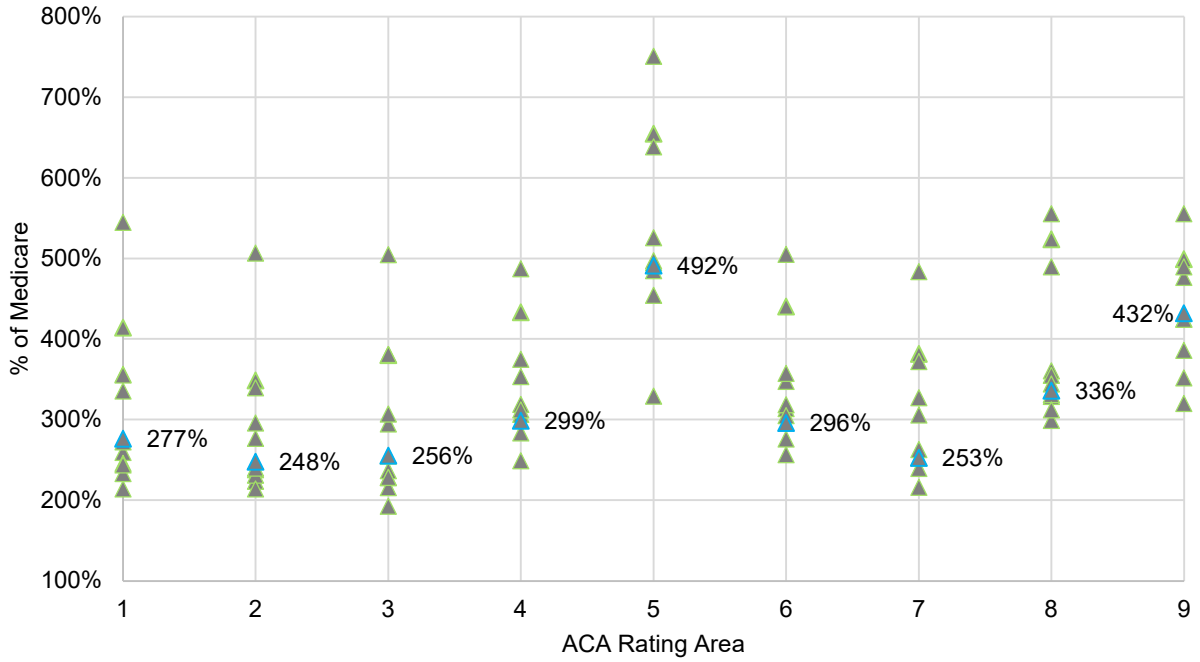
Note: Blue markers denote region average.

Key observations from Figure 9 include:

- The more densely populated areas of Colorado have materially lower provider reimbursement levels relative to the rural areas. Average facility reimbursement in rating areas 1, 2, 3, and 4 (encompassing Boulder, Colorado Springs, Denver, and Fort Collins, respectively and approximately 75% of the population) is estimated to be approximately 210% to 255% of Medicare relative to a range of 280% to 365% of Medicare in the more rural parts of the state.
- As previously discussed, the metropolitan geographic areas have greater insurer competition in Connect for Health Colorado (CFHC). To achieve a lower premium rate relative to competitors, some insurers will employ a narrow network strategy that may result in lower reimbursement rates accepted by a hospital system in exchange for greater patient volume (as a result of the insurer limiting the number of other competing hospitals in its network). In rural areas, the opportunity for provider network variation may be limited due to the lack of hospital competition, with many rural hospitals providing critical access to patients.
- Our modeling suggests substantial variation in insurer facility reimbursement exists in many of the rating areas. The range of facility reimbursement levels across insurers is estimated to have a spread of more than 100 percentage points in several rating areas. For example, rating area 3 has two insurers with estimated facility reimbursement at approximately 155% of Medicare, while also having two insurers with estimated facility reimbursement above 250% of Medicare. Because the network composition and negotiated reimbursement rates

for individual hospitals differ significantly by insurer, particularly in metro areas, the impact of HB 21-1232 will vary to a similar degree by insurer and hospital.

FIGURE 10: COMPOSITE HOSPITAL REIMBURSEMENT (% OF MEDICARE) BY INSURER AND ACA RATING AREA – CY 2021 SMALL GROUP



Note: Blue markers denote region average.

Relative to individual market reimbursement, small group reimbursement is estimated to be generally higher than the individual market, with less variance among competing insurers. In general, narrow network strategies employed in the individual market that result in lower provider reimbursement rates are not as common in the group insurance markets.

In assessing reimbursement differences for a single rating area between the individual and small group markets, it should be noted there is a different mix of insurers participating in each market and rating area that may contribute to observed variances. Additionally, the enrollment distribution for each market across counties in a rating area will differ to some degree between markets.

We note the following limitations with our process to estimate provider reimbursement rates:

- Our methodology assumes that insurer's price to cover their costs, including reimbursement to providers and any administrative costs and risk margins over the medium-to-long term, or they will exit a market. Insurers may, for various reason in the short term, not price to cover costs. If insurers are underpriced for 2021, this would tend to understate provider reimbursement, all else equal.
- Insurers have different degrees of healthcare management capabilities that also influence premiums. Degrees of healthcare management that control the utilization of medical services cannot be determined given the level of data available for this analysis. Therefore, higher degrees of healthcare management (e.g. lower levels of utilization) for a company relative to another will be reflected as an estimated higher reimbursement rate, as we are not able to adjust for this aspect of premiums. It is possible that the provider reimbursement reductions in this analysis may be overstated for more efficient insurers, or understated for less efficient insurers.

While actual insurer facility reimbursement is certain to vary from estimates developed from this methodology due to these limitations, the methodology has the distinct advantage of using actual market prices. *We believe our estimates provide a reasonable approximation of facility reimbursement levels in Colorado's individual and small group markets for purposes of modeling the potential impacts of the bill*.

PROVIDER REIMBURSEMENT FLOORS ESTABLISHED UNDER HB 21-1232

As previously stated, HB 21-1232 allows the DOI commissioner to require a healthcare provider to participate in a standardized plan to meet the insurer's network adequacy standards and if necessary, set reimbursement rates for the provider to meet the premium rate reduction targets for the standardized plan. HB 21-1232 establishes reimbursement floors for hospitals and other healthcare providers (i.e., physicians), as outlined in Figure 11. Our interpretation of HB 21-1232 assumes the DOI commissioner may lower provider reimbursement rates down to these levels to achieve the 2023 through 2025 premium rate reduction targets; however, to the extent the prescribed premium rate reductions can be achieved through the existing insurer-provider rate negotiation process, the reimbursement floors outlined in Figure 11 would not be applied.

FIGURE 11: PROVIDER REIMBURSEMENT FLOORS UNDER HB 21-1232

		% OF MEDICARE
Essential access part of health system		175%
Essential access not part of health system		200%
Independent hospitals (not essential access)		175%
Hospitals serving more than statewide average of Medicare/Medicaid		Up to 185%
"Efficient" hospital[1]		Up to 195%
Hospitals with negotiated reimbursement rate lower than 10% of statewide median		
Greater of:	1) 1/3 difference between 2021 rate and otherwise stipulated rate	
	2) 165% Medicare	
	3) Otherwise stipulated rate	
All Other Hospitals		165%
Medical providers (physicians)		135%

Notes and other provisions:

1. A hospital that is efficient in managing underlying cost of care as determined by the hospital's total margins, operating costs, and net patient revenue.
2. Commissioner may consult employee groups to consider cost of adequate wages, benefits, staffing, and training for quality care.
3. Reimbursement rates may not decrease by more than 20% relative to the previous year's negotiated rates.

