COLORADO
Department of
Regulatory Agencies
Division of Insurance

The Honorable Janet Yellen
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

April 30, 2021

Dear Secretary Yellen and Secretary Becerra,

The State of Colorado is pleased to submit this application for a five-year extension of Colorado's Section 1332 State Innovation Waiver to continue Colorado's reinsurance program for 2022-2026. The State respectfully requests that the U.S. Department of Treasury and the U.S. Department of Health and Human Services approve Colorado's application for a 1332 waiver extension.

Currently, Section 1312(c)(1) of the Affordable Care Act (ACA) is waived for 2020 and 2021 to allow the state to implement a reinsurance program partially funded by federal pass-through savings. We are requesting that Section 1312(c)(1) be waived for an additional five years, for the period of 2022 through 2026, in order for Colorado to continue implementing the reinsurance program for this period.

Colorado's reinsurance program was highly successful in its first two years (2020 and 2021). It reduced premiums over 20% on average statewide for Coloradans who purchase insurance on the individual market. The COVID-19 pandemic and public health emergency further underscored the importance of reinsurance and the affordability it brings to Colorado's individual market. Looking ahead, reinsurance will continue to be a crucial program to keep premiums low in Colorado, and will work in tandem with the American Rescue Plan to make healthcare more affordable and accessible for all.

Thank you for considering our application and supporting Colorado's healthcare affordability goals.

Sincerely,

Michael Conway
Commissioner of Insurance

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Colorado 1332 State Innovation Waiver
Five-Year Extension Application
State Reinsurance Program

April 30, 2021

Submitted by the Colorado Division of Insurance
part of the Department of Regulatory Agencies (DORA)

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Attachments

Section 1: Extension Request and Reinsurance Program Overview

A detailed description of the extension request, including the desired time period for the extension. The state must confirm there are no changes to the current waiver plan for the new waiver period that are otherwise not allowable under the state's STCs, or that could impact any of the section 1332 statutory guardrails or program design.

Waiver Request and Timeframe

The State of Colorado, through its Division of Insurance (Division) submits this 1332 State Innovation Waiver extension request to the Centers for Medicare and Medicaid Services (CMS) in the United States Department of Health and Human Services (HHS), and the Department of the Treasury. Currently, Section 1312(c)(1) of the Affordable Care Act (ACA) is waived for 2020 and 2021 to allow the state to implement a reinsurance program partially funded by federal pass-through savings. We are requesting that Section 1312(c)(1) be waived for an additional five years, for the period of 2022 through 2026, in order for Colorado to continue implementing the reinsurance program for this period.

Aside from the timeframe, no other changes are being proposed to Colorado's existing 1332 waiver. The waiver extension will continue to abide by the Specific Terms and Conditions set forth by CMS. Colorado's waiver extension will also continue adhering to the guardrails established by Section 1332, as well as principles laid out in guidance from CMS, and will not affect other provisions of the ACA.

Colorado Reinsurance Program Overview

The Colorado General Assembly passed House Bill 19-1168 (HB 19-1168) in May 2019, establishing Colorado's state-based individual market reinsurance program. The bipartisan legislation authorized the Colorado Division to apply for a Section 1332 waiver from CMS to implement the program for two years (2020 and 2021). Colorado Senate Bill 20-215 (SB 20-215) was passed in June 2020, and authorized the State to seek a five-year extension to the state's reinsurance program, allowing the Division to apply for a five-year waiver extension from CMS. SB 20-215 also changed the state funding source for the program from its original funding under HB 19-1168 to the newly established Colorado Health Insurance Affordability Enterprise.

Colorado's reinsurance program was highly successful in its first two years (2020 and 2021). It reduced premiums 20% on average statewide for Coloradans who purchase insurance on the individual market, surpassing the premium reduction goals in HB19-1168 and the Section 1332

waiver application. Approximately 150,000 Coloradans saw their premiums decrease from 2019 to 2020 as a result of reinsurance. The program's geographic tier structure reduced premiums more in areas of the state that historically have had the highest premiums - particularly in rural areas. The program also brought stability to Colorado's individual health insurance market, with all insurers remaining in the market from 2019 to 2021, with one new insurer offering plans in 2020. Colorado's 2021 individual market premiums are nearly 21% lower than they would be without reinsurance, indicating the program is succeeding in keeping premiums down.

The COVID-19 pandemic and public health emergency further underscored the importance of reinsurance and the stability and affordable prices it has brought to Colorado's individual insurance market. Significant job losses in 2020 meant thousands of Coloradans lost their employer-based health insurance. These consumers turned to Colorado's individual market to purchase insurance or enroll in Health First Colorado (Colorado's Medicaid Program), if eligible. 14,263 Coloradans purchased coverage on the individual market during Colorado's Special Enrollment Period from March 20 to April 30, 2020. Having reinsurance in place meant these consumers had access to more affordable insurance during a time when they needed it most.

Reinsurance and the American Rescue Plan Act

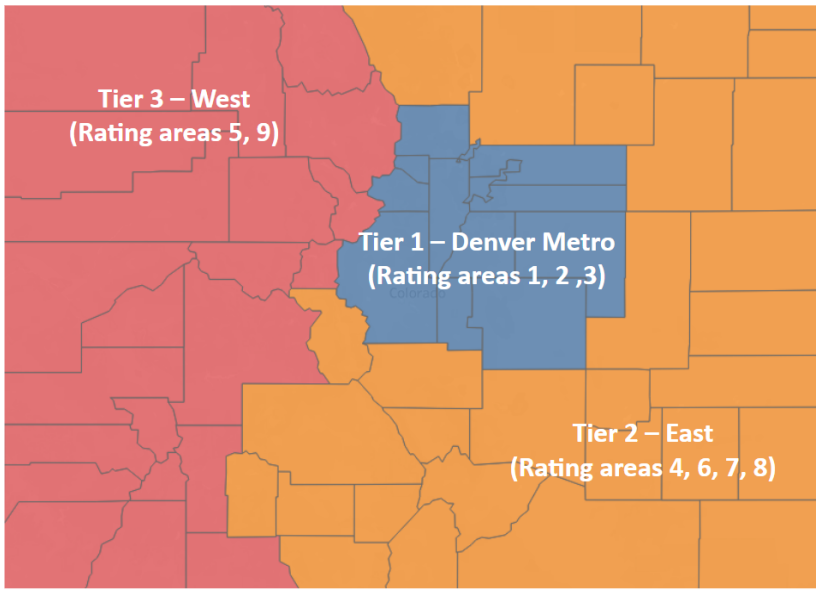
In Spring 2021, upon passage of the federal American Rescue Plan Act (ARP), the Division contracted with an actuarial firm to analyze the impacts of the ARP and reinsurance on Colorado's individual market. Similar to the study on the impact of reinsurance on Colorado's subsidized enrollee population in 2020, the ARP study examined the impact reinsurance would have on consumers' premium prices in a fully subsidized market. The Division aimed to ensure the interaction of these two programs would continue to keep premiums as low as possible, while maximizing buying power for individual market enrollees.

The actuarial analysis indicated that implementing reinsurance alongside ARP would result in significantly lower net (post-subsidy) premiums on average for Colorado consumers than implementing ARP alone without reinsurance. For all consumer groups, but especially for those who purchase insurance off the exchange and/or do not receive federal subsidies, reinsurance will continue to reduce premiums significantly compared to a market without reinsurance. The analysis also compared the current reinsurance program to two different reconfigurations of the program: reinsurance that would reduce premiums less, and reinsurance that would only apply to certain metal tiers. The Division found that neither of these approaches would reduce premiums on the whole as much as the current reinsurance program. As a result, the Division is not proposing to make changes to the reinsurance program structure in light of the ARP.

Reinsurance Program Design

Colorado's reinsurance program is designed to reduce individual market premiums statewide, and to reduce premiums the most in areas of the state that historically have had the highest rates. The program achieves these region-specific savings goals using a tiered payment parameter structure - paying more towards consumer claims in higher cost areas - in order to reduce premiums more in those areas. The map in Figure 1 shows the three geographic tiers created by reinsurance, and the insurance rating areas included in each tier.

Figure 1: Reinsurance Geographic Tiers



For 2020, 2021, and 2022 Colorado set the following tier-specific payment parameters:

Table 1: Reinsurance Payment Parameters

	Tier 1	**Tier 2**	**Tier 3**
	Areas 1, 2, & 3 (Denver Metro)	**Areas 4, 6, 7, & 8 (East)**	**Areas 5 & 9 (West)**
Attachment Point	$30,000	$30,000	$30,000
Cap	$400,000	$400,000	$400,000
Coinsurance (2020)	45%	50%	85%
Coinsurance (2021)	40%	45%	80%
Coinsurance (2022)	43%	50%	73%

The Division of Insurance in the Colorado Department of Regulatory Agencies (DORA) administers the reinsurance program. The Division hired a Reinsurance Program Director in Fall 2019, and incorporated reinsurance into the Division's annual individual market rate review process. The Division has also partnered with the Colorado Department of Health Care Policy and Financing (HCPF), as well as Connect for Health Colorado (Colorado's state-based exchange) to streamline data collection and reporting processes for the reinsurance program. Additionally, the Division signed an agreement with CMS to use the EDGE database for reinsurance claims processing and payment calculations. These partnerships help reduce administrative and regulatory burden on all parties involved in Colorado's reinsurance program, thus minimizing waste and costs and ensuring the Division passes along the maximum benefits to Colorado consumers.

The Division issues reinsurance payments to carriers on an annual basis, in August of the year following the applicable benefit year. Under regulation 4-2-77, the Division will notify carriers of the amounts they are owed in June of the year following the benefit year, and allow for a thirty day appeals process prior to making final payments. All payments to carriers will be made electronically.

Extension Period Goals and Implementation Overview

The goals for the five-year waiver extension period center around maintaining the premium reductions achieved in the program's first two years, including larger reductions in areas of the state where health insurance costs are highest. As shown in Table 2, actuarial analysis for the waiver extension period estimates the reinsurance program will reduce premiums by 19.2% in 2022, making the premium impact (how much higher rates would be without reinsurance) 23.7% for 2022. The average individual market premium is expected to be reduced $116, from $605.12 to $489.11. The reinsurance program will continue to use a geographic tiering approach to reduce premiums more in the state's highest cost areas.

Table 2: 2022 Premium Reduction and Impact Estimate

Description	PMPM
Estimated 2022 Premium per member per month (PMPM) without the program	$605.12
Estimated 2022 Premium per member per month with the program	$489.11
Reduction	-$116.00
Reduction % (-$116.00 ÷ $489.11)	-19.2%

Premium Impact ($605.12 ÷ $489.11-1)[1]	23.7%

Reinsurance is also expected to continue increasing enrollment in Colorado's individual market. As shown in Table 3, actuarial analyses estimate that individual market enrollment will be 2.5% higher in 2022 with reinsurance than enrollment would be absent the program.

Over the five-year waiver extension period, the reinsurance program provides savings to the federal government in the form of Advance Premium Tax Credit (APTC) savings. As shown in Table 3, lower federal APTC payments as a result of reinsurance in 2022 are expected to result in federal savings of approximately $307 million. Table 4 shows the total reduction in federal spending due to reinsurance expected over the five-year waiver extension period is $1.33 billion.

Table 3: 2022 Impact of Waiver on Premium, Enrollment, and Federal Deficit

	Non-Group ACA Premium Impact	**Non-Group ACA Enrollment**	**Federal Savings**
Effect of Reinsurance	-23.7%	2.5%	$307M

Table 4: Five-Year Deficit Impact of Reinsurance Program (2022-2026)

Impacted Federal Cash Flow	**Reduction to Federal Deficit ($ millions)**
Difference in APTCs	$1.33B

The Division has implemented several process updates to ensure the reinsurance program maximizes premium savings for Colorado consumers and to operate the program as efficiently as possible. During the 2021 rate review period (mid-year through the first reinsurance program year), the Division implemented a more scrutinous process for analyzing the impact of reinsurance on premium rates. The Division plans to implement additional process improvements for the 2022 rate review period, including a more extensive analysis of reinsurance impact by geographic rating region and plan metal tier. The Division also plans to use the care management protocols carriers submitted during the rate review process to better understand and evaluate carriers' strategies for managing care and cost of care for their highest cost members (i.e., members whose claims are eligible for reinsurance).[2] These process improvements will continue

[1] Premium impact is defined as the additional premium necessary in the absence of the 1332 Waiver program for a given year. This differs from premium reductions due to program implementations year over year.
[2] All carriers participating in the Colorado reinsurance program are required to file care management protocols annually with the Division, explaining how they support care management practices for members whose claims are eligible for reinsurance.

to strengthen the reinsurance program and support Colorado's broader efforts to make health care more affordable for its residents.

The Division will also continue to monitor the impact of reinsurance on the enrollee population eligible for federal premium subsidies under the ACA and the ARP. Colorado House Bill 19-1168 instructs the Commissioner of Insurance to conduct a study on the impact of reinsurance on the subsidized enrollee population after the program's second year. Recognizing the urgency and importance of this work, the Division expedited the study and completed it a year early, delivering the report in March 2021.

The Division contracted with actuarial firm Lewis & Ellis and the Colorado Health Institute to study the impact of reinsurance on the subsidy-eligible enrollee population. The final report includes a detailed actuarial analysis of changes in Colorado's individual market from 2019 to 2020, including net premium changes for subsidized enrollees, as well as policy recommendations to help maximize the buying power of subsidized consumers. The analysis found that reinsurance did not negatively impact the buying power of consumers on the individual market, but other insurance pricing factors - namely, induced demand factors - did lead to net price increases for some subsidized consumers in 2020. The Division plans to implement the report's key recommendations, including requiring that all insurers use the federal induced demand factors, in the 2022 benefit year.

The Division remains committed to making health insurance more affordable for Coloradans, giving more people improved access to necessary health care - preventive, diagnostic, chronic, and emergency. The Division will take advantage of every tool available to improve affordability, including the many improvements to health insurance markets that are part of the ARP. The state reinsurance program is a key component of Colorado's efforts to make health care more affordable for all Coloradans. The Division looks forward to the opportunity to continue the program for an additional five years through a 1332 waiver extension.

Section 2: Program Outcomes and Section 1332 Guardrails

Preliminary evaluation data and analysis of observable outcomes from the existing waiver program, which includes quantitative or qualitative information on why the state believes the program did or did not meet the statutory guardrails. For example, the state may provide information comparing the originally projected premium reductions or expected claims reimbursements to the actual values of the outcomes observed.

Evaluation and Outcomes Data

Colorado's reinsurance program successfully reduced premiums by over 20% on average statewide in its first year (2020) and maintained the 20% premium impact in its second year (2021). The program has also fully complied with Section 1332 statutory guardrails. Actuarial analysis performed for Colorado's original 1332 waiver application estimated that premiums would be 16% lower on average across the state in 2020 than they would have been absent the waiver. As shown in Table 5, the program surpassed that goal by achieving an average statewide 20.9% reduction in 2020. The program continued to save Coloradans over 20% on average in 2021.

Colorado's reinsurance program is designed to reduce premiums more in areas of the state that have traditionally had the highest health insurance costs. The program achieves its region-specific premium reduction goals using a tiered payment parameter structure - paying higher coinsurance rates in higher cost areas, in order to reduce premiums more in those areas. Table 5 shows the average premium savings in the state's three reinsurance geographic tiers in 2020 and 2021.

Table 5: Reinsurance Premium Savings in 2020 and 2021

	Tier 1	Tier 2	Tier 3	Statewide Average Premium Savings
	Areas 1, 2, & 3 (Denver Metro)	**Areas 4, 6, 7, & 8 (East)**	**Areas 5 & 9 (West)**	
Claims Cost Reduction Targets[3]	*15-20%*	*20-25%*	*30-35%*	*n/a*
Year One (2020) Premium Savings	18.0%	23.5%	29.5%	**20.9%**
Year Two (2021) Premium Savings	17.0%	22.9%	36.9%	**20.8%**

In addition to reducing premiums, reinsurance has also brought stability to Colorado's individual insurance market. As shown in Table 6, all health insurance carriers remained in the individual market from 2019 to 2021, and one new insurer (Oscar Health) entered the market in 2020. The number of plans offered across the state in the individual market also increased, from 252 in 2019 to 326 in 2021, providing Colorado consumers with more choices, and a strong and competitive insurance market.

Table 6: Carriers and Plans in Colorado's Individual Market (2019-2021)

	2019	2020	2021
Number of Carriers	8	9	9
Number of Plans	252	265	326

The reinsurance program also has had a positive impact on individual market enrollment. Actuarial analysis in Colorado's original 1332 waiver application estimated that reinsurance would increase enrollment in Colorado's individual market by approximately 2.9% in 2020, or 6,378 more enrollees in 2020 than would have been expected absent the waiver. Actual 2020 enrollment increased by 11,718 enrollees.[4] The full impact reinsurance has had on Colorado's individual market enrollment in 2020 and 2021 is difficult to estimate, due to the Covid-19 public health emergency and subsequent special enrollment period and related market

[3] HB 19-1168 set targets related to claims cost reduction, C.R.S. §10-16-1105(2). Claims cost reduction is not synonymous with premium impact or savings. Claims cost reduction targets only include claims costs and not carrier administrative costs. Since premium impact also takes into account these other carrier costs, premium savings may be slightly less than claims cost reduction.

[4] According to Connect for Health Colorado data, effectuated enrollment as of February 2020 was 152,690. Effectuated enrollment for 2019 was 140,770.

fluctuations. The Division expects reinsurance will continue driving more consumers to purchase insurance on Colorado's individual market due to the increased affordability it brings.

Impact to 1332 Statutory Guardrails

Colorado's reinsurance program adhered to all four ACA Section 1332 statutory guardrails in its first two years and will continue adhering to the guardrails during the five-year waiver extension period. A description of how the reinsurance program meets each of the statutory guardrails follows below Table 7.

Table 7: Section 1332 Guardrails

Guardrail	**Effect of Waiver**
1) Coverage	Increase in enrollment (estimated 2.5% in 2022)
2) Affordability	Statewide average premium decrease of 20%
3) Comprehensiveness	No change to EHBs
4) Federal Deficit Neutrality	Estimated federal savings of $1.3 billion over 5 years

1) Scope of Coverage Requirement (1332(b)(1)(C)):

   As previously noted, the waiver extension will reduce the cost of coverage in the individual market. As a result, enrollment in the individual market is expected to increase by approximately 6,806 enrollees in 2022, compared to a baseline without reinsurance. These new enrollees are expected to be previously uninsured individuals. The waiver extension will have no material impact on the availability of other types of coverage, such as Health First Colorado (Colorado's Medicaid program), Child Health Plan Plus (CHP+), and employer- based insurance, so no impact is expected on the number of individuals with those types of coverage. By lowering premiums in the individual market, the waiver will continue to have a positive impact on Coloradans who purchase their own health insurance.

2) Affordability Requirement (1332(b)(1)(B)):

   The reinsurance program will, in each year it is in effect, make the cost of individual coverage lower than it would be absent the waiver. The waiver extension will not affect the premiums or cost-sharing for coverage obtained through other means, such as Medicaid, CHP+, and employer-based coverage. The waiver will continue to have a positive impact on Coloradans who buy coverage in the individual market since premiums will be lower.

3) Comprehensiveness Requirement (1332(b)(1)(A)):

The waiver extension will have no material effect on the comprehensiveness of coverage for Colorado residents. Regardless of whether the waiver extension is granted, all Colorado ACA-compliant plans will be required to provide coverage of essential health benefits. Similarly, the scope of benefits provided by other types of coverage such as Medicaid, CHP+, and grandfathered plans will not be impacted. The waiver extension is expected to increase the number of individuals with health coverage. Individuals gaining health coverage under the waiver will have coverage for more comprehensive health benefits than they would absent the waiver, as uninsured individuals.

4) Deficit Neutrality Requirement (1332(b)(1)(D)):

Colorado anticipates that individual premiums, including premiums for the second-lowest-cost silver plan, will be lower under the waiver compared to a market without the waiver in 2022-2026. Because federal APTC and Premium Tax Credit (PTC) costs are tied to the second-lowest-cost silver plan, these lower premiums will result in lower federal spending net of revenues in each year of the waiver. Combining these factors, the waiver extension will produce net federal savings estimated at $307 million in 2022 and $1.3 billion over the five-year waiver extension period. Colorado requests pass-through funds in each year equal to the expected APTC/PTC savings, and not to exceed net expected savings under the waiver. Granting pass-through funding in these amounts will not result in the waiver increasing the federal deficit in any year during the five years of the waiver extension period.

Regulatory Oversight and Implementation

The Division has issued the following rules and bulletins to fully operationalize the reinsurance program and meet state and federal statutory requirements:

- Payment Parameter Rules (5/31/19, 3/15/20, 6/2/20, & 3/15/21)

The Division publishes the reinsurance payment parameters by March 15 of the year prior to the benefit year for each reinsurance program year. The Division published the 2020 payment parameters in May 2019 once the original 1332 waiver application was submitted. The 2021 parameters were published in March 2020 and updated in June 2020, to reflect changes in health care utilization and expenditures resulting from the COVID-19 pandemic. The 2022 parameters were published in March 2021.

- Hospital Fee Rule (12/25/19) - *Repealed 10/1/20*

  Prior to the passage of SB 20-215, the Division adopted a rule regarding hospital special fee payments under HB 19-1168. This rule has since been repealed, as the hospital fee payments under HB 19-1168 have been replaced by a new hospital fee payment under SB 20-215.

- Carrier and Hospital Reporting Bulletin (4/30/20)

  This bulletin informed carriers and hospitals that they are not required to report data to the Division for reinsurance payment calculation or hospital fee calculation purposes. The Division instead established agreements with CMS and HCPF, respectively, to perform these payment calculations, using claims data and hospital revenue data. This programmatic update streamlined reporting processes and reduced administrative burden on carriers, hospitals, and the Division.

- Care Management Protocol Rule (8/15/20 & 6/15/21)

  HB 19-1168 requires all carriers participating in Colorado's reinsurance program to implement care management protocols to promote more cost-effective health care and to restrain growth in federal and state health care spending commitments. The Division adopted the Reinsurance Care Management Protocol rule in August 2020, requiring carriers to complete a Reinsurance Care Management Protocol assessment as part of their annual rate filings. The rule and corresponding Care Management Protocol Reporting Template have been updated for the 2022 benefit year and are effective as of June 15, 2021. The reporting template requires carriers to provide details regarding their care management and cost containment strategies for their highest cost members.

- Reinsurance Payment Process Rule (6/15/21)

  The Division has adopted a new rule, effective June 15, 2021, that provides details regarding the reinsurance payment calculation and disbursal process to carriers. The first reinsurance payments to carriers will be made in August 2021 for the 2020 program year.

Section 3: Authority Under State Law

Evidence of sufficient authority under state law(s) in order to meet the PPACA section 1332(b)(2)(A) requirement for purposes of pursuing the requested extension.

Colorado House Bill 19-1168 (HB 19-1168), signed into law on May 17, 2019, established a reinsurance program to be administered by the Colorado Division of Insurance to address rising health insurance premiums in the state. HB 19-1168 authorized a two-year reinsurance program, for 2020 and 2021. It was bipartisan legislation, garnering support from Democrats and Republicans in both chambers of the General Assembly.

On June 30, 2020, Senate Bill 20-215 (SB 20-215) was signed into law by Governor Jared Polis, establishing the Colorado Health Insurance Affordability Enterprise. SB 20-215 authorizes the reinsurance program to continue for an additional five years, and allows the State to apply for a five-year extension of its 1332 waiver to continue reinsurance from 2022 through 2026. SB 20-215 also changed the state funding source for the reinsurance program from the original funding sources in HB 19-1168 to the new Health Insurance Affordability Enterprise.

The original state funding sources for reinsurance included a fee on hospitals, health insurance premium tax revenue, and state general fund. These funding sources are being replaced entirely by the Enterprise. The primary Enterprise funding source is a fee on health insurers, which is intended to replace the federal Health Insurance Provider Fee under Provision 9010 of the ACA. The Enterprise also receives revenue from a hospital fee in 2022 and 2023 only, and a portion of the annual premium tax revenue. State general fund dollars are used for reinsurance program administration, but will not be used for reinsurance payments to carriers.

Section 4: Stakeholder Engagement and Tribal Consultation

An explanation and evidence of the process to ensure meaningful public input on the extension request, which must include:

- *For a state with one or more Federally-recognized Indian tribes within its borders, providing a separate process for meaningful consultation with such tribes, and providing written evidence of the state's compliance with this requirement.*
    - See below for details about the April 16, 2020 tribal consultation.

- *Publicly posting the submitted LOI on the state's website to ensure that the public is aware that the state is contemplating a waiver extension request*
    - The LOI is posted on the state's reinsurance website here: https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-legislation/reinsurance-program

- *Publicly posting the waiver extension application on the state's website upon its submission of the waiver extension application to the Departments.*
    - The waiver extension is posted on the state's renaissance website here: https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-legislation/reinsurance-program

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Stakeholder Engagement

The Division has ensured that stakeholder engagement is woven into the reinsurance program in multiple ways. From public comments given during meetings and the annual reinsurance forum, to feedback on reinsurance regulations, to regular discussions on the impact of the reinsurance program, stakeholders have many different opportunities to engage with and comment on the reinsurance program. Stakeholder engagement and support was also important during the 2020 Colorado legislative session to ensure passage of SB 20-215, which authorized a five-year extension to the state's reinsurance program. By taking a multi-pronged approach to engaging and updating the public, the Division has ensured stakeholders have multiple ways to provide input on the waiver extension.

Starting in September 2020, the Division began hosting monthly public meetings to provide updates on the Colorado reinsurance program. All meetings are virtual until further notice, are

open to the public, and include dedicated time for public comments. Meetings cover program updates and other reinsurance topic areas as specified, and include dedicated time for members of the public to ask questions and provide feedback on the program. Members of the public who wish to attend may register for upcoming reinsurance meetings on the Division's Reinsurance website. To date, the Division has held eight monthly meetings with an average of 20 attendees per meeting. By holding the meetings virtually, the Division facilitated participation from all parts of the state and not just stakeholders from the Denver metro area.

The Division also hosted a Reinsurance Program Public Forum on June 30, 2020. The event was held virtually, and seventy-nine members of the public attended, representing commercial payers, health care providers, state government agencies, the Colorado health insurance exchange, health care purchasing alliances, consumer advocate groups, consultants, academia, and other stakeholder groups. The Reinsurance Program Director presented slides sharing a program overview, regulatory updates, and future program plans. Attendees shared positive feedback about the reinsurance program during a public comment period. Additional comments and feedback from attendees included questions about the waiver extension process; questions on any impact to non-individual market insurance premiums; clarification on how the reinsurance program works; thanks for premium decreases seen in Colorado in 2020; and questions about claims data compiled.

In addition to monthly public meetings and the Reinsurance Program Public Forum, the Division has also worked with consumer advocates around the Reinsurance Subsidized Enrollee Impact Study (discussed in Section 1 of this application). The Division and actuarial contractor Lewis & Ellis met with various consumer advocacy groups before the start of the study, while the policy options were drafted, and after the study was published. Including stakeholders throughout the subsidized enrollee impact study process ensured that the study and the reinsurance program include meaningful public comment, and that the Division is aware of the impact of the program on diverse groups of Coloradans.

Tribal Consultation

Colorado has two federally-recognized American Indian tribes, the Ute Mountain Ute and Southern Ute Indian tribes. Additionally, as of the 2020 Census, there are 46,395 Coloradans who identify as American Indian/Alaska Native who live in urban areas of the state. The Division worked with the Colorado Commission of Indian Affairs (CCIA) from Lt. Governor Primavera's office to schedule a virtual tribal consultation with representatives from the Southern Ute and Ute Mountain Ute tribes. While Indian Health Services (IHS) representatives could not attend the April 16, 2021 tribal consultation, the Division has previously discussed with CCIA how the reinsurance program impacts providers at IHS facilities. Attendees at the virtual tribal consultation included the health director of the Southern Ute tribe, legal council for the Ute

Mountain Ute tribe, the Commissioner of Insurance, the Reinsurance Program Director, staff from CCIA, and Division staff.

Reinsurance Program Director Mortimer presented a brief overview of the reinsurance program, data on the 2020 and 2021 premium reductions as a result of the reinsurance program, impacts of the reinsurance program on tribal communities, and then left plenty of time for questions and discussion. Questions focused on how to best inform tribal members about the program, how the reinsurance program impacts the health insurance of tribal members, and more broadly about enrolling for health insurance through the state based exchange, Connect for Health Colorado. Deputy Commissioner Harris also made sure that tribal representatives were aware of the new health insurance benefits that are potentially available for tribal members with the recent passage of the ARP.

Section 5: Actuarial and Economic Analysis of Extension Period (2022-2026)

Updated economic or actuarial analyses for the extension period, if the state is aware of changes in state law, the state insurance market, or to the waiver program that are allowable under the STCs and impact waiver assumptions and projections, and that the state has not previously shared with the Departments via its reporting requirements.

The Division contracted with Lewis & Ellis Actuaries & Consultants to perform actuarial and economic analysis on the reinsurance program for the five-year waiver expansion period. The report produced by Lewis & Ellis assumes full implementation of the federal American Rescue Plan Act in 2021 and 2022. It also accounts for state law changes through Colorado Senate Bill 20-215 that impact individual market enrollment starting in 2022. No other current state or federal legislative changes are expected to significantly impact Colorado's reinsurance program during the waiver extension period.

See “State of Colorado Section 1332 State Innovation Waiver Actuarial and Economic Analysis: April 2021” in the following pages for the full analysis by Lewis & Ellis.

STATE OF COLORADO
SECTION 1332 STATE INNOVATION WAIVER
ACTUARIAL AND ECONOMIC ANALYSIS

APRIL 2021

Prepared by
Lewis & Ellis, Inc.

Michael A Brown, FSA, MAAA, Vice President

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Section 1: Introduction and Summary

The State of Colorado non-group health insurance market sustained large rate increases, prior to 2020, due to a number of factors including changes in the risk pool and increasing costs of healthcare. In order to mitigate high prices in the non-group market, Colorado submitted a Section 1332 State Innovation Waiver ("1332 Waiver") in 2019 to receive federal funding to operate a state-based reinsurance program for two years. The 1332 Waiver was approved, allowing Colorado to operate the reinsurance program from January 1, 2020 through December 31, 2021. Colorado House Bill 19-1168 authorized the State to apply for the waiver and provided the state funds for the original two-year program.

The Colorado General Assembly passed Senate Bill 20-215 (SB 20-215) in June 2020, allowing the state to apply for an extension of up to five years for its 1332 Waiver, and changing the state funding source for the reinsurance program. In November 2020, Michael Conway, Colorado Commissioner of Insurance, sent a Letter of Intent to apply for a five-year 1332 Waiver extension. The extension will apply for the period of January 1, 2022 through December 31, 2026. This document is the actuarial and economic analysis to accompany the extension application.

Additionally, in March 2021, Congress passed H.R. 1319 – the American Rescue Plan Act of 2021 (ARP), significantly increasing the premium subsidies available to individuals and families with coverage on the Exchange. For purposes of this analysis, it is assumed the ARP will remain in place only for the 2022 year, and not through 2023-26. SB 20-215 also includes a Cost Share Reduction (CSR) enhancement for the 2022 year, with a potential premium wrap for years 2023-26. Together these programs are expected to provide a significant increase in enrollment to the Individual Exchange Market in Colorado in 2022.

This 1332 Waiver actuarial and economic analysis includes supporting information detailing the impact of the 1332 Waiver on health insurance coverage in the state, and the five-year impact of the 1332 Waiver on the Federal deficit, requiring deficit neutrality. In addition, this analysis demonstrates compliance with these four ACA Section 1332 "guardrails":

1) **Comprehensive Coverage**
   Provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) of the Affordable Care Act and offered through Exchanges

2) **Affordability**
   Provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of the ACA Qualified Health Plans, offered through the Exchange

3) **Scope of Coverage**
   Provide coverage to at least a comparable number of its residents as the provisions currently in place required by the Affordable Care Act would provide

4) **Deficit Neutrality**
   The waiver should not increase the federal deficit.

The waiver would reduce premiums through the continuation of a state-based reinsurance program from 2022 through 2026. This program, established by the state, would pay for a portion of claims for high cost members in the non-group ACA-compliant health insurance market. This portion of claims would be determined by setting payment parameters, defined below:

Attachment point: A threshold, above which a member's annual total claims would be eligible for reimbursement by the reinsurance program.
Cap: The maximum of a member's annual total claims that would be eligible for reimbursement.
Coinsurance: The percent of a member's annual total claims (between the attachment point and the cap) paid by the reinsurance program.

The reinsurance program would pay a percentage of claims, above the attachment point and up to a cap. Covered claims would reduce the total costs paid by carriers in the non-group market. Therefore, any reductions to claims costs due to reinsurance would reduce premiums as well.

Pursuant to House Bill 19-1168, the State of Colorado also established a three-tier geographic stratification for the reinsurance program. Colorado implemented this three-tier program structure in 2020-2021 and plans to maintain this approach during the five-year waiver extension period. To address the inequality of premiums in different geographic areas of the state, the following is required of the program:

Tier 1 – Rating Areas 1, 2, & 3: Claim costs shall be reduced by between 15% and 20%
Tier 2 – Rating Areas 4, 6, 7, & 8: Claim costs shall be reduced by between 20% and 25%
Tier 3 – Rating Areas 5 & 9: Claim costs shall be reduced by between 30% and 35%

To accomplish this end, the reinsurance parameters will be adjusted for the geographical areas to achieve a projected claims reduction in the required range. It is estimated that the overall claims will be reduced by an average of 21.7% when the three tiers are combined. Premium is developed by adding non-claims administrative costs, taxes and fees to expected claims cost. The program does not reduce fixed administrative cost and therefore not all premium components are lowered by the program. The result is a premium reduction that is lower than the claims reduction. Premium reduction is estimated to be 19.2%. A summary of these reductions is presented in the tables below.

Claims Reduction and Impact Estimate

Description	PMPM
Estimated 2022 Claims per member per month without the program	$506.02
Estimated 2022 Claims per member per month with the program	$396.05
Reduction	-$109.97
Reduction % (-$109.97 ÷ $506.02)	-21.7%
Claims Impact ($506.02 ÷ $396.05 -1)[1]	27.8%

Premium Reduction and Impact Estimate

Description	PMPM
Estimated 2022 Premium per member per month without the program	$605.12
Estimated 2022 Premium per member per month with the program	$489.11
Reduction	-$116.00
Reduction % (-$116.00 ÷ $489.11)	-19.2%
Premium Impact ($605.12 ÷ $489.11 - 1)[1]	23.7%

For 2020, 2021 and 2022 Colorado has set the following parameters with resulting premium impacts:

	Tier 1			Tier 2				Tier 3		Premium Impact[1]
	Area 1	*Area 2*	*Area 3*	*Area 4*	*Area 6*	*Area 7*	*Area 8*	*Area 5*	*Area 9*	*All Areas*
Attachment Point	$30,000			$30,000				$30,000		
Cap[2]	$400,000			$400,000				$400,000		
Coinsurance 2020	45%			50%				85%		26%[3]
Coinsurance 2021	40%			45%				80%		21%[3]
Coinsurance 2022	43%			50%				73%		24%[4]

The reinsurance program will be funded, contingent on approval of the 1332 Waiver Extension, through state funding and federal pass-through funding. The state portion of the funding is outlined in Colorado Senate Bill 20-215, and comes from the new Colorado Health Insurance Affordability Enterprise. The program does not use any state general fund revenue, so it is budget neutral for the State as well as the Federal Government.

The goals of the reinsurance program are to reduce the impact of high claims incurred by a small portion of the population, reduce premiums in the non-group market, and encourage enrollment of individuals who are choosing to forego insurance due to high costs of purchasing coverage. In addition to providing lower premiums to Coloradans in the non-group market, the program also reduces federal outlays through lower premium tax credits.

As part of the 1332 Waiver Extension, Colorado is requesting federal funding to offset the cost of the reinsurance program. Colorado's reinsurance program will reduce premiums for those purchasing insurance coverage in the non-group market. It will similarly reduce the cost of the second lowest cost silver plan (SLCSP), which is the benchmark for the value of Advance Premium Tax Credits (APTCs). If SLCSP premiums are reduced, then APTCs are also reduced. This reduces the total amount the Federal Government will pay in APTCs. The waiver requests that Colorado receive the amount of federal savings from APTCs ("pass-through" funding), net of other costs, as a result of the reinsurance program.

The State of Colorado retained Lewis & Ellis, Inc. (L&E) to analyze the potential effects of a state-based reinsurance program on the 2022-2026 non-group Affordable Care Act (ACA) marketplace. This document has been prepared solely to support Colorado's application for a 1332 Waiver Extension and is not intended for any other purpose. L&E understands that this report will be made public and will be used in the waiver process. The assumptions, data, results, and methods identified in this report adhere to applicable Actuarial Standards of Practice. Reliance on the information in this report should include a review of the full report and 1332 Waiver Extension application by qualified individuals.

[1] Claims and Premium Impact are defined as the additional claims and premium necessary in the absence of the 1332 Waiver program for a given year. This differs from claims and premium reductions due to program implementations year over year.
[2] The Attachment Point and Cap amounts are kept the same from year-to-year for administrative ease and simplicity, and to simplify care management reporting when monitoring reinsurance claimants year over year.
[3] Per Colorado Rate Filings, with and without reinsurance
[4] Estimation per Analysis Presented in this Document

This report is a supplement to Colorado's 1332 Waiver extension application. It addresses requirements listed in 45 CFR 155.1308(f)(4)(i)-(iii) including actuarial analysis, economic analysis, data, and assumptions. Other sections of the waiver extension application contain non-actuarial requirements.

Section 2: Impact to Guardrails

As described in Section 1, the four guardrails required for an approved 1332 Waiver are:

1) Comprehensive Coverage
2) Affordability
3) Scope of Coverage
4) Deficit Neutrality

L&E's review has determined that Colorado's proposed reinsurance program meets all four guardrails for 2022-2026. The high-level determination is shown below:

Guard Rail	Effect of 1332 Waiver
Comprehensive Coverage	2.5% increase in 2022 enrollment[5]
Affordability	2022 premium impact of 24%
Scope of Coverage	No change to EHBs or other coverage requirements
Deficit Neutrality	Federal savings of $307M in 2022 and $1.3B in the 5-year window

Comprehensiveness, Affordability, and Scope of Coverage

The Colorado reinsurance program is expected to increase affordability of non-group market plans by decreasing premiums. The reduction in premiums is expected to increase the number of enrollees in the non-group market by 2.5%, which increases the scope of coverage. Finally, the reinsurance program will have no effect on Essential Health Benefits or on Actuarial Value, as these requirements have not changed. Therefore, comprehensive coverage will not be affected by the 1332 Waiver.

Deficit Neutrality

The following table shows the impact of the Colorado reinsurance program on the non-group market in 2022. Based on best-estimate assumptions for 2022, the statewide average premium impact is 24%, enrollment will increase by 2.5%, and $306.6 million in federal savings will result. Note that the 24% statewide average premium impact is a comparison of 2022 premiums without reinsurance to 2022 premiums with the 1332 Waiver reinsurance program in effect. This does not suggest that an individual's actual rate decrease from 2021 to 2022 will be 24%, as the number does not include standard renewal changes from 2021 to 2022.

The detailed impact of the Waiver for years 2022 through 2026 is shown in the Appendix. Below is the high-level impact to the 2022 non-group marketplace, compared to the projected 2022 baseline marketplace.

[5] As compared to an environment without reinsurance, and with the ARP.

2022 Impact of Waiver on Premium, Enrollment and Federal Deficit

	Non-Group ACA Premium Impact	Non-Group ACA Enrollment	Federal Savings
Effect of Reinsurance	24%	2.5%	$307M

Over the 5-year window, the reinsurance program provides savings to the federal government in the form of APTC savings. The impact to the federal deficit is an estimated $1.3B.

5-Year Deficit Impact of Reinsurance Program

Impacted Federal Cash Flow	Reduction to Federal Deficit ($ millions)
Difference in APTCs	$1,330.0M

Section 3: Data and Methodology

To project the impact of the reinsurance program in plan years 2022 through 2026, the following data and methodology was used:

3.1 Data and Reports Used

For this study, the following data sources were used:

- 2019 Non-Group Market EDGE premium and enrollment data, provided by Colorado insurance carriers[6]
- On-exchange 2019, 2020, 2021 enrollment reports from Connect for Health Colorado, Colorado's health insurance marketplace[7]
- Data extracts provided by Connect for Health Colorado showing on-exchange enrollment in February 2021.[8] This data includes Gross Premium, Net Premium, and APTC credits.
- Connect for Health 2022 enrollment projections, including the impact of the American Recue Plan (ARP)
- H.R. 1319 – American Rescue Plan Act of 2021
- Carrier 2020 and 2021 rate filings submitted in 2019 and 2020
- CSR and Premium Wrap Studies Performed for Colorado Department of Insurance by Oliver Wyman
- Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature, Mathematica Policy Research, Inc. March 24, 2006
- The Price Sensitivity of Demand for Nongroup Health Insurance, Congressional Budget Office, August 2005

[6] Most recent full year of EDGE data available.
[7] https://connectforhealthco.com/metric-and-reports/
[8] Most recent data available.

3.2 Methodology

The following steps were taken to estimate the impact of a reinsurance program on Colorado's non-group market, both for the year 2022, and for the 5-year window of 2022 to 2026:

1. A 2022 Baseline was established, using data described in Section 3.1. This baseline represents the expected premium, claims, enrollment, and APTC *without* the 1332 Waiver. These values are listed in the table below. A detailed methodology is provided in the Appendix.

2. The impact of adding the reinsurance program was calculated using an impact to claims to decrease premiums and increase enrollment, relative to the established 2022 baseline. L&E estimates that $306.6M million would be spent reducing claims in the non-group market, using the 2022 parameters listed in Section 1 above. These parameters would reduce premiums in the ACA non-group market by 19%, a statewide average, and would increase enrollment by 6,806 individuals. Below is a table summarizing best-estimate results.

Baseline and Waiver Estimates	Baseline: 2022 w/o Waiver, with ARP	2022 with waiver, with ARP
Average Annual Enrollment		
Total Non-Group ACA-Compliant	266,909	273,715
On-Exchange (Effectuated)	240,832	244,607
APTC Enrollment	219,506	220,802
Non-APTC Enrollment	21,326	23,805
Off-Exchange	26,077	29,108
Per Member Per Month Premium		
Total Non-Group ACA-Compliant PMPM	$605	$489
On-Exchange Premium PMPM	$615	$498
Gross APTC Premium PMPM	$628	$507
APTC PMPM	$533	$414
Net APTC Premium PMPM	$95	$93
Non-APTC Premium PMPM	$501	$408
Off-Exchange Premium PMPM	$512	$417
Total Annual Dollars		
Total Non-Group ACA-Compliant Premium	$1,938,139,440	$1,606,533,458
Total APTC	$1,403,616,083	$1,096,998,218
APTC Savings Compared to Baseline		$306,617,865
Cost of Reinsurance Program		$341,365,999
Percent Funded by APTC Savings		89.8%

3. The reinsurance program reduced premiums state-wide in the non-group market, which also reduces the second lowest cost silver plan in each geographic rating area. This plan is the benchmark for determining advance premium tax credits for enrollees who receive APTC. The impact of the reinsurance program to these silver plans and the subsequent tax subsidies were calculated. The results are displayed in the table below. Detailed methodology is included in the Appendix.

	2022 w/o Waiver	2022 with Waiver
Membership APTC	219,506	220,802
Membership Non APTC	47,403	52,913
Total ACA Individual Membership	266,909	273,715
Gross Premium PMPM APTC	$627.57	$507.35
Gross Premium PMPM Non-APTC	$506.81	$413.04
Gross Premium PMPM ACA	$605.12	$489.11
Claims PMPM ACA	$506.02	$396.05
%Reinsurance Reduction to Claims		-20.9%
%Morbidity Reduction to Claims		-1.0%
%Total Reduction to Claims		**-21.7%**
Reinsurance Reduction to Claims PMPM		-$104
Morbidity Reduction to Claims PMPM		-$6
Total Impact on Claims PMPM		**-$110**
Reinsurance Program Costs		$341.4M
Total Reduction to Claims		$361.2M
Total % of Premium Reduction		-19.2%
Total % of Premium Impact		23.7%
Gross Premium PMPM APTC	$628	$507
Net Premium PMPM APTC	$95	$93
Average PMPM APTC	$533	$414
Total APTC	$1,403.6M	$1,097.0M
Pass Through Funding PMPM Change		$119
Total Pass Through Funding		$306.6M
Pass Through Funding as % of Reinsurance Cost		89.8%
Cost to State		$34.7M

4. In addition to the results displayed above, a series of scenarios were tested to determine the impact of various external forces on the results of the reinsurance program. These scenarios are detailed in the Appendix and are summarized below. Savings from APTC reduction ranged from $281.8 million to $332.0 million.

