COLORADO
Department of Regulatory Agencies
Division of Insurance

Colorado Responses to Questions from CMS - June 08, 2022

1. **Federal Question:** What is the State's rate review timing for the 2023 plan year and when will rate data be publicly available?

   State Response: Please see Colorado's timing for rate review and public release of data below.
   - June 17: Preliminary rates submitted to the Division
   - Early July: Initial Press Release - 2023 Plans and Premiums (with CO Option info). We will forward this release to CMS once it is published.
   - September: 2023 Rates Finalized
   - Mid-October: Final 2023 Press Release. 2023 Plans and Premiums (with CO Option info). We will forward this release to CMS once it is published.

2. **Federal Question:** What is the State's timing for finalizing the state subsidy eligibility amounts for the upcoming plan year?

   State Response: Colorado doesn't have a set date or a date by which statute requires us to finalize subsidy eligibility/ subsidy levels for the upcoming plan year. However, we plan to finalize them prior to when rates are due each year, and are targeting May 31 as our general deadline. We already have the state subsidy eligibility criteria/ subsidy level finalized for 2023:

   - For QIs it's $0 premium and 94% AV (CO Option Silver Enhanced Plan) for all eligible individuals earning <138% FPL (if no ARPA) or <150% FPL (if ARPA subsidies continue).
   - This is in Colorado Insurance Regulation 4-2-83: https://drive.google.com/file/d/1Aec2SGsm3Brru12KFd7NnKFNb9qAh3Rq/view?usp=drivesdk

Colorado Responses to Questions from CMS - May 23, 2022

1. **Federal Question:** What information can you provide from carriers about their ability and willingness to file Colorado Option Plans for 2023?

   State Response: Initial submissions were due to the Division on 5/18/22 and, due to the complexity of these filings, we are still analyzing the initial rates that carriers have indicated they may file with the Division on 6/17/2022. While analyses of these preliminary draft rates are ongoing, all carriers that will continue in the individual and small group markets in Colorado have indicated their intent to file Gold, Silver, and Bronze Colorado Option Plans in all counties they will participate in for 2023. No carrier appears to be significantly reducing its service area and one carrier has indicated a service area expansion in these initial filings.

While analyses are ongoing, based on these initial filings, all 64 Colorado counties are expected to have at least 2 of each of the Bronze, Silver and Gold Colorado Option plans, except Jackson county, which will have only Colorado Option plan at each metal level offered by Anthem (the only carrier in the individual market in that county).

Colorado Responses to Questions from CMS - May 2022

1. **Federal Question:** In the application the language below noted that Colorado will use pass-through funding to increase the generosity of the subsidy program for individuals that qualify for PTC. We want to confirm the state subsidies for the exchange enrollees that are anticipated under the waiver and outside the waiver for 23 and beyond?

   From waiver: The HIAE has a number of populations that it is charged with assisting with its subsidies, including those Coloradans that are ineligible for federal subsidy or coverage assistance due to immigration status or lack of documentation and those ineligible for subsidy due to the so-called "family glitch." The HIAE is currently designing a subsidy program for these populations, identified in Colorado statute as "Qualified Individuals." In November 2021, the HIAE Board recommended a Qualified Individual Subsidy of 94% Actuarial Value and $0 premium, for those up to 150% FPL, if this waiver amendment is approved. This is expected to bring over 10,000 individuals into the individual market currently ineligible for ACA subsidies. Additionally, Colorado will use pass-through funding to increase the generosity of a subsidy program for individuals that qualify for APTC. That program takes effect for plan year 2022.

   State Response: Table 8 on page 54, of Colorado's amendment application provides state subsidy enrollment by year. The APTC eligible population is addressed in the rows titled - "APTC and State Subsidy Enrollment." The pass-through funding attributable to the amendment will be used to support new health insurance affordability programs designed by the Colorado Health Insurance Affordability Enterprise (HIAE). Coloradans who are ineligible for federal subsidies due to the "family glitch" (*unless a federal fix occurs*) and lack of documentation are eligible for the subsidies designed by the HIAE (we refer to these individuals as "Qualified Individuals" or "QI"). The size of the subsidies for APTC eligible and for Coloradans ineligible for APTC are the same in the with and without waiver scenarios, but with the waiver we are able to expand the income eligibility ranges compared to without the waiver to cover more individuals. The subsidies that will be offered to Colorado residents are as follows:
   - Individuals ineligible for APTC will be offered a plan with a $0 monthly premium and 94% actuarial value. Eligibility and enrollment estimates are based on the estimated costs of this plan for persons at given FPL levels up to the amount of funding available to support the subsidy.
   - Cost-sharing subsidies for APTC eligible enrollees also change during the waiver period based on dollars available to the State to support a 94% actuarial value plan for persons over 150% FPL.

   The chart below indicates the FPL range modeled as eligible for the CSR wrap for the APTC-eligible in each year of the program by year.

Table 1. FPL Eligibility for State Cost-Sharing Subsidy for APTC-Eligible Population under Baseline and Waiver Scenarios

	2023	2024	2025	2026	2027
Baseline	150% - 200%	150% - 175%	150% - 165%	150% - 170%	150% - 170%
After Reinsurance	150% - 200%	150% - 175%	150% - 165%	150% - 170%	150% - 170%
After Reinsurance and CO Option Premium Reduction	150% - 210%	150% - 195%	150% - 205%	150% - 210%	150% - 210%

The eligibility ranges are a function of projected enrollment and available funding. In the baseline and reinsurance only scenarios, the CSR wrap is funded by only state funding. In the reinsurance and CO option program scenario (the waiver amendment), federal pass through savings are added to existing state funds to increase the eligibility range for this CSR wrap. Existing state statute specifies how additional funds will be appropriated between reinsurance, subsidies for APTC-eligible individuals, and the QI population. Based on Senate Bill 20-215, in 2023, 30% of eligible funds after reinsurance and administrative fees will be appropriated to subsidies for APTC-eligible members and the remaining 70% for the QI population. In 2024 and beyond, this split shifts to 10% allocation for APTC-eligible members and 90% for the QI population. Based on this allocation method, the amount of pass-through funds that will be used to extend the cost-sharing subsidies available for APTC-eligible individuals will be less than $15 million in all years of the application and significantly less in 2023 and 2024 when the pass-through savings are lowest. Given the limited additional funding for APTC-eligible members under the waiver amendment relative to the baseline and reinsurance scenarios, the number of uninsured APTC-eligible members that would be newly eligible for subsidies is less than 5,000. Also, as the funding is being used for cost-sharing subsidies, rather than premium subsidies, we assumed a smaller impact on the take-up rate relative to the QI population, which would receive both premium and CSR subsidies.

2. **Federal Question:** How and when will the eligibility criteria be set, which year of funding will it be based on? Is the eligibility criteria set retrospectively or prospectively? In other words, when will the 2023 eligibility criteria be set? And when you say it is based on funds available after reinsurance, which year of reinsurance funding is that based on?

   State Response: Eligibility criteria for Health Insurance Affordability Enterprise (HIAE) subsidies are set prospectively by May of each year, prior to the benefit year in which subsidies are implemented. This allows carriers to include these subsidies in their annual ACA rate filing information to the Division and for Connect for Health to update their technological infrastructure in time. The Commissioner of Insurance promulgates regulations to set the eligibility criteria, based on recommendations from the Health Insurance Affordability Board.

The Board recommends and the Commissioner sets the criteria based on the Enterprise budget for the benefit year, which is estimated using actuarial modeling and statutory funding requirements for the Enterprise. Enterprise revenues are allocated according to C.R.S. § 10-16-1205, which includes funding allocations for HIAE subsidies for APTC-eligible individuals and HIAE subsidies for Qualified Individuals (non APTC-eligible).