As illustrated in Figure 11, HB 21-1232 establishes a reimbursement floor for hospitals at equivalent to 165% of Medicare reimbursement. However, there are several provisions that would increase the reimbursement floor for a hospital above the 165% floor if the hospital meets one of the following criteria:

- Defined as a critical access hospital
- Independent (not part of a larger health system)
- Serves more than the statewide average of Medicare or Medicaid patients
- Operates in an "efficient" manner
- Has a reimbursement rate at least 10 percentage points below the statewide median[12] hospital rate previously stated
- The reimbursement rates would otherwise decrease by more than 20% relative to the previous year

Other medical provider reimbursement (physicians) has a reimbursement floor set at 135% of Medicare reimbursement.

It is important to note that the definition of "Medicare reimbursement rate" in HB 21-1232 grants some latitude to DOI in terms of what is considered to be a facility-specific reimbursement rate. Our analysis assumes that adjustments applied in the RAND study (such as disproportionate share hospital (DSH), indirect medical education (IME), and

[12] This is the author's interpretation of the intent of the bill regarding this provision. The actual language of the bill (found in Figure 12) refers to reimbursement lower than 10% of (our emphasis added) the state median. If this language were interpreted literally, then this clause would only affect providers with commercial reimbursement levels significantly below what is paid by Medicare. In our experience, this is never seen in the market. We note that other interpretations could be equally feasible, including lower than 10% above the median. Our use of 10% below the median is illustrative only, and does not represent an endorsement of this particular choice.

uncompensated care adjustments, among others) would be applied in a hospital's "Medicare reimbursement rate" calculation.

MODELING PROVIDER REIMBURSEMENT FLOORS UNDER HB 21-1232

To model the impact of provider reimbursement floors under HB 21-1232, the following modeling steps were followed:

1. *Estimated average hospital reimbursement for each rating area and insurer using market prices.* Using the previously described methodology that incorporated the URRT data, Milliman Guidelines, and Milliman's Commercial Percent of Medicare benchmarks, we establish an estimated average hospital reimbursement rate for each insurer in a rating area in the individual and small group market.
2. *Estimate insurer networks.* Using network information submitted by insurers in connection with ACA products, we attributed hospitals to each of the insurer's networks associated with the plans priced in Step 1.
3. *Determine regional revenue weights.* We used facility revenue weights from RAND's hospital repricing file.
4. *Determine regional average commercial hospital reimbursement (ACR) for an insurer.* Using RAND's hospital repricing file, we applied commercial allowed cost reimbursement repriced as a percentage of Medicare reimbursement for inpatient and outpatient hospital services to the hospitals identified in each insurer's network by rating region.
5. Weights from Step 3 were used to composite unadjusted reimbursement from RAND files to an insurer-specific average for a region.
6. *Calculate scaling factor.* A scaling factor was calculated by taking the average area reimbursement estimate for an insurer derived in Step 1 and dividing it by the insurer's average reimbursement for a region based on pricing from Step 4.
7. *Scale hospital reimbursement.* For hospitals in the insurer's network, hospital-specific reimbursement was then scaled using the average scaling factor for the insurer in that region from Step 5.

   Figure 12 provides an illustrative example of the hospital reimbursement scaling process.

FIGURE 12: ILLUSTRATIVE EXAMPLE OF HOSPITAL REIMBURSEMENT SCALING

STEP NUMBER & FORMULA	STEP DESCRIPTION				
Step 1	Carrier X, Region Y, Implied Average Reimbursement		240%		
Step 2	Determine Carrier's Network within the Region	Hospital A	Hospital B	Hospital C	Average
Step 3	RAND Facility Revenue for Averaging	33%	33%	34%	
Step 4	RAND Commercial Reimbursement for Carrier Network	260%	270%	280%	270%
Step 5 = Step 1 / Step 4 Average	Market Scaling Factor	0.89	0.89	0.89	0.89
Step 6 = Step 4 x Step 5	Individual Market Scaled Reimbursement	231%	240%	249%	240%

8. *Application of reimbursement floors prescribed under HB 21-1232*. After the estimated individual and small group reimbursement levels were established for each hospital by insurer and regional network, we applied the HB 21-1232 reimbursement floor methodology to each hospital's scaled reimbursement levels for 2023 through 2025. The RAND hospital data was used to identify hospitals meeting the following criteria relevant to the reimbursement floors:
   - Critical access hospital (CAH) status.
   - Ownership (independent or affiliated with health system).

   To identify hospitals with a greater share of Medicare and Medicaid patients, we used payer mix data published by the Colorado Hospital Association.[13]

[13] Colorado Hospital Association (2017). The Financial Health of Colorado Hospitals: Trends 2011-2015. Retrieved May 23, 2021, from https://cha.com/wp-content/uploads/2017/10/Financial-Health-of-Colorado-Hospitals-10-6-2017-S.pdf.

We assigned a reimbursement floor to each hospital based on CAH and/or ownership status. While the specific reimbursement floor for hospitals with an above average mix of Medicare and Medicaid patients is unclear (it is defined as "up to 185% of Medicare"), we made a simplifying assumption that hospitals with a Medicare and Medicaid patient mix more than 20 percentage points greater than the statewide average would have a reimbursement floor of 185% (unless other provisions would result in a higher reimbursement floor).

As described above, HB 21-1232 also makes an adjustment to the reimbursement floor for hospitals that had commercial reimbursement 10 percentage points below the statewide median reimbursement rate. Under HB 21-1232, this reimbursement adjustment will be developed in 2023 using 2021 plan year commercial data from the APCD. For a hospital with commercial reimbursement 10 percentage points below the statewide median (estimated at 275% of Medicare based on the RAND data), the reimbursement floor will be established as one-third of the difference between the 2021 commercial reimbursement rate and the rate that otherwise would have been established under HB 21-1232. For example, if the hospital's commercial reimbursement rate in the 2021 APCD was 260% of Medicare and the hospital's reimbursement floor would have otherwise been 165% of Medicare under HB21-1232, then the reimbursement rate is established at 228% (260% - [1/3] x [260% - 165]). To model this provision of HB 21-1232, hospitals with a reimbursement rate 10 percentage points below the 275% median rate contained in the RAND data had this adjustment applied in estimating the facility's reimbursement floor under HB 21-1232.

Finally, we limited hospital reimbursement reductions with each insurer to an annual decrease of 20% for the 2023 through 2025 time period.

Because the criteria has not been fully defined, we did not make any reimbursement adjustments for "efficient hospitals". HB 21-1232 indicates this adjustment may increase the reimbursement floor of certain hospitals up to 195% of Medicare. Additionally, we did not consider any reimbursement changes that may result from the DOI commissioner's consulting of employee groups to consider cost of adequate wages, benefits, staffing, and training for quality care.

Appendix A of this report provides a listing of hospitals contained in the RAND data and the estimated reimbursement floor under HB 21-1232 (excluding the annual 20% reimbursement reduction cap over the contracted rate for the prior year).

ESTIMATED PROVIDER REIMBURSEMENT AND PREMIUM RATE IMPACTS

We modeled the impact to premiums and facility provider reimbursement assuming the entire premium reduction target was obtained via reductions to facility reimbursements. It is important to note that HB 21-1232 does not require insurers to reduce premiums solely with reductions to facility reimbursements. Insurers may have multiple other avenues for affecting premium reductions of 6% annually that the bill requires including, but not necessarily limited to:

- Commissioner-mandated or insurer-negotiated reductions in professional reimbursement
- Lowering profit and risk margins
- Reducing administrative expenses
- Improved management of care
- Improving the accuracy of risk coding and related risk adjustment revenues and payments
- Negotiating better terms on expenses related to prescription drugs from pharmacy benefit managers (PBMs)

Despite these additional levers to pull, our modeling below focuses on impacts to facility reimbursement because the bill provides the most detailed and prescriptive remedies related to impacts to facility provider's reimbursement should insurers fail to reduce premiums by 6% annually after adjusting for healthcare inflation. To the extent that the 6% threshold is met by insurers using a combination of any of the other levers noted above, facility reimbursement will not have to decrease as much as shown in our modeling, if at all.