Scenario Testing	1- Best Estimate	2- Good Experience not realized in premium	3- Good Experience and realized in Premium
Description ($ millions)	Expected Trend, Expected Enrollment	Lower Claims Trend	Lower trend, Lower Premiums, Higher Enrollment
2020 Baseline			
Total Non-Group Enrollment	266,909	266,909	280,254
Total Annual Non-Group Premiums	$1,938.1M	$1,938.1M	$1,936.5M
Total Annual APTCs	$1,403.6M	$1,403.6M	$1,389.6M
After Reinsurance			
Total Non-Group Enrollment	273,715	273,715	287,400
Total Annual Non-Group Premiums	$1,606.5M	$1,605.1M	$1,601.1M
Total Annual APTCs	$1,097.0M	$1,090.6M	$1,077.5M
Percent Change in Total Enrollment	2.5%	2.5%	2.5%
Percent Change to Premiums	-19.2%	-19.2%	-19.4%
Results			
Reinsurance Program Cost	$341.4M	$327.8M	$344.2M
Estimated Net Federal Savings	$306.6M	$313.1M	$312.1M
Cost to State	$34.7M	$14.8M	$32.1M

Scenario Testing	4- Poor Experience but not realized in premium	5- Poor Experience and realized in Premium	6- Lower Enrollment on APTC
Description ($ millions)	Higher Claims Trend	Higher Claims Trend, Higher Premium, Lower Enrollment	Lower enrollment on APTC
2020 Baseline			
Total Non-Group Enrollment	266,909	253,564	244,958
Total Annual Non-Group Premiums	$1,907.9M	$1,972.7M	$1,776.0M
Total Annual APTCs	$1,263.3M	$1,500.3M	$1,263.3M
After Reinsurance			
Total Non-Group Enrollment	273,715	260,029	250,468
Total Annual Non-Group Premiums	$1,581.4M	$1,694.6M	$1,465.0M
Total Annual APTCs	$981.5M	$1,168.3M	$981.5M
Percent Change in Total Enrollment	2.5%	2.5%	2.2%
Percent Change to Premiums	-19.2%	-16.2%	-19.3%
Results			
Reinsurance Program Cost	$355.2M	$337.4M	$312.4M
Estimated Net Federal Savings	$281.8M	$332.0M	$281.8M
Cost to State	$73.4M	$5.4M	$30.6M

5. The reinsurance program must also be reviewed for its impact to the federal deficit over a 5-year window. The 2022 results were projected forward from 2023 through 2026 using 2022 numbers, developed above, as a starting point. The program was assumed to be in effect for the full 5-year period. If the 1332 Waiver application were approved and implemented, there would be no increase to the federal deficit. The results are displayed below.

5-Year Deficit Impact of Reinsurance Program

Impacted Federal Cash Flow	Reduction to Federal Deficit ($ millions)
Difference in APTCs	$1,330.0M

Projecting Years 2022 through 2026

We have included supporting information detailing the 5-year impact of a 1332 Waiver on the Federal deficit. Below is the methodology used to project expenses and experience for 5 years:

1. The 2022 Projection, with parameters and assumptions detailed above, was used as the starting point. For the 5-Year projections

2. The 5-Year Enrollment was projected without the 1332 Waiver Program. We first determined the 2023 enrollment assuming:

    - 6,000 new enrollees are introduced due to the premium wrap
    - Approximately 75% of the new enrollees gained due to subsidy uptake have dropped coverage in 2023
    - Off-exchange remains flat
    - Results in table below

Enrollment, Current and Projected

On/Off Exchange	Feb 2021	Projected 2022 with Reinsurance, with ARP, with State CSR Funding	Projected 2023 w/o ARP, w/o CSR Funding, with Premium Wrap
On-Exchange	158,942	244,607	226,729
On-Exchange Financially Assisted	111,349	220,802	154,787
On-Exchange Not Financially Assisted	47,593	23,805	71,942
Off-Exchange	58,216	29,108	29,108
Total	217,158	273,715	255,837

    - Baseline Enrollment growth for 2023 – 2026 was projected using the National Health Expenditure Data developed by the Office of the Actuary in CMS[9]. L&E used Table 17, annual enrollment growth percent for direct purchase insurance. L&E used the average growth over the three year period.

[9] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

- Enrollment with the program in place assumed a 5% price elasticity applied to the non-APTC enrollment.

3. The 5-Year Premium was projected without the 1332 Waiver Program.
    - Premium increases were projected using Table 17 spending per enrollee annual growth rate for direct purchase insurance.
    - Expected Colorado APTC Net Premium trend from 2023 through 2026 of 1.0% is used.

4. The impact of the Reinsurance Program was projected.
    - The cost of the reinsurance program was set equal to the cost required to lower the premiums the same percentage in each year. This assumption would require the reinsurance attachment point, cap and coinsurance levels to be reviewed and adjusted as needed in each subsequent year. This reduction includes the reduction due to morbidity improvement.

5. The 5-Year Premium was projected with the 1332 Waiver Program.
    - Premiums are projected to increase by the components outlined in #4 above. The resulting impact to premium from the cost of the reinsurance program combined with the morbidity improvement make up the total decrease in baseline premiums.
    - Total reduction of 19.2% is the combination of 18.4% due to the program and 0.9% due to morbidity improvement.

6. A total savings to the federal government under the 1332 Waiver is calculated.
    - This savings is the difference in APTC dollars paid without the 1332 Waiver less the APTC dollars paid with the 1332 Waiver.
    - Total Net Federal savings is estimated as 1.3B

The results of the 5-Year projection are illustrated in the table below.

5-Year Projections, Impact to Federal Deficit

Before Reinsurance	2022	2023	2024	2025	2026	Total
Total Non-Group ACA-Compliant Avg. Enrollment	266,909	245,732	248,241	250,776	253,337	
APTC Avg. Enrollment	219,506	154,787	156,368	157,965	159,578	
Total Non-Group ACA-Compliant PMPM	$605.12	$641.43	$679.91	$709.83	$741.77	
Gross APTC PMPM	$627.57	$655.32	$684.31	$715.20	$748.68	
APTC PMPM	$532.87	$500.79	$528.23	$557.56	$589.47	
Total Premium	$1,938 M	$1,891 M	$2,025 M	$2,136 M	$2,255 M	$10,246 M
Total APTC	$1,404 M	$930 M	$991 M	$1,057 M	$1,129 M	$5,511 M
After Reinsurance	**2022**	**2023**	**2024**	**2025**	**2026**	**Total**
Reinsurance Funding	$341 M	$333 M	$357 M	$376 M	$397 M	
Reduction in Premiums (Reinsurance Funding)	-18.44%	-18.44%	-18.44%	-18.44%	-18.44%	
Reduction in Premiums (Morbidity Improvement)	-0.90%	-0.90%	-0.90%	-0.90%	-0.90%	
Enrollment Increase	2.5%	4.1%	3.7%	3.7%	3.7%	
Total Non-Group ACA-Compliant Avg. Enrollment	273,715	255,837	257,428	260,057	262,713	
APTC Avg. Enrollment	220,802	154,787	156,368	157,965	159,578	
Total Non-Group ACA-Compliant PMPM	$489.11	$517.40	$548.44	$572.57	$598.34	
Gross APTC PMPM	$507.35	$528.60	$551.98	$576.91	$603.91	
APTC PMPM	$414.02	$374.07	$395.91	$419.27	$444.70	
Total Premium	$1,607 M	$1,588 M	$1,694 M	$1,787 M	$1,886 M	$8,562 M
Total APTC	$1,097 M	$695 M	$743 M	$795 M	$852 M	$4,181 M
Estimated APTC Savings	$307 M	$235 M	$248 M	$262 M	$277 M	$1,330 M

Section 4: Disclosures and Limitations

4.1 Intended Users, Scope, and Purpose

This information has been prepared for the Colorado Division of Insurance (DOI) within the Department of Regulatory Agencies (DORA), and the State of Colorado to support their 1332 Waiver Application Extension. Lewis & Ellis, Inc. (L&E) understands that the report will be made public. The report should be reviewed in its entirety by qualified individuals. Parties reviewing this information should retain their own actuarial experts when interpreting results. It should not be used for any other purpose.

4.2 Qualifications

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

4.3 Risk/Uncertainty

The assumptions and results outlined in this report are inherently uncertain. Every effort was made, through scenario and sensitivity testing to review areas of uncertainty, including enrollment assumptions, change in medical costs over time, and changes in the morbidity of the non-group ACA market population. The pass-through funding assumes a 5% reduction for uncertainty and differences in calculation between the L&E model and the calculation performed by HHS and US Department of the Treasury. Actual results may vary, and L&E does not guarantee that predicted results will be realized. Any review an application of this report should be done with care by qualified professionals.

4.4 Conflicts of Interest

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

4.5 Data Reliance

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

4.6 Dates Applicable

This report was prepared in April 2021 and develops the ACA non-group marketplace experience for calendar year 2022, with and without the proposed 1332 Waiver Colorado reinsurance program. Further the report predicts the impact to the federal deficit from 2022 to 2026. This 5-year window is requested in the 1332 Waiver application extension. These findings should not be extrapolated or applied to any other period of time.

4.7 Subsequent Events

This report and the analysis provide herein are based on conditions specific to the ACA non-group marketplace in Colorado, as of April 2020. The report assumes no uncertain and potential future changes to the Affordable Care Act or the healthcare marketplace that could materially impact results. There are several future developments that could materially change these results including court rulings, new regulations, additional allowed ACA exemptions, or a material change to the healthcare markets in general. In addition, any changes made to the parameters or structure of the reinsurance program could have a material impact on the outcomes outlined above. These subsequent events are not included in this report and should be carefully considered by qualified experts before applying the findings contained within this report.

4.8 Contents of Report

This document, including a main report and several appendices, constitutes the entirety of the actuarial analysis required for a 1332 Waiver application. This report supersedes any previous communications on the reinsurance program.

Appendix: Methodology Details

Data and Reports Used

For this study, the following data sources were used:

- 2019 Non-Group Market EDGE premium and enrollment data, provided by Colorado insurance carriers[10]
- On-exchange 2019, 2020, 2021 enrollment reports from Connect for Health Colorado, Colorado's health insurance marketplace[11]
- Data extracts provided by Connect for Health Colorado showing on-exchange enrollment in February 2021.[12] This data includes Gross Premium, Net Premium, and APTC credits.
- Connect for Health 2022 enrollment projections, including the impact of the American Recue Plan (ARP)
- H.R. 1319 – American Rescue Plan Act of 2021
- Carrier 2020 and 2021 rate filings submitted in 2019 and 2020
- CSR and Premium Wrap Studies Performed for Colorado Department of Insurance by Oliver Wyman
- Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature, Mathematica Policy Research, Inc. March 24, 2006
- The Price Sensitivity of Demand for Nongroup Health Insurance, Congressional Budget Office, August 2005

Baseline 2022 and 2022 with program estimates

To create the 2022 baseline estimates, L&E performed the following steps:

1. Collected and summarized 2019 EDGE premium and enrollment for the Colorado non-group health insurance market. The data was compared to publicly available data, data provided by Division of Insurance, and the prior reinsurance report for consistency and reasonableness.

2. Collected and summarized February 2021 enrollment, using information provided by the Connect for Health Colorado. Enrollment is split by FPL level bands, age bands, geographic rating region, gross premium, APTC and net premium.

3. 2022 premium and claims were projected using the following assumptions:
   Annual Allowed Claims Trend Applied to 2019 EDGE Claims: 5%
   Annual Morbidity Increase: 1.0%
   Morbidity Increase assumed if the reinsurance program was not in place. Estimated using 2021 filings with and without reinsurance.
   Assumed Loss Ratio: 83.6% for baseline (81.0% used when reinsurance program is in place)
   Estimated using 2021 filings with and without reinsurance.
   Claims were categorized by geographical region and parameters were chosen so that claims reduction targets, as identified on page 4 were met. See the table below for results.

[10] Most recent full year of EDGE data available.
[11] https://connectforhealthco.com/metric-and-reports/
[12] Most recent data available.

Area	Reinsurance	Claims Decrease
1, 2, 3	43.0%	-19.1%
4, 6, 7, 8	50.0%	-22.3%
5, 9	73.0%	-31.1%
Total		-21.7%

Claims reduction of -21.7% was the result of $103.93 per member per month reduction. Resulting overall costs are illustrated below.

Claims Reduction PMPM	Anticipated Average Enrollment	Anticipated Member Months (Enrollment X 12)	Program Cost (Member Month X PMPM)
$103.93	273,715	3,284,576	$341.4M

4. 2022 Enrollment with reinsurance was projected using the following assumptions:
   - Begin with February 2021 on-exchange enrollment provided by Connect for Health Colorado. Use most recent available off-exchange enrollment statistics from 2021 rate filings.
   - Off exchange enrollment was assumed to remain level, however, 50% of these members are projected to shift to on-exchange taking advantage of the ARP subsidies.
   - On-exchange enrollment expectations were developed in conjunction with Connect for Health estimates and are illustrated below.

On-Exchange Enrollment

Description	Enrollment
Current (February 2021)	158,942
State CSR Funding	12,000
Move from Off-Exchange	29,108
ARP uptake	23,700
Covid SEP	12,400
Medicaid bridge post PHE	7,104
Standard Attrition	-2,668
Standard SEP enrollment	1,867
Easy Enrollment	2,153
Total	244,607

   - Total Enrollment with the reinsurance program is summarized below.

Enrollment, Current and Projected

On/Off Exchange	Feb 2021	Projected 2022 with Reinsurance, with ARP, with State CSR Funding
On-Exchange	158,942	244,607
On-Exchange Financially Assisted	111,349	220,802
On-Exchange Not Financially Assisted	47,593	23,805
Off-Exchange	58,216	29,108
Total	217,158	273,715

- Price elasticity studies indicate individual market price elasticities are between -.2 and -.6. We assumed a price elasticity of -0.5. That is for every 10% change in premium, 5% of members will drop their coverage. The resulting base enrollment is illustrated below. Note that APTC enrollment does not change by much as the members net premium does not change a significant amount due to APTCs in both scenarios.

Baseline and Waiver Estimates	Baseline: 2022 w/o Waiver, with ARP	2022 with waiver, with ARP
Average Annual Enrollment		
Total Non-Group ACA-Compliant	266,909	273,715
On-Exchange (Effectuated)	240,832	244,607
APTC Enrollment	219,506	220,802
Non-APTC Enrollment	21,326	23,805
Off-Exchange	26,077	29,108

5. 2022 Advance Premium Tax Credits were projected using the following assumptions:

- L&E applied the premium increase, described above, to the February 2021 enrollment and to SLCSPs.
- Enrollment changes were then applied to the February 2021 distribution.
- APTCs were calculated using an average FPL level and corresponding maximum premium as illustrated below.

Family Count	FPL_LEVEL	2021 ACA Lower Limit	2021 ACA Upper Limit	American Rescue Plan Lower Limit	American Rescue Plan Upper Limit	2021 ACA Assumed Max Prem	ARP Assumed Max Prem	FPL Average	FPL Level
1	0-100% FPL	2.07%	2.07%	0.00%	0.00%	11.11	0.00	50%	$12,880
1	100.01-133% FPL	2.07%	2.07%	0.00%	0.00%	27.86	0.00	125%	$12,880
1	133.01-150% FPL	3.10%	4.14%	0.00%	0.00%	61.17	0.00	146%	$12,880
1	150.01-200% FPL	4.14%	6.52%	0.00%	2.00%	120.84	31.16	189%	$12,880
1	200.01-250% FPL	6.52%	8.33%	2.00%	4.00%	202.58	90.62	239%	$12,880
1	250.01-300% FPL	8.33%	9.83%	4.00%	6.00%	293.71	171.55	289%	$12,880
1	300.01-400% FPL	9.83%	9.83%	6.00%	8.50%	397.77	320.68	377%	$12,880
1	400.01%-ABOVE FPL	NA	NA	8.50%	8.50%	NA	473.35	519%	$12,880
2	0-100% FPL	2.07%	2.07%	0.00%	0.00%	7.51	0.00	50%	$17,420
2	100.01-133% FPL	2.07%	2.07%	0.00%	0.00%	18.84	0.00	125%	$17,420
2	133.01-150% FPL	3.10%	4.14%	0.00%	0.00%	41.36	0.00	146%	$17,420
2	150.01-200% FPL	4.14%	6.52%	0.00%	2.00%	81.72	21.07	189%	$17,420
2	200.01-250% FPL	6.52%	8.33%	2.00%	4.00%	137.00	61.28	239%	$17,420
2	250.01-300% FPL	8.33%	9.83%	4.00%	6.00%	198.62	116.01	289%	$17,420
2	300.01-400% FPL	9.83%	9.83%	6.00%	8.50%	268.99	216.86	377%	$17,420
2	400.01%-ABOVE FPL	NA	NA	8.50%	8.50%	NA	320.10	519%	$17,420
3	0-100% FPL	2.07%	2.07%	0.00%	0.00%	6.31	0.00	50%	$21,960
3	100.01-133% FPL	2.07%	2.07%	0.00%	0.00%	15.84	0.00	125%	$21,960
3	133.01-150% FPL	3.10%	4.14%	0.00%	0.00%	34.76	0.00	146%	$21,960
3	150.01-200% FPL	4.14%	6.52%	0.00%	2.00%	68.68	17.71	189%	$21,960
3	200.01-250% FPL	6.52%	8.33%	2.00%	4.00%	115.13	51.50	239%	$21,960
3	250.01-300% FPL	8.33%	9.83%	4.00%	6.00%	166.92	97.50	289%	$21,960
3	300.01-400% FPL	9.83%	9.83%	6.00%	8.50%	226.06	182.25	377%	$21,960
3	400.01%-ABOVE FPL	NA	NA	8.50%	8.50%	NA	269.01	519%	$21,960
4+	0-100% FPL	2.07%	2.07%	0.00%	0.00%	5.35	0.00	50%	$31,040
4+	100.01-133% FPL	2.07%	2.07%	0.00%	0.00%	13.43	0.00	125%	$31,040
4+	133.01-150% FPL	3.10%	4.14%	0.00%	0.00%	29.48	0.00	146%	$31,040
4+	150.01-200% FPL	4.14%	6.52%	0.00%	2.00%	58.24	15.02	189%	$31,040
4+	200.01-250% FPL	6.52%	8.33%	2.00%	4.00%	97.64	43.68	239%	$31,040
4+	250.01-300% FPL	8.33%	9.83%	4.00%	6.00%	141.56	82.68	289%	$31,040
4+	300.01-400% FPL	9.83%	9.83%	6.00%	8.50%	191.72	154.56	377%	$31,040
4+	400.01%-ABOVE FPL	NA	NA	8.50%	8.50%	NA	228.15	519%	$31,040

6. Summarized results from the outlined steps above are in the table below.

Baseline and Waiver Estimates	Baseline: 2022 w/o Waiver, with ARP	2022 with waiver, with ARP
Average Annual Enrollment		
Total Non-Group ACA-Compliant	266,909	273,715
On-Exchange (Effectuated)	240,832	244,607
APTC Enrollment	219,506	220,802
Non-APTC Enrollment	21,326	23,805
Off-Exchange	26,077	29,108
Per Member Per Month Premium		
Total Non-Group ACA-Compliant PMPM	$605	$489
On-Exchange Premium PMPM	$615	$498
Gross APTC Premium PMPM	$628	$507
APTC PMPM	$533	$414
Net APTC Premium PMPM	$95	$93
Non-APTC Premium PMPM	$501	$408
Off-Exchange Premium PMPM	$512	$417
Total Annual Dollars		
Total Non-Group ACA-Compliant Premium	$1,938,139,440	$1,606,533,458
Total APTC	$1,403,616,083	$1,096,998,218
APTC Savings Compared to Baseline		$306,617,865
Cost of Reinsurance Program		$341,365,999
Percent Funded by APTC Savings		89.8%

Scenario Testing

To test assumptions, and to provide a range of possible outcomes under a variety of circumstances, L&E calculated results under various scenarios apart from the previously-stated best-case scenario. The following scenarios were considered:

1. Best Estimate- Our best estimate of results based on the parameters outlined above.
2. Good Experience not realized in premium - here we assume claims trend is lower than anticipated, however it is not realized until after pricing. Therefore, premium and enrollment are the same. Lower trend results in claims 4% lower than anticipated. Program cost decreases and APTC savings increase.
3. Good Experience realized in premium - here we assume claims trend is lower than anticipated and it is realized before pricing. Therefore, premium decreases and enrollment increases. Lower trend results in claims 4% lower than anticipated. Program cost decreases due to claims and increases due to enrollment. APTC savings increases with enrollment.
4. Poor Experience not realized in premium - here we assume claims trend is higher than anticipated, however it is not realized until after pricing. Therefore, premium and enrollment are left the same. Higher trend results in claims 4% higher than anticipated. Program cost increases and APTC savings decrease.
5. Poor Experience realized in premium - here we assume claims trend is higher than anticipated and it is realized before pricing. Therefore, premium increases and enrollment decreases. Higher trend results in claims 4% higher than anticipated. Program cost increases due to claims and decreases due to enrollment. APTC savings decreases with enrollment.
6. Lower enrollment on APTC. Here we assume enrollment increases expected due to ARP are 10% lower than expected. Enrollment decreases lowering program cost, however, APTC enrollment decreases at a higher rate than total enrollment. Therefore, APTC savings are not as high, relatively compared to program cost decreases.

A detailed summary of results is illustrated in the table below.

Scenario #	1- Best Estimate	2- Good Experience not realized in premium	3- Good Experience and realized in Premium	4- Poor Experience but not realized in premium	5- Poor Experience and realized in Premium	6- Lower Enrollment on APTC
Description ($ millions)	Expected Trend, Expected Enrollment	Lower Claims Trend	Lower trend, Lower Premiums, Higher Enrollment	Higher Claims Trend	Higher Claims Trend, Higher Premium, Lower Enrollment	Lower enrollment on APTC
2020 without Reinsurance						
Total Non-Group Enrollment	266,909	266,909	280,254	266,909	253,564	244,958
Exchange Enrollment	240,832	240,832	252,873	240,832	228,790	218,881
APTC Enrollment	219,506	219,506	230,481	197,555	219,506	197,555
Total Non-Group Premium PMPM	$605.12	$605.12	$575.82	$595.69	$648.31	$604.20
Exchange Premium PMPM	$615.22	$616.33	$585.52	$604.76	$659.77	$615.20
Gross APTC PMPM	$627.57	$627.57	$596.19	$627.57	$665.22	$627.57
Net APTC PMPM	$94.70	$94.70	$93.75	$94.70	$95.65	$94.70
Total Annual Non-Group Premiums	$1,938.1M	$1,938.1M	$1,936.5M	$1,907.9M	$1,972.7M	$1,776.0M
Total Annual APTCs	$1,403.6M	$1,403.6M	$1,389.6M	$1,263.3M	$1,500.3M	$1,263.3M
After Reinsurance						
Total Non-Group Enrollment	273,715	273,715	287,400	273,715	260,029	250,468
Exchange Enrollment	244,607	243,310	255,476	221,360	243,310	221,360
APTC Enrollment	220,802	219,506	230,481	197,555	219,506	197,555
Percent Change in Total Enrollment	2.5%	2.5%	2.5%	2.5%	2.5%	2.2%
Reinsurance Program Cost	$341.4M	$327.8M	$344.2M	$355.2M	$337.4M	$312.4M
Percent Change to Premiums	-19.2%	-19.2%	-19.4%	-19.2%	-16.2%	-19.3%
Total Non-Group PMPM	$489.11	$488.69	$464.26	$481.46	$543.07	$487.43
Exchange Premium PMPM	$497.68	$497.63	$472.75	$496.67	$527.49	$496.67
Gross APTC PMPM	$507.35	$507.35	$481.98	$507.35	$537.79	$507.35
Net APTC PMPM	$93.33	$93.33	$92.40	$93.33	$94.26	$93.33
Total Annual Non-Group Premiums	$1,606.5M	$1,605.1M	$1,601.1M	$1,581.4M	$1,694.6M	$1,465.0M
Total Annual APTCs	$1,097.0M	$1,090.6M	$1,077.5M	$981.5M	$1,168.3M	$981.5M
Results						
Estimate APTC Savings	$306.6M	$313.1M	$312.1M	$281.8M	$332.0M	$281.8M
Estimated Net Federal Savings (5% reduct	$289.5M	$296.7M	$294.9M	$264.0M	$315.2M	$266.1M
Percent of program funded by Pass Throug	84.8%	90.5%	85.7%	74.3%	93.4%	85.2%
Cost to State	$51.8M	$31.2M	$49.3M	$91.2M	$22.2M	$46.2M

Attachment 1

An Act

HOUSE BILL 19-1168

BY REPRESENTATIVE(S) McCluskie and Rich, Buckner, Esgar, Kennedy, McLachlan, Roberts, Soper, Bird, Caraveo, Cutter, Duran, Exum, Froelich, Garnett, Gonzales-Gutierrez, Gray, Herod, Hooton, Jackson, Jaquez Lewis, Kipp, Lontine, Michaelson Jenet, Mullica, Singer, Sirota, Snyder, Valdez A., Valdez D., Weissman, Will, Becker, Arndt, Buentello, Galindo, Melton, Tipper, Titone;
also SENATOR(S) Donovan and Rankin, Bridges, Coram, Crowder, Fenberg, Fields, Ginal, Gonzales, Pettersen, Rodriguez, Story, Todd, Winter, Garcia.

CONCERNING THE CREATION OF THE COLORADO REINSURANCE PROGRAM TO PROVIDE REINSURANCE PAYMENTS TO HEALTH INSURERS TO AID IN PAYING HIGH-COST INSURANCE CLAIMS, AND, IN CONNECTION THEREWITH, AUTHORIZING THE COMMISSIONER OF INSURANCE TO SEEK APPROVAL FROM THE FEDERAL GOVERNMENT TO WAIVE APPLICABLE FEDERAL REQUIREMENTS, REQUEST FEDERAL FUNDS, OR BOTH, TO ENABLE THE STATE TO IMPLEMENT THE PROGRAM, MAKING THE PROGRAM CONTINGENT UPON WAIVER OR FUNDING APPROVAL, AND MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

SECTION 1. In Colorado Revised Statutes, **add** part 11 to article 16 of title 10 as follows:

PART 11
COLORADO REINSURANCE PROGRAM

10-16-1101. Short title. THE SHORT TITLE OF THIS PART 11 IS THE "COLORADO REINSURANCE PROGRAM ACT".

10-16-1102. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT:

(a) ALL COLORADANS DESERVE ACCESS TO HIGH-QUALITY, AFFORDABLE HEALTH CARE TO HELP SUPPORT THEIR WELL-BEING AND ECONOMIC SECURITY;

(b) INCREASING COSTS OF HEALTH CARE IN COLORADO HAVE LED TO PREMIUM INCREASES FOR HEALTH INSURANCE IN THE INDIVIDUAL MARKET THAT HAVE CREATED A FINANCIAL BURDEN FOR SOME COLORADANS PURCHASING INSURANCE IN THE INDIVIDUAL MARKET;

(c) THAT BURDEN IS HEIGHTENED IN RURAL AREAS OF THE STATE, WHERE PREMIUMS ARE CONSIDERABLY HIGHER THAN IN METROPOLITAN AREAS OF THE STATE AND THERE IS A LACK OF COMPETITION AMONG HEALTH CARE PROVIDERS AND CARRIERS;

(d) BECAUSE OF THE FINANCIAL BURDEN HIGH-COST HEALTH INSURANCE PLACES ON CONSUMERS IN RURAL AREAS, A CONSIDERABLE NUMBER OF THESE COST-BURDENED CONSUMERS MAY NOT PURCHASE HEALTH INSURANCE, EXACERBATING THE PROBLEMS OF FEW CARRIERS, FEW PLAN OPTIONS, AND HIGH HEALTH INSURANCE COSTS IN RURAL REGIONS, AS WELL AS INCREASING THE NUMBER OF UNINSURED COLORADANS; AND

(e) COLORADO HAS HISTORICALLY BEEN A NATIONAL LEADER IN HEALTH CARE INNOVATION, AND IT IS IMPORTANT TO USE THAT INNOVATIVE SPIRIT TO ADDRESS THE RISING COSTS OF HEALTH CARE IN THE STATE BY DIRECTING THE COMMISSIONER OF INSURANCE TO CREATE A REINSURANCE PROGRAM THAT WILL:

(I) MAKE PRIVATE HEALTH INSURANCE IN THE INDIVIDUAL MARKET

MORE ACCESSIBLE AND AFFORDABLE;

(II) ENCOURAGE PARTICIPATION AND COMPETITION BY CARRIERS THROUGHOUT THE STATE, BUT PARTICULARLY IN RURAL AREAS OF THE STATE, IN ORDER TO GIVE CONSUMERS THE ABILITY TO SEEK VALUE IN HEALTH INSURANCE COVERAGE;

(III) DECREASE COSTS OF CARE, LEADING TO LOWER PREMIUMS AND RESTRAINING, IF NOT DECREASING, THE GROWTH IN FEDERAL SPENDING COMMITMENTS IN THE INDIVIDUAL MARKET; AND

(IV) SUPPORT AND EMPOWER, AND INCREASE ACCESS TO AFFORDABLE, HIGH-VALUE HEALTH INSURANCE FOR, CONSUMERS WHO ARE INELIGIBLE FOR PREMIUM TAX CREDIT SUBSIDIES WHILE MINIMIZING ANY POTENTIAL NEGATIVE EFFECTS ON ACCESS TO AFFORDABLE, HIGH-VALUE INSURANCE FOR CONSUMERS WHO ARE ELIGIBLE FOR PREMIUM TAX CREDIT SUBSIDIES AND COST SHARING REDUCTIONS.

10-16-1103. Definitions. AS USED IN THIS PART 11, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ATTACHMENT POINT" MEANS THE AMOUNT SET BY THE COMMISSIONER PURSUANT TO SECTION 10-16-1105 (2) FOR CLAIMS COSTS INCURRED BY AN ELIGIBLE CARRIER FOR A COVERED PERSON'S COVERED BENEFITS IN A BENEFIT YEAR, ABOVE WHICH THE CLAIMS COSTS FOR BENEFITS ARE ELIGIBLE FOR REINSURANCE PAYMENTS UNDER THE REINSURANCE PROGRAM.

(2) "BENEFIT YEAR" MEANS THE CALENDAR YEAR FOR WHICH AN ELIGIBLE CARRIER PROVIDES COVERAGE THROUGH AN INDIVIDUAL HEALTH BENEFIT PLAN.

(3) "COINSURANCE RATE" MEANS THE RATE SET BY THE COMMISSIONER PURSUANT TO SECTION 10-16-1105 (2) AT WHICH THE REINSURANCE PROGRAM WILL REIMBURSE AN ELIGIBLE CARRIER FOR CLAIMS INCURRED FOR A COVERED PERSON'S COVERED BENEFITS IN A BENEFIT YEAR, WHICH CLAIMS EXCEED THE ATTACHMENT POINT BUT ARE BELOW THE REINSURANCE CAP.

(4) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE, THE

COMMISSIONER'S DEPUTIES, OR THE DIVISION OF INSURANCE, AS APPROPRIATE.

(5) "ELIGIBLE CARRIER" MEANS A CARRIER THAT:

(a) OFFERS INDIVIDUAL HEALTH BENEFIT PLANS THAT COMPLY WITH THE FEDERAL ACT; AND

(b) INCURS CLAIMS COSTS FOR A COVERED PERSON'S COVERED BENEFITS IN THE APPLICABLE BENEFIT YEAR.

(6) "HOSPITAL" MEANS A HOSPITAL LICENSED OR CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT PURSUANT TO SECTION 25-1.5-103 (1)(a).

(7) "MEDICAID" MEANS FEDERAL INSURANCE OR ASSISTANCE AS PROVIDED BY TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, AND THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4, 5, AND 6 OF TITLE 25.5.

(8) "MEDICARE" MEANS FEDERAL INSURANCE OR ASSISTANCE PROVIDED BY THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, 42 U.S.C. SEC. 1395 ET SEQ.

(9) "PAYMENT PARAMETERS" MEANS THE ATTACHMENT POINT, REINSURANCE CAP, AND COINSURANCE RATE FOR THE REINSURANCE PROGRAM.

(10) "REINSURANCE CAP" MEANS THE AMOUNT SET BY THE COMMISSIONER PURSUANT TO SECTION 10-16-1105 (2) FOR CLAIMS COSTS INCURRED BY AN ELIGIBLE CARRIER FOR A COVERED PERSON'S COVERED BENEFITS, ABOVE WHICH AMOUNT THE CLAIMS COSTS FOR BENEFITS ARE NO LONGER ELIGIBLE FOR REINSURANCE PAYMENTS.

(11) "REINSURANCE PAYMENT" MEANS AN AMOUNT PAID TO AN ELIGIBLE CARRIER UNDER THE REINSURANCE PROGRAM.

(12) "REINSURANCE PROGRAM" OR "PROGRAM" MEANS THE COLORADO REINSURANCE PROGRAM ESTABLISHED UNDER SECTION

10-16-1105.

(13) "STATE INNOVATION WAIVER" MEANS A WAIVER OF ONE OR MORE REQUIREMENTS OF THE FEDERAL ACT AUTHORIZED BY SECTION 1332 OF THE FEDERAL ACT, CODIFIED IN 42 U.S.C. SEC. 18052, AND APPLICABLE FEDERAL REGULATIONS.

10-16-1104. Commissioner powers and duties - rules - study and report. (1) THE COMMISSIONER HAS ALL POWERS NECESSARY TO IMPLEMENT THIS PART 11 AND IS SPECIFICALLY AUTHORIZED TO:

(a) ENTER INTO CONTRACTS AS NECESSARY OR PROPER TO CARRY OUT THE PROVISIONS AND PURPOSES OF THIS PART 11, INCLUDING CONTRACTS FOR THE ADMINISTRATION OF THE REINSURANCE PROGRAM AND WITH APPROPRIATE ADMINISTRATIVE STAFF, CONSULTANTS, AND LEGAL COUNSEL;

(b) TAKE LEGAL ACTION AS NECESSARY TO AVOID THE PAYMENT OF IMPROPER CLAIMS UNDER THE REINSURANCE PROGRAM;

(c) ESTABLISH ADMINISTRATIVE AND ACCOUNTING PROCEDURES FOR THE OPERATION OF THE REINSURANCE PROGRAM;

(d) ESTABLISH PROCEDURES AND STANDARDS FOR CARRIERS TO SUBMIT CLAIMS UNDER THE REINSURANCE PROGRAM;

(e) ESTABLISH OR ADJUST THE PAYMENT PARAMETERS IN ACCORDANCE WITH SECTION 10-16-1105 (2) FOR EACH BENEFIT YEAR;

(f) ASSESS SPECIAL FEES AGAINST HOSPITALS AND, IF APPLICABLE, CARRIERS FOR THE CONTINUOUS OPERATION OF THE REINSURANCE PROGRAM, AS PROVIDED IN SECTION 10-16-1108;

(g) APPLY FOR A STATE INNOVATION WAIVER, FEDERAL FUNDS, OR BOTH, IN ACCORDANCE WITH SECTION 10-16-1109, FOR THE IMPLEMENTATION AND OPERATION OF THE REINSURANCE PROGRAM;

(h) APPLY FOR, ACCEPT, ADMINISTER, AND EXPEND GIFTS, GRANTS, AND DONATIONS AND ANY FEDERAL OR STATE FUNDS THAT MAY BECOME AVAILABLE FOR THE REINSURANCE PROGRAM; AND

(i) ADOPT RULES AS NECESSARY TO IMPLEMENT, ADMINISTER, AND ENFORCE THIS PART 11, INCLUDING RULES NECESSARY TO ALIGN STATE LAW WITH ANY FEDERAL PROGRAM AND RULES. THE RULES SHALL BE ADOPTED IN ACCORDANCE WITH THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, INCLUDING THE REQUIREMENT TO ESTABLISH A REPRESENTATIVE GROUP OF PARTICIPANTS PURSUANT TO SECTION 24-4-103 (2).

(2) (a) IF THE REINSURANCE PROGRAM IS APPROVED PURSUANT TO SECTION 10-16-1109, THE COMMISSIONER, DURING IMPLEMENTATION OF THE PROGRAM, SHALL EVALUATE THE EFFECT OF THE PROGRAM ON ACCESS TO AFFORDABLE, HIGH-VALUE HEALTH INSURANCE FOR CONSUMERS WHO ARE ELIGIBLE FOR PREMIUM TAX CREDIT SUBSIDIES AND COST SHARING REDUCTIONS AND MINIMIZE ANY POTENTIAL NEGATIVE EFFECTS ON THOSE CONSUMERS.

(b) AFTER THE SECOND FULL YEAR OF OPERATION OF THE PROGRAM, THE COMMISSIONER SHALL COMPLETE A STUDY THAT EVALUATES:

(I) THE EFFECTS OF THE PROGRAM ON ACCESS TO AFFORDABLE, HIGH-VALUE HEALTH INSURANCE FOR CONSUMERS WHO ARE ELIGIBLE FOR PREMIUM TAX CREDIT SUBSIDIES AND COST SHARING REDUCTIONS; AND

(II) HEALTH PLAN AFFORDABILITY, INCLUDING COST SHARING AND PREMIUMS.

(c) THE COMMISSIONER SHALL ISSUE A REPORT ON THE STUDY WITHIN ONE HUNDRED TWENTY DAYS AFTER THE END OF THE SECOND FULL YEAR OF OPERATION OF THE PROGRAM, POST THE REPORT ON THE DIVISION'S WEBSITE, AND SUBMIT THE REPORT TO THE GOVERNOR, THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES OR ITS SUCCESSOR COMMITTEE, AND THE HOUSE OF REPRESENTATIVES HEALTH AND INSURANCE COMMITTEE OR ITS SUCCESSOR COMMITTEE.

10-16-1105. Reinsurance program - creation - enterprise status - subject to waiver or funding approval - operation - payment parameters - calculation of reinsurance payments - eligible carrier requests - definition. (1) (a) THERE IS HEREBY CREATED IN THE DIVISION THE COLORADO REINSURANCE PROGRAM TO PROVIDE REINSURANCE PAYMENTS TO ELIGIBLE CARRIERS. IMPLEMENTATION AND OPERATION OF

THE REINSURANCE PROGRAM IS CONTINGENT UPON APPROVAL OF THE STATE INNOVATION WAIVER OR FEDERAL FUNDING REQUEST SUBMITTED BY THE COMMISSIONER IN ACCORDANCE WITH SECTION 10-16-1109.

(b) (I) THE REINSURANCE PROGRAM CONSTITUTES AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION AS LONG AS THE COMMISSIONER, ON BEHALF OF THE PROGRAM, RETAINS AUTHORITY TO ISSUE REVENUE BONDS AND THE PROGRAM RECEIVES LESS THAN TEN PERCENT OF ITS TOTAL REVENUES IN GRANTS, AS DEFINED IN SECTION 24-77-102 (7), FROM ALL COLORADO STATE AND LOCAL GOVERNMENTS COMBINED. SO LONG AS IT CONSTITUTES AN ENTERPRISE PURSUANT TO THIS SECTION, THE PROGRAM IS NOT A DISTRICT FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION.

(II) SUBJECT TO APPROVAL BY THE GENERAL ASSEMBLY, EITHER BY BILL OR JOINT RESOLUTION, AND AFTER APPROVAL BY THE GOVERNOR PURSUANT TO SECTION 39 OF ARTICLE V OF THE STATE CONSTITUTION, THE COMMISSIONER, ON BEHALF OF THE REINSURANCE PROGRAM, IS HEREBY AUTHORIZED TO ISSUE REVENUE BONDS FOR THE EXPENSES OF THE PROGRAM, SECURED BY REVENUES OF THE PROGRAM.

(c) IF THE STATE INNOVATION WAIVER OR FEDERAL FUNDING REQUEST SUBMITTED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-1109 IS APPROVED, THE COMMISSIONER SHALL IMPLEMENT AND OPERATE THE REINSURANCE PROGRAM IN ACCORDANCE WITH THIS SECTION.

(d) THE COMMISSIONER SHALL COLLECT OR ACCESS DATA FROM EACH ELIGIBLE CARRIER AS NECESSARY TO DETERMINE REINSURANCE PAYMENTS, ACCORDING TO THE DATA REQUIREMENTS UNDER SUBSECTION (3)(c) OF THIS SECTION.

(e) (I) ON A QUARTERLY BASIS DURING THE APPLICABLE BENEFIT YEAR:

(A) EACH ELIGIBLE CARRIER SHALL REPORT TO THE COMMISSIONER ITS CLAIMS COSTS THAT EXCEED THE ATTACHMENT POINT FOR THAT BENEFIT YEAR;

(B) EACH HOSPITAL THAT IS SUBJECT TO THE SPECIAL FEES ASSESSED PURSUANT TO SECTION 10-16-1108 SHALL REPORT TO THE COMMISSIONER

THE AMOUNT THE HOSPITAL IS RESPONSIBLE FOR FUNDING IN THE BENEFIT YEAR; AND

(C) IF SPECIAL FEES ARE ASSESSED AGAINST CARRIERS PURSUANT TO SECTION 10-16-1108 (1)(b), EACH CARRIER THAT IS SUBJECT TO THE SPECIAL FEES SHALL REPORT TO THE COMMISSIONER ON ITS COLLECTED ASSESSMENTS IN THAT BENEFIT YEAR.

(II) FOR EACH APPLICABLE BENEFIT YEAR, THE COMMISSIONER SHALL NOTIFY ELIGIBLE CARRIERS OF REINSURANCE PAYMENTS TO BE MADE FOR THE APPLICABLE BENEFIT YEAR NO LATER THAN JUNE 30 OF THE YEAR FOLLOWING THE APPLICABLE BENEFIT YEAR. BY AUGUST 15 OF THE YEAR FOLLOWING THE APPLICABLE BENEFIT YEAR, THE COMMISSIONER SHALL DISBURSE ALL APPLICABLE REINSURANCE PAYMENTS TO AN ELIGIBLE CARRIER.

(2) (a) FOR PURPOSES OF DETERMINING ELIGIBILITY FOR AND CALCULATING REINSURANCE PAYMENTS UNDER THE REINSURANCE PROGRAM FOR THE 2020 BENEFIT YEAR IN ORDER TO MAKE PRIVATE HEALTH INSURANCE COVERAGE MORE ACCESSIBLE AND AFFORDABLE AND ENCOURAGE INCREASED CARRIER PARTICIPATION IN RURAL PARTS OF THE STATE, THE COMMISSIONER SHALL SET THE PAYMENT PARAMETERS AT AMOUNTS TO ACHIEVE:

(I) A REDUCTION IN CLAIMS COSTS OF BETWEEN THIRTY AND THIRTY-FIVE PERCENT IN GEOGRAPHIC RATING AREA NUMBERS FIVE AND NINE;

(II) A REDUCTION IN CLAIMS COSTS OF BETWEEN TWENTY AND TWENTY-FIVE PERCENT IN GEOGRAPHIC RATING AREA NUMBERS FOUR, SIX, SEVEN, AND EIGHT; AND

(III) A REDUCTION IN CLAIMS COSTS OF BETWEEN FIFTEEN AND TWENTY PERCENT IN GEOGRAPHIC RATING AREA NUMBERS ONE, TWO, AND THREE.

(b) FOR THE 2021 BENEFIT YEAR, AFTER A STAKEHOLDER PROCESS, THE COMMISSIONER SHALL ESTABLISH AND PUBLISH THE PAYMENT PARAMETERS FOR THAT BENEFIT YEAR BY MARCH 15, 2020. IN SETTING THE PAYMENT PARAMETERS UNDER THIS SUBSECTION (2)(b), THE COMMISSIONER

SHALL CONSIDER THE FOLLOWING FACTORS AS THEY APPLY IN EACH GEOGRAPHIC RATING AREA IN THE STATE:

(I) PARTICIPATION AND COMPETITION BY CARRIERS IN THE INDIVIDUAL MARKET;

(II) ENROLLMENT ACROSS ALL INCOME LEVELS AND MORBIDITY IN THE INDIVIDUAL MARKET;

(III) PARTICIPATION AND COMPETITION BY PROVIDERS; AND

(IV) RATES IN THE INDIVIDUAL MARKET.

(c) IF THE AMOUNT OF MONEY FROM FUNDING SOURCES SPECIFIED IN SECTION 10-16-1107 IS ANTICIPATED TO BE INADEQUATE TO FULLY FUND THE PAYMENT PARAMETERS, THE COMMISSIONER SHALL ESTABLISH NEW PAYMENT PARAMETERS WITHIN THE AVAILABLE MONEY. THE COMMISSIONER SHALL ALLOW AN ELIGIBLE CARRIER TO REVISE AN APPLICABLE RATE FILING FOR THE NEXT BENEFIT YEAR BASED ON THE FINAL PAYMENT PARAMETERS ESTABLISHED PURSUANT TO THIS SUBSECTION (2)(c) AND ON ACTUAL REINSURANCE PAYMENTS RECEIVED BY THE ELIGIBLE CARRIER.

(3) (a) AN ELIGIBLE CARRIER THAT MEETS THE REQUIREMENTS OF THIS SUBSECTION (3) AND SUBSECTION (4) OF THIS SECTION MAY REQUEST REINSURANCE PAYMENTS FROM THE REINSURANCE PROGRAM.

(b) AN ELIGIBLE CARRIER MUST MAKE REQUESTS FOR REINSURANCE PAYMENTS IN ACCORDANCE WITH THE REQUIREMENTS ESTABLISHED BY THE COMMISSIONER.

