

HB21-1232: STANDARDIZED HEALTH BENEFIT PLAN COLORADO OPTION

Concerning the establishment of a standardized health benefit plan to be offered in Colorado.

Details

Bill Sponsors:	House – Roberts (D) & Jodeh (D), Mullica (D), Amabile (D), Bennett (D), Caraveo (D), Cutter (D), Duran (D), Gonzales-Gutierrez (D), Hooton (D), Kennedy (D), Kipp (D), McCluskie (D), McCormick (D), Ortiz (D), Ricks (D), Sirota (D), Tipper (D), Valdez A. (D), Weissman (D), Woodrow (D) Senate – Donovan (D), Bridges (D), Danielson (D), Gonzales (D), Jacquez Lewis (D), Pettersen (D), Story (D), Winter (D)
Committee:	House Health & Insurance
Bill History:	3/18/2021- Introduced in House
Next Action:	4/9/2021- Hearing in House Health & Insurance Committee
Fiscal Note:	<u>3/29/2021</u>

Bill Summary

The Colorado Health Insurance Option is a two-phased approach aimed at addressing the affordability of health insurance in Colorado. Phase One includes the creation of a standardized insurance plan by the Division of Insurance (DOI) for carriers to offer in areas where they currently offer plans in both the individual and small group markets. The bill encourages insurance carriers to work with other groups of the health care industry (i.e. hospitals, prescription drug manufacturers, providers) to reduce their insurance premiums by 10 percent each year over two years. If the cost reduction targets are not met, Phase Two is triggered, and the State of Colorado will offer the standardized plan on individual and small group markets through the newly established Colorado Option Authority, a quasi-governmental entity.

The Commissioner of Insurance is required to apply to the secretary of the United States Department of Health and Human Services for a waiver and include a request for a pass-through of federal funding to capture savings as a result of the implementation of the standardized plan.

If the U.S. Congress establishes a national public option program that meets or exceeds requirements in this bill, the bill and program is repealed.

Issue Summary

Affordable Care Act (ACA)

Signed into federal law in 2010, the Patient Protection and Affordable Care Act (ACA) expanded access to health insurance in the United States. Specifically, the ACA allowed for the expansion of Medicaid to all previously non-Medicare eligible individuals under age 65 with incomes up to 133% of the Federal Poverty Level (FPL). The legislation also codified four pillars of protections for people: guaranteed issue, adjusted community rating, prohibition against preexisting condition exclusions, and essential health benefits.¹ Under

¹ Kaiser Family Foundation (KFF) (Apr. 25, 2013). *Summary of the Affordable Care Act*. Retrieved from <https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>

the essential health benefits, certain preventive and wellness services must be covered without imposing any cost-sharing on the patients receiving those services.^{2,3}

The ACA requires plans in both the individual and small group market to cover essential health benefits (EHB). This includes items and services in the following benefit categories:

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| 1. Ambulatory patient services | 7. Rehabilitative and habilitative services and devices |
| 2. Emergency services | 8. Laboratory services |
| 3. Hospitalization | 9. Preventive and wellness services and chronic disease management |
| 4. Maternity & newborn care | 10. Pediatric services, including oral and vision care |
| 5. Mental health and substance use disorder services including behavioral health treatment | |
| 6. Prescription drugs | |

Insurance Coverage in Colorado

Coloradans can get health insurance coverage through a variety of different means, depending on eligibility. There are public programs, such as Medicare, Medicaid, and Child Health Plan Plus (CHP+), or private insurance through an employer, through the marketplace run by Connect for Health Colorado, or insurance that is offered off the marketplace. This figure from the Colorado Health Institute (CHI) demonstrates the proportion of residents in the different types of insurance coverage offered in Colorado.⁴



According to the 2019 Colorado Health Access Survey (CHAS) from CHI, 93.5% of Coloradans are insured.¹ For those who reported being uninsured in the 2019 CHAS, 89.6% cited that the cost of the insurance was a barrier to purchasing coverage, which is much greater than the 78.4% that had the same response in 2017.¹

Each of the 64 counties in Colorado has at least one carrier providing insurance on the marketplace. For the 2021 plan year, 10 of Colorado's 64 counties had only one carrier offering plans, a decrease from 22 counties for the 2020 plan year.⁵

Health insurance plans on the individual market were nearly 50 percent more expensive in 2019 than in 2014.⁶ For employer sponsored insurance, the average annual family premium in 2019 totaled \$20,171, including both the employer and employee contribution.⁷ In comparison, the average annual family premium for employer sponsored insurance totaled \$16,940 in 2015.