The subsidy parameter will generally be set to spend less than the full amount of funding that's expected to be available for the year, with any unspent amount carried over to the subsidy budget for the following year. There are several reasons for this approach. First, we are leaving a buffer in case take-up exceeds expectations to ensure we don't need to reduce subsidies mid-year. Second, the precise amount of funding available will generally not be finalized by the time we establish eligibility criteria for the following year. And third, Connect for Health's capacity imposes some operational limits on flexibility in setting HIAE subsidy parameters. This applies both to subsidy structure (e.g., premium wrap, CSR enhancement) and level of subsidization (e.g., amount of premium assistance), as well as to the FPL thresholds for eligible enrollees.

The State of Colorado will only use federal 1332 pass through funds generated by reinsurance for the reinsurance program. The Colorado Option generated federal 1332 pass through funds will be added to existing state funding and used by the Health Insurance Affordability Enterprise (HIAE) to support additional subsidies according to C.R.S. § 10-16-1205. These pass through dollars will not be used to supplant the state share of reinsurance funding.

Pass-through funds generated for a given year will generally provide program funding for that same year, but will be paid out the following year, since both reinsurance and HIAE subsidy payments to carriers are made retrospectively. For example, pass-through funds generated by reinsurance in 2023 would fund the 2023 reinsurance program and be paid out in August 2024. Pass-through funds generated by the Colorado Option in 2023 would help fund 2023 HIAE subsidies and be paid out in 2024.

3. **Federal Question:** Can you share the most recent Colorado Option regulations?

   State Response:

- Regulation 4-2-80. **Culturally responsive provider network** requirements (effective March 2, 2022)
- Regulation 4-2-81. **Standardized plan** requirements (an emergency regulation has been in place since December 2021. The permanent rule effective date is June 30, 2022. The permanent rule was revised in early May to resolve versioning errors and was reposted on May 12, 2022)
    - Bulletin B-4.120 Concerning the Standardized Plan and Network Adequacy (effective March 7, 2022)
- Regulation 4-2-85. **Premium rate reduction** requirements for the standardized plan (As of Feb 28, an emergency regulation is currently effective and will be in place until the permanent rule effective date of June 14, 2022)
    - BulletinB-4.121 Concerning the **Medical inflation trend** calculation for the premium rate reduction requirements (effective March 31, 2022)

    - Bulletin B-4.123 Concerning the **Pricing AV adjustment** for the premium rate reduction requirements (effective April 14, 2022)
- Regulation 4-2-86. Exemption requirements for **purchasing alliances** (As of Feb 28, an emergency regulation is currently effective and will be in place until the permanent rule effective date of June 14, 2022)

Colorado Responses to Questions from CMS - April 22, 2022

1. **Federal Question:** What data does the State collect for the large group?

   State Response: Colorado tracks premium trend, PMPM earned premium, covered lives, incurred losses and loss ratios for the large group market. We update this data yearly in the fall, so In the fall of 2022, Colorado will have PY2021 large group data.

Colorado Responses to Questions from CMS - April 21, 2022

1. **Federal Question:** Could the state confirm if the upcoming regulation on the methodology for calculating premium rate reductions for the CO Option standardized health benefits plan is expected to materially change the program targets or guardrail analysis? If a change is expected please provide more details.

   State Response: The most significant features of the methodology for calculating premium reductions on the Colorado Option Standardized Plans were incorporated into our waiver amendment submission. Through our stakeholder engagement and rulemaking process, the Division heard from carriers and the Colorado Hospital Association (CHA) regarding the need to include a pricing actuarial value (AV) adjustment in the premium rate reduction methodology. On calls with carriers and their actuaries on February 3rd and February 24th, the Division discussed this adjustment and took carrier feedback. The Division used data submitted by carriers to create the appropriate AV adjustment in Colorado Insurance Emergency Regulation 22-E-05, which was adopted and effective on February 28, 2022. This regulation does not materially change the program targets or the guardrail analysis. While the methodology has been refined, the changes impact both the baseline and waiver scenarios (for example, incorporation of the changes to the EHB benchmark plan, induced demand factor requirements, and pricing AV adjustment). Therefore, the difference between the baseline and waiver scenarios is not anticipated to change materially given the final methodology.
   On March 2, 2022 the Division held a stakeholder meeting to review how carriers will notify the Division if they have or have not met the premium rate reduction targets. In this meeting, the Division walked through draft templates and instructions, and requested carrier feedback. On March 18, 2022 the Division communicated to carriers that they should expect final templates and instructions on the premium rate reduction targets in mid-April. On April 15, 2022 the Division sent each carrier their specific premium targets for their 2023 Colorado Option Standardized Plans; as well as, final templates and instructions that carriers must use to confirm compliance in SERFF.

Colorado Responses to Questions from CMS - March 22, 2022

1. **Federal Question:** Who initiates and approves the enrollment into these plans?

State Response: The Colorado Option Standardized Plans will be offered in the individual and small group markets. For the small group market, plans will be available for purchase through traditional broker channels. For the individual market, plans will be offered on the Colorado Health Benefit Exchange, which is called Connect for Health Colorado, and the Public Benefit Corporation (PBC), being branded as Colorado Connect. Colorado Connect is a subsidiary of Connect for Health Colorado. It was formed under Colorado statute (SB20-215) for the purposes of administering and operating a subsidy to reduce the costs of healthcare coverage offered under a state-subsidized individual health coverage plan sold "off-exchange." If a Colorado resident (regardless of immigration status) is not eligible for other subsidized coverage, they will have the opportunity to be determined eligible for the state-subsidized Colorado Option Standardized Plan offered by Colorado Connect. Coloradans who meet income eligibility requirements will have access to a $0 premium, 94% AV Off-Exchange Silver Enhanced Standardized Plan. In this case, Colorado Connect will determine eligibility and enroll the individual in a plan. Individuals who do not meet income eligibility requirements will still have the option of purchasing non-QHP Colorado Option Standardized Plans through Colorado Connect. If an individual is eligible for APTCs, Connect for Health Colorado will initiate enrollment into Colorado Option Standardized Plans, if selected by the consumer. If the individual is also eligible for CO-based subsidies funded by the Health Insurance Affordability Enterprise, (in the form of enrollment into a 94% AV Plan), Connect for Health CO will initiate that enrollment.

2. **Federal Questions:** Are these plans available to all consumers – at the 94% AV? For the QHP Silver plans, once eligibility is determined, the enrollee can choose from 94% AV silver plans that are available in their area to them and when enrollees go to enroll, are they offered the 94% plan immediately or would they see those after their eligibility is determined?

- Who is the 94% AV plan available to (subsidized and unsubsidized) and who will receive the $0 monthly premium plan and 94% AV with the state subsidy program in years of the waiver and for those under 150%).

State Response: Coloradans eligible for APTC (i.e. eligible to purchase a QHP and meeting other requirements) and who are between 150% FPL and 210% FPL have access to a 94% AV Silver plan in 2023. It does not have a $0 premium. The state subsidy provides for the CSR wrap for this population that would only receive an 87% AV CSR plan with federal subsidies alone. Only those eligible for the CSR wrap will be able to view and purchase the plan with a 94% AV on the exchange.

Coloradans ineligible for APTC because they lack proper documentation or are in the family glitch and who are up to 195% FPL, depending on availability of federal pass-through in a given year, have access to a 94% AV plan with a $0 premium (Silver Enhanced Standardized Plan) through Colorado Connect (the PBC). Only those eligible for the Silver Enhanced Standardized Plan (94%AV) will be able to view and purchase the plan with a $0 premium on the PBC.

