## Abstract

NovaRest was engaged by The Partnership for America's Health Future Action, Inc. (The Partnership) to perform an actuarial review of Colorado Section 1332 Innovation Waiver Amendment Request - Colorado Option

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# Contents

NovaRest Actuarial Review of the Section 1332 Innovation Waiver Amendment Request - Colorado Option

## Purpose of this Report

NovaRest was engaged by The Partnership for America's Health Future Action, Inc. (The Partnership) to perform an actuarial review of Colorado Section 1332 Innovation Waiver Amendment Request - Colorado Option (CO 1332 Amendment). Donna Novak, Annette James, and Al Bingham, Jr. are the actuaries responsible for the statements, opinions, and conclusions in this document. We are all Members of the American Academy of Actuaries, and all meet the Qualification Standards of the American Academy of Actuaries regarding this report's subject and content. We acknowledge the significant contributions of Richard Cadwell and Amanda Rocha to this work.

## Background

### Summary of Colorado HB 21-1232[1]

The bill requires that:

1. A standardized health benefit plan be established by the commissioner on or before January 1, 2022, for the individual and small group markets.[2]
2. That the standardized benefit plan be actuarially sound and allow a carrier to continue to meet the financial requirements in Article 3 of this Title 10.[3]
3. Have a network that is no narrower than the most restrictive network that the carrier is offering for the non-Standardized Plan in the individual market for the metal tier for that rating area.[4]
4. Starting January 1, 2023, individual and small group health benefits plans in Colorado are required to offer the Standardized Plan in those markets and counties that the carrier offers plans.[5]
5. The commissioner may require the carrier to offer the Standardized Plan in specific counties where no carrier is offering the Standardized Plan in that plan year in either the individual or small group market.[6]

[1] 2021a_1232_signed; 2021a_1232_signed.pdf (colorado.gov)
[2] Ibid, 10-16-1304 page 5
[3] Ibid. 10-16-1304 III.B.e page 6
[4] Ibid. 10-16-1305 III.g.II page 6
[5] Ibid. 10-16-1305 1 a and b page 8
[6] Ibid. 10-16-1306 page 13

6. In 2023 the standardized benefit plan must be offered at a premium that is at least 5% less than the lowest premium rate for health benefit plans in the same county that the carrier offered in 2021 prior to the application of the Colorado reinsurance program pursuant to Part 11 of this Article 16, adjusted for medical inflation.[7] In 2024 and 2025 the premiums are required to be 10% and 15% less than the lowest premium rate for health benefit plans in the same county that the carrier offered in 2021 prior to the application of the Colorado reinsurance program pursuant to Part 11 of this Article 16, adjusted for medical inflation.[8]
7. For the premium reduction targets, the Insurance Commissioner shall take into account actuarial differences between the standard plan and the carriers 2021 plan offering, any changes to the standardized plan, and state or federal coverage mandates implemented after the 2021 benefit year.[9]
8. For the plan year beginning on or after January 1, 2026, and each year thereafter, each carrier and health-care coverage cooperative shall limit any annual percentage increase in the premium rate for the Standardized Plan in both the individual and small group markets to a rate that is no more than medical inflation,[10] relative to the previous year.[11]

If carriers are unable to meet the Standardized Plan as required in Section 10-16-1305, the bill requires that:

1. The carrier must notify the commissioner of the reason why.[12]
2. If the commissioner determines that a carrier has not met the premium rate requirements in Section 10-16-1305 or the network adequacy requirements, the Division shall hold a public hearing.[13]
3. Based on evidence presented at the public hearing, the commissioner may establish carrier reimbursement rates under the Standardized Plan for hospital and provider services, if necessary, to meet network adequacy requirements or the premium rate requirements in Section 10-16-1305.

   There are many restrictions on the level of provider rates that can be established by the commissioner (See Appendix I, Provider Reimbursement Rate Restrictions for more detail).[14] Hospital reimbursement floors include as a percent of Medicare:[15]

   a. Essential access part of a health system 175%

[8] 2021a_1232_signed; 2021a_1232_signed.pdf (colorado.gov), 10-16-1305 2.a.I page 8
[8] Ibid. 10-16-1305 II.A and B pages 8-9 and c.I page 9-10
[9] Ibid, 10-16-1306 (9)(b) pages 16-17.
[10] Medical inflation is defined as the annual percentage change in the medical care index component of the United States department of labor's bureau of labor statistics consumer price index for medical care services and medical care commodities, or its applicable predecessor or successor index, based on the average change in the medical care index over the previous ten years.
[11] 2021a_1232_signed; 2021a_1232_signed.pdf (colorado.gov) 10-16-1305 II.A.d page 10
[12] Ibid 10-16-1306 2 page 11
[13] Ibid 10-16-1306 3.a page 12
[14] Ibid 10-16-1306 pages 12-15
[15] These percentages are based on a base of 155% and modified as found in subsection 4 of HB 21-1232

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|---|---|---|
| b. | Essential access not part of a health system | 195% |
| c. | Independent hospitals (not essential access) | 175% |
| d. | Pediatric specialty hospitals | 210% |
| e. | Hospitals serving more than statewide average of Medicare/Medicaid | up to 185% |
| f. | Efficient hospitals | up to 195% |
| g. | Hospitals with negotiated reimbursement rate lower than 10% of statewide median | 165% or more |
| h. | All other hospitals | 165% |

The commissioner may consult with employee membership organizations representing health-care providers' employees in Colorado and with hospital-based health-care providers in Colorado and shall take into account the cost of adequate wages, benefits, staffing, and training for health-care employees to provide continuous quality care.[16]

The reimbursement for a hospital cannot be reduced by more than 20% of the negotiated reimbursement in the prior year.[17]

The healthcare profession reimbursement floor is set at 135% of Medicare.

4. The commissioner may require a provider to participate in a Standardized Plan and accept the reimbursement rates set by the commissioner.[18] Although the section indicates health-care-provider, the fines and penalties for noncompliance apply to hospitals only.

## Prior Reports on Colorado HB 21-1232 and the CO 1332 Amendment

There have been two reports published concerning the Colorado HB 21-1232 legislation and the CO 1332 Amendment. The CO 1332 Amendment, provided projections based on HB 21-1232 provisions. Milliman provided a report for The Partnership doing an analysis of the requirements of HB 21-1232 showing that some of the requirements may not be able to be realized.

### The CO 1332 Amendment Assumed that the Assumptions in HB 21-1232 were Realized[19]

The CO 1332 Amendment includes the actuarial and economic analyses required for the 1332 waiver amendment application, including projections of the impact of HB 21-1232 on future premiums, future membership and future premium tax credits paid by the federal government, as well as estimated federal passthrough funding under the CO 1332 Amendment. [20]

[16] 2021a_1232_signed; 2021a_1232_signed.pdf (colorado.gov) 10-16-1306 page 13
[17] Ibid. 10-16-1306 page 14
[18] Ibid 12-30-117 pages 23 to 24
[19] Colorado Section 1332 Innovation Waiver Amendment Request - Colorado Option, Colorado 1332 Waiver Amendment Submission 11-30 Final2 (2).pdf - Google Drive
[20] Ibid.