After falling from 12% to 4% between 2013 and 2016, in 2019, 8% of Larimer County survey respondents ages 18 to 64 reported having no health insurance. In 2019, 18% of respondents age 18-64 from lower

² HealthCare.gov (n.d.) *Preventive Health Services*. Retrieved from <https://www.healthcare.gov/coverage/preventive-care-benefits/>

³ KFF (n.d.) *Preventive Services Covered by Private Health Plans under the Affordable Care Act*. Retrieved from <https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>

⁴ Colorado Health Institute (CHI) (Jan. 2020). *Progress in Peril: 2019 Colorado Health Access Survey Storybook*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Storybook%202019%20for%20Web.pdf

⁵ Division of Insurance (July 9, 2020). *Same eight companies returning to offer individual health insurance plans 2021 while number of plans increases*. Retrieved from <https://doi.colorado.gov/press-release/same-eight-companies-returning-to-offer-individual-health-insurance-plans-for-2021>

⁶ CHI (March 2020). *ACA at 10 Years: Consumer Costs*. Retrieved from <https://www.coloradohealthinstitute.org/research/aca-10-years-consumer-costs>

⁷ KFF (2020) *Health Costs and Budget Indicators*. Retrieved from <https://www.kff.org/state-category/health-costs-budgets/employer-based-health-insurance-premiums/>

income households (<185% FPL) reported being uninsured.⁸ Further, respondents ages 18-64 in 2019 that identified as Hispanic had significantly higher rate of uninsurance(17.0%) than White non-Hispanic individuals (7.1%). In 2019, 53.8% of Larimer County adults reported being somewhat or very worried about health insurance becoming so expensive that they will not be able to afford it.

Health Care Costs in Colorado

Colorado's health care system currently ranks sixth in the nation according to the Commonwealth Fund.⁹ However, Colorado still struggles to increase access to health care and improve affordability, ranking 24th in the U.S. The report found that Colorado had low marks in adults without a usual source of care, alcohol deaths, and suicide deaths. Coloradans continue to have strong concerns about the cost of health insurance and care, and people in Colorado can have dire financial circumstances if they develop chronic illness or have emergency or other needs for health care that result in high out-of-pocket costs. Coloradans spend an average of \$6,804 per capita (14 percent of their income) on health care, and costs can be far higher for many.¹⁰ Analysis shows that costs will continue to rise and manifest in increased deductibles, with nearly all insurance plans in Colorado relying on deductibles to cover costs. A few of the reasons that the cost of care continues to rise include expensive technologies, consolidation, fee-for-service payments, prescription drugs, low-value care, and the continued aging of the population.¹¹ Currently, some say that health care costs are rising unsustainably, making the availability of affordable health care a concern for many Coloradans.¹²

A 2018 report from the Network of Regional Healthcare Improvement (NRHI) demonstrates how Colorado compares to five other states, which were chosen as part of a pilot, for health care costs of those individuals that are commercially insured.¹³ Colorado's risk-adjusted total cost per person in 2016 was 19% higher than the six-state average. Further analysis of the data by the Center for Improving Value in Health Care (CIVHC) found that Colorado has higher than average prices across all of the service categories, and was the only state of the six to have higher prices than average for these groups.¹⁴ These higher than average prices for inpatient (31%), outpatient (15%), professional (7%) and pharmacy (5%) were found to be the main drivers of the higher total average spend per person. The utilization and price of these services also vary in different areas of the state.

A report from the Colorado Health Institute (CHI) and Colorado Hospital Association (CHA) found that 75% of the total spending by health service category in the state goes to hospitals (34%), physician, professional, and clinical services (29%), and insurance administrative costs (12%).¹⁵ The remainder goes to nursing home/home health/other residential and personal care (10%), retail drugs (7%), medical equipment (3%), and other (5%).

⁸ Health District of Northern Larimer County (2020). *2019 Community Health Assessment*. Retrieved from <https://www.healthdistrict.org/2019-community-health-assessment>

⁹ The Commonwealth Fund. (2020). "2020 Scorecard on State Health System Performance." Retrieved from <https://www.commonwealthfund.org/publications/scorecard/2020/sep/2020-scorecard-state-health-system-performance>

¹⁰ CHI. (Dec. 14, 2018). *Affordability in Colorado: Questions and Answers about Health Care Costs*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHA%20Q%26A%20no%20crops.pdf.

