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February 2, 2022

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Ave, NW
Washington, D.C. 20220

Submitted electronically via stateinnovationwaivers@cms.hhs.gov

RE: Colorado Section 1332 Waiver Amendment Request – AHIP Comments

Dear Secretary Becerra and Secretary Yellen:

On behalf of AHIP and our member health insurance providers, thank you for the opportunity to offer comments on Colorado's Section 1332 State Innovation Waiver Amendment Request ("Waiver Amendment Request") to implement the Colorado Option.¹

AHIP believes all Americans should have both high-quality and affordable health insurance coverage choices. We have historically supported state actions that reduce premiums and out-of-pocket costs including 1332 reinsurance waivers across the country and state programs that reduce cost-sharing. As designed, the Colorado Option program would not achieve this goal. It is important to recognize that the Colorado Option has not been implemented and Colorado's individual market is strong and stable. In recent years, premiums have decreased and health insurance providers have significantly expanded their offerings across the state, providing more choices for Coloradans. We have significant concerns the Colorado Option program will put Colorado's strong and stable insurance market at risk as it creates conflicting and mathematically impossible standards requiring issuers to offer plans at actuarially unsound rates. Faced with this reality, issuers may be unable to meet the requirements in some counties.

We recommend the Departments not approve Colorado's Waiver Amendment Request. The Waiver Amendment Request (1) does not satisfy the Affordable Care Act (ACA) section 1332

¹ AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone. We believe that when people get covered and get and stay healthy, we all do better. The best way to do that is to expand on the market-based solutions and public-private partnerships that are proven successes.

guardrails for affordability, coverage, and deficit neutrality; (2) projects benefits and impacts based on deeply flawed actuarial and economic analyses; (3) does not include sufficient transparency around how passthrough funds associated with the Colorado Option program will be used and kept separate from the passthrough funds for the reinsurance program; and (4) is contingent on future state action, as critical regulatory action to implement the Colorado Option program was not complete prior to the Waiver Amendment Request and, therefore, not reflected in the projection of its savings and benefits. We provide detailed comments around each of the Waiver Amendment Request’s shortcomings. This includes a legal analysis demonstrating the Waiver Amendment Request does not meet the section 1332 statutory guardrails, supported by data from a new actuarial analysis identifying flaws and shortcomings of the Waiver Amendment Request.²

Rigorous and careful review of Colorado’s Waiver Amendment Request is required given it is a wholesale new type of 1332 waiver flexibility. As the precedent-setting first waiver of its kind, the Waiver Amendment Request must clearly meet statutory guardrails—similar to the careful analysis and burden of proof being required of other recent waiver applications. If approved, other states could look to the Colorado Waiver Amendment Request and submit follow-on waiver applications mimicking Colorado’s program design and proposal. Thus, it is critical the Departments conduct a thorough review of the Waiver Amendment Request and not approve an application that fails to meet the standards required under section 1332 of the ACA.

Statutory Guardrail Violations

The Waiver Amendment Request does not satisfy the ACA section 1332 guardrails. In the appendix, we include a legal analysis conducted by Groom Law Group (“Groom”) reviewing the Waiver Amendment Request against the 1332 statutory guardrails. The memo raises significant issues with the affordability, coverage, and deficit neutrality guardrails in addition to major procedural issues.

In its analysis, Groom found the Waiver Amendment Request does not meet the *affordability* guardrail because it (1) assumes all issuers would meet the premium reduction targets; (2) fails to account for the full cost of additional state mandated benefits; and (3) does not isolate the effects of the Waiver Amendment Request from the existing state reinsurance waiver and the state projects premium reductions that reflect both reinsurance and Colorado Option savings. Notably, the Waiver Amendment Request assumes all issuers would meet premium reduction targets in all counties.³ The Waiver Amendment Request fails to account for the fact that certain issuers may not be able to meet these targets in some counties because they already pay below the minimum hospital and provider

² NovaRest Actuarial Review of the Section 1332 Innovation Waiver Amendment Request – Colorado Option. February 1, 2022. <https://coloradoshealthcarefuture.org/wp-content/uploads/2022/02/NovaRest-Report-2.1.22.pdf>

³ Colorado Section 1332 Innovation Waiver Amendment Request - Colorado Option. Page 40. <https://drive.google.com/file/d/1SUy-iNz3i7IIRTPTqy2OJgNYH1oyN5mX/view>

reimbursement rates in the Colorado Option law in addition to other critical actuarial issues raised in a recent analysis.⁴

Regarding the *coverage* guardrail, the Waiver Amendment Request assumes premium reduction targets will be met and fails to consider the impact for plan choice and coverage if issuers are not able to meet premium reduction targets in all counties. If issuers cannot meet the requirements of the Colorado Option law in certain counties, the result could be fewer coverage options in certain counties or bare counties. A decrease in the number of coverage options or decrease in number of covered Coloradans directly resulting from the Waiver Amendment would fail to meet the coverage guardrail.

In addition, the Waiver Amendment Request, may not clearly meet the *deficit neutrality* guardrail because it does not consider the impact on the deficit if issuers do not meet mandatory premium reductions in all counties; and does not meet *procedural requirements* for a waiver, including projecting benefits contingent on future state action and incomplete analyses and data.

Both Groom’s analysis and Colorado data demonstrate the statutory guardrails are not met. AHIP recommends the Departments, therefore, not approve the Waiver Amendment Request.

Actuarial Flaws in the State Waiver

Waiver amendment applications must include updated actuarial and economic analyses demonstrating how the proposed waiver would meet statutory guardrails. In its actuarial and economic analyses, the Waiver Amendment Request projects the impact of the Colorado Option on future premiums, enrollment, and premium tax credits (PTC) as well as estimated pass-through funding under the Waiver Amendment. A recent analysis conducted by the actuarial consulting firm NovaRest, Inc. on behalf of the Partnership for America’s Health Care Future (“NovaRest report”) concluded the projections in the Amendment Waiver Request would have been different if consideration had been given to which assumptions were realistic to achieve.⁵ The analysis found “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.”⁶

Under the Colorado Option law premium reduction targets, issuers currently offering individual and small group coverage would be required to offer a Colorado Option plan with premiums that are 15 percent lower than 2021 premiums offered in that county, adjusted for national medical inflation, over a three-year period. The premium reduction methodology fails to reflect the richness of the standardized plan benefit design, limits on annual reimbursement rate reductions, new network adequacy requirements, or the full impact of state benefit mandates since the 2021 benefit year,

⁴ NovaRest Actuarial Review of the Section 1332 Innovation Waiver Amendment Request – Colorado Option. February 1, 2022. <https://coloradoshealthcarefuture.org/wp-content/uploads/2022/02/NovaRest-Report-2.1.22.pdf>

⁵ Ibid.

⁶ Ibid.

exemptions for state co-ops, and use of the Consumer Price Index for medical care services (CPIM) to adjust premiums.

If an issuer does not meet premium reduction targets, they would be subject to a public rate hearing in which the Commissioner may require that the issuer apply minimum hospital and provider reimbursement rates outlined in the Colorado Option law if necessary. However, a prior analysis found that, in certain counties, issuers already reimburse at levels below the Colorado Option reimbursement rate floors and achieving premium reduction targets in those counties by lowering reimbursement rates is not possible.⁷ The Waiver Amendment Request does not account for these shortfalls.

Further, the Waiver Amendment Request fails to address the full impact of additional state mandated benefits implemented since 2021 that were not included in the reference plan. In comments to the state, the Colorado Association of Health Plans noted, analysis of the same benefits yielded remarkably different results—impacts of 0.28 to 1.45 percent—potentially a nine-fold difference in impact to premiums.⁸ The premium adjustment methodology in Emergency Regulation 21-E-XX does not account for the value of these benefits as part of Colorado option standardized plans.

Finally, the Waiver Amendment Request's actuarial analysis does not reflect several critical policy changes that are either pending or imminent and would impact the Colorado Option program and coverage and affordability more broadly. Specifically, the analysis does not adequately examine the impacts of (1) the state's cost-sharing subsidy program applicable in 2022 with potential to extend into 2023 and beyond; (2) the new proposed state subsidy program that will apply in 2023 and beyond; (3) potential extension of the American Rescue Plan Act temporary subsidy enhancements beyond plan year 2022 for part or all of the waiver amendment period; and (4) Medicaid redeterminations, and the likely influx in individual market coverage, at the end of the federal public health emergency. These factors, individually or combined, could have a significant impact on Colorado's health insurance markets and the Colorado Option.

If approved, the Waiver Amendment Request would require conflicting outcomes. It would increase the underlying costs of health insurance by prescribing robust plan benefits, more restrictive network adequacy standards, cost-sharing restrictions, and statutorily limit the ability of health insurance providers to address high hospital costs. At the same time, it would limit issuers' ability to appropriately reflect those costs in premiums, because it requires annual premium reductions. Compliance with the Waiver Amendment Request's requirements could place plans out of compliance with state actuarial soundness standards and other state pricing, solvency, and capital requirements. Thus, Colorado Option plans may be offered at actuarially unsound rates, inconsistent with actuarial principles. More importantly, it is untenable to create a structure that would result in

⁷ Milliman Analysis of Colorado HB21-1232 Impact on Healthcare Provider Reimbursement and Consumer Premiums. May 26, 2021. <https://coloradoshealthcarefuture.org/wp-content/uploads/2021/05/Milliman-Analysis-of-Colorado-HB-21-1232.pdf>

⁸ NovaRest Actuarial Analysis, p. 19

issuers being out of compliance with one set of the State's requirements, merely by virtue of being in compliance with another State requirement. This is unsound public policy.

The NovaRest report includes a comprehensive analysis of the gaps in the underlying economic and actuarial assumptions and impact of missing considerations in the Waiver Amendment Request.

Passthrough Funding

In its Waiver Amendment Request, Colorado requests passthrough funding to reflect federal PTC savings resulting from the Colorado Option program in addition to passthrough funding for its existing reinsurance program. However, the Waiver Amendment Request does not address how passthrough funds from the Colorado Option program will be separated from passthrough funds associated with the existing reinsurance funds to ensure federal funds are only used for the appropriate program and overall program savings and benefits will be attributed to the appropriate policy levers. Further, the Waiver Amendment Request indicates Colorado Option passthrough funds could be used for a future state cost-sharing reduction program to make coverage more affordable for PTC-eligible people who find coverage remains unaffordable. The details of this program are not defined, but it appears it would operate in addition to the subsidy program for people who are ineligible for federal subsidies.

The lack of transparency around passthrough funding could set a poor precedent for other states to attempt to “borrow” savings from one waiver program to bolster the results of another waiver program. From a policy perspective and for program integrity of federal payments, the Departments should require transparency around accounting for and uses of federal passthrough funding.

Ongoing Regulatory Activity

The Departments have stated that a 1332 waiver request would not be approved if it is contingent on further state action.⁹ At the time of the Waiver Amendment Request, regulations to implement key aspects of the Colorado Option—most notably, implementing regulations for premium reduction methodology and network adequacy—we not final and therefore not reflected in the state's actuarial analysis. Both of these outstanding rules would have a material impact on projected benefits and savings of the program. Also outstanding is rulemaking on the rate hearing process and potential hospital and provider rate setting that would take effect in plan year 2024. In light of the Departments' own position, it cannot at this time approve the Waiver Amendment Request.

⁹ Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53412, 53459 (Sept. 27, 2021); Waivers for State Innovation, 80 Fed. Reg. 78131, 78134 (Dec. 16, 2015).

Recommendations

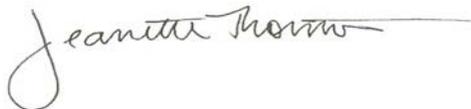
Because projections of benefits in the Waiver Amendment Request's data and impact analysis rely on further state action that will directly impact costs and benefits of the program, and better illuminate the anticipated Colorado health insurance market environment, the Departments should not approve a waiver request while key implementing regulations are outstanding.

We reiterate our support for the general use of section 1332 waivers to provide states the ability to innovate and tailor their health insurance markets. However, as demonstrated in our comments and attached legal analysis, the Colorado Waiver Amendment does not meet the standards of section 1332. We strongly recommend the Departments not approve the Colorado Waiver Amendment Request as it fails to meet ACA section 1332 statutory guardrails and is based on an incomplete actuarial and economic analysis.

If the Departments do not deny the Waiver Amendment Request, we strongly recommend issuing a Notice of Preliminary Determination of Incompleteness. The Departments should identify specific deficiencies in the Waiver Amendment Request for the state to respond to, including requiring Colorado to furnish additional and complete actuarial analyses, reflecting all critical program details including the impact of final regulations, to demonstrate the Waiver Amendment Request meets section 1332 guardrails. We urge the Departments to require the state to be transparent in its process and procedure to isolate premium savings achieved by the existing reinsurance program from savings (if any) achieved by the Colorado Option to ensure passthrough funds and taxpayer dollars are appropriately accounted for and allocated to the correct programs.

AHIP remains committed to working with both states and the federal government to identify and implement solutions that will advance the goals of improving affordability and increasing coverage and we appreciate the opportunity to provide comments on Colorado's Waiver Amendment Request.

