MILLIMAN REPORT

Evaluation of a Colorado Public Option

Prepared for the Kaiser Permanente

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Milliman

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1. EXECUTIVE SUMMARY

Kaiser Permanente (Kaiser) engaged Milliman to assist in analyzing various aspects of the potential introduction of a Public Option in Colorado. In determining the scope, methodology and assumptions for our analysis, we relied in part on the text of Colorado HB19-1004 which laid out the public policy objectives and analysis requirements of a state-sponsored proposal that outlines the most effective implementation of Public Option in Colorado. One of those objectives was to estimate premium rates under a Public Option and the required provider reimbursement levels required underlying those rates.[1]

A major variable in any Public Option scenario is provider reimbursement. Any changes in professional and / or facility reimbursement have significant cost implications. Since the text of the bill did not define "provider," we assumed a broad definition of the word. Given that broadest possible definition of the word "provider," our analysis assumed changes in both professional and facility reimbursement.

On October 7, 2019 and concurrently with finalizing our report, the Colorado Department of Regulatory Agencies and the Colorado Department of Health Care Policy and Financing released their joint report on a Public Option (the joint report).[2] *The analysis in the joint report assumes that only facility reimbursement will be reduced in order to achieve the desired rate impacts. By contrast, our analysis assumes that both professional and facility reimbursement levels would be modified in order to obtain the needed premium rates for the Public Option to be competitive.*

Despite this key difference, we present our analysis in full, under our original assumption, using a provider reimbursement structure that includes changes to both facility and professional providers. While this difference is significant, the overall conclusions drawn related to market impacts are still directionally consistent. Where they are not comparable, however, is in terms of premium rate impact. To facilitate cleaner comparisons between our report and the joint report, we have calculated two scenarios that assume only facility reimbursement is affected in addition to our original four scenarios that assume both facility and professional are affected.

MILLIMAN AND JOINT REPORT PROVIDER REIMBURSEMENT ASSUMPTIONS

- In order to achieve meaningfully lower consumer-facing prices in the individual market for non-subsidized consumer, a Public Option includes mandated reimbursement for facility and professional providers (or for just facilities alone, as in the joint report) that is lower than what underlies current Connect for Health Colorado (CFHC) participating plan offerings. In particular, the *provider payment level for a Public Option would need to be lower than payment levels underlying the current second-lowest-cost silver (SLCS) plan on Connect for Health Colorado (CFHC).*

- There are significantly different reimbursement-related assumptions made between the analyses in our report versus the joint report, specifically:

  - The joint report assumes that facility reimbursement is at a uniform percentage of Medicare across the entire state. Our analysis, based on Milliman research, assumes that there are material variations by geographical region.

  - The joint report assumes a reimbursement level as a percentage of Medicare of 289%[3], which is much higher than what we assume currently underlies premium rates on CFHC, and in particular, for the second lowest cost silver plan.

  In Figure 1 we detail these assumptions for current reimbursement for five representative counties compared to the state-wide assumption used in the joint report.

FIGURE 1: COMPARISON OF ASSUMED PREVAILING REIMBURSMENT LEVELS IN MILLIMAN VS. STATE REPORT ANALYSIS

	MILLIMAN REIMBURSEMENT ASSUMPTIONS BY CLAIM TYPE AND COUNTY, PERCENTAGE OF MEDCIARE BASIS			
County	**INPATIENT**	**OUTPATIENT**	**PROFESSIONAL**	**TOTAL**
Boulder	142%	142%	120%	134%
Denver	130%	167%	116%	138%
Larimer	208%	246%	120%	189%

[1] https://leg.colorado.gov/sites/default/files/documents/2019A/bills/2019a_1004_01.pdf Section1 (4)(a) & (b)

[2] Colorado Department of Regulatory Agencies & Colorado Department of Health Care Policy and Financing (October 7, 2019). DRAFT Report for Colorado's State Coverage Option. Retrieved October 17, 2019, from http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf.

[3] Ibid.

Mesa	214%	241%	140%	196%
Gunnison	216%	345%	180%	250%
State Report	289%	289%	NA	NA

As Figure 1 shows, our research indicates that significantly lower reimbursement currently exists in highly populated and competitive counties such as Boulder and Denver. Reimbursement is higher in rural counties for facilities, but is generally still lower than 289%. *The difference in overall reimbursement and the material variations by geography lead to very different projections of premium savings coming from a Public Option.*

MILLIMAN AND JOINT REPORT PUBLIC OPTION PREMIUM SAVINGS IMPACTS FROM PROVIDER REIMBURSEMENT ASSUMPTIONS

- The impacts of provider reimbursement assumptions on the estimated premium savings of a Public Option relative to the SLCS are illustrated in Figure 2 below[4].

FIGURE 2: COMPARISON OF PREMIUM SAVINGS FROM PUBLIC OPTION

	MILLIMAN ANALYSIS						JOINT REPORT	
	FACILITY AND PROFESSIONAL AT MEDICARE %				FACILITY ONLY AT MEDICARE %		FACILITY ONLY AT MEDICARE %	
County	**SCENARIO A 180% OF MEDICARE**	**SCENARIO B 150% OF MEDICARE**	**SCENARIO C 120% OF MEDICARE**	**SCENARIO D 100% OF MEDICARE**	**SCENARIO E 225% OF MEDICARE**	**SCENARIO F 175% OF MEDICARE**	**225% OF MEDICARE**	**175% OF MEDICARE**
Boulder	21.7%	5.6%	-9.6%	-19.1%	25.7%	9.5%	NA	NA
Denver	22.8%	5.8%	-10.2%	-20.3%	25.9%	8.5%	NA	NA
Larimer	-4.9%	-18.1%	-30.8%	-39.0%	-1.5%	-15.2%	NA	NA
Mesa	-8.1%	-20.1%	-31.6%	-39.0%	-1.4%	-15.6%	NA	NA
Gunnison	-25.0%	-35.1%	-44.6%	-50.7%	-12.4%	-22.8%	NA	NA
Composite	**12.9%**	**-2.5%**	**-17.0%**	**-26.3%**	**16.8%**	**1.0%**	**-9.6%**	**-18.2%**

Scenarios A through D shown in Figure 2 assume that both professional and facility reimbursement are at the percent of Medicare level indicated. In high-density population areas such as Denver and Boulder, which are competitive with five or six carriers offering coverage on CFHC, we estimate current reimbursement for the SLCS to be much lower than in rural counties, which leads to smaller premium savings and, under scenarios A & B, premium rates actually increase. *Thus our analysis indicates that a Public Option may bring little to no price relief to a large portion of Colorado consumers (those residing in urban areas) even when reimbursement as low as 150% of Medicare applies to both facility and professional providers.*

Scenarios E and F of Figure 2, along with the corresponding columns for the joint report, illustrate that our estimates of premium savings are less favorable relative to those in the joint report when put on a comparable basis. For example, while the joint report estimates a state-wide *decrease* in the price of the SLCS of 9.6% under a 225% of Medicare scenario, our analysis produces a population-weighted average *increase* of 16.8%. Again, this is a result of our assumption of much lower provider reimbursement which, at 225% of Medicare, actually produces *higher Public Option premium rates* in the heavily-weighted urban areas.

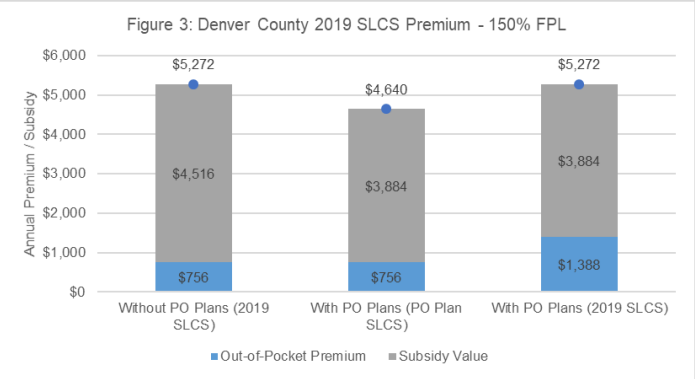
In summary, we find that the ability of the Public Option to provide lower prices for Coloradans purchasing coverage on CFHC, particularly the unsubsidized, is highly dependent on three factors:

- the actual level of reimbursement that currently exists for the SLCS,
- how that reimbursement varies by geography, and
- at what level of reimbursement the Public Option will ultimately contract with providers.

[4] An additional impact report was done by the REMI Partnership (September 2019). Anticipating a State Option for Health Care: Will Businesses Face Higher Costs or Will Quality and Access Be Cut? Retrieved October 9, 2019, from https://www.commonsensepolicyroundtable.org/wp-content/uploads/2019/09/REMI-Partnership-Anticipating-a-State-Option-for-Health-Care-FULL-REPORT-.pdf.

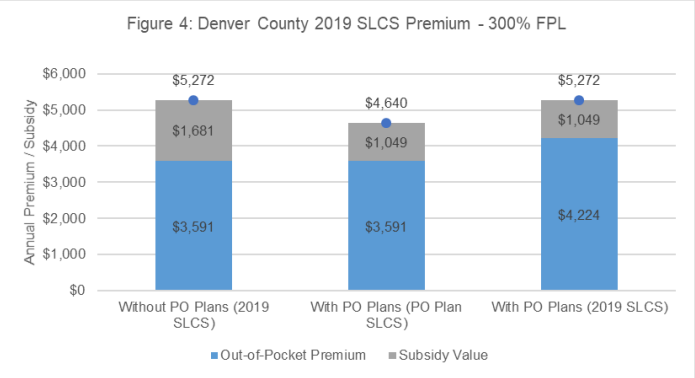
EFFECTS ON CONSUMER PRICES AND CARRIER COMPETITION

- Current carriers (or potential new entrants) may not be able to obtain the same reimbursement terms on non-Public Option offerings as those related to Public Option plans, making a private carrier's CFHC non-Public Option offerings uncompetitive (and possibly irrelevant). This is particularly true after considering the effect of federal premium subsidies on a consumer's net premium. Depending on the degree of price advantage held by a Public Option, individual carriers may be forced to participate in the Public Option program or simply exit the individual ACA-compliant market, thereby accomplishing the opposite effect intended and actually decreasing carrier competition and consumer choice. The leveraged impact of the introduction of a lower priced Public Option on post-subsidy premiums is illustrated in Figure 3 for a single 40-year-old with income equivalent to 150% Federal Poverty Level (FPL).



In this example, the introduction of Public Option plan causes the gross annual premium for a 40 year old for the SLCS plan to decrease by 12% ($5,272 to $4,640). The person can switch to the Public Option (middle column), with the net out-of-pocket annual premium remaining at $756. However, to the extent the person wanted to stay on the same plan (right column), then the annual out-of-pocket premium increases from $756 to $1,388, an *84% increase*. This effect is the result of the premium subsidy value decreasing from $4,516 to $3,884, which in turn is a result of the Public Option becoming the SLCS.

We estimate approximately 36% of the ACA-Compliant Individual market has subsidy levels comparable with those illustrated in Figure 3 (incomes less than 250% of FPL). An additional 24% of the individual ACA-compliant market will have lighter subsidies because there income is between 250% and 400% of FPL and, therefore, will have a lower leveraging affect, as illustrated in Figure 4. In this case, while gross premium declined, there is a 17% increase in out-of-pocket premium (from $3,591 to $4,224), if they want to keep their current plan.



Therefore, under a Public Option, a subsidized person will see no reduction in out-of-pocket premiums and must pay substantially higher out-of-pocket premiums to remain in their same plan.

The market dynamics illustrated in Figures 3 and 4 are magnified in regions where there is potentially a larger spread between the premiums for existing plans and Public Option premiums. As Figure 2 illustrates, estimated current provider reimbursement in rural areas is higher relative to urban areas; therefore, it is projected that a Public Option (assuming uniform, statewide reimbursement levels are implemented) would have a larger price advantage to existing CFHC plans in rural areas and, therefore, a heavy post-subsidy leveraging effect on out-of-pocket premiums. Corresponding out-of-pocket premium increases for 150% of FPL and 300% of FPL for high cost rural areas are 218% and 46% respectively, assuming those consumers want to keep their current plan.

EFFECTS ON INDIVIDUAL AND EMPLOYER-SPONSORED MARKET ENROLLMENT

- We assume that a Public Option would be a qualified health plan (QHP) offered on CFHC. Given the price sensitivity of individual consumers and their acclimation to narrow network products already common on CFHC, the movement to a lower-priced Public Option would make the most economic sense. A large share of the individual market would likely switch to a Public Option under several of the price scenarios we modeled, especially given the leveraged post-subsidy rate increases consumers would experience if they do not switch.

- Just over 50% of Coloradans receive their healthcare coverage through employer-sponsored plans. This is the largest single share of healthcare coverage by market (Medicaid is second, covering approximately 21% of the State of Colorado's population). Depending on reimbursement level and geography, a Public Option could have premium rates that employers currently offering traditional group coverage might find attractive.

  Assuming eligibility for a Public Option would include employees currently covered under employer-sponsored plans, significant migration to the Public Option might occur under certain scenarios. Along with attractive prices, the availability of tax-favored vehicles, such as the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) and the Integrated Individual Health Reimbursement Arrangement (IIHRA) allows employers to fund premium payments for individual health insurance coverage. That could make an employer's decision to fund coverage on CFHC in lieu of a traditional plan much easier. This migration from group segments (small group, large group insured, and self-funded) could increase if product features such as an adequate provider network are satisfactory to employers.

EFFECTS ON COLORADO'S PROVIDER COMMUNITY

- A potentially large membership movement from both the individual and group markets to a Public Option with materially lower provider reimbursement is possible, depending on the Public Option's price. Because of the size of employer group segment (50% of Coloradans), small percentage movements in this segment can have large impacts on Public Option enrollment. The movement of members to a Public Option is anticipated to have at least two effects.

  First, because the cost of the competitive advantage obtained by a Public Option is borne entirely by the provider community, movement to it will reduce provider revenue for each individual purchaser or employee who chooses it.

  Figure 5 illustrates the interplay between lower premium rates, higher enrollment, and reduced provider reimbursement. In short, the relationship becomes nonlinear as each effect compounds the other. For example, under the 150% of Medicare scenario, enrollment is modest at approximately 250,000 and a reduction in provider revenue is seen of slightly above $63 million. However, under the 120% of Medicare scenario, enrollment nearly doubles in the Public Option, but provider revenue losses increase nearly ninefold (from a loss of $63 million to $578 million).

  Second, in response to revenue pressures, providers could react in a variety of ways and most likely in a combination of ways. These potential reactions include (but are not limited to):

  - Choosing not to contract with the Public Option, depending on the level of reimbursement. This could cause network adequacy challenges and result in access issues for Public Option enrollees.

  - Changing patient mix, accepting fewer patients with lower reimbursement coverage, such as Medicaid patients. This will cause access issues for the affected populations.

  - Contracting with the Public Option but attempting to increase revenues on other commercial contracts they may have with payers (cost shifting). Figure 5 shows the impact to commercial contracts under various reimbursement levels (in the "Cost Shift to Commercial Group" line) if providers were able to shift *all* of the costs of the Public Option revenue loss to those contracts.

FIGURE 5: ESTIMATED PUBLIC OPTION MEMBERSHIP, PROVIDER REVENUE IMPACT, AND COST SHIFTING

	LEVEL OF PROVIDER REIMBURSEMENT FOR PUBLIC OPTION			
SCENARIO	**SCENARIOS A** **180%/175% OF MEDICARE**	**SCENARIOS B** **150% OF MEDICARE**	**SCENARIO (C)** **120% OF MEDICARE**	**SCENARIO (D)** **100% OF MEDICARE**
PUBLIC OPTION MEMBERSHIP	31,200	249,600	466,000	619,900
PROVIDER REVENUE CHANGE $ (MILLIONS)	$116	-$63	-$578	-$1,115
PROVIDER REVENUE CHANGE %	0.4%	-0.2%	-1.9%	-3.7%
COST SHIFT TO COMMERCIAL GROUP	-0.8%	0.5%	4.3%	8.7%

As an example, if providers under a Public Option were to accept 120% of Medicare state-wide *and* attempted to recoup all the lost revenue of the 466,000 enrollees by cost shifting to commercial payer contracts, they would need to increase reimbursement levels by 4.3% on the remaining commercial group coverage to be made whole.

Providers could also respond to lower revenues by changing patient mix. One example of this might be by accepting fewer Medicaid patients. Finally, providers could employ a combination of the various strategies mentioned above, improving their efficiency, increasing patient volume, and / or merging with another provider. In extreme cases, physicians may also choose to retire and exit private practice, or close their independent practices and work for a health system.

UNIQUE CONSIDERATIONS FOR RURAL COUNTIES

- HB19-1004 notes specifically the lack of carrier choice in the individual market in 14 Colorado counties. These counties also typically have much higher premium rates due to a combination of lower provider competition (i.e., a single hospital or health system serves the area) and minimal carrier competition.[5] One of the purposes stated for considering a Public Option in the bill is to address these specific issues. As shown in Figure 3 above, rural areas could see significant premium rate relief under a Public Option. However, this price relief comes at the cost of reduced reimbursement to providers (professional and facility) that may be already financially stressed.[6,7]

- Additional financial stress of lower provider reimbursement may induce provider consolidation or even closing of facilities.[8] These actions may exacerbate access issues for rural patients.

- Finally, overall carrier competition in the State of Colorado, as noted above, may not be enhanced with a Public Option. If a private carrier is competing against a Public Option that has a competitive advantage (legislatively mandated lower reimbursement) that it may not be able to match, it may not make business sense to continue offering coverage in that county. The exit of that carrier would leave the county with a single carrier again,[9] but this time it would be the Public Option, which given its lower reimbursement, may or may not have been successful at contracting an adequate network.

OTHER POLICY OPTIONS

Our review of various policy alternatives finds that there are other available options that could be more efficient means to reducing prices in the individual market, particularly for those above 400% FPL. Although a Public Option could set eligibility standards that would allow current employer group members to enroll and employers might benefit from moving employees to the Public Option, current reform strategies, including a Public Option, are largely targeted at the *unsubsidized, individual market*. The individual market is only about 3.8% of Colorado's 2019 health benefits marketplace and the unsubsidized portion is even smaller (approximately 105,000 persons or less than 2% of the State of Colorado's total population). Geographically, the current market challenges lie predominantly in rural regions that are not densely populated, and have limited carrier and healthcare delivery system competition.

[5] See Appendix B of the full report for rates by geographic region and carrier counts.

[6] National Rural Health Association. Advocacy: NRHA Save Rural Hospitals Action Center. Retrieved October 9, 2019, from https://www.ruralhealthweb.org/advocate/save-rural-hospitals.

[7] U.S. Senate Committee on Finance (May 24, 2018). Statement of Konnie Martin: "Rural Health Care in America: Challenges and Opportunities." Retrieved October 9, 2019, from https://www.finance.senate.gov/imo/media/doc/24MAY2018MartinSTMNT.pdf.

[8] Ingold, J. (July 4, 2017). In Colorado's drumbeat of medical mergers, rural hospitals often trade independence for better care. Denver Post. Retrieved October 9, 2019, from https://www.denverpost.com/2017/07/04/colorado-rural-hospitals-merge-with-big-city-health-economic-concerns/.

[9] Colorado currently has 14 one-carrier counties. Please see Appendix B for more information.

Thus, it is important to consider the potentially broad ramifications of an ambitious proposal that is intended to primarily benefit a relatively small sub-segment of the population.

Hence, the discussion of more targeted and efficient solutions to improve Colorado's individual health insurance market relative to a Public Option may include:

- *A state-based program that extends subsidies based on income beyond the federal limit of 400% FPL*. This would not require a 1332 Waiver and could be built off of existing CFHC infrastructure. It can be designed to achieve the same effect as a reinsurance program or Public Option in terms of net premium decreases. Finally, it can eliminate the subsidy cliff that exists at 400% FPL.

  If implemented in lieu of an existing reinsurance program, state-based subsidies eliminate the structural weaknesses that may be inherent in reinsurance programs (such as high-cost carriers receiving disproportionate shares of program funding and duplicative payment by the federal risk adjustment). State-based subsidies could also complement a reinsurance program, achieving even greater out-of-pocket premium rate reductions for targeted populations.

- *A per member per month (PMPM) or flat percentage market subsidy.* These types of market subsidies (received by carriers) can achieve the same price reductions as a Public Option (or reinsurance program), but reduce or eliminate the potential high-cost carrier bias and overpayment issue (double payment by risk adjustment and reinsurance) that are both inherent to a reinsurance program. A market subsidy is much easier to implement than a Public Option and can build off the existing reinsurance infrastructure. Like state-based subsidies, these options can be implemented in lieu of a reinsurance program or as a complementary program.

- *Enhancing the reinsurance program*. A Public Option would be a large investment for the State of Colorado, with both business and insurance risks associated with it. For example, a stand-alone, risk-bearing Public Option entity would have significant startup costs, ongoing and likely increasing capital needs, and other associated expenses. Moreover, it is not entirely clear that a Public Option would achieve the desired policy ends without significant drawbacks. These same funds could be used more efficiently and with less risk to the State of Colorado by simply increasing the funding and, therefore, the rate impact of Colorado's reinsurance program.

  These policy options also come with the additional advantage that there is either no need of a 1332 Waiver to reclaim savings (state-based subsidies) or a low risk of not getting an application approved (reinsurance or market subsidy). Yet these policy options can have virtually the same effects on consumer premiums as a Public Option, without the potential detrimental effect on consumer choice.

2. INTRODUCTION AND BACKGROUND

Kaiser Permanente (Kaiser) has engaged Milliman to assist in analyzing various aspects of the potential introduction of a Public Option in Colorado as well as other possible state reform strategies. Based upon legislation passed and the study mandate described therein,[10] the State of Colorado is interested in understanding whether a Public Option could remediate dysfunctions found in the individual market, most notably 1) the lack of carrier competition in rural areas, and 2) high prices (even after the implementation of the reinsurance program in 2020).[11] Specifically, in the unsubsidized portion of the individual market, high prices are a particularly acute problem as these consumers are paying the full premium, without any federal premium assistance.

A Public Option, depending on its structure and competitive advantages, could have significant impacts to the individual business of current or prospective carriers in Colorado. Moreover, a Public Option, depending on how eligibility for the program is set, could have secondary effects on other markets, such as the commercial employer-sponsored markets, that may be unintended and undesirable.

The introduction of a Public Option will also affect provider reimbursement and may cause providers to counteract revenue reductions by shifting costs to other payers (e.g., employer-sponsored coverage). It is likely that the Public Option could be backed by a mandated reimbursement level that is significantly lower than prevailing commercial market rates. Coupled with broad eligibility, a hypercompetitive price, and the availability of health reimbursement arrangements (HRAs)—vehicles for paying health insurance premiums with pretax wages—the Public Option could ultimately see significant enrollment that would drive provider revenue down.

Finally, a Public Option could have impacts on the amount of federal premium subsidies available to Colorado residents if offered through Connect for Health Colorado (CFHC). It is possible that the reduced federal outlays for premium subsidies could be returned to the state in the form of pass-through funding from a 1332 Waiver.

However, a Public Option is not the only mechanism for achieving the state's policy ends. There are various other avenues to address these issues, each with its own set of trade-offs that should be considered in the context of evaluating a Public Option.