However, beyond existing market premium rate competition, it is not clear what motivation insurers would have to reduce administrative expenses or risk margins in order to meet annual rate reduction thresholds, other than to maintain a competitive advantage or avoid a public hearing. Reducing professional reimbursement, while available as a means to reduce costs, will have a comparatively smaller effect as these costs constitute a smaller portion of the overall costs

underlying premium rates than facility reimbursement does, providing less premium impact per unit of reduction. Moreover, the bill, while allowing for the commissioner to prescribe lower professional reimbursement, prescribes no specific structure for reducing them, other than to state a floor for such reimbursement as a percentage of Medicare (135%). Finally, the bill does not mention anything about reducing prescription drugs costs which are typically a material portion of costs underlying premiums (an estimated 15% to 20%).

Based on these considerations, there seems a high likelihood that the bulk of the cost reduction needed to drive premium reductions required by the bill would fall to facility providers.

Using the modeling described in the previous section, we summarize the impacts to facility reimbursement over a 3-year period for each rating region. The rating region results were compiled by applying the requirements of HB 21-1232 at the hospital level (as required by the bill) and then aggregating it to a regional level using facility reimbursement volume as weights. For convenience Figure 13 contains the number, description, population, and our classification of urban versus rural.

FIGURE 13: RATING AREA SUMMARY

RATING AREA	DESCRIPTION	POPULATION	STATE POPULATION %	CLASSIFICATION
1	Boulder	329,000	6%	Urban
2	Colorado Springs	763,000	13%	Urban
3	Denver-Aurora-Lakewood	3,038,000	52%	Urban
4	Fort Collins	369,000	6%	Urban
5	Grand Junction	157,000	3%	Rural
6	Greeley	344,000	6%	Rural
7	Pueblo	170,000	3%	Rural
8	Eastern Slope	278,000	5%	Rural
9	Western Slope	444,000	8%	Rural
1-4		4,500,000	77%	Urban
5-9		1,394,000	23%	Rural

Individual Market

Figure 14 displays the progression of modeled hospital reimbursement levels *over the 3-year period of the bill* as well as the change year-to year and cumulative. We estimate premium impacts related to these hospital reimbursement changes in shaded areas at the bottom and right side of the table. Figure 15 contains the same information but summarized at the urban-rural level.

FIGURE 14: SUMMARY OF POTENTIAL IMPACTS TO FACILITY REIMBURSEMENT UNDER HB 21-1232 (REGIONAL VIEW)

	INDIVIDUAL MARKET REIMBURSEMENT LEVELS (% OF MEDICARE)					REIMBURSEMENT CHANGES				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
REGION	ESTIMATED CURRENT	AVG. FLOOR	EFFECTIVE YEAR 1	EFFECTIVE YEAR 2	EFFECTIVE YEAR 3	YEAR 1	YEAR 2	YEAR 3	3-YEAR REIMB. CHANGE	3-YEAR PREMIUM IMPACT
1	225%	172%	195%	172%	172%	-13.5%	-10.1%	0.0%	-23.6%	**-10.5%**
2	237%	188%	205%	188%	188%	-13.5%	-6.9%	0.0%	-20.4%	**-9.1%**
3	238%	181%	206%	185%	181%	-13.4%	-8.7%	-1.8%	-24.0%	**-10.7%**
4	255%	168%	220%	186%	168%	-13.5%	-13.5%	-7.2%	-34.2%	**-15.2%**
5	467%	168%	404%	341%	278%	-13.5%	-13.5%	-13.5%	-40.5%	**-18.0%**
6	309%	165%	268%	226%	184%	-13.5%	-13.5%	-13.5%	-40.5%	**-18.0%**
7	292%	170%	252%	213%	174%	-13.5%	-13.5%	-13.5%	-40.5%	**-18.0%**
8	323%	185%	280%	236%	207%	-13.5%	-13.5%	-9.0%	-36.0%	**-16.0%**
9	421%	187%	364%	307%	250%	-13.5%	-13.5%	-13.5%	-40.5%	**-18.0%**
Total	**259%**	**180%**	**224%**	**198%**	**187%**	**-13.5%**	**-10.0%**	**-4.3%**	**-27.8%**	**-12.4%**
	PREMIUM IMPACT					**-6.0%**	**-4.5%**	**-1.9%**	**-12.4%**	

FIGURE 15: SUMMARY OF POTENTIAL IMPACTS TO FACILITY REIMBURSEMENT UNDER HB 21-1232 (URBAN-RURAL VIEW)

	INDIVIDUAL MARKET REIMBURSEMENT LEVELS (% OF MEDICARE)					REIMBURSEMENT CHANGES				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
REGION	ESTIMATED CURRENT	AVG. FLOOR	EFFECTIVE YEAR 1	EFFECTIVE YEAR 2	EFFECTIVE YEAR 3	YEAR 1	YEAR 2	YEAR 3	3-YEAR REIMB. CHANGE	3-YEAR PREMIUM IMPACT
1-4	237%	180%	205%	184%	180%	-13.5%	-9.0%	-1.7%	-24.1%	-10.7%
5-9	375%	178%	325%	274%	225%	-13.5%	-13.5%	-13.2%	-40.2%	-17.8%
Total	259%	180%	224%	198%	187%	-13.5%	-10.0%	-4.3%	-27.8%	-12.4%
PREMIUM IMPACT						-6.0%	-4.5%	-1.9%	-12.4%	

Notes: Regional definitions are based on rating regions defined under the Affordable Care Act, where regions 1-4 are considered urban areas and regions 5-9 are considered rural areas (see Figure 13). Hospital reimbursement rates reductions inherently reflect an increase in the Medicare fee schedule. In accepting these reductions, we note hospitals are also foregoing any additional year-over-year increase in fees they would have typically received in excess of changes in medical inflation underlying the Medicare rates. For purposes of this analysis, we assumed that Medicare rates will increase consistent with the medical inflation allowable under the bill. There is some evidence that Medicare rates increase 0.5% to 1.0% less than CPI.

Key observations from Figures 14 and 15 for the (individual market) include:

- *Columns 2-3:* The estimated current regional reimbursement's proximity to the floor reimbursement under HB 21-1232 in the region varies primarily by urban and rural geographic regions. In rating regions 1-4, where 75% of Colorado's population resides, current facility reimbursement is lower and therefore closer to the floor reimbursement stipulated in the bill. Generally, the closer a region (or specific hospital) is to the floor reimbursement, the more likely it is that the reductions to reimbursement will be smaller in that region (or for a specific facility).

  This illustrates a key design dynamic in the bill that differs from other health policy initiatives undertaken in Colorado, such as the state reinsurance program. Under that program, it was recognized that health care costs differ dramatically by region for a multitude of reasons. Therefore, more rate relief was directed towards rural areas where costs were higher.[14] HB 21-1232 does not have differing reimbursement floors (higher in rural areas and lower in urban areas), but rather uses a uniform set of criteria for establishing floor reimbursements for facilities across the state. As we discuss further below, the use of a uniform set of criteria to establish floor reimbursement across the state will drive non-uniform results by region, resulting in higher percentage decreases in reimbursement for rural facilities versus urban.
- *Columns 7-10:* The composite facility reimbursement shown in columns 3-5 will decline over the course of 2023 through 2025 should the provisions of the bill be enacted to reduce rates and either insurers or the commissioner (or both) utilize them for negotiating or setting, respectively, reimbursement levels. However, these reductions are greater in the rural areas of 5 through 9 where current reimbursement is higher than the urban areas. Over the course of the three years, facilities in rural areas will see reimbursement drop by an additional 16 percentage points over the urban areas (column 10 in Figure 14).
- *Premium impacts:* Given that hospital reimbursement is approximately 40% to 45% of the cost of the average insurance premium, reductions in facility reimbursements are not dollar for dollar on premium. Premium impacts are calculated along the bottom and right sides of both Figures 13 and 14 and displayed in shaded, bold type. HB 21-1232 requires a 6% annual decrease in premium rates over three years, as measured from a trend-adjusted 2021 baseline (after also adjusting to remove the impact of the Colorado reinsurance program). This amounts to an 18% reduction across the 3-year period.