Colorado Responses to Questions from CMS - March 10, 2022

1. **Federal Question:** *If plans are unable to achieve the required premium reductions without cutting provider or hospital rates below the legislated floors, what will happen?*
    - *Would the state require that issuers could then no longer offer products in the market in that rating area or county?*
    - *Does the state expect that issuers will simply drop out of the market? Does the state have a mechanism or actions the state could take in the case of an insurer threatening to or taking action to exit a part of the state (either statewide or in a given county/rating area)?*
    - *Or will the state legislature relax the floors and/or the premium targets? In other words, what is the fallback?*

    State Response: In consultation with our independent actuaries, we expect that plans will be able to achieve the required premium reduction without cutting provider or hospital rates below the legislated floors. A central goal of our legislation, HB21-1232, is making health insurance affordable to the consumer. To meet this legislative charge of *consumer* affordability, carriers offering a Standardized Plan at the bronze, silver, and gold metal level must offer standardized plans with a premium that is reduced by a specified percent relative to their 2021 premiums, after adjustments for changes in benefits, actuarial differences, and national medical inflation. The cost of providing care was considered in developing the legislation and its premium reduction targets. The Division worked with independent actuaries and the state's Medicaid agency to use claims data and industry reported payment to cost ratios to calculate the "break even" point for hospital care. Based on these analyses, hospitals in Colorado break even when they are paid between 117-143% of Medicare payments, depending on the facility's payer mix. Under the Colorado option, when a plan initially fails to meet the premium reduction requirements, the Division of Insurance may require hospitals to accept reimbursement rates that range from 165 - 238% of Medicare rates, depending on the situation of the hospital. These reimbursement "floors" comfortably exceed the cost of providing care and are much lower than average reimbursement rates for Colorado hospitals in the individual market, which is estimated to average 280% of Medicare. The actuarial analysis from Wakely Consulting Group indicated that a similar reimbursement methodology applied to hospital reimbursements alone would result in premium reductions of 12% (see "*Actuarial Analysis of a Colorado Health Insurance Option in 2022*," page 4, https://drive.google.com/file/d/1QQ_ACA87-IjuSJ-JprjD8gIugFzlk1dF/view). The premium reductions may be achieved through a combination of provider payment rate reductions, administrative cost or margin reductions. The NovaRest report[1] indicates many carriers have margins to work with, and it is also our experience that carrier margins have generally been strong in recent years, and carrier participation has increased. Given these dynamics, we do not expect carriers to drop out of the market.

    If carriers are unable to meet the required reductions using these levers, the State has levers to work with carriers and providers to achieve these reductions in an actuarially sound manner. In line with §10-16-1304(e), C.R.S, carriers would not be required to submit actuarially unsound rates and will be required to meet the financial requirements consistent with all other plans.

[1] See "NovaRest Actuarial Review of the Section 1332 Innovation Waiver Amendment Request - Colorado Option" page 23, Table 5 - Financial Summary for Carriers in the Individual Market.

The Division's work is in support of protecting consumers purchasing health insurance in the individual and small group markets. Prohibiting a carrier from offering products if they are unable to meet the premium rate reductions would likely not be in the best interest of Colorado consumers. Although the Division does not anticipate that a carrier would leave the Colorado market, the Division does have the authority through HB21-1232 to require a carrier, after a public hearing, to offer the Standardized Plan in specific counties where no carrier is offering the Standardized Plan in that plan year in either the individual or small group market.

If the State Legislature were to refine the premium rate reduction requirements and/or the provider rate setting floors in HB21-1232, the Division would implement and enforce those changes.

2. **Federal Question:** *Please provide the assumed provider reimbursement rates as a % of Medicare reimbursement rates by provider type specified in the statute for each of the Colorado geographic rating areas, both with and without the waiver amendment for each year of the projections starting in 2023. How do these assumed reductions in reimbursement rates align with the assumed reduction in premium rates for each of the geographic rating areas?*

   State Response: If the waiver amendment is approved, the Colorado Option legislation gives the Colorado Division of Insurance the authority to set reimbursement rates for providers participating in the Colorado Option Plans when plans fail to meet premium reduction targets. It also gives the Division the ability to require providers to participate in Colorado Option Plans.

   Table 1 below compares the average reimbursement rates in the commercial market for hospitals in each DOI region under the current commercial market and the reimbursement "floor" set by the legislation. The legislation requires a facility specific floor be calculated based on the financial and other characteristics of the hospital (e.g. payer mix, profit, price, cost, critical access, and independent/system). In Table 1, the Colorado Division of Insurance calculated average reimbursement floors for each DOI region after utilizing the Colorado Option reimbursement floor formula on a specific facility. These reimbursement floors were compared to commercial reimbursement data from the Colorado All Payer Claims Database, as analyzed by RAND in "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans" (see https://www.rand.org/pubs/research_reports/RR4394.html). Averages in each region and statewide are weighted based on each hospital's market share, as determined by a facility's average net patient revenue over the most recent 3-year period.

Table 1. Comparison of hospital reimbursement rates in the current commercial market and the reimbursement floor under the Colorado Option Legislation.

Division of Insurance Rating Region	Current Average* Hospital Commercial Reimbursement Level (% of Medicare) **	CO Option Legislation (HB21-1232) Average* Reimbursement Floor (% of Medicare) ***
1 - Boulder	233%	180%
2 - El Paso/Teller	242%	175%
3 - Denver Metro	259%	175%
4 - Larimer	354%	167%
5 - Mesa	305%	175%
6 - Weld	324%	175%
7 - Pueblo	271%	207%
8 - East	283%	208%
9 - West	293%	186%
Statewide	272%	179%

*Average reimbursement rates were weighted based on net patient revenue for each hospital in a DOI region.
** Based on Colorado All Payer Claims Database data, as analyzed by RAND in "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans." See https://www.rand.org/pubs/research_reports/RR4394.html. Hospitals that did not have 2018 inpatient and outpatient reimbursement rates in the RAND study were excluded from the analysis.
*** Based on the formula outlined in HB21-1232.

Statewide, Colorado Option reimbursement floors for hospitals are expected to be 93 percentage points of Medicare lower than current hospital commercial reimbursement rates. These reimbursement floors are therefore expected to generate significant premium savings. A previous study from Wakely Consulting Group that used a substantially similar rate setting methodology suggested that Colorado could expect 12 percent premium savings from hospital rate setting (7.1 - 19.8% depending on DOI region; see "Actuarial Analysis of a Colorado Health Insurance Option in 2022;" Page 6 Table 1. https://hcpf.colorado.gov/sites/hcpf/files/Wakely%20Colorado%20Public%20Option%20Report.pdf). If Colorado's waiver amendment is approved, when Colorado Option Plans fail to meet the premium reduction targets, the Division of Insurance may require hospitals to accept reimbursement rates for Colorado Option plans as low as those in column three of the chart above. If the waiver is not approved, the Division of insurance would expect reimbursement rates to be, on average, similar to current rates (column 2).

In addition to setting reimbursement rates for hospitals, if the waiver is approved, the Colorado Option legislation gives the Division of Insurance the authority to set reimbursement levels for other providers. The Colorado Option legislation provides that, if a Colorado Option plan fails to meet the premium reduction targets, the reimbursement floor for other providers is set at 135 percent of Medicare payments. The Division cannot set rates below this level. While information regarding the commercial reimbursement rates is less available for non-facility providers, RAND's analysis of commercial reimbursement rates indicates that physicians practicing in facilities receive an average of more than

165% of Medicare rates from commercial payers (see “Nationwide Evaluation of Health Care Prices Paid by Private Health Plans" https://www.rand.org/pubs/research_reports/RR4394.html). Additionally, while worker compensation insurance fee schedules in Colorado range based on the service, they average roughly 165% of Medicare, similar to estimates of commercial reimbursements for physician services according to RAND’s analysis of the Colorado APCD. These estimates indicate that additional savings may be achieved from setting rates on non-facility providers, as there is an average of 30 percentage point difference between current reimbursement rates and the floors specified in the law.