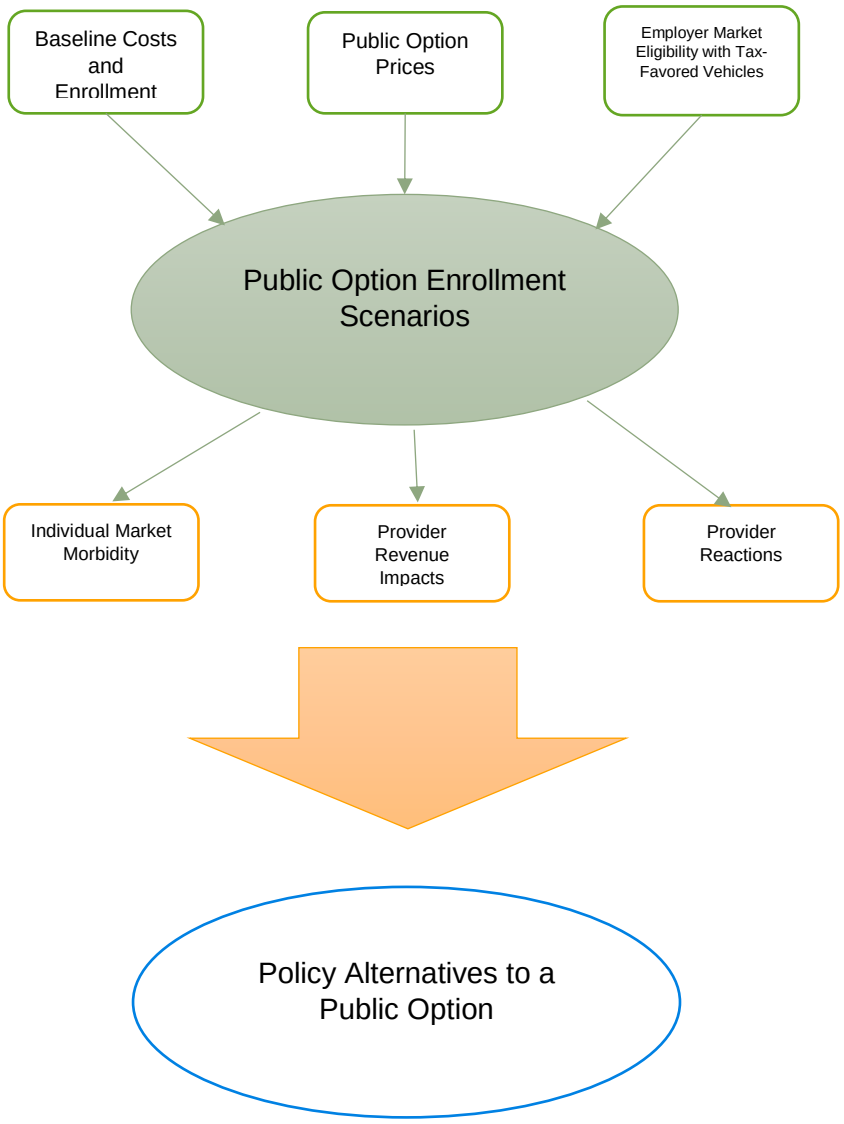
Our report is structured to discuss each of these key features of a Public Option as well as possible alternatives and is outlined below:

- **Establish a baseline scenario for enrollment and costs by market for Colorado in 2019.** This will be used to model two key Public Option features: price and enrollment.
- **Model price scenarios**. Using cost indexes from the baseline analysis and assumptions of reimbursement *levels relative to Medicare, we establish four Public Option price scenarios.*
- **Understand employer market dynamics related to health benefit offerings.** We assume that current members of employer plans would be eligible for Public Option coverage. Therefore, employers' attitudes toward health benefits and any tax-related consequences of health benefits decisions, along with Public Option prices, will have a significant influence on Public Option take-up rates in this large segment of Colorado's health benefits landscape.
- **Model Public Option enrollment scenarios.** Using pricing scenarios and various take-up assumptions from the individual and employer markets, we model four enrollment scenarios that are correlated with price (i.e., higher Public Option price means lower overall enrollment and vice versa).
- **Model impact to provider reimbursement and the potential for cost shifting.** Higher enrollment in the Public Option will put downward pressure on provider revenues. Providers will have various responses to this, including cost shifting to commercial payers. We also model the varying effects of morbidity on the individual pool that may occur as a result of insurance market migration induced by the Public Option.
- **Discuss policy alternatives to Public Option.** Given the various dynamics modeled, alternatives to the Public Option are explored.

[10] See Appendix A for a summary of the key components of the Public Option Study Bill.
[11] See Appendix B for a rate increase history and a carrier participation history.

A diagram of the analysis flow is shown in Figure 6.

FIGURE 6: PUBLIC OPTION IMPACTS ANALYSIS FLOW



3. PUBLIC OPTION[12] HISTORY AND CURRENT STATE-BASED ACTIVITY

The birth of the public option idea traces its development to a California state policy proposal in 2001 through 2002. The goal of the California's "Health Care Options Project," not entirely unlike the goals articulated in the Colorado HB19-004, was to examine options for expanding healthcare coverage in California. The project put forth nine different proposals, including the CHOICE[13] program, which would have created a state-operated insurance option for workers and their dependents, subject to an income-based premium and funded by an assessment on employers for each employee who did not select employer-sponsored coverage.[14] The hope of this proposal, which ultimately was not implemented, was to drive down premiums and lower healthcare costs through an additional competitive option sponsored by the state government.

The public option next emerged as part of the 2008 presidential campaign.[15] A Medicare-based public option that would have utilized a federally run framework was proposed, while John Edwards put forth a health platform that emphasized a state-based public option.[16] As a key element of the healthcare discussion, a *federally run* public option was included in the early versions of the Patient Protection and Affordable Care Act (ACA) and became one of its more controversial elements.[17] The public option was viewed by proponents as a way to increase coverage, limit the growth in healthcare costs, and promote competition by expanding the number of options available to exchange participants.[18] Critics were wary of the ability of the private market to compete with a government-sponsored plan, and worried that this would lead to *reduced competition and innovation* and ultimately higher prices and unsustainable government expenditures.[19] In the end, a lack of support from moderate Democrats led to the removal of a public option from the final version of the ACA, and the public option was again sidelined.[20] Instead, the law contained funding for consumer operated and oriented plans (CO-OPs), which were taxpayer-funded corporations[21] whose goal was to put patients first and focus on ACA-compliant coverage, in essence a privately adminstered but publicly funded option.[22]

> Historically, a public option, in its various forms, has sought to utilize government purchasing power in an attempt to increase carrier competition and lower consumer prices.

At the state level, there has been a much wider variety of activity. The state of Washington passed a public option (Cascade Care) in May 2019, under which the state will select insurers to administer a health plan according to terms established by the state. Cascade Care will have state-determined benefit designs and maximum provider reimbursement levels.

Among states that have not passed legislation, bills for Medicaid buy-in (a form of public option) have been proposed in Maine, Massachusetts, New Jersey, and Oregon. Additionally, Colorado has established a task force to study the issue. Connecticut considered a Washington-style public option, but this bill was opposed by health insurance industry

[12] Note that, when capitalized, "Public Option" will refer specifically to Colorado's proposed program. Without capitalization, it is used generically.
[13] The authors of this proposal did not provide a definition for this acronym, though it appears to have been a reference to Medicare+CHOICE, the name by which the current Medicare Advantage program was known at the time.
[14] Health Access (2002). Health Care Options Project: Nine Options for Health Care Reform in California. Retrieved October 9, 2019, from https://health-access.org/health-care-options-project/.
[15] Health Affairs (June 2010). The Origins and Demise of the Public Option. Retrieved October 9, 2019, from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0363.
[16] Collins, S.R. & Kriss, J.L. (January 2008). Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals. Commonwealth Fund. Retrieved October 9, 2019, from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2008_jan_the_publics_views_on_health_care_reform_in_the_2008_presidential_election_collins_envisioningfuture2008prescandhltreformprop_1092_pdf.pdf.
[17] Washington Post. 8 questions about health-care reform. Retrieved October 9, 2019, from https://www.washingtonpost.com/wp-srv/special/politics/8-questions/.
[18] Reich, R.B. (June 24, 2009). Why we need a public health-care plan. Wall Street Journal. Retrieved October 9, 2019, from https://www.wsj.com/articles/SB124580516633344953.
[19] Cannon, M.F. (August 6, 2009). Fannie Med? Why a "public option" is hazardous to your health. Policy Analysis. Retrieved October 9, 2019, from https://www.cato.org/sites/cato.org/files/pubs/pdf/pa642.pdf.
[20] Health Affairs, Origins and Demise of the Public Option, op cit.
[21] The U.S. Department of Health and Human Services (HHS) awarded $2.4 billion in funding to 23 CO-OPs. Please see https://www.hsgac.senate.gov/imo/media/doc/Majority%20Staff%20Report%20-%20Failure%20of%20the%20Affordable%20Care%20Act%20Health%20Insurance%20CO-OPs.pdf for more information.
[22] Planet Money (September 28, 2009). Podcast: Looking at health care co-ops. NPR. Retrieved October 9, 2019, from https://www.npr.org/sections/money/2009/09/podcast_a_closer_look_at_healt.html.

interests. California, Iowa, Maine, Maryland, Minnesota, Nevada, Wisconsin, and Wyoming have also considered or are considering public option proposals.

OTHER STATE HEALTHCARE REFORM ACTIVITY

As additional background, we note that states have been active with a number of proposals to improve individual market conditions. *All of these proposals share a goal common to the proposed Colorado Public Option, namely that of bringing price relief to the unsubsidized individual market.*

Since 2017, the most popular reform has been the state-based reinsurance program. Under Section 1332 of the ACA, a state can use a state innovation waiver (Section 1332 Waiver) to implement market reforms, to the extent the waiver maintains federal deficit neutrality and does not harm the ACA's insurance coverage improvements. Additionally, to the extent the Section 1332 Waiver reduces federal premium assistance expenditures, a state can receive "pass-through" funding from the federal government for its innovation. As of September 2019, 12 states, including Colorado, have received approval for reinsurance programs via a Section 1332 Waiver, leveraging a variety of funding sources.[23]

The nullification of the individual mandate penalty in 2019 as part of the Tax Cuts and Jobs Act of 2017 led to discussion (and in some cases passage) of state-level health insurance coverage mandates. Massachusetts has had an individual mandate since before the passage of the ACA.[24] California,[25] New Jersey,[26] Rhode Island,[27] Vermont,[28] and Washington, D.C[29].,, have all passed laws establishing their own mandates, with New Jersey and Rhode Island using their mandates to fund their 1332 Waivers. Maryland considered a mandate, but that provision was dropped from a state reform bill.[30]

Another approach that has made some headway is enrollment facilitation via tax returns or means-based programs. Under this reform, states can enroll individuals in Medicaid or proactively reach out to exchange-eligible individuals, simplifying the process of enrolling in health coverage. To date, Maryland has the only program that includes exchange markets,[31] while Louisiana and South Carolina have more limited programs that address likely Medicaid-eligible populations.[32,33]

States have also taken action regarding association health plans (AHP). While federal action on AHPs has met legal opposition, several states have sought to exploit a loophole in the effective rate review program requirements of the Centers for Medicare and Medicaid Services (CMS) that allow for certain self-insured associations to bypass federal restrictions, including Georgia, Iowa, Kansas, Nebraska, and Tennessee. These plans are effectively exempt from many of the ACA's market reforms. AHPs impact the individual market by allowing sole proprietors (many of whom are currently on the individual market and not eligible for subsidies) to qualify for less expensive group coverage under the AHP.

California has taken a wider variety of healthcare reform approaches in the last two years than most other states. While the widely publicized efforts to create a single-payer system have yet to bear fruit, California has expanded subsidies (extending them to households with income up to 600% FPL and increasing the value for households with income at or under 400% FPL), created an individual mandate, and consolidated prescription drug purchasing in a single state agency.[34]

[23] SHADAC. Resource: State-Based Reinsurance Programs via 1332 State Innovation Waivers. Retrieved October 9, 2019, from https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers.
[24] The full text of the Massachusetts law is available at https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58.
[25] The full text of the California law is available at http://www.dof.ca.gov/Budget/Trailer_Bill_Language/documents/HBEXIndividualMandateandStateHealthCareSubsidies.pdf.
[26] The full text of the New Jersey law is available at https://www.njleg.state.nj.us/2018/Bills/AL18/31_.PDF.
[27] The full text of the Rhode Island law is available at http://webserver.rilin.state.ri.us/BillText/BillText19/HouseText19/H5151Aaa.pdf.
[28] The full text of the Vermont law is available at https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT063/ACT063%20As%20Enacted.pdf.
[29] The full text of the Washington, D.C., law is available at https://code.dccouncil.us/dc/council/laws/22-168.html#%C2%A75002(b).
[30] Witte, B. (May 13, 2019). Maryland gov signs 1st-in-nation measure to help uninsured. Minneapolis StarTribune. Retrieved October 9, 2019, from http://www.startribune.com/maryland-gov-signs-1st-in-nation-measure-to-help-uninsured/509857412/
[31] Ibid.
[32] Commonwealth Fund. Louisiana: Streamlining Enrollment With Express Lane Eligibility. Retrieved October 9, 2019, from https://www.commonwealthfund.org/publications/newsletter-article/louisiana-streamlining-enrollment-express-lane-eligibility.
[33] South Carolina Health and Human Services (October 4, 2012). SCDHHS meets promise to insure more poor children through 'Express Lane' eligibility. Press release. Retrieved October 9, 2019, from https://www.scdhhs.gov/press-release/scdhhs-meets-promise-insure-more-poor-children-through-express-lane-eligibility.
[34] Quinn, M. (July 11, 2019). California takes Obamacare to a new level as the law's fate looms. *Governing*. Retrieved October 9, 2019, from https://www.governing.com/topics/health-human-services/gov-california-newsom-obamacare-subsidies-mandate.html.

4. STATE HEALTH BENEFITS PROFILE

In order to better evaluate potential impacts a Public Option would have in Colorado, it is helpful to first establish a baseline for context and comparisons. This section of our report provides an overview of Colorado's health benefits market landscape in 2019. Much of the information presented is used for further analysis, as well as to support assumptions and conclusions. We provide estimates of health benefits enrollment by market in 2019, and further enrollment analyses by age group and household income. Estimates for provider reimbursement (total non-prescription drug claims dollars) are developed by market segment. Finally, we provide an estimate of the 2019 federal premium assistance provided through Connect for Health Colorado (CFHC).

ENROLLMENT BY HEALTH BENEFITS MARKET

Figure 7 provides a summary of the estimated number of Coloradans by health benefits coverage source in 2019. The estimates are developed from a combination of insurer financial information, publicly available reports on Medicaid and Medicare enrollment, and the American Community Survey (ACS). Please see the Methodologies section of this report for further details.

FIGURE 7: COLORADO, ESTIMATED 2019 HEALTH BENEFITS COVERAGE LANDSCAPE

MARKET	PERSONS	% OF POPULATION
Individual	217,000	3.8%
Small Group	299,000	5.2%
Large Group	679,000	11.7%
Self-Funded	1,936,000	33.5%
Employer Group Subtotal	**2,915,000**	**50.4%**
Medicaid	1,199,000	20.7%
Medicare	741,000	12.8%
Duals	83,000	1.4%
Other	155,000	2.7%
Uninsured	476,000	8.2%
Total	**5,786,000**	**100.0%**

Notes:
1. *Values have been rounded to the nearest thousand.*
2. *Employer group subtotal includes small group, large group, and self-funded populations.*
3. *Medicaid enrollment includes CHIP.*
4. *"Other" coverage represents TRICARE, Veterans Health Administration (VHA), and other public healthcare programs.*
5. *"Duals" coverage reflects persons with both Medicaid and Medicare coverage.*
6. *Medicare values reflect traditional and Medicare Advantage enrollment.*

As shown in Figure 7, the employer group market (small group, large group, and self-funded employers) is the source of health benefits for approximately 50% of Colorado's population. However, we estimate only 4% of Coloradans are purchasing coverage in the individual market in 2019. Enrollment in the individual market is estimated to have declined by nearly 50,000 persons since 2017. This may be attributable to a combination of factors, including:

- Significant premium rate increases that have adversely impacted persons not qualifying for federal premium assistance, particularly in 2017 and 2018.[35]
- Improving economy and associated job growth that has resulted in greater access to employer group health benefits and less need for individual market health benefits. The July 2019 unemployment rate was 2.9%,[36] which is at or near record low levels.[37]

[35] McMahon, X. (July 14, 2017). Colorado health insurance companies seek 27 percent premium spike. *CPR News*. Retrieved October 9, 2019, from https://www.cpr.org/2017/07/14/colorado-health-insurance-companies-seek-27-percent-premium-spike/.
[36] Colorado Department of Labor and Employment (August 16, 2019). Colorado Employment Situation, July 2019. Retrieved October 9, 2019, from https://www.colorado.gov/pacific/cdle/news/colorado-employment-situation-july-2019.
[37] U.S. Bureau of Labor Statistics. Colorado Economy at a Glance, Retrieved October 9, 2019, from https://www.bls.gov/eag/eag.co.htm.

- The individual mandate penalty became $0 for 2019, potentially providing less incentive for some consumers to purchase health benefits.

Figure 8 provides estimated 2019 enrollment in each health benefits market by age group.

FIGURE 8: COLORADO, ESTIMATED 2019 HEALTH BENEFITS MARKET ENROLLMENT BY AGE GROUP

MARKET	0 TO 17	18 TO 25	26 TO 34	35 TO 44	45 TO 54	55 TO 64	65+	TOTAL
INDIVIDUAL	26,000	16,000	40,000	35,000	37,000	60,000	3,000	217,000
EMPLOYER GROUP	618,000	355,000	475,000	508,000	491,000	444,000	24,000	2,915,000
MEDICAID	555,000	149,000	160,000	139,000	102,000	94,000	-	1,199,000
MEDICARE	4,000	4,000	4,000	6,000	11,000	27,000	685,000	741,000
DUALS	2,000	1,000	2,000	4,000	7,000	12,000	55,000	83,000
OTHER	39,000	24,000	28,000	20,000	17,000	25,000	2,000	155,000
UNINSURED	63,000	86,000	105,000	86,000	71,000	60,000	5,000	476,000
TOTAL	**1,307,000**	**635,000**	**814,000**	**798,000**	**736,000**	**722,000**	**774,000**	**5,786,000**

Notes:

1. *Values have been rounded to the nearest thousand.*
2. *"Employer" coverage includes small group, large group, and self-funded populations.*
3. *Medicaid enrollment includes CHIP.*
4. *"Other" coverage represents TRICARE, Veterans Health Administration (VHA), and other public healthcare programs.*
5. *"Duals" coverage reflects persons with both Medicaid and Medicare coverage.*

For working age adults, 18 to 64 years old, employer coverage provides health benefits to approximately 61% of the population (2.3 million out of 3.7 million), while individual market coverage is only purchased by 5% of the population (188,000 out of 3.7 million). *In considering potential health benefits policy changes, policies that have a minor impact to the employer market may have a corresponding significant impact to the individual market.* For example, if 10% of the employer market shifted to individual market coverage due to a Public Option, this would increase the size of the individual market from 217,000 to approximately 509,000, a nearly 135% increase in market enrollment. More specifically, if there is systematic bias in terms of which 10% of the employer group market (e.g., a less healthy 10%) moves over to the individual market, it could have a material effect on overall rates in the individual market due to increased morbidity. More discussion on the morbidity impact of moving populations can be found in Section 8 of this report below.

Comparing the individual and employer markets, it is noticeable that the age of consumers in the individual market is significantly older on average. Persons age 45 or older represent approximately 46% of individual market consumers (100,000 out of 217,000), while in the employer group market, this age group represents approximately only one-third of enrollment (1.0 million out of 2.9 million). Age mix differences are a contributing factor to the individual market's higher estimated per capita claims cost relative to the employer group health benefits market (as shown in Figure 8).

Public programs represent a much greater share of health benefits coverage for children (Medicaid) and the elderly (Medicare). Over 40% of children residing in Colorado are estimated to be enrolled in Medicaid, including the Children's Health Insurance Program (CHIP).

We estimate a 2019 uninsured rate for the total Colorado population of 8.2%. The uninsured rate is estimated to be greatest for the 18- to 25-year-old population (approximately 13%), while approximately 9% for adults ages 45 to 64.

The uninsured population represents an important segment of the Colorado market with regard to a potential Public Option. Policy makers would like to see this segment reduced[38] and the lower premiums associated with a Public Option could be an important tool in this effort. We estimate that the overall morbidity of the uninsured is favorable to the current individual and employer group markets and thus their entrance into the individual pool could lower rates all else equal (see Section 8 for more discussion of the impact of morbidity on this analysis).

Figure 9 examines the estimated distribution of health benefits coverage by income level, measured as a percentage of FPL.

[38] University of Pennsylvania (February 6, 2018). State Efforts to Close the Health Coverage Gap. Retrieved October 9, 2019, from https://ldi.upenn.edu/brief/state-efforts-close-health-coverage-gap.

FIGURE 9: COLORADO ESTIMATED 2019 HEALTH BENEFITS ENROLLMENT BY INCOME LEVEL (PERCENTAGE OF FPL)

MARKET	<139%	139% TO 250%	251% TO 400%	401% TO 500%	500%+	TOTAL
INDIVIDUAL	1,000	70,000	47,000	48,000	50,000	217,000
EMPLOYER GROUP	104,000	400,000	632,000	432,000	1,347,000	2,915,000
MEDICAID	606,000	349,000	152,000	42,000	50,000	1,199,000
MEDICARE	128,000	161,000	165,000	73,000	214,000	741,000
DUALS	52,000	15,000	7,000	2,000	6,000	83,000
OTHER	27,000	30,000	35,000	22,000	42,000	155,000
UNINSURED	165,000	110,000	113,000	25,000	62,000	476,000
TOTAL	**1,083,000**	**1,136,000**	**1,151,000**	**645,000**	**1,771,000**	**5,786,000**

Notes:
1. Values have been rounded to the nearest thousand.
2. "Employer" coverage includes small group, large group, and self-funded populations.
3. Medicaid enrollment includes CHIP.
4. "Other" coverage represents TRICARE, Veterans Health Administration (VHA), and other public healthcare programs.
5. "Duals" coverage reflects persons with both Medicaid and Medicare coverage.

Within the full individual market (ACA-compliant and non-ACA-compliant), we estimate 98,000 persons (45% of market enrollment) have household income above 400% FPL and, therefore, do not qualify for federal premium assistance. Thirty-three percent of individual market enrollees are estimated to have income at or below 250% FPL, allowing qualification for both federal premium assistance and cost-sharing reductions through CFHC (to the extent silver-level coverage is purchased). Note, the individual market cohort with income below 139% FPL is assumed to reflect lawfully present individuals who are eligible for federal premium assistance.

Relative to the individual market, the employer market is estimated to have a higher proportion of persons with household incomes above 400% FPL (61% vs. 45%) and significantly fewer persons with incomes below 250% FPL (17% vs. 33%). As discussed in more detail in Section 7, large employers have continued to offer health benefits at high rates even after the introduction of premium assistance through CFHC beginning in 2014. While the ACA's employer mandate likely has had some effect on the continuation of employer-sponsored coverage, this is also attributable to the significant proportion of employees who do not have access to federal premium assistance in CFHC, based on having household incomes above 400% FPL. Particularly for higher-income employees, this results in employer-sponsored coverage continuing to be perceived as an important benefit offered by employers.