The CO 1332 Amendment assumed that all premium reduction requirements in HB 21-1232 could and would be fully realized throughout the state. For example, the Amendment assumed that:[21]

1. The premium for the new Colorado Option plan (Standardized Plan) is based on reductions of carrier 2021 lowest individual and small group metal level premiums in a region prior to the application of the Colorado reinsurance program. Reductions for 2023 through 2025 would be 5%, 10%, and 15% respectively as required by HB 21-1232.
2. After 2025, premiums can only be increased by national medical inflation, and still maintain the premium reductions
3. The standard plan premiums were:
    a. Adjusted for permitted inflation.
    b. Adjusted for the difference in cost sharing between the standard plan and the lowest individual and small group metal level premium in a region using the federal Actuarial Value Calculator to determine the relative value of the plans. This ignores the difference between the pricing actuarial value and the federal Actuarial Value Calculator.
    c. Reduced by the required percentages under HB 21-1232.
4. The second lowest cost silver plan was estimated in each county considering the estimated premium of the Standardized Plan, assuming the premium reduction requirements will be met.

The CO 1332 Amendment Actuarial Report Did Not Consider:

1. Whether the premium reductions in HB 21-1232 could be and actually will be achieved throughout the Colorado market.
2. That some carriers are exempt from the requirements to offering standardized plans and from premium reduction requirements from the 2021 premium levels. Specifically:

    > *A health-care coverage cooperative, and a carrier offering health benefit plans under agreement with the health-care coverage cooperative, that has offered one or more health benefit plans to purchasers in the individual market that previously achieved and maintained at least a fifteen percent reduction in premium rates, regardless of the first year the health benefit plans were offered, shall be deemed by the commissioner as having met the requirements for carriers in sections 10-16-1304 and 10-16-1305 with respect to the counties in which the individual plans are being offered by the health-care coverage cooperative.*[22]

    It is our understanding that this paragraph exempts some carriers from offering Standardized Plans and offering them at a premium reduction as long as the cooperative maintains a previously achieved fifteen percent reduction in premium rates.
3. Premium increases due to recent State mandated benefits, as well as federal benefit mandates, which will make the premium reductions even harder to achieve unless

[21] Ibid., page 40
[22] 2021a_1232_signed; 2021a_1232_signed.pdf (colorado.gov) 10-16-1306 page 16

adjustments based on the pricing actuarial value of the additional benefits and risk adjustment are allowed rather than the federal Actuarial Value Calculator adjustment.

4. Changes in the ACA risk adjustment methodology.
5. The impact of using the "annual percentage change in the medical care index component of the United States Department of Labor's Bureau of Labor Statistics' consumer price index for medical care services and medical care commodities, or its applicable predecessor or successor index, based on the average change in the medical care index over the previous ten years"[23] as the basis for the claims increase assumption.

We believe that the projections in the CO 1332 Amendment actuarial report would have been different if consideration had been given to which assumptions were realistic to achieve. As noted throughout this report, the reimbursement reduction floors and limitations combined with actuarial issues in the allowed adjustments will make it difficult to achieve the premium reductions throughout the State.

### Milliman Report

Milliman did an analysis into what could be achieved by HB 21-1232 given the environment in Colorado.[24] The Milliman report looked at the original assumptions for the first three years of premium reductions of 6%, 12% and 18% respectively rather than the premium reduction assumptions in the final legislation of 5%, 10% and 15%. That difference in assumptions does not negate the conclusions that we feel are an important product of the Milliman analyses as detailed in their report.

Milliman concluded that the physician reimbursements from carriers were already less than the 135% of Medicare that HB 21-1232 requires so that there would be no premium savings from reducing physician costs.

Milliman did an analysis of the HB 21-1232 requirements for hospitals and concluded that the premium reductions may be possible in some areas, but due to hospital reimbursement floors in the legislation and current hospital reimbursement levels by insurance carriers in the market today, the premium reduction requirements will not be able to be met solely using reductions in hospital provider reimbursements in many urban and several other high population center areas of the State.

### NovaRest Report Summary

The NovaRest report will build off the Milliman report and perform a deeper analysis of some of the aspects of HB 21-1232 that the Milliman report did not address. The following sections will provide our high-level conclusions on each topic as well as provide a description of Milliman's analysis, methodology, and assumptions that support its conclusions. NovaRest believes that after our review of the Milliman report that its methodology and conclusions are sound.

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[23] Ibid. 10-16-1305 page 8

[24] 5-27-21-Analysis-Colorado-HB-21-1232-Impact-Healthcare-Provider-Reimbursement-Consumer-Premiums.pdf. "Analysis of Colorado HB 21-1232 Impact on Healthcare Provider Reimbursement and Consumer Premiums." May 26, 2021.

## Reduction in Provider Reimbursement Costs

Milliman concluded that professional reimbursements were already less than the 135% of Medicare required by HB 21-1232 and therefore there would be no premium reductions due to the impact of HB 21-1232 on professional reimbursements.

Milliman's analysis shows that using hospital reimbursement reductions would not be able to reduce premiums by 15% by 2025 in regions 1, 2, 3, and potentially 4 (Boulder, Colorado Springs, Denver-Aurora-Lakewood, and Fort Collins, respectively). These are most of the high population center areas in the state. Milliman used the 2021 Colorado carrier reimbursements and the HB 21-1232 hospital floors to determine the potential decrease in the 2021 premiums for 2023, 2024, and 2025. Milliman predicted that lowering hospital reimbursements resulted in overall premium reductions in 2023, 2024, and 2025 of 6%, 4.5% and 1.9% respectively for a 3-year total reduction of 12.4%. These reductions, although close 15%, are for Colorado in total and the results vary significantly by region and carrier. For example, the lowest cost carrier in a given region will naturally have the lowest provider reimbursement rates and will have a difficult time meeting the premium reductions required by HB 21-1232. If these already low reimbursements are at or below the HB 21-1232 reimbursement floors, the commissioner will not be able to require additional reductions that would be needed to meet the premium reduction requirements.

Furthermore, regarding the Milliman estimated average statewide 12.4% reduction in premiums, Milliman did not have the information at the time to analyze the standardized benefit plan and the CO DOI proposed premium reduction methodology which we address in this report and would further reduce the ability of insurance carriers to meet the premium reduction requirements.

Since hospital reimbursements will increase with Medicare increases, and premiums will increase with the Medical Component of the Consumer Price Index (CPIM) after 2025, the two increases may not be in sync, which could complicate meeting the premium reduction requirements of HB 21-1232.

If carriers are not able to achieve the medical reimbursement targets, carriers would need to achieve the premium reductions through reductions in administrative costs and/or reduction in risk margins. However, some carriers may not have the operational flexibility to reduce administrative expenses or the financial means to absorb the impact of reduced revenue and, if they are not able to raise sufficient additional capital, may face solvency challenges.

Even if reductions in administrative costs or risk margins can be made, the resulting premiums would need to be actuarily sound and be adequate and sufficient to fund claims cost, projected administrative cost and risk margins that are sufficient to protect solvency.

## Use of the Federal Actuarial Value Calculator to Adjust for Plan Design Differences Between the Colorado Option and the 2021 Benchmark Plans

The purpose of the Federal Actuarial Value Calculator (AVC) is to assign metal levels to plan designs. CMS has warned that it should not be used for other purposes, including as an actuarial pricing model. The CO DOI proposed Emergency Regulation 21-E-XX Concerning Colorado

Option Standardized Health Benefit Plan [25] requires the use of the AVC to set the actuarial values of the Standardized Plans for the purpose of adjusting the carriers' 2021 benchmark plans[26] for benefit differences in the benchmark plans and the Standardized Plans. The Standardized Plans' actuarial values are not true reflections of actuarial values of those plans for the Colorado marketplace and for the individual carriers. To the extent that this may cause the adjustment to understate the Standardized Plans' values, the premium reduction requirements will be more difficult to achieve if the resulting standardized premiums are required to be actuarially sound.