3. **Federal Question:** *What did the state’s analysis assume about issuer participation and provider participation? Did the state analysis contemplate changes in participation if issuers/providers are not able to meet targets? How did the state come to that assumption?*

   State Response: Based on market conditions and recent trends, Wakely expects that both issuers and providers would continue to participate at about current levels. In recent years Colorado has seen increases in the number of plans offered in our individual market and carriers have expanded their service areas. Colorado now has only one county where a single carrier offers plans on our exchange, compared to over 20 such counties only a few years ago. Given these trends, we expect a large number of Colorado Option Standardized plans and traditional ACA plans to continue to be available in 2023 and beyond. The Colorado Option was signed into law on June 16, 2021. Carriers who didn’t want to participate, could have pulled out of the Colorado market at this time, but carriers expanded their business in the State. Consistent with Colorado market trends, Wakely’s analysis expects no impact to existing carrier participation and coverage offerings. Wakely did not foresee any issues with risk selection as the combination of risk adjustment and the state reinsurance program should provide significant protection for issuers. As such, the analysis assumed that the current non-standardized plans will continue to be offered and current carriers will continue to participate in the market. Wakely did not include changes in participation if carriers were not able to meet the premium rate reduction targets in its modeling. The analysis assumed that all carriers would meet the legislative premium rate reduction requirements in an actuarially sound manner given historical precedence. Although the Division does not anticipate that a carrier would leave the Colorado market, the Division does have the authority through HB21-1232 to require a carrier, after a public hearing, to offer the Standardized Plan in specific counties where no carrier is offering the Standardized Plan in that plan year in either the individual or small group market.

   Additionally, we have no indication that providers won’t participate in Colorado Option plans. Colorado has experience bringing providers and carriers together to make healthcare more affordable for its residents. Our experience with Peak Health Alliance and their success in engaging providers and carriers in building high quality lower costs plans, supported by lower reimbursement rates, without a loss of coverage or a loss of participation supports our expectations that we will not lose carrier or provider participation as a result of the waiver amendment. The legislation also provides the Division with authority to require providers, after a public hearing, to participate in a carrier’s Standardized Plan network, and accept any reimbursement rate determined as part of the hearing. The reimbursement rates in the legislation are reasonable, and continue to allow providers to more than cover their costs with adequate margins.

The Division worked with independent actuaries and the state's Medicaid agency to use claims data and industry reported payment to cost ratios to calculate the "break even" point for hospital care. Based on these analyses, hospitals in Colorado break even when they are paid between 117-143% of Medicare payments, depending on the facility's payer mix. Under the Colorado option, when a plan initially fails to meet the premium reduction requirements, the Division of Insurance may require hospitals to accept reimbursement rates that range from 165 - 238% of Medicare rates, depending on the situation of the hospital. These reimbursement "floors" comfortably exceed the cost of providing care and are much lower than average reimbursement rates for Colorado hospitals in the individual market, which is estimated to average 280% of Medicare.

4. **Federal Question:** *Based on evidence, does the state expect that certain providers (for at least one contract) are below the floors established in the law and if so can you quantify how many providers may be below the floors? What happens if providers are below the floors established? Will issuers be able to increase their payment to providers to meet these floors and what impact may this have on the premium reduction targets in the waiver?*

   State Response: The state used the best information available to design the reimbursement floors detailed in the law. While estimates vary somewhat, commercial reimbursements to hospitals from individual market plans in Colorado are approximately 280% of Medicare reimbursement. The law would set reimbursement floors for hospitals with a statewide average of 179% of Medicare, well below current reimbursement rates but still well above the break-even point for providers. Table 1 in the question above identifies that there are variations in reimbursements across different insurance rating regions in Colorado but, in all cases, average reimbursement floors for hospitals are significantly lower than estimates of current commercial reimbursements.

   The Division is not aware of any data or analyses that indicate how many providers' contracts from individual market plans may have a reimbursement rate below the floor set by the Colorado Option Law. While some providers may have existing contracts that reimburse at or below the reimbursement targets, analyses of average Colorado commercial reimbursement rates indicate that these would not be common and that most contracts are above the reimbursement floors. The market average reimbursement rates suggest that many contracts significantly exceed the average reimbursement rates for current commercial contracts by hundreds of percentage points of Medicare.

   In the event that a provider's contract with a Colorado Option Plan is currently at or below the reimbursement floor, the Division would not be able to require the provider to accept a lower reimbursement rate. It would also be extremely unlikely that this provider would cause a plan to miss its reimbursement target. If a plan claimed it was unable to meet the premium reduction target, the Division would need to examine the reimbursement rates of other providers contracted with that plan to determine the cause of the higher than allowed premium. We do not expect providers to be able to increase their reimbursement rates from issuers based on this law. The reimbursement floors in the law do not entitle providers to receive higher reimbursement rates from Colorado Option plan issuers even if the provider is currently receiving reimbursements lower than the floor.

While providers may decide to request higher reimbursement rates during the course of normal contract negotiations, the Division does not expect the law itself to cause issuers to pay providers more than current rates. Reimbursement rates are most often dictated by market dynamics such as market share and the relative negotiating strength between an issuer and provider. For providers who are already at or below the reimbursement floors, this law does not alter these fundamental market dynamics.

5. **Federal Question:** *Under the state subsidy program, does the state plan to pay for just those family members who do not have an affordable offer of ESI coverage or the entire family (i.e. including the worker or works with affordable ESI)?*

   State Response: For the purposes of the waiver analysis, Wakely modeled both scenarios (paying for the entire family and paying for only those family members without an affordable offer of ESI) and there was a de minimis impact between the two scenarios. The charts below indicate the FPL range modeled, under the waiver, as eligible for the premium subsidies and/or CSR wrap for the APTC-eligible and Qualified Individuals (QI) members in each year of the program by year. You will see in Table 3 that the projected FPL eligibility upper limit for the QI population in 2023, based on anticipated funding, is up to 90% FPL. Based on this FPL eligibility range, it is expected that only Qualified Individuals (QI) covered under the state subsidy program will be Coloradans without proper documentation for 2023. This is consistent with the 2023 FPL eligibility cut off (138% FPL) determined by the Health Insurance Affordability Enterprise (HIAE) for the QI population. Coloradans who would have been eligible for the state subsidy program due to the Family Glitch, will be eligible for Medicaid (because the eligibility for the subsidy is up to 138% FPL) and therefore will not be eligible for the state subsidy in 2023. For plan year 2024 and beyond, based on Wakely's model, those who fall into the "Family Glitch" whose income exceeds 138% FPL will be eligible to receive the state subsidy in 2024 (as the eligibility upper limit is 190% FPL). The state will work with the HIAE Board to determine the FPL eligibility range based on budget and other considerations.

   Table 3. FPL Eligibility for State Premium and Cost-Sharing Subsidy for QI Population (not APTC eligible) under Baseline and Waiver Scenarios

	2023	2024	2025	2026	2027
Baseline	Up to 70%	Up to 110%	Up to 85%	Up to 90%	Up to 95%
After Reinsurance	Up to 75%	Up to 100%	Up to 75%	Up to 85%	Up to 80%
After Reinsurance and Standard Plan Program	Up to 90%	Up to 180%	Up to 190%	Up to 195%	Up to 195%

6. **Federal Question:** *How have actual premium trends in CO compared to CPI-M historically in the individual and small group market? To the extent there has been variation in premium trends, please provide a range and speak to the trend for the second-lowest cost silver plans in the individual market.If the Commissioner levies penalties on hospitals - where do the penalty dollars go?*

   State Response: The average premium trends for the SLCSP over the last 4 years is reflected in Table A. The SLCSP premiums that were used in Table 1 below, are based on rates for a 40-year old non-tobacco user.