For each health benefits coverage segment in the State of Colorado, Figure 10 provides detail on claims expenses as follows:

- Per capita allowed claims (the cost of all covered services, including both insurer paid expenses and member cost sharing)
- Proportion medical cost (the percentage of allowed claims attributable to medical costs, excluding pharmacy and long-term services and supports (LTSS)
- Per capita allowed medical cost
- Aggregate medical cost, shown in billions of dollars

Note, costs for the uninsured population do not reflect uncompensated care delivered by providers and exclude any indirect payments for the delivery of uncompensated care. Based on national-level information, we have assumed approximately 80% of provider care to the uninsured population is uncompensated.[39]

The information provided in Figure 10 establishes a baseline view of 2019 provider revenue in Colorado. Projected revenue under Public Option enrollment scenarios will be compared to these baseline values later in this report.

[39] Kaiser Family Foundation (May 30, 2014). Uncompensated Care for the Uninsured in 2013: A Detailed Examination. Retrieved March 4, 2019, from https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/.

FIGURE 10: COLORADO, ESTIMATED 2019 HEALTH BENEFITS COVERAGE, ENROLLMENT AND CLAIMS EXPENSE

	PERSONS	PER CAPITA ALLOWED CLAIMS	PROPORTION MEDICAL COST	PER CAPITA ALLOWED MEDICAL COST	AGGREGATE MEDICAL COST ($ BILLIONS)
Individual	217,000	$7,911	80%	$6,329	$1.4
Small Group	299,000	$6,063	80%	$4,851	$1.5
Large Group	679,000	$6,335	80%	$5,068	$3.4
Self-Funded	1,936,000	$6,272	80%	$5,018	$9.7
Employer Group Subtotal	**2,914,000**	**$6,265**	**80%**	**$5,012**	**$14.6**
Medicaid	1,199,000	$4,365	95%	$4,146	$5.0
Medicare	741,000	$10,879	80%	$8,703	$6.4
Duals	83,000	$48,115	35%	$16,840	$1.4
Other	155,000	$6,335	80%	$5,068	$0.8
Uninsured	476,000	$1,038	80%	$830	$0.4
Total	**5,786,000**	**$6,696**		**$5,182**	**$30.0**

Notes:
1. Values have been rounded.
2. Estimates for the individual, small group, and large group markets developed from 2017 medical loss ratio submissions trend to 2019 and Connect for Health's 2019 open enrollment report presentation. Individual market claims expense estimated by 2019 premium estimates, an assumed market loss ratio of 80%, and actuarial value estimates.
3. Estimates for public health benefits programs were estimated based on publicly available CMS data.
4. Percentage of claims by insurer estimates developed from CMS risk adjustment transfer reports and actuarial judgment. The estimate for the individual market includes cost-sharing reduction plan design enhancements.
5. Medicaid per capita costs include supplemental payments and are net of pharmacy rebates.

On a composite basis, we estimate approximately $30 billion in healthcare medical claims cost in 2019, with the individual market generating $1.4 billion or approximately 3% of the total. As shown in Figure 10, the per capita allowed claims costs for the individual market ($7,900) is higher than the employer group health benefits composite ($6,300). This difference is attributable to the following factors:

- As shown in Figure 10 above, the individual market is composed of a greater proportion of adults age 45 and over (46% of enrollees) and significantly fewer children (12% of enrollees) relative to the employer group market (33% of enrollees age 45 and over, and 21% of enrollees' children). As healthcare costs increase with age, the higher age mix in the individual market results in higher per capita claims expenses.

- For a given age, we estimate that the average morbidity (illness burden) in the individual market is approximately 15% to 20% higher relative to the same age in the employer group health benefits market. This is likely driven by the lower average household income[40] of the individual market and adverse selection among consumers (the greater likelihood that persons with greater healthcare needs will purchase coverage).

- All else equal, a non-biased, balanced cross-section of migration from the employer group market could improve overall rates in the individual markets. However, as we discuss in greater detail in Section 7, anti-selective behavior by large employers offering HRAs that result in the movement of sicker individuals could have a detrimental effect on individual morbidity and, therefore, overall premium rates.

- Offsetting age mix and morbidity to some degree, we estimate that current provider reimbursement in the individual market is less, on average, relative to employer group coverage. Narrow network strategies that contribute to lower provider reimbursement are employed by insurers operating in the individual market far more often than in the employer group health benefits market.

- The employer group market is estimated to have approximately $15 billion in aggregate allowed medical costs, reflecting nearly 49% of medical cost expenditures.

[40] Summary Health Statistics, National Health Interview Survey 2017. Retrieved August 29, 2019, from http://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2017_SHS_Table_A-11.pdf.

INDIVIDUAL MARKET DETAIL

This section provides additional information related to enrollment, premiums, federal premium assistance, and benefit design selections for Colorado's individual market. For CFHC, Figure 11 provides additional detail is provided on persons purchasing coverage with an advanced premium tax credit (APTC) relative to those not receiving federal premium assistance (non-APTC).

FIGURE 11: COLORADO, 2019 INDIVIDUAL HEALTH BENEFITS MARKET PROFILE

SEGMENT	PERSONS	ANNUAL PER CAPITA PREMIUM	AGGREGATE PREMIUM ($ MILLIONS)	ANNUAL PER CAPITA APTC	AGGREGATE APTC ($ MILLIONS)
CONNECT FOR HEALTH COLORADO (EXCHANGE)	141,000	$7,775	$ 1,096.0	NA	NA
APTC	112,000	8,300	933.2	$6,700	$ 752.6
NON-APTC	29,000	5,700	162.8	NA	NA
OFF-EXCHANGE	55,000	6,000	389.3	NA	NA
GRANDFATHERED	21,000	6,550	140.6	NA	NA
TOTAL	**217,000**	**7,200**	**$ 1,565.6**	**NA**	**NA**

Notes:
1. Person estimates have been rounded to the nearest thousand. With the exception of aggregate premium and federal premium assistance, other values have been rounded to the nearest multiple of 25.
2. Estimates developed from August 2019 effectuated enrollment reports released by CMS and prior year insurer financial experience. Actual values are certain to vary from the estimates illustrated.

Individual market enrollment is estimated to relatively stable in 2019, with an estimated enrollment decrease from 2018 of 5,000 persons (222,000 to 217,000). Based on effectuated enrollment patterns in 2018 (the number of people paying premiums through the year) and open enrollment selection differences between 2018 and 2019, we estimate an average monthly CFHC enrollment of 141,000 persons in 2019, accounting for 65% of individual market enrollment.

Approximately 80% of consumers purchasing coverage through CFHC receive federal premium assistance. For 2019, we estimate the average annual financial assistance received by APTC-eligible consumers is $6,700, resulting in approximately $750 million in aggregate federal APTC expenditures. As individual market premiums have increased significantly in the last two years, this has resulted in greater levels of premium assistance being provided to Coloradans. From 2018 to 2019, we estimate that federal premium assistance expenditures increased by approximately $136 million ($616 million to $752 million). We believe this increase is largely attributable to the Colorado Department of Insurance permitting insurers to load for CSRs only on silver exchange coverage.[41] In the next section of this report, we model premium rates in the individual market that decrease significantly under a Public Option, depending on underlying provider reimbursement levels and morbidity improvements. This scenario would also result in a corresponding decrease in federal premium assistance expenditures.

SUMMARY

Colorado's individual market provides health benefits to persons without access to employer group or public program coverage. As Colorado has a robust employer group market and public programs, the number of persons covered by the individual market is estimated to represent only 4% of state residents. However, market enrollment may increase materially in periods of higher unemployment (similar to expectations for Medicaid enrollment).[42]

Federal premium assistance is estimated to be responsible for more than half of Connect for Health premium payment in 2019, with 80% of Connect for Health enrollees receiving APTCs. It is important to understand that for many consumers purchasing coverage in Connect for Health, out-of-pocket premiums are capped at levels far below the full premium rate, with the APTC making up the difference. The estimated average annual APTC value of $6,700 per capita is estimated to cover more than 80% of premium for subsidy-eligible enrollees and approximately 50% of total

[41] Colorado Department of Regulatory Agencies (October 4, 2018). Division of Insurance releases state's 2019 health insurance plans and premiums. Retrieved October 9, 2019, from https://www.colorado.gov/pacific/dora/news/division-insurance-releases-states-2019-health-insurance-plans-and-premiums.
[42] Kaiser Family Foundation (December 2011). Medicaid and the Uninsured: Changes in Health benefits Coverage in the Great Recession, 2007-2010. Retrieved March 4, 2019, from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8264.pdf (registration required).

ACA-compliant premiums (across subsidized and nonsubsidized enrollees). Therefore, State of Colorado initiatives, such as a Public Option, that have the effect of reducing individual ACA-compliant rates, have the indirect effect of reducing federal subsidies to the State of Colorado as well.

Among the uninsured population of approximately 476,000, we estimate less than 20% have incomes above 400% FPL and, therefore, do not qualify for federal premium assistance. In evaluating the impact of a potential Public Option on the state's uninsured rate, this higher-income population would receive the direct benefits of lower market premium rates.

5. PUBLIC OPTION RATE DEVELOPMENT SCENARIOS

We model the potential premiums and cost sharing based on the assumptions of provider reimbursement (as a percentage of Medicare) that a Public Option might obtain. The four scenarios assume underlying composite reimbursement (across professional and facility costs) of 100%, 120%, 150% and 180% of Medicare.

We start with plan designs for the lowest and second-lowest-cost silver (LCS and SLCS) and the lowest-cost bronze (LCB) plans in five Colorado counties for 2019. We chose counties that have a range of current underlying provider reimbursement and carrier participation as a Public Option will have disproportionate impacts based on these characteristics. Although open enrollment from these counties accounted for only 33% of total 2019 Connect for Colorado Health (CFHC) open enrollment,[43] we believe a composite of them to be a reasonable estimate for statewide impacts.

ASSUMPTIONS

Public Option assumptions

- **Provider reimbursement:** We assume, regardless of the form the Public Option might ultimately take, that the underlying provider reimbursement for Public Option plans, in order to be a viable competitive offering and provide significant savings to consumers, would need to be equal to or lower than what is currently obtained by the SLCS carrier on CFHC.

  To estimate the current level of reimbursement underlying the SLCS in each county (and hence the maximum level of reimbursement that the Public Option could have to achieve savings, all else equal), we started with provider reimbursement assumptions that are appropriate for the commercial employer group segment in Colorado. This assumption is based on Milliman analysis of the IBM Marketscan® database, proprietary Milliman claims databases, and publicly available data sources. We estimate that current provider reimbursement for non-prescription drug costs for the commercial employer group segment in 2019 ranges across the five Colorado counties from approximately 190% of Medicare to 250% of Medicare for facility and professional services combined. This is shown in line (A) in Figure 12 below.

  We further assume that the provider reimbursement underlying plans available on CFHC is better than standard commercial employer group reimbursement in certain counties. This is an assumption based on our experience and work with previous, similar studies in other states. We further assume that the degree of this favorability varies by county. Specifically, in rural counties where there is likely only one main health system, the incremental improvement in reimbursement for plans available on CFHC over employer group reimbursement is likely very small to non-existent (e.g., Gunnison County). However, in urban counties, such as Denver and Boulder, this incremental improvement could be material, as systems compete for CFHC membership. The assumed reimbursement for CFHC plans is shown in line (B) in Figure 12.

  Finally, we assume the Public Option will need to negotiate provider reimbursement rates that are not just lower than the average exchange reimbursement but also lower than the reimbursement of the carrier with the SLCS (and possibly LCS) rate in a county. It is likely that this reimbursement is lower than the average CFHC reimbursement, hence why that carrier is the SLCS.[44] However, in counties with only one or two carriers, these market dynamics would not hold and, therefore, no additional decrement is made (Gunnison) or a very small decrement is made (Mesa and Larimer).

  The final reimbursement that is assumed for the current SLCS plan is found in line (C) in Figure 12. This is the maximum reimbursement we assume a Public Option can pay providers in order to accomplish the policy goal of lowering gross (prior to application of federal premium subsidies) prices on CFHC.

[43] CFHC. By the Numbers: Open Enrollment Report, Plan Year 2019. Retrieved October 10, 2019, from https://s3.amazonaws.com/c4-media/wp-content/uploads/2019/03/C4HC_OpenEnrollmentReport_WebVersion.pdf.
[44] Other factors impacting premium rates may include underlying medical management efficiency, administrative costs, and degree of pricing conservatism.

FIGURE 12: ASSUMED REIMBURSEMENTS BY COUNTY IN BASELINE SCENARIO

	BOULDER (5 CARRIERS)	DENVER (6 CARRIERS)	LARIMER (3 CARRIERS)	MESA (3 CARRIERS)	GUNNISON (1 CARRIER)
(A) ESTIMATED COMMERCIAL REIMBURSEMENT	191%	197%	234%	229%	250%
(B) ESTIMATED CFHC AVERAGE REIMBURSEMENT	149%	154%	199%	206%	250%
(C) ESTIMATED SLCS CARRIER REIMBURSEMENT	134%	138%	189%	196%	250%

- **Qualified health plan (QHP) status:** We assume that the Public Option would be a QHP and offer its plans through CFHC. Both of these conditions would need to hold in order for the improvement in the cost of the SLCS (if any) to result in potential federal pass-through funding under a 1332 waiver.

- **Reinsurance:** We assume that, as a part of the ACA-compliant individual market, the Public Option would be eligible for payments under the state's reinsurance program that starts in 2020. We also assumed a uniform impact of the reinsurance program across regions and carriers.

- **Provider tolerance:** We discuss provider reactions to lower reimbursement in Section 9 but we note here that, while a 100% of Medicare scenario is modeled, this reimbursement level may not be feasible given the provider reactions and final reimbursement agreed to in Washington under Cascade Care.[45]

Modeling assumptions and methodologies

- **Model:** The Milliman Managed Care Rating Model (MCRM) was used to estimate underlying costs by inpatient, outpatient, and professional categories at current estimated provider reimbursement levels and under four different percentages of Medicare reimbursement: 100%, 120%, 150%, and 180%.

- **Demographics**: Demographic assumptions are based on CFHC's 2019 open enrollment statistics as reported in the State-Level Public Use File.[46] The average assumed age is 42 years old.[47]

- **Prescription drug costs:** We assumed no change in prescription drug (Rx) costs for Public Option plans.

- **Administrative expenses:** We assumed that administrative expenses, taxes, and profit built into CFHC plans are on average approximately 18% of current premiums. We further assume that the fixed portion of these expenses is approximately $55 per member per month (PMPM) and variable expenses are 5% of premium.[48]

  Note, these are industry average loads for administration and, therefore, represent the assumption that the Public Option will have no advantage or disadvantage in pricing due to administrative efficiency.

MODELING RESULTS

The average rate impact across the LCB, LCS, and SLCS by county and scenario is summarized in Figure 13.

[45] Cascade Care originally targeted 100% of Medicare reimbursement but ended up at 160%.
[46] CMS. 2019 Marketplace Open Enrollment Period Public Use Files. Retrieved October 10, 2019, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html.
[47] Note that a per capita premium using a population distribution with an average age of 42 will not be consistent with Connect for Health prices for a person 42 years old due to the nonlinear nature of the ACA age curve.
[48] Assumptions are reasonable pricing assumptions that likely produce an 80% or greater medical loss ratio (MLR) and do not reflect any specific carrier or the actual experience in the Colorado market.

FIGURE 13: ESTIMATED PRICE IMPACT OF MEDICARE REIMBURSEMENT ON CY2020 PREMIUM RATES BY COUNTY

County	180% OF MEDICARE	150% OF MEDICARE	120% OF MEDICARE	100% OF MEDICARE
Boulder	21.7%	5.6%	-9.6%	-19.1%
Denver	22.8%	5.8%	-10.2%	-20.3%
Larimer	-4.9%	-18.1%	-30.8%	-39.0%
Mesa	-8.1%	-20.1%	-31.6%	-39.0%
Gunnison	-25.0%	-35.1%	-44.6%	-50.7%
Composite	12.9%	-2.5%	-17.0%	-26.3%

Key observations from Figure 13 include:

- Within a reimbursement scenario (looking down the columns), premium rate impacts of each of the Medicare reimbursement scenarios vary by region based on our estimates of underlying SLCS reimbursement in that county (Figure 12).

Alternatively, a Public Option could contract with mandated reimbursement levels that are not uniform across the State of Colorado but vary by region. This would produce more uniform savings across regions. For example, the Public Option could contract at a 120% of Medicare in Denver County (to obtain a 12% premium savings) and 180% in Gunnison (to obtain a 15% savings).

- The overall impact on premium rates of Medicare reimbursement levels is dampened due to reimbursement changes not affecting pharmacy costs or fixed administrative expenses. We estimate pharmacy costs represent approximately 20% of incurred health care expenses for individual market coverage.

- In addition to these reimbursement impacts, we estimate that the Public Option rates may benefit from up to a 2% additional reduction due to improved morbidity in an individual market that contains the Public Option offering. The impact of morbidity improvement is not included in the values presented in Figure 13. Please see Section 8 for more discussion of morbidity impacts.

Summary

Individual rates for Public Option plans could be lower than 2020 levels in high-cost counties by 10% to 45% depending on the reimbursement levels that the Public Option obtains. In more urban counties, where there are more carriers and reimbursement is already at lower levels, the introduction of the Public Option is less likely to produce lower-priced options until very low Medicare reimbursement levels are assumed. Thus, the Public Option may be more valuable to non-subsidized consumers in rural counties where costs are high and carrier participation is lowest.

6. IMPACT TO INDIVIDUAL NON-PUBLIC OPTION PLANS

Our modeling assumes the Public Option, regardless of which form it takes, will be offered on Connect for Health Colorado (CFHC) and compete directly against existing QHPs currently offered by private carriers. Depending on the premium rate reduction resulting from the mandated reimbursement level associated with a Public Option, we believe market dynamics may render non-Public Option plans in the individual market unviable for many carriers.

The likelihood of this occurring is greatest in rating areas where underlying provider reimbursement is highest relative to Medicare (or other benchmarks), which is more likely to occur in rural markets from our experience. The market dynamics created by a Public Option that is priced lower than current carrier offerings are attributable to the ACA's premium subsidy structure, which exposes all consumers in the market (regardless of subsidy eligibility and income levels) to the full premium differential between the plan selected and the benchmark silver plan (SLCS).

To illustrate these effects, Figures 15 to 17 illustrate the change in net premium for a single, 40-year-old in Denver County in 2019 at varying household income levels under three purchasing scenarios:

1. The actual 2019 SLCS or subsidy benchmark premium available with a monthly premium of $439.35 or a $5,272 annual premium is purchased.

2. The Public Option plan becomes the subsidy benchmark plan and is purchased by the consumer.

3. The same plan that was purchased in scenario 1 (when it was the SLCS) is purchased but it is offered alongside a Public Option plan that has become the SLCS and, therefore, the subsidy benchmark plan.

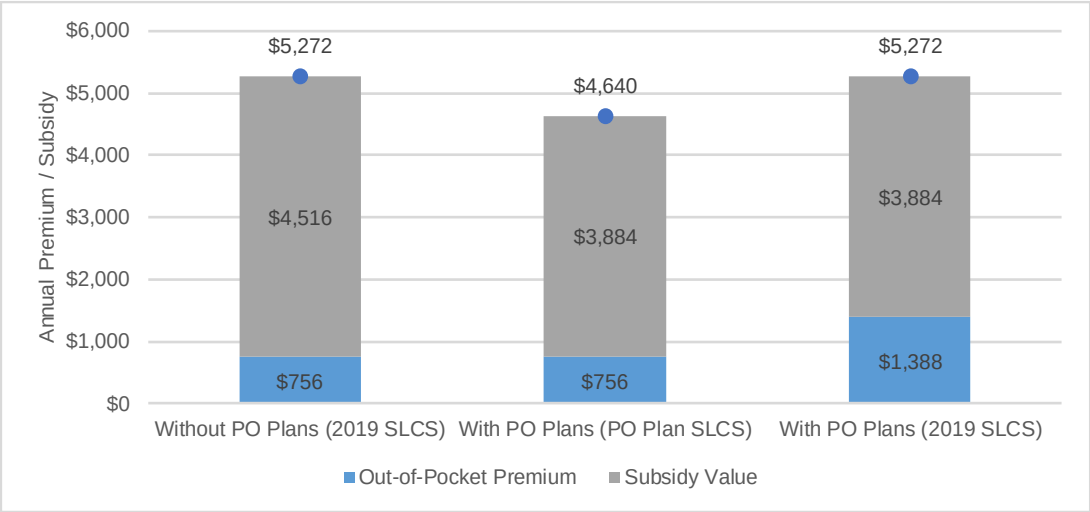
For the provider reimbursement reduction impact on Public Option gross premiums, we assume a premium rate decrease of 12%, reflecting percentage of Medicare reimbursement requirements between 120% and 150%. While we only reflect a single Public Option scenario in Figures 15 to 17, the conclusions made for it will hold true in all cases where the Public Option establishes a price advantage relative to existing QHPs.

- **Consumer 1, Income 150% FPL**: For low income consumers (generally income below 250% FPL), the out-of-pocket cost or net premium for the subsidy benchmark plan will not change, as it will remain capped at the maximum percentage of household income. However, to the extent a consumer wanted to remain in a non-Public Option plan, they would be required to pay the additional premium equal to the full differential between the Public Option plan and the non-Public Option plan. Figure 15 illustrates out-of-pocket premiums for the three purchasing scenarios described above for a single 40-year-old residing in Denver County with household income of 150% FPL.

  - The annual net premium for the subsidy benchmark plan is $756 under both scenarios 1 and 2. However, when the silver Public Option plan becomes the SLCS, the federal government's subsidy decreases from $4,516 to $3,884, as the subsidy value is equal to the difference between the total premium and the maximum the person must pay for the SLCS ($756).

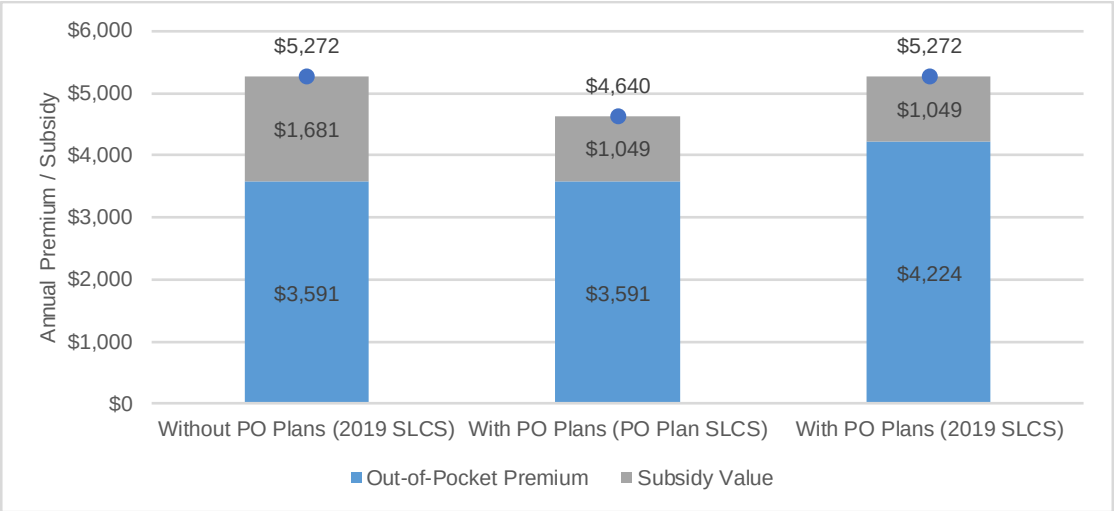
  - However, the cost to the consumer of the former subsidy benchmark plan under scenario 3 increases to $1,388, an 84% premium increase. To the extent the Public Option plan was even less expensive relative to the actual 2019 SLCS (a 12% premium differential is reflected in the illustrated modeling), the out-of-pocket premium change in this scenario would be even greater, as the value of federal premium assistance would be reduced further. Given the price sensitivity of low-income consumers, we estimate the non-Public Option plans that had a material price disadvantage would attract very little market share. As shown in Figure 10 above, we estimate 33% of individual market consumers have income below 250% FPL and would likely shift to Public Option plan coverage.