(c) TO RECEIVE REINSURANCE PAYMENTS THROUGH THE REINSURANCE PROGRAM, AN ELIGIBLE CARRIER MUST, BY APRIL 30 OF THE YEAR FOLLOWING THE BENEFIT YEAR FOR WHICH REINSURANCE PAYMENTS ARE REQUESTED:

(I) PROVIDE THE COMMISSIONER WITH ACCESS TO THE DATA WITHIN THE DEDICATED DATA ENVIRONMENT ESTABLISHED BY THE ELIGIBLE CARRIER UNDER THE FEDERAL RISK ADJUSTMENT PROGRAM UNDER 42 U.S.C. SEC. 18063; AND

(II) SUBMIT TO THE COMMISSIONER AN ATTESTATION THAT THE CARRIER HAS COMPLIED WITH THE DEDICATED DATA ENVIRONMENTS, DATA REQUIREMENTS, ESTABLISHMENT AND USAGE OF MASKED ENROLLEE IDENTIFICATION NUMBERS, AND DATA SUBMISSION DEADLINES.

(d) AN ELIGIBLE CARRIER SHALL MAINTAIN RECORDS SUFFICIENT TO SUBSTANTIATE THE REQUESTS FOR REINSURANCE PAYMENTS MADE PURSUANT TO THIS SECTION FOR AT LEAST SIX YEARS. AN ELIGIBLE CARRIER SHALL ALSO MAKE THOSE RECORDS AVAILABLE UPON REQUEST FROM THE COMMISSIONER FOR PURPOSES OF VERIFICATION, INVESTIGATION, AUDIT, OR OTHER REVIEW OF REINSURANCE PAYMENT REQUESTS.

(e) THE COMMISSIONER MAY HAVE AN ELIGIBLE CARRIER AUDITED TO ASSESS THE CARRIER'S COMPLIANCE WITH THIS SECTION. THE ELIGIBLE CARRIER SHALL ENSURE THAT ITS CONTRACTORS, SUBCONTRACTORS, AND AGENTS COOPERATE WITH ANY AUDIT UNDER THIS SECTION.

(4) (a) (I) THE COMMISSIONER SHALL CALCULATE EACH REINSURANCE PAYMENT BASED ON AN ELIGIBLE CARRIER'S INCURRED CLAIMS COSTS FOR A COVERED PERSON'S COVERED BENEFITS IN THE APPLICABLE BENEFIT YEAR. IF THE CLAIMS COSTS DO NOT EXCEED THE ATTACHMENT POINT FOR THE APPLICABLE BENEFIT YEAR, THE CARRIER IS NOT ELIGIBLE FOR A REINSURANCE PAYMENT.

(II) IF THE CLAIMS COSTS EXCEED THE ATTACHMENT POINT FOR THE APPLICABLE BENEFIT YEAR, THE COMMISSIONER SHALL CALCULATE THE REINSURANCE PAYMENT AS THE PRODUCT OF THE COINSURANCE RATE AND THE ELIGIBLE CARRIER'S CLAIMS COSTS, UP TO THE REINSURANCE CAP.

(b) A CARRIER IS INELIGIBLE FOR REINSURANCE PAYMENTS FOR CLAIMS COSTS FOR A COVERED PERSON'S COVERED BENEFITS IN THE APPLICABLE BENEFIT YEAR THAT EXCEED THE REINSURANCE CAP.

(c) THE COMMISSIONER SHALL ENSURE THAT REINSURANCE PAYMENTS MADE TO AN ELIGIBLE CARRIER DO NOT EXCEED THE TOTAL AMOUNT PAID BY THE ELIGIBLE CARRIER FOR ANY ELIGIBLE CLAIM. "TOTAL AMOUNT PAID BY THE ELIGIBLE CARRIER FOR ANY ELIGIBLE CLAIM" MEANS THE AMOUNT PAID BY THE ELIGIBLE CARRIER BASED ON THE ALLOWED AMOUNT LESS ANY DEDUCTIBLE, COINSURANCE, OR COPAYMENT, AS OF THE TIME THE DATA ARE SUBMITTED OR MADE ACCESSIBLE UNDER SUBSECTION

(3)(c) OF THIS SECTION.

(d) AN ELIGIBLE CARRIER MAY REQUEST THAT THE COMMISSIONER RECONSIDER A DECISION ON THE CARRIER'S REQUEST FOR REINSURANCE PAYMENTS WITHIN THIRTY DAYS AFTER NOTICE OF THE COMMISSIONER'S DECISION. A FINAL ACTION OR ORDER OF THE COMMISSIONER UNDER THIS SUBSECTION (4)(d) IS SUBJECT TO JUDICIAL REVIEW IN ACCORDANCE WITH SECTION 24-4-106.

(5) IN ORDER TO PROMOTE MORE COST-EFFECTIVE HEALTH CARE COVERAGE AND TO BE FAIR TO FEDERAL TAXPAYERS BY RESTRAINING GROWTH IN FEDERAL SPENDING COMMITMENTS, THE COMMISSIONER SHALL REQUIRE EACH ELIGIBLE CARRIER THAT PARTICIPATES IN THE PROGRAM TO FILE WITH THE COMMISSIONER, BY A DATE AND IN A FORM AND MANNER SPECIFIED BY THE COMMISSIONER BY RULE, THE CARE MANAGEMENT PROTOCOLS THE ELIGIBLE CARRIER WILL USE TO MANAGE CLAIMS WITHIN THE PAYMENT PARAMETERS.

10-16-1106. Accounting - reports - audits. (1) THE COMMISSIONER SHALL MAINTAIN AN ACCOUNTING FOR EACH BENEFIT YEAR OF ALL:

(a) MONEY EXPENDED FOR REINSURANCE PAYMENTS AND ADMINISTRATIVE AND OPERATIONAL EXPENSES;

(b) REQUESTS FOR REINSURANCE PAYMENTS RECEIVED FROM ELIGIBLE CARRIERS;

(c) REINSURANCE PAYMENTS MADE TO ELIGIBLE CARRIERS; AND

(d) ADMINISTRATIVE AND OPERATIONAL EXPENSES INCURRED FOR THE REINSURANCE PROGRAM.

(2) BY NOVEMBER 1 OF THE YEAR FOLLOWING THE APPLICABLE BENEFIT YEAR OR SIXTY CALENDAR DAYS AFTER THE FINAL DISBURSEMENT OF REINSURANCE PAYMENTS FOR THE APPLICABLE BENEFIT YEAR, WHICHEVER IS LATER, THE COMMISSIONER SHALL MAKE AVAILABLE TO THE PUBLIC A REPORT SUMMARIZING THE REINSURANCE PROGRAM'S OPERATIONS FOR EACH BENEFIT YEAR. THE COMMISSIONER SHALL POST THE REPORT ON THE DIVISION'S WEBSITE.

(3) THE REINSURANCE PROGRAM IS SUBJECT TO AUDIT BY THE STATE AUDITOR. THE COMMISSIONER SHALL ENSURE THAT ALL OF THE REINSURANCE PROGRAM'S CONTRACTORS, SUBCONTRACTORS, AND AGENTS COOPERATE WITH THE AUDIT.

(4) ON OR BEFORE NOVEMBER 1, 2020, AND ON OR BEFORE NOVEMBER 1, 2021, THE DIVISION SHALL INCLUDE AN UPDATE REGARDING THE PROGRAM IN ITS REPORT TO THE MEMBERS OF THE APPLICABLE COMMITTEES OF REFERENCE IN THE SENATE AND HOUSE OF REPRESENTATIVES AS REQUIRED BY THE "STATE MEASUREMENT FOR ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2 OF ARTICLE 7 OF TITLE 2.

10-16-1107. Funding for reinsurance program - sources - permitted uses - reinsurance program cash fund - calculation of total funding for program. (1) (a) THERE IS HEREBY CREATED IN THE STATE TREASURY THE REINSURANCE PROGRAM CASH FUND, WHICH CONSISTS OF:

(I) FEDERAL PASS-THROUGH FUNDING GRANTED PURSUANT TO 42 U.S.C. SEC. 18052 (a)(3) OR ANY OTHER FEDERAL FUNDS THAT ARE MADE AVAILABLE FOR THE REINSURANCE PROGRAM;

(II) SPECIAL FEES ASSESSED AGAINST HOSPITALS AND, IF APPLICABLE, CARRIERS AS PROVIDED IN SECTION 10-16-1108;

(III) THE FOLLOWING AMOUNTS TRANSFERRED FROM THE GENERAL FUND TO THE REINSURANCE PROGRAM CASH FUND, BUT ONLY IF HOUSE BILL 19-1245 IS ENACTED AT THE FIRST REGULAR SESSION OF THE SEVENTY-SECOND GENERAL ASSEMBLY AND BECOMES LAW:

(A) FIFTEEN MILLION DOLLARS, TRANSFERRED TO THE FUND ON JUNE 30, 2020; AND

(B) FORTY MILLION DOLLARS, TRANSFERRED TO THE FUND ON JUNE 30, 2021;

(IV) AN AMOUNT OF PREMIUM TAX REVENUES DEPOSITED IN THE FUND PURSUANT TO SECTION 10-3-209 (4)(a)(III); AND

(V) ANY MONEY THE GENERAL ASSEMBLY APPROPRIATES TO THE

FUND FOR THE PROGRAM.

(b) ALL MONEY DEPOSITED OR PAID INTO OR APPROPRIATED TO THE REINSURANCE PROGRAM CASH FUND, INCLUDING INTEREST OR INCOME EARNED ON THE INVESTMENT OF MONEY IN THE FUND, IS CONTINUOUSLY AVAILABLE AND APPROPRIATED TO THE DIVISION TO BE EXPENDED IN ACCORDANCE WITH THIS PART 11. ANY INTEREST OR INCOME EARNED ON THE INVESTMENT OF MONEY IN THE FUND SHALL BE CREDITED TO THE FUND.

(c) THE REINSURANCE PROGRAM CASH FUND IS PART OF THE REINSURANCE PROGRAM ENTERPRISE ESTABLISHED PURSUANT TO SECTION 10-16-1105 (1)(b).

(2) THE COMMISSIONER MAY SEEK, ACCEPT, AND EXPEND GIFTS, GRANTS, OR DONATIONS FROM PRIVATE OR PUBLIC SOURCES FOR THE OPERATION, RESERVES, AND SUSTAINABILITY OF THE REINSURANCE PROGRAM.

(3) THE COMMISSIONER MAY EXPEND MONEY RECEIVED FROM THE SOURCES SPECIFIED IN SUBSECTIONS (1) AND (2) OF THIS SECTION FOR:

(a) REINSURANCE PAYMENTS UNDER THE REINSURANCE PROGRAM; AND

(b) ADMINISTRATIVE AND OPERATING EXPENSES OF THE REINSURANCE PROGRAM, THE COMMISSIONER, AND THE DIVISION UNDER THIS PART 11.

10-16-1108. Special assessments against hospitals and carriers - rules - enforcement. (1) (a) (I) FOR THE 2020 AND 2021 BENEFIT YEARS, AS APPLICABLE, THE COMMISSIONER MAY ASSESS SPECIAL FEES AGAINST HOSPITALS, SUBJECT TO THE FOLLOWING:

(A) FEES ASSESSED AGAINST HOSPITALS MUST COMPLY WITH AND NOT VIOLATE 42 CFR 433.68 AND, IN ANY YEAR, MUST NOT EXCEED THE LESSER OF FORTY MILLION DOLLARS OR THE MAXIMUM AMOUNT ALLOWED UNDER 42 CFR 433.68; AND

(B) NO HOSPITAL SYSTEM SHALL BE RESPONSIBLE FOR FUNDING, ON A YEARLY BASIS, MORE THAN TWENTY-FIVE PERCENT OF THE TOTAL FUNDING

REQUIRED FOR THE PROGRAM.

(II) THE COMMISSIONER SHALL NOT FUND THE PROGRAM THROUGH ANY TYPE OF FEE SCHEDULE, RATE SETTING, OR OTHER COST-SAVING MECHANISM IMPOSED ON HOSPITALS.

(b) (I) FOR ANY BENEFIT YEAR STARTING ON OR AFTER JANUARY 1, 2020, IF, AFTER CARRIERS HAVE FILED AND THE COMMISSIONER HAS APPROVED RATES FOR THE BENEFIT YEAR, THE FEDERAL GOVERNMENT SUSPENDS THE FEE IMPOSED PURSUANT TO SECTION 9010 OF THE FEDERAL ACT FOR THAT BENEFIT YEAR, THE COMMISSIONER SHALL ASSESS AGAINST CARRIERS A SPECIAL FEE OF TWO AND TWO-TENTHS PERCENT OF PREMIUMS COLLECTED BY CARRIERS, OR A SPECIAL FEE IN AN AMOUNT EQUAL TO THE AMOUNT OF THE FEE IMPOSED BY THE FEDERAL GOVERNMENT PURSUANT TO SECTION 9010 OF THE FEDERAL ACT IF THAT FEE AMOUNT IS DIFFERENT THAN THE AMOUNT SPECIFIED IN THIS SUBSECTION (1)(b)(I), FOR THE PERIOD THAT CARRIERS COLLECTED THE FEE IMPOSED PURSUANT TO SECTION 9010 OF THE FEDERAL ACT.

(II) THIS SUBSECTION (1)(b) DOES NOT APPLY TO PLANS OR BENEFITS PROVIDED UNDER MEDICARE, MEDICAID, OR THE "CHILDREN'S BASIC HEALTH PLAN" ESTABLISHED UNDER ARTICLE 8 OF TITLE 25.5.

(c) THE COMMISSIONER SHALL USE THE SPECIAL FEES ASSESSED PURSUANT TO THIS SUBSECTION (1) TO PAY THE ADMINISTRATIVE AND OPERATING EXPENSES OF THE REINSURANCE PROGRAM, INCLUDING REINSURANCE PAYMENTS AND EXPENSES OF THE PROGRAM, THE COMMISSIONER, AND THE DIVISION.

(d) THE COMMISSIONER SHALL TRANSMIT SPECIAL FEES COLLECTED PURSUANT TO THIS SUBSECTION (1) TO THE STATE TREASURER FOR DEPOSIT IN THE REINSURANCE PROGRAM CASH FUND CREATED IN SECTION 10-16-1107.

(2) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT THIS SECTION, INCLUDING:

(a) THE REASONABLE TIME PERIODS FOR THE BILLING AND COLLECTION OF THE SPECIAL FEES; AND

(b) DETERMINING THE AMOUNT OF THE ASSESSMENT ON HOSPITALS IN ACCORDANCE WITH SUBSECTION (1)(a) OF THIS SECTION.

(3) A HOSPITAL SHALL PAY THE SPECIAL FEES IMPOSED PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION FROM ITS GENERAL REVENUES AND IS PROHIBITED FROM:

(a) COLLECTING AN ASSESSMENT FROM CONSUMERS AS ANY TYPE OF SURCHARGE ON ITS FEES;

(b) PASSING THE SPECIAL FEES ON TO CONSUMERS AS ANY TYPE OF INCREASE TO FEES OR CHARGES FOR SERVICES; OR

(c) OTHERWISE PASSING THE SPECIAL FEE ON TO CONSUMERS IN ANY MANNER.

(4) IF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES IN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES INFORMS THE STATE THAT THE STATE WILL NOT BE IN COMPLIANCE WITH 42 CFR 433 AS A RESULT OF THE SPECIAL FEES ASSESSED ON HOSPITALS PURSUANT TO THIS SECTION, THE COMMISSIONER SHALL REDUCE THE AMOUNT OF THE SPECIAL FEES AS NECESSARY TO AVOID ANY REDUCTION IN THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTED PURSUANT TO SECTION 25.5-4-402.4.

(5) IF A HOSPITAL OR CARRIER, IF APPLICABLE, FAILS TO PAY A SPECIAL FEE TO THE COMMISSIONER IN ACCORDANCE WITH THE TIME PERIODS ESTABLISHED BY RULE, THE COMMISSIONER MAY USE ALL POWERS CONFERRED BY THE INSURANCE LAWS OF THIS STATE TO ENFORCE PAYMENT OF THE SPECIAL FEES.

10-16-1109. State innovation waiver - federal funding - Colorado reinsurance program. (1) (a) FOR PURPOSES OF IMPLEMENTING AND OPERATING THE REINSURANCE PROGRAM AS SET FORTH IN THIS PART 11 FOR PLAN YEARS STARTING ON OR AFTER JANUARY 1, 2020, THE COMMISSIONER MAY APPLY TO THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR:

(I) A TWO-YEAR STATE INNOVATION WAIVER IN ACCORDANCE WITH SECTION 1332 OF THE FEDERAL ACT, CODIFIED AT 42 U.S.C. SEC. 18052, AND

45 CFR 155.1300;

(II) FEDERAL FUNDS FOR THE REINSURANCE PROGRAM; OR

(III) A STATE INNOVATION WAIVER AND FEDERAL FUNDS.

(b) AN APPLICATION FOR A STATE INNOVATION WAIVER OR FOR FEDERAL FUNDS MUST CLEARLY STATE THAT OPERATION OF THE REINSURANCE PROGRAM IS CONTINGENT ON APPROVAL OF THE WAIVER OR FUNDING REQUEST.

(c) THE COMMISSIONER SHALL ENSURE THAT A WAIVER APPLICATION SUBMITTED PURSUANT TO THIS SECTION COMPLIES WITH THE REQUIREMENTS SPECIFIED IN SECTION 1332 OF THE FEDERAL ACT, CODIFIED AT 42 U.S.C. SEC. 18052, AND 45 CFR 155.1308.

(d) THE COMMISSIONER SHALL INCLUDE IN A WAIVER APPLICATION A REQUEST FOR A PASS-THROUGH OF FEDERAL FUNDING IN ACCORDANCE WITH SECTION 1332 (a)(3) OF THE FEDERAL ACT, 42 U.S.C. SEC. 18052 (a)(3), TO ALLOW THE STATE TO OBTAIN AND USE, FOR PURPOSES OF HELPING FUND THE REINSURANCE PROGRAM, ANY FEDERAL FUNDS THAT WOULD, ABSENT THE WAIVER, BE USED TO PAY ADVANCE PAYMENT TAX CREDITS AND COST-SHARING REDUCTIONS AUTHORIZED UNDER THE FEDERAL ACT.

(2) THE COMMISSIONER SHALL NOTIFY THE FOLLOWING IN WRITING OF ANY FEDERAL ACTIONS REGARDING THE WAIVER OR FUNDING REQUEST:

(a) THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY;

(b) THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES OR ANY SUCCESSOR COMMITTEE; AND

(c) THE HOUSE OF REPRESENTATIVES COMMITTEES ON HEALTH AND INSURANCE AND PUBLIC HEALTH CARE AND HUMAN SERVICES OR ANY SUCCESSOR COMMITTEES.

10-16-1110. Repeal of part - notice to revisor of statutes. (1) (a) THE COMMISSIONER SHALL NOTIFY THE REVISOR OF STATUTES IN WRITING, BY E-MAIL SENT TO REVISOROFSTATUTES.GA@STATE.CO.US, UPON RECEIPT FROM THE SECRETARY OF THE UNITED STATES DEPARTMENT OF

HEALTH AND HUMAN SERVICES OF NOTICE OF APPROVAL OR DENIAL OF THE WAIVER OR FUNDING REQUESTED UNDER SECTION 10-16-1109.

(b) (I) IF THE NOTICE FROM THE COMMISSIONER STATES THAT THE WAIVER OR FUNDING WAS DENIED, THIS PART 11 IS REPEALED, EFFECTIVE UPON THE DATE IDENTIFIED IN THE NOTICE THAT THE WAIVER OR FUNDING WAS DENIED OR, IF THE NOTICE DOES NOT SPECIFY THAT DATE, UPON THE DATE OF THE NOTICE OF DENIAL TO THE REVISOR OF STATUTES.

(II) IF THE NOTICE FROM THE COMMISSIONER STATES THAT THE WAIVER OR FUNDING WAS APPROVED, THIS SUBSECTION (1) IS REPEALED, EFFECTIVE UPON THE DATE IDENTIFIED IN THE NOTICE THAT THE WAIVER OR FUNDING WAS APPROVED OR, IF THE NOTICE DOES NOT SPECIFY THAT DATE, UPON THE DATE OF THE NOTICE OF APPROVAL TO THE REVISOR OF STATUTES.

(2) THIS PART 11 IS REPEALED, EFFECTIVE SEPTEMBER 1, 2023.

SECTION 2. In Colorado Revised Statutes, 10-3-209, **amend** (4)(a) as follows:

10-3-209. Tax on premiums collected - exemptions - penalties - repeal. (4) (a) The division of insurance shall transmit all taxes, penalties, and fines it collects under this section to the state treasurer for deposit in the general fund; except that the state treasurer shall deposit amounts in the specified cash funds as follows:

(I) In the division of insurance cash fund created in section 10-1-103 (3), an amount that is equal to the general assembly's appropriation from the fund to the division for its direct and indirect expenditures less the total fee revenue that is deposited in the fund; except that the amount deposited in the fund under this subparagraph (I) ~~may~~ SHALL not exceed five percent of all taxes collected under this section; ~~and~~

(II) In the wildfire emergency response fund created in section 24-33.5-1226 ~~C.R.S.,~~ and the wildfire preparedness fund created in section 24-33.5-1227, ~~C.R.S.,~~ the amount of the taxes, penalties, and fines that the general assembly appropriates to each of the cash funds; AND

(III) (A) FOR THE 2020-21 AND 2021-22 FISCAL YEARS, IN THE REINSURANCE PROGRAM CASH FUND CREATED IN SECTION 10-16-1107, AN

AMOUNT EQUAL TO THE AMOUNT OF PREMIUM TAXES COLLECTED PURSUANT TO THIS SECTION IN THE 2020 CALENDAR YEAR THAT EXCEEDS THE AMOUNT OF PREMIUM TAXES COLLECTED PURSUANT TO THIS SECTION IN THE 2019 CALENDAR YEAR.

(B) THIS SUBSECTION (4)(a)(III) IS REPEALED, EFFECTIVE SEPTEMBER 1, 2023.

SECTION 3. Appropriation. For the 2019-20 state fiscal year, $785,904 is appropriated to the department of regulatory agencies for use by the division of insurance. This appropriation is from the division of insurance cash fund created in section 10-1-103 (3), C.R.S., and is based on an assumption that the division will require an additional 3.0 FTE. To implement this act, the division may use this appropriation for the Colorado reinsurance program.

SECTION 4. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

KC Becker
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Leroy M. Garcia
PRESIDENT OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED May 17, 2019 at 1:46 p.m.
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

SENATE BILL 20-215

BY SENATOR(S) Moreno and Donovan, Bridges, Danielson, Fenberg, Fields, Ginal, Gonzales, Pettersen, Rodriguez, Story;
also REPRESENTATIVE(S) Kennedy and McCluskie, Benavidez, Bird, Buckner, Buentello, Caraveo, Coleman, Cutter, Duran, Esgar, Gonzales-Gutierrez, Gray, Herod, Hooton, Jaquez Lewis, Kipp, Lontine, Melton, Michaelson Jenet, Mullica, Roberts, Snyder, Valdez A., Valdez D., Weissman, Woodrow.

CONCERNING MEASURES TO ADDRESS THE AFFORDABILITY OF HEALTH INSURANCE FOR COLORADANS PURCHASING COVERAGE ON THE INDIVIDUAL MARKET, AND, IN CONNECTION THEREWITH, ESTABLISHING AN ENTERPRISE TO ADMINISTER A HEALTH INSURANCE AFFORDABILITY FEE ASSESSED ON CERTAIN HEALTH INSURERS AND A SPECIAL ASSESSMENT ON HOSPITALS TO FUND MEASURES TO REDUCE CONSUMER COSTS FOR INDIVIDUAL HEALTH COVERAGE PLANS.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** part 12 to article 16 of title 10 as follows:

PART 12

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

HEALTH INSURANCE AFFORDABILITY ACT

10-16-1201. Short title. THE SHORT TITLE OF THIS PART 12 IS THE "HEALTH INSURANCE AFFORDABILITY ACT".

10-16-1202. Legislative declaration. (1) THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(a) THE STATE, CARRIERS, AND HOSPITALS SHARE A COMMON COMMITMENT TO ENSURING ALL COLORADANS HAVE ACCESS TO AFFORDABLE HEALTH CARE COVERAGE BECAUSE ACCESS TO COVERAGE IMPROVES HEALTH OUTCOMES AND PROVIDES FINANCIAL SECURITY FOR COLORADANS;

(b) HOSPITALS WITHIN THE STATE INCUR THE COSTS OF UNCOMPENSATED CARE TO UNINSURED AND UNDERINSURED POPULATIONS;

(c) THE ECONOMIC DOWNTURN DUE TO COVID-19 AND ITS IMPACTS ON GROUP AND INDIVIDUAL HEALTH CARE COVERAGE IN THE STATE CREATES ECONOMIC CHALLENGES FOR CARRIERS FROM THE POTENTIAL LOST REVENUE IF PEOPLE DROP INSURANCE COVERAGE;

(d) THIS PART 12 IS ENACTED TO PROVIDE THE FOLLOWING SERVICES AND BENEFITS TO CARRIERS:

(I) REDUCING THE NUMBER OF COLORADANS WHO LACK HEALTH CARE COVERAGE BY HELPING COLORADANS TO MAINTAIN CONSISTENT COVERAGE;

(II) PROVIDING STABILITY IN THE INSURANCE MARKET;

(III) REDUCING THE MOVEMENT OF INDIVIDUALS BETWEEN INSURED AND UNINSURED STATUS;

(IV) OFFSETTING THE COSTS CARRIERS WOULD OTHERWISE PAY FOR COVERED PERSONS' HIGH MEDICAL COSTS SO THAT PREMIUMS ARE SET AT MORE AFFORDABLE LEVELS; AND

(V) CREATING A HEALTHIER RISK POOL FOR ALL CARRIERS BY ESTABLISHING A PATH FOR CONSISTENT COVERAGE FOR INDIVIDUALS; AND

(e) THIS PART 12 IS ENACTED TO PROVIDE THE FOLLOWING SERVICES AND BENEFITS TO HOSPITALS:

(I) REDUCING THE AMOUNT OF UNCOMPENSATED CARE PROVIDED BY HOSPITALS;

(II) REDUCING THE NEED OF PROVIDERS TO SHIFT COSTS OF PROVIDING UNCOMPENSATED CARE TO OTHER PAYERS; AND

(III) EXPANDING ACCESS TO HIGH-QUALITY, AFFORDABLE HEALTH CARE FOR LOW-INCOME AND UNINSURED COLORADANS.

(2) THE GENERAL ASSEMBLY FURTHER FINDS AND DECLARES THAT, CONSISTENT WITH THE DETERMINATION OF THE COLORADO SUPREME COURT IN *NICHOLL V. E-470 PUBLIC HIGHWAY AUTHORITY*, 896 P.2d 859 (COLO. 1995), THE POWER TO IMPOSE TAXES IS INCONSISTENT WITH ENTERPRISE STATUS UNDER SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION, AND THE HEALTH INSURANCE AFFORDABILITY FEES AND SPECIAL ASSESSMENTS CHARGED AND COLLECTED BY THE HEALTH INSURANCE AFFORDABILITY ENTERPRISE ARE FEES, NOT TAXES, BECAUSE THE FEES AND ASSESSMENTS ARE IMPOSED FOR THE SPECIFIC PURPOSE OF ALLOWING THE ENTERPRISE TO DEFRAY THE COSTS OF PROVIDING THE BUSINESS SERVICES SPECIFIED IN SECTION 10-16-1204 (1)(a) TO THE CARRIERS AND HOSPITALS THAT PAY THE FEES AND ASSESSMENTS AND ARE COLLECTED AT RATES THAT ARE REASONABLY CALCULATED BASED ON THE BENEFITS RECEIVED BY THOSE CARRIERS AND HOSPITALS.

10-16-1203. Definitions. AS USED IN THIS PART 12, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "BOARD" MEANS THE HEALTH INSURANCE AFFORDABILITY BOARD CREATED IN SECTION 10-16-1207.

(2) "CHILDREN'S BASIC HEALTH PLAN" HAS THE MEANING SET FORTH IN SECTION 25.5-8-103 (2).

(3) "ENTERPRISE" MEANS THE COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE CREATED IN SECTION 10-16-1204.

(4) "FEDERAL POVERTY LINE" HAS THE SAME MEANING AS "POVERTY

LINE", AS DEFINED IN 42 U.S.C. SEC. 9902 (2).

(5) "FEE" MEANS THE HEALTH INSURANCE AFFORDABILITY FEE ESTABLISHED AND ASSESSED PURSUANT TO SECTION 10-16-1205.

(6) "FUND" MEANS THE HEALTH INSURANCE AFFORDABILITY CASH FUND CREATED IN SECTION 10-16-1206.

(7) "HOUSEHOLD INCOME" HAS THE SAME MEANING AS SET FORTH IN 26 U.S.C. SEC. 36B (d)(2) OF THE FEDERAL "INTERNAL REVENUE CODE OF 1986", AS AMENDED.

(8) "MEDICAID" MEANS FEDERAL INSURANCE OR ASSISTANCE AS PROVIDED BY TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, AND THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4, 5, AND 6 OF TITLE 25.5.

(9) "MEDICARE" MEANS FEDERAL INSURANCE OR ASSISTANCE PROVIDED BY THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, 42 U.S.C. SEC. 1395 ET SEQ.

(10) "PREMIUM TAX CREDIT" MEANS THE REFUNDABLE TAX CREDIT AVAILABLE PURSUANT TO THE FEDERAL ACT TO ASSIST CERTAIN INDIVIDUALS IN PURCHASING A HEALTH BENEFIT PLAN ON THE EXCHANGE.

(11) "PUBLIC BENEFIT CORPORATION" MEANS A PUBLIC BENEFIT CORPORATION FORMED PURSUANT TO PART 5 OF ARTICLE 101 OF TITLE 7 THAT IS ORGANIZED AND OPERATED BY THE EXCHANGE PURSUANT TO SECTION 10-22-106 (3) FOR THE PURPOSE OF ADMINISTERING AND OPERATING A SUBSIDY TO REDUCE THE COSTS OF HEALTH CARE COVERAGE OFFERED UNDER A STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLAN.

(12) "QUALIFIED INDIVIDUAL" MEANS AN INDIVIDUAL, REGARDLESS OF IMMIGRATION STATUS, WHO:

(a) IS A COLORADO RESIDENT;

(b) HAS A HOUSEHOLD INCOME OF NOT MORE THAN THREE HUNDRED PERCENT OF THE FEDERAL POVERTY LINE; AND

(c) IS NOT ELIGIBLE FOR THE PREMIUM TAX CREDIT, MEDICAID, MEDICARE, OR THE CHILDREN'S BASIC HEALTH PLAN.

(13) "REINSURANCE PROGRAM" MEANS THE COLORADO REINSURANCE PROGRAM CREATED IN PART 11 OF THIS ARTICLE 16.

(14) "REINSURANCE PROGRAM CASH FUND" MEANS THE REINSURANCE PROGRAM CASH FUND CREATED IN SECTION 10-16-1107.

(15) "STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLAN" MEANS A SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLAN OFFERED BY CARRIERS TO QUALIFIED INDIVIDUALS THROUGH THE PUBLIC BENEFIT CORPORATION.

10-16-1204. Health insurance affordability enterprise - creation - powers and duties - assess and allocate health insurance affordability fee and special assessment. (1) (a) THERE IS HEREBY CREATED IN THE DIVISION THE COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE. THE ENTERPRISE IS AND OPERATES AS A GOVERNMENT-OWNED BUSINESS WITHIN THE DIVISION FOR THE PURPOSE OF ASSESSING AND COLLECTING THE HEALTH INSURANCE AFFORDABILITY FEE FROM CARRIERS THAT OFFER HEALTH BENEFIT PLANS IN THE STATE AND A SPECIAL ASSESSMENT ON HOSPITALS IN THE STATE AND USING AND ALLOCATING THE FEE AND ASSESSMENT FOR THE PURPOSES SPECIFIED IN THIS PART 12 IN ORDER TO:

(I) PROVIDE THE FOLLOWING BUSINESS SERVICES TO CARRIERS THAT PAY THE FEE:

(A) OUTREACH AND RELATED WORK TO INCREASE ENROLLMENT IN HEALTH BENEFIT PLANS OFFERED BY CARRIERS ACROSS THE STATE;

(B) INCREASING THE NUMBER OF INDIVIDUALS WHO PURCHASE HEALTH BENEFIT PLANS IN THE INDIVIDUAL MARKET BY PROVIDING FINANCIAL SUPPORT TO INDIVIDUALS TO PURCHASE PRIVATE HEALTH INSURANCE COVERAGE;

(C) FUNDING THE REINSURANCE PROGRAM THAT OFFSETS THE COSTS CARRIERS WOULD OTHERWISE PAY FOR COVERING CONSUMERS WITH HIGH MEDICAL COSTS;

(D) IMPROVING THE STABILITY OF THE MARKET THROUGHOUT THE STATE BY PROVIDING CONSISTENT PRIVATE HEALTH CARE COVERAGE AND REDUCING THE MOVEMENT OF INDIVIDUALS FROM INSURED TO UNINSURED STATUS;

(E) REDUCING PROVIDER COST SHIFTING FROM THE INDIVIDUAL MARKET AND THE UNINSURED TO THE GROUP MARKET; AND

(F) CREATING A HEALTHIER RISK POOL FOR ALL CARRIERS BY ESTABLISHING A PATH FOR CONSISTENT COVERAGE FOR INDIVIDUALS; AND

(II) PROVIDE THE FOLLOWING BUSINESS SERVICES TO HOSPITALS:

(A) REDUCING THE AMOUNT OF UNCOMPENSATED CARE PROVIDED BY HOSPITALS;

(B) REDUCING THE NEED OF PROVIDERS TO SHIFT COSTS OF PROVIDING UNCOMPENSATED CARE TO OTHER PAYERS; AND

(C) EXPANDING ACCESS TO HIGH-QUALITY, AFFORDABLE HEALTH CARE FOR LOW-INCOME AND UNINSURED COLORADANS.

(b) (I) THE ENTERPRISE CONSTITUTES AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION SO LONG AS IT RETAINS THE AUTHORITY TO ISSUE REVENUE BONDS AND RECEIVES LESS THAN TEN PERCENT OF ITS TOTAL REVENUES IN GRANTS, AS DEFINED IN SECTION 24-77-102 (7), FROM ALL COLORADO STATE AND LOCAL GOVERNMENTS COMBINED. SO LONG AS IT CONSTITUTES AN ENTERPRISE PURSUANT TO THIS SECTION, THE ENTERPRISE IS NOT A DISTRICT FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION.

(II) THE ENTERPRISE IS HEREBY AUTHORIZED TO ISSUE REVENUE BONDS FOR THE EXPENSES OF THE ENTERPRISE, SECURED BY REVENUES OF THE ENTERPRISE.

(2) THE ENTERPRISE'S PRIMARY POWERS AND DUTIES ARE:

(a) TO ASSESS AND COLLECT THE FEE SPECIFIED IN SECTION 10-16-1205 (1)(a)(I);

(b) TO ASSESS AND COLLECT THE SPECIAL ASSESSMENT ON HOSPITALS SPECIFIED IN SECTION 10-16-1205 (1)(a)(II);

(c) TO ALLOCATE MONEY IN THE FUND IN ACCORDANCE WITH SECTION 10-16-1205 (2);

(d) TO ISSUE REVENUE BONDS PAYABLE FROM THE REVENUES OF THE ENTERPRISE;

(e) (I) TO ENGAGE THE SERVICES OF THIRD PARTIES SERVING AS CONTRACTORS AND CONSULTANTS, INCLUDING THE DIVISION, FOR PROFESSIONAL AND TECHNICAL ASSISTANCE AND ADVICE AND TO SUPPLY OTHER SERVICES RELATED TO THE CONDUCT OF THE AFFAIRS OF THE ENTERPRISE, WITHOUT REGARD TO THE "PROCUREMENT CODE", ARTICLES 101 TO 112 OF TITLE 24. THE ENTERPRISE SHALL ENCOURAGE DIVERSITY IN APPLICATIONS FOR CONTRACTS AND SHALL GENERALLY AVOID USING SINGLE-SOURCE BIDS.

(II) THE DIVISION SHALL PROVIDE OFFICE SPACE AND ADMINISTRATIVE STAFF TO THE ENTERPRISE PURSUANT TO A CONTRACT ENTERED INTO UNDER THIS SUBSECTION (2)(e).

(f) TO ENGAGE IN OUTREACH AND RELATED EFFORTS TO INCREASE ENROLLMENT IN HEALTH BENEFIT PLANS ACROSS THE STATE; AND

(g) TO ADOPT AND AMEND OR REPEAL POLICIES FOR THE REGULATION OF ITS AFFAIRS AND THE CONDUCT OF ITS BUSINESS CONSISTENT WITH THIS PART 12.

(3) THE ENTERPRISE SHALL EXERCISE ITS POWERS AND PERFORM ITS DUTIES AS IF THE SAME WERE TRANSFERRED TO THE DIVISION BY A **TYPE 2** TRANSFER, AS DEFINED IN SECTION 24-1-105.

10-16-1205. Health insurance affordability fee - special assessment on hospitals - allocation of revenues. (1) (a) (I) STARTING IN THE 2021 CALENDAR YEAR, THE ENTERPRISE SHALL ASSESS AND COLLECT FROM CARRIERS, BY JULY 15 EACH YEAR, A HEALTH INSURANCE AFFORDABILITY FEE. THE FEE AMOUNT IS BASED ON THE FOLLOWING PERCENTAGES OF PREMIUMS COLLECTED BY THE FOLLOWING CARRIERS IN THE IMMEDIATELY PRECEDING CALENDAR YEAR ON HEALTH BENEFIT PLANS

ISSUED IN THE STATE:

(A) ONE AND FIFTEEN HUNDREDTHS PERCENT OF PREMIUMS COLLECTED BY NONPROFIT CARRIERS; AND

(B) TWO AND ONE-TENTH PERCENT OF PREMIUMS COLLECTED BY FOR-PROFIT CARRIERS.

(II) FOR THE 2022 AND 2023 CALENDAR YEARS, THE ENTERPRISE SHALL ASSESS AND COLLECT FROM HOSPITALS A SPECIAL ASSESSMENT OF TWENTY MILLION DOLLARS PER YEAR, SUBJECT TO SUBSECTION (5) OF THIS SECTION. THE ENTERPRISE SHALL NOT COLLECT THE SPECIAL ASSESSMENT FOR THE 2022 CALENDAR YEAR BEFORE OCTOBER 1, 2022.

(b) THE ENTERPRISE SHALL USE THE FEE, THE SPECIAL ASSESSMENT ON HOSPITALS, AND ANY OTHER MONEY AVAILABLE IN THE FUND AS FOLLOWS, ALLOCATED IN ACCORDANCE WITH SUBSECTION (2) OF THIS SECTION:

(I) TO PROVIDE FUNDING FOR THE REINSURANCE PROGRAM;

(II) TO PROVIDE PAYMENTS TO CARRIERS TO INCREASE THE AFFORDABILITY OF HEALTH INSURANCE ON THE INDIVIDUAL MARKET FOR COLORADANS WHO RECEIVE THE PREMIUM TAX CREDIT;

(III) TO PROVIDE SUBSIDIES FOR STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLANS PURCHASED BY QUALIFIED INDIVIDUALS;

(IV) TO PAY THE ACTUAL ADMINISTRATIVE COSTS OF THE ENTERPRISE FOR IMPLEMENTING AND ADMINISTERING THIS PART 12, LIMITED TO THREE PERCENT OF THE ENTERPRISE'S REVENUES. ACTUAL ADMINISTRATIVE COSTS INCLUDE THE FOLLOWING:

(A) THE ADMINISTRATIVE COSTS OF THE ENTERPRISE, INCLUDING THE COSTS TO IMPLEMENT AND ADMINISTER THE PROGRAMS ESTABLISHED PURSUANT TO THIS PART 12;

(B) THE ENTERPRISE'S ACTUAL COSTS RELATED TO IMPLEMENTING AND MAINTAINING THE FEE AND SPECIAL ASSESSMENT ON HOSPITALS, INCLUDING PERSONAL SERVICES AND OPERATING EXPENSES; AND

(C) THE COSTS FOR CONDUCTING ANALYSES NECESSARY TO DETERMINE THE PAYMENTS TO BE MADE TO CARRIERS FOR THE PURPOSES DESCRIBED IN SUBSECTION (1)(b)(II) OF THIS SECTION AND THE REQUIREMENTS FOR STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLANS OFFERED BY CARRIERS; AND

(V) TO PAY THE COSTS FOR CONSUMER ENROLLMENT, OUTREACH, AND EDUCATION ACTIVITIES REGARDING HEALTH CARE COVERAGE, INCLUDING:

(A) INCREASING GRANTS TO THE EXCHANGE'S CERTIFIED ASSISTANCE NETWORK;

(B) MARKETING FOR THE EXCHANGE;

(C) GRANTS TO COMMUNITY-BASED ORGANIZATIONS THAT ARE ABLE TO ASSIST WITH OUTREACH AND ENROLLMENT, PARTICULARLY IN COMMUNITIES THAT FACE THE GREATEST BARRIERS TO ENROLLING IN HEALTH CARE COVERAGE; AND

(D) IMPROVING THE CONNECTION BETWEEN UNEMPLOYMENT SERVICES AND ENROLLMENT IN HEALTH CARE COVERAGE.

(c) THIS SUBSECTION (1) DOES NOT APPLY TO PLANS OR BENEFITS PROVIDED UNDER MEDICAID, MEDICARE, OR THE CHILDREN'S BASIC HEALTH PLAN.

(2) (a) THE ENTERPRISE SHALL TRANSMIT THE FEES AND SPECIAL ASSESSMENTS COLLECTED PURSUANT TO THIS SECTION TO THE STATE TREASURER FOR DEPOSIT IN THE HEALTH INSURANCE AFFORDABILITY CASH FUND CREATED IN SECTION 10-16-1206 AND, EXCEPT AS PROVIDED IN SUBSECTION (4) OF THIS SECTION, SHALL ALLOCATE THE MONEY IN THE FUND IN ACCORDANCE WITH THIS SUBSECTION (2).

(b) THE ENTERPRISE SHALL ALLOCATE THE REVENUES COLLECTED IN 2021, AND ANY OTHER MONEY DEPOSITED IN THE FUND IN 2021, AS FOLLOWS:

(I) UP TO THREE PERCENT FOR ACTUAL ADMINISTRATIVE COSTS AS SET FORTH IN SUBSECTION (1)(b)(IV) OF THIS SECTION;

(II) TO THE REINSURANCE PROGRAM CASH FUND, AN AMOUNT NECESSARY TO FUND THE PAYMENT PARAMETERS OF THE REINSURANCE PROGRAM, AS DETERMINED PURSUANT TO SECTION 10-16-1105 (2), NOT TO EXCEED NINETY MILLION DOLLARS OR, IF THE REVENUES COLLECTED PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION ARE LESS THAN NINETY MILLION DOLLARS, THE AMOUNT COLLECTED; AND

(III) OF ANY REMAINING BALANCE IN THE FUND AFTER DEDUCTING THE ALLOCATIONS SPECIFIED IN SUBSECTIONS (2)(b)(I) AND (2)(b)(II) OF THIS SECTION:

(A) UP TO ONE PERCENT OF THE TOTAL AMOUNT OF REVENUES COLLECTED OR DEPOSITED INTO THE FUND IN 2021, BUT NOT MORE THAN ONE MILLION FIVE HUNDRED THOUSAND DOLLARS, FOR IMPLEMENTATION COSTS AND CONSUMER ENROLLMENT, OUTREACH, AND EDUCATION ACTIVITIES REGARDING HEALTH CARE COVERAGE AS DESCRIBED IN SUBSECTION (1)(b)(V) OF THIS SECTION; AND

(B) THE REMAINING BALANCE TO CARRIERS TO REDUCE THE COSTS OF INDIVIDUAL HEALTH PLANS FOR INDIVIDUALS WHO PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN ON THE EXCHANGE AND RECEIVE THE PREMIUM TAX CREDIT.

(c) THE ENTERPRISE SHALL ALLOCATE THE REVENUES COLLECTED IN 2022, AND ANY OTHER MONEY DEPOSITED IN THE FUND IN 2022, AS FOLLOWS:

(I) UP TO THREE PERCENT FOR ACTUAL ADMINISTRATIVE COSTS AS SET FORTH IN SUBSECTION (1)(b)(IV) OF THIS SECTION;

(II) TO THE REINSURANCE PROGRAM CASH FUND, EIGHTY-EIGHT MILLION DOLLARS; AND

(III) OF THE REMAINING BALANCE IN THE FUND AFTER DEDUCTING THE ALLOCATIONS SPECIFIED IN SUBSECTIONS (2)(c)(I) AND (2)(c)(II) OF THIS SECTION:

(A) THIRTY PERCENT TO CARRIERS TO REDUCE THE COSTS OF INDIVIDUAL HEALTH PLANS FOR INDIVIDUALS WHO PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN ON THE EXCHANGE AND RECEIVE THE PREMIUM TAX

CREDIT; AND

(B) SEVENTY PERCENT FOR SUBSIDIES FOR STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLANS PURCHASED BY QUALIFIED INDIVIDUALS.