### Use of The Medical Component of the Consumer Price Index to Adjust Premiums

HB 21-1232 requires the use of the Medical Component of the Consumer Price Index (CPIM) to adjust the 2021 benchmark premiums for medical inflation for the purpose of pricing the 2023 and later Standardized Plans. The use of the CPIM to adjust the 2021 benchmark premiums to plan years 2023 and beyond understates the true Standardized Plan premiums by understating the projected claims. This could result in premiums that are not actuarially sound in that the premiums will not be sufficient to cover claims, administrative costs and risk margins. We believe that the CPIM is not an appropriate proxy for medical cost trend, considering that prior years' actual carrier trend assumptions in approved rate filings are higher than adjustment factors using the CPIM.

### Use of 2021 as the Base Year for Determining the Maximum Colorado Option Premium

HB 21-1232 requires the use of 2021 Benchmark premium as the basis for determining the Maximum Colorado Option Premium for 2023 and beyond. It is our understanding that the 2021 premiums reflected regulatory actions[27] that did not allow for adjustments to reflect the impact of COVID-19 related expenses, limited the extent to which trend could be reflected in the rates, and did not allow carriers to reflect an increase in risk margins. This implies that the 2021 rates may be artificially low and therefore, may not be an appropriate basis for determining actuarially sound premiums for the Standardized Plans.

### Additional Premium Adjustments Not Considered in Regulation – Mandated Benefits and Risk Adjustment

As detailed below, the Colorado legislature has enacted benefit mandates to be effective after 2021 which are not part of the new EHB package. There is no adjustment in the premium adjustment methodology in Emergency Regulation 21-E-XX for the value of these benefits. All benefit mandates should be considered in setting the 2023 premiums for Colorado Option Standardized Plans if those premiums are to meet the premium reduction requirements and be actuarially sound.

In addition, the Emergency Regulation 21-E-XX Concerning the Methodology for Calculating Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans indicates a

[25] Emergency Regulation 21-E-XX Concerning Colorado Option Standardized Health Benefit Plan.pdf, DRAFT Proposed Emergency Regulation 22-E-XX Premium Rate Reduction Methodology for CO Option SBP- for external review.pdf - Google Drive

[26] The benchmark plan is for each carrier the carrier's 2021 lowest premium plan per metal level and region.

[27] https://doi.colorado.gov/press-release/reinsurance-saving-consumers-208-on-average-in-2021

1.0016 adjustment for EHB benefit package changes.[28] As detailed below, this adjustment is also inadequate to account for those newly mandated benefits.

Additionally, CMS recently proposed changes to the ACA risk adjustment methodology for plan years 2023 and beyond. In conjunction with that proposal, CMS published the results of a simulation showing carriers' risk adjustment transfers calculated under both the current and proposed methodologies. The results show that for some carriers, there are significant changes in the risk adjustment transfers. The premium adjustment methodology in HB 21-1232 makes no mention of adjustment to 2021 premiums for changes in risk adjustment. A lack of such adjustment, especially for some Colorado individual carriers, will present even further problems with being able to achieve actuarially sound premiums for the Colorado Option Standardized Plans which meet the premium reduction requirements.

### Impact on the 1332 Waiver Federal Passthrough

The 1332 Waiver federal passthrough is based on the reduction in premium tax credits (PTC) with some other adjustments to ensure that the passthrough is budget neutral. The PTC is calculated as the second lowest silver premium (SLSP) in a region compared to the maximum premium paid by subsidized individuals. If the SLSP is reduced, the PTC is reduced. Since health care coverage cooperative can be exempt from the premium reduction requirements, there may be no change in the federal pass through in the regions where the exempt plans have the SLSP today. The CO 1332 Amendment assumed that premiums in all regions would be reduced, which would overstate the federal passthrough in the counties where the exempt plans have the SLSP.

In addition, many of the other assumptions in the CO 1332 Amendment such as assuming that premium reduction requirements can be realized, not accounting for new benefit mandates, and using the federal Actuarial Value Calculator in place of a pricing actuarial value significantly impact the federal passthrough projections in the CO 1332 Amendment.

## Analysis of the CO 1332 Amendment using the HB 21-1232 Requirements

### Reduction in Provider Reimbursement Costs

HB 21-1232 gives the commissioner authority to reduce hospital and professional reimbursement rates, but hospital and professional costs are only 50% to 70% of premium costs. The commissioner does not have the authority to reduce other provider costs such as pharmacy costs, laboratory services, durable medical equipment, and other provider services.

[28] Emergency Regulation 21-E-XX Concerning the Methodology for Calculating Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans.pdf, DRAFT Proposed Emergency Regulation 22-E-XX Premium Rate Reduction Methodology for CO Option SBP- for external review.pdf - Google Drive, Section 5 C.6.

Milliman's Methodology to Determine the Potential of Reduced Provider Reimbursement

As stated above, Milliman provided a report analyzing what premium reductions could be achieved based on the provider reimbursements described in HB 21-1232, given the environment in Colorado.[29]

Milliman gathered data from several sources including the Unified Rate Review Templates (URRTs) filed by carriers in support of 2021 rate filings, the Plan and Benefit Design Templates (PBTs) for 2021 published by CMS, Milliman's Health Cost Guidelines rating model, Milliman's Commercial Percentage of Medicare reimbursement benchmarks, and the RAND Corporation's analysis of commercial hospital reimbursement.[30]

Milliman's methodology to estimate carrier provider reimbursement as a percentage of Medicare included:[31]

1. Using the URRTs to identify each carrier's lowest cost plan in each metal level, in each geographic rating area.
2. Adjusting base rates for the Colorado 1332 reinsurance program by geographic area and carrier and silver loads for cost-sharing reduction (CSR) defunding,
3. Using the URRTs to identify carrier assumptions for administrative costs, taxes, fees, and risk margins,
4. Calculating implied claims expense from premium rates,
5. Adjusting the Milliman Health Care Cost Guidelines from large group, which was the primary source of the Guidelines, to the morbidity levels in the individual and small group markets, using Appendix A of CMS's 2019 Risk Adjustment Transfers Report
6. Using the benefits in the PBTs and the adjusted Milliman Health Cost Guidelines to estimate carrier claim costs as a percentage of Medicare for hospital and professional costs,
7. Estimating professional reimbursements as a percentage of Medicare by adjusting Milliman's Percent of Medicare commercial reimbursement, which is based on large group experience, to an appropriate level for individual and small group experience, and
8. Estimating hospital reimbursement as a percentage of Medicare by backing out the non-hospital reimbursement out of total claims as a percentage of Medicare, assuming that the hospital percent of claims was the same as the industry-average, based on Milliman's benchmarks.

The result of Milliman's methodology was a set of individual and small group market hospital reimbursements as a percent of Medicare for each carrier and each ACA rating area.

Milliman's methodology for determining HB 21-1232 provider reimbursement floors included:[32]

[29] 5-27-21-Analysis-Colorado-HB-21-1232-Impact-Healthcare-Provider-Reimbursement-Consumer-Premiums.pdf. "Analysis of Colorado HB 21-1232 Impact on Healthcare Provider Reimbursement and Consumer Premiums." May 26, 2021.
[30] Ibid, page 12
[31] Ibid, page 12
[32] Ibid page 16

1. Estimating the average hospital reimbursement for each carrier and rating area using market prices and the methodology described above,
2. Matching hospitals to each carrier's network,
3. Determining the regional revenue weights using RAND's hospital repricing file,
4. Determining regional commercial hospital reimbursement as a percentage of Medicare for each carrier's network and rating area,
5. Using the regional revenue weights to the composite unadjusted reimbursement from the RAND files to an insurer-specific average for each rating area,
6. Calculating a scaling factor using the average area reimbursement and the carrier's average reimbursement for a rating area,
7. Scaling the hospitals in each carrier's network for the carrier in that rating area, and
8. Applying the reimbursement floors in HB 21-1232.