FIGURE 14: DENVER COUNTY, SINGLE 40-YEAR-OLD, HOUSEHOLD INCOME 150% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF PUBLIC OPTION PLANS 12% BELOW CURRENT SLCS



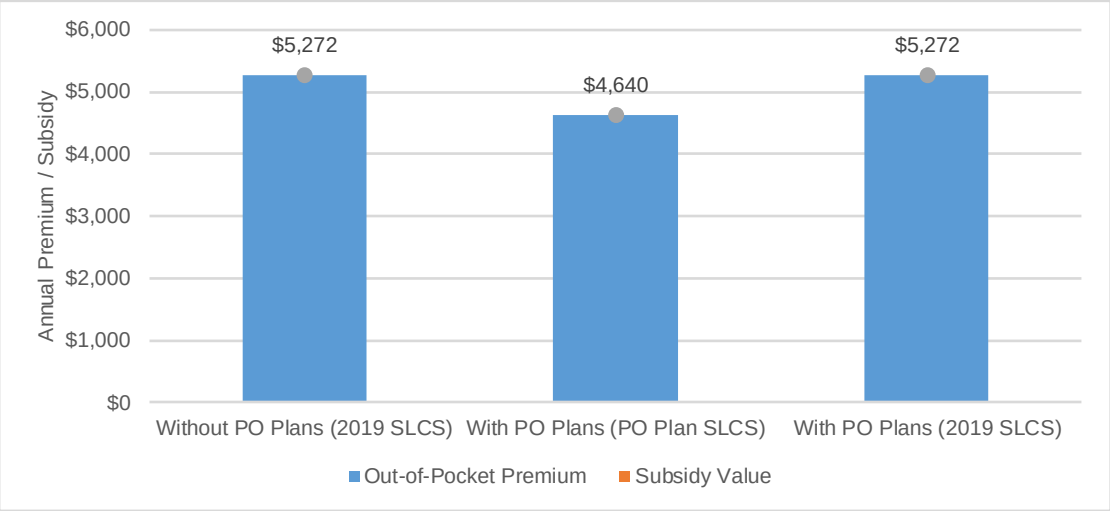
- **Consumer 2, 300% FPL:** For many middle-income consumers (between 250% FPL and 400% FPL) qualifying for lower amounts of federal premium assistance, market dynamics created by the Public Option may be similar to those experienced by consumers with income below 250% FPL. In Figure 15, a consumer with income at 300% FPL currently pays an annual net premium of $3,591 for the subsidy benchmark plan, receiving a premium subsidy value of $1,681 (reflecting a total premium of $5,272).
  - With the introduction of the Public Option plan, the annual premium for the subsidy benchmark plan drops from $5,272 to $4,640, reducing the subsidy value from $1,681 to $1,049. Note that, for some consumers at this income level, particularly young adults, a Public Option may reduce the subsidy value to $0. In these cases, the consumers would experience an out-of-pocket decrease for the SLCS plan, sharing in the premium savings with the federal government.
  - To the extent the consumer wanted to remain in the non-Public Option plan, that person would be required to pay a $4,224 annual out-of-pocket premium, approximately an 18% net premium increase.

FIGURE 15: STATE OF COLORADO, DENVER COUNTY, SINGLE 40-YEAR-OLD, HOUSEHOLD INCOME 300% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF PUBLIC OPTION PLANS 12% BELOW CURRENT SLCS



- **Consumer 3, 500% FPL:** For consumers with income above 400% FPL, the change in cost for the subsidy benchmark plan should equal the premium rate difference between the Public Option and non-Public Option plans. These consumers can benefit from the lower Public Option premium or choose to continue their current plans at no additional cost.

FIGURE 16: STATE OF COLORADO, DENVER COUNTY, SINGLE 40-YEAR-OLD, HOUSEHOLD INCOME 500% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF PUBLIC OPTION PLANS 12% BELOW CURRENT SLCS



The price sensitivity of individual market consumers is supported by CMS research on consumer price sensitivity. CMS reported 64% of individuals selecting a marketplace plan chose the LCS or SLCS plan in a metallic tier in 2014, with this figure reported at 47% for the 2015 coverage year.[49]

As discussed above, the premium rate differential between Public Option and non-Public Option plan options will likely vary across the state. Particularly in rural areas, existing provider reimbursement for CFHC coverage may be comparable to employer group market reimbursement, creating significant premium differential between Public Option and non-Public Option plan options. In urban areas, where a narrow network strategy is more feasible, existing provider reimbursement for marketplace coverage may be significantly less than employer group health benefits, reducing the premium differentials between the Public Option and non-Public Option plan options.

To the extent material network access differences exist between the Public Option plans offered through CFHC and non-Public Option plans offered both inside and outside of CFHC (with presumably broader provider access), it may be possible that a portion of the market will elect to remain enrolled in a non-Public Option plan. This may occur more frequently in urban areas where carriers have already likely developed narrow networks for plans offered through CFHC.

[49] HHS (October 30, 2015). Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace. Retrieved October 10, 2019, from https://aspe.hhs.gov/basic-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace.

7. EMPLOYER GROUP HEALTH BENEFITS MARKET DYNAMICS

With the Public Option creating a potential material premium rate decrease as a result of reduced provider reimbursement and improved morbidity of the risk pool (as well as the State's existing reinsurance program), premium rates for Public Option coverage may be lower relative to comparable benefit plans in the employer group health benefits market. The reduction in premium rates due to provider reimbursement requirements and morbidity improvements may offset the current estimated morbidity difference (15% to 20%) between individual and employer group health benefits markets. Therefore, at face value, Public Option plan premium rates may be less than employer group health benefits rates for comparable plan designs.

However, there are many other factors that employers may consider when assessing whether the lower-cost Public Option plan available on Connect for Health Colorado (CFHC) could be a viable alternative to traditional employer group health benefits. This section provides a summary of why offering employer group health benefits coverage is common among large employers, as well as an examination of how the potentially lower cost of Public Option plans, and changes in regulations governing HRAs, may result in the Public Option plan being viewed by some employers as a superior alternative to offering traditional employer group health benefits.

REASONS EMPLOYERS OFFER HEALTH BENEFITS

Motivations to offer health benefits vary by employer, particularly by size of firm (small group versus large group). However, generally, the following reasons have been broadly applicable since the introduction of employer-based health benefits coverage:

- **Attract and retain employees**. Health benefits are a major part of an employer's compensation strategy. A survey conducted by America's Health Insurance Plans (AHIP) found 56% of workers view health benefits as a key factor in remaining at their current jobs.[50]

- **Employee population health**. A health benefits plan may be used by an employer to reduce employee absenteeism and increase productivity.[51]

- **Tax exclusion**. Employer group health benefits are excluded from state and federal income for employees and payroll taxes for both employers and employees.[52] Therefore, particularly for high-wage earners, employer group health benefits represent a very tax-efficient means of employee compensation.

Additional factors that are now considered after implementation of the ACA and federal premium assistance in the exchanges include:

- **Lack of eligibility for federal premium assistance**. As illustrated in Figure 10 above, approximately 62% of Coloradans covered by an employer group health benefits plan have income above 400% FPL and, therefore, are not eligible for premium assistance. In the absence of eligibility for other types of coverage, it would be necessary to pay the full premium rate for individual market coverage with after-tax wages.

- **For employers in the large group market segment, the ACA's employer mandate**. Under the ACA, an applicable large employer, defined as 50 or more full-time employees (and full-time equivalents), must offer minimum essential health benefits coverage or pay a penalty of approximately $2,300 per full-time employee in 2019 (the first 30 full-time employees are exempted).[53] Additionally, the employer mandate penalties are not tax-deductible.

[50] AHIP (February 6, 2018). The Value of Employer-Provided Coverage. Retrieved October 10, 2019, from https://www.ahip.org/esi-survey/.
[51] Lofland, J.H. & Frick, K.D. (January 2006). Effect of health benefits on workplace absenteeism in the U.S. workforce. *Journal of Occupational and Environmental Medicine*. Retrieved March 4, 2019, from https://journals.lww.com/joem/Abstract/2006/01000/Effect_of_Health_Insurance_on_Workplace.2.aspx.
[52] IRS. Employee Benefits. Retrieved March 4, 2019, from https://www.irs.gov/businesses/small-businesses-self-employed/employee-benefits.
[53] IRS. Employer Shared Responsibility Provisions. Retrieved March 4, 2019, from https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions.

Based on Medical Expenditure Panel Survey (MEPS) data,[54] nearly all large employers in the state of Colorado (with 50 or more employees) offer health benefits. This observation has not changed with the introduction of CFHC and the availability of federal premium assistance beginning in 2014.
Small employers, however, offer traditional employer group coverage at far lower rates. MEPS data indicates that only 28% of Colorado state private sector establishments with fewer than 50 employees offered health benefits in 2017.[55] Some small employers contribute to the cost of individual exchange coverage for their employees, even though up until the passage of the 21st Century Cures Act and the establishment of the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), this was against the law and subject to fines of up $36,500 per year per employee.[56]

FACTORS EMPLOYERS CONSIDER WHEN OFFERING SPECIFIC COVERAGE

In a study sponsored by the U.S. Department of Labor,[57] the RAND Corporation found employers primarily select a health plan based on cost, defined by two measures:

- Provider discounts (including pharmacy costs)
- Administrative costs

These findings suggest that an employer may be open to alternatives to traditional employer group health benefits to the extent it results in cost savings to the organization. According to the U.S. Bureau of Labor Statistics, approximately 8% of 2018 compensation for civilian employees was related to health benefits.[58] Therefore, to the extent significantly more affordable options become available, it may allow an employer to materially reduce its employee benefit costs.

The RAND study also found that network adequacy was a major consideration for employers. To date, employers have been reluctant to offer narrow provider networks in employee health plan offerings. For example, the 2018 Kaiser Family Foundation Employer Health Benefits Survey indicated that only 6% of firms with 50 or more workers offered a narrow network plan.[59] The survey reported only 8% of employers had eliminated a hospital from their networks in the last year to achieve cost savings.[60]

A major contingency influencing employer take-up of Public Option plans, then, is the extent to which adequate networks can be built by participating Public Option carriers or by the stand-alone Public Option entity, especially considering the significant reductions in reimbursement underlying Public Option coverage compared to the reimbursement of coverage available on CFHC.

QSEHRA AND INTEGRATED INDIVIDUAL HRA AS ALTERNATIVES TO TRADITIONAL COVERAGE

Some employers have used health reimbursement arrangements (HRAs) as a means to supplement employer group health benefits coverage for their employees.[61] The following are key aspects of traditional HRAs, prior to recent legislative and regulatory developments:[62]

- An HRA must be funded solely by an employer
- Contributions made by an employer are excluded from an employee's gross income
- Reimbursements for qualified medical expenses from HRA funds are tax-free to the employee
- An employer may elect to carry over unused funds in the HRA to the following year(s)
- There is no limit on the amount of money an employer can contribute to the accounts
- The HRA must be offered in conjunction with other employer-provided health benefits

[54] HHS. Medical Expenditure Panel Survey. Retrieved October 6, 2019, from https://meps.ahrq.gov/.
[55] AHRQ. Table II.A.2: Percent of Private-Sector Establishments That Offer Health Insurance by Firm Size and State: United States, 2017. Retrieved October 10, 2019, from https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2017/tiia2.htm.
[56] Ibid.
[57] Mattke, S., Van Busum, K.R., & Martsolf, G. (2013). Final Report: Evaluation of Tools and Metrics to Support Employer Selection of Health Plans, Section 8.2. Retrieved March 4, 2019, from https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/evaluation-of-tools-and-metrics-to-support-employer-selection-of-health-plans.pdf.
[58] U.S. Bureau of Labor Statistics (December 14, 2018). Employer costs for employee compensation news release text. Retrieved March 4, 2019, from https://www.bls.gov/news.release/ecec.nr0.htm.
[59] Kaiser Family Foundation (October 3, 2018). 2018 Employer Health Benefits Survey, Figure 14.6. Retrieved March 4, 2019, from https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-section-14-employer-practices-and-health-plan-networks/.
[60] Ibid.
[61] The 2018 Kaiser Family Foundation Employer Health Benefits Survey indicates 7% of employers (sponsoring an employer group health plan) offer a high-deductible health plan with an HRA. Please see https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-8-high-deductible-health-plans-with-savings-option/ for more information.
[62] More information about HRAs from the IRS is available at https://taxmap.irs.gov/taxmap/pubs/p969-003.htm.

Prior to plan years beginning in 2020, federal regulation required HRAs to be offered in conjunction with a traditional employer group health plan. Following the passage of the ACA, the U.S Department of Labor ruled that offering employees cash specifically for the purchase of individual health insurance constituted an annual limit on health benefits, and thus would violate the prohibition on dollar-based annual coverage limits under the ACA. However, recent legislative and regulatory developments have modified the requirement for integrated group coverage for employers. These changes create alternatives to traditional group coverage with equivalent tax benefits for both employer and employee, while also fulfilling the ACA's employer mandate for large employers.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

The 21st Century Cures Act (Cures Act), enacted on December 13, 2016, created the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).[63] A QSEHRA allows an eligible small employer to reimburse an employee's medical expenses, including premiums for individual health benefits policies, so long as certain requirements are met:

- As with any HRA, the arrangement is funded solely by an eligible employer (an employee cannot make voluntary salary reduction contributions toward a QSEHRA).
- The amount of payments and reimbursements in the benefit year cannot exceed $5,150 for single coverage, or $10,450 for family coverage (2019 limits). Reimbursement limits are indexed each year.[64]
- The arrangement is generally provided on the same terms to all eligible employees of the eligible employer. Employers can vary contributions using the relevant ACA individual market age and family rating practices.
- The small employer must not offer a traditional group health plan to any of its employees.
- The employee must be covered by minimum essential coverage (which would include individual coverage, but would not include coverage under a short-term limited duration insurance plan).

Additionally, QSEHRA amounts can be supplemented by APTCs under certain conditions:

- The employee's net premium for self-only coverage for the SLCS after the self-only QSEHRA contribution must be above the APTC affordability threshold (9.78% of household income in 2020). The affordability threshold is indexed each year.
- For example, an employee with household income of $25,000 would not be eligible for an APTC to the extent that the post-QSEHRA out-of-pocket annual premium for the SLCS was less than approximately $2,500.
- If individual market coverage is deemed unaffordable with the QSEHRA, then the enrollee can receive an APTC. The normal APTC amount calculated based on the employee's household income as a percentage of FPL is reduced by the funds available within the QSEHRA.

Individual Integrated Health Reimbursement Arrangement (IIHRA)

In June 2019, the U.S. Departments of the Treasury, Health and Human Services (HHS), and Labor finalized new regulations to expand the usability of health reimbursement arrangements (HRAs). The proposed rule permits any employer to offer an HRA that can be used to purchase individual health insurance. An employer's group health plan must meet several conditions for the Individual Integrated HRA to qualify:[65]

- Individual employees (and their dependents) must be covered by an individual health benefits plan that meets minimum essential coverage requirements (i.e., IIHRA funds cannot be used for short-term limited duration coverage).

[63] IRS. Notice 2017-67: Qualified Small Employer Health Reimbursement Arrangements. Retrieved March 4, 2019, from https://www.irs.gov/pub/irs-drop/n-17-67.pdf.
[64] IRS. Rev. Proc. 2018-57: Tax Forms and Instructions. Retrieved March 4, 2019, from https://www.irs.gov/pub/irs-drop/rp-18-57.pdf.
[65] The full text of the final rule is available at https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans.

- Employees who are offered an IIHRA cannot be offered a traditional group health plan (and thus cannot be offered alongside an Excepted Benefits HRA).
- Employees in the same "employee class[66]" are offered an HRA on the “same terms.” Amounts can vary by employee age and family composition.
- Employees would have to be able to opt out of HRA coverage at least annually.
- Employees must substantiate coverage prior to receiving HRA reimbursements.

Unlike the QSEHRA, the employer can have a traditional group health plan along with an HRA offering, so long as no class of employees has access to both options at the same time. Therefore, employers could offer different reimbursement amounts or even different types of coverage to different classes of employees. Under the proposed rules, the following are examples of potential employer benefit offering scenarios:

- Full-time employees could be offered a traditional group plan and part-time employees an IIHRA, so long as the number of part-time employees meets the minimum class size requirement
- An IIHRA with one set of funding amounts could be offered to offices in one ACA rating area and with another set of funding amounts to offices in another ACA rating area

Although these offerings to various classes cannot be discriminatory, it is possible that large employers could establish business classes, such that certain groups of higher-cost individuals or groups of employees were offered HRAs, thereby removing them from employers’ risk pools (and lowering their costs) and moving them into the individual market risk pool.

In general, IIHRAs offer employers more segmenting flexibility than QSEHRAs. However, variations in contributions for age and family size are more of a mixed bag. QSEHRAs can vary contributions according to the exact age and family size combination of each employee, but only according to ACA rate variations that apply, while IIHRAs can apply any nondiscriminatory variation by family size, but can only account for the age of the employee. Additionally, IIHRAs do not have annual contribution maximums, unlike QSEHRAs.

Another key difference between IIHRAs and QSEHRAs relates to the determination of affordability. Affordability of a QSEHRA is determined relative to the second-lowest-cost silver plan, while affordability for an IIHRA would be evaluated against the lowest-cost silver plan instead. This difference can be significant in certain markets. Additionally, an individual who has access to a QSEHRA can still receive a supplementary APTC if coverage is unaffordable, while the employee must decline an unaffordable IIHRA to be eligible for APTC.

Overall, these new regulatory developments, along with the potential for lower-priced Public Option plans with broad eligibility, have the potential to change the employer health benefit landscape in the State of Colorado. By providing large employers (fully insured or self-funded) a legal and tax-efficient vehicle to make cash contributions toward individual market health benefits, it is possible that some employers will elect to forgo traditional group health benefit plan offerings, especially if Public Option plan coverage costs are less relative to traditional employer group coverage.

SUMMARY

Employer group health benefits is an important part of Colorado’s healthcare landscape and most employees are satisfied with their coverage under traditional health plans.[67] However, because cost is a critical consideration for employers, they could view lower-cost Public Option plans as a viable option provided they offer:

- A similar ability to attract and retain employees as current employer group health plans

[66] Classes include full-time employees (EEs), part-time EEs, salaried EEs, non-salaried EEs, EEs whose primary site of employment is in the same rating area, seasonal EEs, EEs covered by a collective bargaining agreement, EEs who have not satisfied a waiting period for coverage, non-resident aliens with no US-based income, and EEs who are provided by a staffing agency that is the actual employer. Combinations of the above classes are also acceptable. However, employers must meet minimum class sizes for classes offered IIHRAs if the employer offers an IIHRA to one class and a traditional group health plan to another class.
[67] AHIP, op cit.

- A contribution strategy that is similar to the current employer group health plan subsidy, funding an equivalent (or better) level of benefits
- Employee access to a similar level of benefits relative to the current employer group health plan available to them
- A tax-equivalent vehicle for funding costs
- Compliance with the ACA's employer mandate for large employers
- Adequate network breadth and provider access similar to the employees' current employer group health plan[68]

We summarize these considerations in Figure 17 and we discuss how these dynamics influence estimates of employer group take-up rates into Public Option plans in the next section.

FIGURE 17: SUMMARY OF EMPLOYER MOTIVATIONS TO MOVE TO INDIVIDUAL MARKET VIA HRA

CONSIDERATION	LARGE EMPLOYER	SMALL EMPLOYER	COMMENTS
ATTRACT AND RETAIN	+/-	+/-	Contingent upon public perception of Public Option plans, likely to vary significantly by employer
LOWER PRICE	+	+	Will vary by area
NETWORK ADEQUACY	+/-	+/-	Contingent on Public Option carrier's ability to contract
BENEFIT RICHNESS	-	+	No platinum-level benefits on CFHC for some large employers
RATING RULES (3:1 AGE LIMITS)	-	NA	Age rating limits on CFHC a disadvantage for large groups with disproportionate share of younger employees
TAX BENEFITS	+/-	+/-	Both QSEHRA and IIHRA offer tax advantages
FULFILL EMPLOYER MANDATE	+/-	NA	Mandate does not apply to employers under 50 lives

Note: A "+" indicates a factor that could motivate an employer to shift employees to the Public Option, "-" is a factor that may prevent shifting to the Public Option, and "+/-" represents an undetermined or neutral consideration.

[68] Larger employers tend to value broad networks. See Kaiser Family Foundation (October 3, 2018). 2018 Employer Health Benefits Survey, Figure 14.6. at https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-section-14-employer-practices-and-health-plan-networks/.

8. PUBLIC OPTION PLAN TAKE-UP RATES AND IMPACT TO PROVIDER REIMBURSEMENT

BACKGROUND

We modeled the potential impact of various Public Option plan take-up rates by commercial market segment (employer group, individual, and uninsured) to quantify the impact on the medical (non-pharmacy) revenues of Colorado providers. The reduction in provider revenue is a result of persons shifting from higher provider reimbursement market segments (e.g., the employer group market) to the lower reimbursement Public Option plans, partially offset by reductions to uncompensated care from decreases to the uninsured population. Therefore, changes in provider revenue are directly correlated with Public Option plan take-up.

Based on these projected movements and the resulting provider revenue reduction, we calculated the "cost-shift" percentage, which represents the incremental provider reimbursement increase to the employer group market that could result in a complete offset to the revenue loss caused by shifts to various percentages of Medicare reimbursement under the Public Option plans. Note that we believe it unlikely that cost shifting could occur in public health benefits programs (Medicare, Medicaid) due to the assumption that provider reimbursement is largely tied to Medicare or state Medicaid fee schedules.

We emphasize that while cost shifting to the employer group market is one possible response by providers, there are other strategies that may be used by them to compensate for revenue reductions. Moreover, market dynamics between payers and providers may only allow varying amounts of this cost shift to actually occur. Further discussion of provider responses to lower reimbursement under Public Option plans is found in Section 9 below.

PUBLIC OPTION PLAN TAKE-UP RATES

As each health benefits market segment has different demographic profiles, motivations, and purchasing habits, the market dynamics that influence overall take up rates are discussed below.

Individual market

As mentioned earlier, individual health benefits purchasers are primarily price-driven. Therefore, we assume that, for comparable benefits and reasonable network access, consumers will readily switch to Public Option plans. Exchange consumers generally are likely acclimated to narrow networks in the current exchange markets. To the extent that plans experience provider contracting difficulties under the Public Option due to lower reimbursement, consumers may be more accepting of provider access limitations, particularly if there are significant premium cost differences between Public Option plans and non-Public Option plans.