Sincerely,



Jeanette Thornton
Senior Vice President, Product, Employer, and Commercial Policy

CC: Chiquita Brooks-LaSure, Administrator, CMS
Dr. Ellen Montz, Deputy Administrator and Director, Consumer Information and Insurance Oversight, CMS

Attachment:

- Groom Law Group Memorandum: Application to amend the Colorado 1332 waiver

MEMORANDUM

February 2, 2022

TO: AHIP

FROM: Groom Law Group, Chartered

RE: Application to amend the Colorado 1332 waiver

The Patient Protection and Affordable Care Act (“ACA”) permits a state to apply to the Secretaries of Treasury and Health and Human Services (“the Departments”) to waive certain provisions of the ACA, *i.e.*, for approval of a state innovation waiver.¹ Approving a waiver is a *discretionary* decision by the Departments. Before granting a waiver, the Departments must first determine the State’s plan will satisfy the waiver standards described in the ACA, referred to as the statutory guardrails.² The Departments have issued regulations and guidance on the statutory guardrails, as well as the evidence required to support a waiver application and the process that must be followed.³

Colorado submitted an application to amend its initial waiver on November 30, 2021. AHIP asked Groom to review the application to determine whether the application meets the waiver requirements. **For the reasons discussed below, we believe that the evidence submitted by Colorado does not demonstrate that the waiver satisfies the requirements, including the statutory guardrails of affordability, coverage, and deficit neutrality.**

Background

The Departments approved Colorado’s initial 1332 waiver on July 31, 2019, and approved a 5-year extension of that initial waiver on August 13, 2021. The initial 1332 waiver sought to implement a reinsurance program for plan years 2020 and 2021; the extension approved the reinsurance program waiver through December 31, 2026. Colorado’s initial reinsurance waiver was estimated by the Center for Consumer Information and Insurance Oversight (“CCIIO”) to result in a 16% reduction in premiums for the first year and an actual premium reduction compared to no waiver in 2020 of 22.44% and 18.47% for 2021.⁴ At the same time, Colorado’s reinsurance program has not reduced issuer participation in the Colorado market.⁵

On June 16, 2021, Colorado enacted the Standardized Health Benefit Act (“CO Act”),⁶ and following the enactment of this statute, Colorado submitted an application to amend its previously

¹ See ACA § 1332(b)(1)(A)-(D).

² See ACA § 1332(b)(1)(A)-(D).

³ See, e.g., Section 1332 Waiver Implementing Regulations, 86 Fed. Reg. 53412 (Sept. 27, 2021) (effective date Nov. 26, 2021); Waivers for State Innovation, 80 Fed. Reg. 78131, 78134 (Dec. 16, 2015).

⁴ CCIIO Data Brief Series, State Innovation Waivers: State-Based Reinsurance Programs, August, 2021, p. 6.

⁵ *Id.* at 7.

⁶ Colo. Rev. Stat. § 10-16-1301, *et. seq.*

granted and extended waiver on November 30, 2021.⁷ The CO Act mandates that health insurance issuers offer a new standardized plan in each individual and small group market where the issuer offers a health benefit plan in the respective market. The new standardized plan is termed the Colorado Option plan.⁸ Most notably, the CO Act requires issuers to “offer the standardized plan in 2023 at a premium rate that is at least five percent less than” the premium rate for health benefit plans that the carrier offered in the 2021 calendar year. For 2024 and 2025, carriers shall offer the standardized plan at a premium rate that is 10% and 15% less, respectively, than the premium rate for health benefit plan that the issuer offered in the 2021 calendar year.⁹

On November 30, 2021, Colorado submitted an application to amend its initial Section 1332 waiver (which was previously approved in August of 2021) (“Amendment Application”) to the Departments. Colorado proposes to extend the waiver of ACA Section 1312(c)(1) “to allow plan-level rating variation based on the premium reduction requirements of the Colorado Option” and “requests to extend the Single Risk Pool waiver to ACA Section 1312(c)(2) to allow Colorado Option premium reductions in the small group market.”¹⁰ Colorado seeks to amend its innovation waiver because the “take-up of the Colorado Option plans may be significantly reduced without the premium reduction elements of the Colorado Option that would be made possible by the waiver.”¹¹

Colorado’s Amendment Application Does Not Meet the Statutory and Departmental Requirements

In summary, based on the information included in the application, Colorado’s amendment fails because –

- A. The evidence and data submitted by Colorado *do not demonstrate that the amendment meets the statutory guardrails* required to be met in order for a waiver to be approved.
- B. The amendment’s projected benefits rely upon state contingencies and the Departments have previously said that they will not approve waivers that are *contingent on further state action*;
- C. The supporting actuarial analyses are based on *incomplete economic data*, so the resulting projections and conclusions should not be accepted at face value.

A. Fails to meet statutory guardrails.

Section 1332 of the ACA permits the Departments to grant a request for a waiver *only* if they determine that the State plan will:

- (A) Provide coverage that is at least as comprehensive as the coverage defined in section 18022(d) of the ACA and offered through the Exchanges;

⁷ Colorado announced its intent to apply for an amendment to this waiver by filing a notice with the Departments and conducted the public comment period from October 15, 2021 to November 15, 2021.

⁸ Colo. Rev. Stat. § 10-16-1305(1)(a).

⁹ *Id.* § 10-16-1305(2)(a) (noting for years after 2026, “carriers shall limit the annual percentage increase in the premium rate” to no more than medical inflation, relative to the previous year).

¹⁰ Amendment Application, p. 3.

¹¹ *Id.* at 17.

- (B) Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of the ACA;
- (C) Provide coverage to least a comparable number of its residents as the provisions of the ACA; and
- (D) Not increase the Federal deficit.¹²

As discussed below, the evidence and data submitted by Colorado as part of its application indicates that the statutory guardrails are not met by the Amendment Application.

1. Affordability

The affordability guardrail requires the coverage under the state innovation waiver to be “forecast[] to be at least as affordable overall for state residents absent the waiver.”¹³ As the Departments have explained, affordability “refers a resident’s ability to pay for health care and may be generally measured by comparing residents’ net out-of-pocket spending for health coverage and services to their incomes.”¹⁴ A waiver request will fail to meet this guardrail if it increases “the number of state residents with large health care spending burdens relative to their incomes...[and] reduces the number of individuals with coverage providing a minimal level of protection against excessive cost sharing.”¹⁵

In its Amendment Application, Colorado argues the “CO Option, the reinsurance program, and the subsidy programs all have the effect of lowering premium costs to the individual as compared to costs without the waiver.”¹⁶ The Amendment Application predicts a 32.1% reduction in premiums, supported by the Wakely actuarial analysis in Table 15. However, the evidence and data submitted by Colorado does not support the affordability guardrail for the following reasons.

First, the Wakely actuarial analysis, conducted on behalf of Colorado and included in the Amendment Application, assumes plans can and will reduce “their adjusted premiums by the percentages required under the [CO Act],” but Wakely does not consider the likelihood of an issuers’ inability actually achieve such a reduction.¹⁷ Actuarial assumptions must be realistic to be useful evaluative tools. Colorado’s existing reinsurance waiver has already resulted in substantial premium reductions in Colorado and the details of precisely how Colorado expects issuers, particularly the issuers offering the lowest and second-lowest cost silver plans in the individual market, to be able to meet these new statutory premium reduction standards has not been established. Thus, it is unclear how to confidently predict that premiums will, in fact, be reduced. As explained in the NovaRest Actuarial Analysis (drafted by NovaRest Actuarial Consulting, Inc.

¹² ACA § 1332(b)(1)(A)-(D); *see also* 45 C.F.R. § 155.1308(f)(3)(iv) (describing the coverage, affordability, comprehensiveness, and deficit neutrality statutory guardrails); Section 1332 Waiver Implementing Regulations, 86 Fed. Reg. 53412 (Sept. 27, 2021) (effective date Nov. 26, 2021).

¹³ 45 C.F.R. § 155.1308(f)(3)(iv).

¹⁴ 80 Fed. Reg. at 78132.

¹⁵ *Id.*

¹⁶ Amendment Application, p. 13.

¹⁷ Amendment Application, p. 40.

on behalf of The Partnership for America’s Health Future Action),¹⁸ issuers will face considerable difficulty in reducing premiums as mandated in the CO Act in an actuarially sound manner, and it is likely that some issuers will be unable to reach a 15% reduction in premiums in certain counties over the course of three years.

Importantly, issuers determine premiums based on a variety of costs, including provider and facility reimbursements, costs for prescription drugs, and administration. Milliman, in its actuarial analysis of Colorado HB-21-1232 (written by Milliman on behalf of The Partnership for America’s Health Future Action, Inc.) (“Milliman Report”),¹⁹ suggests that some provider reimbursement rates in a number of areas of the state are already near the floor for such reimbursements set in the CO Act.²⁰ The Milliman Report concludes that reducing provider and facility rates in those areas (assuming it is possible) will have limited impact in achieving premium reductions.²¹ Furthermore, because provider reimbursement rates are merely one portion of overall costs, reducing provider reimbursement rates will likely provide a smaller dollar for dollar impact on reducing overall premiums.²² Finally, the Milliman actuarial analysis notes “existing plan options may become less affordable if provider reimbursement remains at current levels for all existing plans.”²³ Accordingly, Colorado’s waiver application has not demonstrated a likelihood of success for this metric.

Second, Colorado uses data from 2020 and 2021 to support its analysis of the coverage guardrail. These data are likely anomalous due to COVID-19 utilization factors and federal interventions (such as increased premium subsidies) and therefore are unlikely to be replicated.²⁴

¹⁸ NovaRest Actuarial Analysis, Feb. 1, 2022, available at <https://coloradoshealthcarefuture.org/wp-content/uploads/2022/02/NovaRest-Report-2.1.22.pdf>. *See, e.g.*, p. 7-8 (explaining using hospital reimbursement reductions would not be able to reduce premiums by 15% by 2025 in certain counties), p. 8 (explaining that the federal actuarial calculator may understate the value of the Colorado Option, and if so, “the premium reduction requirements will be more difficult to achieve.”), p.8-9 (explaining that the use of the Medical Component of the Consumer Price Index (CPIM) to adjust the 2021 benchmark premiums “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.”)

¹⁹ Milliman Report, Analysis of Colorado HB 21-1232 Impact on Healthcare Provider Reimbursement and Consumer Premiums, May 26, 2021, available at <https://www.milliman.com/-/media/milliman/pdfs/2021-articles/5-27-21-analysis-colorado-hb-21-1232-impact-healthcare-provider-reimbursement-consumer-premiums.ashx>.

²⁰ *See, e.g.*, Milliman Report, p. 2 (“Physician reimbursement in the individual and small group markets today is most often lower as a percentage of the Medicare fee schedule than inpatient and outpatient hospital services. In Colorado, our analysis suggests that it is near or below the 135% floor enforceable under HB 21-1232. For this reason, we have made the simplifying assumption that physician reimbursement will not be reduced from where it is today.”).

²¹ *See, e.g.*, Milliman, p. 19 (“We estimate that only four regions (5, 6, 7 and 9; all rural) will obtain the full 18% reduction required over the three year period, if facility reimbursement rates alone are used to reduce premiums. Other regions will have insurer contracts that are either already below floored reimbursements or are above these floors such that, over the three-year period, reductions will cause them to be limited to the floor.”).

²² Milliman Report, p. 15-21, NovaRest Actuarial Analysis, p.7-11.

²³ Milliman Report, p. 26.

²⁴ Amendment Application, p. 78 (“There remains significant uncertainty as to the effects the COVID pandemic will have on enrollment, premiums, health care utilization, the economy, and other factors. Additionally, the ending of the Public Health Emergency could result in a number of individuals transitioning from Medicaid to the individual market.”)

The NovaRest Actuarial Analysis explains the 2021 premiums “reflected regulatory actions that did not allow for adjustments to reflect the impact of COVID-19 related expenses, limited the extent to which trends could be reflected in the rates, and did not allow carriers to reflect an increase in risk margins.”²⁵ Therefore, NovaRest concludes “2021 rates may be artificially low.”²⁶ Given that we are in what appears to be the later stages of the COVID-19 public health crisis, and the extraordinary relief efforts used to combat it, it is unrealistic to assume such trends will continue throughout 2022 and into 2023.

Third, Colorado fails to account for the full cost of additional benefit mandates in its Amendment Application. Colorado plans to update its Essential Health Benefit (“EHB”) in 2023 to include acupuncture, gender affirming care, mental health wellness exams, and changes to drug coverage.²⁷ The NovaRest Actuarial Analysis, relying upon the Colorado Association of Health Plans, notes these additional EHBs may raise actuarial estimates for benefit changes between 0.28-1.45%.²⁸ Additionally, Colorado mandated the provision of infertility and reproductive health services, 6 physical therapy, occupational therapy, chiropractic and acupuncture visits, and directed insurers to eliminate donor costs for living organ donations for the 2022 premium year.²⁹ However, Colorado’s application does not mention or discuss the impact of these additional costs on the EHB benchmark plan.