¹¹ CHI. (2017). *A Fresh Look at Health Care Cost Drivers: Exploring Free Market and Regulatory Solutions*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/X_Cost_Drivers_fact_sheet_SENT.pdf

¹² Colorado Consumer Health Initiative (Feb. 2019). *What Coloradans Are Saying About Health Care*. Retrieved from <https://www.cohealthinitiative.org/what-coloradans-are-saying-about-health-care>

¹³ NRHI (Nov. 8, 2018). *Healthcare Affordability: Data is the Spark, Collaboration is the Fuel*. Retrieved from http://www.nrhi.org/uploads/rwj_tcoc_phaseiii_benchmark_2018_r7.pdf

¹⁴ CIVHC (Nov. 8, 2018). *Colorado's Health Care Costs Continue to Rise Above Other States*. Retrieved from <https://www.civhc.org/2018/11/08/colorados-health-care-costs-continue-to-rise-above-other-states/>

¹⁵ CHI (2018). *Affordability in Colorado: Answers about Health Care Costs*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHA%20Q%26A%20no%20crops.pdf

Colorado Health Insurance Affordability Enterprise

The Health Insurance Affordability Enterprise was established in Colorado with the passage of SB20-215.¹⁶ It is designed to address the affordability of health insurance on the individual market and to expand subsidies for those not eligible for federal subsidies under the ACA. The enterprise administers a health insurance affordability fee assessed on health insurers and hospitals to fund measures to reduce consumer costs for individual health coverage plans. The enterprise is governed by an 11 person board.¹⁷

1332 Waiver

Within the Affordable Care Act (ACA), section 1332 allows for states to implement elements of the ACA in alternative manners. Section 1332 waivers are limited as these novel approaches must be as successful in providing affordable, quality health coverage and cost the federal government either the same amount or less than the standard implementation. There are four specific limitations for this waiver, known colloquially as “guardrails.” The innovation must:

1. Provide coverage that is the same or more comprehensive than the original;
2. Provide coverage that is at least as affordable;
3. Provide coverage for the same amount or more people; and
4. Not add to the federal deficit.

These guardrails were set forth in the statutory language, but can be interpreted differently by each administration. The Centers for Medicare and Medicaid Services (CMS) has created detailed guidance, which leads states through the 1332 waiver process, which was updated in October 2018 by the Trump Administration.¹⁸ The new guidance outlined that waiver applications that incorporate one or all of the dictated principles that are preferred by the agency:

1. Provide increased access to affordable private market coverage over public programs, and increase insurer participation and promote competition;
2. Encourage sustainable spending growth by promoting more cost-effective coverage, restraining growth in federal spending, and eliminating state regulations that limit market choice and competition;
3. Foster state innovation;
4. Support and empower those in need; and
5. Promote consumer-driven health care.

The new guidance largely maintains the 2015 guidance’s approach to budget neutrality.¹⁹ However, a sentence was removed that stated that a waiver application that increases the deficit in any given year may not meet the deficit neutrality requirement. This suggests that a waiver could increase the federal deficit during the waiver’s effect and still be approved (so long as the overall waiver does not increase the federal deficit).

It is yet to be seen how the Biden Administration will likely change the 1332 waiver guidance that was updated by the Trump Administration.

¹⁶ <https://leg.colorado.gov/bills/sb20-215>

¹⁷ Division of Insurance (2021). *Health Insurance Affordability Enterprise*. Retrieved from <https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-legislation/health-insurance-affordability>

¹⁸ The Centers for Medicare and Medicaid Services [CMS]. (2018) *State Relief and Empowerment Waivers*. Retrieved from <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf>

¹⁹ Keith, K. (Oct. 23, 2018). Feds Dramatically Relax Section 1332 Waiver Guardrails. *Health Affairs Blog*. DOI:

10.1377/hblog20181023.512033. Retrieved from

<https://www.healthaffairs.org/doi/10.1377/hblog20181023.512033/full/#:~:text=Section%201332%20allows%20states%2C%20with,the%20goals%20of%20the%20ACA.>

Federal Legislation

United States Senators Michael Bennet (D-CO) and Tim Kaine (D-VA) introduced S. 386, “Medicare-X Choice Act of 2021”²⁰ on February 23, 2021, with a companion bill in the House (H.R. 1227²¹) sponsored by Representative Antonio Delgado (D-NY).²² The bill would create a federal public option (“Medicare-X”) available on the individual and small group markets. Medicare-X would use the existing Medicare program’s network of providers, guarantee the essential health benefits of the ACA, and prescription drug costs would be negotiated in conjunction with the Medicare Part D program. Enhanced marketplace subsidies would help finance the program for all participants. Medicare-X would still retain other current sources of private and public health insurance coverage.