We assume no changes to the ACA's premium subsidy structure. It is anticipated that Public Option plans will become the "subsidy benchmark plan" or SLCS, as well as the LCS offered through Connect for Health Colorado (CFHC) in each geographic area. As illustrated in Section 6 of this report, while subsidy-eligible consumers could continue to purchase non-Public Option plans, consumers will be exposed to the plan's full premium difference relative to the Public Option plan. Therefore, to the extent a Public Option is introduced with meaningful price advantages relative to existing carriers, we estimate significant Public Option plan take-up during the first year it is offered.

Fully insured small groups

Only an estimated 27.6% of Colorado state private sector establishments with fewer than 50 employees currently offer health benefits to their employees.[69] Small employer groups that currently either offer transitional small group plans or ACA-compliant plans may have some incentive to move to Public Option plans due to lower price. Small employers, like individuals, are also price-sensitive and, assuming that both silver and gold level of benefits would be available under Public Option plans, small groups could receive a level of benefits comparable to their current plans and at potentially lower prices. Small employers may also be less averse to narrow networks, which are common on exchanges and could be a part of Public Option plans due to contracting challenges.

Given the past history of small employers contributing funds toward the cost of exchange coverage even when illegal, it is reasonable to assume that this practice will continue and expand with the introduction of QSEHRAs and, likely to

[69] AHRQ. Table II.A.2, op cit.

a smaller degree, the IIHRA introduced by the Trump administration (both would be available to small employers). These HRAs provide legal avenues for employers to establish alternative means of coverage for their employees on the individual market by making contributions both legal and tax-favored. Small employers *not* currently offering health benefits could now also use an HRA to reenter the employee health benefits market and adopt defined contribution approaches to health benefits offerings that are affordable for them. This may result in a reduction in Colorado's uninsured population.

For these reasons, the Public Option plan take-up assumptions for small groups are less than for individuals but more than the for the large group market. While employees of at least some of the employers not offering coverage are already purchasing coverage in the individual market, Public Option plan enrollment may occur from a portion of the approximately 70% of small employers that do not offer any coverage at all and are not captured in the small group enrollment numbers shown in Figure 8 above. We account for this potential enrollment by having slightly higher migration assumptions than we otherwise would.

The migration of fully insured small groups to the individual market could have a favorable impact to Public Option plan rates, given that the morbidity level in the small group market is estimated to be 15% to 20% lower relative to the individual market. If small employers with ACA-compliant coverage move employees into Public Option plans on CFHC, they will most likely move their entire groups. First, if a QSEHRA were used, the small employer could not offer traditional group benefits to any employee. Second, there is little motivation to move only certain employees to Public Option plans (such as the less healthy) via an IIHRA because health status rating is not permitted in the ACA-compliant small group market.

However, small employers that fund their current group health plans through self-funded or level-funded[70] arrangements might be motivated to offer an HRA to certain classes of employees to remove them from the group's risk pool, thereby directly reaping the benefits of improved overall medical costs. Self-funded small groups are considered in the self-insured market discussion below.

Large group fully insured and self-insured

Consistent with the previous section on employer group health benefits dynamics, we would generally assume no take-up from the large group employer market (either fully insured or self-insured) into Public Option plans in the absence of the IIHRA, for the following reasons:

- Large employers appear to have greater motivation to provide traditional employer group coverage and employees are generally satisfied with that offering.
- The termination of a group health plan would lessen the perceived ability for many employers to attract and retain employee talent. Even with the availability of the IIHRA to large employers, employee recruitment and retention will be a primary factor in maintaining traditional group coverage.

However, rules related to the IIHRA are finalized and these HRAs are now available to large employers. This means that they could opt to establish what amounts to a defined contribution approach to their health benefit plans. They could legally contribute to an employee's IIHRA to purchase a potentially lower-cost Public Option plan on CFHC. Moreover, if Public Option plans offer adequate networks and comparable benefits, there may be less risk of employee dissatisfaction.

For these reasons, we project in three of our four scenarios at least some take-up into Public Option plans by the large group segment and in both the medium and high scenarios for the self-insured segment, with take-up rates greater for the fully insured large group segment relative to the self-funded segment. Based on insurer financial data, the average fully insured large employer has approximately 180 insured employees, while self-funded groups have an average of more than 1,000 employees covered. Therefore, at the low end of the fully insured large group market, employer behavior under a Public Option may have more parallels with small employers, given that the IIHRA is now available to subsidize the purchase of individual market coverage.

Note, while not inherently considered in our modeling, we would anticipate that any employer migration to a defined contribution approach through an IIHRA would gradually occur over several years (5+ years).[71] Before terminating

[70] Level-funded products are a form of self-funding for small groups. Small employers who purchase them are contained in the self-funded lines of Figures 8 and 11.
[71] A defined contribution reflects an employer contributing a set amount of money (e.g., percentage of salary) towards a health benefits benefit. The contribution is not tied directly towards the cost of the benefit.

traditional employer group health benefits coverage, Public Option plans would need to have a favorable public perception in terms of provider access, ease of enrollment, and premium payment, as well as benefit design choices.

Uninsured

The impact of a Public Option on the uninsured population will most likely vary significantly by income level. In Section 4 of this report above, we provide estimates of the uninsured population by income level. Approximately 60% of uninsured Coloradans have incomes below 250% FPL, with the remaining 40% split almost evenly between the 251% FPL to 400% FPL and 400%+ FPL cohorts. In assessing the potential reduction to the statewide uninsured rate from the Public Option, consideration should be given to out-of-pocket premium rate impact to each income cohort and the relative size of the uninsured population within each income cohort. These effects are similar in nature to the out-of-pocket premium changes estimated for persons currently in the individual market with the same respective household incomes.

Household income below 250% FPL, premium rate savings retained by federal government

Lower-income households purchasing health benefits coverage in CFHC are currently receiving significant federal premium assistance. The value of the premium assistance caps out-of-pocket premium expenditures at a specified percentage of household income.

- We estimate that premium rates for Public Option plans will remain above the out-of-pocket premium limits, with out-of-pocket premiums for the vast majority of households at these lower income levels not changing.
- However, as previously discussed, the federal government will accrue savings from a reduction in premium subsidy costs.

Household income between 250% FPL and 400% FPL, premium rate savings shared between consumers and federal government

Consumers at this higher income level are still eligible for federal premium assistance for coverage purchased through CFHC. However, the value of premium assistance is significantly lower relative to lower income levels.

- Depending on the magnitude of premium rates decreases associated with the Public Option, some consumers in this income cohort will no longer receive premium assistance, as the cost of the SLCS plan may be below the limit specified by the ACA's premium subsidy formula.
- However, despite not being eligible for premium assistance for this reason, these consumers may have a lower out-of-pocket premium rate as the full premium rate of the Public Option plan may be less than the current subsidized premium for a non-Public Option plan. This is most likely to occur for young adults in this income cohort.
- As the federal government will no longer be providing premium assistance or providing a lower subsidy amount per capita, it will share in the Public Option plan premium savings with consumers in this income cohort.
- For some consumers in this income cohort, particularly adults approaching age 65, the premium rate for the SLCS plan will still be high enough to trigger federal premium subsidy payments. The federal government will accrue the full savings from the Public Option plans for these consumers.

The out-of-pocket premium rate changes for this income cohort will be mixed, with some consumers (particularly younger adults with higher incomes currently receiving limited premium subsidies) realizing direct premium rate savings from Public Option plans, while other consumers (older adults, particularly those with lower incomes) may not experience reductions in out-of-pocket premium rates. While we estimate that lower out-of-pocket premium rates for some consumers in this income cohort will reduce the state's uninsured rate, the impact will be muted relative to the population with income above 400% FPL that is currently not eligible for premium assistance.

Household income above 400% FPL, premium rate savings retained by consumers

The impact to consumer premium rates as a result of the introduction of Public Option plans is most straightforward for the income cohort above 400% FPL. These consumers do not qualify for premium assistance under the ACA and will realize the full premium rate reduction from the introduction of the Public Option plans.

IMPACT TO PROVIDER REIMBURSEMENT: PUBLIC OPTION MIGRATION SCENARIOS

Based on assumptions about general market dynamics resulting from the Public Option described in the above discussion, we modeled four market shift scenarios, as shown in Figure 18. These percentages, applied to baseline enrollment estimates, represent the portion of each market segment that is estimated to transition to a Public Option plan under the Public Option. These estimates reflect long-term (3-5 years) migration impacts. While we believe the majority of migration to Public Option plans in the individual market will occur immediately upon implementation, migration from the employer market (if it occurs) is more likely to happen gradually over the course of several years.

FIGURE 18: ASSUMPTIONS OF MIGRATION TO PUBLIC OPTION PLANS BY MARKET SEGMENT AND UNINSURED

SCENARIO	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	SELF-INSURED LARGE GROUP	UNINSURED
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
SCENARIOS A: LOW ENROLLMENT SHIFT – 180% OF MEDICARE	10%	0%	0%	0%	2%
SCENARIO B: MEDIUM ENROLLMENT SHIFT – 150% OF MEDICARE	30%	10%	5%	5%	5%
SCENARIO C: HIGH ENROLLMENT SHIFT – 120% OF MEDICARE	85%	15%	10%	7%	7%
SCENARIO D: EXTRA HIGH ENROLLMENT SHIFT – 100% OF MEDICARE	100%	20%	15%	10%	10%

Figure 19 illustrates the baseline 2019 medical revenue—excluding prescription drugs and long-term services and supports (LTSS)—for each market segment, prior to any migration that is assumed to be caused by the introduction of Public Option plans (the development of these estimates is provided in Figure 11 of this report above). Additionally, we provide the estimated payment index for each market, which reflects the estimated relative provider reimbursement compared to the employer group markets (shown as 100%). For example, the payment index for the individual market is 82%, which indicates the estimated provider reimbursement in the market is approximately 18% less than the employer group markets. We exclude prescription drugs for all segments because these costs are not affected by Medicare fee-for-service reimbursement. We also estimate the portion of Medicaid and Medicare costs attributable to LTSS (nursing facility and waiver services) and exclude those costs, as well.

Uninsured revenue is assumed to be the portion of revenue actually collected by providers directly from the patient.

FIGURE 19: COLORADO ESTIMATED 2019 PAYMENT INDEX, MEDICAL MEMBERSHIP, AND ALLOWED CLAIMS DISTRIBUTIONS BY MARKET SEGMENT

MARKET SEGMENT	PERSONS	ASSUMED PAYMENT INDEX	ESTIMATED PROVIDER MEDICAL REVENUE ($ BILLIONS)	PERCENTAGE OF TOTAL MEDICAL REVENUE
INDIVIDUAL	217,000	82%	$1.4	4.7%
SMALL GROUP	299,000	100%	$1.5	5.0%
LARGE GROUP	679,000	100%	$3.4	11.3%
SELF-FUNDED	1,936,000	100%	$9.7	32.3%
MEDICAID	1,199,000	40%	$5.0	16.7%
MEDICARE	741,000	47%	$6.4	21.3%
DUALS	83,000	47%	$1.4	4.7%
OTHER	155,000	100%	$0.8	2.7%
UNINSURED	476,000	26%	$0.4	1.3%
TOTAL	5,785,000	74%	$30.0	100.0%

Based on the interaction of the market enrollment shifts illustrated in Figure 19 above and the estimated provider reimbursement levels in each market, we modeled the net change in provider revenue under the Public Option for the four take-up scenarios. Additionally, we modeled the necessary cost shift (increase in provider reimbursement) to the residual employer group market to completely offset the provider revenue loss under the Public Option. For example, if the provider revenue reduction were estimated at $300 million prior to cost shifting, we assumed the employer group market would absorb a $300 million provider revenue increase to result in provider revenue neutrality under the Public Option.

As noted in Section 9, cost shifting is one of many possible provider responses to the Public Option. The cost shift estimates reflected in the four scenarios reflect providers only cost shifting in response to the Public Option. Therefore, cost shifting estimates illustrated in the four scenarios should be considered maximum estimates to employer group reimbursement. Particularly under the high and extra-high take-up scenarios, it is unlikely the employer market would be able to absorb the full cost increase and thus providers would need to take other actions to offset the reductions and may not be able to offset 100% of the reduction.

Public Option at 180% of Medicare: Low take-up scenario

Figure 20 illustrates the estimated Public Option plan enrollment and associated provider revenue impacts under the low take-up scenario. Figure 20 provides the following information for the commercial markets (employer group and individual) and the uninsured population:

- **Baseline membership in each market:** The 2019 estimated enrollment by market, taken from Figure 8.
- **Percentage of market enrolling in Public Option plans:** This reflects the estimated proportion of baseline enrollment in each market assumed to migrate to Public Option plans.
- **Market enrollment shifting to Public Option plans:** This reflects the estimated number of individuals in each market assumed to migrate to Public Option plans, calculated as the baseline membership in each market multiplied by the percentage of market shifting to Public Option plans.
- **Cumulative Public Option plan membership:** From left to right, these values represent the cumulative Public Option membership as membership from each market migrates. In Figure 20, under the Individual column, enrollment of 21,700 is shown, which reflects 10% of the baseline enrollment of 217,000 shifting to Public Option plans. For this scenario we assume that 0% of the small group market baseline enrollment of 299,000 will shift to Public Option

plans. This enrollment is added to the individual market Public Option plan enrollment, resulting in a cumulative enrollment value of 21,700 for Public Option plans in this scenario. For other scenarios where the percentage of small group market shifting to the Public Option is not zero, this will be a different value, higher than the previous one. The Public Option plan enrollment migration estimates continue from left to right in Figure 20. As the cumulative Public Option plan enrollment changes from 21,700 to 31,200 for the uninsured population, this indicates an assumption of 9,500 currently uninsured persons purchasing Public Option plans. The 9,500 value is 2% of the total uninsured population but equivalent to approximately 10% of the uninsured population with income above 400% FPL (as shown in Figure 10 above).

- **Cumulative total medical revenue impact:** Based on the market migration and estimated provider reimbursement relativities, this line item represents the cumulative aggregate provider medical revenue under the Public Option. In a manner identical to the Cumulative Public Option Membership line item, the values represent the cumulative effect of Public Option plan migration by market. For example, we estimate a provider medical revenue *decrease* of $34 million from individual market migration. We assume previously uninsured persons purchasing Public Option plans will increase provider medical revenue by $150 million (through a combination of additional services and higher reimbursement), resulting in a final cumulative provider revenue increase of $116 million.

- **Cumulative total medical revenue impact, % of total baseline revenue:** In addition to illustrating the provider revenue impact in millions of dollars, we also give the provider revenue change as a percentage of the baseline medical revenue estimate of $30.0 billion. The cumulative $116 million net provider revenue increase represents a 0.4% increase in provider revenue relative to the aggregate baseline value. In other scenarios, this will be a reduction in revenue and hence a negative percentage.

- **Remaining employer group only medical revenue base ($ millions):** Based on the cumulative migration to Public Option plans across each market, this value represents the remaining residual provider revenue base derived from the employer group market. For the Individual column, the value of $14.6 billion is equal to the baseline value for the Employer Group illustrated in Figure 11. The value is the same under the small group column because no small group membership is assumed to move to the Public Option in this scenario. However, other scenarios reflect reductions in provider medical revenue resulting from small group migration to Public Option plans.

- **Remaining employer group only medical revenue base, % of total baseline revenue:** These values represent the estimated residual provider revenue derived from patients in the employer group market relative to the total baseline medical revenue estimate of $30 billion. Based on cumulative Public Option plan migration across markets, providers' medical revenue derived from patients in the employer group market is estimated to be reduced in all other scenarios.

- **Cost shift for budget neutrality:** Finally, we illustrate the increase in revenue associated with patients with employer group coverage that would completely offset the reduction in revenue resulting from Public Option plan migration.

FIGURE 20: CUMULATIVE ENROLLMENT AND PROVIDER REVENUE IMPACTS: 180% OF MEDICARE AND LOW PUBLIC OPTION ENROLLMENT

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS) **$30.0 BILLION**

MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
PERCENTAGE OF MARKET SHIFTING TO PUBLIC OPTION	10%	0%	0%	0%	2%
MARKET ENROLLMENT SHIFTING TO PUBLIC OPTION	21,700	-	-	-	9,500
CUMULATIVE PUBLIC OPTION MEMBERSHIP	21,700	21,700	21,700	21,700	31,200
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$34	-$34	-$34	-$34	$116
% OF TOTAL BASELINE REVENUE	-0.1%	-0.1%	-0.1%	-0.1%	0.4%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$14,600	$14,600	$14,600	$14,600	$14,600
% OF TOTAL BASELINE REVENUE	48.7%	48.7%	48.7%	48.7%	48.7%
(C) = (A) / (B) PROVIDER REVENUE NEUTRAL COST SHIFT	0.2%	0.2%	0.2%	0.2%	-0.8%

Public Option at 150% of Medicare: Medium take-up scenario

Figure 21 illustrates the estimated Public Option plan enrollment and associated provider revenue impacts under the 150% of Medicare reimbursement level and medium Public Option take-up scenario. Under this scenario, there are almost 250,000 members in Public Option plans. Provider revenue declines by $373 million from shifts to Public Option plans but is offset by approximately $310 million when additional uninsured enter the market. The net provider medical revenue loss of $63 million is then shifted to the remaining employer group market revenue base of approximately $13.8 billion, resulting in a cost shift of 0.5%.

FIGURE 21: CUMULATIVE ENROLLMENT AND PROVIDER REVENUE IMPACTS: 150% OF MEDICARE AND MEDIUM PUBLIC OPTION ENROLLMENT

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS) **$30.0 BILLION**

MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
PERCENTAGE OF MARKET SHIFTING TO PUBLIC OPTION	30%	10%	5%	5%	5%
MARKET ENROLLMENT SHIFTING TO PUBLIC OPTION	65,100	29,900	34,000	96,800	23,800
CUMULATIVE PUBLIC OPTION MEMBERSHIP	65,100	95,000	129,000	225,800	249,600
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$140	-$182	-$232	-$373	-$63
% OF TOTAL BASELINE REVENUE	-0.5%	-0.6%	-0.8%	-1.2%	-0.2%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$14,600	$14,500	$14,300	$13,800	$13,800
% OF TOTAL BASELINE REVENUE	48.7%	48.2%	47.7%	46.0%	46.0%
(C) = (A) / (B) COST SHIFT FOR REVENUE NEUTRALITY	1.0%	1.3%	1.6%	2.7%	0.5%

Public Option at 120% of Medicare: High take-up scenario

Figure 22 illustrates the estimated Public Option plan enrollment and associated provider revenue impacts under the high take-up scenario. Under this scenario, Public Option prices are even lower and almost 500,000 persons migrate to Public Option plans. Provider revenue declines by $919 million from shifts to Public Option plans, but is offset by approximately $341 million from previously uninsured persons purchasing coverage. The net loss of $578 million in provider revenue is then shifted to the remaining employer group market revenue base of $13.4 billion. Note that the employer group revenue base for the high scenario is smaller than the medium scenario. The combination of the smaller residual employer group revenue base and larger provider revenue reduction from Public Option plan migration, creates a compounding effect on the cost shift percentage. Thus the ultimate cost shift for revenue neutrality is 4.3%

FIGURE 22: CUMULATIVE ENROLLMENT AND PROVIDER REVENUE IMPACTS: 120% OF MEDICARE AND HIGH PUBLIC OPTION ENROLLMENT

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$30.0 BILLION				
MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
PERCENTAGE OF MARKET SHIFTING TO PUBLIC OPTION	85%	15%	10%	7%	7%
MARKET ENROLLMENT SHIFTING TO PUBLIC OPTION	184,500	44,800	67,900	135,500	33,300
CUMULATIVE PUBLIC OPTION MEMBERSHIP	184,500	229,300	297,200	432,700	466,000
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$383	-$477	-$625	-$919	-$578
% OF TOTAL BASELINE REVENUE	-1.3%	-1.6%	-2.1%	-3.1%	-1.9%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$14,600	$14,400	$14,000	$13,400	$13,400
% OF TOTAL BASELINE REVENUE	48.7%	48.0%	46.8%	44.6%	44.6%
(C) = (A) / (B) COST SHIFT FOR REVENUE NEUTRALITY	2.6%	3.3%	4.5%	6.9%	4.3%

Public Option at 100% of Medicare: Extra-high take-up scenario

Analysis similar to the previous paragraphs can be done on the final scenario shown in Figure 23. For clarity, we note, a 100% of Medicare scenario may not be realistic. We display it here because other public options (such as Washington State's Cascade Care program) started with this assumption. Analysis done by the REMI Partnership[72] appears to assume this level of reimbursement, as well.

FIGURE 23: CUMULATIVE ENROLLMENT AND PROVIDER REVENUE IMPACTS: 100% OF MEDICARE AND VERY HIGH PUBLIC OPTION ENROLLMENT

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$30.0 BILLION				
MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
PERCENTAGE OF MARKET SHIFTING TO PUBLIC OPTION PLANS	100%	20%	15%	10%	10%
MARKET ENROLLMENT SHIFTING TO PUBLIC OPTION	217,000	59,800	101,900	193,600	47,600
CUMULATIVE PUBLIC OPTION MEMBERSHIP	217,000	276,800	378,700	572,300	619,900
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$578	-$731	-$1,003	-$1,514	-$1,115
% OF TOTAL BASELINE REVENUE	-1.9%	-2.4%	-3.3%	-5.1%	-3.7%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$14,600	$14,300	$13,800	$12,800	$12,800
% OF TOTAL BASELINE REVENUE	48.7%	47.8%	46.0%	42.8%	42.8%
(C) = (A) / (B) COST SHIFT FOR REVENUE NEUTRALITY	4.0%	5.1%	7.3%	11.8%	8.7%

INDIVIDUAL MARKET MORBIDITY CHANGES

The premium changes shown above in Section 5 isolate the impact of reimbursement and do not include any potential morbidity effects of migration from small group and large group markets or from the uninsured into the Public Option. It is reasonable to assume that employers may have interest in allowing employees access to the potentially lower costs of a Public Option through tax-enabling vehicles, such as the IIHRA and the QSHERA, described earlier. Employer group markets tend to be healthier than the individual market because employees have to maintain reasonable health status in order to work and because carriers typically enforce a minimum percentage of employees who must be enrolled in the plan. This helps ensure a balanced cross-section of risk in each employer group.

[72] REMI Partnership, op cit.

By contrast, the individual market is the market of last resort and individual consumers may choose to enroll when they anticipate the need for services. The uninsured also tend to be healthier than those in the individual insured market, particularly at higher incomes because, for the reverse reason, they will choose to "self-insure" when they are healthy.

We estimate the favorable effects of these dynamics for the employer group market and the uninsured population by normalizing composite per capita allowed amounts derived from Figure 11 above for differences in estimated provider reimbursement levels and age differences, thereby isolating differences in morbidity between markets. We then calculate the impact of migration from employer group markets and the uninsured over to individual (using the migration scenarios outlined in Figure 18 of this report above). The results of this analysis are summarized in Figure 24.