(d) (I) THE ENTERPRISE SHALL ALLOCATE THE REVENUES COLLECTED IN 2023 AND EACH YEAR THEREAFTER, AND ANY OTHER MONEY DEPOSITED IN THE FUND IN 2023 AND EACH YEAR THEREAFTER, IN THE FOLLOWING AMOUNTS AND ORDER OF PRIORITY:

(A) FIRST, UP TO THREE PERCENT FOR ACTUAL ADMINISTRATIVE COSTS AS SET FORTH IN SUBSECTION (1)(b)(IV) OF THIS SECTION;

(B) SECOND, EIGHTEEN MILLION DOLLARS FOR SUBSIDIES FOR STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLANS PURCHASED BY QUALIFIED INDIVIDUALS;

(C) THIRD, THE AMOUNT REMAINING IN THE FUND, UP TO SEVENTY-THREE PERCENT OF THE TOTAL AMOUNT OF REVENUES COLLECTED OR DEPOSITED INTO THE FUND IN THE APPLICABLE YEAR, BUT NOT TO EXCEED NINETY MILLION DOLLARS, TO THE REINSURANCE PROGRAM CASH FUND; AND

(D) FOURTH, TEN PERCENT OF THE TOTAL AMOUNT OF REVENUES COLLECTED OR DEPOSITED INTO THE FUND IN THE APPLICABLE YEAR OR THE AMOUNT REMAINING IN THE FUND, WHICHEVER IS LESS, TO CARRIERS TO REDUCE THE COSTS OF INDIVIDUAL HEALTH PLANS FOR INDIVIDUALS WHO PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN ON THE EXCHANGE AND RECEIVE THE PREMIUM TAX CREDIT.

(II) IF, AFTER MAKING THE ALLOCATIONS SPECIFIED IN SUBSECTION (2)(d)(I) OF THIS SECTION, THERE IS MONEY REMAINING IN THE FUND IN THE APPLICABLE YEAR, THE ENTERPRISE SHALL ALLOCATE THE REMAINING MONEY FOR SUBSIDIES FOR STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLANS PURCHASED BY QUALIFIED INDIVIDUALS.

(3) THE ENTERPRISE SHALL DISTRIBUTE THE ALLOCATIONS SPECIFIED IN SUBSECTION (2) OF THIS SECTION IN ACCORDANCE WITH THE REQUIREMENTS DETERMINED BY THE BOARD PURSUANT TO SECTION 10-16-1207 (4).

(4) IF THE COMMISSIONER, PURSUANT TO SECTION 10-16-1107 (4), NOTIFIES THE BOARD THAT THE REINSURANCE PROGRAM WILL RECEIVE FEDERAL FUNDING PURSUANT TO A FEDERAL REINSURANCE PROGRAM OR OTHER FEDERAL FINANCIAL ASSISTANCE FOR THE REINSURANCE PROGRAM THAT IS IN EXCESS OF FEDERAL PASS-THROUGH FUNDING RECEIVED PURSUANT TO SECTION 10-16-1107 (1)(a)(I), THE ENTERPRISE MAY ELIMINATE OR REDUCE THE AMOUNT OF ENTERPRISE REVENUES ALLOCATED TO THE REINSURANCE PROGRAM PURSUANT TO SUBSECTION (2) OF THIS SECTION BASED ON THE AMOUNT OF FEDERAL FUNDING THE REINSURANCE PROGRAM RECEIVES, AS INDICATED IN THE COMMISSIONER'S NOTICE, AND SHALL REALLOCATE THE PORTION OF THE ENTERPRISE REVENUES NO LONGER ALLOCATED TO THE REINSURANCE PROGRAM TO THE OTHER PURPOSES SPECIFIED IN SUBSECTION (2) OF THIS SECTION IN ACCORDANCE WITH THAT SUBSECTION (2).

(5) (a) THE SPECIAL ASSESSMENTS ON HOSPITALS UNDER SUBSECTION (1)(a)(II) OF THIS SECTION MUST COMPLY WITH AND NOT VIOLATE 42 CFR 433.68. IF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES IN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES INFORMS THE STATE THAT THE STATE WILL NOT BE IN COMPLIANCE WITH 42 CFR 433.68 AS A RESULT OF THE SPECIAL ASSESSMENT ON HOSPITALS PURSUANT TO SUBSECTION (1)(a)(II) OF THIS SECTION, THE ENTERPRISE SHALL REDUCE THE AMOUNT OF THE SPECIAL ASSESSMENT AS NECESSARY TO AVOID ANY REDUCTION IN THE HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTED PURSUANT TO SECTION 25.5-4-402.4.

(b) A HOSPITAL SHALL PAY THE SPECIAL ASSESSMENT IMPOSED PURSUANT TO SUBSECTION (1)(a)(II) OF THIS SECTION FROM ITS GENERAL REVENUES AND IS PROHIBITED FROM:

(I) COLLECTING AN ASSESSMENT FROM CONSUMERS AS ANY TYPE OF SURCHARGE ON ITS FEES;

(II) PASSING THE SPECIAL ASSESSMENT ON TO CONSUMERS AS ANY TYPE OF INCREASE TO FEES OR CHARGES FOR SERVICES; OR

(III) OTHERWISE PASSING THE SPECIAL ASSESSMENT ON TO CONSUMERS IN ANY MANNER.

10-16-1206. Health insurance affordability cash fund - creation.

(1) THERE IS HEREBY CREATED IN THE STATE TREASURY THE HEALTH INSURANCE AFFORDABILITY CASH FUND. THE FUND CONSISTS OF:

(a) THE FEES COLLECTED FROM CARRIERS PURSUANT TO SECTION 10-16-1205 (1)(a)(I);

(b) THE SPECIAL ASSESSMENTS COLLECTED FROM HOSPITALS PURSUANT TO SECTION 10-16-1205 (1)(a)(II);

(c) AN AMOUNT OF PREMIUM TAX REVENUES DEPOSITED IN THE FUND PURSUANT TO SECTION 10-3-209 (4)(a)(III), NOT TO EXCEED, IN ANY YEAR, TEN PERCENT OF THE TOTAL AMOUNT THE ENTERPRISE COLLECTS FROM CARRIERS AND HOSPITALS UNDER SECTION 10-16-1205 (1)(a);

(d) THE REVENUE COLLECTED FROM REVENUE BONDS ISSUED PURSUANT TO SECTION 10-16-1204 (1)(b)(II); AND

(e) ALL INTEREST AND INCOME DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEY IN THE FUND.

(2) MONEY IN THE FUND SHALL NOT BE TRANSFERRED TO ANY OTHER FUND, EXCEPT AS PROVIDED IN SECTION 10-16-1205 (2), AND SHALL NOT BE USED FOR ANY PURPOSE OTHER THAN THE PURPOSES SPECIFIED IN THIS PART 12.

(3) ALL MONEY IN THE FUND IS CONTINUOUSLY AVAILABLE AND APPROPRIATED TO THE ENTERPRISE TO USE IN ACCORDANCE WITH THIS PART 12.

(4) THE FUND IS PART OF THE ENTERPRISE ESTABLISHED PURSUANT TO SECTION 10-16-1204 (1).

10-16-1207. Health insurance affordability board - creation - membership - powers and duties - subject to open meetings and public records laws - commissioner rules. (1) (a) THERE IS HEREBY CREATED THE HEALTH INSURANCE AFFORDABILITY BOARD, WHICH BOARD IS RESPONSIBLE FOR GOVERNANCE OF THE ENTERPRISE ESTABLISHED IN THIS PART 12. THE BOARD CONSISTS OF THE FOLLOWING ELEVEN VOTING MEMBERS:

(I) THE EXECUTIVE DIRECTOR OF THE EXCHANGE OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

(II) THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE; AND

(III) NINE MEMBERS APPOINTED BY THE GOVERNOR, WITH THE CONSENT OF THE SENATE, AS FOLLOWS:

(A) ONE MEMBER WHO IS EMPLOYED BY A CARRIER;

(B) ONE MEMBER WHO IS A REPRESENTATIVE OF A STATEWIDE ASSOCIATION OF HEALTH BENEFIT PLANS;

(C) ONE MEMBER REPRESENTING PRIMARY CARE HEALTH CARE PROVIDERS WHO DOES NOT REPRESENT A CARRIER;

(D) THREE MEMBERS WHO ARE CONSUMERS OF HEALTH CARE WHO ARE NOT REPRESENTATIVES OR EMPLOYEES OF A HOSPITAL, CARRIER, OR OTHER HEALTH CARE INDUSTRY ENTITY. TO THE EXTENT POSSIBLE, THE GOVERNOR SHALL ENSURE THAT THE CONSUMER MEMBERS OF THE BOARD ARE INDIVIDUALS WHO LACK AFFORDABLE OFFERS OF COVERAGE FROM THEIR EMPLOYERS AND OTHERWISE STRUGGLE TO AFFORD TO PURCHASE HEALTH INSURANCE.

(E) ONE MEMBER WHO REPRESENTS A HEALTH CARE ADVOCACY ORGANIZATION;

(F) ONE MEMBER WHO IS A REPRESENTATIVE OF A BUSINESS THAT PURCHASES OR OTHERWISE PROVIDES HEALTH INSURANCE FOR ITS EMPLOYEES; AND

(G) ONE MEMBER WHO REPRESENTS A RURAL, CRITICAL ACCESS, OR INDEPENDENT HOSPITAL.

(b) TO THE EXTENT POSSIBLE, THE GOVERNOR SHALL ATTEMPT TO APPOINT BOARD MEMBERS WHO REFLECT THE DIVERSITY OF THE STATE WITH REGARD TO RACE, ETHNICITY, IMMIGRATION STATUS, INCOME, WEALTH, ABILITY, AND GEOGRAPHY. IN CONSIDERING GEOGRAPHIC DIVERSITY, THE GOVERNOR SHALL ENSURE AT LEAST ONE MEMBER RESIDES ON THE EASTERN PLAINS AND ONE MEMBER RESIDES ON THE WESTERN SLOPE AND, TO THE

EXTENT POSSIBLE, SHALL ATTEMPT TO APPOINT MEMBERS FROM EACH CONGRESSIONAL DISTRICT IN THE STATE.

(c) THE GOVERNOR SHALL MAKE INITIAL APPOINTMENTS TO THE BOARD BY OCTOBER 1, 2020.

(2) (a) (I) EXCEPT AS PROVIDED IN SUBSECTION (2)(a)(II) OF THIS SECTION, THE TERM OF OFFICE OF THE MEMBERS OF THE BOARD APPOINTED BY THE GOVERNOR IS FOUR YEARS, AND THOSE MEMBERS MAY SERVE NO MORE THAN TWO FOUR-YEAR TERMS.

(II) IN ORDER TO ENSURE STAGGERED TERMS OF OFFICE, THE INITIAL TERM OF OFFICE OF THE MEMBERS OF THE BOARD IS:

(A) TWO YEARS FOR THE MEMBERS APPOINTED PURSUANT TO SUBSECTIONS (1)(a)(III)(A), (1)(a)(III)(C), AND (1)(a)(III)(F) OF THIS SECTION AND FOR TWO OF THE MEMBERS APPOINTED PURSUANT TO SUBSECTION (1)(a)(III)(D) OF THIS SECTION; AND

(B) FOUR YEARS FOR THE MEMBERS APPOINTED PURSUANT TO SUBSECTIONS (1)(a)(III)(B), (1)(a)(III)(E), AND (1)(a)(III)(G) OF THIS SECTION AND FOR ONE OF THE MEMBERS APPOINTED PURSUANT TO SUBSECTION (1)(a)(III)(D) OF THIS SECTION.

(b) MEMBERS OF THE BOARD APPOINTED BY THE GOVERNOR SERVE AT THE PLEASURE OF THE GOVERNOR AND MAY BE REMOVED BY THE GOVERNOR.

(c) A MEMBER WHO IS APPOINTED TO FILL A VACANCY SHALL SERVE THE REMAINDER OF THE UNEXPIRED TERM OF THE MEMBER WHOSE VACANCY IS BEING FILLED.

(d) MEMBERS OF THE BOARD MAY BE REIMBURSED FOR ACTUAL AND NECESSARY EXPENSES, INCLUDING ANY REQUIRED DEPENDENT CARE AND DEPENDENT OR ATTENDANT TRAVEL, FOOD, AND LODGING, WHILE ENGAGED IN THE PERFORMANCE OF OFFICIAL DUTIES OF THE BOARD.

(3) THE BOARD SHALL MEET AS OFTEN AS NECESSARY TO CARRY OUT ITS DUTIES PURSUANT TO THIS PART 12.

(4) THE BOARD IS AUTHORIZED TO:

(a) IMPLEMENT AND ADMINISTER THE ENTERPRISE;

(b) ESTABLISH ADMINISTRATIVE AND ACCOUNTING PROCEDURES FOR THE OPERATION OF THE ENTERPRISE;

(c) RECOMMEND, FOR APPROVAL AND ESTABLISHMENT BY THE COMMISSIONER BY RULE:

(I) THE TIMING AND METHODOLOGY FOR ASSESSING AND COLLECTING THE FEE AND SPECIAL ASSESSMENT, SUBJECT TO SECTION 10-16-1205 (1)(a);

(II) THE DISTRIBUTION OF ENTERPRISE REVENUES ALLOCATED FOR CARRIER PAYMENTS AND SUBSIDIES IN A MANNER THAT IMPROVES AFFORDABILITY FOR SUBSIDIZED POPULATIONS AND INDIVIDUALS NOT ELIGIBLE FOR THE PREMIUM TAX CREDIT, MEDICAID, MEDICARE, OR THE CHILDREN'S BASIC HEALTH PLAN;

(III) THE PAYMENTS AUTHORIZED BY THIS PART 12 TO BE MADE TO CARRIERS TO REDUCE THE COSTS OF INDIVIDUAL HEALTH PLANS FOR INDIVIDUALS WHO PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN ON THE EXCHANGE AND RECEIVE THE PREMIUM TAX CREDIT; AND

(IV) THE PARAMETERS FOR IMPLEMENTING THE SUBSIDIES FOR STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLANS AUTHORIZED BY THIS PART 12, INCLUDING:

(A) THE COVERAGE REQUIRED UNDER STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLANS, WHICH COVERAGE MUST MAXIMIZE AFFORDABILITY FOR QUALIFIED INDIVIDUALS AND MUST INCLUDE COVERAGE FOR THE LOWEST INCOME GROUP, AS DETERMINED BY THE BOARD, THAT HAS NO PREMIUM AND PROVIDES BENEFITS ACTUARIALLY EQUIVALENT TO NINETY PERCENT OF THE FULL ACTUARIAL VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN; AND

(B) THE CRITERIA AND PROCEDURES FOR DETERMINING WHETHER AN INDIVIDUAL IS A QUALIFIED INDIVIDUAL ELIGIBLE TO ENROLL IN A STATE-SUBSIDIZED INDIVIDUAL HEALTH COVERAGE PLAN; AND

(d) ESTABLISH BYLAWS, AS APPROPRIATE AND CONSISTENT WITH THIS PART 12, FOR ITS EFFECTIVE OPERATION.

(5) THE COMMISSIONER SHALL ADOPT RULES NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION OF THIS PART 12. IN ADOPTING THE RULES, THE COMMISSIONER SHALL CONSIDER THE RECOMMENDATIONS OF THE BOARD AND SHALL EXPRESS IN WRITING THE REASONS FOR ANY DEVIATION FROM THE BOARD RECOMMENDATIONS.

(6) MEETINGS OF THE BOARD ARE SUBJECT TO THE OPEN MEETINGS PROVISIONS OF THE "COLORADO SUNSHINE ACT OF 1972", CONTAINED IN PART 4 OF ARTICLE 6 OF TITLE 24. EXCEPT AS OTHERWISE PROVIDED IN THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24, OR OTHER APPLICABLE STATE OR FEDERAL LAW, RECORDS OF THE BOARD AND THE PROGRAM ARE SUBJECT TO THE "COLORADO OPEN RECORDS ACT".

10-16-1208. Limitation on authority - public option. NOTHING IN THIS PART 12 AUTHORIZES THE ENTERPRISE, THE BOARD, OR THE COMMISSIONER TO ESTABLISH, ADMINISTER, OPERATE, OR REQUIRE PARTICIPATION BY CARRIERS OR HOSPITALS IN A STATE OR PUBLIC OPTION HEALTH COVERAGE PLAN.

SECTION 2. In Colorado Revised Statutes, 10-16-107, **add** (8) as follows:

10-16-107. Rate filing regulation - benefits ratio - rules. (8) (a) THE COMMISSIONER MAY ADOPT RULES DESIGNED TO:

(I) MAXIMIZE THE PURCHASING POWER OF EXCHANGE CONSUMERS WHOSE HOUSEHOLD INCOME IS UP TO FOUR HUNDRED PERCENT OF THE FEDERAL POVERTY LINE; AND

(II) ASSURE PREMIUM PRICING THAT COMPLIES WITH THE REQUIREMENTS IN THE FEDERAL ACT FOR MODIFIED COMMUNITY RATING.

(b) IN ADOPTING THESE RULES, THE COMMISSIONER MAY CONSIDER THE RESULTS OF THE EVALUATION AND STUDY OF THE REINSURANCE PROGRAM CONDUCTED PURSUANT TO SECTION 10-16-1104 (2).

SECTION 3. In Colorado Revised Statutes, 10-16-1104, **amend**

(1)(g); and **repeal** (1)(f) as follows:

10-16-1104. Commissioner powers and duties - rules - study and report. (1) The commissioner has all powers necessary to implement this part 11 and is specifically authorized to:

(f) ~~Assess special fees against hospitals and, if applicable, carriers for the continuous operation of the reinsurance program, as provided in section 10-16-1108;~~

(g) IN ACCORDANCE WITH SECTION 10-16-1109, apply for a state innovation waiver OR AN EXTENSION OF A STATE INNOVATION WAIVER; APPLY FOR federal funds; or APPLY FOR both ~~in accordance with section 10-16-1109,~~ A WAIVER OR EXTENSION OF A WAIVER AND FEDERAL FUNDS for the implementation and operation of the reinsurance program;

SECTION 4. In Colorado Revised Statutes, 10-16-1105, **amend** (1)(a), (1)(b), (1)(c), (1)(e)(I), and (2)(b) introductory portion; and **add** (2)(a.5) as follows:

10-16-1105. Reinsurance program - creation - enterprise status - subject to waiver or funding approval - operation - payment parameters - calculation of reinsurance payments - eligible carrier requests - definition. (1) (a) There is hereby created in the division the Colorado reinsurance program to provide reinsurance payments to eligible carriers. Implementation and operation of the reinsurance program is contingent upon approval of ~~the~~ A state innovation waiver, AN EXTENSION OF A STATE INNOVATION WAIVER, or A federal funding request submitted by the commissioner in accordance with section 10-16-1109.

(b) (I) The reinsurance program ~~constitutes an enterprise for purposes of section 20 of article X of the state constitution as long as the commissioner, on behalf of the program, retains authority to issue revenue bonds and the program receives less than ten percent of its total revenues in grants, as defined in section 24-77-102 (7), from all Colorado state and local governments combined. So long as it constitutes an enterprise pursuant to this section, the program is not a district for purposes of section 20 of article X of the state constitution~~ IS PART OF THE COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE ESTABLISHED PURSUANT TO PART 12 OF THIS ARTICLE 16.

(II) ~~Subject to approval by the general assembly, either by bill or joint resolution, and after approval by the governor pursuant to section 39 of article V of the state constitution, the commissioner, on behalf of the reinsurance program, is hereby authorized to issue revenue bonds for the expenses of the program, secured by revenues of the program.~~

(c) If ~~the~~ A state innovation waiver, AN EXTENSION OF A STATE INNOVATION WAIVER, or A federal funding request submitted by the commissioner pursuant to section 10-16-1109 is approved, the commissioner shall implement and operate the reinsurance program in accordance with this section.

(e) (I) On a quarterly basis during the applicable benefit year,

~~(A)~~ each eligible carrier shall report to the commissioner its claims costs that exceed the attachment point for that benefit year.

~~(B) Each hospital that is subject to the special fees assessed pursuant to section 10-16-1108 shall report to the commissioner the amount the hospital is responsible for funding in the benefit year; and~~

~~(C) If special fees are assessed against carriers pursuant to section 10-16-1108 (1)(b), each carrier that is subject to the special fees shall report to the commissioner on its collected assessments in that benefit year.~~

(2) (a.5) TO THE GREATEST EXTENT POSSIBLE, THE COMMISSIONER SHALL SET THE PAYMENT PARAMETERS FOR THE 2021 BENEFIT YEAR AT AMOUNTS TO MAINTAIN THE TARGETED CLAIMS REDUCTIONS ACHIEVED IN THE 2020 BENEFIT YEAR.

(b) For the ~~2021~~ 2022 benefit year AND EACH BENEFIT YEAR THEREAFTER, after a stakeholder process, the commissioner shall establish and publish the payment parameters for that benefit year by March 15 ~~2020~~ OF THE IMMEDIATELY PRECEDING CALENDAR YEAR. In setting the payment parameters under this subsection (2)(b), the commissioner shall consider the following factors as they apply in each geographic rating area in the state:

SECTION 5. In Colorado Revised Statutes, 10-16-1106, **amend** (4) as follows:

10-16-1106. Accounting - reports - audits. (4) On or before November 1, 2020, and on or before November 1 ~~2021~~ OF EACH YEAR THEREAFTER, the division shall include an update regarding the program in its report to the members of the applicable committees of reference in the senate and house of representatives as required by the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2.

SECTION 6. In Colorado Revised Statutes, 10-16-1107, **amend** (1); and **add** (4) as follows:

10-16-1107. Funding for reinsurance program - sources - permitted uses - reinsurance program cash fund - calculation of total funding for program. (1) (a) There is hereby created in the state treasury the reinsurance program cash fund REFERRED TO IN THIS SECTION AS THE "FUND", which consists of:

(I) Federal pass-through funding granted pursuant to 42 U.S.C. sec. 18052 (a)(3) or any other federal funds that are made available for the reinsurance program;

~~(II) Special fees assessed against hospitals and, if applicable, carriers as provided in section 10-16-1108;~~

~~(III) The following amounts transferred from the general fund to the reinsurance program cash fund, but only if House Bill 19-1245 is enacted at the first regular session of the seventy-second general assembly and becomes law:~~

~~(A) Fifteen million dollars, transferred to the fund on June 30, 2020; and~~

~~(B) Forty million dollars, transferred to the fund on June 30, 2021;~~

~~(IV) An amount of premium tax revenues deposited in the fund pursuant to section 10-3-209 (4)(a)(III); and~~

~~(V)~~ (II) Any money the general assembly appropriates to the fund for the program; AND

(III) ANY AMOUNTS ALLOCATED TO THE FUND PURSUANT TO SECTION 10-16-1205 (2).

(b) All money deposited or paid into or TRANSFERRED, ALLOCATED, OR appropriated to the reinsurance program cash fund, including interest or income earned on the investment of money in the fund, is continuously available and appropriated to the division to be expended in accordance with this part 11. Any interest or income earned on the investment of money in the fund shall be credited to the fund.

(c) The reinsurance program cash fund is part of the ~~reinsurance program enterprise established pursuant to section 10-16-1105 (1)(b)~~ COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE ESTABLISHED PURSUANT TO PART 12 OF THIS ARTICLE 16.

(4) (a) IF, AFTER THE EFFECTIVE DATE OF THIS SUBSECTION (4), THE UNITED STATES CONGRESS ENACTS AND THE PRESIDENT SIGNS FEDERAL LEGISLATION ESTABLISHING OR THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES IMPLEMENTS A FEDERAL REINSURANCE PROGRAM THAT PROVIDES FEDERAL FUNDING FOR THE REINSURANCE PROGRAM OR OTHERWISE MAKES ADDITIONAL FEDERAL FUNDS AVAILABLE FOR THE REINSURANCE PROGRAM IN EXCESS OF THE AMOUNT RECEIVED AS FEDERAL PASS-THROUGH FUNDING PURSUANT TO SUBSECTION (1)(a)(I) OF THIS SECTION, THE COMMISSIONER SHALL NOTIFY THE HEALTH INSURANCE AFFORDABILITY BOARD CREATED IN SECTION 10-16-1207 OF THE AMOUNT OF FEDERAL FUNDING IN EXCESS OF THE FEDERAL PASS-THROUGH FUNDING THAT WILL BE AVAILABLE FOR THE REINSURANCE PROGRAM AND THE DATE THE FUNDING IS EXPECTED TO BE RECEIVED.

(b) IF THE REINSURANCE PROGRAM RECEIVES FEDERAL FUNDING AS DESCRIBED IN THIS SUBSECTION (4) TO MAKE REINSURANCE PAYMENTS TO CARRIERS IN A GIVEN YEAR AFTER THE HEALTH INSURANCE AFFORDABILITY ENTERPRISE HAS ALLOCATED MONEY TO THE REINSURANCE PROGRAM PURSUANT TO SECTION 10-16-1205 (2) FOR THAT YEAR, THE COMMISSIONER SHALL RETURN TO THE ENTERPRISE THE ALLOCATION OR A PORTION OF THE ALLOCATION, AS DETERMINED BY THE ENTERPRISE, BASED ON THE AMOUNT OF FEDERAL FUNDING RECEIVED FOR THAT YEAR.

SECTION 7. In Colorado Revised Statutes, **repeal** 10-16-1108.

SECTION 8. In Colorado Revised Statutes, 10-16-1109, **amend** (1)(a) as follows:

10-16-1109. State innovation waiver - federal funding - Colorado reinsurance program. (1) (a) For purposes of implementing and operating the reinsurance program as set forth in this part 11 for plan years starting on or after January 1, ~~2020~~ 2021, the commissioner may apply to the secretary of the United States department of health and human services for:

(I) ~~A two-year state innovation waiver~~ In accordance with section 1332 of the federal act, codified at 42 U.S.C. sec. 18052, and 45 CFR 155.1300:

(A) ONE OR MORE EXTENSIONS OF THE INITIAL TWO-YEAR STATE INNOVATION WAIVER RECEIVED BEFORE THE EFFECTIVE DATE OF THIS SUBSECTION (1)(a)(I), AS AMENDED, OF UP TO FIVE YEARS PER EXTENSION; OR

(B) A NEW STATE INNOVATION WAIVER OF UP TO FIVE YEARS TO FOLLOW THE INITIAL TWO-YEAR STATE INNOVATION WAIVER APPROVED BEFORE THE EFFECTIVE DATE OF THIS SUBSECTION (1)(a)(I), AS AMENDED, AND SUBSEQUENT EXTENSIONS OF ANY NEW STATE INNOVATION WAIVER APPROVED BY THE SECRETARY;

(II) Federal funds for the reinsurance program; or

(III) A NEW OR EXTENDED state innovation waiver and federal funds.

SECTION 9. In Colorado Revised Statutes, 10-16-1110, **repeal** (2) as follows:

10-16-1110. Repeal of part - notice to revisor of statutes. (2) ~~This part 11 is repealed, effective September 1, 2023.~~

SECTION 10. In Colorado Revised Statutes, 10-3-209, **amend** (4)(a)(III) as follows:

10-3-209. Tax on premiums collected - exemptions - penalties. (4) (a) The division of insurance shall transmit all taxes, penalties, and fines it collects under this section to the state treasurer for deposit in the

general fund; except that the state treasurer shall deposit amounts in the specified cash funds as follows:

(III) (A) For the 2020-21 STATE FISCAL YEAR and ~~2021-22~~ EACH state fiscal ~~years~~ YEAR THEREAFTER, in the ~~reinsurance program~~ HEALTH INSURANCE AFFORDABILITY cash fund created in ~~section 10-16-1107~~ SECTION 10-16-1206, an amount equal to the amount of premium taxes collected pursuant to this section in the 2020 calendar year OR ANY SUBSEQUENT CALENDAR YEAR that exceeds the amount of premium taxes collected pursuant to this section in the 2019 calendar year, SUBJECT TO SUBSECTION (4)(a)(III)(B) OF THIS SECTION.

(B) ~~This subsection (4)(a)(III) is repealed, effective September 1, 2023~~ THE AMOUNT OF PREMIUM TAXES DEPOSITED IN THE HEALTH INSURANCE AFFORDABILITY CASH FUND PURSUANT TO THIS SUBSECTION (4)(a)(III) IN ANY GIVEN YEAR SHALL NOT EXCEED TEN PERCENT OF THE AMOUNT OF REVENUES COLLECTED BY THE HEALTH INSURANCE AFFORDABILITY ENTERPRISE PURSUANT TO SECTION 10-16-1205 IN THAT YEAR. THE HEALTH INSURANCE AFFORDABILITY BOARD ESTABLISHED IN SECTION 10-16-1207 SHALL NOTIFY THE TREASURER OF THE MAXIMUM AMOUNT OF PREMIUM TAXES THAT MAY BE DEPOSITED IN THE HEALTH INSURANCE AFFORDABILITY CASH FUND TO COMPLY WITH THIS SUBSECTION (4)(a)(III)(B).

SECTION 11. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Leroy M. Garcia
PRESIDENT OF
THE SENATE

KC Becker
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED June 30, 2020 at 8:46 pm
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO

Attachment 3

COLORADO
Department of Regulatory Agencies
Division of Insurance

Impact of Reinsurance on Colorado's Subsidized Enrollee Population

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

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

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

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

Sincerely,

Michael Conway
Commissioner of Insurance

Reinsurance and Affordability

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

MARCH 2021

COLORADO HEALTH INSTITUTE
Informing Policy. Advancing Health.

Reinsurance and Affordability

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

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

Introduction

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

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

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

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

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

Key Takeaways

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

Reinsurance in Colorado

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

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

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

The Impact of Reinsurance on Affordability

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

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

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

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

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

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

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

Financial Help Available Through Connect for Health Colorado

There are two sources of financial support available through C4HC.

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

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

Actuarial Value and Metal Tiers

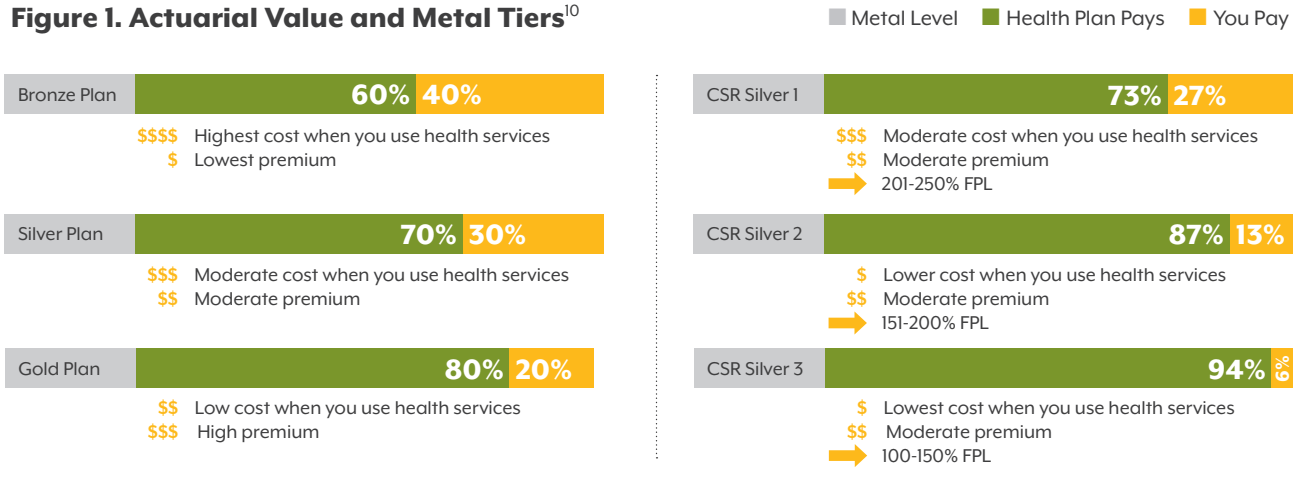
Actuarial value (AV) is the percentage of total health costs a plan will cover on average. Particular individuals could pay more or less than average. The remaining percentage is paid for by the enrollee through premiums and cost sharing such as deductible payments, copayments, and coinsurance.

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

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

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

Figure 1. Actuarial Value and Metal Tiers[10]



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

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

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

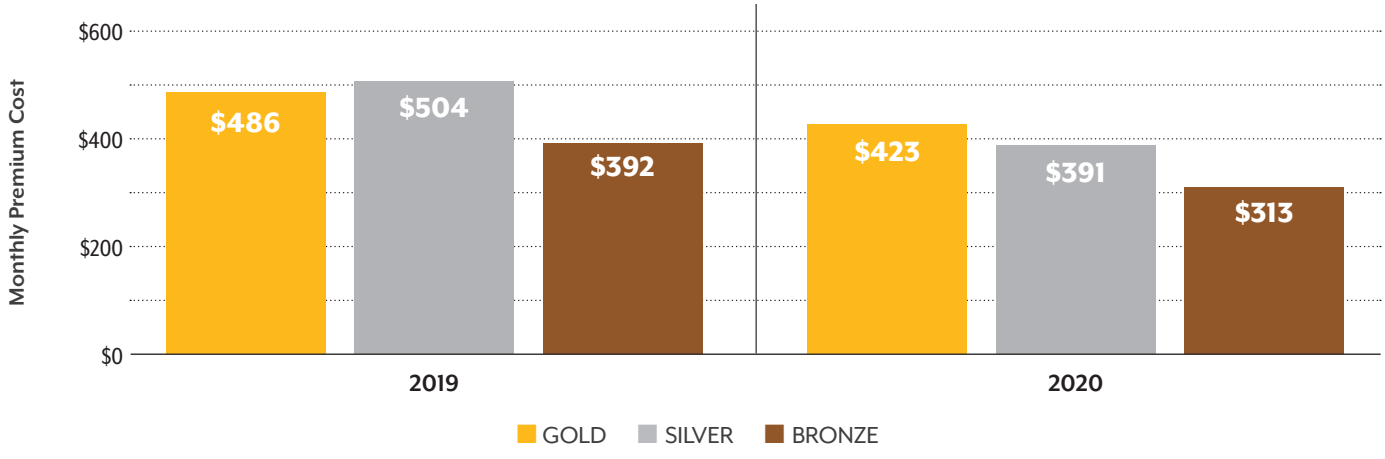
In 2019, with additional clarity from the federal government, DOI instructed insurers to "load," or apply, CSR costs onto on-exchange silver plans only, since CSRs are only available through those plans. This is a practice known as "silver loading."

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

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

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

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



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

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

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

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

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

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

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

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

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

Reinsurance and the Importance of Relative Price Changes

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

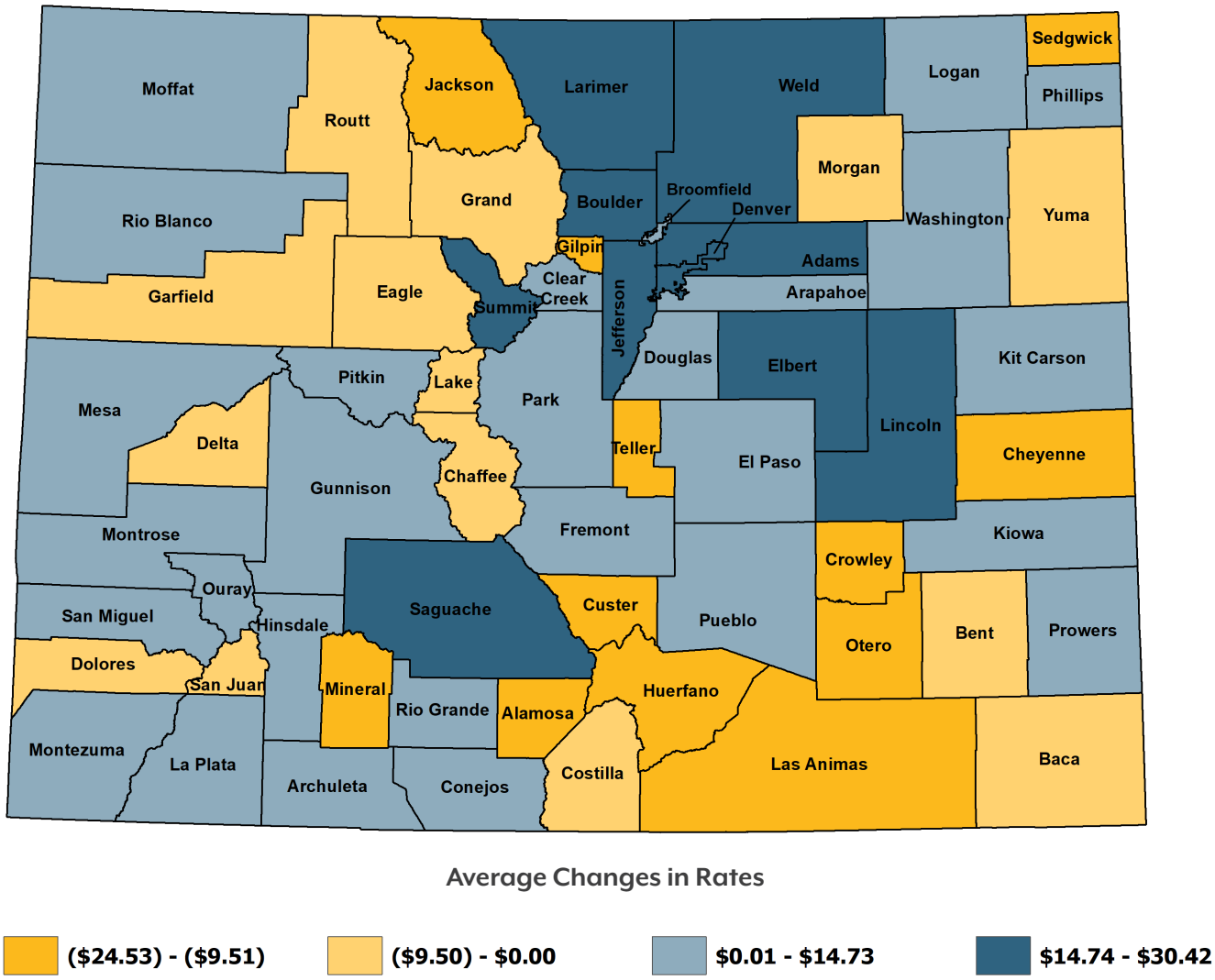
For example, in Weld County in 2019, one insurer reduced its rates on average by 25%, compared to another insurer that cut rates by just 13%. Because the first insurer happens to offer the benchmark plan (the second-lowest-cost on-exchange silver plan) for the county, subsidized consumers enrolled in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

Figure 4. The Importance of Relative Prices for Subsidized Consumers

Example: Weld County Carrier Profile

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

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



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

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

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

Consumer Shopping Preferences and COVID-19 Special Enrollment Period

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

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

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

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

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

Policy Options for Consideration

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

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

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

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

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

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

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

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

Option 1: Align Coverage Costs with Plan Value

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

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

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

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

Prevent the inflation of gold prices by limiting induced utilization

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

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

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

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

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

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

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

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

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

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

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

Impact on Consumer Buying Power and Enrollment

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

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

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

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

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

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

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

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

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

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

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

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

Consumer Feedback

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

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

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

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

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

Considerations for Implementation

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

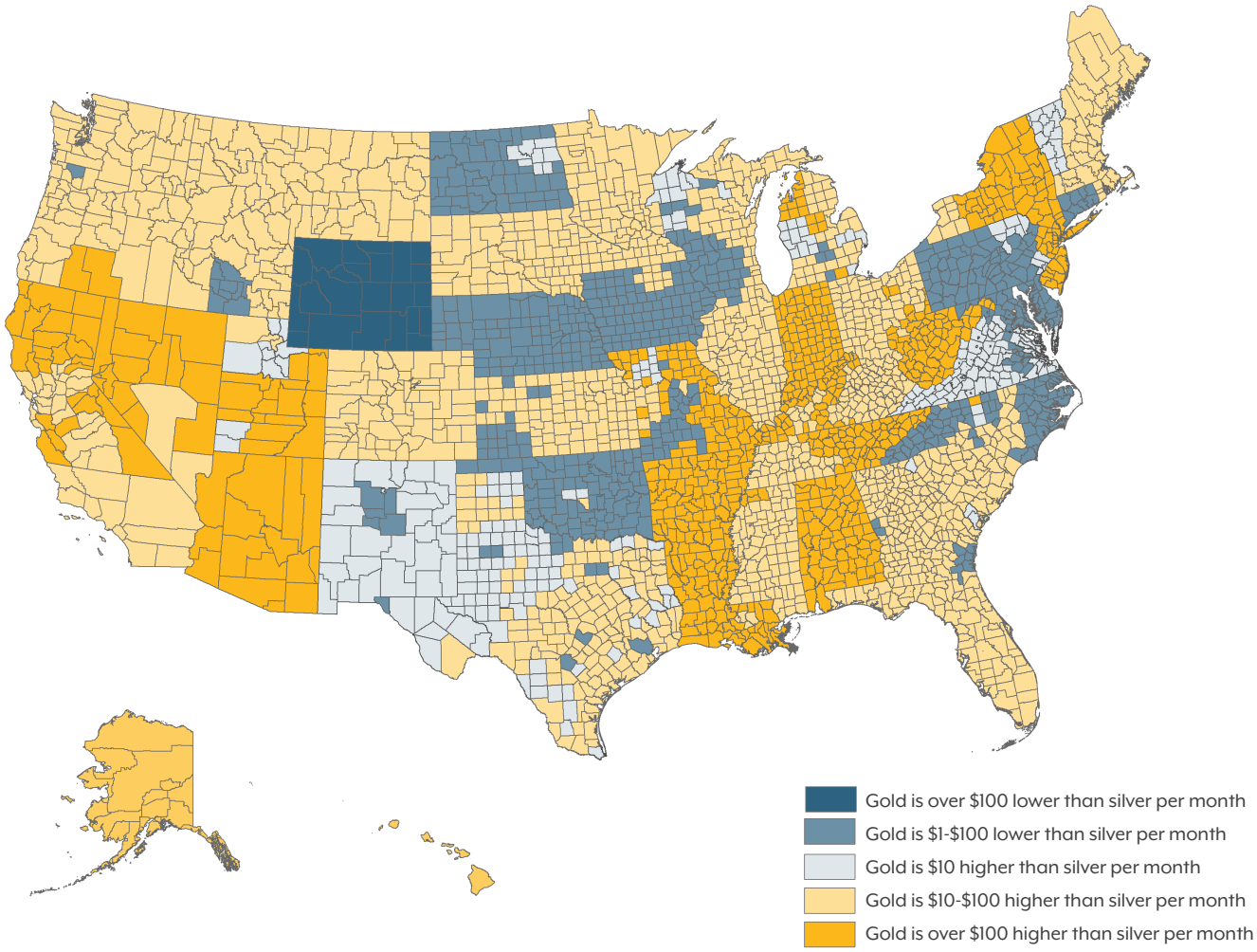
Further analysis is needed to understand how the induced utilization and silver plan pricing changes have affected affordability for the subsidized population in Pennsylvania, but initial analyses show affordability improvements for gold and bronze plans available to subsidized consumers in both 2020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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

Impact on Consumer Buying Power and Enrollment

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

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

Consumer Feedback

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

Considerations for Implementation

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

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

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

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

Option 3: Institute New Auto-Enrollment Rules

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

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

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

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

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

Impact on Consumer Buying Power and Enrollment

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

Consumer Feedback

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

Considerations for Implementation

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

Active Shopping Improves Coverage Quality and Affordability

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

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

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

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

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

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

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

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

Conclusion

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

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

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

Endnotes

[1] Department of Health & Human Services. (2019, July 31). State of Colorado—Patient Protection and Affordable Care Act Section 1332 Waiver Approval. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-STC-CO-Signed.pdf

[2] Governor Jared Polis. (2019, October 10). Gov. Polis: 2020 ACA Premiums Going Down by an Average of 20.2%. https://www.colorado.gov/governor/news/gov-polis-2020-aca-premiums-going-down-average-202

[3] Governor Jared Polis. (2020, October 8). Reinsurance Saving Consumers 20.8% on Average in 2021. https://www.colorado.gov/governor/news/3171-reinsurance-saving-consumers-208-average-2021

[4] Lewis & Ellis, Inc. (2020). State of Colorado Subsidized Population Study: Individual Health Insurance Market, 2019 to 2020.

[5] Note: This group includes consumers who rolled their coverage over from the prior year, either by actively reviewing it and opting in (active auto-enrollment) or simply by auto-renewing into the same or similar coverage without reviewing (passive auto-enrollment).

[6] Lewis & Ellis, Inc. (2020).

[7] Connect for Health Colorado. Lower Your Monthly Premiums. Retrieved December, 2020, from https://connectforhealthco.com/financial-help/lower-your-monthly-premiums/

[8] KFF. Health Insurance Marketplace Calculator. Retrieved December, 2020, from https://www.kff.org/interactive/subsidy-calculator/

[9] Connect for Health Colorado. Healthcare Discounts. Retrieved December, 2020, from https://connectforhealthco.com/financial-help/healthcare-discounts/

[10] Connect for Health Colorado. Bronze, Silver & Gold Plans. Retrieved December, 2020, from https://connectforhealthco.com/find-answers/before-you-buy/bronze-silver-gold-plans/

[11] Eilperin, J., Goldstein, A., & Johnson, C.Y. (2017, October 13). White House's decision to stop ACA cost-sharing subsidies triggers strong opposition. Washington Post. https://www.washingtonpost.com/politics/white-house-tells-court-it-is-immediately-stopping-aca-cost-sharing-subsidies/2017/10/13/4c404234-b01d-11e7-be94-fabb0f1e9ffb_story.html

[12] Lewis & Ellis, Inc. (2020).

[13] Lewis & Ellis, Inc. (2020).

[14] Colorado Division of Insurance. Next year will also see fewer counties with only one on-exchange company. (2020, July 9). https://www.colorado.gov/same-eight-companies-returning-offer-individual-health-insurance-plans-2021-while-number-plans

[15] Lewis & Ellis, Inc. (2020).

[16] Lewis & Ellis, Inc. (2020).