Finally, it is often unclear whether the data and analyses provided to support the Amendment Application demonstrate that the *amendment*—rather than the already approved reinsurance program—meets the guardrails or provides any savings or benefits. Although the regulations and guidance on the Departments review of waiver amendments is not explicit, in the instructions to Colorado for its waiver application, the Departments instructed Colorado to include an “analysis [that] *must separately identify*, in the “with waiver” scenario, the impact of the requested amendment on the statutory guardrails.”³⁰ We interpret this instruction to mean that Colorado must show the *amendment*—not the existing waiver in addition to the amendment—meets the statutory guardrails. The Departments are already aware of the premium reduction effects of reinsurance and, in the case of Colorado, have suggested that the reinsurance program alone has decreased premiums for Colorado residents from 16 to 22%, depending upon the year. Similarly, NovaRest found the existing reinsurance program reduced premiums by 20.8% in 2021.³¹ We believe that the amendment is supposed to be judged based on the amendment’s effects alone and not in conjunction with other measures.³²

²⁵ NovaRest Actuarial Analysis, p. 9.

²⁶ *Id.*

²⁷ Amendment Application, p. 258; NovaRest Actuarial Analysis, p. 18-20.

²⁸ NovaRest Actuarial Analysis, p. 19.

²⁹ NovaRest Actuarial Analysis, p. 20.

³⁰ Instructions, ¶ 4 (emphasis added).

³¹ NovaRest Actuarial Analysis, p. 21.

³² To this point, we note that Colorado’s application does, at times, suggest that it views the amendment and the reinsurance waiver as separate. *See, e.g.*, Amendment Application at 10 (“Colorado proposes that the pass-through funding attributable to the reinsurance program continue to be used to support the reinsurance program as described in the waiver extension approved on August 13, 2021. The pass-through funding attributable to the amendment will

In this case, the Colorado Option would require issuers to further lower premiums, initially by 5% and eventually by 15%, and in its Amendment Application, Colorado argues a 32% reduction in premiums will occur by 2025 (which appears to reflect combined savings from reinsurance and required premium reductions, although it is not clear). In addition, Colorado’s actuarial analysis generally examines the impact of the reinsurance program in the aggregate on coverage and affordability.³³ Although table 10 examines the impact of the existing reinsurance program and waiver amendment on premium costs and enrollment, it does not examine the impact of the waiver amendment independently from the reinsurance program.³⁴ As explained above, we believe that to demonstrate the amendment meets the guardrails, the Amendment Application must include an analysis that disaggregates the impact of the existing waiver from the impact of the amendment. Moreover, we note that to do otherwise would allow states to piggyback on top of existing reinsurance waivers changes in state law that increase costs so long as their added costs do not eat up the unrelated savings of the original reinsurance program.

2. Coverage

To satisfy the coverage requirement, “a comparable number of state residents must be forecast to have [minimal essential] coverage under the waiver as would have coverage absent the waiver.” Importantly, the Departments will consider “whether the proposal sufficiently prevents gaps in or discontinuation of coverage.”³⁵

In its Amendment Application, Colorado argues the waiver “will have the effect of increasing the number of Coloradans covered by insurance as compared to without the waiver amendment.”³⁶ The application further posits “Colorado does not expect any loss of coverage directly attributable to the proposed waiver amendment” and projects a 15% increase in enrollment.³⁷ The actuarial analysis conducted by Wakely notes it “estimates that 11,000 individuals that would be uninsured would take-up coverage as a result of the waiver amendment in the first year” as a result of premium reductions and making more individuals eligible for subsidies.³⁸

be used to support new health insurance affordability programs.”). At other times, however, the Amendment Application is less clear. *See, e.g.*, with respect to affordability, Colorado says that “[t]he Colorado Option, the reinsurance program, and the subsidy programs all have the effect of lowering premium costs in the individual market as compared to costs without the waiver. The waiver amendment does not impact the premiums or cost-sharing for [other coverage].” The first sentence may imply that Colorado expects the Amendment Application to be judged based on costs without *any* waiver (including the currently approved reinsurance waiver); *i.e.*, that the amendment’s impact should be included with the initial waiver’s impact to determine whether the guardrails are met. But the second sentence is limited to the amendment. It is unclear if “the waiver” and “waiver amendment” are synonyms here, making it difficult to parse Colorado’s claims and analysis and making it more challenging to meaningfully comment on the application.

³³ Amendment Application, p. 38-42.

³⁴ *Id.* at p. 60.

³⁵ 45 C.F.R. § 155.1308(f)(3)(iv).

³⁶ Amendment Application, p. 12.

³⁷ *Id.* at p. 13.

³⁸ *Id.* at p. 65.

However, the Amendment Application does not clearly explain how the waiver amendment will cover an additional 11,000 individuals. Rather, the Amendment Application mentions that pass-through funding will be used to support affordability programs offered through the Health Insurance Affordability Enterprise (HIAE).³⁹ The HIAE has recommended a certain subsidy program for individuals up to 150% FPL,⁴⁰ but that subsidy program has not been finalized.⁴¹ Nonetheless, table 6 of the Wakely actuarial analysis included individuals who may become eligible for any subsidies because it “reflect changes related to the subsidies newly available Qualified Individuals as well as the APTC eligible population.”⁴² This assumption is unsupported without details about the complete subsidy program. Accordingly, the Amendment Application does not establish that the waiver amendment will result in an additional 11,000 people receiving coverage.

Additionally, Colorado’s analysis regarding the impact of any premium reductions in expanding coverage to individuals appears flawed. As explained in the Milliman Report and NovaRest Actuarial Analysis, issuers’ primary lever to meet the premium reductions would be to reduce reimbursement rates to hospitals and providers; however, some low-cost issuers and issuers in certain counties may find it difficult to reduce any rates any further.⁴³ Therefore, some issuers may not be able to achieve a 15% premium reduction by 2025 in some of the counties of the state. These issuers may attempt to achieve savings by reducing administrative costs or profit margins, but there are limited levers for issuers to pull, given the other state and federal requirements that must be met, including the required benefits, required coverage levels, network adequacy, medical loss ratio requirements, and actuarial soundness. Faced with this reality, issuers may be able to meet the requirements in some counties, but find themselves unable to meet the requirement in others, leaving those counties with fewer participating issuers.⁴⁴ Therefore, granting Colorado’s amendment waiver may actually result in a decline in the number of covered individuals and a decline in consumer choice of plans. In its application, Colorado claims a loss of coverage directly attributable to the waiver amendment will not occur. However, if the waiver amendment application is granted, issuers will be required to reduce premiums pursuant to the CO Act, and the Milliman Report concluded such a mandatory reduction in premiums may result in issuers exiting specific counties, which suggests that the Application Amendment does not meet the coverage guardrail.⁴⁵

³⁹ *Id.* at p. 10. *See also* Colo. Rev. Stat. § 10-16-1308(2) (noting the Department of Insurance may allocate federal money for use by the HIAE “to increase the value, affordability, quality and equity of health-care coverage for all Coloradans”).

⁴⁰ Amendment Application, p. 10.

⁴¹ *Id.* (“The HIAE is currently designing a subsidy program for these populations, identified in the Colorado statute as ‘Qualified Individuals.’”)(emphasis added).

⁴² *Id.* at p. 41.

⁴³ NovaRest Actuarial Analysis, p. 7 (“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.”)

⁴⁴ Milliman Report, p. 26 (Milliman stated that “to the extent an insurer believes it no longer has a competitive advantage in the market from negotiating lower provider reimbursement rates relative to competitors, it may elect to leave the market.”).

⁴⁵ *Id.* at 2.

Finally, we note that Colorado’s plan is based upon unrealistic deadlines. Colorado’s failure to propose practical and achievable deadlines suggests that the analyses of the impact of Colorado’s proposal may not have been thoroughly considered by the state. Moreover, although setting reasonable deadlines is not an explicit guardrail requirement, based on NovaRest and Milliman’s actuarial analyses, it seems that many of Colorado’s proposed targets (including its coverage target) may not be met, in part, due to the unrealistic timeline in the waiver request, so that Colorado’s program may fail as a result of impracticability.

3. Deficit Neutrality

The statute prohibits a waiver from “increas[ing] the Federal deficit.”⁴⁶ Under the deficit neutrality statutory guardrail, “the projected Federal spending net of Federal revenues under the State Innovation Waiver must be equal to or lower than the projected Federal spending net or Federal revenues in the absence of a waiver.”⁴⁷ The estimated effect of the innovation waiver should “include all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue.”⁴⁸

Colorado explains the “amendment waiver will produce net federal savings estimated at \$209 million in 2023 and \$1.69 billion over the course of the five-year waiver.”⁴⁹ Furthermore, the application notes “reduced spending on health benefits [by employers] are offset by increased wages.”⁵⁰ Table 10 of the Wakely actuarial analysis displays its analysis showing deficit neutrality and estimates a total savings of \$214 million in 2023 because of the reinsurance program and the waiver amendment. These savings will increase to \$368 million in 2027.⁵¹ Finally, the Amendment Application states “the decrease in premiums (specifically the [silver plan] will result in lower per person PTC amounts in 2023.”⁵² As previously mentioned, the Wakely actuarial analysis assumes the premium reduction will occur without accounting for the likelihood that issuers may be unable to reduce premiums in accordance with the CO Act, or the increased costs of the new EHB benchmark, or the changes in health care demand (and cost) as the pandemic ends. The Amendment Application also does not address the effect of the waiver on deficit neutrality in the event such a projected premium reduction does not occur. Without analyzing the impact of the waiver amendment without the mandatory reduction in premiums, the impact on the deficit remains unknown, so it is difficult to conclude that this guardrail has been met.

B. Contingent on Further State Action.

When considering whether to grant a state’s innovation waiver, the Departments have consistently stated that they will not consider the impact of policy changes that are contingent on

⁴⁶ 45 CFR § 155.1308(f)(3)(iv)(D).

⁴⁷ 80 Fed. Reg. at 78133.

⁴⁸ *Id.*

⁴⁹ Amendment Application, p. 14.

⁵⁰ *Id.* at p. 16.

⁵¹ *Id.* at p. 60.

⁵² *Id.* at p. 66.

further state action.⁵³ Importantly, Colorado’s projections and data in support of the Amendment Application depend on further state action. For example, the state regulations describing the premium reduction methodology and rate setting have not been finalized.⁵⁴ But the Departments have explained that they will not consider contingencies, “such as state legislation that is proposed but not yet enacted that would be in effect during the timeframe for the section 1332 waiver.”⁵⁵ Although Colorado’s *law* is enacted, critical *regulations and policies* that support Colorado’s proposed projections and clarify and define the law’s actual requirements, like the premium reduction methodology, were not final when Colorado submitted its Amendment Application. Similarly, the network adequacy provisions were not final at the time when the Amendment Application was submitted (and thus, the impact could not be properly reflected in the analyses accompanying the amendment); as HHS is aware, network adequacy provisions can increase issuer costs.⁵⁶ Changes to any of those critical policies may materially change the ability of Colorado to deliver the benefits and savings under the waiver that it projects. Because the assessment of the waiver is not supposed to consider the impact of changes that are contingent on further state action, the guidance indicates that the Department should not consider any evidence in the Amendment Application that relies upon projected savings or benefits (or assumptions that the waiver will not decrease benefits or increase costs) that are based on proposed rules, guidance or policies.

⁵³ Section 1332 Waiver Implementing Regulations, 86 Fed. Reg. at 53459 (“ Specifically, the Departments will not consider the potential impact of policy changes that are contingent on further state action, such as state legislation that is proposed but not yet enacted that would be in effect during the timeframe for the section 1332 waiver. For example, the Departments will not consider the potential impact of state legislation to expand Medicaid that is not yet enacted. The Departments also will not consider the impact of changes contingent on other Federal determinations, including approval of Federal waivers (such as waivers under section 1115 or titles XVIII, XIX, or XXI of the Act) pursuant to statutory provisions other than section 1332 of the ACA.”); Waivers for State Innovation, 80 Fed. Reg. 78131, 78134 (Dec. 16, 2015)(“ The assessment does not consider the impact of policy changes that are contingent on further state action, such as state legislation that is proposed but not yet enacted. It also does not include the impact of changes contingent on other Federal determinations, including approval of Federal waivers pursuant to statutory provisions other than Section 1332. Therefore, the assessment would not take into account changes to Medicaid or CHIP that require separate Federal approval, such as changes in coverage or Federal Medicaid or CHIP spending that would result from a proposed Section 1115 demonstration, regardless of whether the Section 1115 demonstration proposal is submitted as part of a coordinated waiver application with a State Innovation Waiver. Savings accrued under either proposed or current Section 1115 Medicaid or CHIP demonstrations are not factored into the assessment of whether a proposed State Innovation Waiver meets the deficit neutrality requirement. The assessment also does not take into account any changes to the Medicaid or CHIP state plan that are subject to Federal approval.”)