  The bill does not require reimbursement reductions beyond what is needed to obtain a 6% premium reduction and we assume in our modeling that neither insurers' negotiations nor the mechanics of the bill will produce reductions greater than the 6% per annum.

  We estimate that only four regions (5, 6, 7 and 9; all rural) will obtain the full 18% reduction required over the three-year period, if facility reimbursement rates alone are used to reduce premiums. Other regions will have insurer contracts that are either already below floored reimbursements or are above these floors such that, over the three-year period, reductions will cause them to be limited to the floor.

[14] Please see https://www.colorado.gov/reinsurance-saving-consumers-208-average-2021 for more information.

We also note from both Figures 14 and 15 that the annual reductions in reimbursement and premiums at the region level decline over the three year period in all regions except 5, 6, 7, and 9 where current reimbursement rates are sufficiently above the floor to allow for the full effect of the bill's provisions to be incorporated.

HB 21-1232 allows for the DOI commissioner to "consult with hospital-based health-care providers in Colorado, and shall take into account the cost of adequate wages, benefits, staffing, and training for health-care employees to provide continuous quality care." National analysis indicates that rural hospitals had a median overall profit margin of 2.7% in 2017 relative to 5.6% for urban hospitals.[15] While an analysis of Colorado hospital margins was outside the scope of our analysis, low margins may inhibit the provider reimbursement floors from being implemented in some cases, which would also impact premium rates.

Small group market

The small group market has dynamics similar to those shown in the individual market above and many of the same comments apply. However, the small group market is characterized by higher reimbursements than the individual market with some exceptions by region. Also, the insurers that offer plans in each of the markets are not the same in each region and if they are, they often do not have the same network configurations between the markets.

FIGURE 16: SUMMARY OF POTENTIAL IMPACTS TO FACILITY REIMBURSEMENT UNDER HB 21-1232 (REGIONAL VIEW)

	SMALL GROUP REIMBURSEMENT LEVELS (% OF MEDICARE)					REIMBURSEMENT CHANGES				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
REGION	ESTIMATED CURRENT	AVG. FLOOR	EFFECTIVE YEAR 1	EFFECTIVE YEAR 2	EFFECTIVE YEAR 3	YEAR 1	YEAR 2	YEAR 3	3-YEAR REIMB. CHANGE	3-YEAR PREMIUM IMPACT
1	275%	175%	238%	201%	184%	-13.5%	-13.5%	-6.0%	-33.0%	-14.7%
2	241%	203%	214%	203%	203%	-10.9%	-4.7%	0.0%	-15.6%	-6.9%
3	251%	181%	217%	195%	183%	-13.5%	-8.5%	-4.9%	-26.9%	-12.0%
4	301%	167%	261%	220%	179%	-13.5%	-13.5%	-13.5%	-40.5%	-18.0%
5	482%	168%	417%	352%	287%	-13.5%	-13.5%	-13.5%	-40.5%	-18.0%
6	289%	165%	250%	211%	172%	-13.5%	-13.5%	-13.5%	-40.5%	-18.0%
7	243%	171%	210%	177%	171%	-13.5%	-13.5%	-2.5%	-29.5%	-13.1%
8	337%	186%	292%	246%	213%	-13.5%	-13.5%	-9.8%	-36.8%	-16.3%
9	426%	184%	368%	311%	253%	-13.5%	-13.5%	-13.5%	-40.5%	-18.0%
Total	**273%**	**181%**	**237%**	**209%**	**191%**	**-13.3%**	**-10.1%**	**-6.4%**	**-29.8%**	-13.2%
PREMIUM IMPACT						**-5.9%**	**-4.5%**	**-2.9%**	**-13.2%**	

FIGURE 17: SUMMARY OF POTENTIAL IMPACTS TO FACILITY REIMBURSEMENT UNDER HB 21-1232 (URBAN-RURAL VIEW)

	SMALL GROUP REIMBURSEMENT LEVELS (% OF MEDICARE)					REIMBURSEMENT CHANGES				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
REGION	ESTIMATED CURRENT	AVG. FLOOR	EFFECTIVE YEAR 1	EFFECTIVE YEAR 2	EFFECTIVE YEAR 3	YEAR 1	YEAR 2	YEAR 3	3-YEAR REIMB. CHANGE	3-YEAR PREMIUM IMPACT
1-4	256%	182%	222%	198%	185%	-13.3%	-9.2%	-5.1%	-27.6%	-12.3%
5-9	372%	176%	322%	272%	228%	-13.5%	-13.5%	-11.7%	-38.7%	-17.2%
Total	**273%**	**181%**	**237%**	**209%**	**191%**	**-13.3%**	**-10.1%**	**-6.4%**	**-29.8%**	-13.2%
PREMIUM IMPACT						**-5.9%**	**-4.5%**	**-2.9%**	**-13.2%**	

Notes: Regional definitions are based on rating regions defined under the Affordable Care Act, where regions 1-4 are considered urban areas and regions 5-9 are considered rural areas (see Figure 13). Hospital reimbursement rates reductions inherently reflect an increase in the Medicare fee schedule. In accepting these reductions, we note hospitals are also foregoing any additional year-over-year increase in fees they would have typically received in excess of changes in medical inflation underlying the Medicare rates. For purposes of this analysis, we assumed that Medicare rates will increase consistent with the medical inflation allowable under the bill. There is some evidence that Medicare rates increase 0.5% to 1.0% less than CPI.

[15] https://www.healthaffairs.org/do/10.1377/hblog20200630.208205/full/#:~:text=In%202017%2C%20rural%20hospitals%20had,financial%20pressures%20on%20rural%20hospitals.

There are number of factors that will result in the actual impact of HB 21-1232 differing from the above modeling results. Some of these factors include the following:

- It is certain that actual commercial hospital reimbursement rates for 2021 will differ relative to the 2016 through 2018 time period used in the RAND repricing analysis.
- For purposes of this analysis, we made the simplifying assumption that the impact of HB 21-1232 on pediatric hospitals in the individual and small group markets would be similar to the impact on non-pediatric hospitals. Pediatric hospitals were excluded from the RAND repricing analysis (and are excluded from the Colorado APCD).
- Second, provisions of HB 21-1232 that could not be modeled (efficiency adjustment, consulting with healthcare provider employees) will have an unknown impact on the reimbursement floors established based on HB 21-1232.
- The interpretation of the “10% of median reimbursement” clause in the bill may be different than what we assumed in our analysis.
- Finally, hospital revenue mix will vary among insurers and will differ from that used in RAND’s repricing analysis.

Despite these limitations, we believe the above methodology is a reasonable attempt to model the provider reimbursement floors and net impacts of provisions related to facility reimbursement that may be implemented under HB 21-1232.

IV. Considerations related to federal subsidy outlays and impact to consumer out-of-pocket premiums

Individual market premium rate changes impact expenditures of both consumers and the federal government (in the form of premium subsidy tax credits). Under the ACA and excluding temporary changes to the level of tax credits under the American Rescue Plan (discussed in the next section of this report), Coloradans with income from 139% to 400% of the federal poverty (FPL) who do not qualify for public health insurance programs or have access to affordable employer-sponsored insurance are eligible for a premium tax credit that may be applied to any Qualified Health Plan (QHP) offered in CFHC, Colorado's state-based insurance marketplace.[16] Coloradans may also purchase coverage outside of CFHC, but pay the full premium amount for coverage out-of-pocket. Figure 18 summarizes the number of estimated Coloradans purchasing coverage through CFHC, as well as outside the marketplace in CY 2019, prior to the onset of the COVID-19 pandemic, which has likely created temporary changes in insurance market enrollment patterns. As shown in Figure 18, nearly 60% of the ACA-compliant individual market qualified for an advanced premium tax credit (APTC) during CY 2019.

