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ResearchReport

Summary of Colorado State Public Option Health Insurance Draft Proposal

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November 15, 2019 | 2019-R-0268

Issue

Summarize the draft proposal for the Colorado state public option health insurance plan, which was released October 7, 2019.

Summary

On May 17, 2019, Colorado enacted HB19-1004, requiring its Department of Health Care Policy and Financing (HCPF) and Division of Insurance (DOI) to develop a proposal for a state public option health insurance plan ("state option"). The proposal must consider the feasibility and cost of implementing a state option that:

1. leverages existing state health care structures,
2. increases competition,
3. improves quality, and
4. provides Colorado residents with stable access to affordable health insurance.

On October 7, 2019, HCPF and DOI released a draft proposal based on the legislative charge, stakeholder feedback, research, and actuarial analyses, outlining recommended state option plan components. Under the proposal, large insurers would offer and administer a health insurance plan that HCPF and DOI develop. The state option would:

1. cover the Colorado essential health benefits (EHBs);

2. utilize a value-based insurance design (VBID) that, among other things, includes more pre-deductible benefits than high deductible health plans (HDHPs); and

3. limit provider reimbursement rates.

The specific benefit structure has not been finalized.

The state offered a public comment period on the draft proposal, from October 7, 2019, until October 25, 2019. Under HB19-1004, the final proposal is due to the Colorado legislature by November 15, 2019.

Colorado State Option

Under the draft proposal, all Colorado residents would be eligible for state option coverage beginning January 1, 2022, without means-testing. The proposal does not include a specific state option plan design. Instead, it outlines general plan parameters, as summarized below.

Oversight

The draft proposal makes the following three state agencies responsible for overseeing the state option: HCPF, DOI, and Connect for Health Colorado (the state's health insurance exchange). Generally, HCPF and DOI must jointly develop the specific plan structure, including reimbursement rates; DOI must continually monitor the plans for regulatory compliance; and the exchange must provide an infrastructure to sell, market, and enroll people in the plan. The proposal also calls for the state to create a State Option Advisory Board to ensure that stakeholder voices continue to inform the plan's ongoing development and implementation.

Table 1 summarizes HCPF's, DOI's, and Connect Health Colorado's main oversight and administrative responsibilities under the draft proposal.

Table 1: Colorado State Option Oversight and Administrative Responsibilities

Agency	*Responsibilities*
HCPF	• Partner with DOI to develop plan specifics, including goals, operational requirements, benefit designs, reimbursement benchmarks, and any reporting and monitoring requirements • Leverage volume discounts for plan enrollees • Track emerging best practices in cost control strategies, alternative payment methodologies, delivery system influences, and technological innovations

Table 1 (continued)

Agency	Responsibilities
DOI	• Partner with HCPF to develop plan specifics, including goals, operational requirements, benefit designs, reimbursement benchmarks, and any reporting and monitoring requirements • Review and approve premium rates and plan designs under existing rate approval processes • Monitor state option plans for regulatory compliance • Monitor and publicly report on evidence of cost-shifting, including to the large group market
Connect for Health Colorado	• Sell the plan through existing exchange infrastructure • Assist individuals in enrolling • Leverage exchange resources to publicize and market the plan

Benefit Coverage

Under the draft proposal, the state option covers, at a minimum, the Colorado EHBs. Additionally, it may also cover certain other high value services, such as dental services, pending savings and federal waiver approval. (EHBs are 10 broad categories of health services, ranging from outpatient care to preventive and wellness services, which most individual and small group health insurance plans must cover under federal law. States can select a "benchmark plan" that more fully defines the state EHBs. Information on Colorado's current benchmark plan is available here.)

Plan Design

According to the draft proposal, the plan establishes a reasonable price structure while also addressing the financial well-being of the state's providers, particularly rural and critical access hospitals. It uses VBID, which creates incentives for patients and providers to use high value care by decreasing out-of-pocket costs, adding more pre-deductible benefits for individuals with HDHPs, and increasing provider reimbursements. (For more information, see OLR Issue Brief 2017-R-0286, "Value Based Insurance Design.")

Additionally, the plan uses a medical loss ratio (MLR) of at least 85%, up from the 80% minimum required by the federal Affordable Care Act (ACA). (MLR is the amount of premium dollars spent on direct patient care. See "Increased MLR" below for more information.)