We reviewed this methodology and found it reasonable for the purpose, and actuarially sound.

Possible Reduction in Non-Hospital Professional Reimbursement

Milliman's report states that: [33]

> *In Colorado, our analysis suggests that it [physician reimbursement]is near or below the 135% floor enforceable under HB 21-1232.*

Milliman therefore assumes that physician reimbursement will not be reduced by the authority given to the commissioner by HB 21-1232 to reduce physician reimbursement.[34]

Possible Reduction in Hospital Reimbursement

Hospital inpatient and outpatient costs are approximately 35% to 50% of premiums.

The Milliman report states:

> *Our analysis suggests that the minimum hospital reimbursement levels established in the bill may be higher than the contracted arrangements that certain insurers (particularly those insurers in lower cost premiums) currently have in place with at least some of their providers, there may be limited ability for the commissioner to enforce premium rate reductions for those insurers in rating areas where those providers are located.*[35]

Milliman estimated the impact of HB 21-1232 on provider reimbursement and premium rates by:[36]

a. Estimating the CY 2021 hospital reimbursement by insurer and rating region for individual market,

[33] 5-27-21-Analysis-Colorado-HB-21-1232-Impact-Healthcare-Provider-Reimbursement-Consumer-Premiums.pdf page 2, "Analysis of Colorado HB 21-1232 Impact on Healthcare Provider Reimbursement and Consumer Premiums."
[34] Ibid. page 2
[35] Ibid. page 2
[36] Ibid. pages 12-20

b. Applying hospital reimbursement floors prescribed by HB 21-1232, and
c. Assessing the impact to premium rates from 2023 to 2025.

Milliman's analysis shows that using reductions in hospital reimbursement that the premium impact in regions 1, 2 and 3 will not be able to comply with the 15% reduction required by HB 21-1232 in 2025 and region 4 will barely comply. As Milliman pointed out:[37]

> *The estimated current regional reimbursement's proximity to the floor reimbursement under HB 21-1232 in the region varies primarily by urban and rural geographic regions. In rating regions 1-4, where 75% of Colorado's population resides, currently facility reimbursement is lower and therefore closer to the floor reimbursement stipulated in the bill. Generally, the closer a region (or specific hospital) is to the floor reimbursement, the more likely it is that the reductions to reimbursement will be smaller in that region (or for a specific facility).*
>
> *HB 21-1232 allows for the DOI commissioner to "consult with hospital-based health-care providers in Colorado and shall take into account the cost of adequate wages, benefits, staffing, and training for health-care employees to provide continuous quality care." National analysis indicates that rural hospitals had a median overall profit margin of 2.7% in our analysis, low margins may inhibit the provider reimbursement floors from being implemented in some cases, which would also impact premium rates.*

Based on Milliman's analysis, it is likely that hospital reimbursements will not be able to be reduced sufficiently to allow carriers to meet the premium reductions requirements of HB 21-1232.

## Use of the Federal Actuarial Value Calculator to Adjust for Plan Design Differences Between the Colorado Option and the 2021 Benchmark Plans

Emergency Regulation 21-E-XX Concerning the Methodology for Calculating Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans [38] specifies the adjustments to the 2021 Plan Premiums when measuring the required premium reductions for the Colorado Option Standardized Health Benefit Plans (Colorado Option Plans). Regarding the adjustment for differences in the plan design features, the regulation states:[39]

> *An adjustment factor will be applied to reflect changes in the member cost sharing from the 2021 Baseline Plan to the applicable Colorado Option Standardized Plan design.*
>
> *The Changes in Member Cost Sharing Adjustment will be calculated as follows:*
>
> *(Colorado Option Standardized Plan AV) ÷ (2021 Baseline Plan AV)*

[37] Ibid. pages 19-20
[38] Emergency Regulation 21-E-XX Concerning the Methodology for Calculating Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans.pdf, DRAFT Proposed Emergency Regulation 22-E-XX Premium Rate Reduction Methodology for CO Option SBP- for external review.pdf - Google Drive
[39] Ibid, Section 5 C.3

*a. Colorado Option Standardized Plan AV can be found in Appendix A of 4-2-81 for the applicable metal level.*

*b. The 2021 Baseline Plan AV will be determined by the value entered in the carrier's PBT for the 2021 Baseline Plan.*

The Colorado Option Required Premium Rate Reduction Methodology,[40] states:

*Changes in Member Cost Sharing: This adjustment will be a factor equal to the benefit year AV for the Colorado Option plan, calculated using the Federal Actuarial Value Calculator for the appropriate benefit year, divided by the carrier AV for 2021. This will be determined based on the carrier AV submitted in the Plan & Benefits Template for the 2021 benchmark plan.*

The use of the Federal Actuarial Value Calculator (AVC) to develop the Colorado Option Standardized Plan AV premium presents an actuarial difficulty in that the AVC is not an appropriate tool or model for making plan design adjustments in premium determination.

The Introduction section of the CMS Draft 2023 Actuarial Value Calculator Methodology document dated December 30, 2021, notes the purpose and intended use of the Federal Actuarial Value Calculator:

*Under the Essential Health Benefits, Actuarial Value, and Accreditation final rule (EHB Final Rule) that was published in the Federal Register at 78 FR 12834 on February 25, 2013, the Department of Health and Human Services (HHS) generally requires carriers of non-grandfathered health insurance plans offered in the individual market, both inside and outside of the Affordable Insurance Exchanges ("Exchanges") to use an Actuarial Value (AV) Calculator for the purposes of determining levels of coverage. Section 1302(d)(2)(A) of the Affordable Care Act (ACA) stipulates that AV be calculated based on the provision of essential health benefits (EHB) to a standard population. The statute groups health plans into four tiers: bronze, with an AV of 60 percent; silver, with an AV of 70 percent; gold, with an AV of 80 percent; and platinum, with an AV of 90 percent.*

CMS and CCIIO officials and actuaries have consistently and often warned that the AVC is to be used only for the purpose of assigning plans to metal levels and should not be used as a pricing model or to estimate a plan's true actuarial value. The Draft 2023 Actuarial Value Calculator Methodology document includes the statement,

*In addition to the regulatory provisions at 45 CFR 156.135 and 156.140, additional guidance on AV is available in the May 16, 2014 FAQs. Specifically, in Question 3, we clarify that carriers must always use an actuarially justifiable process when inputting their plan designs into the AV Calculator and that the AV Calculator is intended to establish a comparison tool and was not developed for pricing purposes.*

[40]Emergency Regulation 21-E-XX Concerning Colorado Option Standardized Health Benefit Plan.pdf, DRAFT Proposed Emergency Regulation 22-E-XX Premium Rate Reduction Methodology for CO Option SBP- for external review.pdf - Google Drive

Additionally, this warning has been discussed by CCIIO actuaries and other leadership in breakout sessions of the American Academy of Actuaries Annual Meetings. CCIIO has continued to stress that the AVC should not be used for pricing, which includes adjustments to premiums for plan design features and other considerations which impact expected claims costs and plan premiums.

It is easy to understand why CMS instructs carriers to not use the AVC for pricing. First, the claims data underlying the AVC is developed to represent a standard population (as detailed in the Actuarial Value Methodology document). The standard population uses underlying projected claims experience which is derived from a mixture of claims for individual plan enrollees from a mixture of types of plans (HMO, EPO, PPO) and for a national average (not specific for any state or rating area). Also, the claims used as the basis of the AVC are also adjusted to the appropriate plan year using medical trends assumptions for medical and prescription drug claims. The trend assumptions used and description of how they are chosen are presented in the CMS Actuarial Value Methodology document. But it is important to note that the trends used are not intended to represent actual trend experience or expectations of any particular carrier in any particular state, and, indeed, carrier trend assumptions in approved rate filings differ from those used in the development of each year's AVC. Thus, plan relativities based on AVC results in no way reflect true actuarial differences for individual plans for a specific carrier in a specific rating area.