FIGURE 18: COLORADO, 2019 INDIVIDUAL MARKET ACA-COMPLIANT MARKET

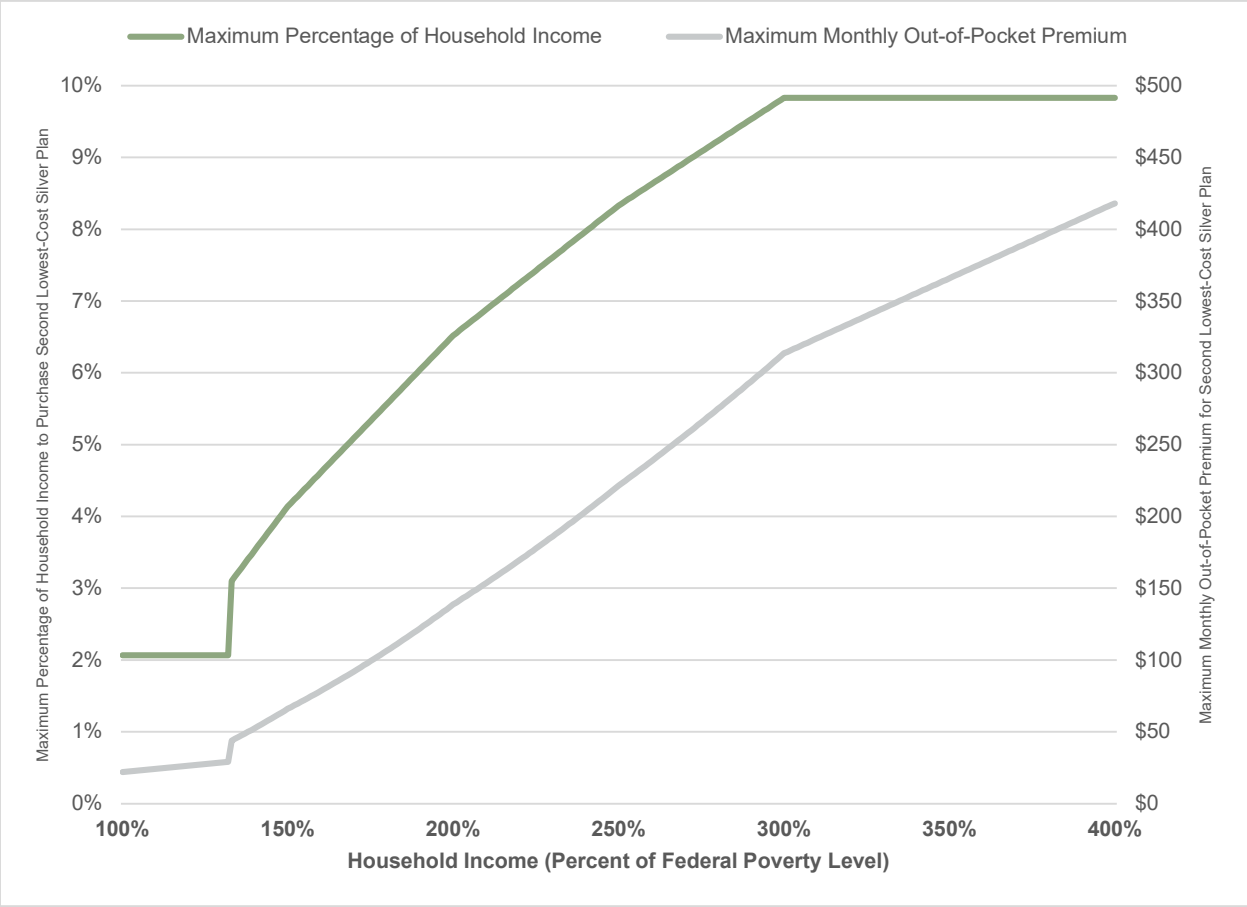
MARKET SEGMENT	PERSONS	ENROLLMENT DISTRIBUTION
CONNECT FOR HEALTH COLORADO (EXCHANGE)	**142,000**	**72%**
APTC	112,000	57%
NON-APTC	30,000	15%
OFF-EXCHANGE	**56,000**	**28%**
TOTAL ACA COMPLIANT ENROLLMENT	**198,000**	100%

Notes:
1. Person estimates have been rounded to the nearest thousand and reflect average monthly enrollment.
2. Estimates developed from July 2020 effectuated enrollment reports released by CMS and CY 2019 risk adjustment transfer report.
3. Billable member months reported on the risk adjustment transfer report have been adjusted by a 1.005 factor to reflect non-billable member months.

The ACA's premium tax credits are calculated based on the maximum required out-of-pocket premium for a household to purchase the second-lowest cost silver plan (SLCSP, also known as the 'subsidy benchmark plan' offered in CFHC). The maximum out-of-pocket premium for the SLCSP increases as household income rises, with the subsidy eligibility ending for households with income above 400% FPL (again, ignoring temporary subsidy changes under the ARP). Figure 19 illustrates the maximum out-of-pocket premium requirements to purchase the SLCSP, measured as a percentage of household income, as well as monthly dollar amount.

[16] Legal immigrants with income below 139% FPL who are not eligible for Medicaid are eligible for premium tax credits to extent other criteria are met.

FIGURE 19: CY 2021 (WITHOUT ARP) MAXIMUM OUT-OF-POCKET PREMIUM REQUIREMENTS TO PURCHASE SECOND-LOWEST-COST SILVER PLAN (PERCENTAGE OF HOUSEHOLD INCOME AND MAXIMUM MONTHLY OUT-OF-POCKET PREMIUM)



As shown in Figure 19, the value of premium subsidies is greatest at lower income levels and then decreases as household income increases. Based on recent CY 2021 open enrollment data, approximately 80% of Coloradoans receiving an APTC have income below 300% FPL.[17]

Because the premium subsidy is calculated based on the difference between the full premium amount and the maximum out-of-pocket premium requirement for the SLCSP, older adults (due to 3:1 age rating) and persons residing in high cost premium rating areas qualify for the largest subsidies. For example, if two individuals have a maximum monthly out-of-pocket premium of $200 and the SLCSP is $400 per month for the first person and $600 per month for the second, the resulting subsidy values will be $200 and $400, respectively.

For perspective, the SLCSP rate in CFHC varied from approximately $250 per month (rating area 9) to $305 (rating area 8) for a 21 year old. For a 64 year old, the monthly premium rates for the SLCSP are approximately $751 and $915 for rating areas 9 and 8, respectively.[18] The monthly premium rates include approximately a 15% reduction from the Colorado reinsurance program in Rating Area 8 and 43% in Rating Area 9.[19]

[17] CMS. 2021 OEP State-Level Public Use File. Retrieved May 23, 2021, from https://www.cms.gov/files/zip/2021-oep-state-level-public-use-file.zip (zip file download).

[18] Premium rate and reinsurance impact information is available at: https://doi.colorado.gov/for-consumers/consumer-resources/insurance-plan-filings-approved-plans.

[19] Colorado Division of Insurance. 2021 Individual Market – Reinsurance Impact by Carrier. Retrieved May 24, 2021, from https://drive.google.com/file/d/1Y3RntH6vEJOM13qDvL-Er7sva6CVSCLh/view.

Eligibility for federal premium assistance is dependent upon the SLCSP exceeding the maximum monthly premium requirements illustrated in Figure 19.

- For a 21 year old, the full premium amount for the SLCSP will exceed the maximum monthly premium requirement between approximately 275% FPL and 325% FPL (dependent upon rating area), resulting in no subsidy value above these income levels.
- For a 64 year old, the full premium amount for the SLCSP remains significantly above the maximum out-of-pocket premium of approximately $420 at 400% FPL.