⁵⁴ The Colorado Department of Regulatory Affairs, Division of Insurance, released Emergency Regulation 21-E-16, with an effective date of January 1, 2022, on December 1, 2021. This Emergency Regulation describes the specific health benefits mandated pursuant to the CO Act. On January 22, 2022, the Division released a draft proposed emergency regulation – “Concerning the Methodology for Calculating Premium Rate Reduction for Colorado Option Standardized Health Benefit Plan.” The proposed rule outlines a proposed required premium reduction methodology for the Colorado Option bronze, silver and gold health benefit plans issued after January 1, 2023. The Division has not engaged in rulemaking for the rate hearings and potential hospital and provider rate setting that CO Act indicates would take effect starting in the 2024 benefit year.

⁵⁵ Section 1332 Waiver Implementing Regulations (Sept. 27, 2021), 86 Fed. Reg. at 53459.

⁵⁶ See, e.g., HHS Notice of Benefit and Payment Parameters for 2023, proposed rule, 87 Fed. Reg. 584, 684 (Jan. 5, 2022) (Solicitation of Comments—Unintended Impacts of Stronger Network Adequacy Standards, where HHS notes that “there is some risk that stronger network adequacy standards could be leveraged to create an uneven playing field in network agreement negotiations that could result in higher health care costs for consumers” and that “[s]trengthening network adequacy standards may increase the market power of some providers and inadvertently increase the cost of health care—for issuers, and, consequently, for enrollees.”)

In sum, key regulations and methodologies have not been finalized. As such, Colorado’s analysis and projections are necessarily preliminary and incomplete; under the guidance provided, the Departments should not grant Colorado’s request to amend its innovation waiver based on state contingent policies.

C. Incomplete Analyses and Data.

A state innovation waiver application must include analysis and supporting data establishing each statutory requirement.⁵⁷ However, as discussed in some detail with respect to certain guardrails, the actuarial and economic analysis upon which Colorado relies contains incomplete or inappropriate data. For example, as the NovaRest Actuarial Analysis explains, Colorado’s analysis does not consider the premium savings or benefits from the waiver if all issuers cannot meet the premium reduction targets in one or more counties. As the potential exits by one or more issuers at the county level would likely affect the ability of Colorado to meet each guardrail, especially in densely populated areas of state. It seems that, to meet the minimum data requirements of the waiver process, Colorado should explain how, in the event of any county exits, the waiver continues to meet the statutory requirements.

Nor does Colorado analyze the expected increased costs that will result from new state mandated benefits and more stringent network adequacy standards or grapple with how the premium reductions will nevertheless be achieved given these expensive new state requirements. Similarly, the Milliman Report concluded that as a result of certain factors in Colorado’s insurance market, “the ability of insurers to achieve target premium rate reductions will vary in ways that may influence competition.”⁵⁸ Colorado’s analysis does not consider the effects of less participation in the market (*i.e.*, county exits) on benefits and premiums that may be a direct result of its new proposal. Colorado also fails to adequately address the effect, if any, of its existing and proposed state subsidy programs on the amendment and Colorado’s analysis often relies on data gathered during the public health emergency—which may reflect unusual use and cost trends. The same time period reflected unprecedented federal efforts to stabilize providers, facilities and to subsidize consumer’s health premiums, also trends not likely to be repeated, and thus, data that should not be used to project costs and benefits during periods not subject to a public health emergency and federal subsidization efforts.

Simply put, there are data and analyses that are inappropriate or missing, and some of Colorado’s assumptions appear unrealistic and unduly optimistic as a result. The Departments have explained, that “the Departments will not prescribe any particular method of actuarial analysis to estimate the potential impact of a section 1332 waiver. However, the state should explain its modeling in sufficient detail to allow the Secretaries to evaluate the accuracy of the state’s modeling and the comprehensiveness and affordability of the coverage available under the state’s section 1332 waiver proposal. ... [T]he state may be required to provide, upon request by the Secretaries, data or other information that it used to make its estimates, including an explanation of the assumptions used in the actuarial analysis.”⁵⁹ In addition, “[d]uring the Federal review

⁵⁷ 45 C.F.R. § 155.1308(f)(4) (noting a complete application must contain sufficient supporting information to indicate that the State’s proposed waiver will comply with the coverage, comprehensiveness, and affordability requirements in the ACA).

⁵⁸ Milliman Report, p. 2.

⁵⁹ 86 Fed. Reg. at 53473.

process, the Secretary may request additional supporting information from the State as needed to address public comments or to address issues that arise in reviewing the application.”⁶⁰

Two independent actuarial analyses, conducted by Milliman and NovaRest, suggest that Colorado’s actuarial report is insufficient. As a result, it is likely 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.”⁶¹ At the very least, the Departments should request additional supporting information from Colorado to address these issues.

Conclusion

Granting a waiver is a discretionary act by the Departments. As a threshold matter, the ACA provides that “Secretary *may* grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan”⁶² satisfies the statutory guardrails. Moreover, the Departments “retain their discretionary authority under section 1332 to deny waivers when appropriate given consideration of the application as a whole, *even if an application meets the four statutory guardrails.*”⁶³ In other words, while a waiver allows a state to disregard or not implement otherwise applicable federal law, the ACA grants the Departments discretion to deny such a waiver and require the state to continue to comply with federal requirements. **Because of the speculative and uncertain benefits of the proposal as outlined above, the Departments should exercise that discretion and deny Colorado’s request to amend its Section 1332 waiver.**

At a minimum, the Departments should consider the actuarial studies that call into question the data, analyses and conclusions in the record provided by the state in the Amendment Application, and given the doubts raised by those independent studies, require Colorado to provide additional data or other information to address the issues raised in the comments to the Amendment Application. Based on the independent actuarial reports, it seems likely that further analysis by the Departments will show that the premium reduction estimated by the state is higher than what is realistically achievable, which will necessarily reduce substantially any pass through savings that might be provided under an amended waiver.

⁶⁰ 45 C.F.R. § 155.1308(g)(1).

⁶¹ NovaRest Actuarial Analysis, p. 7.

⁶² ACA Section 1332(b)(1)(emphasis added).

⁶³ 86 Fed. Reg. at 53485.



February 2, 2022

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Colorado 1332 State Innovation Waiver Amendment Request

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to submit comments on Colorado's 1332 state innovation waiver application amendment to implement the Colorado Option program.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource as we work to find solutions to expand access to high-quality coverage. We urge the Department of the Treasury and the Department of Health and Human Services (Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that any changes to the healthcare system achieve coverage that is adequate, affordable and accessible for patients and consumers.¹ We have supported Colorado's previous efforts to strengthen its marketplace through a reinsurance program, and we are pleased that the state is continuing to innovate to improve coverage for consumers via the Colorado Option program. Our organizations urge the Departments to approve this proposal and offer the following comments on the waiver:

Guardrails

Our organizations are pleased to see that Colorado's waiver would expand the number of people with coverage in the state as well as improve the affordability of that coverage. Excluding the impact of the state's reinsurance program, the state estimates that individual market enrollment would increase by more than 11% and individual market premiums would decrease by more than 13% by 2025. These changes will benefit many patients and consumers directly, while also strengthening the individual marketplace in Colorado as a whole.

As you know, this waiver amendment is just one piece of the broader Colorado Option program, which requires participating individual and small group market insurers to offer some plans with standardized features and meet additional network adequacy protections intended to ensure that the plans are culturally responsive and reflect the diversity of the enrollees in the network's service area. Waiving the single risk pool requirements will allow the Colorado Option to work as intended, enabling Colorado Option plans to offer reduced premiums that fully reflect the savings they have achieved under the program. This fair accounting should help to drive enrollment towards these new plans and increase the chances that the Colorado Option program can make progress on health equity.

Our organizations strongly support Colorado's efforts to improve health equity through this proposal. As discussed in more detail below, the state estimates that 88% of the individuals who are currently ineligible for federal subsidies and would benefit from the new financial assistance supported by the waiver's pass-through funding will be people of color. Additionally, the changes Colorado is pursuing concurrently related to standard plans and network adequacy are purposefully designed to improve access to services needed by communities of color and construct culturally responsive networks.

Subsidy Program

Our organizations support the use of waiver savings to expand coverage to individuals with incomes below 300% of the federal poverty level who are currently not eligible for federal subsidies. Qualified individuals will receive a plan with a \$0 monthly premium and significant cost-sharing reductions. This could include individuals who are in the family glitch (76,000 individuals in Colorado),² as well as other individuals who cannot afford the employer-sponsored coverage offered to them but do not qualify for subsidies. The cost of employer-sponsored coverage can be a significant burden for patients and consumers – in Colorado, the average annual employee premium contribution is \$5,016, in addition to an average \$3,059 in employee spending to meet a deductible – and we appreciate Colorado's efforts to address this issue.³ Funds can also be used to expand financial assistance for individuals who are ineligible for federal subsidies due to their immigration status. Nearly half of this population is estimated to be uninsured, and without coverage, these individuals must rely on safety net providers and often go without the care that they need.⁴ Our organizations support Colorado's plans to expand financial assistance through the Colorado Option program.

Our organizations also support Colorado's decision to use waiver savings to offer additional financial assistance to certain Coloradans currently eligible for federal subsidies. In the first year, individuals with incomes between 150 and 200% of the federal poverty level would receive additional cost-sharing reductions beyond those currently available. There are many factors impacting affordability for this population, including the extension of the additional federal financial assistance provided by the American Rescue Plan Act beyond 2022, (which are our organizations are actively advocating for Congress to pass this year) and the final design of the standard plans currently being developed by the

state. We look forward to continuing to work with the state to provide feedback on the best use of the pass-through funding as these other factors impacting affordability become clearer.

Reinsurance

Colorado's application also extends its reinsurance program for another year, through 2027. Many of our organizations have previously supported this program; we believe it has contributed to ensuring a stronger, more robust marketplace, which is essential for people with pre-existing conditions to access comprehensive coverage that includes all of the treatments and services that they need to stay healthy at an affordable cost. A recent data brief released by the Center for Medicare & Medicaid Services shows that states with reinsurance waivers have experienced significantly lower individual market premiums than they would have otherwise and have seen gains in insurer participation.⁵ We are pleased that this has held true in Colorado, where premiums have been about 20% lower in 2020 and 2021 as a result of the waiver, and the state has seen a new entrant into the individual market. Our organizations continue to support Colorado's reinsurance program.

Our organizations support Colorado's waiver application to expand access to quality, affordable coverage and urge the Departments to approve this proposal. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Lung Association
Arthritis Foundation
Epilepsy Foundation
Hemophilia Federation of America
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society

¹ "Consensus Health Reform Principles." September 20, 2021. Available at: <https://www.lung.org/getmedia/24309f63-74e9-4670-8014-d59f21104cfd/092021-ppc-healthcare-principles-42-logos-final.pdf>.

² Cynthia Cox et al. The ACA Family Glitch and Affordability of Employer Sponsored Coverage. Kaiser Family Foundation. April 7, 2021. Available at: <https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage/>

³ Sara R. Collins et al. State Trends in Employer Premiums and Deductibles, 2010–2019. Nov. 20, 2020. Commonwealth Fund. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/state-trends-employer-premiums-deductibles-2010-2019>.

⁴ Health Coverage of Immigrants. Kaiser Family Foundation. July 15, 2021. Available at: <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/>

⁵ Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight (CCIIO). State Innovation waivers: State-Based Reinsurance Programs. August 2021. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-Aug2021.pdf>.



Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

Alpha-1 Foundation
ALS Association
American Cancer Society Cancer Action Network
American Diabetes Association
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation
Autism Speaks
Cancer Support Community
CancerCare
Chronic Disease Coalition
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Immune Deficiency Foundation
Juvenile Diabetes Research Foundation

The Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Coalition for Cancer Survivorship
National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
United Way Worldwide
Volunteers of America
WomenHeart: The National Coalition for Women with Heart Disease

The ACA Family Glitch and Affordability of Employer Coverage

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Published: Apr 07, 2021

Issue Brief

Financial assistance to buy health insurance on the Affordable Care Act (ACA) Marketplaces is primarily available for people who cannot get coverage through a public program or their employer. Some exceptions are made, however, including for people whose employer coverage offer is deemed unaffordable or of insufficient value. For example, people can qualify for ACA Marketplace subsidies if their employer requires them to spend more than 9.83% of his household income on the company's health plan premium.

Currently, this affordability threshold of household income is based on the cost of the employee's self-only coverage, not the premium required to cover any dependents. In other words, an employee whose contribution for self-only coverage is less than 9.83% of household income is deemed to have an affordable offer, which means that the employee and his or her family members are ineligible for financial assistance on the Marketplace, even if the cost of adding dependents to the employer-sponsored plan would far exceed 9.83% of the family's income. This definition of "affordable" employer coverage has come to be known as the "[family](http://kff.org/health-costs/perspective/measuring-the-affordability-of-employer-health-coverage/) [glitch](https://www.kff.org/health-costs/perspective/measuring-the-affordability-of-employer-health-coverage/) (<https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/my-employer-offers-health-benefits-to-me-and-my-family-the-company-pays-the-entire-cost-of-my-coverage-but-contributes-nothing-toward-the-cost-of-covering-my-family-we-cant-afford-to-enroll/>)."