FIGURE 24: CUMULATIVE MORBIDITY IMPACT OF EMPLOYER GROUP AND UNINSURED MIGRATION TO INDIVIDUAL SEGMENT

MIGRATION / REIMUBURSEMENT SCENARIO	BASELINE INDIVIDUAL MARKET	AFTER SMALL GROUP MIGRATION	AFTER LARGE GROUP MIGRATION	AFTER SELF-INSURED MIGRATION	AFTER UNINSURED MIGRATION
SCENARIOS A: LOW ENROLLMENT SHIFT – 180% OF MEDICARE	0.0%	0.0%	0.0%	0.0%	-1.3%
SCENARIO B: MEDIUM ENROLLMENT SHIFT – 150% OF MEDICARE	0.0%	-2.6%	-3.0%	-3.9%	-3.9%
SCENARIO C: HIGH ENROLLMENT SHIFT – 120% OF MEDICARE	0.0%	-1.6%	-2.2%	-3.1%	-3.2%
SCENARIO D: EXTRA HIGH ENROLLMENT SHIFT – 100% OF MEDICARE	0.0%	-1.8%	-2.4%	-3.3%	-3.4%

Figure 24 illustrates that by adding members to the individual market from employer group markets and the uninsured population, the acuity of the individual market is reduced in all scenarios relative to the baseline.

However, these estimates should be dampened as we anticipate there could be some anti-selective behavior on the part of large groups related to IIHRA offerings. It is conceivable, although against regulations, that employers would seek to make HRA offerings to certain classes of employees that are higher-cost, thereby moving them out of the traditional employer group health plan and improving the employer's risk pool while worsening the individual pool. Offsetting this to some degree is the additional premium that will be realized as younger uninsured individuals enter the market. Because of the 3:1 age restriction on premiums in the ACA, younger people are paying more than their expected claims costs will be. All in, we estimate the net effect of the anti-selective behavior and the improved premium yield due to a younger age to reduce the favorable impact shown above by approximately 50%.

Based on these considerations, we estimate that the individual market could see a range of improvement in overall morbidity and claims costs of between 0% and 2%. Unlike the impact of reimbursement changes, which would be immediate upon implementation of a Public Option, the impact of morbidity improvements in the individual market would occur over time, as actual migration takes place over several years.

Summary

Depending on network adequacy and the price, Public Option plans could see a wide range of take-up rates. The scenarios modeled are intended to illustrate potential ranges and impacts to provider revenue. To the extent Public Option plans have a material advantage relative to other plans offered in the individual market, it is reasonable to assume that a very large portion of the individual business will switch to Public Option plans. There is greater uncertainty

with Public Option migration, as it likely depends on perceived network adequacy of the Public Option and the adoption of defined contribution strategies for health benefits through tax-favored vehicles that fulfill the employer mandate.

With regard to the uninsured population, the Public Option is estimated to reduce the uninsured population by 10% in the extra-high scenario. Because a Public Option will have limited to no impact on the out-of-pocket premium for the SLCS plan, insurance take-up rates are unlikely to change materially for households with income under 400% FPL (accounting for more than 80% of the estimated uninsured population). This results in a stand-alone Public Option (without additional state-based subsidies) reducing the State of Colorado's uninsured rate only from 8.2% to 7.4%.

9. RESPONSE BY PROVIDERS

Depending on the number of enrollees covered by Public Option plans, providers will experience varying levels of reduced reimbursement. Providers' reactions will also vary accordingly. Moreover, those reactions may vary by geographical area as well. However, the most likely reactions may be:

Do not accept Public Option plan patients

The success of the Public Option depends on the willingness of providers to accept lower reimbursement levels because consumers' coverage is less useful if they lack access to providers. The Public Option's below-market reimbursement could discourage providers from contracting with carriers that are seeking to build out a network for a Public Option plan offering (under a contracted approach), or from contracting with the Public Option stand-alone entity. Depending on a particular provider's reimbursement mix from other payers, both Public Option plans and private, some may choose to contract and some may not.

While contracting at lower than market reimbursement rates could be challenging for insurers in urban areas, it may be an even greater challenge in rural areas. In a 2019 10-state survey of marketplace administrators and insurers, the Urban Institute reported narrow networks (which typically include lower reimbursement) were difficult to establish in rural areas due to a limited number of existing providers and the resulting negotiating leverage retained by them.[73] In addition, state network adequacy requirements would still apply to Public Option plans, and an inability to negotiate contracts with a sufficient number of providers may prevent Public Option plans from being offered in rural and / or high-cost areas. Yet these areas are one of the main focuses of HB19-004.

The breadth and quality of the networks associated with the Public Option's plans, based on the acceptance or lack of acceptance of the relatively lower reimbursement, will have other downstream impacts. As previously discussed in this report, an employer's strategy of terminating its traditional employer group health plan and funding IIHRAs for employees to purchase Public Option plans would likely be preconditioned upon there being reasonable provider access available through Public Option plan networks. To the extent provider access in Public Option plans is publicly perceived as limited, lower take-up rates for Public Option plans from persons currently enrolled in employer group plans would be anticipated.

Shift costs to other markets when possible

In order to offset the reduction in reimbursement from enrollment in the Public Option, a provider may attempt to negotiate higher reimbursement levels for other markets, particularly the employer group market. To the extent cost shifting occurs, higher underlying provider reimbursement rates will need to be absorbed in those markets, and all else equal, premiums will increase in the markets to which costs are shifted. This dynamic was quantified in Section 8 of this report.

Change the payer mix

The provider may assess its mix of patients among employer group, Connect for Colorado Health (CFHC) coverage (specifically Public Option plans), Medicaid, and Medicare. To the extent reimbursement associated with health benefits purchased through the CFHC is reduced, the provider could elect to accept fewer Medicaid, Medicare, or Public Option patients (and increase the number of employer group patients if possible), offsetting the Public Option reimbursement reduction. This option may not be possible in rural areas where provider access is limited. However, where it is possible to do this, it could cause access issues for vulnerable populations, such as low-income and elderly under both Medicaid and Medicare programs.

Other responses by providers could include:

Increase efficiency. To the extent a provider can reduce underlying expenses associated with the delivery of healthcare services, the provider may be able to mitigate some of the margin decrease experienced from reduced reimbursement levels.

Increase volume. Particularly under fee-for-service reimbursement, a provider may elect to deliver more services per patient or add patients (if the provider currently has excess capacity). Adding patients could reduce visit times or otherwise compromise quality of care.

[73] Holahan, J., Blumberg, L.J., Wengle, E., & Elmendorf, C. (January 2019). What's Behind 2018 and 2019 Marketplace Insurer Participation and Pricing Decisions? Robert Wood Johnson Foundation. Retrieved February 14, 2019, from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2019/rwjf451264 (PDF download).

Accept lower reimbursement. To the extent a provider's underlying expenses are not reduced, lower reimbursement will result in lower margins for the provider.
Pursue consolidation with other providers. Small physician practices may join large medical groups or become hospital employees to take advantage of typically higher negotiated commercial rates. Hospital mergers may occur to increase negotiating leverage, economies of scale, or population health management capabilities.

Exit market. A provider could exit the market (retire, move to a different state, etc.)

Additionally, it may be possible that a provider reacts to reduced reimbursement rates with a combination of behaviors. For example, healthcare delivery efficiency may be increased, and higher employer group reimbursements could be negotiated (cost shifting) while accepting slightly lower margins.

10. SECTION 1332 WAIVERS

Section 1332 of the ACA permits a state to apply for a waiver to "pursue innovative strategies for providing their residents with access to high quality, affordable health benefits while retaining the basic protections of the ACA."[74] In November 2018, CMS issued guidance describing several "waiver concepts," including state-specific premium assistance proposals.[75] In order for a waiver to be approved, the state's application must meet the following criteria, known as "guardrails":

- Health benefits coverage (coverage): The waiver must provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver.
- Health benefits affordability and comprehensiveness: The waiver would provide access to coverage that is as affordable and comprehensive as would be accessible absent the waiver.
- Deficit neutrality: The waiver would not increase the federal deficit.

To the extent a waiver generates savings to the federal government, a state may receive federal pass-through funding based on the difference between federal expenditures with and without the waiver.

Our modeling shows that the Public Option could potentially reduce premium rates relative to the current 2020 plans by material amounts, depending on provider reimbursement and geographic region. This will reduce premium rates for consumers not qualifying for premium assistance. Additionally, it will reduce federal outlays for premium tax credits for the nearly 80% of the population purchasing Connect for Health Colorado (CFHC) coverage with premium assistance. Figure 25 illustrates how pass-through funding under a section 1332 Waiver may be generated by the Public Option based on current federal premium assistance being received by three households.

FIGURE 25: ILLUSTRATION OF POTENTIAL SECTION 1332 WAIVER PASS-THROUGH FUNDING UNDER THE PUBLIC OPTION

	PREMIUM AND SUBSIDIES WITHOUT THE PUBLIC OPTION			PREMIUM AND SUBSIDIES WITH THE PUBLIC OPTION			PUBLIC OPTION IMPACT	
Household	Full Premium	Premium Subsidy	Net Premium	Full Premium	Premium Subsidy	Net Premium	Consumer Savings	Federal Government Savings
A	$500	$300	$200	$300	$100	$200	$0	$200
B	$500	$100	$400	$300	$0	$300	$100	$100
C	$500	$0	$500	$300	$0	$300	$200	$0

Household A. Consumers qualifying for premium assistance with value greater than the premium reduction resulting from the introduction of Public Option plans are unlikely to see reductions in net premium cost (federal government retains 100% of premium savings, which becomes pass-through funding under the 1332 Waiver). Consumers with household incomes under 250% FPL with be represented by Household A. As illustrated in Section 4, consumers in this income cohort are estimated to reflect approximately 33% of the population currently purchasing coverage in the individual market.

Household B. For consumers qualifying for limited premium assistance, such as Household B, premium savings will be shared by the consumers and the federal government. Household B does not qualify for premium assistance after the introduction of the Public Option plans, but experiences a $100 reduction in monthly net premiums (federal government retains 50% of premium savings, which become pass-through funding under the 1332 Waiver). Consumers with household incomes between 250% FPL and 400% FPL are most likely to be represented by Household B. As illustrated in Section 4, consumers in this income cohort are estimated to reflect approximately 22% of the population currently purchasing coverage in the individual market.

Household C. Higher-income consumers who did not qualify for premium assistance prior to the implementation of the Public Option plans will realize the full premium savings from the reinsurance program (consumer retains 100% of

[74] CMS. Section 1332: State Innovation Waivers. Retrieved October 10, 2019, from https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html.
[75] CMS (November 29, 2018). Fact Sheet: State Empowerment and Relief Waiver Concepts. Retrieved October 9, 2019, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf.

premium savings, no pass-through funding available). Consumers with household incomes above 400% FPL are most likely to be represented by Household C. As illustrated in Section 4, consumers in this income cohort are estimated to reflect approximately 45% of the population currently purchasing coverage in the individual market.

By requiring lower than market reimbursement for private individual market coverage, the implementation of Public Option plans is estimated to reduce premium rates through what is, in essence, a provider assessment. This subsidy to the individual market will reduce premiums by reducing claims expenses in a similar manner as a state-based reinsurance program. One important difference between these two options, however, is that a reinsurance program reduces an insurer's expenses *after* the direct provider payment is made. However, the Public Option reduces both carrier (whether a stand-alone or a contracted entity) and consumer claims expenses at the point of service.[76] As a result, it will also reduce consumers' claims expenses when services are subject to a deductible and / or coinsurance.

To the extent the State of Colorado seeks a 1332 Waiver for the Public Option, approval may result in the return of federal pass-through savings to the state.

Summary

The implementation of Public Option plans is anticipated to result in significant premium rate reductions to the subsidy benchmark plans offered in CFHC in rural areas and, under some scenarios, urban areas as well. These premium rate savings will be fully realized by consumers who do not currently qualify for subsidy assistance and partially by consumers who qualify for only limited premium assistance. However, the federal government will realize the entire amount of savings for low-income consumers.

A 1332 Waiver may be one policy option that would allow Colorado's healthcare delivery system to retain federal premium assistance savings. Because no public option has been submitted to CMS for approval under a Section 1332 Waiver, some initial conversations with CMS regarding a 1332 Waiver submission based on the Public Option may be helpful.

[76] Note that, for provider-owned insurers, while the Public Option plans may reduce claims expenses on paper from the view of the insurance entity, participation as a Public Option plan does not reduce the actual cost to deliver healthcare services. Therefore, with respect to the parent company, offering a Public Option plan may result in an overall system net revenue reduction.

11. OVERVIEW OF POLICY OPTIONS

As noted in Section 3, many of the historical and most recent state reform activities, including the public option, have the following in common:

1. The reforms attempt to reduce premiums, and the most recent initiatives focus on the individual market and then primarily on the unsubsidized portion of that market (persons with household incomes above 400% FPL).

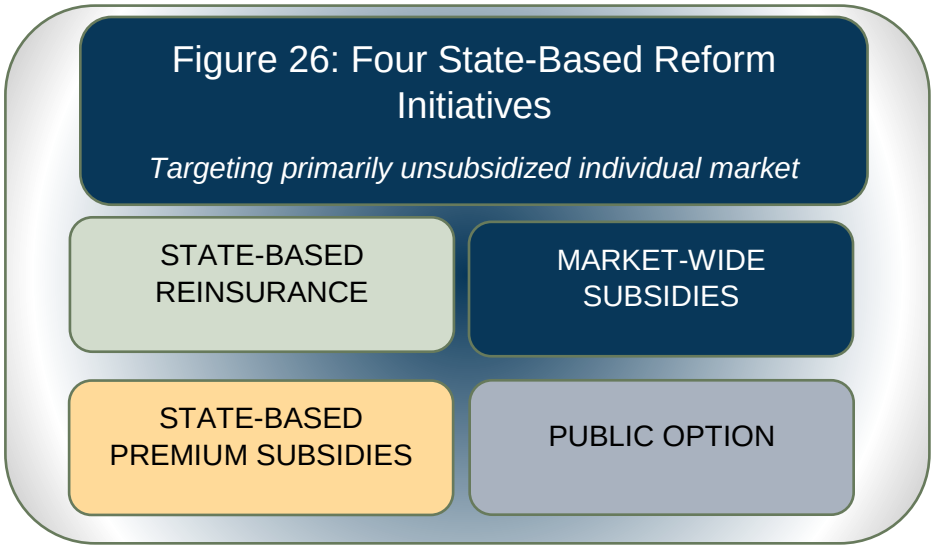
2. A secondary goal is to increase consumers' choice of insurance carrier and / or increase market competition by encouraging more carriers to enter, particularly in regions that have only one carrier.

The enabling legislation for Colorado's Public Option study (see Appendix A) cites very similar motivations. The assembled public data in Appendix B reinforces the State of Colorado's concerns related to affordability and carrier participation. Appendix B illustrates that the individual market in Colorado has seen both increasing prices (approximately a 90% SLCS cumulative rate increase from 2014 to 2019) and a decreasing number of participating carriers (the average number of carriers offering coverage per county has decreased from 6.6 in 2014 to 2.4 in 2019). A Public Option, regardless of the form it takes, attempts to address both of these policy goals *directly* but is just one of several alternatives that are intended to address similar challenges.

The Public Option addresses both affordability and carrier participation directly…

To that end, we have identified four reform initiatives, shown in the graphic in Figure 26, that could (or do currently) address one or both of these concerns, affordability and carrier participation. This section describes the details as well as the advantages and disadvantages of each initiative. Note, we review reinsurance as a policy "option," albeit one that is already exercised in Colorado, because it will be important to understand the potential benefits or drawbacks of this option as it is reviewed by policy makers annually, as well as part of the waiver renewal with CMS after five years. It is also important to consider a Public Option in light of what has been (or will be accomplished) by the reinsurance program starting in 2020.

Our evaluation of benefits and drawbacks is done primarily from a public policy perspective but we also articulate various features of each option that could be challenging for private market carriers.



STATE-BASED REINSURANCE

As noted earlier, 13 states have now been approved for state-based reinsurance waivers or the related concept of an invisible high-risk pool, the most recent being Delaware, Montana, and Rhode Island in August 2019.[77] State-based reinsurance programs make the state (or a state-sponsored entity) the risk-bearing entity for claims above a certain threshold and likewise reduce risk for carriers, both incumbent and those entering the market.

Reinsurance waivers are popular because they are relatively straightforward conceptually, have limited implementation risk, have been approved by CMS in a timely fashion, and carriers seem to be comfortable with the idea and the impact of the programs. The demonstration of compliance with the 1332 Waiver guardrail requirements is relatively simple, as evidenced by the number of approved waiver applications. Reinsurance has both market subsidy and true insurance elements, meaning that the total market-wide subsidy (which reduces gross premiums of all carriers) is "allocated" across carriers and benefit plans via the reinsurance element.

Because the reinsurance program reduces the premium for the SLCS, it generates federal "pass-through" funding that helps offset program costs. In effect, CMS reimburses the state for the reduction in costs for the subsidized portion of the market, leaving the state with a net cost of reinsurance for the unsubsidized populations. *Thus, the net benefits of the program accrue largely (but not entirely) to those over 400% FPL.*

Attachment points, carrier coinsurance percentage, and the total per member reinsurance payout cap can be set to fulfill policy and budget goals. For example, Colorado has set varying attachment points by region to bring a greater reinsurance impact to high-cost rural parts of the state and a smaller reinsurance impact to lower-cost urban parts of the state.[78]

BENEFITS AND DRAWBACKS OF A STATE-BASED REINSURANCE PROGRAM

Because Colorado has already been approved by CMS for a state-based reinsurance program under a 1332 Waiver, it is important to understand how the reinsurance program has attained some of the same goals or benefits of a Public Option, potentially making the Public Option (regardless of actual form) marginally less valuable. Moreover, it is important to consider how the Public Option would interact with the reinsurance program, which we discuss further below. Finally, a firm understanding of reinsurance mechanics relative to other policy options can help shape future policy modifications as the Colorado reinsurance program comes up for renewal with CMS and the State of Colorado potentially considers other reform options.

Benefits

Along with the fact that reinsurance waivers are currently the only successfully approved waiver affecting the individual market[79] (which should not be discounted), reinsurance has the following additional strategic advantages:

1. **Reduced claims expense volatility:** The insurance element of reinsurance reduces claims expense volatility for all carriers. However, this protection could be more valuable for smaller carriers and new carriers, either of which will likely have smaller individual market membership.

2. **May encourage private competition:** The insurance protection noted above might provide additional incentive for new carriers to enter the market or existing smaller carriers to stay, thereby improving private plan competition. The ACA's transitional reinsurance program, which is similar to most current state-based reinsurance programs, was a part of the "3Rs" package of stabilization mechanisms, which were intended to provide some protections to encourage additional carriers to enter the ACA's insurance marketplaces. This aspect of a state-based reinsurance program is important as it is aligned with one of the State of Colorado's primary objectives with its Public Option (e.g., introducing more carrier choices and competition, particularly in rural and / or one-carrier counties).

3. **Ease of compliance:** The demonstration of a reinsurance program's 1332 Waiver guardrail compliance is straightforward.

[77] CMS, Section 1332: State Innovation Waivers, op cit.
[78] CMS (July 31, 2019). Colorado: State Innovation Waiver under Section 1332 of the PPACA. Press release. Retrieved October 10, 2019, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/CO-Fact-Sheet-.pdf.
[79] Hawaii's waiver allowed it to no longer operate a Small Business Health Options Program (SHOP). For more information, please see: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Hawaii-1332-Waiver-Fact-Sheet-12-30-16-FINAL.pdf.

a. Comprehensiveness. The reinsurance program makes no changes to covered benefits.

b. Coverage. As the reinsurance program reduces out-of-pocket premium rates for persons not qualifying for federal premium assistance, health insurance enrollment is projected to be flat or increase relative to the market without the waiver.

c. Affordability. The market subsidy introduced by the reinsurance program creates more affordable coverage relative to the market without the waiver.

d. Federal deficit neutrality. The federal deficit neutrality requirement is reasonably straightforward as well, but does involve the projection of multiple elements, such as premium tax credits (PTCs), enrollment, and market morbidity changes.

4. **Increases subsidized individual's purchasing power on higher-cost plans:** Because reinsurance will have a tendency to benefit higher-cost carriers (see the first discussion point below under Drawbacks), those carriers may reduce their rates more than the carrier that currently offers the SLCS. This will narrow the gap between higher-cost plans and lower-cost plans, making the former marginally more attractive after federal subsidies (as well as on an unsubsidized basis). This phenomenon is illustrated in Figure 27 with a hypothetical $400 gross premium for the SLCS, an assumed market-wide reinsurance impact of -18%, and the assumption that carriers will price in their expected returns from the reinsurance program.

FIGURE 27: SAMPLE ILLUSTRATION, IMPACT OF REINSURANCE PROGRAM ON CONSUMER NET PREMIUMS

Silver Rank	1st LCS	2nd LCS	3rd LCS	4th LCS
PRE- REINSURANCE PRICE	$380	$400	$450	$500
SUBSIDY	$300	$300	$300	$300
NET CONSUMER PREMIUM	$80	$100	$150	$200
NET PREMIUM RELATIVE TO THE SLCS	-$20	$0	$50	$100
REINSURANCE BENEFIT ASSUMED IN PRICING	12%	15%	18%	21%
POST-REINSURANCE PRICE	$334	$340	$369	$395
SUBSIDY	$240	$240	$240	$240
NET CONSUMER PREMIUM	$94	$100	$129	$155
NET PREMIUM RELATIVE TO THE SLCS	-$6	0	$29	$55
PERCENTAGE CHANGE IN NET PREMIUM	18%	0%	-14%	-23%
CHANGE IN NET PREMIUM DIFFERENTIAL RELATIVE TO THE SLCS	$14	$0	-$21	-$45

Note, the LCS plan saw an increase in net consumer premiums after reinsurance of 18% ($80 to $94) and a deterioration of its position relative to the SLCS plan of $14 (the $20 net premium price advantage was reduced to $6). Conversely, both the third-ranked and fourth-ranked silver plans improved on both of these measures. These phenomena continue, but are less dramatic, even if carriers do *not* make different assumptions about the impact of reinsurance.

5. **Ease of expansion:** Colorado's reinsurance program is effective for the 2020 coverage year and is projected to reduce premiums approximately 16%.[80] Because the state is exploring potentially additional price relief in

[80] CMS (July 31, 2019), op cit.

the form of the Public Option, it could also consider using funds that would otherwise be put into a Public Option to simply increase the price relief of the current reinsurance program.

Drawbacks

Despite the advantages noted above, reinsurance programs have drawbacks that should be considered strategically by both the State of Colorado and carriers.

1. **Potential bias:** Parameter-based reinsurance programs will allocate funds based on a carrier's incurred claims above a certain threshold. Carriers that consistently attract higher-risk and, therefore, higher-cost claimants serve to benefit from a reinsurance program more so than carriers attracting lower-risk claimants. This bias may be seen as a strategic advantage by some carriers as the disproportionate benefits likely accrue to carriers that have broader networks, loosely managed degrees of healthcare management, or more generous out-of-network benefits. Critics of this aspect would argue that it simply compensates for a carrier's strategic weaknesses and helps perpetuate the carrier's inefficiencies.

   The practical implication to this bias, the effect of which has been explored above in the context of a consumer advantage, is that a carrier will likely price to its expected reinsurance payout, thereby improving its pricing disproportionately relative to lower-cost carriers.

   Condition-based reinsurance programs, such as the invisible high-risk pools operated by Alaska and Maine under 1332 Waivers, require the ceding of a reinsured premium to the high-risk pool (or a substantial portion of it). This additional requirement may reduce the impact of carrier bias as carriers would be required to "pay" to receive the benefits of the program. The inherent bias in reinsurance programs favoring higher-cost carriers would be reduced due to this requirement. However, the ceded premiums are likely to only fund a small portion of overall reinsurance program payouts.