Additionally, the AVC is designed to evaluate only Essential Health Benefits (EHBs), and then only a limited number of EHB plan benefit design features through a limited number of design inputs, and, thus, will not properly measure the true actuarial value that considers all the design features of different plan designs. (In fact, even for the AVC inputs, it is permitted and often necessary for determining metal level actuarial value to provide actuarial analyses outside of the AVC and certification for plan features that do not fit the AVC expected input.) It is important to note that the features that the AVC cannot evaluate can add significantly to a plan's true pricing actuarial value. For example, the AVC cannot account for a carrier's prescription drug formulary or the impact of specific state mandated benefits. Nor, because of the use of underlying data for a standard population, can it properly model a particular carrier's plan differences that relate to the utilization and cost characteristic (morbidity) of the carrier's population covered by that plan, or the impact of that carrier's medical management programs or prescription drug formulary, or that carrier's network provider practice patterns.

It is important to consider that current ACA pricing regulations appropriately call for the use of a carrier's "pricing actuarial value" to adjust the Market Adjusted Index Rate in determining the premium rates for different plan offerings, and not the use of the AVC. The pricing actuarial value is the calculated paid to allowed amount from a carrier's own actuarial models which consider relative plan values for that carrier's own plan designs, covered population utilization, provider network and reimbursement levels, medical management impact, prescription drug formulary and other items unique to that carrier. These models appropriately project changes in projected claims for different plan design configurations. As noted above, because of its structure and limitations (all related to its actual intended use) the AVC cannot accurately or reasonably model the impact of any of these.

To understand the magnitude of the difference in values from the Federal Actuarial Value Calculator and the pricing actuarial value we gathered the federal and pricing actuarial values from the 2018 URRTs in Colorado. We found that actuarial values derived using the Federal Actuarial Value Calculator results in only a 5% or 6% difference between the lowest and highest value in a metal level. This would imply that there would only be a 5% or 6% differential between the Colorado standardized plan and the non-standardized plans at the same metal level. More importantly, some Colorado issuers provided us their pricing actuarial values of the Colorado Option Standardized Plans' benefits. That information showed that the true actuarial value could be as much as 12% greater than the Standardized Silver Plan actuarial value from the Federal Actuarial Value Calculator, and 14% higher than the Standardized Bronze Plan actuarial value from the Federal Actuarial Value Calculator.

To the extent that the "true" actuarially determined actuarial values of the Colorado Option Standardized Plans (calculated using carriers' actuarial models) differ from those used to establish the actuarial values in the regulation, the resulting adjustment will misstate the true cost differences in accounting for the differences in plan designs. Should the actuarial values of the Standardized Plans in the regulation prove to be lower than the actuarial values of those plans calculated by the carriers using their actuarial pricing models, the adjusted premium will be too low and – all other things being equal – not actuarially sound. This misstatement may further impact that ability for carriers' Colorado Option Standardized Plans' premiums to meet the premium reduction requirements and still maintain actuarially sound premiums given the limitations and floors for provider reimbursement reduction.

### Use of The Medical Component of the Consumer Price Index to Adjust Premiums

The Colorado legislation, as part of the determination of premium reductions, allows for adjustment of 2021 premiums for medical trend. Specifically, with regard to the adjustment for increased medical costs, the legislation and regulation calls for the use of a medical cost adjustment based on the annualized average change in the medical care index component of the United States Department of Labor's Bureau of Labor Statistics Consumer Price Index for medical care services and medical care commodities over the previous 10 years (CPIM). This presents an actuarial technical issue – one that will likely result in the need for even further reduction in provider reimbursement to meet premium reduction requirements and create actuarially sound premiums. To the extent that the CPIM is lower than the actual medical trend, the adjustment is understated.

The CPIM is not an adequate or appropriate proxy for medical trend that applies to health insurance plans' costs. Medical trend involves changes in cost of medical services as well as changes in the utilization of services for a covered population. Health carriers use expected medical trends to project the claims costs for their covered population using estimates of future trend. These estimates are typically made by studying the past changes in the components of trend (service cost and utilization) with adjustments for known and anticipated circumstances which directly impact those components, such as provider reimbursement changes, provider network changes, new medical technologies and prescription drugs.

CPIM, on the other hand, is a very different metric, not anticipated to be a proxy for, or appropriate estimation of, medical trend. As the American Academy of Actuaries wrote to the President of the Massachusetts Senate in 2010 concerning legislation that was being considered by the Massachusetts legislature:[41]

> *The medical component of CPI measures price inflation at the retail level—it measures the prices paid for a fixed market basket of medical goods and services. It does not, however, measure any potential changes in the level of services or the full extent of changes in service intensity. In other words, medical CPI does not fully account for many significant factors that affect how average claim costs change from year to year[42], such as:*
>
> - *Utilization changes,*
> - *New technologies,*
> - *Changes in provider practices or the intensity of health care services being provided,*
> - *New mandated benefits not completely covered in the past,*
> - *Changes in enrollment mix,*
> - *Adverse selection,*
> - *The leveraging effect of the deductible, and*
> - *Changes in provider mix and negotiated provider payment arrangements.*
>
> *The relative importance of these factors can change over time. More importantly, medical CPI is a retrospective measure and does not account for expected future spending, which is the basis for actuarial rate-setting.*

As the American Academy of Actuaries letter notes, CPIM is a very different metric than medical trend, and we believe that it should not be used as part of any adjustment to adjust 2021 premium costs to future years. Additionally, the CPIM includes a cost of health insurance components including the portion paid by employees (employee contribution). As this is a backward look, this includes changes in benefit designs and employer changes in employee contribution percentages, both of which are not related to true claims cost increases. CPIM inclusion of these items is another reason why it is an inappropriate proxy for medical trend.

The examples in Appendix A of Draft Emergency Regulation 22-E-XX provides the "Trend Adjustment" for the 24 months from the midpoint of the 2021 benefit year to the midpoint of the 2023 benefit year as 1.061. (Note that this is the total adjustment, and not the annualized trend). The table below shows trends from approved carrier individual ACA market rate filings in Colorado and a calculated overall individual market weighted average over three plan years.