H.R. 1976, “To establish an improved Medicare for All national health insurance program,” was recently introduced by Representative Pramila Jayapal (D-WA), along with 112 other cosponsors, including Colorado Representatives Diana DeGette (D), Joe Neguse (D), and Ed Perlmutter (D).²³ Medicare-for-All would serve as a single federal program with comprehensive benefits for all US residents. It would be tax-financed and require no premiums or cost sharing. Medicare for All would replace all private insurance, Medicaid, Medicare, and the Children’s Health Insurance Plan (known as CHP+ in Colorado) for covered benefits. This would include primary care, vision, dental, prescription drugs, mental health, substance use disorder, long-term services and supports, reproductive health care, and other services.

This Legislation

Legislative Declaration

The General Assembly, exercising its powers, finds the following. Health insurance coverage has a positive impact on people’s health outcomes as well as their financial security and well-being. Ensuring access to affordable, quality, continuous, and equitable health care is a challenge that officials and experts have faced for decades despite seemingly constant efforts to address the issue. Great strides have been made in increasing access to health care coverage through federal and state legislation. However, not enough has been accomplished to address the affordability of health insurance in Colorado, particularly in the state’s rural areas and for groups historically and systematically disinvested in public policy including people of color and undocumented Coloradans. The health care system is a complex system wherein consumers rely on insurance carriers to negotiate the rates paid to providers, pharmaceutical companies, and hospitals for services provided to consumers and expect that the negotiated rates are closely tied to the amount of the insurance premiums paid by consumers. Despite efforts to address access to and affordability of health care, underlying health care costs continue to rise, thus driving up the costs of premiums, often at disproportionate rates in rural areas of the state. In order to ensure that health insurance is affordable, it is critical that Colorado establishes a standardized plan for carriers to offer in the state and to set premium targets for carriers to achieve. If carriers cannot offer the standardized plan at the premium targets, a quasi-governmental entity is needed to offer the Colorado option, an affordable option for the purpose of increasing equitable access to and availability of statewide affordable, quality health insurance in the small group market and to any resident seeking coverage in the individual market.

Definitions

Advisory Committee. The Colorado option advisory committee.

Authority. The Colorado option authority.

²⁰ As of February 23, 2021, Senator Michael Bennet (D-CO) is a cosponsor.

²¹ As of March 18, 2021, Representative Ed Perlmutter (D-CO) is a cosponsor.

²² Congress (March 23, 2021). *S. 386- Medicare-X Choice Act of 2021*. Retrieved from <https://www.congress.gov/bill/117th-congress/senate-bill/386/cosponsors?q={%22search%22:%22medicare+x%22}&r=2&s=1&searchResultViewType=expanded>

²³ Congress (March 23, 2021). *H.R. 1976- To establish an improved Medicare for All national health insurance program*. Retrieved from <https://www.congress.gov/bill/117th-congress/house-bill/1976/cosponsors?r=1&s=3&q=%7B%22search%22%3A%5B%22medicare+for+all%22%5D%2C%22cosponsor-state%22%3A%22Colorado%22%7D>

Board. The Colorado option authority board.

Colorado Option. The standardized plan offered by the authority.

Health Care Coverage Cooperative. A health care coverage cooperative created as an entity that provides to its members health coverage and health care purchasing services, including but not limited to detailed information on comparative prices, usage, outcomes, quality, and member satisfaction with provider networks.²⁴

Health Care Provider. A health care professional who is registered, certified, or licensed under Title 12²⁵ or a health facility licensed under Title 25.²⁶

Small Group Market. The market for small group sickness and accident insurance.

Standardized Plan. The standardized health benefit plan designed by rule of the Commissioner of Insurance.