[17] Dorn, S. (2019, June 6). Silver Linings For Silver Loading. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20190530.156427/full/

[18] The National Center for Coverage Innovation at Families USA. (2020).

[19] Fann, G. & Cruz, D. (n.d.). Fields of Gold: Reaping a Harvest from the ACA. Axene Health Partners. Retrieved December, 2020, from https://axenehp.com/fields-of-gold/

[20] Fann, G. & Cruz, D. (n.d.).

[21] Pope, C., Bachofer, H., Pearlman, A., Kautter, J., Hunter, E., Miller, D., & Kennan, P. (2014). Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act. Medicare & Medicaid Research Review, Volume 4(3). https://www.cms.gov/mmrr/downloads/mmrr2014_004_03_a04.pdf

[22] Fann, G. & Cruz, D. (n.d.).

[23] Fann, G. & Cruz, D. (n.d.).

[24] Note: Platinum plans are not offered by any carrier in Colorado but, if offered, must have an AV of 90%. CSR silver plans available to consumers between 100% and 200% FPL have an AV of either 87% or 94%.

[25] Connect for Health Colorado. Explore Plans. Retrieved December, 2020, from https://connectforhealthco.com/get-started/explore-plans/

[26] Note: Projected enrollment should be used for weighting purposes rather than current enrollment because enrollment in CSR 1 plans (which have an AV of 73%, slightly above the standard silver plan) is expected to decrease once this policy option is implemented. Those currently enrolled in CSR 1 plans (and standard, on-exchange silver plans) will be able to select a gold plan with a higher AV (80%) and a lower net premium. Carriers' projected enrollment distributions will be evaluated by DOI during the annual rate review process.

[27] Lewis & Ellis, Inc. (2020).

[28] The National Center for Coverage Innovation at Families USA. (2020).

[29] The National Center for Coverage Innovation at Families USA. (2020).

[30] Colorado Health Institute. (2019). 2019 Colorado Health Access Survey: Progress in Peril. https://www.coloradohealthinstitute.org/research/coloardo-health-access-survey

[31] Colorado Health Institute. (2019).

[32] KFF. (2020, October 30). Explaining Health Care Reform: Questions About Health Insurance Subsidies. https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/

[33] Lewis & Ellis, Inc. (2020).

[34] Pennsylvania Insurance Department. (2019, April 3). 2020 ACA-Compliant Health Insurance Rate Filing Guidance. https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/2020%20ACA/2020%20ACA%20Compliant%20Health%20Insurance%20Rate%20Filing%20Guidance%204-3-2019.pdf

[35] Pennsylvania Insurance Department. (2020, April 13). 2021 ACA-Compliant Health Insurance Rate Filing Guidance. https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/2021%20ACA/2021%20ACA%20Compliant%20Health%20Insurance%20Rate%20Filing%20Guidance%2004-13-2020.pdf

[36] Governor Tom Wolf. (2020, July 24). Gov. Wolf: Reinsurance Program Application Receives Federal Approval. https://www.governor.pa.gov/newsroom/gov-wolf-reinsurance-program-application-receives-federal-approval/.

[37] Centers for Medicare & Medicaid Services. (2020, July 24). Pennsylvania: State Innovation Waiver under section 1332 of the PPACA. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-PA-Fact-Sheet.pdf

[38] Centers for Medicare & Medicaid Services. (2019, September 18). https://www.cms.gov/CCIIO/Resources/Files/Downloads/PA-blueprint-exchange-letter.pdf

[39] XPostFactoid. (2020, November 18). Pennsylvania transforms its ACA marketplace with one sentence. https://xpostfactoid.blogspot.com/2020/11/pennsylvania-transforms-its-aca.html

[40] KFF. (2019, November 7). How ACA Marketplace Premiums Are Changing by County in 2020. https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2020/

[41] KFF. (2020, November 11). How ACA Marketplace Premiums Are Changing by County in 2021. https://www.kff.org/private-insurance/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2021/

[42] Virginia State Corporation Commission. (n.d.). SERFF Instructions. https://www.scc.virginia.gov/getattachment/085963bc-f4c6-4e19-86bf-99a11c8803f0/SERFFInstr.pdf

[43] Maryland Insurance Administration. (2020, January 7). Bulletin 20-01. https://insurance.maryland.gov/Insurer/Documents/bulletins/20-01-2020-ACA-Rate-and-Form-Filing.pdf

[44] The National Center for Coverage Innovation at Families USA. (2020).

[45] Lewis & Ellis, Inc. (2020).

[46] KFF. (2020, November 11). How ACA Marketplace Premiums Are Changing by County in 2021. https://www.kff.org/private-insurance/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2021/

[47] KFF. (2020, November 23). Insurer Participation on the ACA Marketplaces, 2014-2021. https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/

[48] The National Center for Coverage Innovation at Families USA. (2020).

[49] Colorado Revised Statutes 10-16-107.

[50] Colorado Department of Regulatory Agencies, Division of Insurance. (2020, June 30). Colorado Reinsurance Program Public Forum. https://drive.google.com/file/d/1anVGiBCjoPBhRJkDYhOjYVhlSYuCFWCp/view

[51] Colorado Revised Statutes 10-16-107.

[52] Lewis & Ellis, Inc. (2020).

[53] Lewis & Ellis, Inc. (2020).

[54] Fabian-Marks, J. & Plunkett, B. Maryland Health Benefit Exchange. Interview. Conducted December 9, 2020.

[55] Audrey Taylor, E., Grace Carman, K., Lopez, A., Muchow, A., Roshan, P., & Eibner, C. (2016). Consumer Decisionmaking in the Health Care Marketplace. Rand Corporation. https://www.rand.org/pubs/research_reports/RR1567.html

[56] Fabian-Marks, J. & Plunkett, B. (2020).

[57] Covered California. (2020, February 18). New California Policies Make Huge Difference, Increasing New Signups During Covered California's Open Enrollment by 41 Percent. https://www.coveredca.com/newsroom/news-releases/2020/02/18/new-california-policies-make-huge-difference-increasing-new-signups-during-covered-californias-open-enrollment-by-41-percent/

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

Prepared by
Lewis & Ellis, Inc.

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Table of Contents

Executive Summary

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

The following are the key conclusions from the analysis.

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

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

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

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

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

Section 1: Introduction and Purpose

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

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

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

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

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

Section 2: Market Changes from 2019 to 2020

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

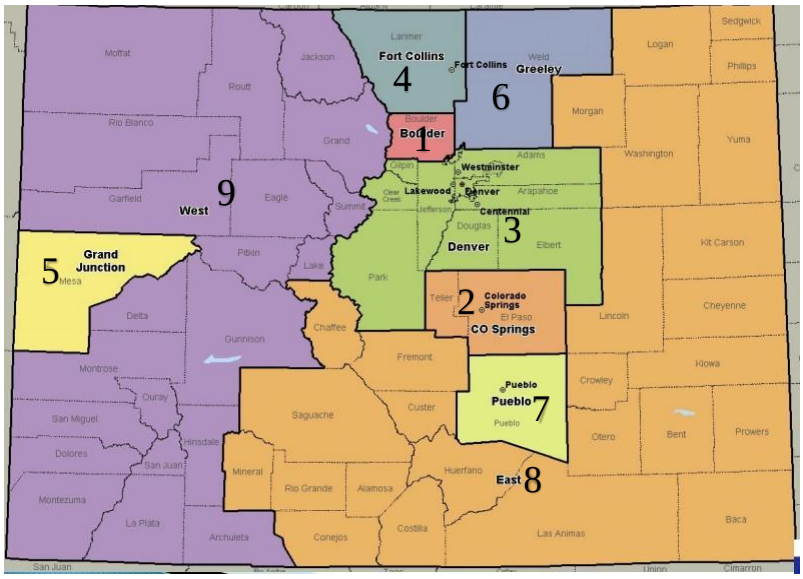
Open Enrollment in the Colorado Individual Health Insurance Marketplace for calendar year 2020 began November 1, 2019. Enrollees from across the state logged in to discover that rates had dropped substantially from the prior year. This drop in costs was due to the implementation of a state-based reinsurance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

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

Figure 1: Colorado State Reinsurance Program Parameters, 2020

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

Figure 2: Colorado Allowable Rating Regions, ACA Market



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

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

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

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

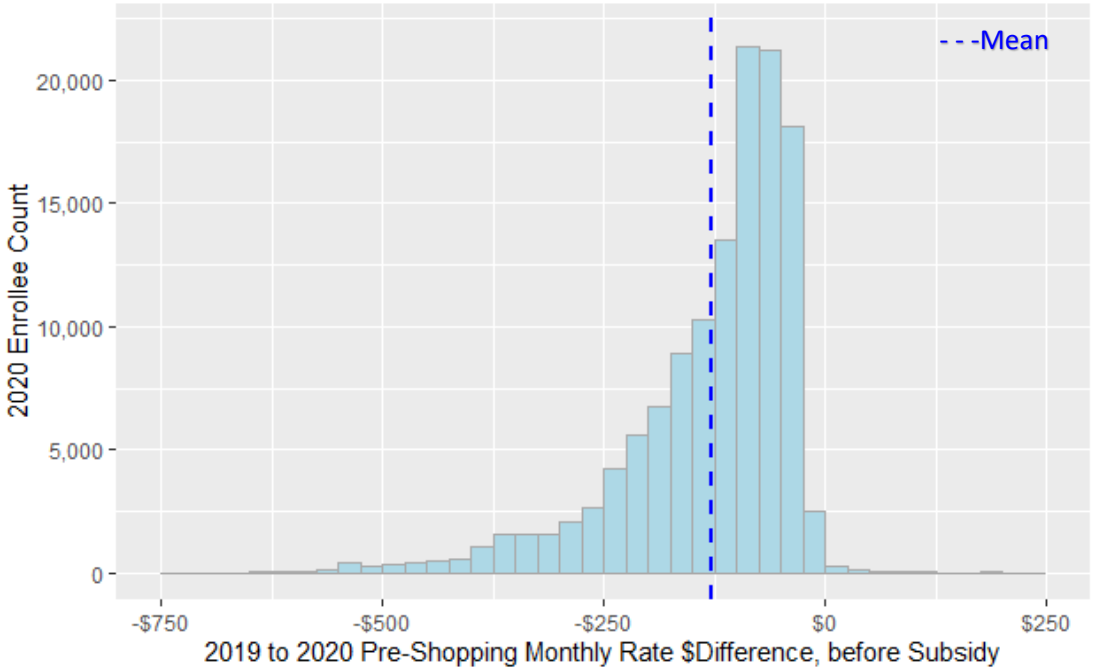
	2019	2020	Δ from 2019
Total On-Exchange Rate	$617	$473	-23.4%
Members not eligible for Subsidy, final rate	$508	$400	-21.2%
Members eligible for Subsidy, rate ***before*** subsidy	$648	$499	-23.0%

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

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

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

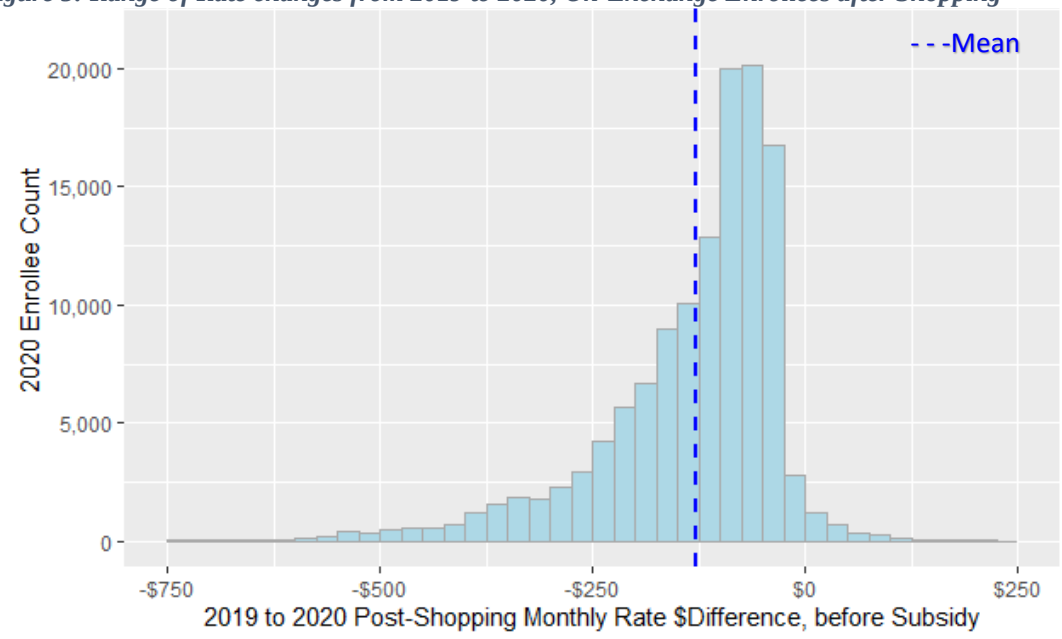
Figure 4: Range of Rate changes from 2019 to 2020, On-Exchange Enrollees before Shopping



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

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

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

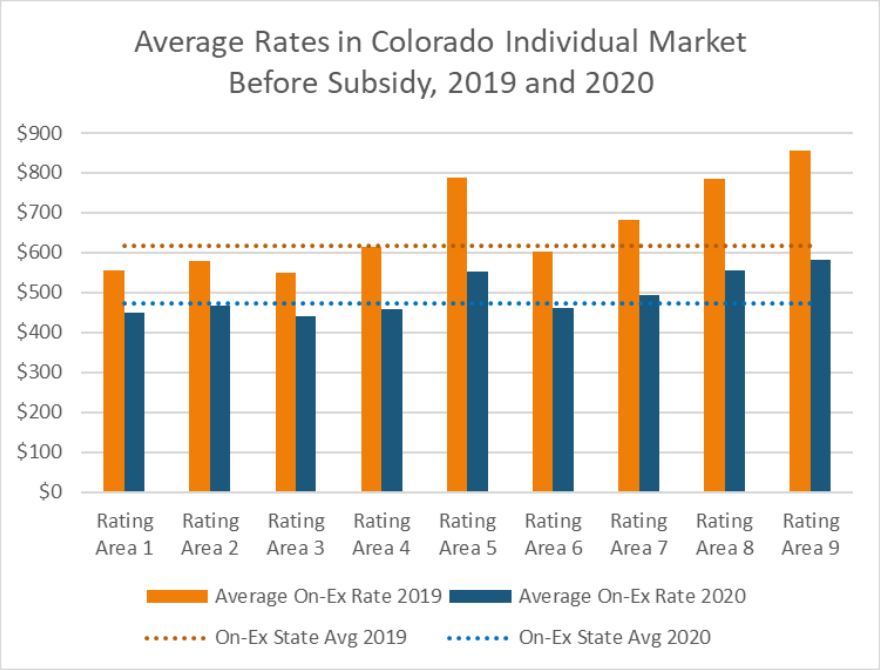


The distribution above (prior page) peaks in the same place. Mean has decreased to -$132. The median remains at -$100. There is a slight impact for 1 year of aging, which the pre-shop rates do not include.

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

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

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



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

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

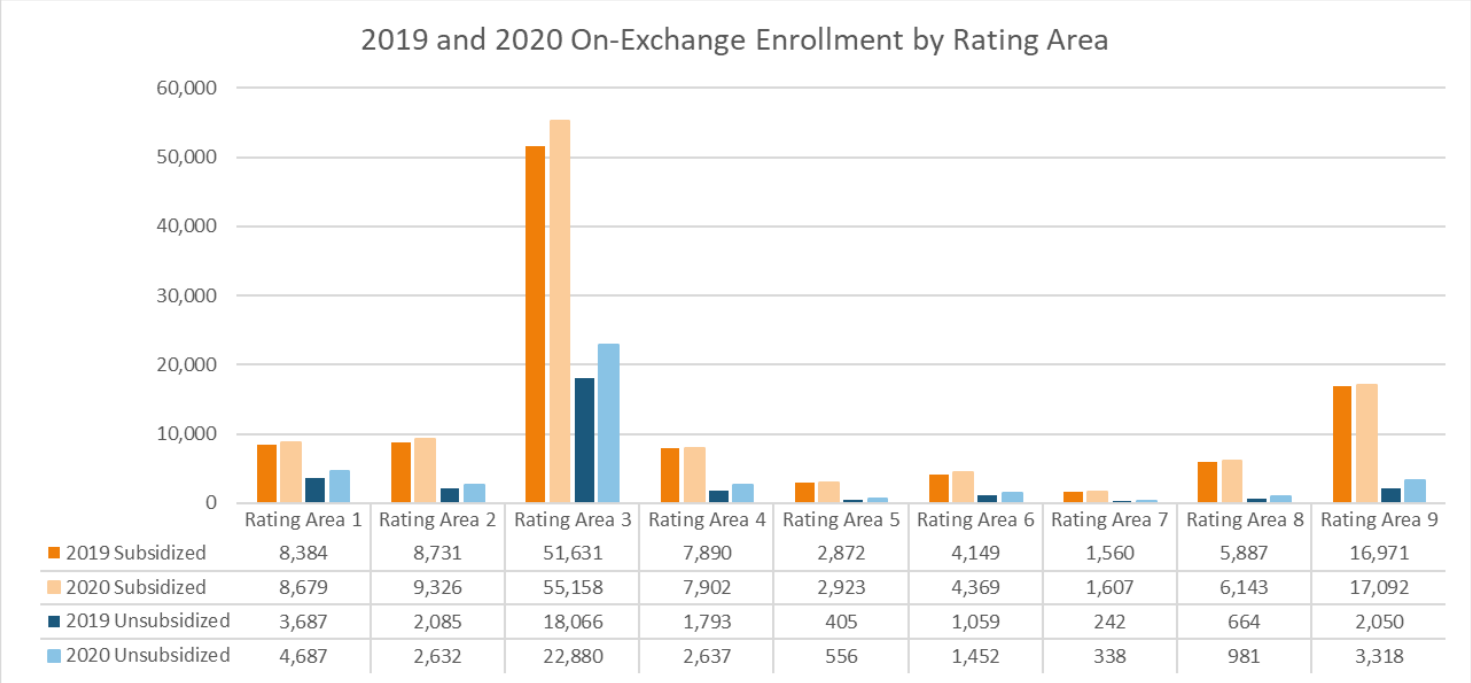
Figure 7: Enrollment in 2019 and 2020, ACA Individual Market

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

*Estimated from URRT Experience Period and Current Member Months

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

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



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

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

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

Observations about Diversity by %FPL

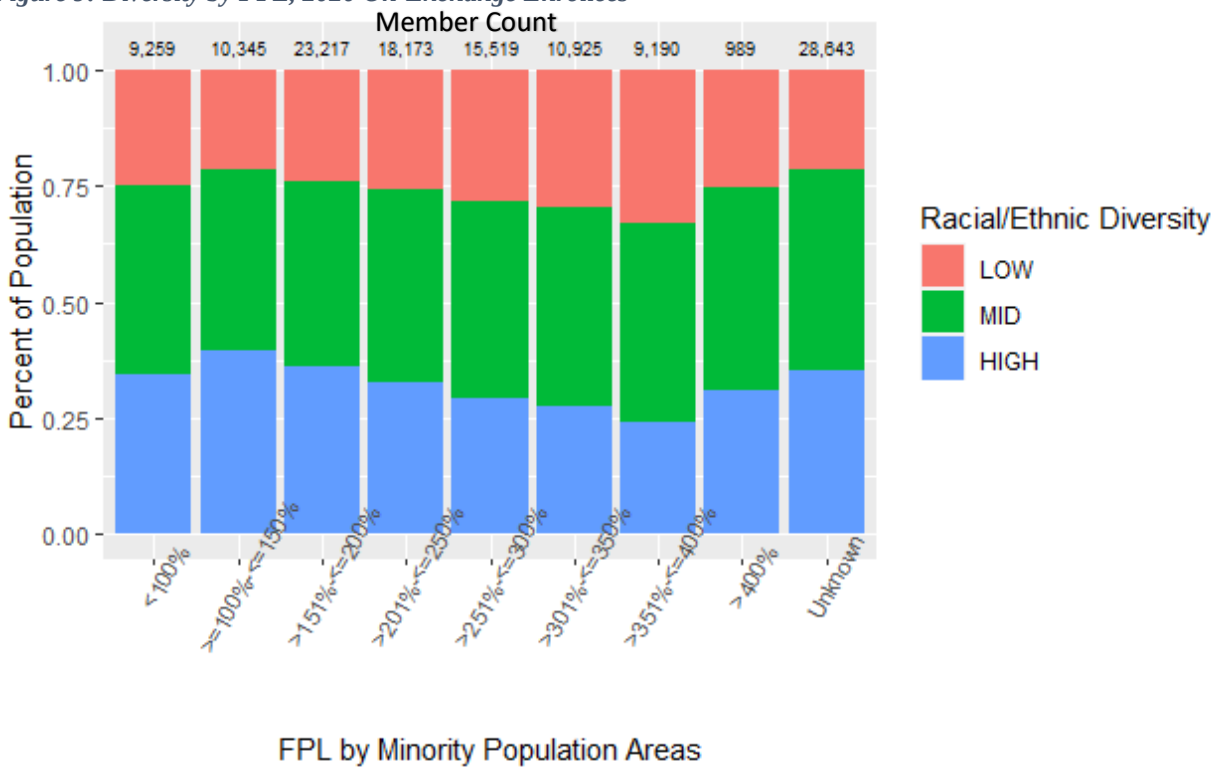
Diversity data was largely not available for the on-exchange enrollees, but the US Census allows us to consider the locations of our enrollees and provide some broad insights around race and ethnicity in the context of the individual market.

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

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

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

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



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

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

Figure 10: Diversity of member counties by Rating Area

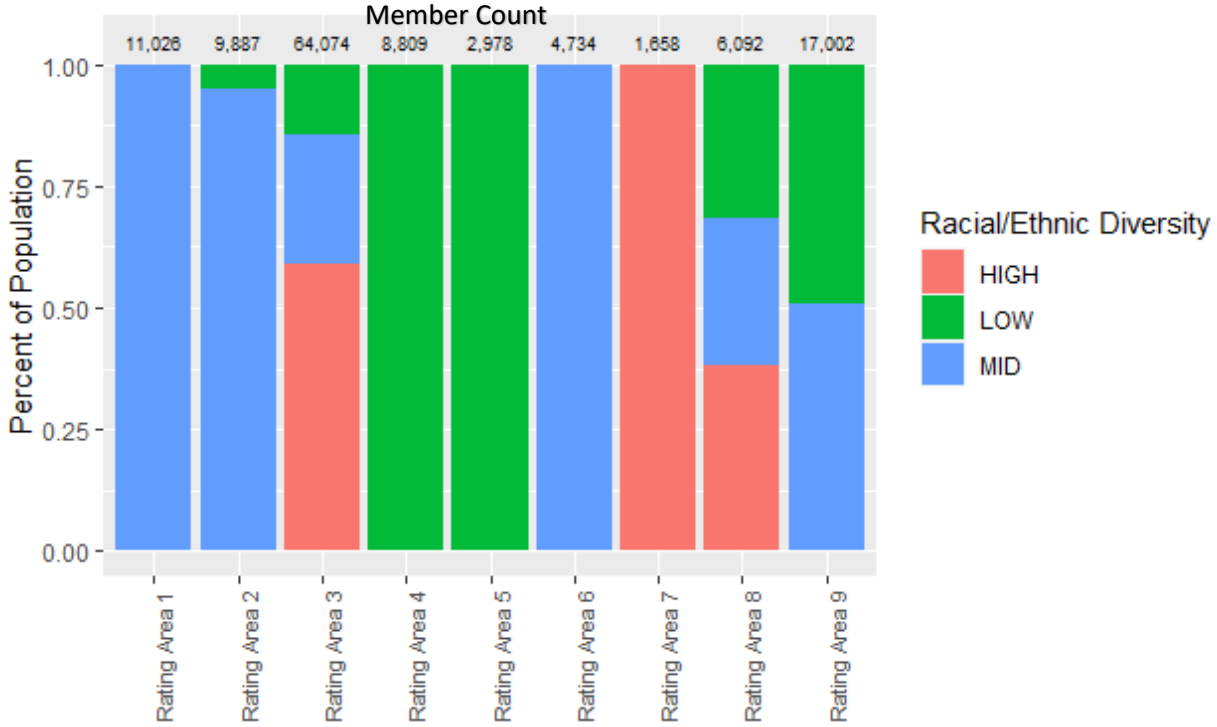
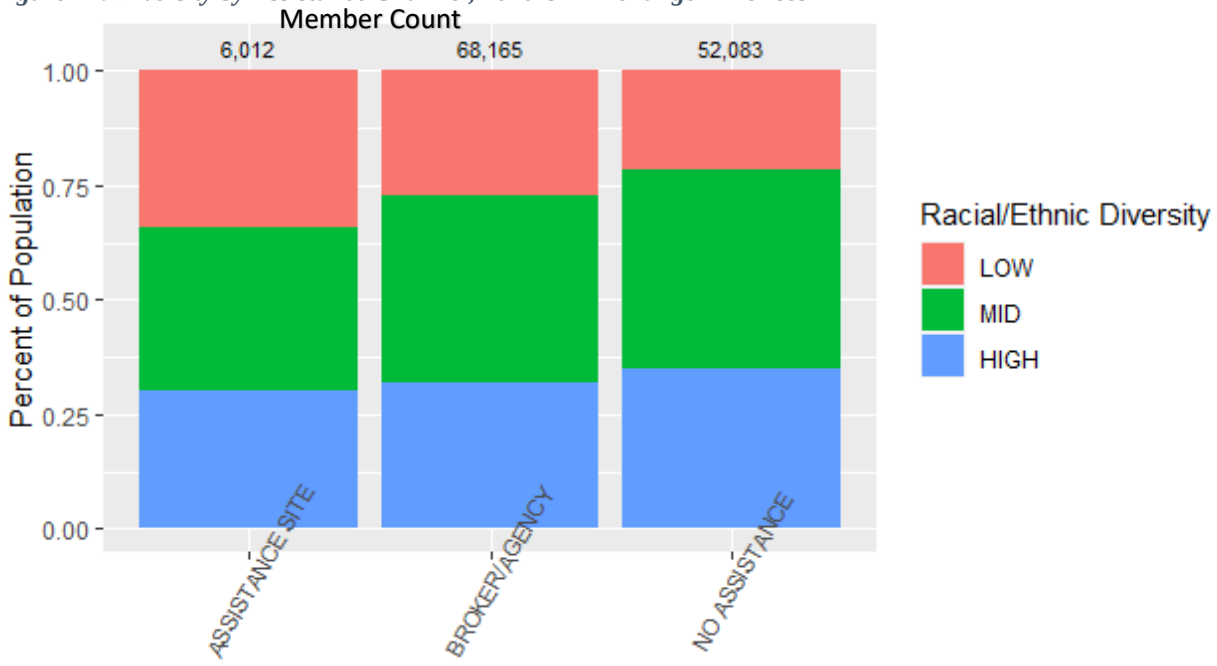


Figure 11: Diversity by Assistance Channel, 2020 On-Exchange Enrollees



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

Section 3: Impact of Unfunded CSRs, Detail

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

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

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

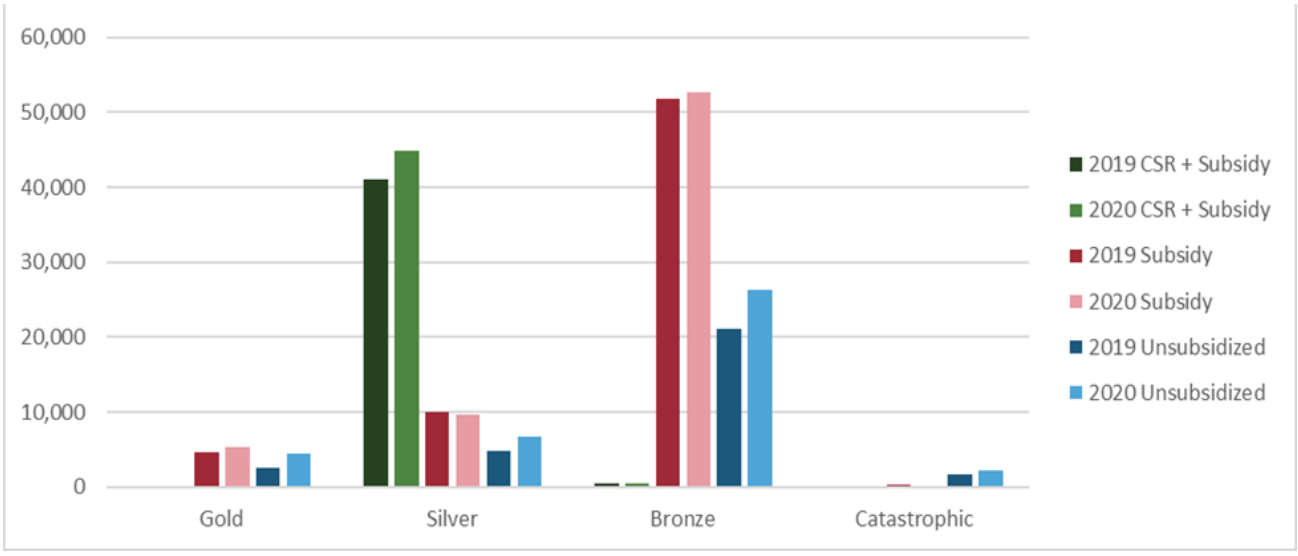
These methods include:

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

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

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

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

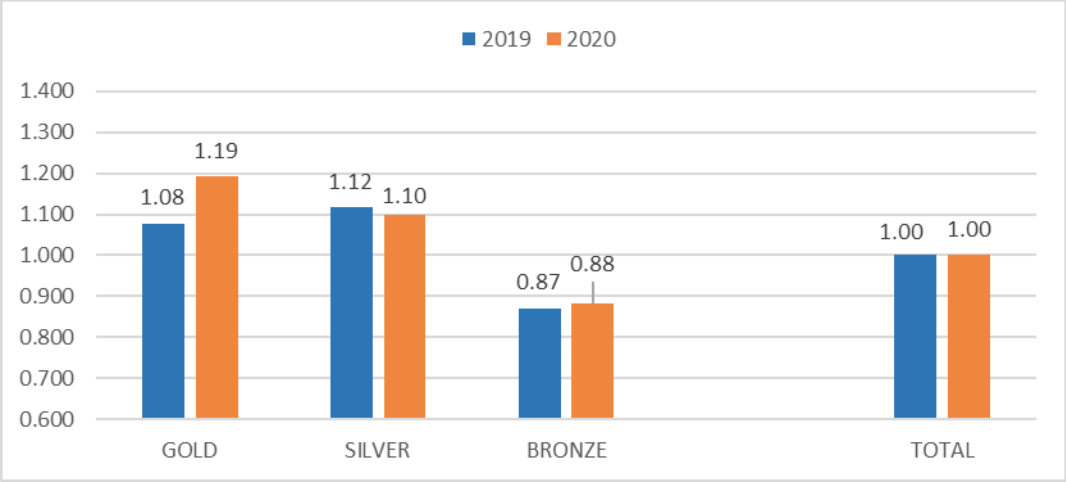


This matters, because members are changing their insurance plan based on logical comparisons and good shopping sense. This also matters because health insurance companies in this market are concerned about the migration away from Silver.
Insurers are allowed to adjust their plan pricing ratios by:

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

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

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



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

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

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

Example: Change in Pricing Ratios

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

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

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

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

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

Figure 15: Example of Silver Decrease → Subsidy Decrease

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

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

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

Section 4: Subsidized Population Changes from 2019 to 2020

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

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

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

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

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

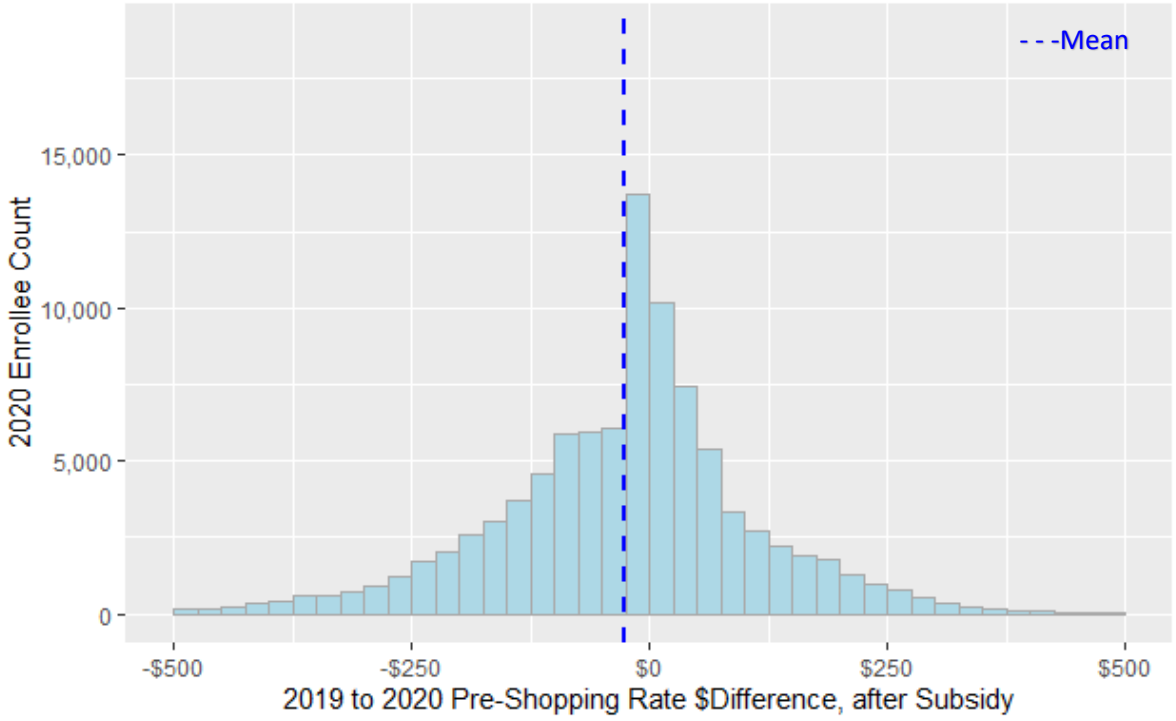
Here is an example of how this decrease in silver plan pricing and the Second Lowest Cost Silver Plan (SLCSP) would impact the total rate:

Figure 17:Example, Change in SLCSP

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

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

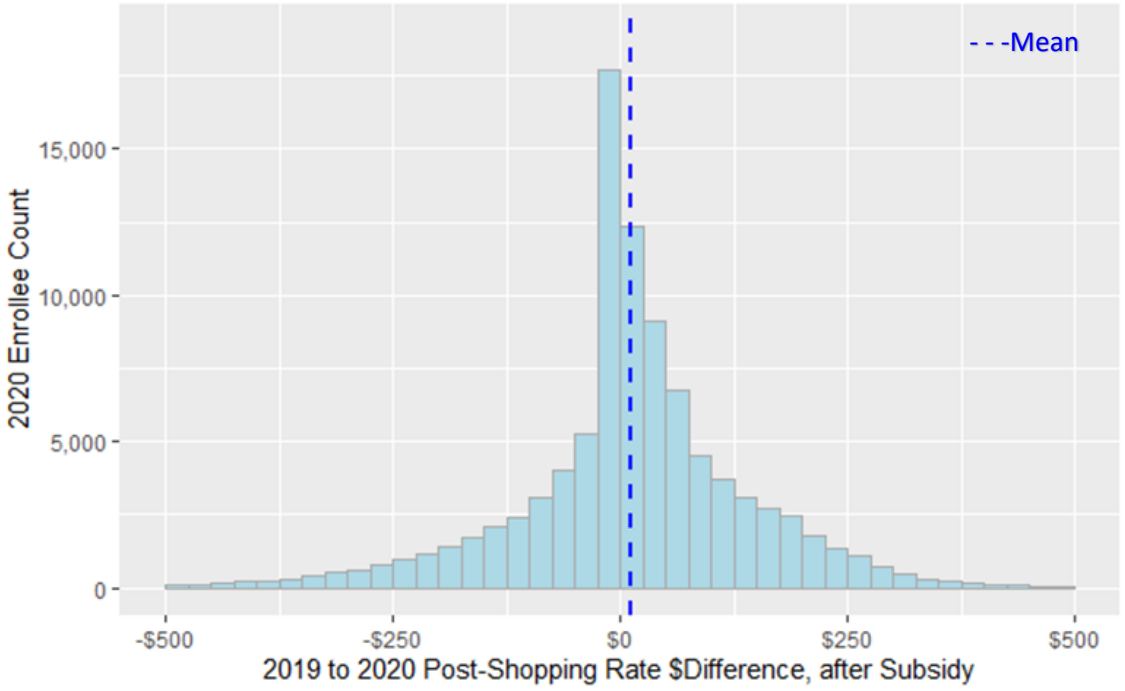
Figure 18: Range of Rate changes from 2019 to 2020, On-Exchange Subsidized Enrollees before Shopping



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

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

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

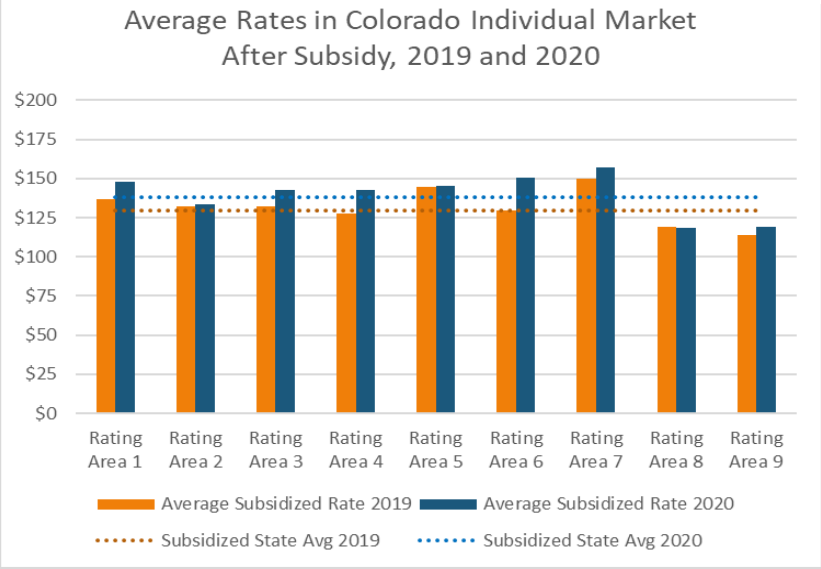


Subsidized Members After Shopping…	
...receiving Rate Increase	54%
...receiving Rate Decrease	46%

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

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

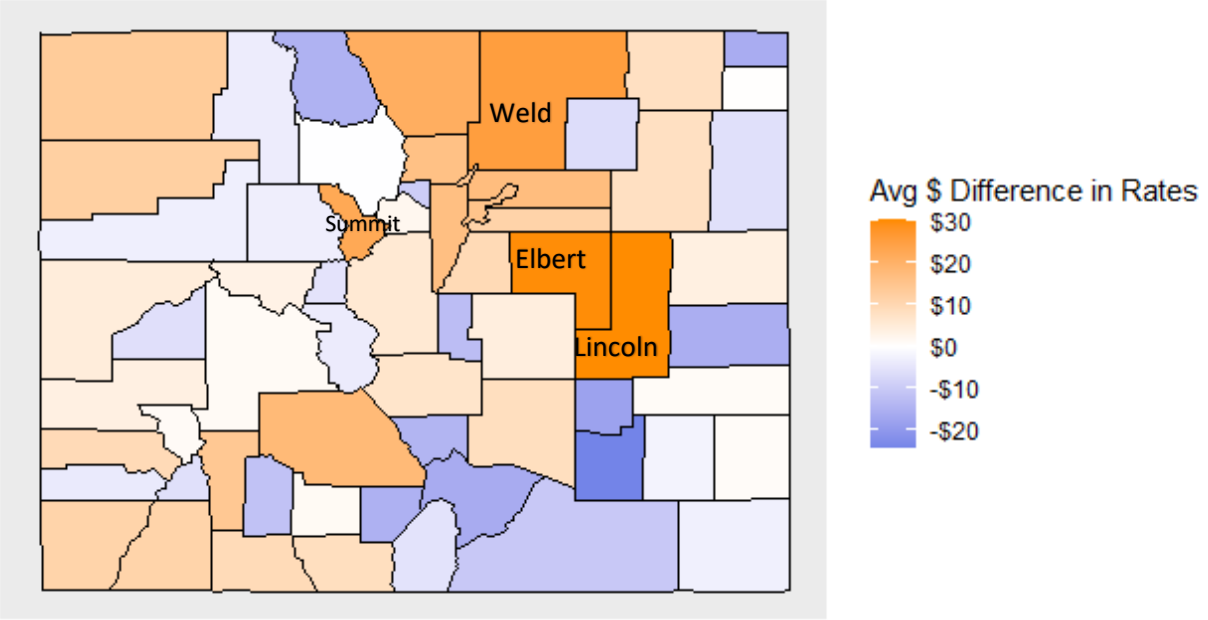
Figure 20: Rates by Rating Area, 2019 and 2020, Subsidized Enrollees



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

See the map below:

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



Example 1: Second Lowest Silver Mismatch in Weld County

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

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

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

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

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

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

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

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

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

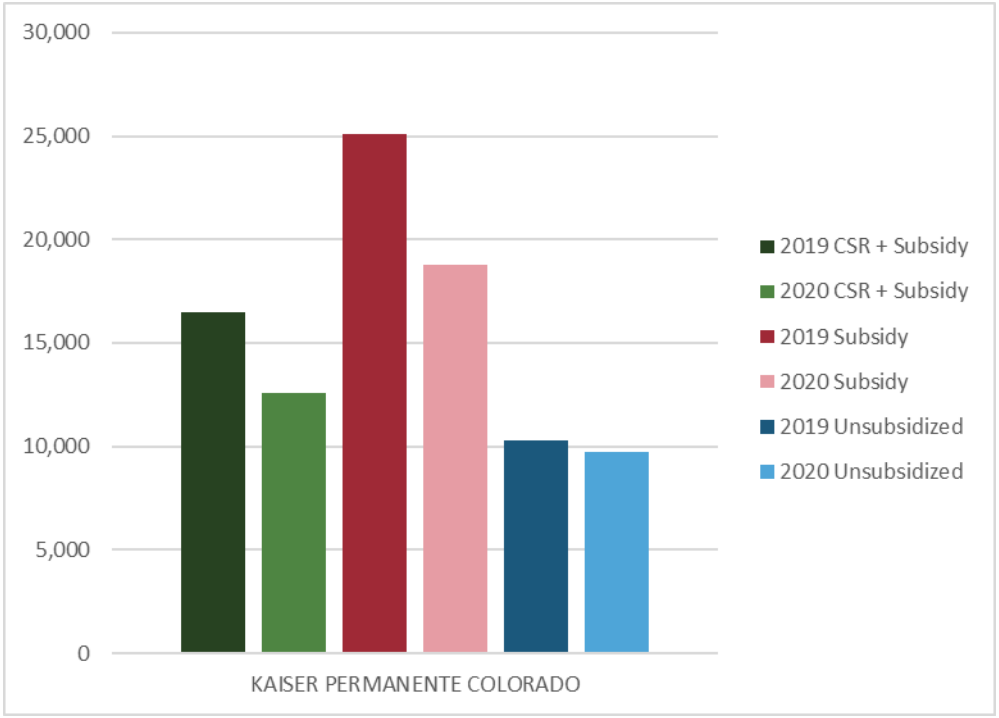
SLCSP Carrier	Change in SLCSP	% Membership
KAISER -> BRIGHT	-44%	29%
KAISER -> BRIGHT	-44%	71%

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

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

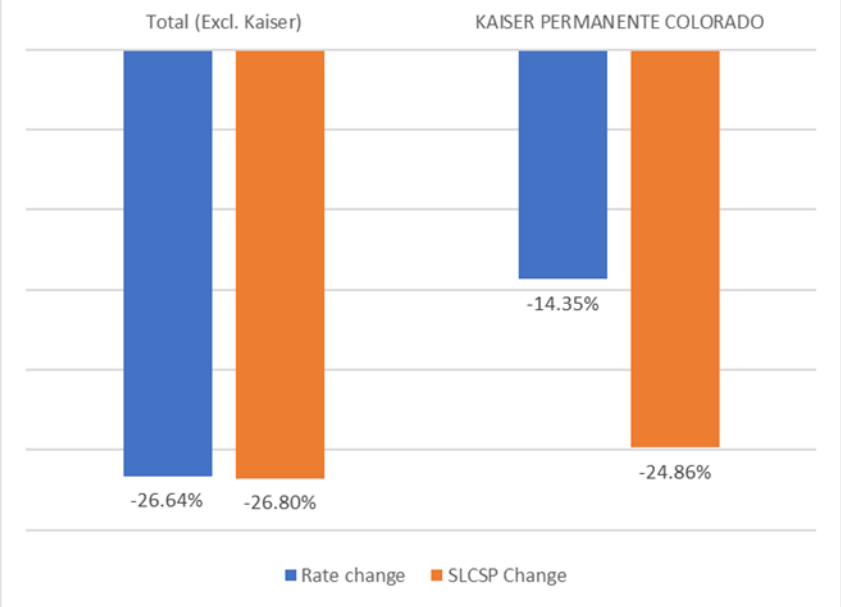
See below for a Kaiser enrollment chart by subsidy:

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



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

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



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

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

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

Section 5: Impact of Enrollment Choices

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

Members may make the following decisions:

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

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

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

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

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

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

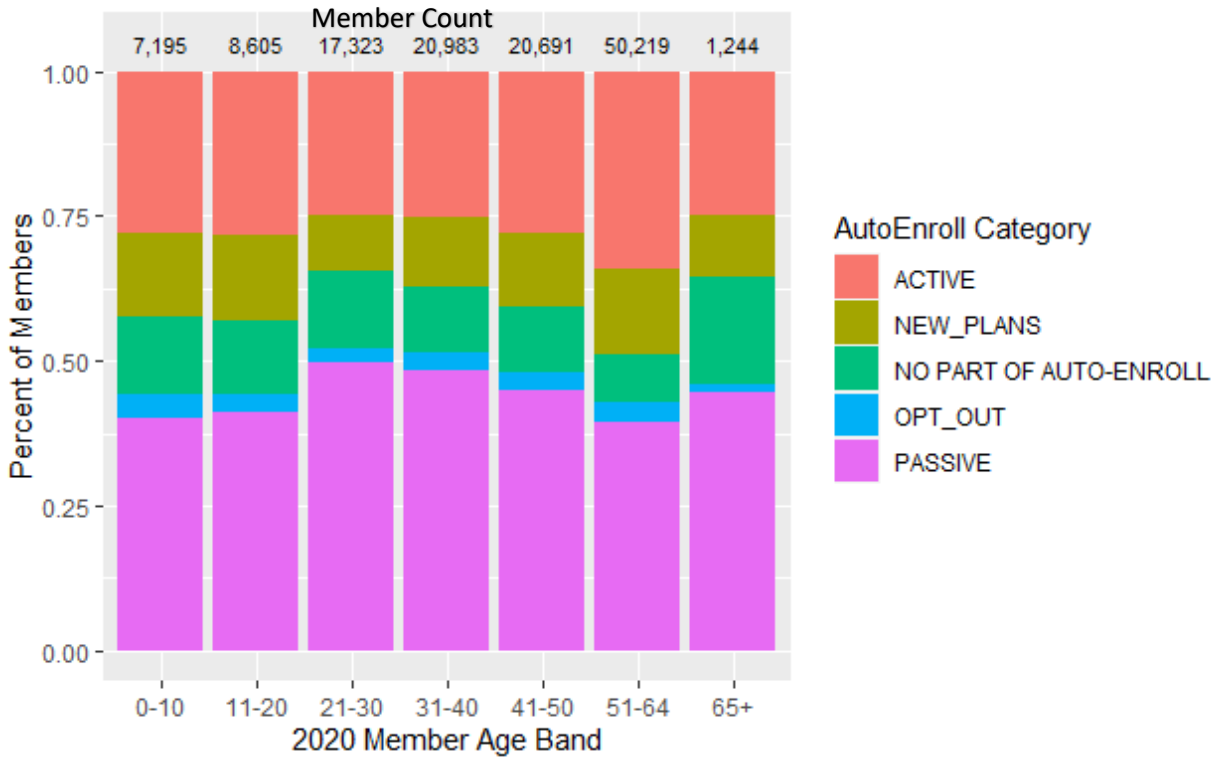
Continuing On-Exchange Members	Active	Passive	New Plan	Opt-Out	No Part of Auto-Enroll
Unsubsidized	28%	44%	13%	2%	12%
Subsidized	30%	43%	13%	3%	10%

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

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

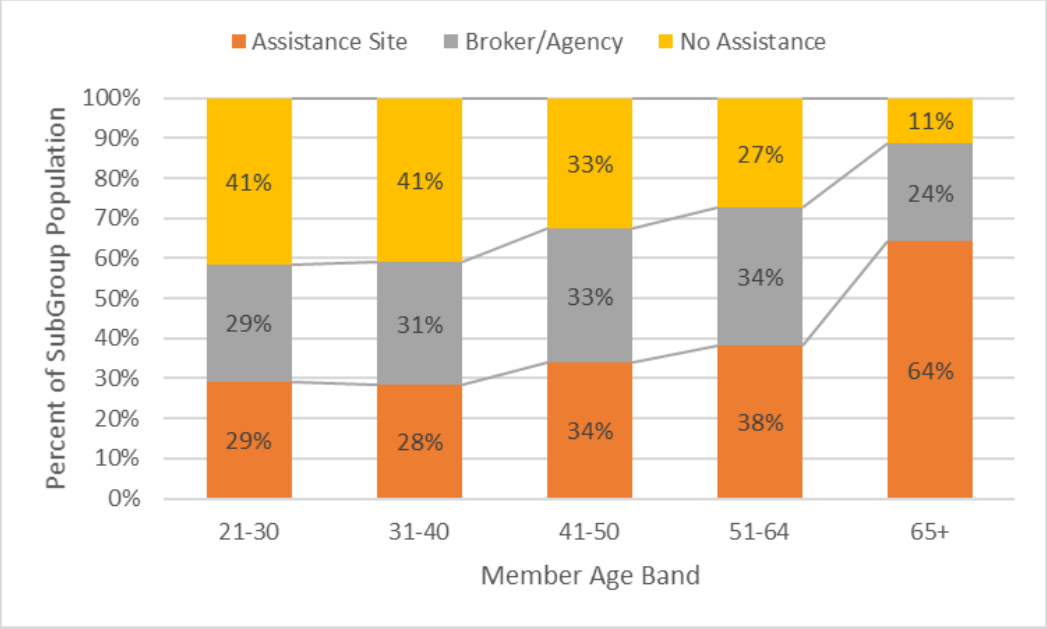
What follows is a description of characteristics that define member auto-enroll actions.