The average premium trends over the last 5 years in Colorado have been 3.8% and 6% annually in the individual and small group markets respectively. The 10 year average of the medical component of CPI-U, which is defined by the Colorado Option law and is an important component of determining premium reduction targets in a given year, grows at approximately 3% per year. Trends in the individual market were volatile up until 2020 and trends since 2020 in the small group have averaged around 4%. See Tables B and C below for more detail.

Table A. Second Lowest Cost Silver Plan (SLCSP) Premium Trends by Year

Plan Year	Percent change from the previous year
2019	9%
2020	-27%
2021	-5%
2022	-1%

Table B. Individual Market Premium Trends by Year

2018	34.3%
2019	5.6%
2020*	-20.2%
2021	-1.4%
2022	1.1%

*2020 was the first year reinsurance was in effect.

Table C. Small Group Market Premium Trends by Year

2018	6.6%
2019	7.3%
2020	7.9%
2021	3.8%
2022	4.4%

A large portion of the trends in premiums that exceed medical inflation (CPI-M) are driven by increases in the cost of providing care. As we have previously noted, the actual cost of providing care was considered in developing the legislation and its premium reduction targets. The Division worked with independent actuaries and the state's Medicaid agency to use claims data and industry reported payment to cost ratios to calculate the "break even" point for hospital care. Based on these analyses, hospitals in Colorado break even when they are paid between 117-143% of Medicare payments, depending on the facility's payer mix. Currently, in a recent analysis for the Division of Insurance, Wakely Consulting Group estimated current commercial reimbursement rates to be approximately 280% of Medicare. The Colorado Option law's reimbursement floors, which range from 165 - 238% of Medicare for hospitals, will help ensure that reimbursement rates and premiums do not continue to increase at unsustainable rates.

The Commissioner would only be able to levy penalties on hospitals who refused to participate in a Colorado Option plan or refused to participate at a particular reimbursement rate, after a Colorado Option plan had failed to meet the premium reduction target and the hospital in question was determined to have been a reason why. The Division does not expect hospitals in this circumstance to refuse to participate. However, if this were to occur, the legislation requires penalties to be deposited in the general fund of the State of Colorado.

7. **Federal Question:** The state's law notes that health care cooperatives that have previously achieved and maintained at least a 15% premium reduction will have met the premium reduction targets. Could the state confirm that the state's actuarial analysis accounts for state law, such as for the exemption for cooperatives (e.g., Peak Health Alliance)? If not, how would this exemption impact the state's projections with respect to coverage, deficit neutrality/pass-through, etc.?

   State Response: Exemptions for purchasing alliance plans were considered in the analysis. Only 7 counties, representing less than 3% of enrollment, had a purchasing alliance plan available in 2021 that may qualify for exemption. For these counties, the waiver amendment assumed no change in benchmark plan premiums, however, due to the small populations of these counties, the impact of this assumption on the modeling was negligible.

8. **Federal Question:** Does the state (or state analysis from Wakely) project that any existing plan offerings will be strictly dominated by the Colorado Option plans (e.g., to oversimplify, that the Colorado Option plans are less expensive, have broader networks, and more comprehensive benefits than some existing plans in the same tier) and, therefore, no longer commercially viable? If so, does that impact the state's assumption that all non-standardized plans will continue to be offered? What could the potential impact be on the projected SLCSPs with- and without-waiver? Are there certain counties/markets where this is more likely to happen, and what could the potential impact be on the guardrails or on pass-through funding?

   State Response: The Colorado Option Standardized Plans will be another plan choice for consumers purchasing insurance in the individual and small group market. In consultation with our independent actuaries, the State expects "traditional ACA" (non-standardized) plans will continue to be offered, and over time, believe that non-standardized plan premiums will also reduce due to the entrance of Standardized Plans.

In recent years, we have seen increases in the number of plans offered in our individual market and carriers have expanded their service areas. Colorado currently has only one county where a single carrier offers plans on our exchange, compared to over 20 such counties only a few years ago. Additionally, Colorado's experience with Peak Health Alliance and their success in engaging providers and carriers in building high quality lower costs plans, supported by lower reimbursement rates, without a loss of coverage or a loss of carrier participation supports our expectations that we will not lose carrier participation as a result of the waiver amendment. Given these trends, Colorado's Division of Insurance expects a large number of Colorado Option Standardized plans and traditional ACA plans to continue to be available in 2023 and beyond. Consistent with Colorado market trends, Wakely's analysis expects no impact to existing carrier participation and coverage offerings. Additionally, since Colorado option standardized plans are expected to be lower cost, in the event plans are discontinued, there should be de minimis impact to SLCPs with the waiver. Consequently, there would be no material changes to the analysis in the event of plan discontinuation or the estimates that the waiver meets all of the guardrails. Wakely did not foresee any issues with risk selection as the combination of risk adjustment and the reinsurance program should provide significant protection for issuers. As such, the analysis assumed that the current non-standardized plans will continue to be offered and current carriers will continue to participate in the market. Consequently, we do not have insights into differing probabilities by county or market of such events.

9. **Federal Question:** The state's waiver notes that the premium reduction targets for the individual and small group at 5%, 10%, 15% on pg 7 of the application. Does the state's projection that there will be no migration from the small group market to the individual market account for 2021 premium differentials between the two markets? Specifically, does the state's projection reflect that the resulting premiums after the target premium reductions from the waiver for the Colorado Option plans will be different in the small group and individual markets?

   State Response: The state's projection that there will be no migration between the small group and individual market accounts for premium differentials in the two markets. The state does not expect migration from the small group market to the individual market as a result of the waiver for the following reasons.

   1. Prior research on the effects of the ACA has shown no impact on Employer Sponsored Insurance (see "Disentangling the ACA's Coverage Effects -Lessons for Policymakers" https://dash.harvard.edu/bitstream/handle/1/28547756/Frean%20Gruber%20Sommers%20NEJM%20ACA%20Perspective%202016.pdf?sequence=1).
   2. Prior Congressional Budget Office analysis has estimated that small employers are less likely to drop coverage if premiums decrease (see "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans" https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf).
   3. The premium reduction targets in the Colorado Option law affect both the individual and small group markets equally. Coloradans are not expected to move from one market to another because the relative premiums in both markets will remain constant.

4. Colorado does not expect migration between the two markets because of our recent experience with a successful reinsurance program. In 2020, the state of Colorado implemented a reinsurance program that reduced premiums on the individual market by more than 20%. However, even with this large change in the relative price between the individual and small group markets, Colorado did not experience a material shift from the small group to the individual market. Additionally, with the entrance of PEAK Alliance in 2020 in Summit County, where PEAK was able to reduce premiums by approximately 20%, the Division did not see any migration from the small group market to individual market.
5. Historically, premiums in the Colorado small group market are more expensive than those in the Colorado individual market and yet, small employers still maintain their coverage and we have not seen a large migration of employees moving to the individual market for coverage. See the table below for a comparison of individual market and small group market average premiums.