PHASE ONE

Establishing Standardized Health Plan

By January 1, 2022, the Commissioner will establish a standardized health plan to be offered by carriers in the individual and small group markets. The standardized plan must:

- Offer health care coverage at the bronze, silver, and gold levels
- Include, at a minimum, all essential health benefits
- Be offered through Connect for Health Colorado and through the Public Benefit Corporation (to be established)
- Be a standardized benefit design that:
 - Is created through a stakeholder engagement process, including health care industry, consumer representatives, and individuals working in or representing communities that are diverse (race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic regions of the state or are affected by higher rates of health disparities and inequities)
 - Has defined benefit design and cost sharing and
 - Is designed to improve racial health disparities, through a variety of means, including the improvement of perinatal health care coverage
- Provide first-dollar, pre-deductible coverage for certain high-value services identified collaboratively with consumer stakeholders, which reduce racial disparities in health outcomes, such as primary care and behavioral health
- Comply with the ACA and the requirements under this new Article 16 under Title 10

The standardized plan must be offered in a way that allows consumers to compare the standardized plans offered by different carriers. The Commissioner can update the standardized plan annually, by rule through the aforementioned stakeholder process.

Standardized Health Plan- Carrier Requirements

Starting January 1, 2023, and every year after, a carrier that offers an individual plan in Colorado is encouraged to offer the standardized plan in the market in each zip code where they offer an individual plan.

²⁴ Definition from C.R.S. § 10-16-1002(2)

²⁵ This includes the following professionals: acupuncturists, athletic trainers, audiologists, chiropractors, dentists, dental hygienists, direct-entry midwives, hearing aid providers, massage therapists, physicians, physician assistants, psychologists, social workers, marriage and family therapists, licensed professional counselors, unlicensed psychotherapists, addiction counselors, naturopathic doctors, nurses, nurse aides, nursing home administrators, occupational therapists, occupational therapy assistants, optometrists, pharmacists, physical therapists, physical therapy assistants, podiatrists, psychiatric technicians, respiratory therapists, speech-language pathologists, surgical assistants, surgical technologists, and veterinarians.

²⁶ Specifically, licensed pursuant to C.R.S. § 25-1.5-103. This includes: general hospitals, freestanding emergency departments, psychiatric hospitals, community clinics, rehabilitation hospitals, convalescent centers, community mental health centers, acute treatment units, behavioral health entities, facilities for persons with intellectual and developmental disabilities, nursing care facilities, hospice care, assisted living residences, dialysis treatment clinics, ambulatory surgical centers, birthing centers, home care agencies, and other facilities of a like nature

Similarly, a carrier offering a small group plan is encouraged to offer the standardized plan in the market in each zip code where it currently offers a small group plan.

In the individual and small group market beginning plan year 2023, each carrier offering a standardized plan is to set a goal of offering the plan at a premium rate that is at least 10% less than the premium rate for plans offered by the carrier in that county in 2021. The Commissioner must calculate the rate reduction based on the rates charged in the same county, prior to the application of the reinsurance program. For a carrier offering the standardized plan in a county where it did not offer a plan in the individual or small group market in 2021, the carrier shall set a goal of offering the standardized plan with a premium that is at least 10% less than the average premium rate for plans offered in that county in 2021, calculated based on the average premium prior to applying the reinsurance program. The average premium is based on the county's individual market for individual plans and small group market for small group plans.

For plan year 2024, the carriers offering a standardized plans are to set a goal to reduce premiums at least 20% in comparison to 2021. The aforementioned reduction calculations and stipulations for plan year 2023 would be applied in plan year 2024.

For plan year 2025, and each year after, each carrier and health care cooperative is encouraged to limit annual premium rate increases for the standardize plan in both markets by a rate that is no more than the consumer price index for all urban consumers plus one percent, in comparison to the previous year.

The premium rate reductions in plan years 2023 and 2024 must account for policy adjustments deemed necessary to prevent people with low and moderate income from experiencing net increases in premium costs.

PHASE TWO

Creation of Colorado Option Authority

The Colorado Option Authority is created as a nonprofit, unincorporated public entity. The implementation and operation of the Authority is contingent on receiving a federal waiver and receiving the correlated federal funds. The Authority is to operate as a health insurance carrier in Colorado to offer the Colorado Option on the individual and small group market, if an independent actuarial analysis demonstrates that carriers failed to meet the premium rate reduction goals. The rate reduction goals are to be adjusted for changes in the standardized plan based on plan coverage requirement changes imposed by state or federal law. The actuarial analysis must take into account any coverage requirement changes. The Commissioner shall establish, through rulemaking, the requirements for the methods to calculate the rate reductions. If it is determined that carriers failed to meet the premium rate reductions, the Commissioner notifies the Governor and the Board that the Authority is required to offer the Colorado Option.