Figure 27: 2020 Auto-Enroll Action by Age Band



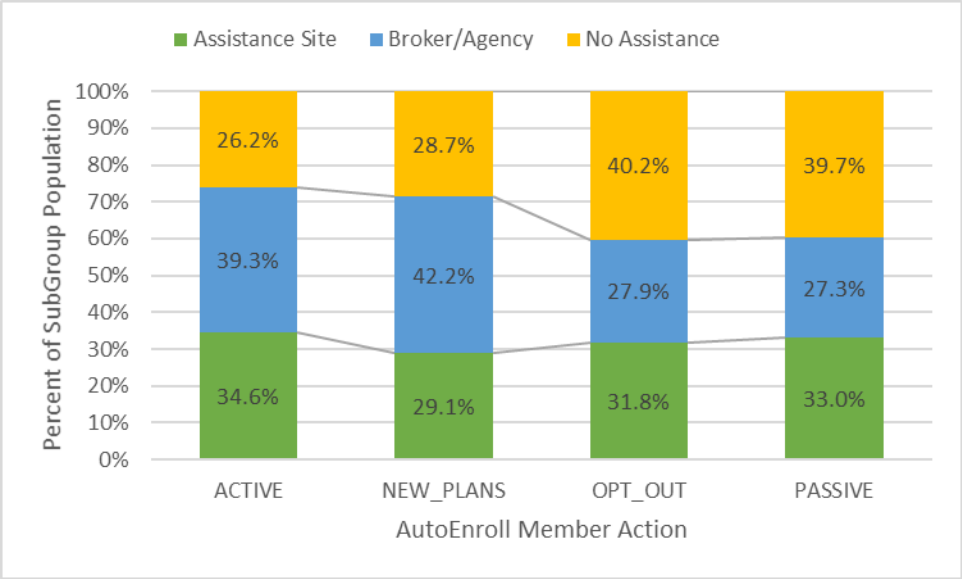
Older members are less likely to passively accept their auto-enroll plan. They are more likely to review their choices, and more likely to shop. This may partially be a result of larger rates as a member ages, or it might be a function of those older members seeking enrollment assistance, as the next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

Figure 28: 2020 Assistance Channel by Age Band



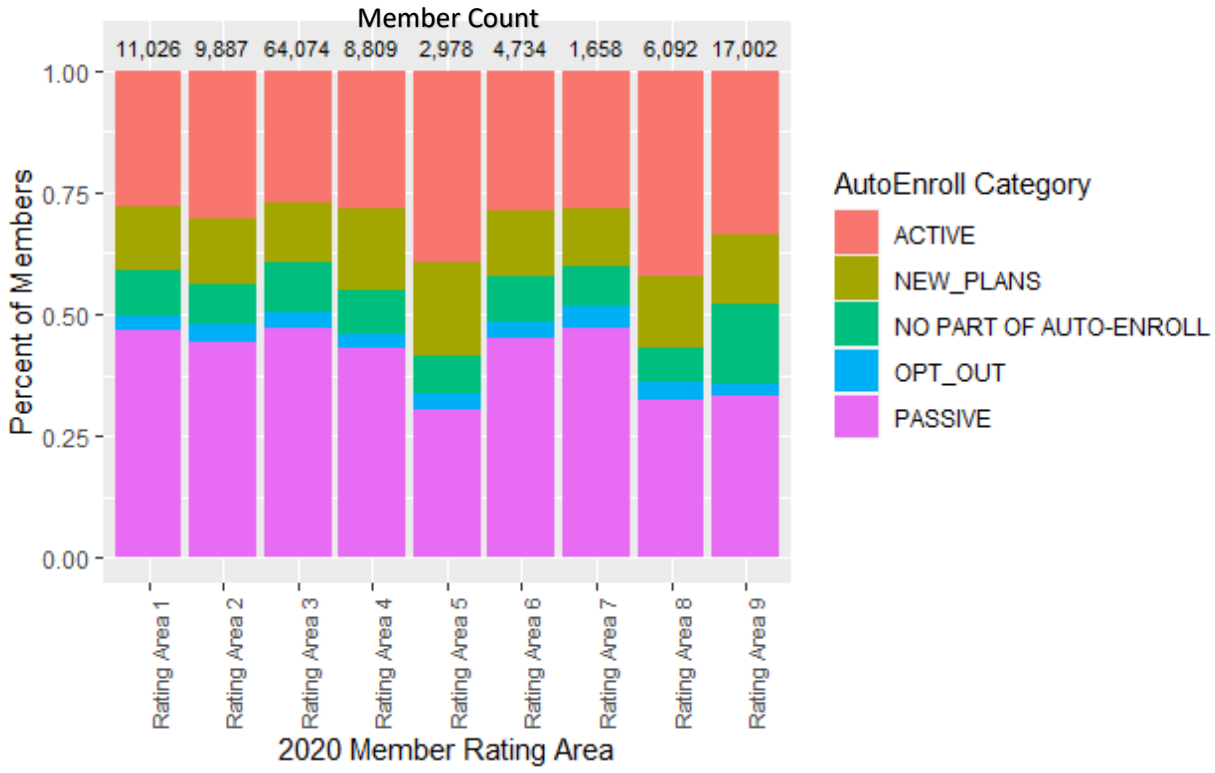
The above chart (prior page) shows that use of enrollment assistance is not propotional by age group. Older members are more likely to utilize the Assistance Site. Younger members are much more likely to enroll without assistance.

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



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

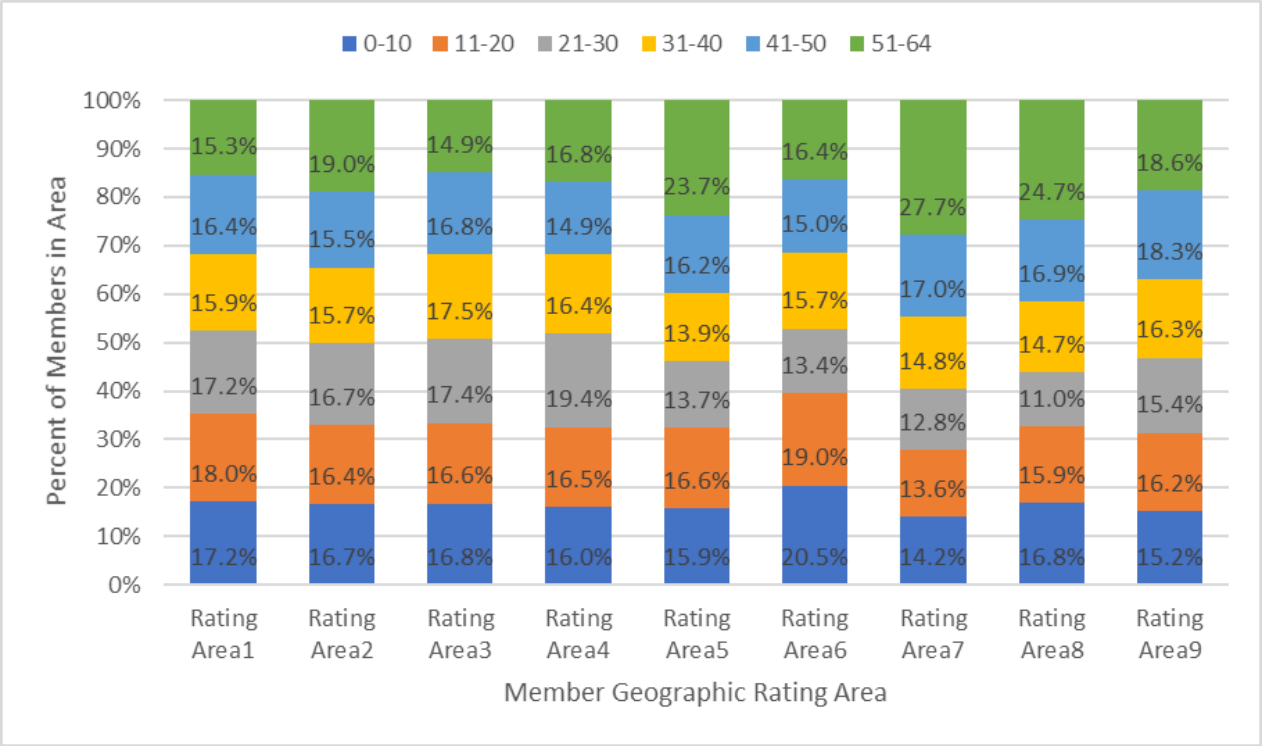
Figure 30: 2020 Auto-Enroll Action by Geographic Rating Area



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

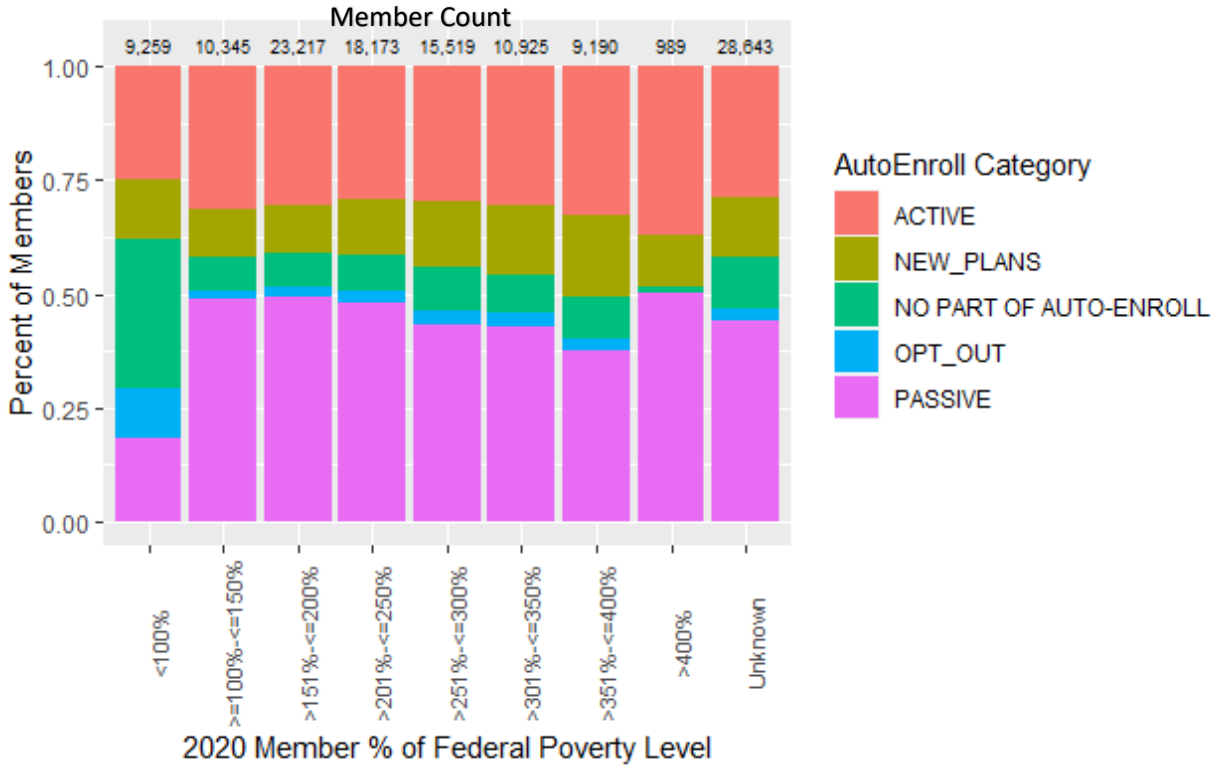
The next chart explores age by rating area:

Figure 31: Age Band by Geographic Rating Area



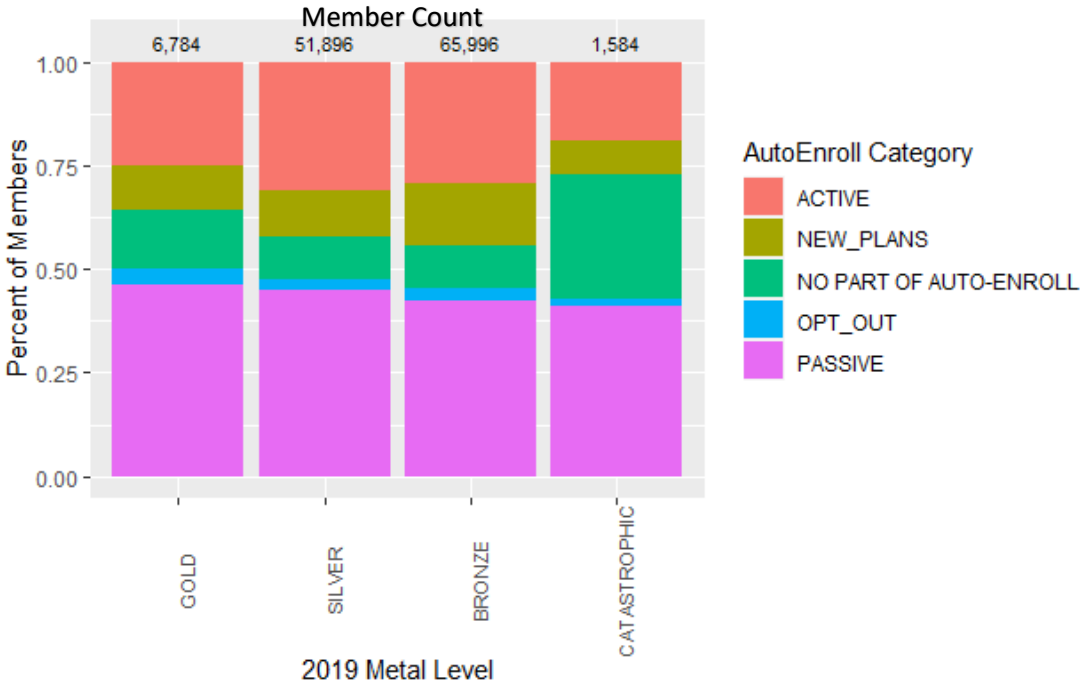
The graph above indicates that members ages 51 to 64 are a smaller portion of members in Rating Area 3, and a larger portion in Rating Areas 5 and 8. The lower passive enrollments in Areas 5 and 8, and higher passive enrollments in Area 3 may be connected to age of the members living in those areas.

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



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

Figure 33: 2020 Auto-Enroll Actions by Metal Level



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

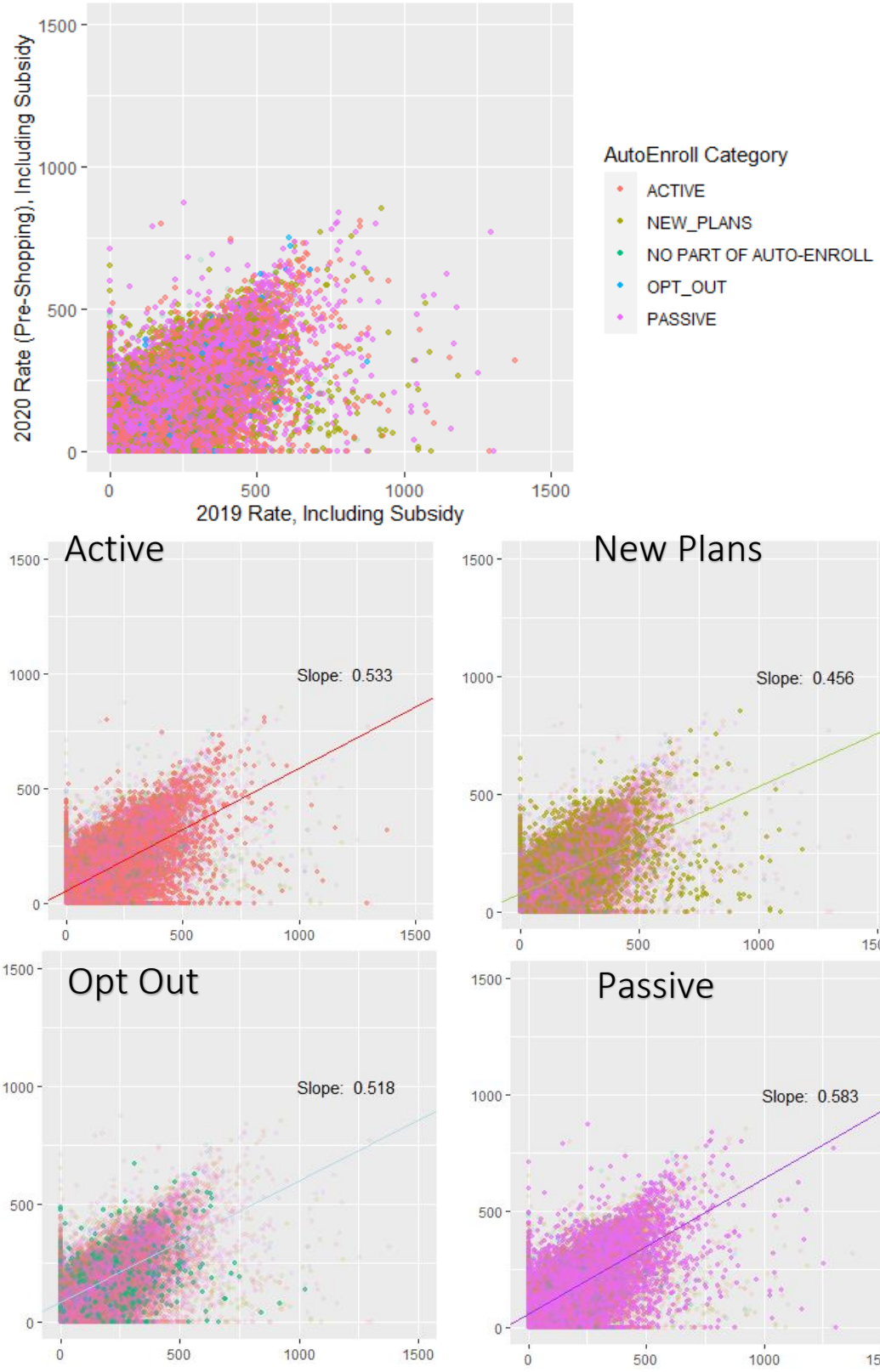
Overall, the common thread driving active auto-enroll decisions is a sensitivity to cost, especially for those paying larger premiums and getting smaller subsidies. It is more likely active enrollment and shopping will occur among older, healthier members, receiving a small subsidy, and dwelling in the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

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

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

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

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



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

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

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

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

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

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

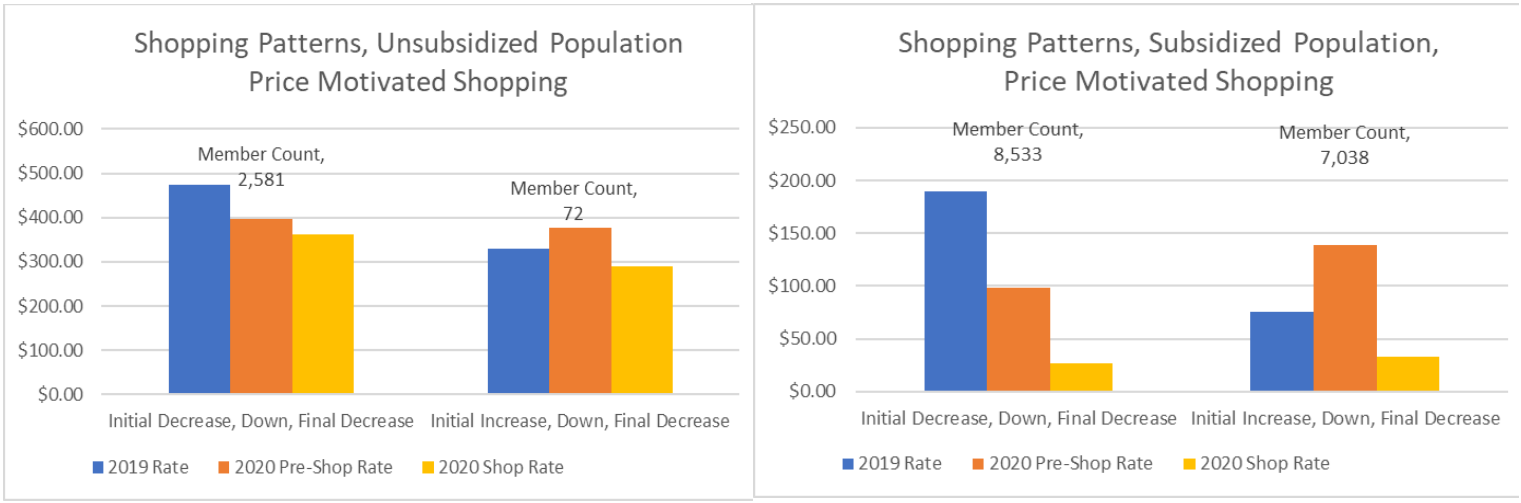
Of these:

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

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

Price Motivated Shoppers:

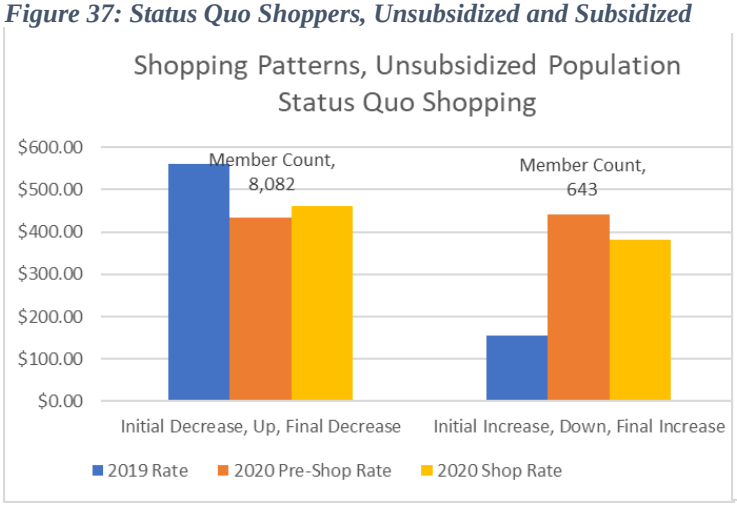
Figure 36: Price Motivated Shoppers, Unsubsidized and Subsidized

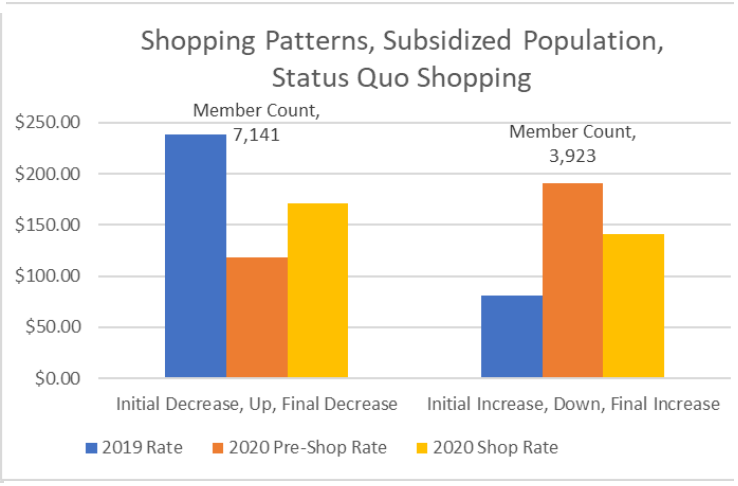


No matter what initial rate is presented, these members will shop for a lower price and this is more likely to occur for subsidized members. Between 15% and 20% of these members dropped to a lower metal level in pursuit of a cheaper plan.

Status Quo Shoppers:

Figure 37: Status Quo Shoppers, Unsubsidized and Subsidized

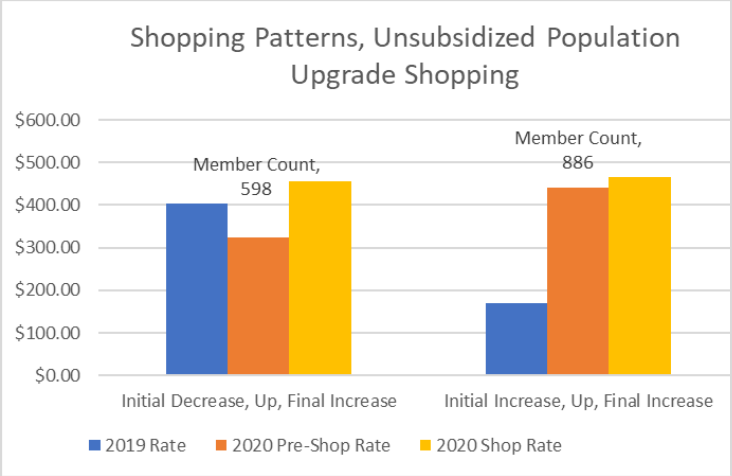


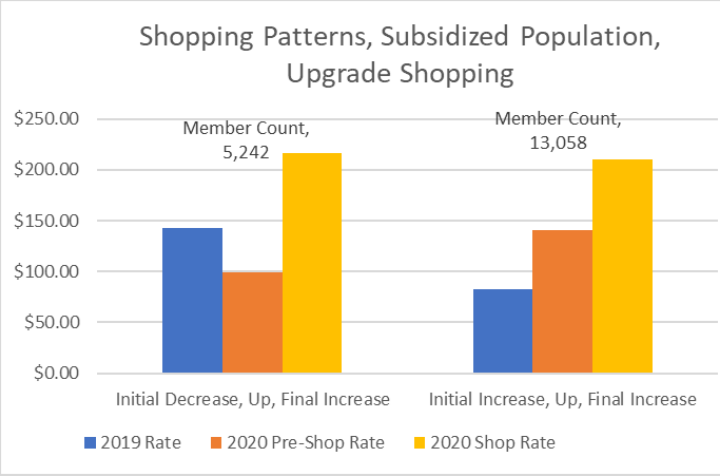


Status Quo Shoppers is the largest group for the unsubsidized population and the smallest group for the subsidized. These members are trying to keep their costs consistent with the prior year. 26% had a change in income that made shopping necessary. 30% of this category moved to another insurance carrier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

Upgrade Shoppers:

Figure 38: Upgrade Shoppers, Unsubsidized and Subsidized

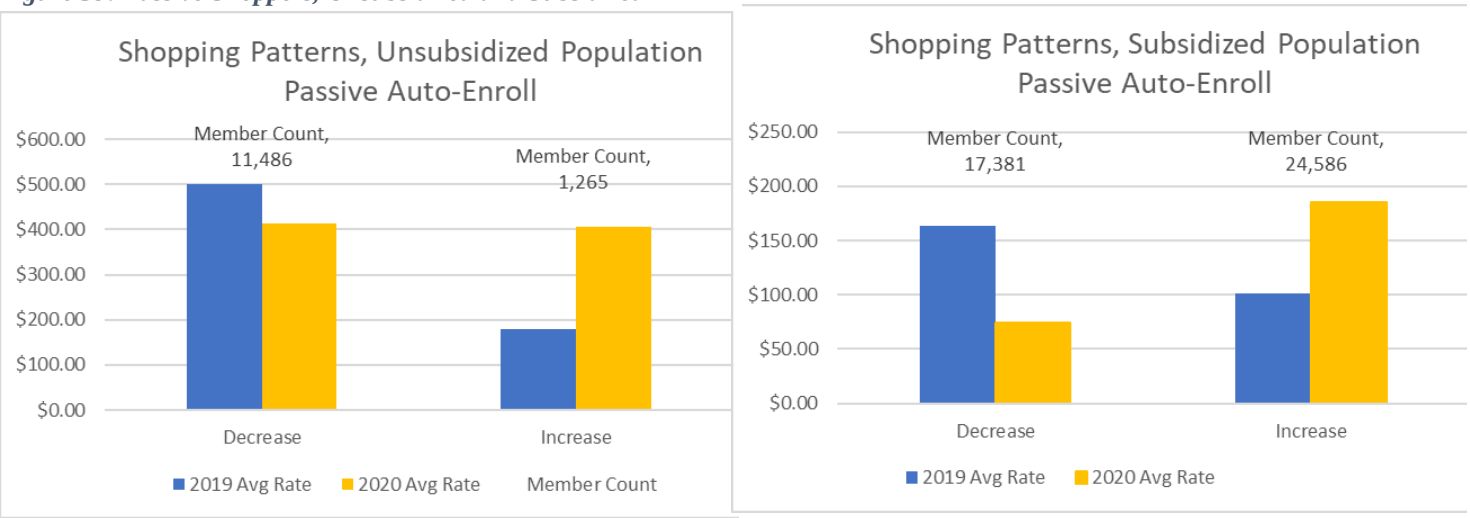




Upgrade shoppers are the largest group for subsidized members; these shoppers are selecting a more expensive plan than what they were presented, and more expensive than current. Roughly 28% had a change in income that would motivate the switch. Of the unsubsidized, roughly 53% of the Upgrade shoppers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

Passive Shoppers:

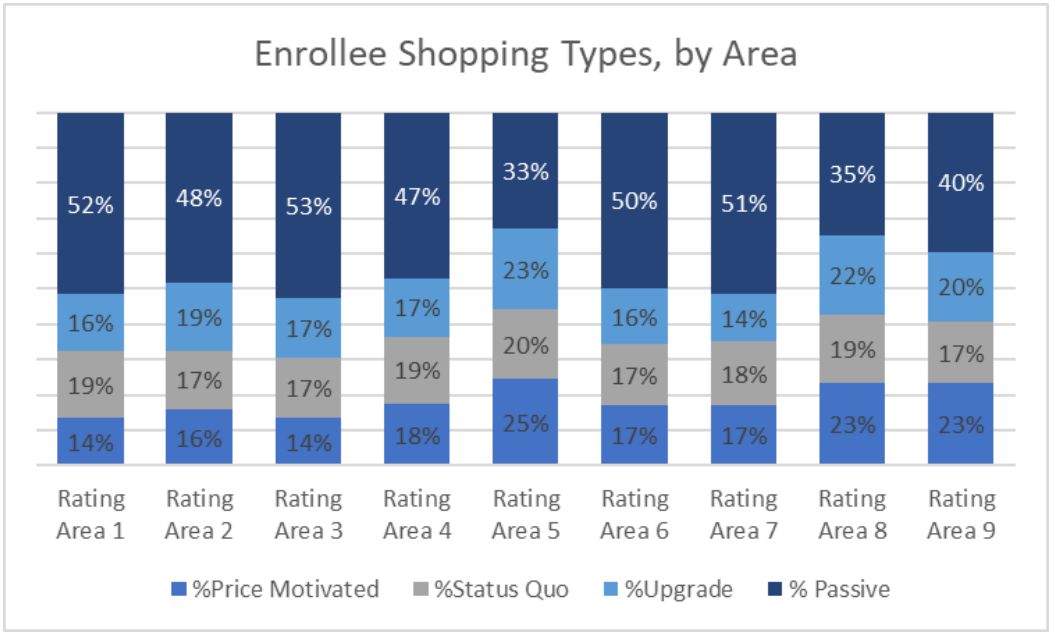
Figure 39: Passive Shoppers, Unsubsidized and Subsidized



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

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

Figure 40: 2020 Shopping Type by Rating Area



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

Section 6: Data and Methodology

6.1 Data Used

For this study, the following data sources were used:

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

6.2 Methodology

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

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

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

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

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

Section 7: Disclosures and Limitations

7.1 Intended Users, Scope, and Purpose

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

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

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

7.2 Qualifications

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

7.3 Risk/Uncertainty

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

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

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

7.4 Conflicts of Interest

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

7.5 Data Reliance

L&E relied upon data provided by the Colorado Division of Insurance, the non-group ACA market carriers in Colorado, Connect for Health Colorado, and several US Federal Government data sources, listed in our data section. L&E has reviewed the data and assumptions for reasonableness but has not performed an independent audit. To the extent that information provided is inaccurate or incomplete, the analysis could be materially impacted. For a list of data sources, please see Section 6.1 of the report. Key assumptions are outlined in the methodology section.

7.6 Dates Applicable

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

7.7 Subsequent Events

This report was finalized on October 31, 2020. The report assumes no uncertain and potential future changes to the Affordable Care Act or the Colorado health care marketplace that could materially impact how results should be interpreted or acted upon. There are many future developments that could materially change these results including court rulings, new regulations, additional allowed ACA exemptions, a continuation of the COVID-19 pandemic that could impact enrollment decisions, or a material change to the health care markets in general. In addition, any changes made to the parameters or structure of the reinsurance program could have a material impact on the outcomes outlined above. These subsequent events are not included in this report and should be carefully considered by qualified experts before applying the findings contained within this report.

Attachment 4

COLORADO
Department of Regulatory Agencies
Division of Insurance

Instructions for Completing the URRT Supporting Statement

For the Filing Without Reinsurance

It is critical for carriers to supply reasonable best estimate assumptions in both the URRT without reinsurance and the URRT with reinsurance. The differences in these filings directly impact the calculation of federal pass-through funding for the Colorado Reinsurance Program. It is important to have accurate information to calculate pass-through funding as this impacts overall funding to the Reinsurance program and therefore payments to each carrier.

As such, the Division is requiring carriers to provide brief supporting statements (1-2 pages total) that explain differences between the two URRTs. In the filing without reinsurance, please attach the statement under the URRT heading on the Supporting Documents tab in SERFF. The following factors must be considered:

1. Unit Cost and Utilization Trends (URRT worksheet 1)
   The removal of reinsurance reimbursement may have an indirect impact to claims that could be addressed either through trend values, or through the population and morbidity adjustments.

2. Morbidity Adjustment (URRT worksheet 1)
   Enrollment changes, due to removal of reinsurance, might impact the underlying health of enrollees.

3. Demographic Shifts (URRT worksheet 1)
   Enrollment changes might impact the mix of enrollees.

4. Reinsurance Impact (URRT worksheet 1 and 2)
   It is expected this value will be zero in any filing without reinsurance.

5. Risk Adjustment Payment/Charge (URRT worksheet 1 and 2)
   If a change in population morbidity is assumed, in a scenario with no reinsurance, risk adjustment assumptions should be adjusted according.

6. Projected Member Months (URRT worksheet 1 and 2)
   Based on assumed enrollment changes without reinsurance.

7. Expenses (URRT worksheet 2)
   Non-claim expenses are shown as a percent of premium on the URRT. An increase in premium, due to removal of the reinsurance program, might lower the necessary non-claim percentages to collect the same total dollars.

8. Rating Area Factors (URRT worksheet 3)
   The reinsurance program pays differently depending on what area of the state a member resides in. These differences are generally reflected in area factors if business is written in multiple areas of the state. If reinsurance were removed, these factors would also be altered.

9. Calibration Factors (URRT worksheet 2)
   Area factors may have changed, and population shifts may have occurred. Depending on materiality, calibration factors could be impacted.

Attachment 5

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-71

CONCERNING CARRIER CARE MANAGEMENT PROTOCOLS FOR THE COLORADO REINSURANCE PROGRAM

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, and 10-16-1105(5), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to amend the carrier submission requirements for the Reinsurance Program Care Management Protocols, pursuant to § 10-16-1105(5), C.R.S. Care Management Protocols are intended to promote more cost-effective health care and to be fair to federal taxpayers by restraining growth in federal health care spending commitments. Eligible Carriers are required to submit Care Management Protocols to confirm their strategies for managing claims within the Colorado Reinsurance Program Payment Parameters.

Section 3 Applicability

This regulation applies to all eligible carriers that participate in the Colorado Reinsurance Program pursuant to Title 10, article 16, part 11.

Section 4 Definitions

A. “Attachment Point” shall have the same meaning as found at § 10-16-1103(1), C.R.S.

B. “Benefit Year” shall have the same meaning as found at § 10-16-1103(2), C.R.S.

C. “Care Protocols” means the strategy an Eligible Carrier implements to manage claims within the Reinsurance Payment Parameters and promote more cost-effective health care, pursuant to § 10-16-1105(5), C.R.S.

D. “Eligible Carrier” shall have the same meaning as found at § 10-16-1103(5), C.R.S.

E. "Health Care Provider" means a hospital, physician group, or other medical provider entity licensed or certified by the Department of Public Health and environment pursuant to § 25-1.5-103.

F. "Payment Parameters" shall have the same meaning as found at § 10-16-1103(9), C.R.S.

G. "Reinsurance Program" shall have the same meaning as found at § 10-16-1103(12), C.R.S.

H. "SERFF" means the System for Electronic Rates and Forms Filing.

Section 5 Care Management Protocol Requirements

A. Eligible Carriers must develop and implement Care Management Protocols that promote cost-effective care and manage claims costs for enrollees whose claims are expected to exceed the Reinsurance Program Attachment Point. The Division of Insurance (Division) publishes the Reinsurance Program Payment Parameters, including the Attachment Point, on or before March 15th annually for the following program year.

B. Beginning in 2020, Eligible Carriers shall file the Reinsurance Care Management Protocol Assessment (available in SERFF) for the applicable benefit year with their annual rate filings, submitted to the Division per the requirements of § 10-16-107, C.R.S. Care Management Protocols describe Eligible Carriers' strategies for managing high-cost claims and providing effective care management for members whose claims costs are expected to exceed the Reinsurance Program Attachment Point.

1. Eligible Carriers must use the Reinsurance Care Management Protocol Assessment form (available in SERFF) to submit information to the Division to fulfill this requirement.

2. Eligible Carriers must identify enrollees whose claims are expected to fall within the Payment Parameters.

    a. Carriers must identify reinsurance-eligible individuals prospectively, when possible, based on claims history.

    b. In cases where prospective identification of reinsurance-eligible individuals is not possible (e.g. new enrollee with no claims history, or unexpected claims costs due to emergency care), carriers must have care management strategies in place with contracted providers to implement as needed for enrollees whose claims become reinsurance-eligible.

    c. Carriers must describe any efforts to include social determinants of health in their member risk stratification models, as well as any other efforts to address health equity issues among reinsurance-eligible members through Care Management Protocols.

3. Eligible Carriers must implement strategies with contracted providers to manage care costs and utilization for enrollees whose claims are expected to fall within the Payment Parameters.

    a. Carriers must describe the care management services and activities they require contracted providers or other entities to perform for the impacted enrollee population.

    b. Carriers must describe how they track care management services and activities performed by contracted providers or other entities.

c. Carriers must note any significant differences in care management strategies or services performed by geographic region.

4. Eligible Carriers must describe any payments made to contracted providers or other entities for the provision of care management services and activities.

5. Eligible Carriers must estimate the annual savings to the Colorado Reinsurance Program they expect to generate through their Care Management Protocols. “Savings” are generally defined as the difference between a carrier’s estimated total reinsurance payment amount with Care Management Protocols implemented and the estimated reinsurance payment amount without them.

6. Eligible Carriers must include in their submission of the Reinsurance Care Management Protocol Assessment any contracts (e.g. participation agreements, provider agreements, etc.), actuarial analysis or data, and other documentation that support the Eligible Carriers’ responses to the Assessment.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This amended regulation shall be effective June 15, 2021.

Section 9 History

New regulation effective August 15, 2020.
Amended regulation effective June 15, 2021.

COLORADO
Department of Regulatory Agencies
Division of Insurance

Reinsurance Care Management Protocol Assessment

Eligible Carriers must submit written responses to the following questions. Responses should address all bulleted items below each question.

(Limit: 1500 words, not including attachments or supporting materials)

Carrier Name:

NAIC Number:

Carrier Reinsurance Point of Contact (POC) Name:

Carrier POC Email:

Carrier POC Phone:

1) Provide an overview of the carrier's care management strategy for members whose annual claims costs are expected to exceed the Reinsurance Program Attachment Point.

- Describe how the carrier supports the provision of care management through its provider contracts and how it uses care management to promote cost-effective health care.
- State the carrier's financial and care delivery goals related to care management.
- Describe how the carrier identifies members whose claims may be eligible for reinsurance.
- NEW: Describe any ways the carrier includes social determinants of health in its member risk stratification model, as well as any efforts to address health equity issues among reinsurance-eligible members.
- NEW: Note any significant geographic differences in the carrier's care management strategy or services performed by geographic region.

2) State the carrier's requirements for contracted providers or other entities regarding patient care management for members whose claims may be eligible for reinsurance.