Table 4. PY2022 Individual Market vs. Small Group Market Average Premium PMPM, by Rating Area

Rating Area	INDIVIDUAL MARKET Average Premium Per Member per Month, with Reinsurance	SMALL GROUP MARKET Average Premium Per Member per Month, with Reinsurance
Rating Area 1 - Boulder	$452.44	$547.40
Rating Area 2 - Colorado Springs	$431.59	$537.51
Rating Area 3 - Denver	$418.18	$542.25
Rating Area 4 - Fort Collins	$489.55	$536.08
Rating Area 5 - Grand Junction	$497.53	$619.89
Rating Area 6 - Greeley	$471.06	$548.24
Rating Area 7 - Pueblo	$513.56	$548.93
Rating Area 8 - East	$569.83	$608.26
Rating Area 9 - West	$567.09	$713.50
Statewide	**$457.24**	**$553.49**

Colorado Responses to Questions from CMS - February 23, 2022

1. **Federal Question:** *If the Colorado option will be significantly less expensive than traditional ACA plans and will not be priced as part of the single risk pool, does the state believe that traditional ACA plans will continue to be offered/available? What other plans does CO expect issuers to offer? Will the standardized plans become the floor or ceiling?*
    - *What was assumed in terms of plan offerings in the Wakely analysis? Is it correct that the analysis assumes no impact to existing carrier participation and coverage options.*
    - *Does the state foresee any issues with adverse selection under this plan?*

    State Response: The Colorado Option Standardized Plans will be another plan choice for consumers purchasing insurance in the individual and small group market. In consultation with our independent actuaries, the State expects "traditional ACA" (non-standardized) plans will continue to be offered, and over time, believe that non-standardized plan premiums will also reduce due to the entrance of Standardized Plans. In recent years we have seen increases in the number of plans offered in our individual market and carriers have expanded their service areas. Colorado now has only one county where a single carrier offers plans on our exchange, compared to over 20 such counties only a few years ago. Additionally, Colorado's experience with Peak Health Alliance and their success in engaging providers and carriers in building high quality lower costs plans, supported by lower reimbursement rates, without a loss of coverage or a loss of carrier participation supports our expectations that we will not lose carrier participation as a result of the waiver amendment. Given these trends, Colorado's Division of Insurance expects a large number of Colorado Option Standardized plans and traditional ACA plans to continue to be available in 2023 and beyond. Consistent with Colorado market trends , Wakely's analysis assumes no impact to existing carrier participation and coverage offerings. Wakely did not foresee any issues with risk selection as the combination of risk adjustment and the reinsurance program should provide significant protection for issuers. As such, the analysis assumed that the current non-standardized plans will continue to be offered and current carriers will continue to participate in the market.

    In our waiver amendment, we request to continue to waive the Section 1312(c)(1) – the Single Risk Pool - through 2027 in order to continue to support our existing reinsurance Program. This amendment adds the request that we be allowed to waive Section 1312(c)(1) to allow plan-level rating variation based on the premium reduction requirements of the Colorado Option. We also request to waive Section 1312(c)(2) to support carriers in meeting the premium rate reduction requirements of the Standardized Plan. Consequently standardized plans would still be a part of the single risk pool.

2. **Federal Question:** *Commenters have raised concern that the analysis does not account for impact of recent EHB additions (i.e., acupuncture, gender affirming care, mental health wellness exams, changes to drug coverage, plus recent state legislation requiring coverage of infertility & reproductive services).*[1] *Does the state submitted analysis accounts for EHB that will be in place for the 2023 plan year?*

State Response: Yes. Our analysis accounts for our federally approved 2023 EHB package. As part of the approval process for our 2023 EHB package, we had an independent actuarial firm analyze the cost impact of the recent benefit additions (acupuncture, gender affirming care, mental health wellness exams, and changes to drug coverage). The cost impact was determined to be 0.16%. These costs were submitted as part of the application that CMS approved in 2021 that changed Colorado's EHB benchmark plan. The cost difference in EHBs from 2021 to 2023 has been considered in our 1332 waiver amendment request analysis. With respect to considerations of discrimination and mental health parity, these are requirements that existed prior to 2021 that carriers should be in compliance with and are considered as part of the baseline in our analysis.

3. **Federal Question:** *In establishing the premium reduction targets in the state's legislation and analysis did the state account for the following, and if so please explain what the state assumed and why.*
    - *actual costs of providing care;*
    - *limits on annual reimbursement rate reductions;*
    - *new network adequacy requirements;*
    - *full impact of state benefit mandates since 2021;*
    - *competing state and federal requirements like actuarial soundness;*
    - *rich standardized benefit designs and associated adverse selection issues;*
    - *exemptions for state co-ops;*

    State Response: A central aspect of our legislation, HB21-1232, is making health insurance affordable to the consumer. To meet this legislative charge of *consumer* affordability, carriers offering a Standardized Plan at the bronze, silver, and gold metal level must offer standardized plans with a premium that is reduced by a specified percent relative to their 2021 premiums, after adjustments for changes in benefits, actuarial differences, and national medical inflation.

    The Division considered the actual cost of providing care in developing the legislation and its premium reduction targets. The Division worked with independent actuaries and the state's Medicaid agency to use claims data and industry reported payment to cost ratios to calculate the "break even" point for hospital care. Based on these analyses, hospitals in Colorado break even when they are paid between 117-143% of Medicare payments, depending on the facility's payer mix. Under the Colorado option, when a plan initially fails to meet the premium reduction requirements, the Division of Insurance may require hospitals to accept reimbursement rates that range from 165 - 238% of Medicare rates, depending on the situation of the hospital. These reimbursement "floors" comfortably exceed the cost of providing care and are much lower than average reimbursement rates for Colorado hospitals in the individual market, which is estimated to average 280% of Medicare. The actuarial analysis from NovaRest indicated that a similar reimbursement methodology applied to hospital reimbursements alone would result in premium reductions of 12%.

    Based on the requirements in the legislation, the Division developed a methodology to calculate the premium reduction requirements outlined in the legislation. This methodology was incorporated into the Division's waiver amendment, including guardrail analyses and pass through calculations.

The premium rate reduction methodology takes into account the following changes from 2021 to 2023:

- Changes in benefit relativity,
- Induced demand,
- Medical inflation Trend,
- Changes in pricing AV,
- CSR loading (for individual market Silver plans only),
- EHB Changes due to the new 2023 EHB package, and
- Non-EHB Changes.

The Colorado Option Legislation does not allow the Division's methodology to account for differences that may impact a carrier's administrative costs, even when specified in new state or federal legislation (e.g. HB21-1297 Pharmacy Benefit Manager/Insurer Requirements). The infertility legislation that was referenced in public comments has not gone into effect, as it would require state defrayal, and therefore, it is not considered in our analysis. HB21-1140 (Living Organ Donor) was determined to have a de minimis-to-no impact on premiums and therefore was not considered in our analysis. HB21-1276 (Substance Abuse Prevention) was considered to also have a de minimis impact in that any premium impact from this legislation would impact both the baseline and waiver amendment scenarios as this coverage is required on both non-Standard plans and Standard plans. Induced demand, changes in network adequacy requirements, medical inflation trend, CSR loading, EHB changes due to the changes in the benchmark, and non-EHB changes were accounted for in the modeling and in the standard plan methodology as they'd have impact to both the baseline and waiver amendment scenarios.

As noted below, the premium reductions may be achieved through a combination of provider payment rate reductions, administrative cost or margin reductions. In addition, as noted in more detail below, issuers would not be required to submit actuarially unsound rates. If carriers are unable to meet the required reductions using these levers, the State has levers to work with carriers and providers to achieve these reductions in an actuarially sound manner.

Exemptions for purchasing alliance plans were considered in the analysis. Only 7 counties, representing less than 3% of enrollment, had a purchasing alliance plan available in 2021 that may qualify for exemption. For these counties, the waiver amendment assumed no change in benchmark plan premiums, however, due to the small populations of these counties, the impact of this assumption on the modeling was negligible.

4. **Federal Question:** *Could the state provide more information on state funding for the waiver:*
    - *How much does the state expect to bring in from the hospital fee?*
    - *How does the state intend to fund the waiver for years after 2023?*
    - *How is the issuer assessment levied? What amount of funds is it projected to bring in each year to the HIAE? Will these assessments be built into premiums?*

State Response: The Division will collect $20 million in 2022 and $20 million in 2023 from the hospital special assessment (fee) for a total of $40 million. These amounts are set in Colorado statute (10-16-1207(5)).