The Authority is an instrumentality of the state, except that its debts and liabilities do not constitute the debts and liabilities of the state. The Authority is not an agency of the state, not a district for the purposes of the Taxpayer's Bill of Rights (TABOR),²⁷ and is not authorized to promulgate rules. The Authority implements the provider reimbursement fee schedule for services covered by the Colorado Option.

The Colorado Option Authority Board is created with 9 members appointed by the Governor and confirmed by the Senate. The Board is the Authority's governing body and shall determine its development, governance, and operation. The Board is not an agency of the state. In making Board appointments, the Governor shall appoint individuals who have experience or expertise in at least two of the following areas:

- Individual health insurance coverage

²⁷ Section 20 of Article X of the Colorado Constitution

- Value-based purchasing and plan design
- Health care consumer navigation and assistance in accessing health care
- Health care finance
- Provision of health care services in rural areas
- Provision of health care services to uninsured and low-income populations
- Health care actuarial analysis
- Member of an employee organization that represents employees in the health care industry
- Health care delivery systems
- Representing consumers in the development of health care policy
- Hospital administration
- Insurance brokerage
- Improving health equity for communities of color and decreasing racial disparities in health care

The Governor must ensure that the Board's membership as a whole has demonstrated experience and expertise in most of the listed categories. At least 5 members of the Board must be consumers, representatives of consumers, and small business owners. One member must represent hospitals. One member must represent providers. To the extent possible, the Governor shall appoint members who reflect the diversity of the state with regards to race, ethnicity, immigration status, income, wealth, ability, and geography. A person employed by a carrier or managed care organization is not eligible for appointment.

The Governor shall appoint 5 members to an initial term of 4 years and 4 members to an initial term of 2 years. After those initial terms, all terms are for 4 years. Each member may serve no more than 2 full, 4 year terms. Members who are appointed to an initial 2 year term can serve up to 2 additional 4 year terms after their initial term. The members serve at the pleasure of the Governor. The Governor can fill any vacancies.

Members must publicly disclose whether they have any financial interest in the implementation of the Colorado Option. Members may receive a per diem for their service and may be reimbursed for actual and necessary expenses, including any required dependent care, dependent or attendant travel, food, and lodging while engaged in performing their official duties.

The Board and its members are subject to the state's Open Meetings Law²⁸ and Colorado Open Records Act.²⁹ Additionally, it is not required to comply with the state procurement code and is not subject to or part of the state personnel system. The Board must hire an Executive Director of the Authority, seek and maintain the ability to operate as a carrier in Colorado, consult with and consider recommendations from the advisory committee, not duplicate or replace the powers and duties of the Commissioner of Insurance, and may contract with state agencies to implement the Colorado Option.

Provider Fee Schedule

The Commissioner must promulgate rules to establish a reasonable reimbursement fee schedule for health care services that are covered by the Colorado Option. The Commissioner is to consult with the Executive Director of the Department of Health Care Policy and Financing (HCPF) to inform providers concerning the proposed fee schedule. The fee schedule is to be made available to the Authority to enable it to set premium rates. The premium rates are subject to review and approval pursuant to the typical rate filing process.

In establishing the fee schedule, the circumstances of critical access hospitals, rural and independent providers, and providers that serve a high percentage of uninsured and Medicaid patients may be taken into account. The Commissioner may also take into account the cost of adequate wages, benefits, staffing, and training to provide adequate care. The fee schedule must:

²⁸ Part 4, Article 6, Title 24 of the Colorado Revised Statutes

²⁹ Part 2, Article 72, Title 24 of the Colorado Revised Statutes

- Apply to hospitals, health care providers, pharmacies, and all other providers delivering health care services in Colorado, which are covered by the Colorado Option
- Set the reimbursement fees for 2025 to achieve at least a 20% decrease in premiums when compared to rates for health plans offered in the individual and small group markets in 2021
- Set reimbursement fees for 2026 and each year after at rates that ensure the premiums do not increase by more than the Consumer Price Index (CPI) for all urban consumers³⁰ plus 1%, relative to the previous year, and
- Be available to other plans, as determined by the Commissioner, including health coverage cooperatives, if members of the cooperative opt to be subject to the regulatory authority of the Commissioner

Each health care provider shall accept patients enrolled in any Colorado Option plan. The exception is that the Commissioner, in consultation with HCPF and the Authority Board, can exempt a particular provider, hospital, or pharmacy from the fee schedule or change the fee schedule for that entity upon a demonstration that the fee schedule will reduce their ability to accept or provide health care services to patients who are uninsured or enrolled in Medicaid or the Children's Health Plan Plus (CHP+). A provider cannot balance bill Colorado Option enrollees and shall accept the fee for the service provided to the consumer.