To the extent HB 21-1232 reduces premium rates, the consumers benefiting will be young adults with income generally above 300% FPL and older adults with income above 400% FPL, who are not eligible for federal premium assistance. Premium savings for other more heavily subsidized consumers will be realized by the federal government or potentially captured by the state of Colorado via pass-through funding from a Section 1332 waiver. These effects are very similar in nature to Colorado's existing state-based reinsurance program.

ASSESSING HB 21-1232'S ABILITY TO REDUCE THE SECOND-LOWEST COST SILVER PREMIUM

As discussed earlier in this report, estimated underlying hospital reimbursement varies materially by rating area and insurer in Colorado's individual market. In Colorado's most populous rating areas (1, 2, and 3), accounting for nearly 70% of CFHC enrollment in 2021.[20] While we estimate aggregate premium rate reductions will occur in Regions 1, 2, and 3, it is entirely possible that HB 21-1232 will not have a material impact on the SLCSP rates as estimated insurer reimbursement levels for the lowest-premium rate insurers are already at or below the reimbursement floors established under the legislation. To the extent this occurred, it would be consistent with Washington state's experience implementing public option plans in CY 2021 with provider reimbursement requirements similar to HB 21-1232 (provider reimbursement is capped at 160% of Medicare, with exceptions for rural hospitals and primary care)[21]. In many counties, including King (Seattle), the public option plan is more expensive relative to other silver plan offerings in the county.[22]

To illustrate why the SLCSP may not be impacted materially in some rating areas, Figure 20 provides a sample illustration of a low cost insurer's estimated current reimbursement contracts for five hospitals.

FIGURE 20: LOW SLCSP IMPACT

HOSPITAL	WEIGHT	CURRENT REIMBURSEMENT % OF MEDICARE	FLOOR REIMBURSEMENT % OF MEDICARE	YEAR 1 REIMBURSEMENT IMPACT	YEAR 1 PREMIUM RATE IMPACT
Hospital 1	13%	137%	165%	0%	0%
Hospital 2	25%	147%	165%	0%	0%
Hospital 3	13%	172%	214%	0%	0%
Hospital 4	23%	161%	165%	0%	0%
Hospital 5	27%	191%	165%	-14%	-6%
Total	**100%**	**155%**	**171%**	**-4%**	**-2%**

Note: Reimbursement rates are for inpatient and outpatient hospitals. Values are rounded to the nearest percentage.

In this example, the insurer's current reimbursement levels to its network providers are all below the floor amount dictated by HB 21-1232, with the exception of one. Thus for hospitals 1, 2, 3, and 4, the existing reimbursement rates with the insurer would be unaffected by the bill and therefore would have no rate impact for all three years of the bill.

[20] CFHC. By the Numbers: Open Enrollment Report for Plan Year 2021, p. 17. Retrieved May 23, 2021, from https://c4-media.s3.amazonaws.com/wp-content/uploads/2021/04/07154007/2021-By-the-Numbers-final.pdf

[21] Norris, L. (May 19, 2021). Washington Health Insurance Marketplace: History and News of the State's Exchange. HealthInsurance.org. Retrieved May 23, 2021, from https://www.healthinsurance.org/health-insurance-marketplaces/washington/.

[22] Bloomberg Law (November 18, 2020). First government-run health plan portends rocky start for Biden. Retrieved May 23, 2021, from https://news.bloomberglaw.com/health-law-and-business/public-option-health-plan-in-washington-state-a-caution-to-biden.

Hospital 5 will have a 14% reduction in year 1, after which it will be at its floor and no additional reductions will be made under the bill. The first year rate impact of this reduction is only 2%.

This situation, or some variation of it, is most likely to occur in lower cost regions of Colorado (areas 1-4), where it is estimated that some insurers have average hospital reimbursement at or below the reimbursement floors established under HB 21-1232.

In more rural counties, there is a greater potential that HB 21-1232 will reduce the cost of the SLCSP, as well as federal premium subsidy expenditures, as estimated provider reimbursement rates in the current market are estimated to be materially higher than the floors established under HB 21-1232.

In the example in Figure 21, an insurer has higher contracted reimbursement with its network hospitals and therefore will be affected by the reductions dictated by the bill. This insurer's contracted reimbursement rate with two of the hospitals is above the floor and therefore, in years 1 and 2, reimbursement reductions are possible for these hospitals. In the third year (assuming reductions are taken in years 1 and 2), the hospitals will have reached their floors and no further reductions are taken under the bill. The change in hospital reimbursement as a percentage of Medicare by year and the corresponding reimbursement rate impacts are shown below the first two tables. The estimated premium rate changes are shown in the third table. This insurer would clear the annual 6% premium rate reduction requirement in years 1 and 2, but not in year 3.

FIGURE 21: HIGH SLCSP IMPACT

HOSPITAL	WEIGHT	CURRENT REIMBURSEMENT % OF MEDICARE	FLOOR REIMBURSEMENT % OF MEDICARE	YEAR 1 REIMBURSEMENT	YEAR 2 REIMBURSEMENT	YEAR 3 REIMBURSEMENT
Hospital 1	4%	127%	207%	127%	127%	127%
Hospital 2	57%	258%	165%	221%	185%	165%
Hospital 3	40%	255%	165%	219%	184%	165%
Total	**100%**	**251%**	**167%**	**217%**	**182%**	**164%**

HOSPITAL	WEIGHT	CURRENT REIMBURSEMENT % OF MEDICARE	FLOOR REIMBURSEMENT % OF MEDICARE	YEAR 1 REIMBURSEMENT CHANGE	YEAR 2 REIMBURSEMENT CHANGE	YEAR 3 REIMBURSEMENT CHANGE
Hospital 1	4%	127%	207%	0.0%	0.0%	0.0%
Hospital 2	57%	258%	165%	-14.0%	-14.0%	-7.9%
Hospital 3	40%	255%	165%	-14.0%	-14.0%	-7.3%
Total	**100%**	**251%**	**167%**	**-13.5%**	**-13.5%**	**-7.4%**

HOSPITAL	WEIGHT	CURRENT REIMBURSEMENT % OF MEDICARE	FLOOR REIMBURSEMENT % OF MEDICARE	YEAR 1 PREMIUM RATE CHANGE	YEAR 2 PREMIUM RATE CHANGE	YEAR 3 PREMIUM RATE CHANGE
Hospital 1	4%	127%	207%	NA	NA	NA
Hospital 2	57%	258%	165%	NA	NA	NA
Hospital 3	40%	255%	165%	NA	NA	NA
Total	**100%**	**251%**	**167%**	**-6.0%**	**-6.0%**	**-3.3%**

Note: Reimbursement rates are for inpatient and outpatient hospitals. Values are rounded to the nearest percentage.

HB 21-1232 allows for the DOI commissioner to "consult with hospital-based health-care provider in Colorado, and shall take into account the cost of adequate wages, benefits, staffing, and training for health-care employees to provide continuous quality care." National analysis indicates that rural hospitals had a median overall profit margin of 2.7% in

2017 relative to 5.6% for urban hospitals.[23] While an analysis of Colorado hospital margins was outside the scope of our work, low margins may inhibit the provider reimbursement floors from being implemented in some cases, which would also impact premium rates.

OUT-OF-POCKET PREMIUM RATE IMPACT FOR CONSUMERS NOT PURCHASING THE SLCSP

For consumers in the individual market not purchasing the SLCSP, out-of-pocket premium rates will be influenced by premium rate changes for their plans in relation to the SLSCP (the same dynamics that occur in the current market). For example, if the individual's monthly out-of-pocket premium for the SLCSP was capped at $100 and the SLCSP had a $450 monthly premium, then the individual would qualify for a $350 monthly premium subsidy which could be applied to any QHP offered in CFHC.

- If the person wanted a lower out-of-pocket premium, the $350 subsidy could be applied to a $400 monthly premium plan and the out-of-pocket premium would be reduced to $50 per month.
- Conversely, if the person wanted to enroll in a plan with a richer benefit design, the person could apply the $350 subsidy to a $500 monthly premium plan and have a $150 per month out-of-pocket premium.