The Division will notice a regulation on February 24, 2022, which will lay out the process by which the Division will calculate and collect the fee from hospitals.

The state will use funds from the Health Insurance Affordability Enterprise (HIAE), created by Colorado SB 20-215, and funds from the Colorado General Assembly, as designated by the passage of the Colorado Option Bill HB 21-1232, to provide the state portion funding for the waiver. State funding sources for the HIAE are the Health Insurance Affordability fee on carriers (all years), the hospital special assessment (2022 and 2023), and a portion of the state's annual premium tax revenue (all years). Past 2023 and through 2028, the HIAE portion of funding for reinsurance and the insurance affordability subsidies will follow state statute as outlined in SB 20-215 and C.R.S. 10-16-1205.

The issuer assessment (i.e. the Health Insurance Affordability fee) is levied based on C.R.S. 10-16-1205 and is as follows: 1.15% of the prior year's gross premium revenue for non-profit carriers and 2.10% of premium revenue for for-profit carriers. Additionally, a portion of the annual premium tax revenue is transferred to the HIAE cash fund each year, as designated by Colorado statute. The amount that the HIA fee (i.e., issuer assessment) brings into the HIAE is dependent upon health insurance premiums and varies each year. The total HIA fee amount collected in 2021 (based on 2020 premium revenue) was roughly $110 million. The Division expects to collect a similar amount each year going forward. The HIA fee is built into carriers' filed and approved premiums.

5. **Federal Question:** *Analysis assumes all issuers will meet premium reduction targets, yet certain issuers may not be able to meet these targets in some counties because they already pay below the minimum hospital and provider reimbursement rates under CO Option law. How does CO expect these carriers to meet the requirements?*

   State Response: House Bill 21-1232, establishing The Colorado Option, was a compromise between consumer advocates, carriers, providers and many other stakeholder groups. The premium rate reduction requirements that are built into the legislation, are based on the belief that the private market can reduce healthcare costs for consumers and make health insurance more affordable for Coloradans. The Division believes that carriers have multiple levers of control to achieve the phased-in premium rate reduction requirements of the Colorado Option program. Savings can be achieved through lower contracted rates with facilities and professional service providers, lower administrative costs, and lower margin (and as the NovaRest report indicates, many carriers have substantial margin to work with). The cited report from Milliman, assumes only facility costs can be impacted, and assumes no savings from professional services, administrative costs, or margin. While on average the provider payment rate reductions (using facility only costs) get close to the target reductions, lower premium plans might be less able to reduce premiums by the same amount as higher premium plans. Consequently, Colorado issuers, on average, have the ability to meet the target. However in the event that a particular issuer in a particular year is unable to meet the required reduction, there is a process for such a situation. In particular, contrary to the comments provided by Kaiser Permanente, AHIP, and the Partnership for America's Health Care Future Action; issuers would not be forced to submit actuarially unsound rates. Instead issuers could have rates that do not include the full required reduction.

The Division will continue to exercise its rate review authority to scrutinize rates, and would not approve any rate that is actuarially unsound. Even in such a scenario, the 1332 guardrails would still be met. For example, if instead of a full 15% reduction, the average reduction was 10%, while the magnitude of the effects would be reduced, the directionality would not. Consumers would still have more affordable premiums in a waiver scenario than without. Lower premiums would result in higher enrollment in a waiver scenario than without. The slightly lower premium reduction would not change the provision of comprehensive coverage. Finally, federal savings would still occur as a result of the lower premiums/benchmarks. While savings would be not as high in a scenario in which the full reduction is met, the downward pressure on premiums would still result in lower federal spending/higher federal savings. Consequently, even in a scenario where reductions do not meet the full requirements, the waiver would still meet all guardrails.

6. **Federal Question:** *How would the state's premium reduction targets impact safety net providers? Would the premium reduction targets be more challenging for those providers?*

   State Response: Our formula for hospitals contemplates different rates for different hospitals. Hospitals that treat larger percentages of Medicare patients, have low margins, or are considered critical access hospitals receive a higher reimbursement floor, in the event that a plan they are contracted with does not meet the premium reduction targets. For community health centers and federally qualified health centers, the floor only kicks in if the Division believes that their prices are somehow impacting the carrier's ability to meet the premium rate reduction targets for their Standardized Plan. It is unlikely that commercial reimbursement rates to federally qualified health centers and community health centers will have a significant impact on whether plans meet premium reduction targets.

7. **Federal Question:** *The application notes that "To effectuate the CO Option plan premium reduction requirements, the Division of Insurance will create an actuarially validated tool to determine the target premiums for each carrier in each rating area." Could you describe this tool further?*

   State Response: The Division, with support from independent actuaries, has developed a methodology to calculate the premium rate reduction requirements for the Standardized Plan. This methodology is described in our Emergency Regulation 22-E-XX "Concerning the Methodology for Calculating Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans." Using this methodology, the Division will publish rate targets for each carrier in each rating area. Carriers will build their standardized plan rates, ensuring that they are less than or equal to their rate targets. By May 13, 2022, carriers will use a Colorado Option Premium Rate Reduction template, developed by the Division, to notify the Commissioner whether they have or have not met the premium rate reduction targets. The carriers will resubmit this template in June when their final rate filings are due for plan year 2023.

8. **Federal Question:** *Does the DOI have any concerns with solvency of issuers in trying to achieve these savings?*

   State Response: Based on issuer feedback during the legislative process, the Colorado Option legislation requires that all rates submitted to the Division be actuarially sound. The Division of Insurance cannot require issuers to lose money on these products. All premium rates approved by the Division must continue to be adequate to cover costs of the plan as well as not excessive. Based on these requirements and utilizing the Colorado Division of Insurance's normal rate review process, Colorado Option Plans cannot create solvency issues for issuers. Aside from the Colorado Option plans, if there are solvency concerns for individual issuers, we will address them as part of the normal rate review process. At this time we don't have any particular solvency concerns with any of our issuers.

9. **Federal Question:** Could the state clarify *who is eligible for subsidies? How much is the subsidy for each group (subsidized, family glitch, undocumented)? Without the waiver, what is the total funding level for the state subsidy program? With the waiver, what is the total funding level for the state subsidy program? In both scenarios can you define how much the subsidy is increasing for each group (subsidized, family glitch, undocumented)?*

   State Response: The pass-through funding attributable to the amendment will be used to support new health insurance affordability programs designed by the Colorado Health Insurance Affordability Enterprise (HIAE). Coloradans who are ineligible for federal subsidies due to the "family glitch" and lack of documentation are eligible for the subsidies designed by the HIAE (we refer to these individuals as "Qualified Individuals" or "QI"). The size of the subsidies for APTC eligible and for Coloradans ineligible for APTC are the same in the with and without waiver scenarios, but with the waiver we are able to expand the income eligibility ranges compared to without the waiver to cover more individuals. The subsidies that will be offered to Colorado residents are as follows:

   - Individuals ineligible for APTC will be offered a plan with a $0 monthly premium and 94% actuarial value. Eligibility and enrollment estimates are based on the estimated costs of this plan for persons at given FPL levels up to the amount of funding available to support the subsidy.
   - Cost-sharing subsidies for APTC eligible enrollees also change during the waiver period based on dollars available to the State to support a 94% actuarial value plan for persons over 150% FPL.

   The charts below indicate the FPL range modeled as eligible for the premium subsidies and/or CSR wrap for the APTC-eligible and QI members in each year of the program by year.