[41] https://www.actuary.org/sites/default/files/pdf/health/AAA_letter_on_medical_CPI_072710.pdf
[42] American Academy of Actuaries, Critical Issues in Health Reform: Premium Setting in the Individual Market (March 2010)

Table 1 – Individual Market Approved Trends

| | | Individual Market Approved Trends | | |
|---|---|---|---|---|
| **Company** | **HIOS ID** | **PY2020** | **PY2021** | **PY2022** |
| Rocky Mountain Hospital and Medical Service, Inc., D.B.A. Anthem Blue Cross and Blue Shield | 87269 | 7.21% | 5.91% | 5.05% |
| Bright Health Insurance Company | 31070 | 7.24% | 1.66% | 10.11% |
| Cigna Health and Life Insurance Company | 49375 | 4.79% | 2.58% | 6.57% |
| Denver Health Medical Plan, Inc. | 66699 | 0.85% | -2.36% | -1.42% |
| Friday Health Plans | 63312 | 4.54% | 1.97% | 1.96% |
| HMO Colorado, Inc. | 76680 | 7.77% | 5.93% | 5.07% |
| Kaiser Foundation Health Plan of Colorado | 21032 | 4.80% | 3.97% | 4.59% |
| Oscar Insurance Company | 44559 | | | 4.34% |
| Rocky Mountain HMO | 97879 | 8.06% | 4.74% | 0.00% |
| **Weighted Average Annual** | | **6.05%** | **3.94%** | **5.56%** |
| **Three Year Weighted Average Trend** | | | | **16.4%** |
| **Annualized Weighted Average Trend** | | | | **5.2%** |

As can be seen in the table above, medical trends used to project claims in approved rate filings in Colorado have been higher than the comparable Trend Adjustment factor calculated using the CPIM (3.0% Medical Inflation Trend shown in the Examples in Appendix A of DRAFT Proposed Emergency Regulation 22-E-XX). Indeed, the annual trends shown in the table are greater than the total two-year trend adjustment of 1.061. Using a weighted average trend of 5.2%, the trend adjustment factor would be 1.1067. Thus, the CPIM-based Trend Adjustment will yield an adjusted 2023 benchmark plan premium that is lower than what the carriers will very likely experience. This will make achieving the premium reduction requirements even more difficult while still producing actuarially sound premiums, especially given the current reimbursement levels and limitations on the reduced provider reimbursement. We anticipate that actual medical trend will continue to outpace the CPIM especially in the near term, for the same reasons noted above that trend and CPIM are very different concepts, and that CPIM is not a realistic or appropriate proxy for medical trend. As we have already noted in this report, the current levels of provider reimbursement and the floors and other limitations that will limit the amount of reimbursement reduction the Commissioner may impose, will make it very difficult and, in fact, highly unlikely that the premium reduction requirements will be achieved throughout the state (in all rating areas) for actuarially sound premiums for the Standardized Plans.

## Additional Premium Adjustments Not Considered in Regulation – Mandated Benefits and Risk Adjustment

The Colorado Option legislation calls for the use of adjustments for federal and state mandated benefits. We note that the State of Colorado has implemented several benefit mandates that are

applicable to 2023 plans (and will need to be reflected in 2023 premiums) which were not applicable to 2021 plans and premiums, including mandates related to acupuncture, gender affirming care, mental health wellness exams, and changes to drug coverage as part of its EHB benefits. However, it may be that the adjustment in DRAFT Proposed Emergency Regulation 22-E-XX of 1.0016 may be understated. In its April 30, 2021, letter to Commissioner Michael Conway of the Colorado Division of Insurance regarding the Proposed Changes to Colorado's Essential Health Benefits Package, The Colorado Association of Health Plans stated:

> *As Wakely noted in their report, Colorado individual and small group ACA carriers provided Wakely with actuarial estimates for the benefit changes under consideration. CAHP would like to note that there is variation between Colorado's individual and small group ACA carriers' estimates and Wakely's estimates. These differences raise concerns for CAHP that the proposed EHB Benchmark Plan is not equal to a typical employer plan and exceeds the generosity of the most generous among a set of comparison plans discussed in the Wakely report.*

CAHP members estimate the impact of the proposed benefit changes to be the following:

Table 2 – Impact of proposed benefit changes

| **Benefit Difference** | **CAHP Estimates: Allowed Cost Impact** | **Wakely Estimates: Allowed Cost Impact** |
|---|---|---|
| Acupuncture | 0.11% - 0.13%<br>*12 visits | 0.08%<br>*6 visits |
| Gender Affirming Care | 0.13% - 1.14% | 0.04% |
| Mental Health Wellness Exam | 0.01% - 0.14% | 0.02% |
| Expand Number of Drugs Covered in Certain USP Classes | 0.03% - 0.04% | 0.02% |
| **Total** | **0.28% - 1.45%** | **0.16%** |

Wakely notes in their analysis that costs for gender affirming care, due to pent up demand, may be higher in the first year or two of these services being offered, therefore their estimate of 0.04% represents a point estimate of the long-term steady state cost of the proposed gender affirming care services. While CAHP members share Wakely's view that the gender affirming care surgeries would add significant costs in the short term, once pent-up demand is met, CAHP members estimate the long-term annual costs would be roughly 0.50% of added annual premium.

> *CAHP members also have concerns that cost estimates were not provided for all of the proposed benefit changes to the EHB Benchmark Plan. For example, Wakely's report notes that mental health services that are custodial or residential in nature should be included in the EHB Benchmark Plan under the guise of mental health parity, even though non-mental health custodial and residential services are typically not covered by health insurance. If Colorado is seeking to add mental health custodial and residential care, actuarial estimates should be included in Colorado's application to CMS. Removing this exclusion and requiring carriers to cover mental health custodial and residential care, could significantly impact the actuarial value of the EHB Benchmark Plan and Colorado consumers' premiums.*

Additionally, there have been other recent mandated benefits that were not part of the EHB Benefits Package:

- HB 20-1158 requires coverage of additional infertility and reproductive services. This was not included in the State's recent EHB package but will be required to be built into premiums for 2023 plans. Some actuarial estimates have a range of 0.6% to 1.0% increase in premium for this.
- HB 21-1276 – Prevention of Substance Abuse Disorder requires that effective 1/1/2023, the required cost sharing must include an amount that does not exceed the cost sharing amount for a primary care visit for non-preventive services, at least 6 physical therapy visits, at least 6 occupational therapy visits, 6 chiropractic visits, and 6 acupuncture visits.
- Also, HB 21-1297 Pharmacy Benefit Manager and Insurer Requirements, and HB 21-1140 Eliminate Donor Cost for Living Organ Donations are effective for the 2022 plan year.

Inability to appropriately adjust for the premium increases resulting from an understated EHB cost adjustment from not reflecting increased costs for mandated benefits that are not a part of the regulation's premium adjustments will directly impact the ability to achieve the required premium reductions for the Colorado Option Standardized Plans for actuarially sound premiums. This is because the resulting adjusted premiums will not reflect all of the increased costs. Not reflecting all costs in premiums will lead to premiums that are not actuarially sound.

The federal government recently announced a requirement that, beginning in 2022, health plans must pay for over-the counter COVID tests with no cost sharing by covered individuals. If this requirement continues such that it applies to plans for 2023 and beyond, the adjustments to 2021 plan premiums should also recognize this mandate.

Changes to the risk adjustment methodology has recently been proposed in the HHS Notice of Benefit Payment and Parameters for the 2023 Proposed Rule[43]. If finalized, the change in risk adjustment methodology will impact all carriers' expected (and ultimately actual) risk adjustment transfer payments compared to what they would have been under the methodology applicable to the 2021 benefit year. CMS recently performed a risk adjustment transfer simulation to show the impact of the risk adjustment changes using 2020 EDGE data. Each carrier was provided detailed information on the impact of the changes including the impact of risk scores for their plans. Additionally, CMS published a summary of the changes in the overall state risk scores for individual market, as well as changes in total risk transfer amounts by carrier. The results show that the changes in methodology result in different risk adjustment transfers, and the difference is significant for some carriers. A true actuarial adjustment to 2021 plan premiums for purposes of the Colorado Option premium reductions should reflect any impact of the risk adjustment methodology change, yet we do not see that any such adjustment is anticipated or permitted in the regulations.

[43] https://www.federalregister.gov/public-inspection/current

## Other Items that Impact Premiums

Table 3 shows the main components of rate changes over the last two years. For 2022 rates, trend ranged from -1.4% to 10.1%, and, for most carriers, accounted for the largest change in rates prior to reflecting the reinsurance program. Statewide, rates decreased by an average of 1.4% for 2021 in the individual market, with significant variation by geographic area; Park, Mesa and Summit counties experienced rate decreases of 12.3%, 8.1% and 7.5% respectively, while Washington, Phillips and Logan counties had the largest rate increase of 12% or higher. We note that the reinsurance program decreased average premiums by 20.8% for 2021. For 2022, the average rate increase in the individual market was 1.1%; the reinsurance program decreased premiums by 24.1%, from 25.5% to 1.1%, with the biggest impact on the West rating area.