As HB 21-1232 is likely to have a varying impact on premium rates for each insurer and across rating areas, the impact on out-of-pocket premium rates for a given QHP will also vary significantly. The following are some of the potential market dynamic scenarios that consumers may experience as a result of HB 21-1232:

- To the extent the standardized benefit plan premium offered under HB 21-1232 is not below the existing SLCSP (which is possible in rating areas where insurers are estimated to have already negotiated reimbursement rates at or below hospital reimbursement floors), consumers' out-of-pocket premiums for their current plans may not experience material changes (as the premium rate relationship between their current plans and the SLCSP remains relatively constant).
- A consumer who is enrolled with a high cost insurer currently, but switches to a standardized plan offered by the insurer may experience an out-of-pocket decrease if HB 21-1232 results in the insurer being able to contract at lower provider reimbursement rates, bringing the insurer's premium rate closer to the SLCSP.
- If a standardized plan becomes the SLCSP (through lower provider reimbursement), existing plan options may become less affordable if provider reimbursement remains at current levels for the existing plans.
- To the extent an insurer believes it no longer has a competitive advantage in the market from negotiating lower provider reimbursement rates relative to competitors, it may elect to leave the market and require consumers to enroll with a different insurer if they wish to remain insured.

As the insurer and provider market dynamics are likely to differ by rating area, consumer impacts from HB 21-1232 are also likely to vary across the state.

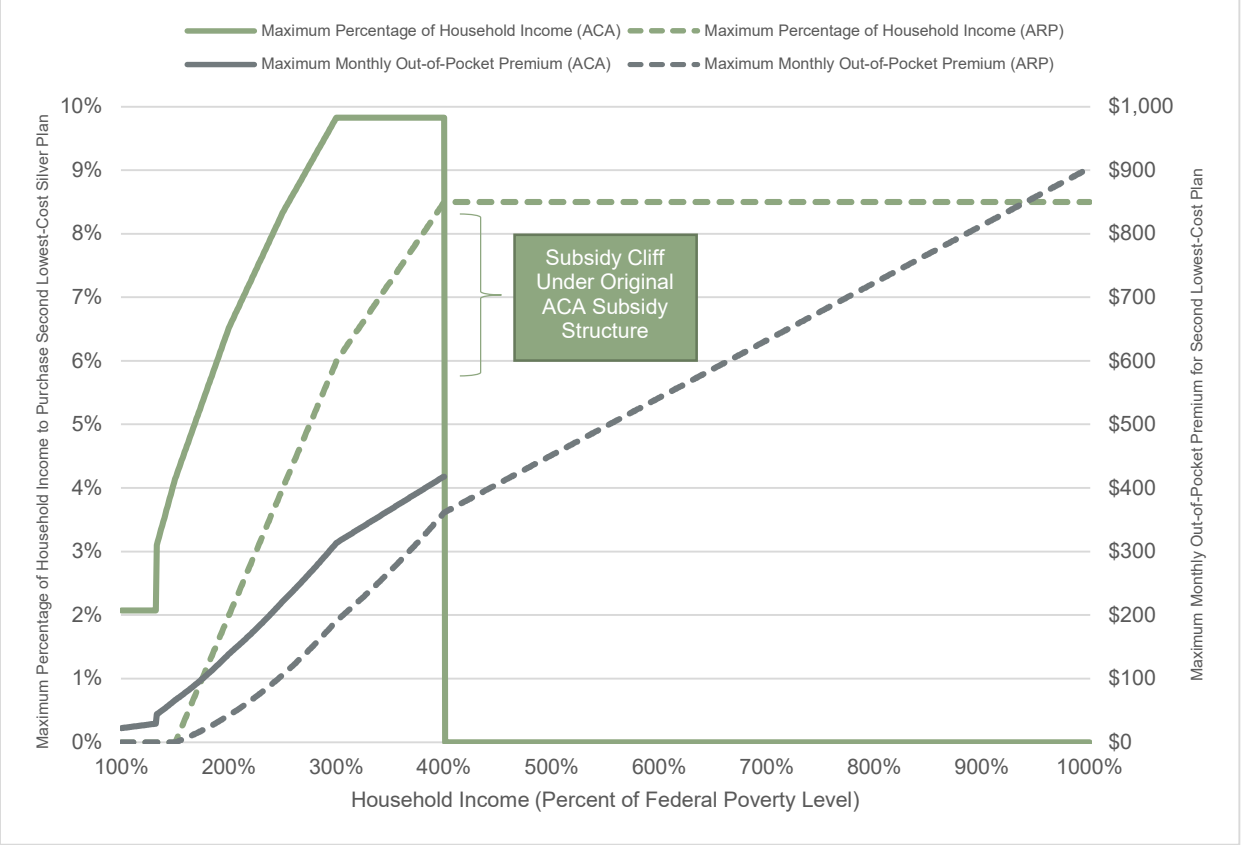
[23] Bai, G. & Anderson, G.F. (July 1, 2020). COVID-19 and the financial viability of US rural hospitals. Health Affairs Blog. Retrieved May 23, 2021, from https://www.healthaffairs.org/do/10.1377/hblog20200630.208205/full/#:~:text=In%202017%2C%20rural%20hospitals%20had,financial%20pressures%20on%20rural%20hospitals.

V. Considerations Related to Enhanced Subsidies Available in the American Rescue Plan (ARP)

President Biden signed the American Rescue Plan Act of 2021 (ARP) into law on March 11, 2021.[24] The law established a temporary increase in premium tax credits available through the insurance marketplaces to purchase individual market coverage. We were requested by Partnership for America's Healthcare Future Action to assess changes to the estimated impact from HB 21-1232 with the assumption that the premium tax credit percentages legislated for 2021 and 2022 under the ARP were extended indefinitely.

As discussed previously, the structure of the premium tax credits caps the amount of income a household must pay for the "benchmark" plan, which is established as the SLCSP. Figure 22 illustrates the maximum amount a household must pay for the benchmark plan (measured as a percentage of household income and monthly out-of-pocket premium) prior to the ARP and under the ARP during 2021 (enhanced subsidies will also apply in 2022, but FPL will be indexed, resulting in small changes to out-of-pocket premium requirements).[25]

FIGURE 22: CY 2021 (WITH AND WITHOUT ARP) MAXIMUM OUT-OF-POCKET PREMIUM REQUIREMENTS TO PURCHASE SECOND LOWEST-COST SILVER PLAN (PERCENTAGE OF HOUSEHOLD INCOME AND MAXIMUM MONTHLY OUT-OF-POCKET PREMIUM)



As illustrated in Figure 22, the ARP subsidies result in two major changes to the ACA's original subsidy structure. First, subsidies are increased materially below 400% FPL. The enhanced subsidies will reduce the number of young adults with income up to 400% FPL that would potentially realize out-of-pocket premiums savings under HB 21-1232.

- For example, with the SLCSP premium rate in CFHC varying from approximately $250 per month (rating area 9) to $305 (rating area 8) for a 21 year old, a person with income at 300% FPL would not qualify for a premium subsidy under the ACA's original subsidy structure as the premium would not exceed the $315 out-of-pocket maximum.

[24] CMS (March 12, 2021). Fact Sheet: American Rescue Plan and the Marketplace. Retrieved May 23, 2021, from https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace.

[25] Busch, F., Karcher, J., Fink, J. et al. (March 2021). "A" Is for Affordable. Milliman White Paper. Retrieved May 23, 2021, from https://frm.milliman.com/-/media/milliman/pdfs/2021-articles/3-17-21-a-is-for-affordable.ashx.

- Under the ARP, the out-of-pocket maximum is decreased to $190, resulting in a monthly subsidy value of approximately $60 ($250- $190) in rating area 9 and $115 in rating area 8 ($305 - $190). If the premium rates in rating area 9 ($250) and rating area 8 ($305) were reduced by 18% (resulting in premium rates of $205 and $250, respectively), then out-of-pocket monthly premium maximum for the individual would remain at $190.