Table 1. FPL Eligibility for State Cost-Sharing Subsidy for APTC-Eligible Population under Baseline and Waiver Scenarios

	2023	2024	2025	2026	2027
Baseline	150% - 200%	150% - 175%	150% - 165%	150% - 170%	150% - 170%
After Reinsurance	150% - 200%	150% - 175%	150% - 165%	150% - 170%	150% - 170%
After Reinsurance and CO Option Premium Reduction	150% - 210%	150% - 195%	150% - 205%	150% - 210%	150% - 210%

Table 2. FPL Eligibility for State Premium and Cost-Sharing Subsidy for QI Population (not APTC eligible) under Baseline and Waiver Scenarios

	2023	2024	2025	2026	2027
Baseline	Up to 70%	Up to 110%	Up to 85%	Up to 90%	Up to 95%
After Reinsurance	Up to 75%	Up to 100%	Up to 75%	Up to 85%	Up to 80%
After Reinsurance and Standard Plan Program	Up to 90%	Up to 180%	Up to 190%	Up to 195%	Up to 195%

The eligibility ranges are a function of projected enrollment and available funding. In the baseline and reinsurance only scenarios, the CSR wrap is funded by only state funding. In the reinsurance and CO option program scenario (the waiver amendment), federal pass through savings are added to existing state funds to increase the eligibility range for this CSR wrap. Existing state statute specifies how additional funds will be appropriated between reinsurance, subsidies for APTC-eligible individuals, and the QI population. Individuals eligible for these state-based subsidies, but not federal subsidies, are referred to as Qualified Individuals (QI) throughout the 1332 report. This includes those who are currently not eligible for federal premium tax credits, such as Coloradans without documentation and people who are subject to the ACA's "family glitch". The "family glitch" refers to the rule under which a family's eligibility for premium subsidies turns on whether available employer-sponsored insurance is affordable for the employee only, even if it's not actually affordable for the whole family.

Based on Senate Bill 20-215, in 2023, 30% of eligible funds after reinsurance and administrative fees will be appropriated to subsidies for APTC-eligible members and the remaining 70% for the QI population. In 2024 and beyond, this split shifts to 10% allocation for APTC-eligible members and 90% for the QI population. Based on this allocation method, the amount of pass-through funds that will be used to extend the cost-sharing subsidies available for APTC-eligible individuals will be less than $15 million in all years of the application and significantly less in 2023 and 2024 when the pass-through savings are lowest.

Given the limited additional funding for APTC-eligible members under the waiver amendment relative to the baseline and reinsurance scenarios, the number of uninsured APTC-eligible members that would be newly eligible for subsidies is less than 5,000. Also, as the funding is being used for cost-sharing subsidies, rather than premium subsidies, we assumed a smaller impact on the take-up rate relative to the QI population, which would receive both premium and CSR subsidies.

10. **Federal Question:** *Commenters noted that "the market will have less than three months to respond to the rate targets with new rate and form filings. In addition, that leaves no time for negotiating rates with providers and hospitals to a mandated lower price point." Could the state describe the timeline and steps in more detail on meeting the premium reduction targets? In terms of exercising the commissioner's authority to lower premiums further, when would the commissioner exercise that authority. For example, after initial rates, but before final rate submission?*
    - *Has the state considered if there is any flexibility in that timeline to allow more time for issuers?*

    State Response: While much of the timeline is dictated in statute, the Division is using its available authority to provide flexibility in this timeline for issuers. House Bill 21-1232 requires carriers to inform the Division if they expect to be able to meet rate targets by May 1 for the 2023 benefit year, and by March 1 for subsequent years. For the 2023 benefit year the following timeline will be followed:
    - **By March 30, 2022**: The Division will publish carrier target rates for the Standardized Plan
    - **By May 13, 2022:** Carriers will notify the Division on whether they meet the 5% premium rate reduction requirement on their Standardized Plans (<u>while the statute sets this deadline at May 1, the Division is using enforcement discretion and will consider submissions prior to May 13th to meet this requirement</u>).
    - **By June 17, 2022**: Following the same timing as all ACA plans, carriers will submit final rate filings to the Division
    - **June 17, 2022 - August 15, 2022:** The Division, along with independent actuaries, will conduct rate review of all 2023 plans, inclusive of the Standardized Plans
    - **August 16, 2022:** The Division will make final determinations on 2023 rates.

    For the 2023 plan year, the Division may use its rate review authority if we determine that a carrier's rates need to be lowered. The Division would exercise this authority during the rate review process between mid-June and mid-August. Based on carrier feedback and federal comment period comments, the Division is offering an extension for carriers in submitting their premium rate reduction notifications. Any carrier who submits their premium rate reduction notification by May 13, 2022 will be considered in compliance with the statutory deadline of May 1 for the 2023 benefit year. For the 2024 plan year, when rate hearings are in effect, we are working with our Attorney General's Office to develop a process that is in line with due process requirements.

11. **Federal Question:** *The state's waiver said that additional stakeholder meetings and public hearings have been scheduled for the next month. Could you describe if those meetings happened and what stakeholder engagement is planned for the future?*

State Response: The following stakeholder meetings and public hearings were held since the waiver amendment was submitted on November 30, 2021.

- **December 15, 2021:** Stakeholder meeting to discuss the standardized plan's premium rate reduction requirements
- **January 4, 2022:** Public Hearing on Colorado Insurance Regulation 4-2-80 on the Standardized Plan's culturally responsive provider network requirements.
- **January 13, 2022:** Stakeholder meeting to discuss the standardized plan's premium rate reduction requirements
- **January 18, 2022:** Public Hearing on Colorado Insurance Regulation 4-2-81 on the Standardized Plan benefit design
- **February 03, 2022:** Stakeholder call with the Colorado Association of Health Plan and its members to discuss the standardized plan's premium rate reduction requirements
- **February 24, 2022:** Second Stakeholder call with the Colorado Association of Health Plan and its members to discuss the standardized plan's premium rate reduction requirements

The Division has scheduled two carrier meetings to support the 2023 plan filing season.

- **March 2, 2022**: Carrier stakeholder meeting to review the Colorado Option requirements and how they impact plan filing, specifically changes to MHPAEA and rate filing
- **May 16, 2022**: Carrier stakeholder meeting to review rate filing and the network adequacy requirements of the Colorado Option

The Division also plans to hold additional stakeholder meetings in the Spring of 2022 on the design of the rate hearing process.

12. **Federal Question:** Does the state have any concerns regarding provider participation with the reduced rates? Please explain the rationale either way.

State Response: We have no indication that providers won't participate in Colorado Option plans. Colorado has experience bringing providers and carriers together to make healthcare more affordable for its residents. Our experience with Peak Health Alliance and their success in engaging providers and carriers in building high quality lower costs plans, supported by lower reimbursement rates, without a loss of coverage or a loss of participation supports our expectations. The legislation also provides the Division with authority to require providers, after a public hearing, to participate in a carrier's standardized plan network, and accept any reimbursement rate determined as part of the hearing. The reimbursement rates in the legislation are reasonable, and continue to allow providers to more than cover their costs with adequate margins. The Division worked with independent actuaries and the state's Medicaid agency to use claims data and industry reported payment to cost ratios to calculate the "break even" point for hospital care. Based on these analyses, hospitals in Colorado break even when they are paid between 117-143% of Medicare payments, depending on the facility's payer mix. Under the Colorado option, when a plan initially fails to meet the premium reduction requirements, the Division of Insurance may require hospitals to accept reimbursement rates that range from 165 - 238% of Medicare rates, depending on the situation of the hospital. These reimbursement "floors" comfortably exceed the cost of providing care and are much lower than average reimbursement rates for Colorado hospitals in the individual market, which is estimated to average 280% of Medicare.

[1] See NovaRest: Analysis of the same benefits yielded different results—impacts of 0.28 to 1.45 percent—potentially a nine-fold difference in impact to premiums

[1] See NovaRest: Analysis of the same benefits yielded different results—impacts of 0.28 to 1.45 percent—potentially a nine-fold difference in impact to premiums