2. **Pricing risk:** Although smaller and / or newer insurers to the market may benefit from the insurance element of a reinsurance program, some pricing risk is introduced as carriers must estimate the claims impact from the reinsurance program in developing premium rates. Smaller insurers whose experience is less credible and new insurers who have no claims experience may have to price conservatively in this regard, which will disadvantage them pricewise relative to larger carriers that have credible experience or large enough blocks of business where pricing risk is smaller.

3. **Overpayment:** An important aspect of a claims-based reinsurance program is that members who qualify for reinsurance may also be compensated as high-risk under the federal risk adjustment program. Carriers with high-cost claimants are effectively paid twice, once under each program. If all the high-risk, and therefore likely the high-claims, individuals were distributed evenly across carriers, this would not be an issue. However, this certainly is not the case in many if not most markets. Cursory reviews of the CMS risk adjustment reports (which indicate material variances in risk adjustment transfer payments among carriers), along with membership data from medical loss ratio (MLR) reporting, prove this point.

   Without some correction, the double reimbursement only serves to magnify the favorable bias to high-risk and / or low-efficiency carriers, noted above. For example, recognizing this overpayment as a significant issue, Maryland added a "dampening" factor of 70% to payments under the risk adjustment program for claims that were also reinsured.[81] It can also be corrected for with a state-based risk adjustment program that is calibrated using post-reinsurance payout, state-specific claims data.

4. **Pass-through funding inefficiency:** Another side effect of the potential bias issue noted above is that it is entirely possible that the effect of a reinsurance program will not result in the maximum reduction to the SLCS plan, and hence, will not maximize federal pass-through funding under a 1332 Waiver. This could occur because it is more likely that the carrier that has the SLCS plan does not cover as many high-cost claimants (or does not project that it will do so) and therefore, will likely receive less benefit from the program.[82] Hence, it will not lower its rates as much as other carriers that project disproportionately higher benefits from the program. This will reduce federal pass-through funds and put more pressure on state-based funding sources.

[81] The full text of the Maryland Health Benefit Exchange resolution is available at https://www.marylandhbe.com/wp-content/uploads/2018/11/MHBE-Board-Resolution-Interaction-Between-Risk-Adjustment-and-Reinsurance_Programs.pdf.
[82] Note that a carrier could be more efficient with medical management, have better unit-cost contracts with providers, have lower administrative costs, or a combination of these in order to position itself as offering the second-lowest-cost silver plan.

5. **OOP pocket premium impacts:** The out-of-pocket (OOP) premium benefits will accrue to both the "lightly subsidized" (i.e., those with incomes between 300% FPL and 400% FPL, generally young adults) and the wholly unsubsidized (those with incomes over 400% FPL). This may not necessarily be a disadvantage depending on how the State of Colorado defines affordability. For example, if Colorado defines affordability as out-of-pocket premiums less than or equal to 9.86% of income, then the lightly subsidized would not require a price reduction. Yet under a reinsurance program, this is precisely what could happen. Figure 28 illustrates these dynamics.

FIGURE 28: REINSURANCE IMPACT TO CONSUMER OUT-OF-POCKET PREMIUMS BY SUBSIDY LEVEL

	Base Market Case			Reinsurance Scenario		
Subsidy Level	**Heavy**	**Light**	**None**	**Heavy**	**Light**	**None**
2019 FPL %	150%	350%	401%	150%	350%	401%
Income (thousands)	$18.2	$42.5	$48.6	$18.2	$42.5	$48.6
Gross Premium	$400	$400	$400	$320	$320	$320
2019 % of Income Cap	4.15%	9.86%	NA	4.15%	9.86%	NA
Federal Subsidy $s	$337	$51	$0	$257	$0	$0
State Subsidy	NA	NA	NA	NA	NA	NA
Net Premium	$63	$349	$400	$63	$320	$320
Consumer Savings (State's Net Funding)				$0	-$29	-$80
Federal Savings (Pass-Through Funding)				-$80	-$51	$0
Gross Premium Savings (Total Funding)				-$80	-$80	-$80

Note, the lightly subsidized individual receives a $29 reduction in premium even though the pre-reinsurance premium was considered "affordable" according to the ACA's premium assistance structure. This phenomenon (the already-subsidized receiving the benefits of a reform initiative) is consistent across several of the four reform scenarios.

6. **CMS pass-through determination risk:** Because a reinsurance program requires a 1332 Waiver, the pass-through funding is subject to recalculation by CMS each year. This determination may vary significantly from amounts calculated by the State of Colorado and its actuaries.[83] State-based programs that do not involve a 1332 Waiver, such as a Public Option or state-based subsidies, do not involve this risk, and therefore , may be favorable from the State of Colarado's perspective.

7. **Decreases subsidized individuals' purchasing power on lower-cost plans:** As described above in the advantages for reinsurance programs, reinsurance will likely not result in uniform impacts across carriers and it can alter the competitive positions of carriers somewhat artificially (i.e., not necessarily related to any change in the true value of the plan), particularly on a net basis (after federal subsidy). As the price for the SLCS drops, higher-cost plans improve competitively on a net basis. Conversely, lower-cost plans will become less competitive. This includes the LCS and most bronze plans (see Figure 27 above, specifically the 1st LCS column).

MARKET-WIDE SUBSIDIES

Market-wide subsidies are simply state funds that are allocated to each carrier proportionally. The proportionality is typically implemented in one of two ways: allocating either 1) a flat per member per month (PMPM) payable for each market enrollee, or 2) a flat percentage of claims or premium. In either case, the allocation of funds is *not* based on the existence of a high claims threshold, which is what reduces (in the case of a percentage allocation) or eliminates (in the case of a flat PMPM) the carrier bias and removes the double-counting issues present in a

[83] See https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers for more information on pass-through estimates vs. approved amounts.

reinsurance program. Each carrier and plan receives the same PMPM or percentage claims or premium reduction from the program regardless of risk or high claims.

A market-wide subsidy takes its form by attempting to remedy some of the drawbacks of the state-based reinsurance previously discussed. Specifically, the potential bias toward high-risk carriers and the overpayment due to the presence of risk adjustment are both addressed via a market-wide subsidy program. To date, no state has proposed this idea, officially or otherwise. However, the reinsurance challenges that it solves are real and other solutions have been proposed. For example, the reinsurance double-counting can be solved with a state-based risk adjustment program that is calibrated using post-reinsurance payout, state-specific claims data. As we mentioned previously, Maryland addressed this with a dampening factor on the risk-adjustment payouts for reinsured claims.

Note, a percentage of claims subsidy would still favor higher-cost carriers; however, the fixed percentage eliminates the differential pricing that might occur among carriers estimating claims expense reductions from the program, as all market participants would reflect the exact same percentage in rate development. The flat PMPM subsidy will tend to actually favor lower-cost carriers, as the fixed PMPM will result in a larger percentage reduction to claims expense relative to high-cost carriers.

Variations of the idea include varying market subsidy amounts for geographic areas that are higher-cost or lower-cost. An additional variation, albeit more complicated, is to define a preset level of affordability as a percentage of income, in a region (effectively extending the federal percentage of income premium caps), and then set regionally based subsidies to reach this predetermined level of affordability on that region's SLCS plan. This variation directly addresses the affordability challenges that Colorado sees in its rural counties.

Benefits

1. **Eliminates bias and overpayment:** The key benefit to the market-wide subsidy approach is the elimination of the potential favorable bias toward high-risk, high-cost carriers, as well as the overpayment due to risk adjustment.

2. **Eliminates pass-through funding inefficiency:** The market subsidy approach also eliminates the pass-through funding inefficiency challenge because all plans (including the current or pending SLCS plan) will receive the same amount of price relief with certainty.

3. **Reduces pass-through funding uncertainty:** Because the amount of the reduction to the SLCS plan is known with certainty, the amount of pass-through funding as determined by CMS will have less uncertainty associated with it.

4. **Interaction with current reinsurance program:** A market subsidy program could be implemented as supplemental price relief for the market, in addition to the relief already brought by the reinsurance program, or it could be implemented in lieu of reinsurance in future years.

5. **Guardrail compliance:** Other advantages related to reinsurance hold here as well, namely the ease of demonstrating compliance with guardrails.

Drawbacks

Despite solving several of the downsides of reinsurance, the market subsidy approach removes several key advantages to a reinsurance program, namely:

1. **Eliminates insurance protection:** Claims volatility will be higher for carriers relative to a reinsurance program, all else equal, and smaller carriers or new carriers in the market will be affected to a greater degree than larger carriers by this loss of protection.

2. **Impacts private competition:** The elimination of the insurance protection and lower claims volatility brought with a reinsurance program may deter smaller companies or new entrants from participating in the individual market, particularly in rural areas where populations and hence membership are already small and claims can be volatile.

3. **Less choice for subsidized enrollees:** To the extent that a pure reinsurance program likely narrows the gap between lower-cost and higher-cost plans and facilitates more affordable choices for those receiving subsidies on higher-cost plans, this benefit is eliminated under a market subsidy approach. Each carrier (high-cost or low-cost) would receive the same amount under a PMPM approach or the same percentage under a percentage of claims or premium approach. Conversely, lower-cost plans including the LCS and many bronze plans would no longer be affected negatively, as under a reinsurance program.
4. **Funding requirement uncertainty:** To the extent a fixed PMPM or percentage of claims or premium market subsidy is provided by a state, the cost of these subsides will vary based on future claims expense and market enrollment. Because of financial resource constraints, a state may need to reduce the level of funding provided if enrollment or claims expense is higher than expected.

STATE-BASED PREMIUM SUBSIDIES

State-based premium subsidies can be additional state-funded subsidies for those who already receive federal subsidies, subsidies for higher-income levels that currently do not receive any federal subsidies at all (i.e., persons with income above 400% FPL), or both. A prime example of state-based premium subsidies is California's introduction of state-based subsides for the 2020 coverage year. Beginning in 2020, the following new state-based premium subsidies will be available to persons purchasing coverage through Covered California:[84]

- Extension of PTCs for households with income up to 600% FPL
- Additional $15 subsidy for the average household that previously qualified for federal PTC
- For persons with household incomes under 138% FPL, out-of-pocket premiums are reduced to $1 per member per month

As demonstrated by California, state-based premium subsidies do not require a 1332 Waiver as the State of Colorado would not be waiving any provision of the ACA, only expanding on the existing subsidy structure established by the ACA.[85] This means there is no federal application or approval process and no federal pass-through funding involved. The target demographic to which Colorado funds are applied can be broad or reflect only the nonsubsidized or lightly subsidized segments (hereafter referred to as just the "unsubsidized segment") of the individual market.

State-based premium subsidy programs can bypass CMS and directly reduce premiums for unsubsidized individuals and / or enhance subsidies for the existing eligible population.

In fact, state-based subsidies are a more direct method of addressing affordability concerns for the unsubsidized segment than a reinsurance model. In the reinsurance model, the total program costs are used to reduce gross premium rates for the *entire market*. The federal government then reimburses the State of Colorado for the portion of the program costs applicable to the *subsidized segment*, leaving Colorado with a net cost of reinsurance applicable to just the *unsubsidized segment*.

Figure 29 illustrates this dynamic, without regard to age variation among members. Note, the state's required funding (**in bold**) is identical by design in order to highlight the direct path (i.e., no federal government pass-through funding) to a similar end that is offered by the state-based premium subsidies approach.

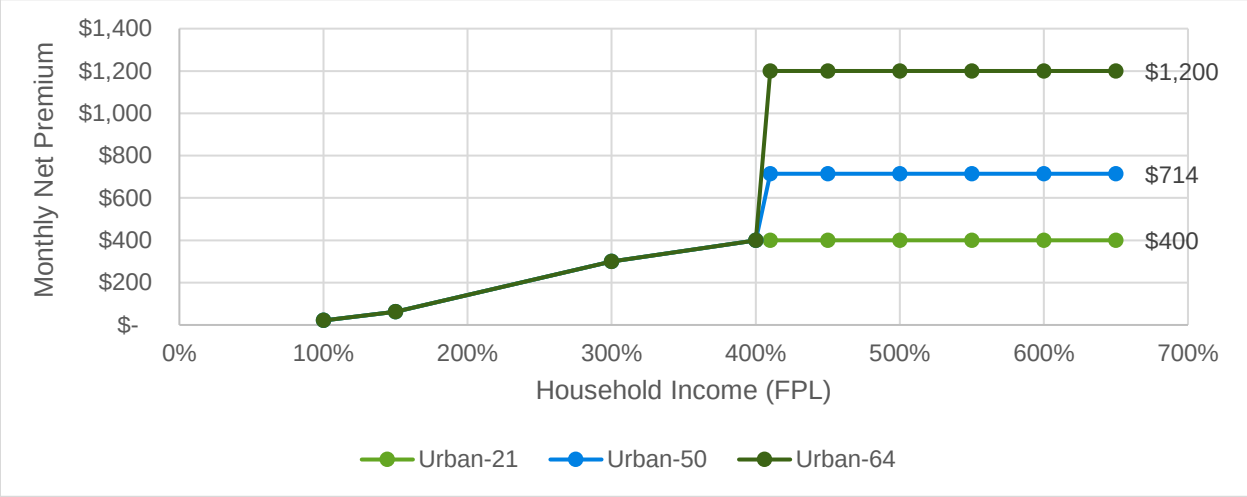
[84] Covered California. Projected Impacts of State Laws Affecting Health Care Consumers and Covered California in 2020. Retrieved October 10, 2019, from https://www.coveredca.com/news/pdfs/State_Subsidy_and_Mandate_Fact_Sheet.pdf.
[85] CMS has proposed a version of state-based subsidies that would seek to waive all federal subsidies due to a state, with those funds then redistributed at the state's discretion. Obviously, this would require a waiver.

FIGURE 29: HOW REINSURANCE AND STATE-BASED SUBSIDIES CAN HAVE THE SAME NET EFFECT

	Base Market Case			20% Reinsurance Scenario			State-Based Premium Subsidies		
Subsidy Level	Heavy	Light	None	Heavy	Light	None	Heavy	Light	None
2019 FPL %	150%	350%	400%	150%	350%	400%	150%	350%	400%
Income	$18.2k	$42.5k	$48.6k	$18.2k	$42.5k	$48.6k	$18.2k	$42.5k	$48.6k
Gross Premium	$400	$400	$400	$320	$320	$320	$400	$400	$400
2019 Federal % of Income Cap	4.15%	9.86%	NA	4.15%	9.86%	NA	4.15%	9.86%	NA
Federal Subsidy $s	$337	$51	$0	$257	$0	$0	$337	$51	$0
State Subsidy	NA	NA	NA	NA	NA	NA	$0	$29	$80
Net Premium	$63	$349	$400	$63	$320	$320	$63	$320	$320
Consumer Savings (State Funding)				**$0**	**-$29**	**-$80**	**$0**	**-$29**	**-$80**
Federal Savings (Pass-Through Funding)				-$80	-$51	$0	$0	$0	$0
Total Gross Premium Savings				-$80	-$80	-$80	$0	$0	$0

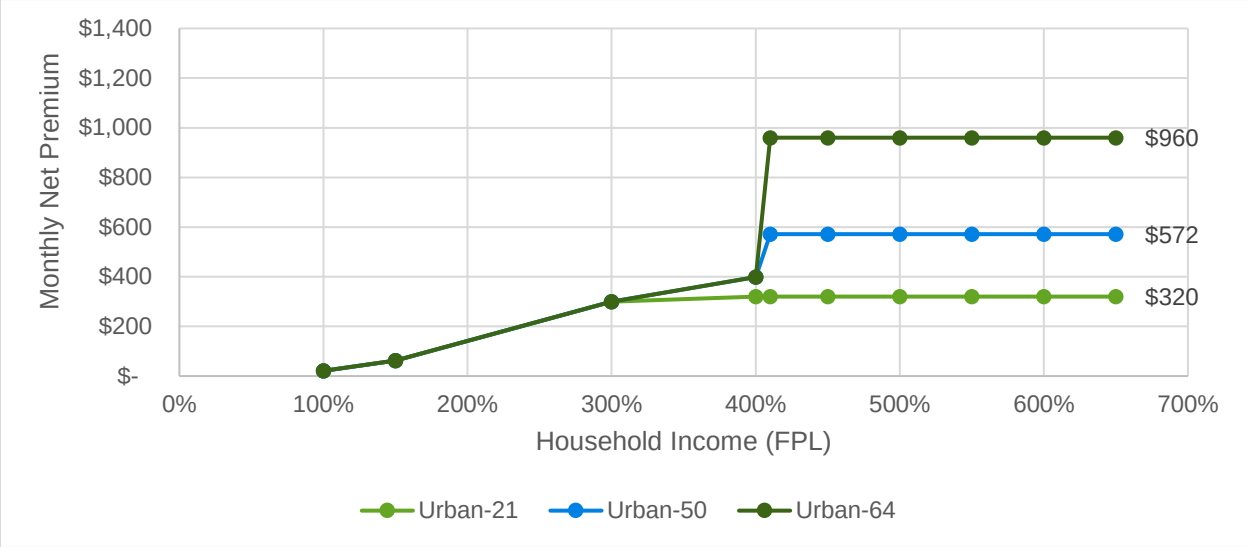
Figures 30 to 32 illustrate the general impact of state-based subsidies versus a reinsurance program when age *and* household income (FPL) are considered. We use a hypothetical age 21 gross premium (prior to the application of federal subsidies) of $400, identical to Figure 29 above. The net premiums (after application of federal subsidies) are then shown by three ages (21, 50, and 64) and by FPL.

FIGURE 30: NET CONSUMER PREMIUMS, BASE SCENARIO (NO REINSURANCE PROGRAM)



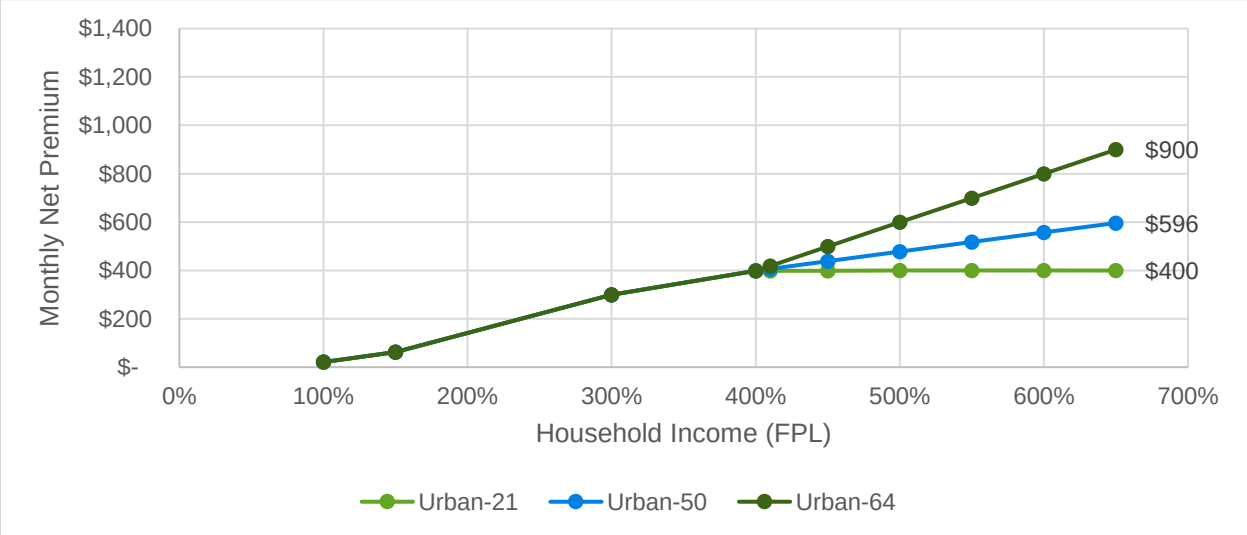
Note, the dramatic increase in the consumer's net premium at just over 400% FPL for the two older ages, otherwise known as the "subsidy cliff." Colorado's reinsurance program will mitigate, but not eliminate, the subsidy cliff by lower prices, as the graph in Figure 31 shows (again, using a hypothetical but realistic 20% reinsurance impact target).

FIGURE 31: NET CONSUMER PREMIUMS, REINSURANCE SCENARIO



With the use of state-based subsidies, greater premium relief for older enrollees above 400% FPL is achieved, as well as the elimination of the subsidy cliff at just over 400% of FPL.[86] The state-based subsidy structure used in the graph in Figure 32 extends subsidies to enrollees who are currently *not* receiving federal subsidies up to 650% FPL. The premium at that point is just slightly lower ($900) than in the case of reinsurance in Figure 31 ($960), thereby greatly reducing the subsidy cliff for the 64-year-old.

FIGURE 32: NET CONSUMER PREMIUM, STATE-BASED SUBSIDIES TO 650% FPL



State-based subsidies obviously require a mechanism for administration, as the federal exchange platform only accommodates the federal subsidy structure. Because Colorado already has a state-based exchange, this hurdle is already cleared, other than the incremental cost of incorporating the new subsidies on the existing platform.

[86] Note that there is a smaller cliff, affecting substantially fewer people once subsidies go to zero at 650% FPL.

Benefits

1. **Eliminates structural weaknesses of reinsurance programs:** With state-based premium subsidies, many of the disadvantages of reinsurance programs and some of the disadvantages of market subsidies (both flat and percentage of claims) are eliminated. This includes potential carrier bias, overpayment, and subsidy inefficiency.

2. **Eliminates need for a 1332 Waiver and related costs:** Because the state would not have to waive any provisions of the ACA in order to simply supplement already available federal subsidies, state-based premium subsidies eliminate the risks of non-approval of a waiver, pass-through funding determination risk, and any related costs and regulatory hurdles related to the waiver application.

3. **State retains program control:** With complete control of the supplemental state-based subsidies, the State of Colorado can design a program based on state-determined affordability levels. In the example above, the state determined a percentage of income affordability cap for income levels above 400% FPL that continues the pattern established by federal subsidies (increasing percentage of income as income rises). The example above also assumes that those receiving small federal subsidies would not receive any additional state-based subsidies, a drawback of a reinsurance program in most states that may be unavoidable. Other subsidy structures could also be considered by a state.

4. **Could be implemented in addition to, or in lieu of, a state-based reinsurance program:** Similar to other policy options, state-based subsidies can be implemented in lieu of a reinsurance program, as Figure 32 indicates, or the state could retain its reinsurance program and simply use any additional available funds to extend subsidies and / or supplement current subsidies.

Drawbacks

1. **Requires modifications to the state-based exchange:** As mentioned earlier, CFHC would need to modify its subsidy structure from the ACA's parameters, which may require an initial investment.

2. **Funding requirement uncertainty:** With a reinsurance program, a state could modify the attachment point or coinsurance rate to match reinsurance payouts to insurers' expenses. However, with state-based premium subsidies, it would likely be difficult to modify consumer premium assistance amounts during the coverage year. To the extent a recession occurred that reduced employer-sponsored coverage, additional Coloradans might seek coverage in the individual market, resulting in additional state expenditures for subsidies in a declining tax revenue environment.

PUBLIC OPTION

The preceding discussion of the other policy options is intended to put context around the evaluation of a Public Option in the State of Colorado in terms of its ability to address the issues of affordability and introducing competition and choice to the Individual market. As we have seen, each of these policy options address at a minimum the affordability challenges *directly* and, in certain cases, such as reinsurance, the issue of additional competition *indirectly*. A Public Option attempts to address the two core challenges of affordability and increased competition directly but does so in a way that introduces different considerations, and hence, our evaluation framework will change slightly.