Plan Administration

The draft proposal calls for private insurers to offer the state option in the fully insured individual market and on the state exchange. According to the actuarial assumptions, it would be the second lowest cost silver plan on the exchange's individual marketplace, which is generally the plan on which federal premium tax credits are based under the ACA.

Affordability to Insureds

Under the draft proposal, the state option achieves savings for insureds primarily by (1) reducing payments to providers and hospitals, from an estimated average of 289% of Medicare rates, to between 175% to 225% of Medicare rates, and (2) increasing the minimum MLR, from 80% to 85%. The proposal indicates that reducing average provider payments reduces the plan's cost and provides savings to the insurer; increasing the MLR ensures that at least some of those new savings are passed to consumers in the form of lower premiums. Together, the plan estimates this will reduce an insured's monthly health insurance premium by 9% to 18%, compared to the average ACA premiums.

Provider Payments. To determine how much to pay providers and hospitals, Colorado first estimated current provider payments using an actuarial analysis by the Wakely Consulting Group and a 2019 study by the RAND Corporation of the average prices paid to hospitals by private health plans in 25 states. The RAND study found that private payers in Colorado paid an average of 269% of Medicare rates for care in 2017, which is higher than 20 of the 25 states studied. Additionally, the average price for care in Colorado is trending up, from 254% of Medicare rates in 2015, to 261% of the rates in 2016, and to 269% in 2017. (Connecticut was not included in the RAND study.)

According to the analysis, provider payments in Colorado can vary by up to 400% for the same services. The plan recommends standardizing payment rates across providers using a benchmark of between 175% to 225% of Medicare rates. Some providers will see a decrease in reimbursement payments while others (e.g., those in rural areas) may see an increase. Taken together, the plan anticipates generating savings and passing them on to consumers.

Increased MLR. Increasing MLR requires insurers to spend more premium dollars on direct health care expenses, reducing the amount spent on administrative expenses, overhead, and profit. However, Wakely's analysis (page 32) indicates that the MLR increase would have an "immaterial impact since average MLRs for 2015 through 2017 are reported to be above the proposed 85% target." Although the proposal states that increased MLR would directly impact premiums, it is not clear such savings are supported by the actuarial analysis.

Additional Affordability Considerations. DOI and HCPF indicate in the draft proposal that the state option would reduce enrollment in higher-premium qualified health plans, thus decreasing the amount the federal government spends on ACA premium tax credits. As a result, the state could apply for a federal 1332 waiver to pass these savings on to insureds. (A 1332 waiver allows a state to waive certain federal requirements when piloting new programs, as long as a comparable number of people remain insured.) Additionally, the proposal would require prescription drug rebates and other pharmaceutical manufacturer compensation to be passed on to insureds.

Impact on State Budget

Because the draft proposal calls for private insurers to administer the state option, the insurers and not the state would bear the associated financial risks. Additionally, HCPF and DOI would design the plan primarily using existing resources. As a result, the proposal indicates that the plan's impact on the state budget is expected to be negligible.

Additional Considerations

In addition to the plan parameters discussed above, the draft proposal identifies various other policy considerations. Primarily, these include (1) how to ensure adequate provider participation, (2) how to define affordability, and (3) whether to build on Medicaid's infrastructure.

With respect to provider participation, Colorado has many rural areas with fewer providers than in other areas of the state. If those providers are unwilling to participate in the state option network, an insured's access to care would be at risk. Thus, the state may be required to implement measures to ensure that health systems participate in the state option. The proposal indicates that HCPF and DOI would seek an open dialogue with providers and carriers in order to achieve this goal.

HB19-1004 requires the state to establish a definition of affordability to guide the state option's development and implementation. The draft proposal calls for the definition to include the following considerations: (1) total out-of-pocket costs, including premiums, copays, deductibles, and prescription drug prices and (2) the ability for Colorado residents to purchase the plan without sacrificing other budgetary priorities and irrespective of family size, location, income level, or degree of illness.

Finally, the proposal recommends not leveraging the state's Medicaid infrastructure. According to the proposal, the state Medicaid program is uniquely situated to meet the needs of certain target populations (e.g., low-income, medically fragile, or disabled) and could not be reoriented to provide a state option without considerable expense.

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