While the Obama administration interpreted the ACA as excluding these dependents from subsidy eligibility, [some](https://www.healthaffairs.org/doi/10.1377/hpb20141110.62257/full/) [have](https://www.healthaffairs.org/doi/10.1377/hpb20141110.62257/full/) [suggested](https://www.healthaffairs.org/doi/10.1377/hblog20151217.052352/full/) that the IRS interpretation was narrow and that the family glitch can be addressed through administrative action. President [Biden's](https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-) [executive order](https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-) on strengthening Medicaid and the Affordable

care-act/) health care executive order called for federal agencies to review whether administrative policies could improve the affordability of dependent coverage, hinting at a potential administrative fix to the family glitch.

In this brief, we estimate that 5.1 million people fall into the family glitch. A majority of them are children, and among adults, women are more likely to fall into the glitch than men. We explore demographic characteristics of people who fall into the family glitch, present state-level estimates, and discuss how many people may benefit from policies aimed at addressing the family glitch. While estimates of the cost of eliminating the family glitch are beyond the scope of this analysis, the Congressional Budget Office (CBO) has previously projected it would cost the federal government \$45 billion over 10 years. Our estimate includes people with incomes above 400% of poverty, who are temporarily eligible for Marketplace financial assistance under the [American Rescue Plan Act](https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/) (<https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>) of 2021 (ARPA) passed in March 2021.

Who falls into the family glitch?

Using 2019 data from the Current Population Survey (CPS), we estimate how many people are affected by the family glitch across three groups: dependents with employer coverage, those with individual market coverage, and those without health insurance. In all three groups, we exclude people who are eligible for a public program (Medicare, Medicaid, the Children's Health Insurance Program, or Basic Health Program). Dependents were considered as falling in the family glitch if a worker in the family had an employer offer of affordable self-only coverage but unaffordable family coverage. More details are available in the Methods section.

One limitation of this analysis is the use of 2019 survey data, which – although it is the most recent year of data available – may not accurately represent current household circumstances during the pandemic and resulting economic downturn. In an earlier analysis, we estimated that, on net, about 2-3 million people lost employer-sponsored [coverage](https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/) (<https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/>) between March and September of 2020. Others may have lost their own employer coverage but transitioned onto a family member's employer plan. It is therefore difficult to know whether or how pandemic-related coverage changes have affected the current number of people falling into the family glitch as more recent data are not yet available.

In total, we find more than 5.1 million people fall in the ACA family glitch. The vast majority of those who fall in the glitch, 4.4 million people (85%), are currently enrolled through employer-sponsored health insurance. These families are likely spending far more for health insurance coverage than individuals with similar incomes eligible for financial assistance on the ACA Marketplaces and could spend less on premiums if they

could enroll in Marketplace plans and qualify for subsidies. One study estimated that those who fall into the family glitch are spending on average 15.8% of their incomes (<https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1491>), on employer-based coverage.

<https://embeds.kff.org/protected-iframe/26d26375e52b62e9e04594ab606b0faf>
(<https://embeds.kff.org/protected-iframe/26d26375e52b62e9e04594ab606b0faf>)

```
( function() {
var func = function() {
var iframe = document.getElementById('wpcom-iframe-
26d26375e52b62e9e04594ab606b0faf')
if ( iframe ) {
iframe.onload = function() {
iframe.contentWindow.postMessage( {
'msg_type': 'poll_size',
'frame_id': 'wpcom-iframe-26d26375e52b62e9e04594ab606b0faf'
}, "https://embeds.kff.org" );
}
}
}

// Autosize iframe
var funcSizeResponse = function( e ) {

var origin = document.createElement( 'a' );
origin.href = e.origin;

// Verify message origin
if ( 'embeds.kff.org' !== origin.host )
return;

// Verify message is in a format we expect
if ( 'object' !== typeof e.data || undefined === e.data.msg_type )
return;

switch ( e.data.msg_type ) {
case 'poll_size:response':
var iframe = document.getElementById( e.data._request.frame_id );

if ( iframe && " === iframe.width )
iframe.width = '100%';
if ( iframe && " === iframe.height )
iframe.height = parseInt( e.data.height );
```

```
return;
default:
return;
}
}
```

```
if ( 'function' === typeof window.addEventListener ) {
window.addEventListener( 'message', funcSizeResponse, false );
} else if ( 'function' === typeof window.attachEvent ) {
window.attachEvent( 'onmessage', funcSizeResponse );
}
}
if ( document.readyState === 'complete' ) { func.apply(); /* compat for infinite scroll */ }
else if ( document.addEventListener ) { document.addEventListener(
'DOMContentLoaded', func, false ); }
else if ( document.attachEvent ) { document.attachEvent( 'onreadystatechange', func ); }
}());
```

```
document.querySelectorAll('iframe.wpcom-protected-iframe').forEach( item => {
item.scrolling = 'no';
})
```

Of the remaining people who fall into the family glitch, 315,000 people (6% of those falling in the family glitch) are currently buying unsubsidized individual market coverage and 451,000 people (9%) do not have any health insurance.

More than half of those who fall in the ACA family glitch (about 2.8 million people) are children under the age of 18. These are children who do not qualify for the Children's Health Insurance Program (CHIP). About 0.5 million people in the family glitch are ages 18-26. The ACA requires employers to offer coverage to dependents up to age 26, but that coverage does not need to meet affordability standards set elsewhere in the ACA.

People who fall in the family glitch are more likely to be female (54%) than male (46%). Among adults falling in the family glitch (those over the age of 18), 59% are women and 41% are men.

<https://embeds.kff.org/protected-iframe/50d02dc157c6102fbe865e6080580c88>
(<https://embeds.kff.org/protected-iframe/50d02dc157c6102fbe865e6080580c88>)

```
( function() {
var func = function() {
var iframe = document.getElementById('wpcom-iframe-
50d02dc157c6102fbe865e6080580c88')
if ( iframe ) {
iframe.onload = function() {
```

```

iframe.contentWindow.postMessage( {
'msg_type': 'poll_size',
'frame_id': 'wpcom-iframe-50d02dc157c6102fbe865e6080580c88'
}, "https://embeds.kff.org" );
}
}

// Autosize iframe
var funcSizeResponse = function( e ) {

var origin = document.createElement( 'a' );
origin.href = e.origin;

// Verify message origin
if ( 'embeds.kff.org' !== origin.host )
return;

// Verify message is in a format we expect
if ( 'object' !== typeof e.data || undefined === e.data.msg_type )
return;

switch ( e.data.msg_type ) {
case 'poll_size:response':
var iframe = document.getElementById( e.data._request.frame_id );

if ( iframe && " " === iframe.width )
iframe.width = '100%';
if ( iframe && " " === iframe.height )
iframe.height = parseInt( e.data.height );

return;
default:
return;
}
}

if ( 'function' === typeof window.addEventListener ) {
window.addEventListener( 'message', funcSizeResponse, false );
} else if ( 'function' === typeof window.attachEvent ) {
window.attachEvent( 'onmessage', funcSizeResponse );
}
}

if ( document.readyState === 'complete' ) { func.apply(); /* compat for infinite scroll */ }
else if ( document.addEventListener ) { document.addEventListener(

```

```
'DOMContentLoaded', func, false ); }  
else if ( document.attachEvent ) { document.attachEvent( 'onreadystatechange', func ); }  
} );
```

```
document.querySelectorAll('iframe.wpcom-protected-iframe').forEach( item => {  
item.scrolling = 'no';  
})
```

The states with the largest number of people falling into the family glitch are Texas (671,000), California (593,000), Florida (269,000), and Georgia (206,000).

How many might benefit from a fix to the family glitch?

The American Rescue Plan Act (ARPA) recently (<https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>) passed (<https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>) by Congress and signed into law by President Biden in March 2021 does not address the family glitch, but it does include provisions temporarily extending the ACA subsidy eligibility beyond 400% of poverty in 2021 and 2022. The bill also increases the affordability of Marketplace coverage by reducing premium contribution requirements for people already eligible for subsidies. ARPA limits Marketplace premium contributions for eligible people to 8.5% of income, which is well below the contributions people in the family glitch are expected to pay toward employer-based coverage (above 9.83% of income). These provisions only last through the 2022 plan year, but at least for that period, a policy fix to the family glitch would extend subsidy eligibility to virtually all the 5.1 million people who fall in the glitch.

However, even if the family glitch is addressed, unless Congress extends the ARPA subsidies beyond 2022, the roughly 1.1 million people who fall into the family glitch and have incomes above 400% of poverty would no longer be eligible for subsidies starting in 2023.

Additionally, the availability of Marketplace tax credits may not be enough to substantially improve affordability for some families, particularly if the worker is not made eligible to join the family members on a subsidized Marketplace plan. Even if the family glitch is addressed, many families may have to contribute toward two health plan premiums – an employer plan for the worker and a subsidized Marketplace plan for the dependents – and these two plans would also have separate deductibles and out-of-pocket maximums.

How might a fix to the family glitch affect insurance markets?

The vast majority (94%) of those who fall into the family glitch are in better health (self-reported as being in good, very good, or excellent health). A similar share of people currently purchasing health coverage directly in the individual market (94%) are in better health. Therefore, the individual market risk pool may remain unchanged or even benefit if these individuals who are currently in employer-sponsored coverage or uninsured were to shift to enrolling through the Marketplaces. The ACA requires that individual market premiums be based on the average cost of insuring consumers in the market and region. If a number of healthy people who currently fall into the family glitch instead were to get insurance through the Marketplaces, the average cost of insuring individual market consumers could decrease, having a downward effect on premiums, all else being equal.

<https://embeds.kff.org/protected-iframe/28792258631347595f9252114f007540>
(<https://embeds.kff.org/protected-iframe/28792258631347595f9252114f007540>)

```
( function() {  
var func = function() {  
var iframe = document.getElementById('wpcom-iframe-  
28792258631347595f9252114f007540')  
if ( iframe ) {  
iframe.onload = function() {  
iframe.contentWindow.postMessage( {  
'msg_type': 'poll_size',  
'frame_id': 'wpcom-iframe-28792258631347595f9252114f007540'  
}, "https://embeds.kff.org" );  
}  
}  
  
// Autosize iframe  
var funcSizeResponse = function( e ) {  
  
var origin = document.createElement( 'a' );  
origin.href = e.origin;  
  
// Verify message origin  
if ( 'embeds.kff.org' !== origin.host )  
return;  
  
// Verify message is in a format we expect  
if ( 'object' !== typeof e.data || undefined === e.data.msg_type )  
return;  
  
switch ( e.data.msg_type ) {  
case 'poll_size:response':  
var iframe = document.getElementById( e.data._request.frame_id );
```

```

if ( iframe && " === iframe.width )
iframe.width = '100%';
if ( iframe && " === iframe.height )
iframe.height = parseInt( e.data.height );

return;
default:
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}

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}
}
if ( document.readyState === 'complete' ) { func.apply(); /* compat for infinite scroll */ }
else if ( document.addEventListener ) { document.addEventListener(
'DOMContentLoaded', func, false ); }
else if ( document.attachEvent ) { document.attachEvent( 'onreadystatechange', func ); }
}());

document.querySelectorAll("iframe.wpcom-protected-iframe").forEach( item => {
item.scrolling = 'no';
})

```

Discussion

The ACA made insurance coverage more affordable and accessible for millions of people. However, 30 million Americans remain uninsured and millions more [underinsured people](https://www.healthsystemtracker.org/indicator/access-affordability/percent-insured/) struggle with the cost of premiums and out-of-pocket expenses. President Biden campaigned on building on the ACA and addressing affordability of coverage more broadly. Although not as ambitious as his campaign pledge to remove the [firewall](https://www.kff.org/health-reform/issue-brief/affordability-in-the-aca-marketplace-under-a-proposal-like-joe-bidens-health-plan/) between employer coverage and the Marketplaces altogether, a fix to the family glitch could improve the affordability of health coverage for millions of people.

Our analysis finds 5.1 million people fall into the ACA's family glitch. Most Americans who fall in the family glitch are currently enrolled in employer-based coverage, but some could pay lower premiums if they are allowed to buy subsidized Marketplace coverage. A smaller number of uninsured people may also gain coverage with a fix to

the family glitch. The vast majority of those who fall in the family glitch and have individual market coverage would also pay lower premiums with a fix to the family glitch.

The exact number of people who would benefit from a fix to the family glitch will depend in part on how such a policy change is made and other potential changes to the ACA. Since Congress has temporarily expanded ACA subsidies for people with incomes above 400% of poverty and increased the amount of assistance available to nearly all Marketplace shoppers, virtually all of people currently in the family glitch could become eligible for Marketplace subsidies with a fix to the family glitch. However, even if the family glitch is addressed, when the ARPA's temporary subsidies expire, people who fall into the family glitch and have incomes over 400% of poverty would no longer be eligible for financial assistance on the exchange due to their incomes.