When implementing the hospital reimbursement rate formula, the Commissioner and the Authority Board are to consult with employee membership organizations representing health care providers' employees and with hospital-based providers. Changes can be made by rule to the hospital reimbursement rate formula so that reimbursement rates reflect the cost of adequate wages, benefits, staffing, and training for these employees to provide quality care.

Colorado Option Authority Advisory Committee

The Authority's Board is to appoint an advisory committee to make recommendations to the Board and the Authority concerning the development, implementation, an operation of the Authority and the Colorado Option. In its recommendations, the advisory committee shall give special consideration to those with low incomes and to communities of color. The Board determines the terms for the members of the advisory committee and must ensure that they represent the diversity of the state, including members who intend to enroll in the Colorado Option.

Federal Waiver

On and after the effective date of the bill, the Commissioner can apply to the Secretary of the U.S. Department of Health and Human Services for a Section 1332 waiver. Upon approval of the waiver, the Commissioner can use any federal funds that are derived from the waiver to establish the Authority and for the Colorado Health Insurance Affordability Enterprise to increase the value, affordability, quality, and equity of health care coverage. The implementation and operation of the Authority is contingent upon approval of the 1332 waiver and receiving the related federal funds.

Rules

The Commissioner can promulgate rules that are necessary to develop, implement, and operate both phase one and phase two of the bill.

Severability

If any provision of phase one or two of the Colorado Option is judged invalid, it does not affect the provisions that can continue to occur without the invalid provision.

³⁰ The 12-month CPI from February 2020-February 2021 is 1.7%. More information on the CPI can be found here: <https://www.bls.gov/cpi/>

Repeal on Enactment of National Public Option

The bill is repealed if the U.S. Congress enacts and the President signs a national public option program that meets or exceeds the premium reduction goals and covers the populations that will receive coverage under the Colorado Option. The exception to the repeal includes the definitions of “small group market” and “standardized plan”, the establishment of a standardized health benefit plan, and the requirement for carriers to provide the standardized health benefit plans.

Rate Filing

The bill adds a provision to the reasons why the Commissioner shall disapprove of requested rate increase. If the rate filing reflects a cost shift between the standardized plan and the plan for which rate approval is being sought, the rate increase shall be disapproved. The Commissioner may consider the total cost of health care when making this determination.

Health Insurance Affordability Cash Fund

The bill allows for money to be allocated to the fund pursuant to the funds received under the 1332 waiver. Also, the fund consists of all interest and income derived from the deposit and investment of money in the fund.

Connect for Health Colorado Board Duties

The bill adds to the duties of the Board of Connect for Health Colorado. The Board shall conduct a survey, through Connect for Health Colorado, of consumers who purchased the standardized health plan, addressing the consumers’ purchasing experience and whether the plan addresses health equity and disparity issues.

Professional Disciplinary Action

The following professionals can face disciplinary action by their licensing board if they do not accept patients enrolled in the Colorado Option or balance bill enrolled patients:

- Acupuncturist
- Chiropractors
- Direct-entry Midwives
- Massage Therapists
- Physicians
- Physician Assistants
- Mental Health Professionals
- Nurses
- Nurse Aides
- Occupational Therapists
- Optometrists
- Physical Therapists
- Podiatrists

Health Facilities & the Colorado Option

A health facility licensed or certified by CDPHE that provides services covered under the Colorado Option must accept Colorado Option enrolled consumers, cannot balance bill enrolled patients, and accept the fee schedule established for the Colorado Option. CDPHE may suspend, revoke, or impose conditions on a health facility’s license or certificate of authority for noncompliance.

Effective Date

The bill is effective upon the Governor’s signature or if the Governor allows it to become law without their signature.

Fiscal Note

The fiscal note estimates that state expenditures include costs to establish and implement the standardized plan to be offered by private health insurance carriers, as well as to seek federal approval of a State Innovation Waiver. These costs are estimated to be \$868,684 and 3.5 FTE in FY 2021-22, and \$790,424 and 4.9 FTE in FY 2022-23.