- Which members receive care management? How, when, and by whom are these members identified? How are members notified regarding care management?
- State the care management activities or services that providers are required to offer. What is the typical frequency and duration of these services?
- NEW: Who performs care management activities (e.g. physicians, non-physician practitioners, care coordinators, patient navigators, etc.)? Does the carrier contract with any care management companies to provide services? If so, which one(s)?
- Approximately how many FTEs does the carrier expect providers to allocate per patient for care management?

3) Describe how the carrier tracks care management services and activities performed by contracted health care providers or other entities.

- Does the carrier require contracted providers to report on the care management services and activities they perform? If yes, describe the reporting requirements.
- To what extent does the carrier use claims data to track care management?
- Does the carrier require providers to report particular quality measures (MIPS, NQF, etc.) related to care management or care coordination? If yes, list the measures.
- Describe any data validation or auditing processes the carrier uses to verify care management data from providers.
- Describe any penalties the carrier imposes in cases where providers do not meet care management requirements.

4) Describe any claims-based or non-claims-based payments the carrier provides for care management activities and services.

- Does the carrier provide per-member-per-month or other regularly scheduled payments for member care management? If yes, describe the amount and frequency of the payment, and state the activities and services it covers.

5) Estimate the savings to the Colorado Reinsurance Program the carrier expects its Care Management Protocols to generate.

- NEW: Savings are generally defined as the difference between a carrier's estimated total reinsurance payment amount with Care Management Protocols implemented, and the estimated reinsurance payment amount without them.
- Savings should be represented by average annual claims reductions per enrollee for enrollees whose claims are eligible for reinsurance, along with aggregate savings across all eligible enrollees.

6) Attach any contracts (e.g. participation agreements, provider agreements, etc.), actuarial analysis or data, and other documentation supporting the responses above. List attachments here:

COLORADO
Department of Regulatory Agencies
Division of Insurance

Colorado Reinsurance Care Management Protocols
2020 Assessment Summary

Overview and Background

In order to promote more cost-effective health care coverage and to be prudent with federal taxpayer funds by restraining growth in federal spending commitments, Colorado House Bill 19-1168 stipulates that Colorado's Insurance Commissioner shall require each health insurance carrier eligible for the Reinsurance Program to file the care management protocols the carrier will use to manage claims within the payment parameters. The Commissioner shall establish by rule the deadlines for filing this information, along with the form and manner of filing.

In June 2020 the Division adopted New Regulation 4-2-71: Concerning Carrier Care Management Protocols for the Colorado Reinsurance Program (effective 8/15/20). As stated in the rule:

> *The purpose of this regulation is to establish carrier submission requirements for the Reinsurance Program Care Management Protocols, pursuant to § 10-16-1105(5), C.R.S. Care Management Protocols are to promote more cost-effective health care coverage and to be fair to federal taxpayers by restraining growth in federal health care spending commitments. Eligible Carriers are required to submit Care Management Protocols to confirm their strategies for managing claims within the Colorado Reinsurance Program Payment Parameters.*

Starting in 2020, all individual market carriers eligible for reinsurance payments must submit their care management protocols in their annual rate filings, using the Colorado Reinsurance Care Management Protocol Assessment developed by the Division (available here). The Assessment aims to capture the information required by Colorado statute and was informed by care management programs from state, federal, and commercial payers, including the Maryland Carrier State Reinsurance Program Accountability Report and the Centers for Medicare and Medicaid Services (CMS) Chronic Care Management services.

Key topics covered by the Reinsurance Care Management Protocol Assessment include:

- Identification of members who generate reinsurance-eligible claims
- Care management strategies, goals, activities, and providers furnishing care management services
- Payments to providers for care management services

- Savings to the Reinsurance Program resulting from care management

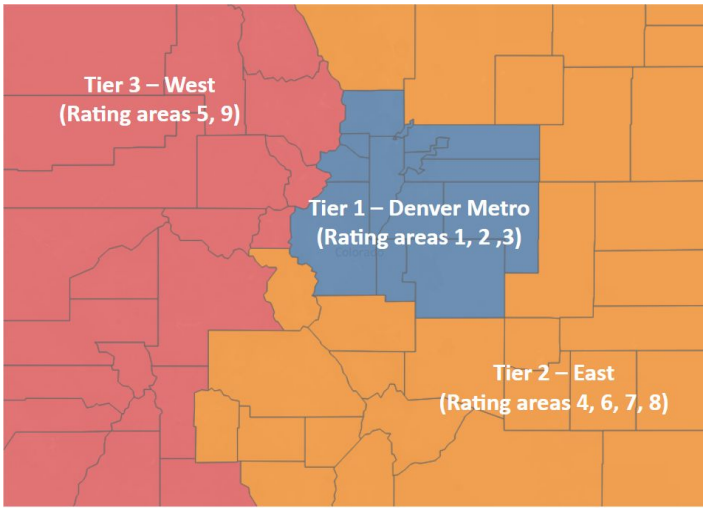
The Division plans to update the Assessment prior to the 2021 rate review period, based on carriers' responses and feedback from the 2020 Assessment. Topic areas that may be added or amended include:

- Member satisfaction surveys and feedback on care management services
- Geographic variation in care management strategies and goals
- Overlap and alignment between payer care management programs (including CMS)
- Addressing equity by including social determinants of health in member risk stratification
- Consistent savings measurement approach between carriers
- Financial counseling about out-of-pocket costs with reinsurance-eligible members
- More focus on reducing low-value care and increasing high-value care

Participating Carriers and Regions

All carriers offering individual health benefit plans in Colorado that comply with Affordable Care Act (ACA) requirements are eligible for the Reinsurance Program, and must complete the Reinsurance Care Management Protocol Assessment. Eight (8) carriers were eligible in 2020: Anthem (HMO Colorado), Bright, Cigna, Denver Health, Friday Health Plan, Kaiser Permanente, Oscar, and Rocky Mountain Health Plan. Carriers offer plans in various insurance rating areas throughout the state.

Colorado's Reinsurance Program is designed to reduce individual market premiums statewide, and to reduce premiums the most in areas of the state that historically have had the highest rates. The program achieves these region-specific savings goals using a tiered payment parameter structure - paying consumer claims more in higher cost areas, in order to reduce premiums more in those areas.The Reinsurance Program's three geographic tiers are shown here on the map.



Summary of 2020 Assessment Findings

All Colorado carriers eligible for the Reinsurance Program submitted Reinsurance Care Management Protocol Assessments during the 2020 rate review process. The Division reviewed all submissions for completion and to ensure carrier compliance with the statutory requirement

to implement care management protocols. All carriers submitted complete and timely assessments, and no objections were filed by the Division. Carrier responses to key questions from the 2020 Assessment are summarized below.

Identification of Reinsurance-Eligible Members

Colorado statute requires carriers to implement care management protocols for all members whose claims fall within the reinsurance payment parameters. To do so, carriers must first identify members whose annual claims are expected to exceed the $30,000 attachment point under the 2020 reinsurance payment parameters. Assessment responses indicate nearly all carriers use claims data algorithms, including diagnosis codes, pharmacy claims, and utilization data, to identify eligible members. Some carriers also use provider or care team referrals to identify potentially eligible members. Since claims data is retrospective, carriers typically use members' prior diagnoses, health care spend, and utilization to predict which members' claims will likely reach the reinsurance attachment point.

Most carriers risk-stratify their members into groups based on case complexity and chronic disease. A typical risk stratification paradigm classifies members into complex member groups, healthy member groups, and potential or emerging risk member groups. Carriers generally implement outreach plans to connect members in the complex and emerging risk groups with care management services and personnel. Outreach strategies may include phone calls, emails, electronic patient portal messages, and/or in-person assistance during provider visits.

"Bright uses a proprietary identification and stratification algorithm based on pre-existing and compounding conditions, pharmacy utilization, and projected disease associated costs."

The Division notes that identification of reinsurance-eligible members and subsequent member outreach efforts may be easier for carriers that are part of integrated delivery systems than for carriers that are entirely separate business entities from their provider partners. Integrated networks have less cumbersome and restrictive data sharing processes, which allows carriers to more easily access and analyze member data, including claims and other electronic medical record data. Such data is crucial to identify reinsurance-eligible members. Carriers with easier data access may be more successful in their reinsurance care management protocol implementation.

Care Management Strategies, Goals, Activities, and Providers

The Assessment asks carriers to describe their care management goals and strategies for identified members, including care management activities performed by providers and other care team members. Most carriers reported increasing health care value - through care quality enhancement and/or cost reduction - as a key goal of their care management work. Carriers also reported moving towards more patient-centered care approaches and helping members

improve or maintain their health as important goals. Carriers were adamant about providing the best possible care for members and removing barriers to care, especially for those with the greatest health care needs.

"Denver Health Medical Plan uses care management protocols to ensure that the most cost-effective and appropriate services and treatment plans are delivered to members."

Steering Members to Appropriate Care Settings

Nearly all carriers listed steering members to the most appropriate site of service ("right place") at the appropriate time ("right time") as a core component of their care management strategies. Such steerage may help reduce overall cost of care, as it generally reduces the number of unnecessary emergency room visits, and may also improve patient experience by providing more tailored and appropriate care.

Managing Chronic Conditions and Transitional Care

Management of multiple chronic conditions and transitional care management also emerged as important strategies for carriers. Members with comorbidities and those transitioning from acute care facilities to longer term or home-based care usually have significant care management and care coordination needs. These needs may include medication management, scheduling follow-up appointments, communication between health care providers and facilities, monitoring for duplicative services, and other types of member support.

Using Care Teams Effectively

Most carriers report relying on care teams consisting of many different roles and responsibilities to provide services for members with complex care needs. Care teams typically include clinical and non-clinical personnel, with nurses and social workers handling most of the direct member support. Primary care providers usually serve as the hub or quarterback of a care team, and coordinate activities and services with other providers as needed. Carriers noted that clear and consistent communication channels between providers are crucial for successful coordination.

"Anthem has a care management program focused on the role of primary care providers. This model promotes access to care, coordination of care, wellness and prevention by collaborating with primary care physicians in ways that allow them to successfully manage the health of their patients and thrive in a value-based reimbursement environment."

Exploring Innovative Approaches to Care Management and Cost Containment

One carrier uses an innovative care management program that helps members optimize use of available community resources in order to maximize their health coverage benefits and access high quality care in all settings. This carrier's care managers collaborate with members to

develop personalized care plans that focus on each member's self-identified health needs. These plans make optimal use of program benefits and available community resources, ensuring members can access the care they need, and helping to address the social determinants of members' health.

Pharmacy spending is another key area of interest for carriers. While most use pharmaceutical claims data to help identify members whose claims may be eligible for reinsurance, only a few carriers note using pharmacy utilization management in their broader care management strategies. One carrier assigns nurses to track reinsurance-eligible members and look for pharmaceutical programs that can help reduce drug costs for members with high-cost medications. While this approach does not impact drug selection, it may help reduce plan costs and member out-of-pocket spending on expensive medications. Carriers may continue exploring ways to shift members towards higher value, lower cost drugs.

Payments for Care Management Services

Carriers also report on reimbursement strategies and payment mechanisms for care management activities and services. Nearly all carriers provide per-member-per-month (PMPM) care management payments for members with complex cases or chronic conditions (i.e., members whose claims are likely reinsurance-eligible). These payments are often *not* claims-based or traditional fee-for-service (FFS) expenditures, since they may cover a broad range of services that occur at different times and places, depending on patients' needs. Carriers often include these PMPM payments in alternative payment models (APMs), which aim to increase quality of care while maintaining or reducing its cost.

One carrier offers a claims-based care management payment, similar to Medicare's Chronic Care Management (CCM) and Transitional Care Management (TCM) payments. Claims-based payments may be administratively easier for carriers than non-claims-based payments because they utilize existing claims processing mechanisms. However, these payments often include the same limitations as other FFS payments, namely, a lack of flexibility in coverage due to their prescriptive nature. One carrier reported offering no specific payments for care management.

"Payments made by [Kaiser] to Colorado Permanente Medical Group for patient care services including care management activities are not made on a claims basis, but are part of an annual contract and are made monthly based on a per member, per month formula. This allows for outcomes-based focus without fee-for-service constraints."

Carriers generally reported either contracting with care management companies to provide services (three carriers), or paying contracted providers directly for care management services (six carriers). While partnering with companies that specialize in patient care management may offer more consistent care across a carrier's member population, this approach risks disconnection between care managers and other members of the care team. Coordination and

communication between case managers and other providers is essential for its success. On the other hand, carriers that pay contracted providers directly for care management services must ensure all providers offer appropriate services and must compensate providers for additional services. Carriers' assessments did not show a preferred approach or best practice between partnering with care management companies or paying providers directly for care management.

Savings Resulting from Care Management

Nearly all carriers reported their care management protocols generate savings on total cost of care, compared to expected expenditures without care management. Carriers generally expect savings to result from fewer unnecessary emergency room visits and better management of comorbidities and chronic conditions. Some carriers noted prescription drug selection and management as another potential avenue for savings. While most carriers acknowledged the importance of preventive care, they did not expect prevention to drive significant savings. This may be more true for reinsurance-eligible members than for others, since the former group tends to have chronic conditions, making health maintenance the primary goal, rather than prevention.

"[Cigna's] financial goal is to continue driving savings of at least $4,200 per member per year while not compromising customer satisfaction, which was 95% in 2017."

Savings estimates, goals, and calculation methodologies vary between carriers. Some reported having specific savings targets per reinsurance-eligible member per year, compared to expected spending without care management. However, most carriers reported more general savings goals and did not provide specific line item breakdowns of their savings estimates. Carriers did not always specify whether their savings were reported on net, accounting for any additional payments for care management services. The Division plans to revise care management protocol assessment questions around savings to ensure more detailed and consistent responses from carriers going forward.

Finally, several carriers reported utilizing APMs to reimburse and reward providers for offering care management services. Shared savings models, where carriers share savings resulting from better care management with their contracted providers, are a common approach. Capitated or PMPM payments for care management enable providers to determine how best to use financial resources to improve care for patients and contain costs. Many carriers report moving towards these types of payment models, particularly for reinsurance-eligible members.

Conclusion

Carriers' first annual Reinsurance Care Management Protocol Assessment submission showed Colorado's insurance carriers are testing and implementing strategies to effectively manage care and contain costs for their highest needs members. The Division will use information gathered in this initial assessment to help explore best practices in member care management

for reinsurance-eligible members in Colorado's individual market. The Division hopes to convene carriers to disseminate and discuss these experiences and lessons learned from care management protocol implementation. Carriers' submissions and feedback will help inform updates to the annual Assessment, as well as inform broader policy efforts around care management and health care cost containment.

Attachment 7

American Rescue Plan Impact on the Colorado Reinsurance Program

3/31/2021

Michael Brown, FSA, MAAA
Brad Blankenship, Actuarial Associate, Director of Data Science

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Max Premium for SLCSP – Current vs ARP

- Maximum premiums for second lowest reduced significantly with ARP

			2021 ACA		American Rescue Plan		ACA	ARP			
Family Count	Family Size	FPL_LEVEL	Lower Limit	Upper Limit	Lower Limit	Upper Limit	Model Max	Model Max	Max Change	FPL Average	FPL Level
1	Sub + 0	0-100% FPL	2.07%	2.07%	0.00%	0.00%	$11.11	$0.00	-$11.11	50%	$12,880
1	Sub + 0	100.01-133% FPL	2.07%	2.07%	0.00%	0.00%	$27.86	$0.00	-$27.86	125%	$12,880
1	Sub + 0	133.01-150% FPL	3.10%	4.14%	0.00%	0.00%	$61.17	$0.00	-$61.17	146%	$12,880
1	Sub + 0	150.01-200% FPL	4.14%	6.52%	0.00%	2.00%	$120.84	$31.16	-$89.68	189%	$12,880
1	Sub + 0	200.01-250% FPL	6.52%	8.33%	2.00%	4.00%	$202.58	$90.62	-$111.96	239%	$12,880
1	Sub + 0	250.01-300% FPL	8.33%	9.83%	4.00%	6.00%	$293.71	$171.55	-$122.16	289%	$12,880
1	Sub + 0	300.01-400% FPL	9.83%	9.83%	6.00%	8.50%	$397.77	$320.68	-$77.09	377%	$12,880
1	Sub + 0	400.01%-ABOVE FPL	NA	NA	8.50%	8.50%	NA	$473.35	NA	519%	$12,880
1	Sub + 0	UNKNOWN	NA	NA	8.50%	8.50%	NA	$473.35	NA	519%	$12,880

2021 APTC Savings Estimates

- Estimated 2021 APTC savings could increase from 136M to 211M if all enrollees take advantage of APTC

		w Reinsurance				w/o Reinsurance				
FA Enrollment	Count	Gross Premium	APTC	Net Premium	APTC	Gross Premium	APTC	Net Premium	APTC	APTC
Current FA Enrollment w/o ARP	111,407	492	340	153	454,138,135	595	442	153	590,615,881	136,477,746
Current FA Enrollment with ARP	111,407	492	403	89	538,981,709	595	506	89	676,040,991	137,059,282
Current FA Enrollment + On Exchange NFA Enrollment with ARP	159,016	464	324	140	618,730,592	560	420	140	800,706,859	181,976,267
Current FA Enrollment + On Exchange NFA Enrollment + Off Exchange Enrollment with ARP	217,232	463	275	188	716,247,050	544	356	188	927,873,128	211,626,078

  - In 2022 , we estimate approximately 208K enrollees with APTC which includes a pickup of newly insured and approximately 50% of current on exchange NFA members 50% off exchange members

2022 Reinsurance Models

- Current: $30,000 Attachment, $400,000 Cap
  - Region 1, 2, 3: 43% Coinsurance
  - Region 4, 6, 7, 8: 50% Coinsurance
  - Region 5, 9: 73% Coinsurance
  - Lowers premium approximately 20%-22%
- Lower Reinsurance: $30,000 Attachment, $400,000 Cap
  - Region 1, 2, 3: 15% Coinsurance
  - Region 4, 6, 7, 8: 20% Coinsurance
  - Region 5, 9: 30% Coinsurance
  - Lowers premium approximately 8%-10%

2021 to 2022 Rate Change for FA

- 2021 with Rein w/o ARP to 2022 with Rein with ARP
  - Net Premium Avg for FA decrease from $153 to $78.17, 0.1% of enrollees see high increase
- 2021 with Rein w/o ARP to 2022 without Rein with ARP
  - Net Premium Avg for FA decrease from $153 to $78.17, 1.2% of enrollees see high increase
- 2021 with Rein with ARP to 2022 with Rein with ARP
  - Net Premium Avg for FA decrease from $89 to $77.53, 0.2% enrollees see high increase
- 2021 with Rein with ARP to 2022 without Rein with ARP
  - Net Premium Avg for FA decrease from $89 to $78.17, 6.1% enrollees see high increase
- 2021 with Rein with ARP to 2022 with Lower Rein with ARP
  - Net Premium Avg for FA decrease from $89 to $78.17, 2.2% enrollees see high increase

2021 to 2022 Rate Change for FA

- Majority of enrollees with FA and no ARP recognition in 2021 will experience small or negative rate change in 2022. ARP recognition means the enrollee experiences a rate change in 2021.
- Majority of enrollees with FA and ARP recognition in 2021 will experience small or negative rate change in 2022
  - However, 6% of enrollees will experience a high rate change if reinsurance is removed versus 0.2% with reinsurance and 2.2% with lower reinsurance model

2021 to 2022 Rate Change for On-Exchange NFA

- 2021 with Rein with ARP to 2022 with Rein with ARP
  - Premium Avg for NFA increase from $398 to $408, 5.7% enrollees see higher increase
- 2021 with Rein with ARP to 2022 without Rein with ARP
  - Premium Avg for NFA increase from $398 to $501, 78% enrollees see higher increase
- 2021 with Rein with ARP to 2022 with Lower Rein with ARP
  - Premium Avg for NFA increase from $89 to $78.17, 41% enrollees see higher increase

Projected 2022 Enrollment

- On exchange, not including off-exchange migration, uses C4H estimations
- Assume approximately 50% of on-exchange not financially assisted (NFA) move to FA
- Assume approximately 50% of off-exchange move to FA
- Assume off-exchange distribution (Area, FPL level, age) is the same as on-exchange NFA
- Enrollment growth applied uniformly to 2021 distribution by age, FPL level and region
- Overall growth from 217K to 261k enrollees
- Assume NFA is split evenly between 450%, 500%, 550% and 600% FPL

On/Off Exchange	Feb-21	Projected 2022 with ARP	Change
On-Exchange	158,942	232,609	73,667
On-Exchange Financially Assisted	111,349	208,804	97,455
On-Exchange Not Financially Assisted	47,593	23,805	-23,788
Off-Exchange	58,216	29,108	-29,108
Total	217,158	261,717	44,559

Projected 2022 Claims

- Begin with Carrier 2019 submitted EDGE claims and enrollment
- Project 2022 claims using 5% allowed trend and recent carrier filed experience
- Measure variance, Low Trend 3%, High Trend 7%
- Apply anticipated claims PMPM by region to 2021 expected enrollment distribution
- Calibrate final estimate with projected 2022 premium resulting in overall 4.5% rate increase in 2022 compared to 2021
- Assume higher silver increases with silver load and limited induced utilization
- Estimated Pass through savings is $297M

Area	Reinsurance	Projected Member Months	Total Claims	Reinsured Claims	Claims Decrease	PMPM Net Claims	PMPM Reinsured Claims	Premium Decrease
1, 2, 3	43.0%	2,186,154	1,042,845,649	193,163,654	-20.1%	$388.67	$88.36	-18.7%
4, 6, 7, 8	50.0%	513,476	258,944,328	56,358,381	-23.3%	$394.54	$109.76	-21.9%
5, 9	73.0%	440,974	247,052,225	75,359,854	-31.9%	$389.35	$170.89	-30.6%
Total		3,140,604	1,548,842,203	324,881,889	-22.5%	$389.72	$103.45	-21.1%
Low Trend				299,559,351				
High Trend	Range			352,980,761				

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Projected 2022 Claims – Lower Reinsurance

- Reinsured Claims drop from 325M to 121M
- Estimated Pass through savings is $121M

Projected Distribution

Area	Reinsurance	Projected Member Months	Total Claims	Reinsured Claims	Claims Decrease	PMPM Net Claims	PMPM Reinsured Claims	Premium Decrease
1, 2, 3	15.0%	2,186,154	1,042,845,649	67,382,670	-8.3%	$446.20	$30.82	-6.6%
4, 6, 7, 8	20.0%	513,476	258,944,328	22,439,256	-10.5%	$460.60	$43.70	-8.8%
5, 9	30.0%	440,974	247,052,225	30,969,803	-14.3%	$490.01	$70.23	-12.7%
Total		3,140,604	1,548,842,203	120,791,729	-9.6%	$454.71	$38.46	-8.0%
Low Trend				111,336,865				
High Trend	Range			131,258,046				

Results with Current Reinsurance Parameters

- Net Premium for FA remains relatively flat with or without reinsurance
- Average Premium for NFA is approximately $90 more when reinsurance is removed
- Cost to State estimate is $27M
- Cost to State estimate is $27M +/- $28M with +/- 2% claims trend

Results with Current Reinsurance Parameters - Detail

		2022 Without Reinsurance - with ARP				2022 With Reinsurance - with ARP				
FA / NFA	FPL Level	Enrollment	Gross Premium	APTC	Net Premium	Enrollment	Gross Premium	APTC	Net Premium	Premium Change
Current Financially Assisted	0-100% FPL	11,494	646	616	30	11,494	529	504	24	-5
	100.01-133% FPL	3,567	626	587	38	3,567	515	484	31	-7
	133.01-150% FPL	19,165	691	652	39	19,165	561	529	32	-8
	150.01-200% FPL	47,696	668	614	54	47,696	540	493	47	-7
	200.01-250% FPL	36,152	645	576	69	36,152	521	457	64	-5
	250.01-300% FPL	33,209	575	497	78	33,209	463	382	81	3
	300.01-400% FPL	39,311	613	455	158	39,311	491	320	171	13
	400.01%-ABOVE FPL	1,606	576	299	277	1,606	470	192	278	1
	Unknown	16,605	503	218	285	16,605	411	134	277	-8
	Total FA	208,804	625	528	97	208,804	505	409	96	-1
Not-Financially Assisted	0-100% FPL	403	486	0	486	403	396	0	396	-90
	100.01-133% FPL	71	462	0	462	71	379	0	379	-83
	133.01-150% FPL	120	522	0	522	120	425	0	425	-96
	150.01-200% FPL	479	522	0	522	479	423	0	423	-99
	200.01-250% FPL	673	492	0	492	673	400	0	400	-93
	250.01-300% FPL	1,024	436	0	436	1,024	353	0	353	-83
	300.01-400% FPL	3,101	470	0	470	3,101	379	0	379	-91
	400.01%-ABOVE FPL	1,595	576	0	576	1,595	470	0	470	-107
	Unknown	16,341	503	0	503	16,341	411	0	411	-92
	Total NFA	23,805	501	0	501	23,805	408	0	408	-93
	Total	232,609	612	474	138	232,609	495	368	128	-10
Program Cost, 43% / 50% / 73%						$324,881,889				
Annual APTC		$1,323,345,352				$1,025,861,759				
APTC Savings						$297,483,593				
Cost to State						$27,398,296		+/- 28M with +/- 2% trend		

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Results with Lower Reinsurance Parameters

- Net Premium for FA remains relatively flat with or without reinsurance
- Average Premium for NFA is approximately $38 more when reinsurance is removed
- Cost to State estimate is $0M
- Cost to State estimate is $0M +/- $11M with +/- 2% claims trend

Results with Lower Reinsurance Parameters - Detail

		2022 Without Reinsurance - with ARP				2022 With Lower Reinsurance - with ARP				
FA / NFA	FPL Level	Enrollment	Gross Premium	APTC	Net Premium	Enrollment	Gross Premium	APTC	Net Premium	Premium Change
Current Financially Assisted	0-100% FPL	11,494	646	616	30	11,494	599	571	28	-2
	100.01-133% FPL	3,567	626	587	38	3,567	581	546	35	-3
	133.01-150% FPL	19,165	691	652	39	19,165	638	602	36	-3
	150.01-200% FPL	47,696	668	614	54	47,696	615	564	51	-3
	200.01-250% FPL	36,152	645	576	69	36,152	594	527	67	-2
	250.01-300% FPL	33,209	575	497	78	33,209	530	451	79	1
	300.01-400% FPL	39,311	613	455	158	39,311	563	401	163	5
	400.01%-ABOVE FPL	1,606	576	299	277	1,606	533	255	278	1
	Unknown	16,605	503	218	285	16,605	466	183	283	-2
	Total FA	208,804	625	528	97	208,804	576	480	97	0
Not-Financially Assisted	0-100% FPL	403	486	0	486	403	449	0	449	-37
	100.01-133% FPL	71	462	0	462	71	430	0	430	-33
	133.01-150% FPL	120	522	0	522	120	484	0	484	-38
	150.01-200% FPL	479	522	0	522	479	481	0	481	-40
	200.01-250% FPL	673	492	0	492	673	454	0	454	-39
	250.01-300% FPL	1,024	436	0	436	1,024	402	0	402	-35
	300.01-400% FPL	3,101	470	0	470	3,101	432	0	432	-38
	400.01%-ABOVE FPL	1,595	576	0	576	1,595	533	0	533	-43
	Unknown	16,341	503	0	503	16,341	466	0	466	-37
	Total NFA	23,805	501	0	501	23,805	463	0	463	-38
	Total	232,609	612	474	138	232,609	565	431	134	-4

Program Cost, 15% / 20% / 30%		$120,791,729		
Annual APTC	$1,323,345,352	$1,202,293,267		
APTC Savings		$121,052,085		
Cost to State		-$260,356	+/- 11M with +/- 2% trend	

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Results with Lower Reinsurance Parameters

- Net Premium for FA remains relatively flat with or without reinsurance
- Average Premium for NFA is approximately $38 more when reinsurance is removed
- Cost to State estimate is $0M
- Cost to State estimate is $0M +/- $11M with +/- 2% claims trend

Other reinsurance options considered

- A reinsurance program was reviewed that covered bronze and gold levels only
  - Silver plans were increased with silver loading and limited IUF while bronze and gold net premiums are stabilized
  - Can introduce market disruption as bronze plans are priced at or below silver plans
  - Many silver members will see high increase
- Targeting Segments: FPL level, age, region, family size
  - Add complexity with no “silver bullet”

STATE OF COLORADO
ACTUARIAL ANALYSIS OF
COVID-19 AND 2021 STATE REINSURANCE PARAMETERS

MAY 2020

Prepared by
Lewis & Ellis, Inc.

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Section 1: Introduction and Purpose

In February and March 2020, the State of Colorado ran analysis on the individual market, and, subject to state funding allocated, set new reinsurance parameters for 2021. In mid-March, a global pandemic, Coronavirus or Covid-19, began to pick up speed in the United States. Lewis & Ellis, Inc. (L&E) was asked to review the reinsurance program, in light of Covid-19 impact on overall healthcare expenditures in Colorado, and determine potential changes to the state's reinsurance program payment parameters for 2021. What follows are multiple scenarios that could occur over the next 19 months with regard to the Coronavirus, and in particular, how this might impact the ACA Individual Market in Colorado.

Section 2: Scenario Testing for 2021

2.1 Scenario Overview

Any future is inherently uncertain, but with a pandemic such as this, the future is constantly in flux. It relies heavily on the everyday decisions of politicians, healthcare workers, and ordinary citizens. We can, however, select a specific future scenario and model how that single case may impact our metrics of interest. Scenario modeling is never done to predict the future. Instead, it is done to show a range of outcomes that could occur. Each scenario below shows a different glimpse of the future and will hopefully provide some insight into how the reinsurance program (and other metrics) might change.

2.2 Covid Impact on Reinsurance

The State of Colorado is considering the impact of coronavirus claims and the reduction in other claims when reviewing 2021 Reinsurance Payment Parameters. Covid-19 claims would be covered to the extent that an individual with the disease has claims that fall between the threshold ($30,000) and the cap ($400,000), subject to a coinsurance (varies by rating area).

The impact to claims dollars and change in enrollment could have a large impact on the ultimate cost to the state for the reinsurance program. Below is a summary of the 2021 cost under the three Covid scenarios, for three 2021 parameter options. As you can see, under the current 2021 parameters, the cost to the state is lower than initially projected, due to the lowered utilization of elective healthcare services. This is true under all three Covid scenarios. The modified parameters presented will produce results that are more in line with state funding expectations.

Reinsurance Options for 2021- Expected APTC Enrollment			
	Current 2021 Parameters	Modified Parameters	Same As 2020 Parameters
Threshold	$30,000	$30,000	$30,000
Coinsurance	27/39/53	40/45/80	45/50/85
Cap	$400,000	$400,000	$400,000
Scenario 1- Impact to Premium	-12.6%	-18.0%	-19.8%
Scenario 1- Cost to State	$69.5M	$89.8M	$96.4M
Scenario 2- Impact to Premium	-12.6%	-17.9%	-19.7%
Scenario 2- Cost to State	$69.2M	$89.0M	$95.5M
Scenario 3- Impact to Premium	-12.4%	-17.7%	-19.5%
Scenario 3- Cost to State	$66.8M	$84.6M	$90.8M

2.3 Scenario 1: Smaller, Regular Waves

This scenario imagines a situation where coronavirus will continue to be present in Colorado with peaks and valleys in the incidence rate throughout 2020 and 2021. The subsequent peaks will be less intense than the initial wave, and valleys will be marked by eased social restrictions, leading to another wave. Unemployment will ease slightly as time goes on but will not rebound to prior numbers in the timeframe. Non-essential healthcare will increase during the valleys but restrict again during the peaks. Carriers will rate assuming 2021 claims will revert to the mean, with a slight reduction in claims overall. A vaccine will be made available for half of the population, starting in June 2021. (Image and 3 scenario ideas from epidemiologist Michael Osterholm of the University of Minnesota and his colleagues[1].)

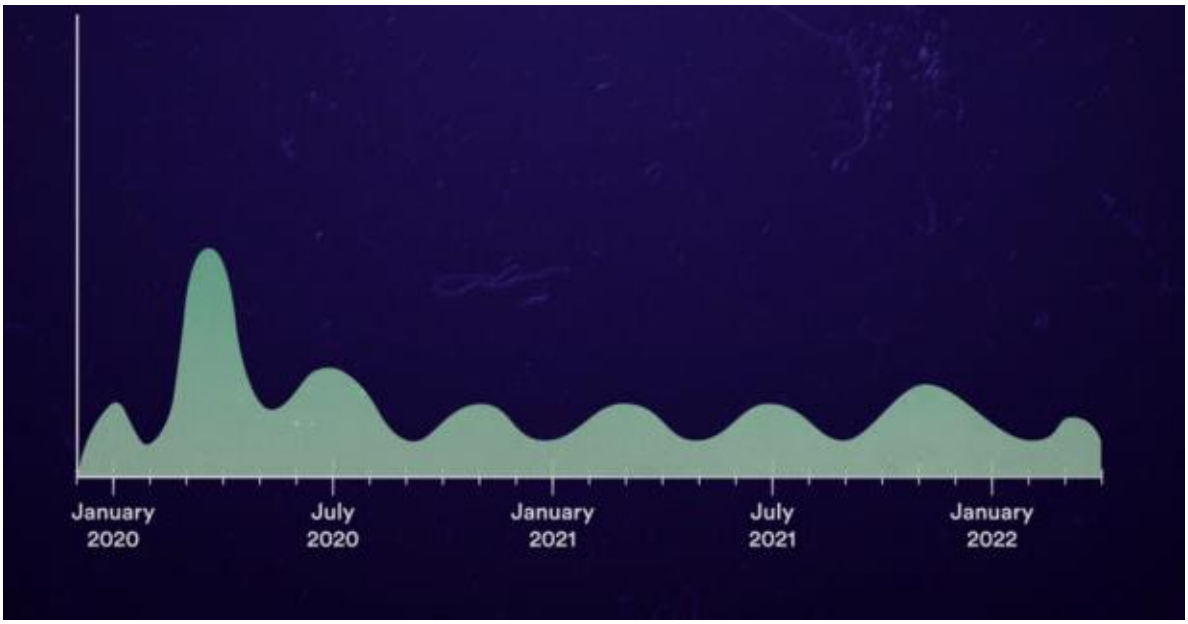


Figure 1: Scenario 1 from Osterholm et al. University of Minnesota

The following assumptions were built into the model for this scenario:

Covid-19 incidence rate
- 2020: 732 per 100,000, cumulative for the year
- 2021: 549 per 100,000, cumulative for the year

Unemployment rate
- 2020: 15%
- 2021: 10%

Covid-19 Testing rate
- 2020: 8.4% of population
- 2021: additional 5.6% of population

Given testing, Positive result rate
- 2020: 15%
- 2021: 15%

[1] https://www.statnews.com/2020/05/01/three-potential-futures-for-covid-19/?campaign_id=9&emc=edit_nn_20200505&instance_id=18228&nl=the-morning&regi_id=97980726&segment_id=26626&te=1&user_id=a66a6a45d771978396caf9fb469148e7

Arrival date of vaccine

June 1, 2021

Will be available in 2021 for 50% of population

Impact of Covid on Elective Procedures

2020: Elective down 50% from baseline for remainder of the year

2021: Elective down 30% from baseline

Impact of Covid on Office Visits and Telehealth Claims

2020: Office Visits down 10%; Telehealth up 40%

2021: Office Visits equal to baseline; Telehealth up 40%

Morbidity Change

Rate filings for 2021 Colorado Individual carriers must be complete by July 2020. If there is a perceived uptick in Covid-19 cases before this deadline, the carriers may include a morbidity increase. We assumed a 0% morbidity increase for this scenario, as cases appear to be declining rapidly by July 2020.

The impacts of this scenario are as follows:

Enrollment:

Uninsured +31,000 members

Public Coverage +162,000 members

Group Coverage -80,000 members

Individual Coverage minimal net change (after initial SEP enrollees), increase in APTC-eligible members, decrease in off-exchange enrollment

**Note, enrollment changes between 2020 and 2021 also include migration into the state, at average rates. Therefore, enrollment changes will not sum to 0.

Claims:

Claims Impact	2020	2021
Claims Impact	-17.8%	-8.8%
Elective Procedures	-18.1%	-9.9%
Mental Health Claims	0.9%	1.1%
Office Visit vs Telehealth	-0.6%	0.0%
Covid-19 Impact	0.8%	0.9%
Total Impact	-17.1%	-7.9%

Impacts are shown as a percent change to total claims.

Covid-19 Impacts:

Impact of Covid-19, Cases

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	558	1,144	875
Individual-ACA On nonAPTC	225	464	355
Individual-ACA Off	228	461	349
Total Colorado	21,049	42,058	32,211

Impact of Covid-19, Hospitalizations

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	82	201	160
Individual-ACA On nonAPTC	24	65	52
Individual-ACA Off	31	85	61
Total Colorado	3,684	8,341	6,346

Impact of Covid-19, Deaths

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	7	23	15
Individual-ACA On nonAPTC	0	4	2
Individual-ACA Off	3	9	5
Total Colorado	1,106	2,215	1,685

Covid-19 Cost- ACA Individual Market

	Total- Statewide		
	2020YTD	**2020**	**2021**
Expected Covid-19 Claim Dollars	$3,995,113	$11,080,753	$15,462,468
PMPM	$1.37	$3.80	$5.19
Covid-19 Below Threshold			85.0%
PMPM			$4.41
Covid-19 Above Threshold, Below Cap			13.7%
PMPM			$0.71
Covid-19 Above Cap			1.3%
PMPM			$0.07

Reinsurance:

Under Scenario 1, we have listed the reinsurance impacts. Note, with the estimated increase in APTC-eligible members, the amount of pass-through funding has also increased and cost to the state has decreased. Also note the % impact to premium varies slightly from the initial calculation performed in March 2020. This is assumed to be a slight variation, but still within the margin of error.

Under expected enrollment, the reinsurance parameters could be increase slightly, although not quite up to 2020 levels. However, this depends greatly on the ultimate estimate of APTC enrollees. For this estimate, we relied upon the expected effectuated enrollees, provided by Connect for Health Colorado. If enrollees have a higher or lower effectuated rate than predicted, the cost to state could vary significantly. We have shown 3 options below:

1. Assuming an expected subsidized population for 2021 of roughly 130,000
2. Assuming the subsidized population for 2021 is roughly 120,000
3. Assuming the subsidized population for 2021 is roughly 110,000.

See below for the impacts:

	Current 2021 Parameters	Modified Parameters	Same As 2020 Parameters
Threshold	$30,000	$30,000	$30,000
Coinsurance	27/39/53	40/45/80	45/50/85
Cap	$400,000	$400,000	$400,000
% Impact to Claims	-14.3%	-19.6%	-21.4%
% Impact to Premiums	-12.6%	-18.0%	-19.8%
Total Cost of Program	$181.7M	$250.0M	$272.5M
Reinsurance Options for 2021- Expected APTC Enrollment			
Estimated Pass-Through Funding	$112.2M	$160.1M	$176.2M
Estimated Cost to State	$69.5M	$89.8M	$96.4M
Reinsurance Options for 2021- Lower APTC Enrollment (-10K)			
Estimated Pass-Through Funding	$103.8M	$148.1M	$162.9M
Estimated Cost to State	$77.9M	$101.9M	$109.7M
Reinsurance Options for 2021- Lowest APTC Enrollment (-20K)			
Estimated Pass-Through Funding	$95.3M	$136.0M	$149.6M
Estimated Cost to State	$86.4M	$114.0M	$122.9M

Premium:

Overall rate change for 2021 will reflect several factors:

- Changing impact of reinsurance savings from 2020 parameters to 2021 Modified parameters.
- Reduction in claims due to the impact of Covid-19 on elective services, predicted for 2021.
- Trend to 2021. This will depend on the carrier and should reflect changes from 2019 to 2021, including reductions in cost due to Covid-19.

2.4 Scenario 2: The Monster Wave

Also known as the "Spanish Flu" model, this scenario imagines that a huge spike in cases will begin in late summer of 2020, and last until January or February of 2021. Much worse than the last wave, this monster wave will overwhelm the healthcare system, and all other non-essential services will grind to a halt. Unemployment will skyrocket as the state shuts down non-essential businesses and reinstates shelter-at-home orders. After the giant wave ends, a vaccine will be available on a rolling basis, and a small volume of cases will continue to trickle in throughout 2021.

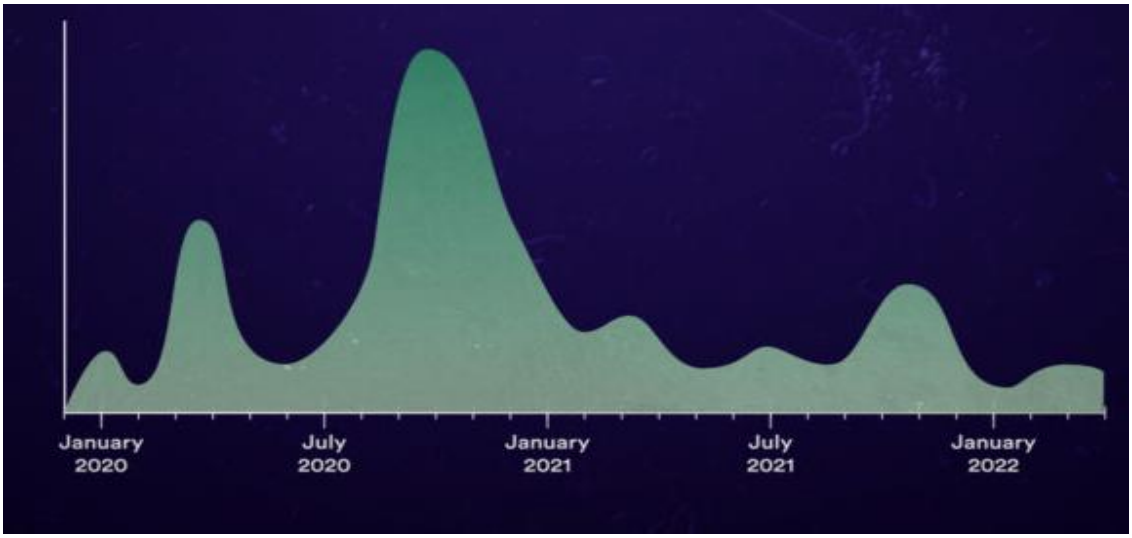


Figure 2: Scenario 2 from Osterholm et al. University of Minnesota

The following assumptions were built into the model for this scenario:

Covid-19 incidence rate
- 2020: 2196 per 100,000, cumulative for the year
- 2021: 122 per 100,000, cumulative for the year

Unemployment rate
- 2020: 20%
- 2021: 15%

Covid-19 Testing rate
- 2020: 16.8% of population
- 2021: additional 5.6% of population

Given testing, Positive result rate
- 2020: 15%
- 2021: 10%

Arrival date of vaccine
- June 1, 2021
- Will be available in 2021 for 50% of population

Impact of Covid on Elective Procedures
- 2020: Elective down 100% from baseline for remainder of year, Possible Electives down 50% for remainder of year
- 2021: Elective down 30% from baseline, Possible Electives down 10%

Impact of Covid on Office Visits and Telehealth Claims
- 2020: Office Visits down 40%; Telehealth up 65%

2021: Office Visits down 15%; Telehealth up 40%

Morbidity Change

Rate filings for 2021 Colorado Individual carriers must be complete by July 2020. If there is a perceived uptick in Covid-19 cases before this deadline, the carriers may include a morbidity increase. We assumed a 2% morbidity increase for this scenario, although it could be larger depending on when the monster wave starts to hit.

The impacts of this scenario are as follows:

Enrollment:

Uninsured +50,000 members
Public Coverage +257,000 members
Group Coverage -139,000 members
Individual Coverage +5,000 members (after initial SEP enrollees), largest increase in APTC-eligible members

**Note, enrollment changes between 2020 and 2021 also include migration into the state, at average rates. Therefore, enrollment changes will not sum to 0.

Claims:

Claims Impact	2020	2021
Claims Impact	-29.2%	-9.8%
Elective Procedures	-28.7%	-10.3%
Mental Health Claims	0.9%	1.1%
Office Visit vs Telehealth	-1.3%	-0.6%
Covid-19 Impact	2.8%	0.6%
Total Impact	-27.2%	-9.2%

Impacts are shown as a percent change to total claims.

Covid-19 Impacts:

Impact of Covid-19, Cases

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	558	3,490	182
Individual-ACA On nonAPTC	225	1,436	72
Individual-ACA Off	228	1,421	69
Total Colorado	21,049	126,662	7,060

Impact of Covid-19, Hospitalizations

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	82	635	26
Individual-ACA On nonAPTC	24	220	6
Individual-ACA Off	31	271	11
Total Colorado	3,684	25,306	1,367

Impact of Covid-19, Deaths

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	7	87	0
Individual-ACA On nonAPTC	0	22	0
Individual-ACA Off	3	36	0
Total Colorado	1,106	6,857	356

Covid-19 Cost- ACA Individual Market

	Total- Statewide		
	2020YTD	**2020**	**2021**
Expected Covid-19 Claim Dollars	$3,995,113	$34,764,802	$9,412,418
PMPM	$1.37	$11.93	$3.16
Covid-19 Below Reinsurance Threshold			90.3%
PMPM			$2.85
Covid-19 Above Threshold, Below Cap			9.7%
PMPM			$0.31
Covid-19 Claims Above Cap			0.0%
PMPM			$0.00

Reinsurance:

Under Scenario 2, we have listed the reinsurance impacts. Note, with the estimated increase in APTC-eligible members, the amount of pass-through funding has also increased and cost to the state has decreased. Also note the % impact to premium varies slightly from the initial calculation performed in March 2020. This is assumed to be a slight variation, but still within the margin of error.