For a variety of reasons, some families may prefer to stay on the same employer plan rather than move dependents onto the Marketplace, even if premium subsidies are made available to them. Families will need to consider their total costs of care, including their premium and out-of-pocket costs, and some may benefit from sharing a single employer-sponsored family plan with a shared out-of-pocket limit. This may be the case particularly for families with relatively high health costs and those with higher incomes that would not qualify them for substantial ACA premium subsidies or cost sharing reductions. Provider networks will be another consideration for some families, as they tend to be broader in employer plans relative to the ACA Marketplace plans.

The bulk of people in the family glitch, however, are healthy and relatively low-income. If these low-income family members are allowed to purchase subsidized Marketplace coverage, some would also qualify for financial assistance to bring down their out-of-pocket costs. In contrast to means-tested Marketplace plans, employer plans typically do not reduce premium contributions or cost sharing based on the employee's income, so lower-income families with employer coverage end up paying much more (<https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/>) of their income toward health costs than their higher-income counterparts, on average.

A fix to the family glitch would increase government spending, with the amount depending how many of those who fall in the glitch choose to enroll through the Marketplaces. A Congressional Budget Office (CBO) score of a bill that passed in the U.S. House of Representatives (<https://www.congress.gov/bill/116th-congress/house-bill/1425/text>) estimates a fix to the family glitch would increase federal spending (<https://www.cbo.gov/publication/56434>) by \$45 billion over 10 years. This estimate does not include the temporarily expanded subsidies under ARPA.

Methods

We used data from the 2019 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) to estimate the number of people who might fall in the ACA "family glitch." Premium tax credit eligibility is based on the affordability of self-only coverage offer rather than affordability for the family. To estimate the number of people who would fall in the family glitch, income data were aggregated at the tax unit level.

First, we look at households with employer-sponsored health insurance and the contributions toward family coverage. If the family's contribution toward health insurance as a share of the family's income exceeds the affordability threshold, then family members are considered to fall in the family glitch. Second, we include dependents who have individual market insurance. In this group, we look at whether the dependent has a family member with self-only employer coverage or an offer of employer coverage. Family members with individual market insurance are included as falling in the family glitch if the potential contribution toward employer-based family coverage exceeds the affordability threshold. In the third group, we include uninsured people who have a family member with affordable self-only employer coverage or an offer of affordable self-only coverage through their employer.

In tax units with one employer-sponsored insurance (ESI) family policy and total ESI contributions as a share of total tax income exceeding the affordability threshold, dependents without independent coverage (including through eligibility in Medicare, Medicaid, or Basic Health Program (BHP)) or independent ESI offers were counted as falling into the family glitch.

In tax units without any ESI policies but at least one worker with an ESI offer or only one person with ESI self-only coverage and no other ESI policy holder, we imputed a family coverage contribution. Family contribution and ESI offer were imputed based on groups with family employer coverage by their poverty category (under 250, 250 to 400, 400 to 600, or 600+ percent FPL) and tax unit size. These tax units were limited to those with at least one other person who is uninsured or has individual market coverage but does not have other coverage or eligibility through Medicare, Medicaid, or a BHP. Then, if the imputed contribution as a share of tax income exceeded the affordability threshold, the persons with non-group coverage or who are uninsured but not eligible for Medicare, Medicaid, or a BHP were counted as falling into the family glitch. Households where a family member had self-only employer coverage or offer and that self-only coverage or offer was unaffordable were excluded since those people would not fall in the family glitch.

People with social security income and their premium contributions were excluded from the tax units. For tax units where a person without a tax id (unauthorized people) is the source of an employer offer, the whole tax unit was excluded because there is no eligible person in the tax unit identified as having an offer of ESI. Tax units with multiple ESI family policies were also excluded. Tax units with zero or less tax income and premium contribution of \$500 or less were excluded.

To reflect 2021 values, we adjusted tax unit income for inflation and adjusted tax unit premium payments using the average growth in employer sponsored premiums. We used this adjusted premium value to calculate the share of the unit's income that was going toward premiums and compared that percentage to the affordability threshold for 2021. The affordability threshold for 2021 ([9.83% \(https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/\)](https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/)) was used for this analysis.

There are limitations to this analysis. The CPS data imputes employer-based premium contributions for the entire family. We also are unable to estimate how many families would pay less in total premiums with a fix to the family glitch after accounting for contributions toward employer-based coverage (for the worker) and Marketplace coverage (for dependent family members).

Endnotes

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State Trends in Employer Premiums and Deductibles, 2010–2019



TOPLINES

Middle-income workers spent an average 6.8 percent of their incomes on employer premium contributions in 2019, up from 5.8 percent in 2010; deductibles rose as well

If premiums and deductibles for employer health coverage don't fall this year, household income lost during the current economic crisis will increase cost burdens for middle-income families

AUTHORS

Sara R. Collins, David C. Radley, Jesse C. Baumgartner

Roughly half the population of the United States — about 160 million people — had insurance through employers just prior to the start of the coronavirus pandemic.¹ The

pandemic's massive disruption to the economy resulted in a loss of coverage for an estimated 14.6 million workers and their dependents by June of this year.² The crisis will likely lead to additional losses well into 2021. Millions who still have employer benefits have lost wages and income, making their insurance costs an increased burden on household budgets.

The Affordable Care Act provides a safety net for people who lose employer coverage by offering coverage through the individual market and the marketplaces or Medicaid. However, while people with unaffordable employer plans have some options through Medicaid and the marketplaces, these options are limited and eligibility rules are complex.

In this brief we focus on the extent to which people with moderate incomes in employer plans face high premium and deductible costs relative to their income. We examine trends in each state over 2010–2019, just before the pandemic hit, using the most recent data from the federal Medical Expenditure Panel Survey–Insurance Component, to inquire: How much were workers spending on premiums and deductibles? How do those costs compare to median income in each state?³

Highlights

- Premium contributions and deductibles in employer plans accounted for 11.5 percent of median household income in 2019, up from 9.1 percent a decade earlier.
- Premium contributions and deductibles were 10 percent or more of median income in 37 states in 2019, up from 10 states in 2010. Nine states have combined costs of 14 percent or more of median income.
- The total cost of premiums and potential spending on deductibles across single and family policies ranged from a low of \$5,535 in Hawaii to a high of more than \$8,500 in nine states.
- If premiums and deductibles do not fall this year, household income lost during the current economic crisis will increase cost burdens for middle-income families.

Premium Contributions and Deductibles Added Up to More Than 11 Percent of Median Income in 2019

Share of median income (%)

Note: Combined estimates of single and family premium contributions and deductibles are weighted for the distribution of single-person and family households in the state.

Data: Premium contributions and deductibles – Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2010–2019; Median household income and household distribution type – U.S. Census Bureau, Current Population Survey (CPS), 2010–2020, analysis by Benjamin Zhu and Sherry Glied of New York University for the Commonwealth Fund.

Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2019* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7n7x-sj69>

Premium contributions and deductibles in employer plans took up a growing share of worker’s incomes over the past decade. Those costs together accounted for 11.5 percent of median household income in 2019, up from 9.1 percent a decade earlier ([Table 6](#)).

On average, the employee share of premium amounted to 6.8 percent of median income in 2019. This was up from 5.8 percent in 2010 but has remained largely constant since 2015 ([Table 6](#)).

The average deductible for a middle-income household amounted to 4.7 percent of income in 2019 ([Table 6](#)). This was up from 3.3 percent in 2010.

The Number of States Where Worker Premium Contributions and Deductibles Were 10 Percent or More of Median Income Grew over the Decade

Average employee share of premium plus average deductible as percent of median state incomes

Note: Combined estimates of single and family premium contributions and deductibles are weighted for the distribution of single-person and family households in the state.

Data: Premium contributions and deductibles – Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2010–2019; Median household income and household distribution type – U.S. Census Bureau, Current Population Survey (CPS), 2010–2020, analysis by Benjamin Zhu and Sherry Glied of New York University for the Commonwealth Fund.

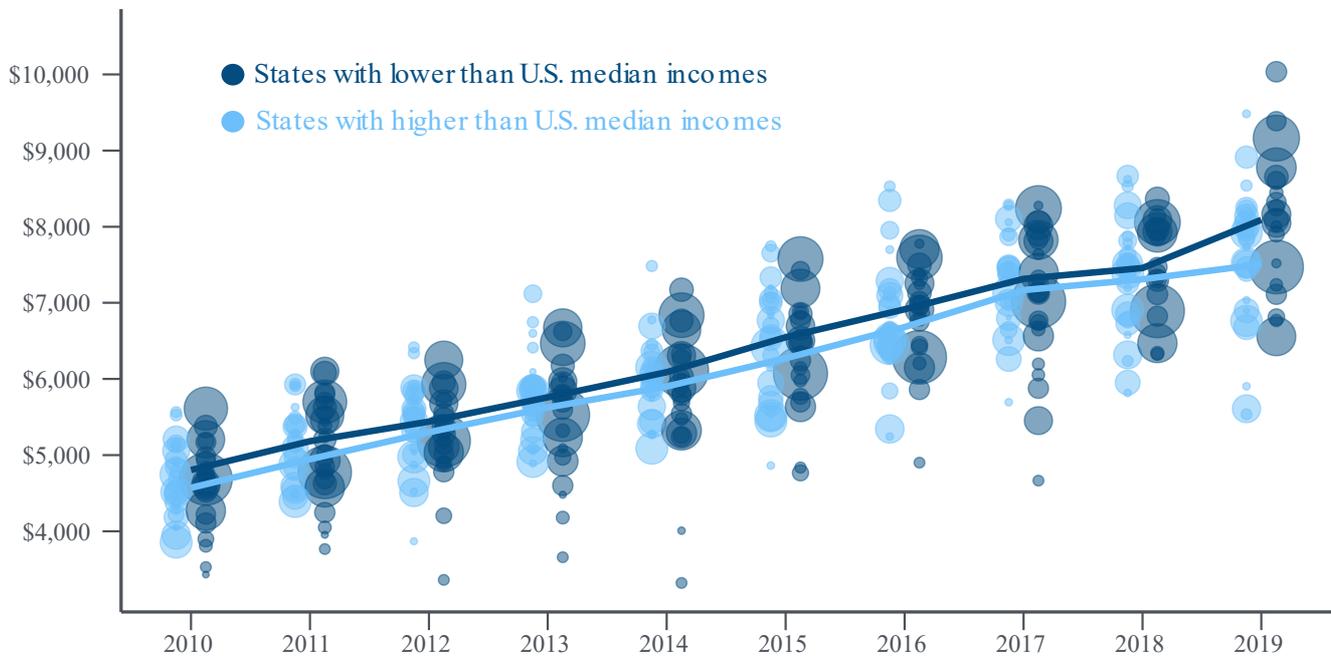
Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2019* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7n7x-sj69>

Premium contributions and deductibles were 10 percent or more of median income in 37 states in 2019, up from 10 states in 2010. Nine states (Arkansas, Florida, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, Tennessee, and Texas) have combined costs of 14 percent or more of median income (Table 6). Middle-income workers in New Mexico and Louisiana faced the highest potential costs relative to their income (17.4% and 17.2%, respectively).

Added together, the total cost of premiums and potential spending on deductibles across single and family policies climbed to \$7,806 in 2019 (Table 5). This ranged from a low of \$5,535 in Hawaii to a high of more than \$8,500 in nine states (Florida, Louisiana, Missouri, New Hampshire, Oklahoma, South Carolina, South Dakota, Tennessee, and Texas).

Workers in States with Lower Median Incomes Faced Higher Combined Premium Contributions and Deductibles

Combined premium contribution + deductible (\$)



Note: Bubbles are proportionate to the states' populations. Lines represent the average among the associated group of states, weighted by population.

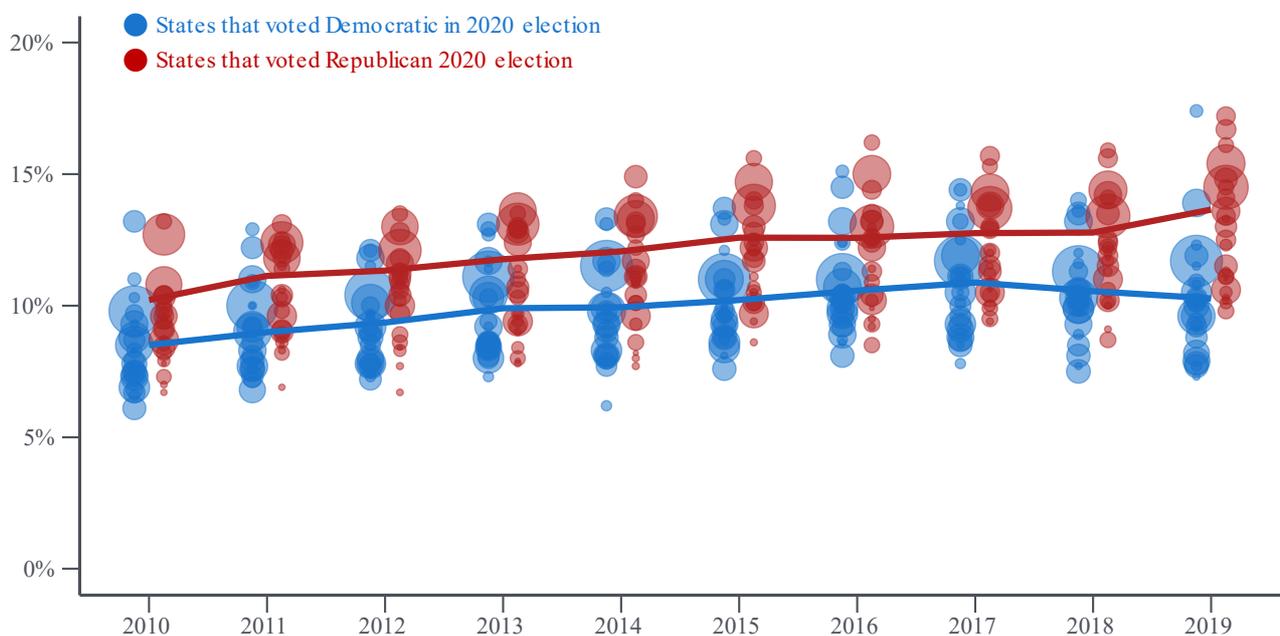
Data: Premium contributions and deductibles – Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2010–2019; Median household income and household distribution type – U.S. Census Bureau, Current Population Survey (CPS), 2010–2020, analysis by Benjamin Zhu and Sherry Glied of New York University for the Commonwealth Fund.

Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2019* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7n7x-sj69>

Workers across the income spectrum have experienced steady growth in the combined cost of premiums and deductibles. But people living in states with lower median incomes are doubly burdened. On average, workers in states where the median income is lower than national median income face higher absolute costs compared to people in states with higher median incomes.

Workers in Republican-Leaning States Faced Higher Insurance Cost Burdens on Average Than Those in Democratic-Leaning States

Combined premium contribution + deductible as a share of median state incomes (%)



Note: Note: Bubbles are proportionate to the states' populations. Lines represent the average among the associated group of states, weighted by population. Political affiliation based on 2020 election results as of 11/13/2020 – Nebraska is considered Republican and Maine is considered Democratic despite likely split electoral votes in each state.

Data: Premium contributions and deductibles – Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2010–2019; Median household income and household distribution type – U.S. Census Bureau, Current Population Survey (CPS), 2010–2020, analysis by Benjamin Zhu and Sherry Glied of New York University for the Commonwealth Fund.

Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2019* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7n7x-sj69>

Looking at voting patterns in the 2020 presidential election, on average workers in states that President Trump won have higher premium and deductible burdens relative to median income than those who voted for President-elect Joe Biden.

Employee Premium Contributions for Single Coverage Ranged from \$718 in Hawaii to \$1,793 in Massachusetts in 2019

Dollars

U.S. average = \$1,489

Low: Hawaii = \$718

High: Massachusetts = \$1,793

Note: Employee premium contributions are for insurance policies offered by private-sector employers in the U.S.

Data: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2019.

Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2019* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7n7x-sj69>

U.S. workers in employer plans contributed about 21 percent of their overall premium for single plans and 28 percent for family plans in 2019. This has not changed over the decade ([Table 2](#)). In some states the share is much higher; workers were responsible for a third or more of their family-plan premium in 10 states (Arkansas, Delaware, Florida, Louisiana, Maryland, Mississippi, Missouri, New Mexico, South Carolina, and South Dakota).

Worker contributions to single-plan premiums averaged \$1,489 in 2019. They ranged from a low of \$718 in Hawaii to a high of \$1,793 in Massachusetts ([Table 3a](#)). Contributions to family plans averaged \$5,726 in 2019 and ranged from a low of \$3,685 in Michigan to a high of \$8,202 in South Carolina ([Table 3b](#)).

Workers' Premium Contributions Were 8 Percent or More of Median Income in Nine States in 2019

Average employee share of premium as percent of median state incomes

Note: Single and family premium contributions are weighted for the distribution of single-person and family households in the state.

Data: Premium contributions and deductibles – Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2019; Median household income and household distribution type – U.S. Census Bureau, Current Population Survey (CPS), 2019–2020, analysis by Benjamin Zhu and Sherry Glied of New York University for the Commonwealth Fund.

Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2019* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7n7x-sj69>

In nine states (Arkansas, Florida, Georgia, Louisiana, Mississippi, New Mexico, Oklahoma, South Carolina, and Texas), premium contributions were 8 percent or more of median income, with a high of 10.7 percent in South Carolina ([Table 6](#)).

Average Deductibles for Single Coverage Ranged from \$1,264 in Hawaii to \$2,521 in Montana in 2019

Dollars

U.S. average = \$1,931

Low: Hawaii = \$1,264

High: Montana = \$2,521

Note: Deductibles are for insurance policies offered by private-sector employers in the U.S.

Data: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2019.

Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2019* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7n7x-sj69>

In most states, even though people are paying high premiums relative to their income, they are potentially exposed to high out-of-pocket costs because of large deductibles. Research has indicated that high deductibles can act as a financial barrier to care, discouraging people with modest incomes from getting needed services. This a particular problem during the COVID-19 pandemic, when people with symptoms may delay care because of cost concerns.

In 2019, the average deductible for single-person policies was \$1,931 (Table 4), with average deductibles ranging from \$1,264 in Hawaii to \$2,521 in Montana.

Average Deductibles Were 5 Percent or More of Median Income in 20 States in 2019

Average deductible as a percent of median state incomes

Note: Single and family deductibles are weighted for the distribution of single-person and family households in the state.

Data: Premium contributions and deductibles – Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey–Insurance Component (MEPS–IC), 2019; Median household income and household distribution type – U.S. Census Bureau, Current Population Survey (CPS), 2019–2020, analysis by Benjamin Zhu and Sherry Glied of New York University for the Commonwealth Fund.

Source: Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2019* (Commonwealth Fund, Nov. 2020). <https://doi.org/10.26099/7n7x-sj69>

The Commonwealth Fund has found that insured people who have high out-of-pocket costs and deductibles relative to their income are more likely to face problems accessing care and paying medical bills than those who do not. We have defined someone with insurance as “underinsured” if their plan’s deductible equals 5 percent or more of income or if their out-of-pocket costs reach similar thresholds.⁴

Across the country, many people in employer plans are underinsured by this measure. Average deductibles relative to median income were 5 percent or more in 20 states and ranged as high as 7 percent in New Mexico ([Table 6](#)).

Looking Forward

In this analysis, the burden of health care costs for U.S. workers with job-based health insurance is determined by three factors: median income, premium contributions, and deductibles. This cost burden has increased over the past decade because cumulative income growth over this period has lagged growth in premium contributions and deductibles. While our research indicates that the burden has not worsened significantly over the past couple years, it has not improved, either. A recent survey of employer benefits in the first half of 2020 reached a similar conclusion.⁵

But what impact will the coronavirus pandemic and the associated recession have on these variables? First, it is likely that the deep and prolonged recession will lower U.S. median income growth. While the recession initially had the greatest impact on

industries most affected by the pandemic, those effects are now spilling over into other sectors.⁶ This means that even if premium contributions and deductibles do not change, they could take up a larger share of workers' incomes in 2020 and 2021.

The pandemic's effects on premium contributions and deductibles is uncertain. Both variables are driven by trends in health care costs. The past year has seen both spikes in health care spending from COVID-19 hospitalizations and deep declines in spending from drops in elective surgery and other nonurgent care. The net effect appears to be overall lower spending and higher profits for insurance companies. Because the Affordable Care Act (ACA) requires insurers to return excess profits to employers and their workers, this could mean lower premiums in 2021 if insurers anticipate these trends will continue. An analysis of rate filings in the ACA marketplaces for the 2021 plan year found that some insurers increased premiums in anticipation of higher COVID-19-related costs while others decreased premiums because they anticipate ongoing lower health care use.⁷ Just under half of plans that cited COVID-19 in their rate filings either viewed the countervailing effects on spending as a wash or noted the effects were too uncertain to have an impact on premiums.

In the employer market, even if premium contributions and deductibles fall, remain unchanged, or grow more slowly, incomes could fall or grow more slowly, leaving household cost burdens unchanged or higher.

Higher health insurance cost burdens will place people in a precarious spot. People with low and moderate incomes may decide to go without insurance if it competes with other expenses — for example, housing and food, which consumed 35 percent of average family income in 2019.⁸ People who are uninsured or underinsured may forgo getting tested for COVID-19, delay getting care if they fall ill, or delay getting vaccinated when that becomes possible.⁹

The ACA provides some cost protection to people with employer coverage in high-cost plans. First, people with low incomes — less than 138 percent of the federal poverty level (or \$17,609 for an individual) — are eligible for Medicaid in the 38 states, as well as D.C., that have expanded eligibility under the ACA. This is true regardless of whether they are offered a plan through their job. People enrolled in Medicaid pay no premiums or cost-sharing or very limited costs. Second, people with employer premium expenses that exceed 9.83 percent of income are eligible for marketplace subsidies, which trigger a federal tax penalty for their employers. This penalty is also triggered if the actuarial value of their plan is less than 60 percent (i.e., covers less than 60% of their costs, on average). But there's a catch: these provisions only apply to single-person policies, leaving many middle-income families caught in the so-called family coverage glitch if they have an expensive family plan but do not qualify for marketplace subsidies. The data in this

report show that the average employee contribution to a family plan was 10 percent or more of median income in eight states in 2019 (Tables 3b and 7).

President-elect Biden and members of Congress have proposed fixing the family coverage glitch or further easing ACA restrictions to give more people in employer plans a choice of enrolling in a plan offered through the marketplaces. They also would enhance marketplace premium and cost-sharing subsidies and extend them further up the income scale.¹⁰ The 12 states that have not yet expanded Medicaid are among those where workers are experiencing the highest cost burdens. Expanding Medicaid would provide relief. These changes have the potential to help millions of people struggling to afford their health care.

How We Conducted This Study

This data brief analyzes state-by-state trends in private sector employer health insurance premiums and deductibles for the under-65 population from 2010 to 2019.

The data on total insurance costs, employee premium contributions, and deductibles come from the federal Agency for Healthcare Research and Quality's annual survey of employers, conducted for the insurance component of the Medical Expenditure Panel Survey (MEPS-IC). The MEPS-IC is administered to workplace establishments. Establishments represent a work location, not necessarily a firm, which can employ people in many locations. Workplace establishments are selected each year from the Census Bureau's Business Register — a confidential list of such establishments in the United States. Once selected, establishments are contacted via mail and phone to establish a contact person who is knowledgeable about the health insurance benefits offered to employees. This contact (generally a workplace administrator) is asked about each of the health plans offered to employees that work at the establishment location. If the establishment offers more than four plans, details are collected about the four plans with the largest enrollment. In 2019, MEPS-IC surveyed 40,451 establishments and had a response rate of 59.2 percent. The total number of surveys sent in 2019 was similar to prior years, but there was a lower response rate.

Total premium and other insurances costs are compared with median household incomes for the under-65 population in each state. Income data come from the U.S. Census Bureau's Current Population Survey (CPS) of households. In the CPS, a "household" includes all persons residing at a single address, regardless of their relationship; a "family" includes all related members of a household. Neither of these definitions reflect a "family unit" for purposes of determining health insurance eligibility. The measure of household income reported here is adjusted to account for the likelihood that individuals residing in the same household are likely to purchase

health insurance together — referred to as a health insurance unit (HIU). HIUs are defined based on household and family members' relationships with the intention of grouping health insurance subscribers and their dependents. For example, a HIU would include the head of household insurance subscriber, spouse, dependent children residing in the same address, and dependent children who are full-time students but not residing at the same address. It would exclude nondependent family members (e.g., an elderly grandparent) who reside at the same address, but who would be included in the Census Bureau's family or household definition.

Note that the CPS revised its income questions in 2013, affecting the denominator in our ratio estimates. Prior to 2014, this is derived from the traditional CPS income questions, while ratio estimates from 2014 and later are derived from the revised income questions. In 2019, the Census Bureau also updated the way it processes CPS response data; the biggest changes are in the ways missing response data are imputed.¹¹ The Census Bureau's new imputation strategies resulted in a less than 1 percent change in the median income estimates. Two years of CPS data are combined to generate reliable state-level income estimates. For example, the 2019 income estimates reported here ([Table 7](#)) reflect incomes in 2018 and 2019, as reported in the 2019 and 2020 CPS Annual Social and Economic Supplement (ASEC) data files. The Census Bureau found that income data for 2019, collected in March 2020, potentially overestimates household income as the result of a nonresponse bias, introduced by data collection issues as travel and social distancing restrictions were beginning to be implemented. We have adjusted 2019 incomes downward to account for this bias.¹²

The premiums in this brief represent the average total annual cost of private group health insurance premiums for employer-sponsored coverage, including both the employer and employee shares. We also examine trends in the share of premiums that employees pay and average deductibles. We compared average out-of-pocket costs for premiums and average deductibles to median income in states to illustrate the potential cost burden of each and the total if the worker/family incurred these average costs. The Agency for Healthcare Research and Quality reports MEPS–IC premium, employee contribution, and deductible data separately for single (i.e., employee only) and family plans — we include these data in [Tables 1](#) through [4](#). However, average employee out-of-pocket costs ([Tables 5](#) and [6](#)) are combined estimates, weighted for the distribution of single-person and family households in the state. For example, the average total employee premium contribution reported in [Table 5](#) is equal to (MEPS–IC single plan contribution for state i * share of single-person households in state i) + (MEPS–IC family plan contribution for state i * share of multiple-person households in state i). The same approach is used to calculate average total deductibles. Average combined employee premium contribution and deductible — also referred to as total potential out-of-pocket spending — is the sum of the household distribution weighted premium contribution and deductible estimates.