The second major ARP change is the extension of subsidies past 400% FPL, capping out-of-pocket premium expenses for the SLCSP at 8.5% of household income. This eliminates the 'subsidy cliff' illustrated in Figure 21 that occurs at 400% FPL under the ACA's original subsidy structure. While this provision will generally not impact young adults, older adults may benefit greatly from the subsidy extension past 400% FPL, particular in high cost rating areas and adults who are approaching age 65.

- For example, with the SLCSP premium rate in CFHC varying from approximately $751 (rating area 9) to $915 (rating area 8) for a 64 year old, a person with income above 400% FPL would not qualify for a subsidy under the ACA's original subsidy structure.
- Under the ARP, the SLCSP out-of-pocket maximum for a person with income at 401% FPL is set at $362, resulting in a monthly subsidy value of approximately $389 ($751 - $362) in rating area 9 and $553 in rating area 8 ($915 - $362).
- A large number of older adults are likely to gain access to premium subsidies. For example, a person age 64 in rating area 8 would still qualify for a premium subsidy even with income at 1,000% FPL (income of approximately $128,000 per year).

As the ARP insulates additional Coloradoans from the individual market premium rate increases, both under and over 400% FPL, it reduces potential consumer premium savings from HB 21-1232, as well as those achieved through a state-based reinsurance program. Conversely, a greater share of premium rate savings would accrue to the federal government in the form of reducing premium tax credit expenditures. It is possible that the state of Colorado may receive the majority of these federal premium tax credit expenditure savings in the form of federal pass-through funding if it successfully applied for a Section 1332 waiver.

VI. Data reliance and limitations

The services provided for this report were performed under the Consulting Services Agreement between Milliman Inc. (Milliman) and Partnership for America's Healthcare Future Action (PAHCFA) dated April 1, 2020 and the Statement of Work executed on April 20, 2021.

The information contained in this report has been prepared for the PAHCFA to provide data and information related to the evaluation of potential health benefits market impacts from the insurance market requirements contained in Colorado House Bill 21-1232 (HB 21-1232) as of April 27th, 2021, as passed by the House Health & Insurance Committee. The data and information presented may not be appropriate for any other purpose. To the extent HB 21-1232 is further amended, the contents of this report may need to be updated.

It is our understanding that the information contained in this report may be released publicly. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling, so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for PAHCFA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the premium rates, insurance market population estimates, trend rates, and other assumptions.

Milliman has developed certain models to estimate the values included in this correspondence. The intent of the models was to model market impacts from HB 21-1232. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models.

Milliman has relied upon certain data and information that is publicly available from the Connect for Health Colorado exchange, Colorado Insurance Commissioner, the RAND Corporation, and the Centers for Medicare and Medicaid Services (CMS). Additionally, we relied on statutory financial statement information downloaded from S&P Global Market Intelligence. Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose

It should be noted that there is significant uncertainty surrounding future enrollment and premiums in health benefits programs, particularly the individual and small group health insurance markets. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Appendix A: Estimated Hospital Reimbursement Floors

HOSPITAL NAME	RATING AREA	HB 21-1232 REIMBURSEMENT FLOOR (% OF MEDICARE)
Avista Adventist Hospital	Area 1, CO	190%
Boulder Community Hospital	Area 1, CO	165%
Good Samaritan Medical Ctr	Area 1, CO	175%
Longmont United Hospital	Area 1, CO	165%
Memorial Health System	Area 2, CO	165%
Penrose/St. Francis Healthcare	Area 2, CO	232%
Pikes Peak Regional Hospital	Area 2, CO	175%
Castle Rock Adventist Hospital	Area 3, CO	165%
Denver Health Medical Center	Area 3, CO	201%
Littleton Adventist Hospital	Area 3, CO	165%
Lutheran Medical Center	Area 3, CO	165%
National Jewish Health	Area 3, CO	165%
North Suburban Medical Center	Area 3, CO	165%
Orthocolorado Hospital	Area 3, CO	214%
Parker Adventist Hospital	Area 3, CO	165%
Platte Valley Medical Center	Area 3, CO	165%
Porter Adventist Hospital	Area 3, CO	231%
Presbyterian St. Lukes Medical Ctr	Area 3, CO	228%
Rose Medical Center	Area 3, CO	228%
Saint Joseph Hospital	Area 3, CO	165%
Sky Ridge Medical Center	Area 3, CO	230%
St Anthony Hospital	Area 3, CO	165%
St Anthony North Health Campus	Area 3, CO	165%
Swedish Medical Center	Area 3, CO	165%
The Medical Center Of Aurora	Area 3, CO	229%
University Of Co Hospital	Area 3, CO	165%
Banner Fort Collins Medical Center	Area 4, CO	165%
Estes Park Medical Center	Area 4, CO	207%
Mckee Medical Center	Area 4, CO	165%
Medical Center Of The Rockies	Area 4, CO	165%
Poudre Valley Hospital	Area 4, CO	165%
Colorado Canyons Hospital & Med Ctr	Area 5, CO	201%
Community Hospital	Area 5, CO	165%
St. Marys Hospital & Medical Center	Area 5, CO	165%
North Colorado Medical Center	Area 6, CO	165%
Parkview Medical Center	Area 7, CO	165%

HOSPITAL NAME	RATING AREA	HB 21-1232 REIMBURSEMENT FLOOR (% OF MEDICARE)
St Mary Corwin Medical Center	Area 7, CO	185%
Arkansas Valley Regl Med Ctr	Area 8, CO	200%
Colorado Plains Medical Center	Area 8, CO	165%
Conejos County Hospital	Area 8, CO	185%
East Morgan County Hospital	Area 8, CO	185%
Haxtun Hospital District	Area 8, CO	200%
Heart Of The Rockies Reg Med Center	Area 8, CO	219%
Kit Carson County Memorial Hospital	Area 8, CO	200%
Lincoln Community Hospital	Area 8, CO	200%
Melissa Memorial Hospital	Area 8, CO	175%
Mt. San Rafael Hospital	Area 8, CO	200%
Prowers Medical Center	Area 8, CO	195%
Rio Grande Hospital	Area 8, CO	200%
San Luis Valley Reg Med Center	Area 8, CO	165%
Sedgwick County Health Center	Area 8, CO	200%
Southeast Colorado Hospital	Area 8, CO	200%
Spanish Peaks Regional Health	Area 8, CO	200%
Sterling Regional Medcenter	Area 8, CO	165%
Weisbrod Memorial County Hospital	Area 8, CO	200%
Wray Community District Hospital	Area 8, CO	200%
Yuma District Hospital	Area 8, CO	200%
Animas Surgical Hospital	Area 9, CO	165%
Aspen Valley Hospital District	Area 9, CO	200%
Delta County Memorial Hospital	Area 9, CO	175%
Grand River Hospital District	Area 9, CO	219%
Gunnison Valley Hospital	Area 9, CO	204%
Kremmling Memorial Hospital District	Area 9, CO	200%
Mercy Regional Medical Center	Area 9, CO	165%
Montrose Memorial Hospital	Area 9, CO	165%
Pagosa Springs Medical Center	Area 9, CO	200%
Pioneers Medical Center	Area 9, CO	175%
Rangely District Hospital	Area 9, CO	200%
Southwest Memorial Hospital	Area 9, CO	203%
St Anthony Summit Medical Center	Area 9, CO	165%
St. Vincent General Hospital	Area 9, CO	200%
The Memorial Hospital	Area 9, CO	200%
Vail Valley Medical Center	Area 9, CO	207%
Valley View Hospital	Area 9, CO	165%
Yampa Valley Medical Center	Area 9, CO	222%

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Lindsy Kotecki
lindsy.kotecki@milliman.com

Fritz Busch
fritz.busch@milliman.com

Paul Houchens
paul.houchens@milliman.com