Under expected enrollment, the reinsurance parameters could be increase slightly, although not quite up to 2020 levels. However, this depends greatly on the ultimate estimate of APTC enrollees. For this estimate, we relied upon the expected effectuated enrollees, provided by Connect for Health Colorado. If enrollees have a higher or lower effectuated rate than predicted, the cost to state could vary significantly. We have shown 3 options below:

1. Assuming an expected subsidized population for 2021 of roughly 130,000
2. Assuming the subsidized population for 2021 is roughly 120,000
3. Assuming the subsidized population for 2021 is roughly 110,000.

See below for the impacts:

	Current 2021 Parameters	Modified Parameters	Same As 2020 Parameters
Threshold	$30,000	$30,000	$30,000
Coinsurance	27/39/53	40/45/80	45/50/85
Cap	$400,000	$400,000	$400,000
% Impact to Claims	-14.2%	-19.5%	-21.2%
% Impact to Premiums	-12.6%	-17.9%	-19.7%
Total Cost of Program	$181.5M	$249.2M	$271.8M
Reinsurance Options for 2021- Expected APTC Enrollment			
Estimated Pass-Through Funding	$112.3M	$160.2M	$176.3M
Estimated Cost to State	$69.2M	$89.0M	$95.5M
Reinsurance Options for 2021- Lower APTC Enrollment (-10K)			
Estimated Pass-Through Funding	$103.8M	$148.2M	$163.0M
Estimated Cost to State	$77.7M	$101.0M	$108.8M
Reinsurance Options for 2021- Lowest APTC Enrollment (-20K)			
Estimated Pass-Through Funding	$95.4M	$136.1M	$149.7M
Estimated Cost to State	$86.1M	$113.1M	$122.1M

Premium:

Overall rate change for 2021 will reflect several factors:

- Changing impact of reinsurance savings from 2020 parameters to 2021 Modified parameters.
- Reduction in claims due to the impact of Covid-19 on elective services, predicted for 2021.
- Trend to 2021. This will depend on the carrier and should reflect changes from 2019 to 2021, including reductions in cost due to Covid-19.

2.5 Scenario 3: Duplicate Waves

In this scenario, waves continue, at the same size as the current wave experienced in March/April/May of 2020. This is similar to scenario 1, with more intense consequences. Non-essential medical services continue to be delayed as new waves break out; hospitals will be full for a few months, then empty for a few months, then full again. Unemployment will remain steadily high, as those who lost their job in the first wave might get rehired only to be laid off once again. Carriers pricing for 2021 might recognize a new normal in lower claims dollars but may adjust morbidity assumptions upward to reflect dropped members who are healthy but can no longer afford coverage.

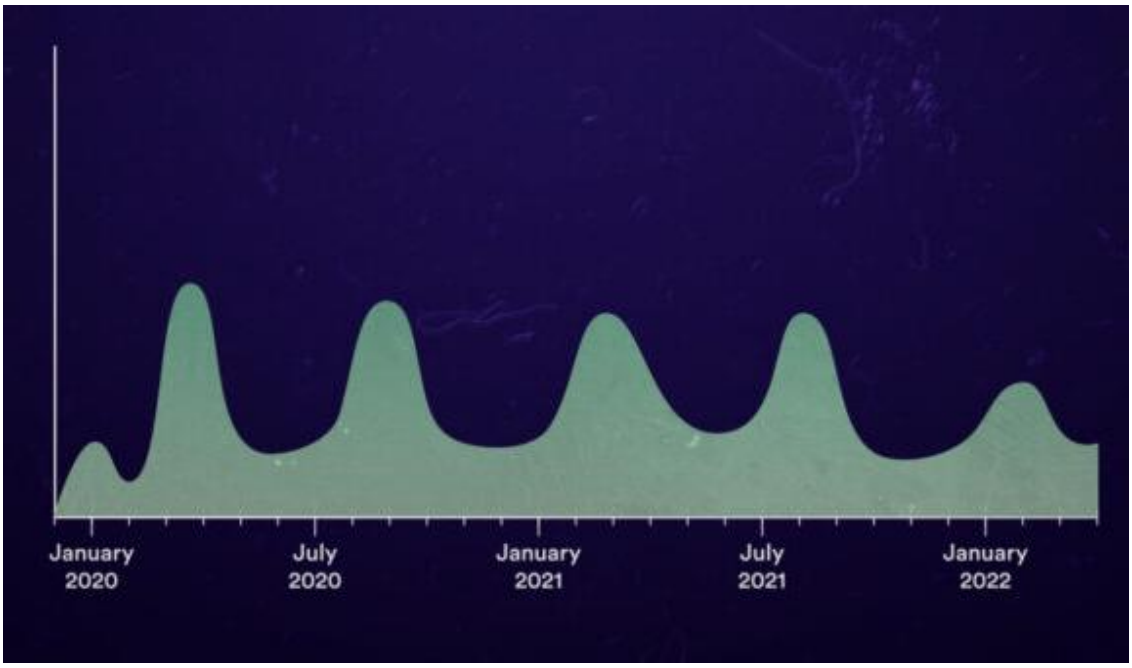


Figure 3: Scenario 3 from Osterholm et al. University of Minnesota

The following assumptions were built into the model for this scenario:

Covid-19 incidence rate
- 2020: 1000 per 100,000, cumulative for the year
- 2021: 1000 per 100,000, cumulative for the year

Unemployment rate
- 2020: 15%
- 2021: 15%

Covid-19 Testing rate
- 2020: 7.0% of population
- 2021: additional 7.0% of population

Given testing, Positive result rate
- 2020: 15%
- 2021: 15%

Arrival date of vaccine
- June 1, 2021
- Will be available in 2021 for 50% of population

Impact of Covid on Elective Procedures

2020: Elective down 50% from baseline for remainder of the year, Possible Electives down 10% for remainder of the year

2021: Elective down 40% from baseline, Possible Electives down 8%

Impact of Covid on Office Visits and Telehealth Claims

2020: Office Visits down 40%; Telehealth up 65%

2021: Office Visits down 40%; Telehealth up 65%

Morbidity Change

Rate filings for 2021 Colorado Individual carriers must be complete by July 2020. If there is a perceived uptick in Covid-19 cases before this deadline, the carriers may include a morbidity increase. We assumed a 2% morbidity increase for this scenario.

The impacts of this scenario are as follows:

Enrollment:

Uninsured +50,000 members

Public Coverage +257,000 members

Group Coverage -172,000 members

Individual Coverage +5,000 members (after initial SEP enrollees), largest increase in APTC-eligible members

**Note, enrollment changes between 2020 and 2021 also include migration into the state, at average rates. Therefore, enrollment changes will not sum to 0.

Claims:

Claims Impact	2020	2021
Claims Impact	-18.7%	-14.0%
Elective Procedures	-18.3%	-13.5%
Mental Health Claims	0.9%	1.1%
Office Visit vs Telehealth	-1.3%	-1.6%
Covid-19 Impact	1.0%	1.5%
Total Impact	-17.9%	-12.7%

Impacts are shown as a percent change to total claims.

Covid-19 Impacts:

Impact of Covid-19, Cases

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	558	1,568	1,610
Individual-ACA On nonAPTC	225	648	671
Individual-ACA Off	228	639	647
Total Colorado	21,049	57,521	58,474

Impact of Covid-19, Hospitalizations

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	82	279	286
Individual-ACA On nonAPTC	24	103	107
Individual-ACA Off	31	117	117
Total Colorado	3,684	11,433	11,611

Impact of Covid-19, Deaths

	Total- Statewide		
Enrollment Cohort	**2020YTD**	**2020**	**2021**
Individual-ACA On APTC	7	30	32
Individual-ACA On nonAPTC	0	6	6
Individual-ACA Off	3	13	14
Total Colorado	1,106	3,027	3,152

Covid-19 Cost- ACA Individual Market

	Total- Statewide		
	2020YTD	**2020**	**2021**
Expected Covid-19 Claim Dollars	$3,995,113	$14,796,479	$22,968,066
PMPM	$1.37	$5.08	$7.71
Covid-19 Below Reinsurance Threshold			86.6%
PMPM			$6.67
Covid-19 Above Threshold, Below Cap			13.2%
PMPM			$1.02
Covid-19 Claims Above Cap			0.2%
PMPM			$0.01

Reinsurance:

Under Scenario 3, we have listed the reinsurance impacts. Note, with the estimated increase in APTC-eligible members, the amount of pass-through funding has also increased and cost to the state has decreased. Also note the % impact to premium varies slightly from the initial calculation performed in March 2020. This is assumed to be a slight variation, but still within the margin of error.

Under expected enrollment, the reinsurance parameters could be increase slightly, although not quite up to 2020 levels. However, this depends greatly on the ultimate estimate of APTC enrollees. For this estimate, we relied upon the expected effectuated enrollees, provided by Connect for Health Colorado. If enrollees have a higher or lower effectuated rate than predicted, the cost to state could vary significantly. We have shown 3 options below:

1. Assuming an expected subsidized population for 2021 of roughly 130,000
2. Assuming the subsidized population for 2021 is roughly 120,000
3. Assuming the subsidized population for 2021 is roughly 110,000.

See below for the impacts:

	Current 2021 Parameters	Modified Parameters	Same As 2020 Parameters
Threshold	$30,000	$30,000	$30,000
Coinsurance	27/39/53	40/45/80	45/50/85
Cap	$400,000	$400,000	$400,000
% Impact to Claims	-14.1%	-19.2%	-21.0%
% Impact to Premiums	-12.4%	-17.7%	-19.5%
Total Cost of Program	$173.7M	$237.2M	$258.6M
Reinsurance Options for 2021- Expected APTC Enrollment			
Estimated Pass-Through Funding	$106.9M	$152.5M	$167.8M
Estimated Cost to State	$66.8M	$84.6M	$90.8M
Reinsurance Options for 2021- Lower APTC Enrollment (-10K)			
Estimated Pass-Through Funding	$98.8M	$141.1M	$155.2M
Estimated Cost to State	$74.9M	$96.1M	$103.5M
Reinsurance Options for 2021- Lowest APTC Enrollment (-20K)			
Estimated Pass-Through Funding	$90.8M	$129.6M	$142.5M
Estimated Cost to State	$82.9M	$107.6M	$116.1M

Premium:

Overall rate change for 2021 will reflect several factors:

- Changing impact of reinsurance savings from 2020 parameters to 2021 Modified parameters.
- Reduction in claims due to the impact of Covid-19 on elective services, predicted for 2021.
- Trend to 2021. This will depend on the carrier and should reflect changes from 2019 to 2021, including reductions in cost due to Covid-19.

Section 3: 2020 Impact Scenarios

For the state of Colorado, it is important to determine the impact of Covid-19 and subsequent changes in claim levels to the 2020 reinsurance program. In other words, the reduction in claims due to shelter-at-home orders, the pause on elective services, the increase in mental health claims, and other unknown effects may significantly impact the total dollars paid out by the state to cover claims between the reinsurance threshold and cap. Although we still don't have a clear picture how the virus will unfold for the rest of 2020, we can use the three scenarios outlined above to provide a range of possible impacts to the 2020 program.

2020 Reinsurance Estimates				
Category	1332 Waiver Pre-Covid Projections	Scenario 1 Smaller Regular Wave	Scenario 2 Monster Wave	Scenario 3 Duplicate Waves
Total Cost of Program	249,829,497	$234,775,657	$219,285,832	$228,880,782
Pass through funding	162,796,500	169,447,687	169,447,687	169,447,687
Cost to state	87,032,997	65,327,969	49,838,144	59,433,095
Change in Cost to State		-21,705,028	-37,194,852	-27,599,902

The Pre-Covid Projections are the estimated costs developed when determining the 2020 Reinsurance Parameters, consistent with the 1332 Waiver application.

For each scenario, the impact to electives, office visits and mental health claims were applied to each category for large claimants using 2018 EDGE data trended to 2020. The scenario impact was then applied to 2020 projected cost of program as determined in the Section 1332 State Innovation Waiver Actuarial and Economic Analysis approved in 2019. In addition, we assumed the total cost of the program and the pass through funding were adjusted by the enrollment changes updated in this study. Finally, actual 2020 pass through funding approved by CMS was used for each of the three scenarios.

Section 4: Data and Methodology

4.1 Data Used

For this study, the following data sources were used:

- 2018 Non-Group Market EDGE premium, enrollment and claims data, provided by Colorado insurance carriers
- 2020 Initial Enrollment on the exchange, and additional Special Enrollment Period counts, provided by Connect for Health Colorado
- 2019 and 2020 Enrollment counts by requested split-outs, provided by Colorado insurance carriers
- Carrier 2020 rate filings submitted in 2019, with reinsurance.
- 2021 CO Reinsurance Parameters Study, Performed by L&E in March 2020.
- Draft of CIVHC Study on Elective Services 2020, provided for this study
- Various publicly available sources for setting assumptions. Listed in section 3.2 below.

4.2 Assumptions

Population Splits

The state of Colorado has made publicly available statistics for Covid-19 in the state, by county[2]. These are regularly updated and serve as the base of for population infection, hospitalization, and death. This data is split out by age and health insurance status, using population splits from the US Census Bureau[3]. The uninsured rate was adjusted to reported 2020 levels, and splits were rolled up to 10-year age bands by the following insurance categories:

Type	Member Count (2020 est)
Uninsured	353,515
Public	1,840,474
Individual-ACA On APTC	129,638
Individual-ACA On nonAPTC	53,464
Individual-ACA Off	59,820
SmallGrp-ACA	260,911
Other Commercial	3,060,295
Total	5,758,117

Individual ACA market enrollment was split out from the census category of "Direct purchase" using 2020 enrollment estimates provided by carriers for the 2021 reinsurance study, and 2020 enrollment provided by Connect for Health Colorado, which included the recent special enrollment period specifically for Coronavirus. Remaining members were included in "Other Commercial"
Small Group ACA market enrollment was determined using EDGE data from 2018 and split by 10-year age bands and by county using the census employer-based coverage population splits.

This data is the starting point for estimating costs by insurance type, and for estimating likelihood of infection, hospitalization, and death due to Covid-19.

[2] Colorado Department of Public Health and Environment (CDPHE) and the Colorado State Emergency Operations Center, https://covid19.colorado.gov/data/case-data, as of 6am (Mountain Time) May 15, 2020.
[3] US Census- ACS 5 year (2014-2018), Type of Health Insurance Coverage by Age, by counties in Colorado

Population Changes for 2020 Year End and 2021

For 2020, we would expect the population to shift towards more public coverage, Individual Market coverage, and uninsurance as the unemployment rate rises. These shifts were estimated using a study that reviewed the connection between unemployment and insurance rates after the recession in 2008-2009[4]. For 2020, we assumed that 2020YTD estimates have already included the population shift to the ACA Individual market, during the special enrollment period, so no further shift was assumed for the rest of the year.

For 2021, we use similar shifts based on the estimated unemployment rate, which is scenario-based. We also consider the impact of rate increases on enrollment for the individual market, using the same elasticity formula used in the reinsurance parameter study. In general, we expect off exchange enrollment to reduce the most, proportional to a rate increase, and on-exchange no APTC enrollment to reduce slightly less, proportional to a rate increase.

Infection Rates

Initial infection and death rates by county were obtained from the State of Colorado Covid-19 data, with a more detailed data repository on the Colorado Department of Public Health and Environment (CDPHE) open data site[5]. The splits of infection and death by age band were also available. Hospitalization rates were only available by age group.

In general, for 2020 year-to-date, 0.37% of the population has been infected with Covid-19. This varies widely by county and age. Of those infected, 18.2% will be hospitalized, and 5.25% will ultimately die from Covid-19. These are the starting assumptions as of 6am (MDT) May 15, 2020, adjusted by age band and county, according to the latest information from the state of Colorado. We would expect hospitalization and death percentages to hold, at a high level, for 2020 and 2021.

2020 infection rates and 2021 infection rates will depend on which future scenario is being tested. See each scenario's details in Section 2 for infection rates assumed for 2020 and 2021.

Similarly, the availability of the vaccine is unknown for 2020 and 2021. The model has an input for time the vaccine will become available and to what percentage of the population. It is assumed, if the vaccine is not widely available at once, that it will be made available to the most vulnerable populations first. The model reflects this by applying available vaccines to the oldest age bands first.

Cost Assumptions

The model must consider costs associated with treating Covid-19 patients, but it must also consider the pandemic's overall impact on healthcare costs in the individual market.

To estimate Covid-19 treatment costs, we've made the following assumptions:

Covid-19 testing costs between $35 and $50 for those on public insurance, and $100 (or more) for those who have insurance in the commercial market[6]. The prices are widely reported. Total cost will vary,

[4] "The Impact of the Macroeconomy on Health Insurance Coverage: Evidence from the Great Recession", Cawley et al, Institute for the Study of Labor, November 2011

[5] https://data-cdphe.opendata.arcgis.com/search?tags=covid19

[6] https://www.healthsystemtracker.org/brief/how-health-costs-might-change-with-covid-19/

depending on the percentage of population who will be tested. For 2020 Year-to-date, testing rates have been reported on the Colorado Covid-19 website, by county. These rates have adjusted by likelihood of Covid-19 by age. Overall, the state has tested 2.8% of their population.

Any patient who tests positive for Covid will likely see medical care. This may include a telehealth virtual doctor's visit, or less likely, an in-person doctor's visit. Telehealth visits are relatively inexpensive, while an actual doctor's visit, depending on insurance type, could cost several hundred dollars. This cost averages to $57 to $96 per person[7]. For simplicity, we scale up by age.

For members who are hospitalized, costs can start to increase significantly. For a hospitalization that doesn't involve the Intensive Care Unit or a ventilator, costs could range from $10,000 to $20,000, depending on age, area, and source of insurance. For hospitalization considered severe[8], which includes a stay in the ICU and/or a ventilator, costs could range from $34,000 up to $88,000, or even higher[9], depending on severity, area, and source of insurance. In our model we have scaled costs for age (as a proxy of severity) and area.

Hospitalization costs are supported by 2018 EDGE data, where any respiratory illness that led to hospitalization was reviewed for allowed charges. In general, cases that required hospitalization were within the ranges listed above.

It is uncertain when the vaccine will be available, or what the cost will ultimately be. There have been sources citing costs from $10 a dose up to $1000+ per dose. It is clear that the pharmaceutical companies must balance public responsibility (and likelihood of outrage if the cost is too high) against the need to break even on their expenses. We have assumed the vaccine will cost $50 per dose, but this can be scaled up or down for scenario testing. We also assume vaccines will not be available for everyone at once. Therefore, the first available vaccines will be provided to the most vulnerable populations first. In our model, we use age a proxy.

Estimated costs are increased by a 3% annual cost trend for 2021 estimates.

Claims Impact

To estimate the direct and indirect impacts of Covid-19, we started with expected 2020 claims by inpatient, outpatient, professional, other medical, capitation, and pharmacy. The expected claims were obtained using a weighted average of 2020 (trended) allowed claims from the 2020 individual market URRTs. Any necessary split outs from these high-level categories were obtained using industry data percentages.

CIVHC provided L&E with a draft of their report, "Impact of Cessation of Elective Procedures" for an estimate of elective procedures temporarily cancelled by a Governor's order, as of March 23, 2020 in the state of Colorado. This report estimated that roughly 21% (combined 2018 and 2019) of inpatient claims are elective, and another 6% are possible elective procedures. We assumed for 2020YTD, that 100% of elective claims did not occur for 2 months, and 20% of possible elective claims did not occur for

[7] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00426
[8] Assumed to be roughly 25% of hospitalizations, determined using COVID-Net estimations of ICU and Ventilator demand in Colorado: https://covid19.healthdata.org/united-states-of-america/colorado
[9] https://www.healthsystemtracker.org/brief/how-health-costs-might-change-with-covid-19/

2 months. We made similar assumptions for outpatient and professional elective and possible elective claims. These reductions changed for Year-End 2020 and 2021, based on the scenario selected.

A few other adjustments were made to claim levels:

Mental Health and Substance Abuse claims were expected to increase by 27% for all claims, and 61.5% for severe claims[10]. These increases are expected to remain through 2020 and 2021.

Telehealth usage is increasing in lieu of doctor's office visits. Based on reported upticks, telehealth usage is expected to increase by 65% while office visits are decreasing by 40%[11].

Covid-19 related claims were simulated for each time period (2020YTD, 2020 full year, and 2021 full year). These claims were added into expected and adjusted claim costs as a Per Member Per Month (PMPM) value.

No changes were forecast for "Capitation", "Other Medical", and "Prescription Drug".

Expected impact to claims by category was applied to 2020 URRT claims. The resulting claims estimates were then trended forward to 2021, using the carrier's annual trends from the 2020 rate filings.

Reinsurance Assumptions

Reinsurance was estimated by simulating claims for each member in the individual market, by carrier, using a random number generator applied to the claim distribution tables from the ACA Final AV Model (2019). A different distribution was applied depending on the member's metal level, and claims were adjusted by standard age factors and area factors (by carrier). Claims were also adjusted to match expected 2021 claims levels for the carrier and specified scenario.

For each member line, a covid infection/treatment path was simulated, using the same assumptions as detailed above for covid infection, hospitalization, and costs.

Using each member's total claim costs plus simulated covid-19 costs, reinsurance is calculated based on the 2021 reinsurance parameters. As a reminder:

Threshold: $30,000
Cap: $400,000
Coinsurance: 27% / 39% / 53%

Reinsurance is also calculated using the 2020 Parameters:

Threshold: $30,000
Cap: $400,000
Coinsurance: 45% / 50% / 85%

And a modified set of parameters:

Threshold: $30,000
Cap: $400,000
Coinsurance: 40% / 45% / 80%

[10] https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
[11] https://www.medicaleconomics.com/news/physician-practices-reeling-covid-19-financial-losses

The calculation of reinsurance impact and pass-through funding was done consistent with the method used in the 2021 CO Reinsurance Payment Parameters study.

Premiums 2021
For each carrier in the individual market, 2020 URRTs calculations were included, up to the average plan adjusted index rate (AvgPAIR). Beyond this point in the rate calculation, calibration factors are applied, and then rates are further split depending on a member's plan selection, age, rating area, and tobacco status. Therefore, the AvgPAIR is a good estimate of premiums for the carrier, before these splits occur.

Using the initial 2020 estimates, 2021 is projected, using the following adjustments:

- Expected change in claims for 2021 (detailed in "Claims Impact" above) and trended using annual trends from the carrier-specific URRTs.
- Reinsurance, which is calculated for each carrier (described above in "Reinsurance Assumptions")
- Enrollment, which changes based on unemployment and expected rate increases

4.3 Methodology

To perform the analysis, the following steps are taken:

1. **Determine scenario.** This includes a narrative of what the next year and a half will hold, and a change of various assumptions throughout the model to match that narrative. The following assumptions might change, depending on the scenario considered:
    a. Covid-19 incidence rate, 2020 and 2021
    b. Unemployment rate, 2020 and 2021
    c. Testing rate, 2020 and 2021
    d. Given testing, Positive result rate, 2020 and 2021
    e. Arrival date of vaccine in 2020 and 2021, and percentage of the population for which it will be available
    f. Impact of Covid on Elective and Possible Elective Procedures, 2020 and 2021
    g. Impact of Covid on Mental Health claims, 2020 and 2021
    h. Impact of Covid on Office Visits and Telehealth Claims, 2020 and 2021
2. **Calculate changes to enrollment**. Based on adjustments to unemployment rate, and estimated rate change.
3. **Estimate covid impacts**. Based on changed testing, incidence, and vaccine inputs.
4. **Estimate reinsurance impacts**. Recalculate reinsurance with adjusted claims assumptions and covid likelihood assumptions. Determine how this impacts total reinsurance costs, pass-through funding, and costs to the state.
5. **Estimate premium changes.** Recalculate 2021 projected URRTs based on updated claims, enrollment, and reinsurance.
6. **Produce results for scenario.** Using model outputs, provide results that answer key questions, and develop a narrative about how the scenario played out.

Section 5: Disclosures and Limitations

5.1 Intended Users, Scope, and Purpose

This information has been prepared for the Colorado Division of Insurance (DOI) within the Department of Regulatory Agencies (DORA), and the State of Colorado to support their 2021 Reinsurance Parameter setting and any potential adjustments in light of the global pandemic that has impacted the state. The report should be reviewed in its entirety by qualified individuals. Parties reviewing this information should retain their own actuarial experts when interpreting results. It should not be used for any other purpose.

5.2 Qualifications

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

5.3 Risk/Uncertainty

The assumptions and results outlined in this report are inherently uncertain. Every effort was made, through scenario testing to review areas of uncertainty, including enrollment assumptions, change in medical costs over time, projection of Covid-19 impacts and changes in the costs of the ACA non-Group population.

Since Covid-19 is an everyday changing event, all results in this report simply reflect the scenarios that have been tested, using assumptions available as of May 15, 2020. The situation may change in unexpected ways that are not reflected in this report.

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

5.4 Conflicts of Interest

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

5.5 Data Reliance

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

5.6 Dates Applicable

This report was prepared in May 2020 with COVID-19 state counts as of 6am (MDT) May 15, 2020. Any subsequent events or changes in the trajectory of the virus may not be captured in this analysis. These findings should be carefully reviewed by qualified individuals and considered in light of daily changes to the number of virus infections, hospitalizations and deaths.

5.7 Subsequent Events

This report and the analysis provide herein are based on conditions specific to the commercial healthcare marketplace in Colorado, as of May 2020. The report assumes no uncertain and potential future changes to the Affordable Care Act or the Colorado health care marketplace that could materially impact results. There are several future developments that could materially change these results including court rulings, new regulations, additional allowed ACA exemptions, or a material change to the health care markets in general. In addition, any changes made to the parameters or structure of the reinsurance program could have a material impact on the outcomes outlined above. These subsequent events are not included in this report and should be carefully considered by qualified experts before applying the findings contained within this report.

COLORADO
Department of Regulatory Agencies
Division of Insurance

Bulletin No. B-4.109

Collection of Reinsurance Program Data from Carriers and Hospitals

I. Background and Purpose

The purpose of this bulletin is to clarify the reinsurance program reporting requirements for eligible carriers and hospitals, pursuant to § 10-16-1105(1), C.R.S.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.

II. Applicability and Scope

This bulletin is intended to apply to every insurance company doing business in this state that meets the definition of "Eligible Carrier" and every hospital that meets the definition of "Hospital" pursuant to § 10-16-1103, C.R.S.

III. Division Position

The Division is committed to implementing the Colorado reinsurance program efficiently and effectively, minimizing the reporting burden for carriers and hospitals, and maintaining complete and accurate program data.

The Commissioner has authority to collect data quarterly from carriers on claims costs that exceed the reinsurance attachment point, in order to calculate annual reinsurance payments to carriers. At this time, the Division will not collect this data directly from carriers. Instead, the Division will consider carriers to have met their obligations under 10-16-1105(1) if they have submitted required individual market data to the Centers for Medicare and Medicaid Services (CMS) for use in federal EDGE data servers. The Division has entered into an Intergovernmental Agreement with CMS to use the federal EDGE data servers to identify paid claims eligible for reimbursement under the Colorado reinsurance program payment parameters. CMS will calculate the total reinsurance payment due to a carrier on account of each eligible claim CMS identifies and will issue reports to the Division detailing carrier-specific reinsurance payment amounts. Carriers are not required to submit any additional data to the Division for purposes of calculating reinsurance payments.

The Commissioner has authority to collect data quarterly from hospitals regarding the amount of the special fees for which each hospital is responsible pursuant to § 10-16-1108, C.R.S. At this time, the Division will not collect this data from hospitals. Instead, the Division will consider a hospital to have met this requirement if a hospital has submitted data to the Colorado Department of Health Care Policy and Financing (HCPF) so that the data may be

used by the Colorado Healthcare Affordability and Sustainability Enterprise in calculating fees and supplemental hospital payments. The Division is entering into an Interagency Agreement with HCPF whereby HCPF will determine the amounts of the reinsurance Hospital special fee to be collected annually from each hospital, in compliance with the requirements found at 42 CFR § 433.68. HCPF will provide notice to hospitals of their specific amounts owed and will collect payments using the Automated Clearing House debit process as provided in 10 CCR 2505-10, Section 8.3002.B.1. Hospitals are not required to submit any additional data to the Division for purposes of determining the amounts owed for reinsurance special fees.

IV. Additional Division Resources

A. For More Information

Colorado Division of Insurance
Reinsurance Program
1560 Broadway, Suite 850
Denver, CO 80202
Tel. 303-894-2302
Internet: https://www.colorado.gov/pacific/dora/division-insurance

V. History

Issued April 30, 2020

INTERGOVERNMENTALAGREEMENT
BETWEEN
THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
AND
THE STATE OF COLORADO
DIVISION OF INSURANCE

I. PURPOSE

This Agreement sets forth the terms and conditions governing the arrangement between the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), and the Colorado Division of Insurance (DOI) on behalf of the State of Colorado, under which CMS will calculate reinsurance payments to issuers participating in the State of Colorado's reinsurance (RI) program under Colorado's State Innovation Waiver under section 1332 of the Patient Protection and Affordable Care Act (PPACA).

II. INTEGRATION

This Agreement including any attachments, as well as the Standard Terms and Conditions applicable to Colorado's State Innovation Waiver under section 1332 of the PPACA, constitute the entire agreement between CMS and the DOI with respect to their subject matter. There have been no representations, warranties, or promises made outside of this Agreement or the Standard Terms and Conditions. This Agreement will take precedence over any other documents that may be in conflict with it solely with regard to CMS' calculation of reinsurance payments under the State of Colorado's RI program and Colorado's compensation to CMS for such services.

III. AUTHORITY

Transfer of Funds and Programmatic Authority:
The legal authority to enter into this Agreement is as follows: Title III of the Intergovernmental Cooperation Act of 1968, and its implementing guidance at the Office of Management and Budget (OMB) Circular No. A-97: Rules and regulations permitting Federal agencies to provide specialized or technical services to state and local units of government.

IV. BACKGROUND

Section 1332 of the PPACA permits a state to apply for a State Innovation Waiver (referred to as a section 1332 waiver or a State Relief and Empowerment Waiver) to pursue innovative strategies for providing their residents with access to higher value, more affordable health coverage. States can request that the Secretaries of Health and Human Services (HHS) and the Department of the Treasury (collectively, the Secretaries) waive certain provisions of the PPACA provided that a state's waiver application meets specific statutory requirements: (1) will provide coverage that is at least as comprehensive as coverage defined in PPACA's section 1302(b) and offered through Exchanges established under title I of the PPACA; (2) the proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that

are at least as affordable for the state's residents as would be provided under title I of PPACA; (3) the proposal will provide coverage to at least a comparable number of the state's residents as would be provided under title I of PPACA; and (4) the proposal will not increase the federal deficit.

On October 24, 2018, the Centers for Medicare and Medicaid Services (CMS) and the Department of the Treasury (collectively, the Departments) published guidance that provided information on how state waiver applications would be evaluated based on the four statutory guardrails. The guidance also stated that CMS may provide services in support of the state's section 1332 waiver plan under Title III of the Intergovernmental Cooperation Act of 1968 (ICA) OMB Circular No. A-97. The ICA is intended to: 1) encourage intergovernmental cooperation in the conduct of specialized or technical services and provisions of facilities essential to the administration of state or local governmental activities; 2) enable state and local governments to avoid unnecessary duplication of special service functions; and 3) authorize federal agencies that do not have such authority to provide reimbursable specialized and technical services to state and local governments. Accordingly, the ICA authorizes the head of any federal agency, within his discretion and upon written request from a state or political subdivision thereof, to provide specialized or technical services, upon payment to the federal agency by the unit of government making the request, of salaries and all other identifiable direct or indirect costs of performing such services.

Where a state intends to rely on CMS to perform administrative activities in connection with its section 1332 waiver program, the state must cover CMS' costs. For this reason, the Departments will not consider costs for CMS services covered under this Agreement an increase in federal spending resulting from the state's waiver plan for purposes of the deficit neutrality analysis under section 1332.

On May 20, 2019, the State of Colorado, through the DOI, submitted a section 1332 waiver application to waive certain PPACA requirements and implement a reinsurance program called the Colorado Reinsurance Program for 2020 through 2021 (the Colorado Reinsurance Program). Colorado's waiver application was approved on July 31, 2019, and the waiver is effective for January 1, 2020 through December 31, 2021. The state, through the DOI, requested that CMS calculate issuer reinsurance payments in support of the state's waiver plan from January 1, 2020 to December 31, 2021.

V. STATEMENT OF WORK

The parties agree to the following Roles and Responsibilities:

A. CMS' Responsibilities:

1. CMS will identify paid claims eligible for reimbursement under the Colorado Reinsurance Program (eligible claims) for services provided on or between January 1, 2020 to December 31, 2021. CMS will identify such claims from data submitted to "EDGE Servers" maintained by issuers offering coverage in the State of Colorado. CMS will identify such claims based on the parameters for the Colorado Reinsurance

Program as described in the state's section 1332 waiver application approved on July 31, 2019, and as confirmed by the DOI as described under paragraph V.B.1 below.

2. CMS will calculate the total reinsurance payment due to an issuer on account of each eligible claim CMS identifies. CMS will provide the DOI a monthly report detailing the reinsurance payments on a cumulative basis to date owed to specific issuers under Colorado Reinsurance Program criteria by the 30th of the month.

3. CMS will perform development, implementation, maintenance, operations, and customer support work for the state for the activities outlined in section V.A.

4. The parties acknowledge and agree that CMS is not performing services under this Agreement in its capacity as a HIPAA covered entity. The DOI further acknowledges that no data or information CMS evaluates under this Agreement will constitute protected health information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or will otherwise constitute information protected by any Colorado state law that would require CMS to comply with privacy and information security requirements or standards that are more onerous or stringent than the standards with which CMS complies as described in section XIII of this Agreement.

B. Colorado DOI Responsibilities:

1. On or before January 1st of each year during the term of this Agreement, the DOI will confirm the parameters (i.e., eligibility criteria) for payment of claims under the Colorado Reinsurance Program for the purposes of facilitating CMS' work under this Agreement. The DOI is responsible for updating CMS during a calendar year if there are any changes to the reinsurance program from what is described in the state's approved waiver application. Any changes to the parameters after January 1st could result in CMS incurring additional costs for which the DOI will be responsible.

2. The DOI will reimburse CMS in the amounts and at the times designated in this Agreement for CMS' actual costs related to development, implementation, maintenance, operation, and customer support (including overhead) and maintenance costs of performing the tasks requested by the state as described in section V.A.

3. The DOI is responsible for operating the reinsurance program and making reinsurance payments to issuers as described in the state's waiver application.

VI. DURATION OF AGREEMENT

Effective Date: This agreement is effective when signed by both parties and will terminate on December 31, 2022. This parties' performance under this Agreement is contingent on the state meeting the obligations specified in the specific terms and conditions to which the state agreed in connection with its section 1332 waiver.

VII. FUNDS

The DOI shall reimburse CMS for all services provided under this Agreement.

CMS cannot begin work until this Agreement is fully executed by all parties. The DOI will be invoiced for actual costs incurred by CMS. The state can elect to submit payment to CMS via a CMS-approved method in one or multiple payments during the plan year.

At this time, CMS estimates that the total cost for the support services CMS will provide for the 2020 plan year pursuant this Agreement will be $31,000 – 36,000 for support costs. CMS will inform the DOI of the actual costs for the tasks in section V.A. for Colorado by March 31st of each calendar year during the term of this Agreement from between January 1, 2020 to December 31, 2022.

The DOI should send any documentation or required information to the CMS staff identified below:

Lina Choudhry Rashid
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
7501 Wisconsin Ave
Bethesda, MD 21814
e-mail: Lina.Rashid@cms.hhs.gov
Phone #: 202-260-6098

Milan Shah
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
7501 Wisconsin Ave
Bethesda, MD 21814
e-mail: Milan.Shah@cms.hhs.gov
Phone #: (301) 492-4427

John Maynard
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
7501 Wisconsin Ave
Bethesda, MD 21814
e-mail: John.Maynard@cms.hhs.gov
Phone #: (301) 492-4439

CMS will send any documentation or required information to the DOI staff identified below:

Laura Mortimer
Reinsurance Program Director
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
e-mail: Laura.Mortimer@state.co.us
Phone #: 720-701-0075

X. DE-OBLIGATION OF FUNDS

CMS receives annual appropriations; therefore, all of CMS' obligations under this Agreement must be incurred within the time-frame of the current Fiscal Year (FY) of the bona fide need. Any funds (including "No Year") that have not been obligated by the end of the FY by September 30th requires amending the agreement to de-obligate the funds. Funds cannot be held as advance funds or used for another FY other than the bona fide need that the funds were intended.

XI. DUPLICATION

Full implementation of this Agreement will not duplicate any existing agreements.

XII. MODIFICATION AND TERMINATION

Any modification or amendment of this Agreement must be agreed to by both parties in writing. This Agreement may be modified to incorporate new sections or language as required to insure compliance with parties' legislative mandates and internal policies and processes. Either party may terminate this Agreement by giving the other party 30 days' notice in writing. If the state cancels its order for the services described under this Agreement, CMS is authorized to collect costs incurred prior to cancellation of the state's order, plus any termination costs charged to CMS.

XIII. INFORMATION PRIVACY AND SECURITY

This Agreement has been reviewed for privacy and information security implications. Consistent with section V.A.4 of this Agreement, the parties acknowledge and agree that none of the data or information CMS will access to provide the services under this Agreement constitutes protected health information as defined by HIPAA or other relevant Colorado state law. Information from Colorado issuers will be provided to CMS as indicated in Section V.A.1 of this Agreement. To the extent that CMS maintains in its systems any data used to provide services under this Agreement, CMS will maintain such information in information technology systems that are compliant with applicable requirements under the Federal Information Security Management Act of 2002, 44 U.S.C §§ 3541-3549, as amended by the Federal Information Security Modernization Act, 44 U.S.C. §§ 3551-3558 (FISMA).

Consistent with section V.B.2, the parties acknowledge and agree that none of the information the DOI will provide to CMS constitutes protected health information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The parties to this Agreement will ensure the terms are in compliance with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. §794 (d), as amended by the Workforce Investment Act of 1998 (P.L. 105-220), August 7, 1998, and to implement the Department of Health & Human Services' *HHS Policy for Section 508 Electronic and Information Technology (EIT)* issued January 2005.

IX. Signatures

The parties below from CMS and the DOI are agreeing to this Agreement on behalf of their organization.

Jeffrey Grant -S Digitally signed by Jeffrey Grant -S
Date: 2019.12.19 10:18:28 -05'00'

Jeffrey Grant
Deputy Director for Operations
Center for Consumer Information and Insurance Oversight (CCIIO)

Date: 12/19/2019

Patty Salazar
Executive Director
Colorado Department of Regulatory Agencies

Date: 12/26/19

Mariam Habtemariam
Controller
Colorado Department of Regulatory Agencies

Date: 12-26-2019

Attachment 11

Colorado Reinsurance Program

Tribal Consultation

April 16, 2021

COLORADO
Department of Regulatory Agencies
Division of Insurance

Reinsurance Program Overview

Program Goals

- Reduce health insurance premium prices for Coloradans who buy insurance on the individual market
- Lower premiums more in areas of the state where insurance prices are highest
- Stabilize and strengthen Colorado's individual insurance market

Legislative & Operating Authority

- Established as a 2 year program under HB 19-1168 (2020-2021)
- Extended 5 years under SB 20-215 (2022-2026)
- Operates under a CMS Section 1332 State Innovation Waiver
- Administered by the Colorado Division of Insurance

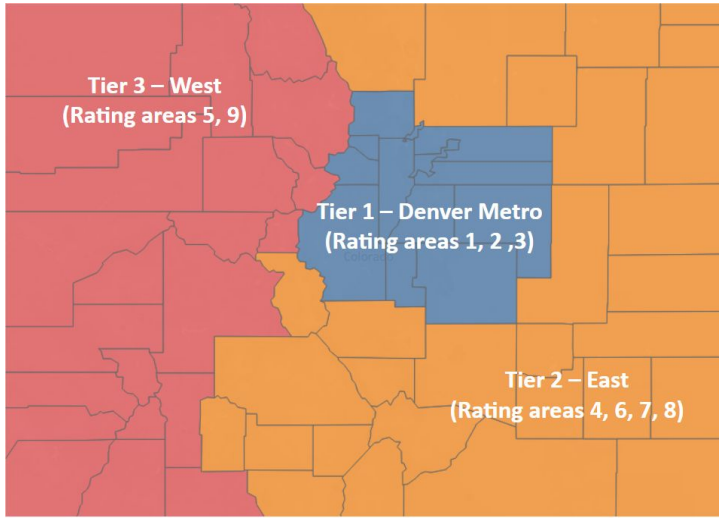
Program Funding

- Combination of federal "pass-through" funds (federal savings) and state funding through SB 20-215 (CO Health Insurance Affordability Enterprise)
- Budget neutral for the federal and state governments

COLORADO
Department of Regulatory Agencies
Division of Insurance

Reinsurance Lowers Premiums

Reinsurance reduced individual market premiums by over 20% on average statewide in 2020 and 2021, and more in higher cost areas (Tiers 2 & 3).



	Tier 1	Tier 2	Tier 3
	Areas 1, 2, & 3 (Denver Metro)	Areas 4, 6, 7, & 8 (East)	Areas 5 & 9 (West)
Year One (2020) Premium Savings	18.0%	23.5%	29.5%
Year Two (2021) Premium Savings	17.0%	22.9%	36.9%

COLORADO
Department of Regulatory Agencies
Division of Insurance

Impact to Tribal Communities

- **Reinsurance reduces premiums for any Native Americans who buy their own health insurance on Colorado's individual market**
  - Approximately 700 Connect for Health enrollees identify as American Indian / Alaksan Native
  - Most of Colorado's ~55,000 Native Americans are covered by Medicaid, Medicare, or an employer
- **Reinsurance does not impact the normal financial assistance that is available to Native Americans through Connect for Health Colorado**
  - Year-round open enrollment
  - Zero or reduced out-of-pocket costs and premiums for those who qualify
  - Cost-sharing discounts may be applied to any plan sold through C4
- **Reinsurance does not impact health care services provided through Indian Health Service, tribal or urban Indian health programs, or other providers**
  - Reinsurance *does* help reduce uncompensated care costs for these providers by helping more people afford insurance coverage

COLORADO
Department of Regulatory Agencies
Division of Insurance

Questions?

Reinsurance Program website:

https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-legislation/reinsurance-program

Laura Mortimer

Reinsurance Program Director
Colorado Division of Insurance
laura.mortimer@state.co.us
(720) 701-0075

COLORADO
Department of Regulatory Agencies
Division of Insurance

Attachment 12

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Regulation 4-2-77

CONCERNING PAYMENTS TO CARRIERS FOR THE COLORADO REINSURANCE PROGRAM

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-16-1104(1)(i), 10-16-1105(1)(d); 10-16-1105(1)(e); 10-16-1105(3)(c); and 10-16-1105(4)(d), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the process and timeline by which the Division of Insurance will notify carriers and disburse reinsurance payments to carriers for the applicable benefit year.

Section 3 Applicability

This regulation applies to all eligible carriers that participate in the Colorado Reinsurance Program pursuant to Title 10, article 16, part 11.

Section 4 Definitions

A. "Benefit Year" shall have the same meaning as found at § 10-16-1103(2), C.R.S.

B. "Eligible Carrier" shall have the same meaning as found at § 10-16-1103(5), C.R.S.

C. "Payment Parameters" shall have the same meaning as found at § 10-16-1103(9), C.R.S.

D. "Reinsurance Program" shall have the same meaning as found at § 10-16-1103(12), C.R.S.

Section 5 Reinsurance Payment Process to Carriers

A. The Division of Insurance (Division) shall notify eligible carriers by email of reinsurance payment amounts that will be distributed for the applicable benefit year by June 30 of the year following the applicable benefit year.

1. The Division shall use the Centers for Medicare and Medicaid (CMS) External Data Gathering Environment (EDGE) Server to calculate reinsurance payments due to each eligible carrier.

    a. Payment amounts are based on the reinsurance payment parameters for the applicable benefit year.

    b. Eligible carriers must have submitted all claims for the applicable benefit year to the EDGE server by April 30 of the year following the applicable benefit year in order for claims to be included in the reinsurance payment calculation.

B. Consistent with section 10-16-1105(4)(d), C.R.S., carriers must notify the Division in writing within thirty (30) days of notification of the reinsurance payment amount if they wish for the Division to reconsider their reinsurance payment amount.

    1. Requests for reconsideration must clearly state all of the grounds on which the carrier's request is based, and should include evidence and other materials as necessary to support the request. No late filings, including any supplemental evidence or materials, will be accepted after the deadline.

    2. The Division will respond in writing to a request for reconsideration within ten (10) days of the request deadline, and will notify carriers of any changes to their reinsurance payment amounts as soon as practicable thereafter.

C. The Colorado Department of Regulatory Agencies (DORA) shall disburse electronic funds transfer (EFT) payments to all carriers for the reinsurance payment amounts by August 15 of the year following the applicable benefit year.

    1. Carriers must have submitted a W9 and have a current account set up in the Colorado Operations Resource Engine (CORE) to receive reinsurance payments.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall be effective June 15, 2021.

Section 9 History

New regulation effective June 15, 2021.