Reasons to Support

Many Colorado residents continue to struggle with health insurance costs and too few options. A public option program could offer consumers across the state a lower-cost plan option than would otherwise not be available. This two phased approach gives the industry - including hospitals, insurance carriers, and drug manufacturers - the chance to work together to lower the driving costs of health care first. If the industry is not able or willing to realize lower health care costs while maintaining quality and access, the state will move forward with the Colorado Health Insurance Option. This is a long term solution to create affordable insurance options, holding the entire health care industry accountable for cost, in order to make it easier for Coloradans, including people of all races and incomes, to afford and access health insurance – assuring everyone an equitable chance for good health.

The standardized plan means there will be a uniform set of services and out-of-pocket costs that the health care industry must comply with. This will make it easier for consumers to access care with their coverage without fear of unpredictable costs or high deductibles. It will also make it easier for consumers to compare plans from different carriers because they will all have to meet the same standards for out-of-pocket costs and plan benefits.

Small businesses have consistently seen premium hikes, making it increasingly difficult for business owners to afford and provide coverage to their employees. Small businesses will have access to the more affordable plans in phase one and phase two. This will ensure that small businesses have more affordable options and can more easily offer health benefits and retain employees.

Supporters

- Centennial State Prosperity
- Colorado Center on Law & Policy
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
- Good Business Colorado
- Healthier Colorado
- Justice Reskill
- League of Women Voters
- Mental Health Colorado

Reasons to Oppose

If too many people move to the public option, some believe it could negatively impact the private marketplace and possibly increase prices for those who buy health insurance without the use of tax credits. Some assert that increased government intervention in the marketplace could destabilize both the private and public insurance markets. The small group market has a different regulatory framework than the individual market, which could make standardizing the plan product difficult and skew the affordability benchmarking.

During Phase One, some assert that physicians and other health care providers will be the levers used by other health care industries to achieve the premium cost-cutting goals.

The state option is likely based on a fee for service model, which moves the system away from value-based reimbursement, a system that many believe offers the best chance of incentivizing the most effective care and cutting cost.

In Phase Two, the mandate for providers to participate may harm access to care, or “crowd out” Coloradans on other insurance plans. If rural health care facilities, who already see disproportionately higher rates of public insurance, are required to accept the Colorado Option, they may have to reduce care for people who

are covered by public insurance (since public insurance also has limited fee schedules, often not covering the full cost of care) in order to remain financially solvent.

Opponents

- Adams County Regional Economic Partnership
- America's Health Insurance Plans
- Americans for Prosperity
- Anthem Blue Cross and Blue Shield
- Centennial Institute at Colorado Christian University
- Cigna
- Colorado Ambulatory Surgery Center Association
- Colorado Association of Health Plans
- Colorado Association of Medical Equipment Services
- Colorado Bankers Association
- Colorado Chamber of Commerce
- Colorado Chapter, College of Emergency Physicians
- Colorado Competitive Council
- Colorado Concern
- Colorado Farm Bureau
- Colorado Obstetrical & Gynecological Society
- Colorado Radiological Society
- Colorado Rural Health Center
- Colorado Society of Anesthesiologists
- Colorado Springs Chamber
- Colorado State Association of Health Underwriters
- Columbine Health Plan
- CVS Health
- Denver Metro Chamber of Commerce
- Douglas County
- Douglas County Business Alliance
- HCA- The Healthcare Company
- Kaiser Foundation Health Plan
- Kaiser Permanente
- Mednax
- Optum
- Pacific Dental Services
- Rocky Mountain Mechanical Contractors Associations
- South Metro Denver Chamber
- United Health Care
- U.S. Anesthesia Partners of Colorado

Other Considerations

Organizations with an Amend Position

- Children's Hospital Colorado
- Colorado Academy of Family Physicians
- Colorado AFL-CIO
- Colorado Hospital Association
- Denver Health & Hospital Authority
- Peak Health Alliance
- SCL Health
- Service Employees International Union
- UCHealth

Is there room to negotiate the amount of premium rate reduction targets to a lower number?

Reductions in costs in the health care industry could have a ripple effect to the wider economy as a significant portion of cost in the health care industry is for personnel. Is there are way to study that impact?

Is there a course of action in the case that either phase of the bill creates insurmountable unintended consequences?

In the introduced version of the bill, why is it not grounds for disciplinary action to not accept patients enrolled in the Colorado Option or balance bill enrolled patients for the following licensed/registered/certified professions?

- Audiologists
- Hearing Aid Providers
- Pharmacists
- Psychiatric Technicians

- Respiratory Therapists
- Speech-language Pathologists
- Surgical Assistants and Surgical Technologists

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.