It is our understanding that the 2021 premiums reflected regulatory actions[44] that did not allow for adjustments to reflect the impact of COVID-19 related expenses, limited the extent to which trend could be reflected in the rates, and did not allow carriers to reflect an increase in risk margins. We also note that three of the four largest carriers had a much larger rate increases in 2022, compared to 2021. This could mean that 2021 rates may be artificially low and using 2021 as the base year for implementing the reimbursement and trend limitations on rates could exacerbate the potential negative impact on some carriers if requirements are not attainable.

Table 3 - Claim trends compared to premium increases – Individual[45]

| | **Premium Increases** | | **Trend used in Rate filing** | | **Change in Morbidity** | | **Demographic, Plan Design and Other Changes** | | **State Reinsurance Adjustment** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2021** | **2022** | **2021** | **2022** | **2021** | **2022** | **2021** | **2022** |
| Bright Health | -5.5% | -0.9% | 1.7% | 10.1% | 0.0% | -2.7% | 9.4% | -0.3% | -17.4% | -21.2% |
| Cigna | 3.0% | -0.3% | 2.6% | 6.6% | -4.6% | -5.8% | -1.6% | 4.9% | -21.9% | -25.8% |
| Denver Health | -4.6% | -8.9% | -2.4% | -1.4% | 0.0% | 0.0% | 6.6% | 2.3% | -14.8% | -30.3% |
| Friday | -5.1% | -0.3% | 2.0% | 2.0% | 6.0% | 3.3% | -11.9% | -3.4% | -20.9% | -23.8% |
| HMO Colorado | 0.3% | 3.5% | 5.9% | 5.1% | 1.0% | 0.0% | -10.6% | -6.7% | -29.2% | -30.9% |
| Kaiser | -1.5% | 1.6% | 4.0% | 4.6% | 6.1% | -2.0% | -3.5% | -2.7% | -13.1% | -15.5% |
| Oscar | -4.2% | 6.1% | N/A | 4.3% | 0.0% | 0.0% | 0.0% | 0.0% | -16.8% | -15.5% |
| Rocky Mtn HMO | -10.0% | -4.3% | 4.7% | 0.0% | 0.0% | 0.0% | -19.4% | 0.0% | -30.2% | -30.7% |
| **Overall** | **-1.4%** | **1.1%** | **3.9%** | **5.6%** | **1.6%** | **-1.2%** | **-4.5%** | **-2.5%** | **-20.8%** | **-24.1%** |

## Administrative Fees

Table 4 shows a comparison of administrative fees for carriers in the individual market, as a per member per month and percent of claims basis, as stated in the 2022 rate filings. HB 21-1232 specifies required reductions in premiums over the next five years. If carriers are not able to

[44] https://doi.colorado.gov/press-release/reinsurance-saving-consumers-208-on-average-in-2021
[45] https://doi.colorado.gov/for-consumers/consumer-resources/insurance-plan-filings-approved-plans

achieve these reduced premiums through favorable renegotiated provider reimbursement contracts, a reduction in administrative expenses may be one way to achieve the premium reduction goals. However, since some of the administrative expenses are related to overhead expenses, which do not change as premiums decline, administrative expenses, as a percentage of premium, increase, e.g., information technology (IT) expenses. Table 4 shows the administrative expense load used by each of the carriers in the individual market in determining their premium rates for 2022. As a percentage of premium, administrative expenses (such as consumer support services) averaged 12 percent of premium and ranged from 9.6% to 18.1%. These values are on the average to low side of the range for the industry and indicate there may not be much room to decrease expenses if premium reduction requirements are not met.

Table 4 – Comparison of Administrative Fees

| Carrier | 2022 Admin Expenses | |
|---|---|---|
| | PMPM | % of Premium |
| Bright Health Insurance Co. | $54.48 | 14.1% |
| Cigna Health & Life Insurance Company | $41.73 | 9.6% |
| Denver Health Medical Plan Inc | $67.33 | 18.1% |
| Friday Health Plans | $56.18 | 13.4% |
| HMO Colorado Inc. | $54.83 | 11.0% |
| Kaiser Fndtn Hlth Plan of CO | $56.35 | 12.0% |
| Oscar Insurance Co. | $49.46 | 12.5% |
| Rocky Mtn Hlth Maintenance Org | $61.11 | 11.9% |
| **Overall** | **$54.25** | **12.0%** |

## Financial Solvency

If carriers are not able to achieve these reduced premiums through favorable renegotiated provider reimbursement contracts, a reduction in risk margins may be another way to achieve the premium reduction goals.

Even though 2020 was a very unusual year due to COVID, we used it in our analysis since it was the most recent complete year where we had financial information. COVID resulted in the elimination of elective surgeries for a significant period of time, many services being deferred, and individuals hesitant to seek medical services due to COVID concerns. The result was typically increased underwriting gains based on premiums that were set not anticipating COVID.

Table 5 below shows the financial indicators for the carriers in the individual market. This illustrates that three of the nine carriers in the individual market experienced a net loss related to their comprehensive medical business in 2020. As of December 31, 2021, four carriers reported premium deficiency reserves, which indicates that premiums are expected to be insufficient to cover related benefits and expenses and therefore not a good basis for future premium reductions as required by HB 21-1232. The risk margins included in the 2021 and 2022 rate filings are shown below and range from 1.6% to 5.1%. These results illustrate that, if provider reimbursement targets are not met, some carriers may not have sufficient margin to absorb the

additional claims liability and may find themselves in financial difficulty if they are not able to raise additional capital.

The information displayed below was gathered from public sources that may include states beyond Colorado, for example, Cigna's underwriting gains are nationwide. Table 5 shows that some carriers experienced a net underwriting loss during 2020, a year when many health carriers experienced a net underwriting gain due to the deferral of medical care during the start of the COVID-19 pandemic.

Table 5 – Financial Summary for Carriers in the Individual Market

| | Risk Margin used in Rate filing | | Net UW Gain / (Loss) for Comp Med as of 12/31/220* | |
|---|---|---|---|---|
| | 2021 | 2022 | $M | % |
| Bright Health Insurance Co. | 2.8% | 2.9% | ($2.1) | (1.2%) |
| Cigna Health & Life Ins Co. | 3.5% | 3.5% | $908.1 | 6.9% |
| Denver Health Medical Plan Inc | 3.0% | 3.0% | $6.0 | 4.8% |
| Friday Health Plans | 5.1% | 2.1% | ($18.1) | (17.0%) |
| HMO Colorado Inc. (Anthem) | 3.4% | 3.0% | $40.6 | 6.5% |
| Kaiser Fndtn Hlth Plan of CO | 2.0% | 2.2% | $245.9 | 9.9% |
| Oscar Insurance Co. | 2.1% | 1.6% | ($63.3) | (123.1%) |
| Rocky Mtn Hlth Maintenance Org | 3.7% | 3.7% | $15.0 | 8.5% |

*The net underwriting gain/(loss) is for the commercial (individual and group) comprehensive medical line of business across the entire legal entity. For multi-state carriers, these amounts may reflect experience in states other than Colorado.