VARIATIONS OF PUBLIC OPTIONS

The Colorado legislation enabling the study of a Public Option appears to have at least two variations in mind. One variation is a newly created, stand-alone, risk-bearing entity. The second is an approach similar to the state of Washington's, whereby the state contracts with existing carriers to offer Public Option plans. Because each variation has key features that drive differing advantages, disadvantages and market dynamics, we consider each separately. However, under either construct, the following would likely apply:

- First, a Public Option all but guarantees, by definition and design, to produce an offering that is lower in price than current offerings. This is because it has a strategic advantage that most likely cannot be matched by incumbent private carriers: provider reimbursement that is significantly lower than what is generally currently negotiable by

carriers. This lower "cost of goods sold" is mandated by legislative fiat and the authority of the State of Colorado government is used to enforce and maintain this advantage.

This could be a significant concern for private carriers as, all else equal, they will have a difficult time competing, particularly on the CFHC where the presence of subsidies leverages competitive price advantages. Moreover, this should be a significant concern to the Colorado as private carriers that are currently offering in the market may decide to exit due to the lack of competitiveness. It may also be possible that providers agree to lower rates for non-Public Options plans after the Public Option is implemented, reflecting the new market benchmarks for provider reimbursement.

- Second, a Public Option could be offered anywhere in the State of Colorado, including current one-carrier counties. Under the stand-alone approach, the Public Option would contract its own network. Presumably Colorado would be able to compel a sufficient number of providers (hospitals and physicians) to accept its reimbursement terms. In the contracted approach, carriers could build on existing networks but would re-contract at the mandated reimbursement levels.

While these two facets of a Public Option provide the distinct advantage of solving each of the policy objections (affordability and competition) both directly and with certainty, the means of establishing these advantages may have various negative side effects, which are discussed further below.

Contracted carriers

This approach was utilized by the Washington state for its' recently passed public option program "Cascade Care."[87] In this approach Washington utilizes existing carriers to offer a set of public option plans that are built on a legislatively mandated reimbursement level, presumably much more favorable than current market rates that underlie other private carriers' offerings. Private carriers that are approved to offer these plans and that agree to do so would attempt to contract a network of providers who agree to take the state-mandated reimbursement. All else equal, this would drive a significantly lower premium relative to existing exchange plans, depending on the level of reimbursement (100% of Medicare, 150%, etc.). The contracted approach would require carriers, as terms of their participation in the program, to offer plans in all geographic areas the state requires or all areas that are feasible for the carrier, given its geographic service area.

Benefits of the contracted carrier approach

1. **More cooperative with less crowd-out:** By engaging with carriers to solve the affordability and carrier choice issues, particularly in one-carrier counties, a state will likely be building on existing relationships rather than introducing the state (or other public entity) as a competitor to carriers and potentially creating adversarial relationships. As noted earlier, a stand-alone risk-bearing entity as a Public Option runs the risk of discouraging private carriers from offering coverage on exchanges or in the individual market overall.

2. **Marginal enrollment impacts:** Existing carriers in the individual market and in the small group and large group markets may benefit from becoming "approved" Public Option offerings. By capturing enrollment that might otherwise have been lost by not offering coverage in the individual market or lost to a stand-alone version of the Public Option, a carrier can spread fixed costs and other investments across a broader membership base.

3. **Harness existing infrastructure and industry expertise:** The HB19-1004 bill seeks to build on "existing infrastructure" and it could be argued that a certain material portion of that infrastructure is contained within the private carrier market. This would include operational capabilities such as enrollment and billing, medical management, and claims payment. Intangible assets, such as brand awareness, provider relationships, and industry expertise, are easily harnessed with a contracted approach.

4. **Network contracting:** A significant challenge, depending on the level of mandated reimbursement chosen for a Public Option, will be the contracting of a broad enough network that accepts the lower reimbursement. Private carriers may have a higher likelihood of building such a network than a stand-alone state entity.

[87] Jenkins, A. (May 16, 2019). Will Washington state's new 'public option' plan reduce health care costs? NPR. Retrieved October 10, 2019, from https://www.npr.org/sections/health-shots/2019/05/16/723843559/will-washington-states-new-public-option-plan-reduce-heath-care-costs.

5. **More likely to preserve value and innovation:** To the extent that private carriers improve value and innovate to acquire and maintain membership, this dynamic may be lost or diminished if private carriers are not a direct part of the Public Option solution.

6. **Solvency concerns are minimal:** As current carriers are going concerns and constantly financially monitored both internally and externally, capital requirements should be of minimal concern. Any additional membership due to the Public Option offering will not likely impact carriers, as 1) much of that membership will be from existing books of business, and 2) any new membership coming from the uninsured will be relatively small compared to total books of business.

7. **Reduces claims costs at the point of service:** Because reimbursement is lower at the time services are rendered to a patient, the patient will in many cases have lower cost sharing if claims are subject to the deductible and coinsurance.

Drawbacks of the contracted carrier approach

1. **FFS-based reimbursement metric:** Not all carriers reimburse on a purely fee-for-service (FFS) basis, and requiring a carrier to verify that the underlying reimbursement is at the required percentage of Medicare may be difficult or impossible to do. This requirement may exclude or severely disadvantage certain carriers, such as integrated delivery systems. For example, it may be more difficult for a carrier to engage a provider in a value-based contract or shared savings arrangement where reimbursement is not entirely on a FFS basis.

2. **Network contracting:** Carriers' industry expertise and provider relationships, while valuable assets for private carriers, may not be sufficient to create a network for a Public Option, particularly at lower reimbursement levels, such as 120% of Medicare or lower.

3. **Provider cost shifting:** Lower reimbursement from the Public Option is almost certainly going to result in an attempt by providers to cost shift to the commercial market segment. The degree of that shift will depend on the level of reimbursement that the Public Option is built around and the breadth of the eligibility criteria for enrollment in the Public Option.

Stand-alone state-sponsored entity

The second approach that is contemplated is the "stand-alone, risk-bearing entity" approach, which would essentially create a state-sponsored insurer. Similar to the contracted carrer approach, the state would endow this Public Option with significantly lower reimbursement than what underlies currently offered plans. It could be offered statewide or could be offered only in counties that currently have limited carrier choices, such as the 14 one-carrier counties.

A state-sponsored carrier would need to perform all of the functions of a private market insurer or have those functions contracted out to a third-party administrator. This would include the critical function of network contracting. Moreover, being a risk-bearing entity, the Public Option would need to raise and hold capital and surplus to remain solvent (or be backed by the state with sufficient funds as needed). If the Public Option were to fall below the risk-based capital standard for authorized control, it is not entirely clear how the State of Colorado would mitigate what could be perceived as a conflict of interest.

Proponents of the Public Option contend that a publicly sponsored entity would provide consumers with at least one additional choice of carrier and introduce more competition in the market. However, there is not universal agreement around the idea that carrier competition, at least by itself, reduces premium rates. In a May 2019 report, the Colorado Health Institute noted that higher premiums were not simply a function of fewer carriers, but also of reduced hospital system competition.[88] This would imply that introducing a Public Option would not, by itself, bring meaningful competition because the Public Option would be subject to the same hospital system pricing power as current insurers. Because being a part of the Public Option's network would likely require lower reimbursement, the system's pricing power might translate into simply not participating in the Public Option.

[88] Colorado Health Institute (May 14, 2019). The Competition Conundrum. Retrieved October 10, 2019, from https://www.coloradohealthinstitute.org/research/competition-conundrum.

Benefits of the stand-alone entity approach

1. **Direct resolution to issues of carrier choice and consumer affordability:** Of all the policy options, the stand-alone approach to a Public Option might be the single solution that solves both of the primary policy goals outlined in the legislation directly, rather than indirectly. Reinsurance is an example of indirectly attempting to improve carrier choices by creating market conditions that are conducive to more carriers but does not guarantee that any carriers will actually enter the market or increase their presence.

2. **State control:** The State of Colorado, or a state-sponsored entity, would retain direct control of Public Option operations, including network contracting, administrative expenses, service regions, and benefit plans offered.

3. **Reduces claims costs at the point of service:** Both stand-alone and contracted carrier approaches will in many cases have lower patient cost sharing if claims are subject to the deductible and coinsurance as a result of lower provider reimbursement.

Drawbacks of the stand-alone entity approach

1. **Provider cost shifting:** As in the case of the contracted carrier approach, a stand-alone option would likely cause varying degrees of provider cost shifting to commercial markets, driving up prices in that market, all else equal.

2. **Crowd-out:** Rather than improving carrier competition, a Public Option might cause carrier exits due to a private carrier's inability to match legislatively mandated reimbursement levels that can only be accessed by the Public Option. Without the possibility of being able to match this strategic advantage, carriers would quickly see their membership migrate to the Public Option, assuming the Public Option had similar value-added features such as customer service and network adequacy.

3. **Inability to spread fixed costs and amortize investments:** Depending on the Public Option's overall value to consumers, membership in the Public Option could be quite low. Our modeling shows that the Public Option may not have a significant price advantage in high-density population areas even under a 150% of Medicare scenario. Modeling of enrollment and premium scenarios for the Public Option can be found in Section 8 of this report.

   In order to accumulate enough membership to make a stand-alone Public Option viable, it may need to be made available to a broad population base, specifically small group and large group segments, and likely at a very competitive price in order to overcome the inertia elements of those markets. (See Sections 7 and 8 of this report above for broader discussions of employer market segment dynamics and tax-favored vehicles that may enable employer group migration to a Public Option.)

4. **Large up-front implementation requirements:** Implementing a stand-alone entity will practically be the equivalent of starting a new carrier from the ground up. Although much of the execution of that can be outsourced to third-parties, it nonetheless will be expensive and the value proposition of the resulting offering may not be any better than what is currently available, save for the artificially lower price due to mandated price controls.

   Critics might argue that the cost of such an endeavor might be better spent on increasing funding for the existing reinsurance program, instituting state-based subsidies to directly reduce out-of-pocket premium expenses, or improving access to primary care or some other care delivery innovation or improvement.

5. **Solvency concerns:** Smaller insurers (which the Public Option would almost certainly be considered, under any scenario) and newly established ones are far more likely to be thinly capitalized and to ultimately run into solvency problems. This is especially true if membership materializes at higher levels than expected. This happened to several of the previous generation of "Public Options," namely the CO-OPs. While the CO-OPs offered competitively priced premiums, it caused a flood of membership that ultimately proved to be underpriced.[89] For the Public Option to attract material enrollment, it will most likely need a reimbursement advantage that cannot be matched by other carriers. To the extent the Public Option's premium rates are

[89] U.S. Senate (March 10, 2016). Failure of the Affordable Care Act Health Insurance CO-OPs. Retrieved October 10, 2019, from https://www.hsgac.senate.gov/imo/media/doc/Majority%20Staff%20Report%20-%20Failure%20of%20the%20Affordable%20Care%20Act%20Health%20Insurance%20CO-OPs.pdf.

aggressive in relation to its underlying provider reimbursement, the potential for solvency concerns or additional outside capital will be greater.

We close this section with a summary table that compares the four policy options discussed above.

FIGURE 33: COMPARISON OF FOUR POLICY OPTIONS

	REINSURANCE	MARKET SUBSIDY ($ OR %)	STATE-BASED SUBSIDIES	PUBLIC OPTION
ADDRESSES SUBSIDY CLIFF	No	No	Yes	No
CARRIER BIAS IN PROGRAM BENEFITS	Yes	No / Yes	No	No
REQUIRES 1332 WAIVER	Yes*	Yes*	No	No
PROGRAM BENEFICIARIES**	U & L	U & L	U (State discretion)	U & L
EFFECTS ON CARRIER PARTICIPATION	Indirect	No	No	Yes
OVERPAYMENT DUE TO RISK ADJUSTMENT	Yes	No	No	No
EFFECTS ON PROVIDER REIMBURSEMENT	No	No	No	Yes
STATE ADMINISTRATIVE BURDEN	Low	Low	Low	High (Stand Alone) / Medium (Contracted

* A waiver is required to request and receive federal pass-through funding.

** "U" = Currently receiving no federal subsidies; "L" = Currently receiving small (light) federal subsidies

12. RATE IMPACT ANALYSIS ADDENDUM

During the finalizing of this report, the Colorado Department of Regulatory Agencies and the Colorado Department of Healthcare Policy and Financing released their report "DRAFT Report Colorado's State Coverage Option" (the joint report)[90].

The State Report analysis assumes provider reimbursement changes needed to obtain the second lowest cost silver plan position in a particular county would only affect facilities (both inpatient and outpatient) but professional reimbursement would stay at current levels. Moreover, the State Report assumes a single reimbursement percentage for facility currently exists across the entire state of Colorado (289% of Medicare). Our analysis, by contrast, assumes that facility and professional reimbursement would be affected and *that reimbursement currently varies materially by geographical region.*

To facilitate comparisons of rate impacts between reports, we have recalculated our rate impacts under the assumption of facility-only reimbursement changes and adopted 175% and 225% of Medicare scenarios[91] both consistent with the State Report. However, as this assumption materially changes the evaluation of the effectiveness of a Public Option in Colorado, we continue to assume geographical variation in underlying provider reimbursement.
Figure 34 shows these results:

FIGURE 34: COMPARISON OF PRICE IMPACT OF REIMBRUSEMENT ASSUMPTIONS ON PUBLIC OPTION PREMIUM RATES

	MILLIMAN ANALYSIS						JOINT REPORT	
	FACILITY AND PROFESSIONAL AT MEDICARE %				FACILITY ONLY AT MEDICARE %		FACILITY ONLY AT MEDICARE %	
County	SCENARIO A 180% OF MEDICARE	SCENARIO B 150% OF MEDICARE	SCENARIO C 120% OF MEDICARE	SCENARIO D 100% OF MEDICARE	SCENARIO E 225% OF MEDICARE	SCENARIO F 175% OF MEDICARE	225% OF MEDICARE	175% OF MEDICARE
Boulder	21.7%	5.6%	-9.6%	-19.1%	25.7%	9.5%	NA	NA
Denver	22.8%	5.8%	-10.2%	-20.3%	25.9%	8.5%	NA	NA
Larimer	-4.9%	-18.1%	-30.8%	-39.0%	-1.5%	-15.2%	NA	NA
Mesa	-8.1%	-20.1%	-31.6%	-39.0%	-1.4%	-15.6%	NA	NA
Gunnison	-25.0%	-35.1%	-44.6%	-50.7%	-12.4%	-22.8%	NA	NA
Composite	**12.9%**	**-2.5%**	**-17.0%**	**-26.3%**	**16.8%**	**1.0%**	**-9.6%**	**-18.2%**

As can be seen from Figure 34, our estimates of premium changes are not as favorable as what is shown in the State Report. This difference stems primarily from differing assumptions of reimbursement that currently underlie plans available on Connect for Health Colorado (CFHC) and in particular, the reimbursement that underlies the second lowest cost silver plan in each region. We isolated our assumptions related to facility-only reimbursement and compared those with the 289%[92] of Medicare assumption used in the State Report in Figure 35.

FIGURE 35: COMPARISON OF REIMBURSMENT ASSUMPTIONS IN MILLIMAN REPORT VERSUS STATE REPORT ANALSYSIS

	MILLIMAN REPORT REIMBURSEMENT ASSUMPTIONS BY CLAIM TYPE AND COUNTY – PERCENT OF MEDCIARE BASIS			
County	INPATIENT	OUTPATIENT	PROFESSIONAL	TOTAL
Boulder	142%	142%	120%	134%
Denver	130%	167%	116%	138%
Larimer	208%	246%	120%	189%
Mesa	214%	241%	140%	196%
Gunnison	216%	345%	180%	250%

[90] http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
[91] Ibid. The state's report also included a 200% of Medicare scenario that we did not model.
[92] Ibid Pg. 29

State Report	289%	289%	NA	NA

As Figure 35 displays, our research would indicate significantly lower reimbursement currently exists in highly populated and competitive counties such Boulder and Denver but that reimbursement is higher in rural counties. This geographical variation drives different rate impacts of a Public Option by county.

13. DATA RELIANCE AND LIMITATIONS

The services provided for this report were performed under the Consulting Services Agreement between Milliman Inc. (Milliman) and the Kaiser Foundation Health Plan dated August 1, 2019. Kaiser Permanente is the organization's trade name.

The information contained in this report has been prepared for the Kaiser Foundation Health Plan to provide data and information related to the evaluation of potential health benefits market impacts from the introduction of a Public Option in Colorado. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report could be released publicly in summary form once it is finalized. Any distribution of the summary information should be done so in conjunction with access to the full report. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

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

Milliman has relied upon certain data and information that is publicly available from the Connect for Health Colorado, Colorado Insurance Commissioner, and the Centers for Medicare and Medicaid Services (CMS). Additionally, we relied on statutory financial statement information downloaded from S&P Global Market Intelligence (formerly SNL Financial). Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data provided are not accurate, the estimates provided in this report would need to be modified to reflect revised information.

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

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

14. METHODOLOGIES

In preparing this report, we relied on data, information, and assumptions based on public data sources. Data sources utilized in our analysis include, but are not limited to, the following:

- Health plan financial information downloaded from S&P Global Market Intelligence
- Health insurer rate review information available at https://ratereview.healthcare.gov/
- Insurer rate filing information
- Medical Loss Ratio Reporting Form data, 2015 through 2017
- Current and historical Medical Expenditure Panel Survey data
- HHS Marketplace Open Enrollment reports
- Reports released by the federal government related to premium stabilization programs, APTC amounts, and effectuated marketplace coverage
- CFHC premium and enrollment information
- U.S. Bureau of Labor Statistics employment statistics
- Proprietary provider reimbursement levels for health benefits coverage offered through CFHC provided by participating health insurers

We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

It should be noted there is significant uncertainty surrounding future enrollment and premiums in health benefits programs, particularly the individual market. Uncertainty arises from the inability to predict individual behavior, as well as the inability to predict the business decisions of carriers in the market, as well as state and federal legislators and regulators. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The actuarial analyses presented in this report solely reflect the estimated incremental impacts from the introduction of a Public Option in Colorado. Other state or federal policy changes may impact actual amounts presented in this report. This report does not constitute an actuarial certification for a 1332 Waiver.

We specifically note that our projections of enrollment and premium rates in the individual market assume that federal funding of cost-sharing reduction (CSR) subsidies remains terminated, and that the individual mandate penalty remains $0. To the extent that judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted by a significant degree.

APPENDICES

APPENDIX A: Legislative Background for Public Option Study in Colorado

In the spring of 2019, the Colorado legislature passed House Bill 19-1004 (HB19-1004) which was ultimately signed into law by Governor Polis. This bill tasked the Colorado Department of Regulatory Agencies (DORA) to develop a proposal that considers the feasibility and costs of implementing a state option for healthcare coverage that:

- Leverages existing state healthcare infrastructure
- Increases competition and improves quality
- Provides stable access to affordable health insurance

The preamble to the bill notes what appears to be the impetus for this task: high prices and reduced carrier choice in at least 14 Colorado counties on the individual market. The specific aspects of the study are to include:

- *Conducting actuarial research to identify the potential cost of premiums and cost sharing to pay claims in a plan that is, at a minimum, a plan compliant with the ACA's essential health benefits (EHBs)*
- *Evaluate provider rates necessary to incentivize participation and encourage network adequacy and high-quality healthcare delivery*
- *Evaluate eligibility criteria for individuals and small businesses to participate*
- *Determine the impact, if any, on the state budget*
- *Determine the impact on the stability of the individual market, the small group market, and the Colorado health benefit exchange*
- *Evaluate the impact on consumers eligible for financial assistance for plans purchased on the exchange*
- *Determine whether a state option plan should be offered on or off the exchange*
- *Determine whether the state option plan should be a fully at-risk, managed care, fee-for-service plan, or an accountable care collaborative plan, or a combination thereof*
- *Determine whether the state option should be offered through the state department, and identify the expected impact, if any, to the Colorado Medical Assistance program*
- *Identify the expected impact, if any, to the children's basic health plan*
- *Investigate funding options, including but not limited to state funds and federal funds secured through available waivers*
- *Evaluate the feasibility, legality, and scope of any necessary federal waivers*
- *Review information relating to any pilot program that may be operated by the state personnel director pursuant to Section 24-50-620, as enacted in Senate bill 19-1004*
- *Create a statewide definition of affordability for consumers*

APPENDIX B: ACA Individual Market Rate Increase History and Carrier Participation

ACA Carriers by County 2014 to 2019							
		2014	2015	2016	2017	2018	2019
Average Carriers per County		6.63	6.73	3.58	2.34	2.36	2.41
Total Carrier Counties*		424	431	229	150	151	154
Count of 1-Carrier Counties		0	0	0	14	14	14

Colorado Second-Lowest Silver Plan Rates (21 Year-Old) and Increase 2014 to 2019										
		2014	2015	2016	2017	2018	2019	Est. 2020	Annualized Increase 2014 to 2019	Cumulative Increase 2014 to 2019
Rating Area 1	Premium	$197.60	$161.30	$219.57	$247.07	$310.90	$364.60	$301.59	13%	85%
	Rate Increase		-18.4%	36.1%	12.5%	25.8%	17.3%	-17.3%		
Rating Area 2	Premium	$192.22	$152.13	$202.99	$240.52	$318.84	$360.97	$305.21	13%	88%
	Rate Increase		-20.9%	33.4%	18.5%	32.6%	13.2%	-15.4%		
Rating Area 3	Premium	$196.59	$161.65	$189.71	$238.75	$297.98	$343.78	$285.28	12%	75%
	Rate Increase		-17.8%	17.4%	25.8%	24.8%	15.4%	-17.0%		
Rating Area 4	Premium	$187.72	$175.93	$230.55	$282.73	$341.98	$401.06	$323.32	16%	114%
	Rate Increase		-6.3%	31.0%	22.6%	21.0%	17.3%	-19.4%		
Rating Area 5	Premium	$228.81	$229.23	$291.96	$388.93	$457.17	$447.62	$359.55	14%	96%
	Rate Increase		0.2%	27.4%	33.2%	17.5%	-2.1%	-19.7%		
Rating Area 6	Premium	$187.72	$176.76	$230.55	$282.73	$341.98	$398.70	$323.32	16%	112%
	Rate Increase		-5.8%	30.4%	22.6%	21.0%	16.6%	-18.9%		
Rating Area 7	Premium	$237.12	$220.08	$255.17	$289.01	$347.15	$361.51	$296.15	9%	52%
	Rate Increase		-7.2%	15.9%	13.3%	20.1%	4.1%	-18.1%		
Rating Area 8	Premium	$239.31	$162.79	$214.48	$289.01	$348.64	$461.72	$375.85	14%	93%
	Rate Increase		-32.0%	31.8%	34.7%	20.6%	32.4%	-18.6%		
Rating Area 9	Premium	$267.02	$195.00	$271.06	$321.12	$425.69	$538.04	$438.34	15%	101%
	Rate Increase		-27.0%	39.0%	18.5%	32.6%	26.4%	-18.5%		
State Average	Premium	$214.90	$181.65	$234.00	$286.65	$354.48	$408.67	$334.29	14%	90%
	Rate Increase		-15%	29%	22%	24%	15%	-18%		

Sources: 2014-2019 rates are from Colorado state exchange at http://connectforhealthco.com/. 2020 rates are calculated from information contained in Colorado's 1332 Waiver application

*** Sum total across all counties of carriers in each county.**

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