## Reliances

In developing the findings and opinions in this report, we relied upon information obtained from and/or provided by other sources. We have reviewed this information for reasonableness and applicability but have performed no audits of the information. These include:

- 2020 Annual Statements and 3Q 2021 Quarterly Financial Statements for Colorado individual health carriers from SNL
- Colorado individual health carrier rate filings approved by the Colorado Division of Insurance for plan years 2020, 2021, and 2022. These filings are publicly available at https://filingaccess.serff.com/sfa/home/CO.
- Information on pricing actuarial values and actuarial values developed using the applicable Federal Actuarial Value Calculator for rate filings for the 2018 plan year for Colorado individual health carriers reviewed by NovaRest under a past contract with the Colorado Division of Insurance.
- Information provided by some Colorado individual plan carriers regarding the actuarial values of the Standardized Individual Silver and Bronze Plans developed from those carriers' actuarial pricing models.

- Information on Colorado individual carriers' estimates of the actuarial values of the Colorado Option Standardized Plans developed using the actuarial models used to develop their pricing actuarial values provided by The Partnership.
- Information in the Colorado Association of Health Plan Letter Regarding Colorado's Preposed EHB Benchmark Plan provided by The Partnership.
- Information on Colorado mandated benefits effective after Calendar Year 2021 provided by The Partnership.

## Limitations

This report and the conclusions and opinion herein have been developed for the exclusive use of The Partnership for use in developing and for inclusion in that organization's comments to CMS regarding the Colorado Section 1332 Innovation Waiver Amendment – 11/30/21 as part of the CMS comment period for that application. Other uses of this report and its comments and opinions may not be appropriate for other uses. NovaRest assumes no obligation or liability for other such uses. Users of this report should read the entire report and should possess a general and working knowledge of the Colorado Section 1332 Innovation Waiver Amendment Request, the Colorado individual health insurance market and the Affordable Care Act.

## Subsequent Events

To our knowledge, there have been no subsequent events that impact this report and our findings and conclusions. Should there be subsequent events or actions after the delivery of this report, such as changed methodologies in final regulations or modifications to existing regulations, such events or actions could impact our findings.

(4) based on evidence presented at a hearing held pursuant to subsection (3) of this section and other available data and page 12-house bill 21-1232 actuarial analysis, the commissioner may:

(a) (I) establish carrier reimbursement rates under the standardized plan for hospital services, if necessary, to meet network adequacy requirements or the premium rate requirements in section 10-16-1305.

(II) the base reimbursement rate for hospital services shall not be less than one hundred fifty-five percent of the hospital's Medicare reimbursement rate or equivalent rate.

(III) a hospital that is an essential access hospital or that is independent and not part of a health system must receive a twenty-percentage-point increase in the base reimbursement rate.

(IV) a hospital that is an essential access hospital that is not part of a health system must receive a forty-percentage-point increase in the base reimbursement rate.

(V) a hospital that is a pediatric specialty hospital with a level one pediatric trauma center must receive a fifty-five-percentage-point increase in the base reimbursement rate and is not eligible for additional factors under this subsection (4).

(VI) a hospital with a combined percentage of patients who receive services through programs established through the "Colorado medical assistance act", articles 4 to 6 of title 25.5, or Medicare, title xviii of the federal "social security act", as amended, that exceeds the statewide average must receive up to a thirty-percentage-point increase in its base reimbursement rate, with the actual increase to be determined based on the hospital's percentage share of such patients.

(VII) a hospital that is efficient in managing the underlying cost of care as determined by the hospital's total margins, operating costs, and net patient revenue must receive up to a forty-percentage-point increase in its base reimbursement rate.

(VIII) notwithstanding subsections (4)(a)(III) TO (4)(a)(VII) of this section, in determining the reimbursement rates for hospitals, the commissioner may consult with employee membership organizations representing health-care providers' employees in Colorado and with hospital-based health-care providers in Colorado and shall take into account the cost of adequate wages, benefits, staffing, and training for health-care employees to provide continuous quality care.

(b) establish reimbursement rates under the standardized plan, if necessary, for health-care providers for categories of services within the geographic service area for the standardized plan to meet network adequacy requirements or the premium rate requirements in section 10-16-1305 (2), which rates may not be less than one hundred thirty-five percent of the Medicare reimbursement rates within the applicable geographic region for the same services;

(c) require hospitals that are licensed pursuant to Section 25-1.5-103 to accept the reimbursement rates established pursuant to subsection (4)(a) of this section if necessary to ensure the standardized plan meets the premium rate requirements and the network adequacy requirements;

(d)

(I) require health-care providers to accept the reimbursement rates established pursuant to subsection (4)(b) of this section, if necessary, to ensure the standardized plan meets the premium rate requirements and the network adequacy requirements.

(II) the commissioner shall not require a health-care provider, other than a hospital that provides a majority of covered professional services through a single, contracted medical group for a nonprofit, nongovernmental health maintenance organization, to contract with any other carrier; and

(e) require the carrier to offer the standardized plan in specific counties where no carrier is offering the standardized plan in that plan year in either the individual or small group market. In determining whether the carrier is required to offer the standardized plan in a specific county, the commissioner shall consider:

(I) the carrier's structure, the number of covered lives the carrier has in all lines of business in each county, and the carrier's existing service areas; and

(II) alternative health-care coverage available in each county, including health-care coverage cooperatives.

(5) notwithstanding subsection (4) of this section, the commissioner shall not set the reimbursement rates for:

(a) a hospital at less than one hundred sixty-five percent of the Medicare reimbursement rate or the equivalent rate; and

(b) any hospital for any plan year at an amount that is more than twenty percent lower than the rate negotiated between the carrier and the hospital for the previous plan year.

(6)

(a) the commissioner shall promulgate rules to ensure that there is not an unfair competitive advantage for a carrier that intends to offer the standardized plan in the individual or small group market in a county where it has not previously offered health benefit plans in that market or with a hospital with which the carrier has not previously had a contract.

(b) the rules promulgated pursuant to this subsection (6) must align with the hospital reimbursement methodologies described in subsections (4) and (5) of this section.

(7) notwithstanding subsections (4) and (5) of this section, for a hospital with a negotiated reimbursement rate that is lower than ten percent of the statewide hospital median reimbursement rate measured as a percentage of Medicare for the 2021 plan year using data from the Colorado all-payer claims database described in section 25.5-1-204, the commissioner shall set the reimbursement rate for that hospital at no less than the greater of:

(a) the hospital's commercial reimbursement rate as a percentage of Medicare minus one-third of the difference between the hospital's 2021 commercial reimbursement rate as a percentage of Medicare and the rate established by subsection (4) of this section;

(b) one hundred sixty-five percent of the hospital's Medicare reimbursement rate or equivalent rate; or

(c) the rate established by subsection (4) of this section.

(8) a carrier or health-care provider may appeal a decision by the commissioner made pursuant to subsection (4) of this section to the district court in the applicable jurisdiction. The decision of the commissioner is a final agency action subject to judicial review pursuant to section 24-4-106 (6).

(9) for the purpose of making the determination in subsection (3) of this section:

(a) a health-care coverage cooperative, and a carrier offering health benefit plans under agreement with the health-care coverage cooperative, that has offered one or more health benefit plans to purchasers in the individual and small group markets that previously achieved and maintained at least a fifteen percent reduction in premium rates, regardless of the first year the health benefit plans were offered, shall be deemed by the commissioner as having met the requirements for carriers in sections 10-16-1304 and 10-16-1305 with respect to the counties in which the individual and small group plans are being offered by the health-care coverage cooperative.

(b) the commissioner shall take into account:

(I) any actuarial differences between the standardized plan and the health benefit plans the carrier offered in the 2021 calendar year;

(II) any changes to the standardized plan; and

(III) state or federal health benefit coverage mandates implemented after the 2021 plan year.