The tables provide state-specific data. This analysis updates previous Commonwealth Fund analyses of state health insurance premium and deductible trends.

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NOTES

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2. Paul Fronstin and Stephen A. Woodbury, *How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?* (Commonwealth Fund, Oct. 2020).
3. The MEPS–IC is the most comprehensive national survey of U.S. businesses on their health insurance plans. It surveyed more than 40,000 private-sector employers in 2019. The sampling unit used in the MEPS-IC is the “business establishment.” The Agency for Healthcare Research and Quality identifies an “establishment” as “a particular workplace or location” and a firm as “a business entity consisting of one or more business establishments under common ownership or control.” This means that multiple establishments owned by the same firm, but that operate in different locations, would be treated as independent respondents in this survey.
4. In addition to having a high deductible relative to income, people who are insured all year are considered underinsured if their out-of-pocket costs are high relative to income. See Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, Aug. 2020).
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AREA OF FOCUS

Achieving Universal Coverage

TOPICS

**Coverage and Access,
Government Programs & Policies,
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Affordability,
Out-of-Pocket Health Care Costs,
Private Insurance,
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Health Coverage of Immigrants

Published: Jul 15, 2021



Summary

In 2019, there were 21.3 million noncitizens in the United States, accounting for about 7% of the total U.S. population. Noncitizens include lawfully present and undocumented immigrants. Many individuals live in mixed immigration status families that may include lawfully present immigrants, undocumented immigrants, and/or citizens. One in four children has an immigrant parent, and the majority of these children are citizens.

Noncitizens are significantly more likely than citizens to be uninsured. In 2019, among the nonelderly population, 25% of lawfully present immigrants and more than four in ten (46%) undocumented immigrants were uninsured compared to less than one in ten (9%) citizens. Among citizen children, those with at least one noncitizen parent are more likely to be uninsured compared to those with citizen parents (9% vs. 5%).

Research (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/>) **suggests that the changes to immigration policy enacted by the Trump administration contributed to increased fears among immigrant families about participating in programs and seeking services, including health coverage and care.** (<https://www.kff.org/medicaid/issue-brief/impact-of-shifting-immigration-policy-on-medicaid-enrollment-and-utilization-of-care-among-health-center-patients/>) These include policies focused on curbing immigration, enhancing immigration enforcement, and limiting the use of public assistance (<https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/>) among immigrant families.

The pandemic has likely contributed to increased health and financial needs (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-financial-risks-noncitizen-immigrants-covid-19-pandemic/>) **and declines in health coverage among immigrant families.** Immigrants' work, living, and transportation situations put them at increased risk for potential exposure to coronavirus. Noncitizen immigrants also face risk of financial difficulties due to the pandemic, as many are working in service industries, such as restaurants and food services, that have suffered cutbacks. Initial job losses (<https://www.migrationpolicy.org/research/covid-19-unemployment-immigrants-other-us-workers>) amid the pandemic were particularly high

among immigrants. Given their low incomes, job loss could lead to significant financial pressures and increase the share who are uninsured, as people lose access to employer-sponsored insurance or are no longer able to afford coverage.

Restrictions limit immigrants' access to COVID-relief, and ongoing immigration-related fears are making some reluctant to access assistance, services, and COVID-19 vaccines. Although noncitizen immigrants face increased risks associated with the pandemic, restrictions limit immigrants' eligibility for federal health and financial relief provided in response to COVID-19. Moreover, even though the Biden administration has reversed (<https://www.uscis.gov/sites/default/files/document/notices/SOPDD-Letter-to-USCIS-Interagency-Partners-on-Public-Charge.pdf>) many immigration policy changes made by the Trump administration that increased fears, recent data (<https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-access-information-experiences-hispanic-adults/>) suggest that ongoing immigration-related fears are contributing to reluctance to access assistance and services as well as COVID-19 vaccines.

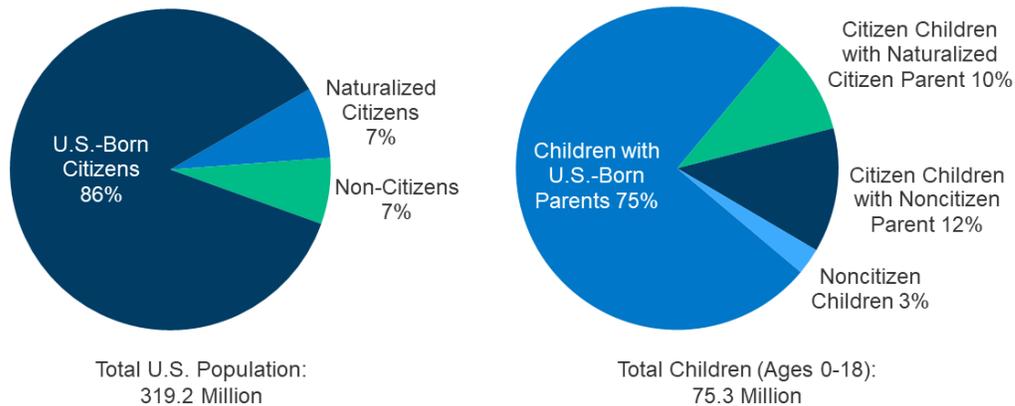
Overview of Immigrants

In 2019, there were 21.3 million noncitizens and 22.9 million naturalized citizens residing in the U.S., who each accounted for about 7% of the total population (Figure 1). About six in ten noncitizens were lawfully present immigrants, while the remaining four in ten were undocumented immigrants (see Text Box 1).¹ Many individuals live in mixed immigration status families that may include lawfully present immigrants, undocumented immigrants, and/or citizens.

A total of 18.6 million or one in four children had an immigrant parent as of 2019, and the majority of these children were citizens. About 9.4 million or 12% were citizen children with a noncitizen parent.

Figure 1

Immigrants and Children of Immigrants as a Share of the Total U.S. Population, 2019



NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF analysis of 2019 American Community Survey, 1-Year Estimates.

KFF

Figure 1: Immigrants and Children of Immigrants as a Share of the Total U.S. Population, 2019

Text Box 1: Overview of Lawfully Present and Undocumented Immigrants

Lawfully present immigrants are noncitizens who are lawfully residing in the U.S. This group includes legal permanent residents (LPRs, i.e., “green card” holders), refugees, asylees, and other individuals who are authorized to live in the U.S. temporarily or permanently.

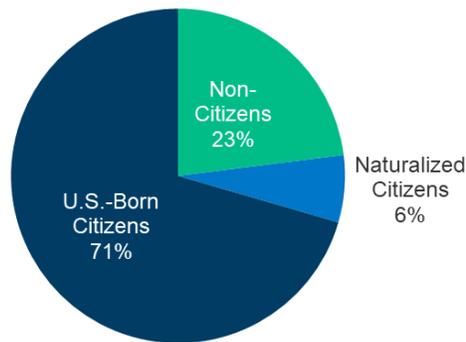
Undocumented immigrants are foreign-born individuals residing in the U.S. without authorization. This group includes individuals who entered the country without authorization and individuals who entered the country lawfully and stayed after their visa or status expired.

Health Coverage for Nonelderly Noncitizens

In 2019, more than three-quarters of the 28.9 million nonelderly uninsured were U.S.-born and naturalized citizens (Figure 2). The remaining 23% were noncitizens.

Figure 2

Nonelderly Uninsured by Citizenship Status, 2019



Total Nonelderly Uninsured:
28.9 Million

NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF analysis of 2019 American Community Survey, 1-Year Estimates.

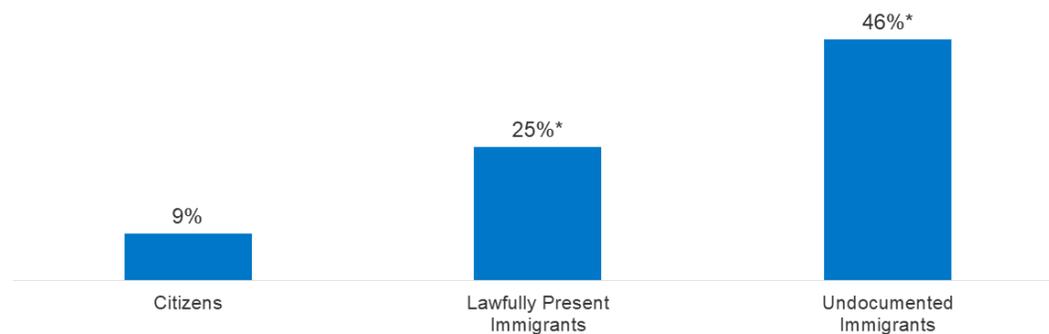
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Figure 2: Nonelderly Uninsured by Citizenship Status, 2019

However, noncitizens, including lawfully present and undocumented immigrants, were significantly more likely to be uninsured than citizens. Among the nonelderly population, 25% of lawfully present immigrants and more than four in ten (46%) undocumented immigrants were uninsured compared to 9% of citizens (Figure 3).

Figure 3

Uninsured Rates Among Nonelderly Population by Immigration Status, 2019

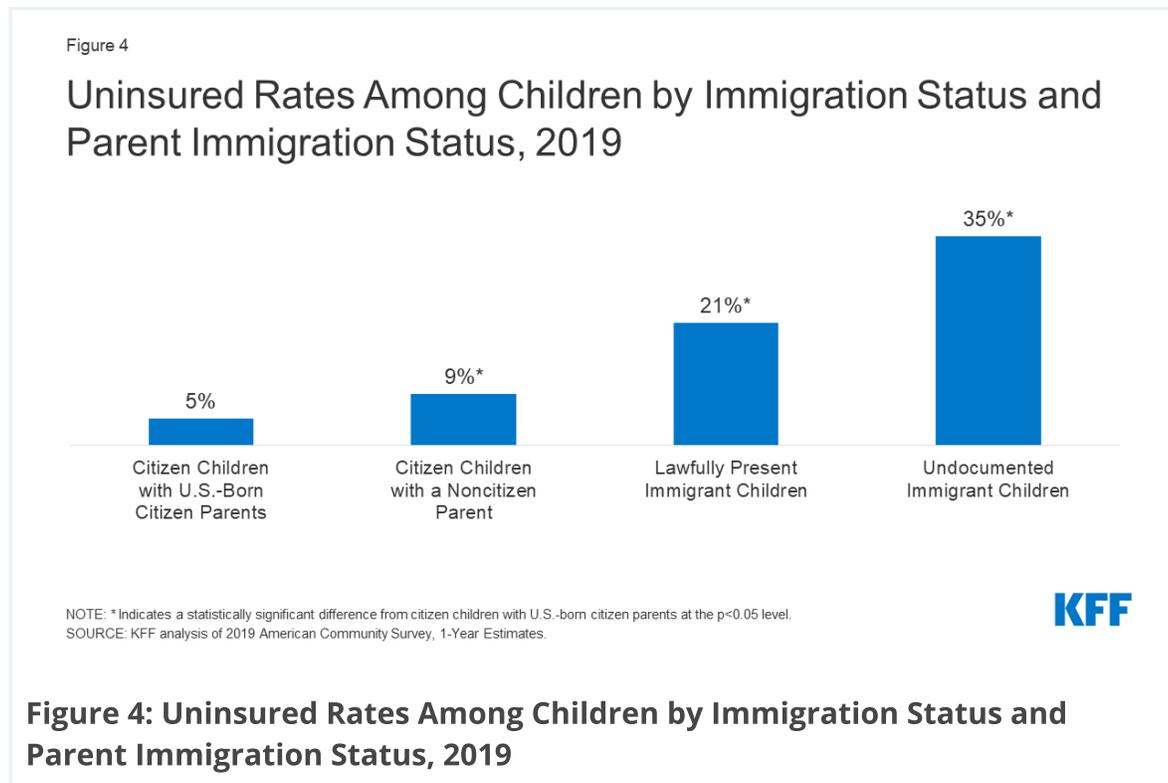


NOTE: * Indicates a statistically significant difference from citizens at the $p < 0.05$ level.
SOURCE: KFF analysis of 2019 American Community Survey, 1-Year Estimates.

KFF

Figure 3: Uninsured Rates Among Nonelderly Population by Immigration Status, 2019

These differences in coverage also occur among children, with noncitizen children more likely to lack coverage compared to their citizen counterparts. Moreover, among citizen children, those with at least one noncitizen parent were significantly more likely to be uninsured as those with citizen parents (Figure 4).



Barriers to Health Coverage for Noncitizens

The higher uninsured rate among noncitizens reflects limited access to employer-sponsored coverage; eligibility restrictions for Medicaid, CHIP, and ACA Marketplace coverage; and barriers to enrollment among eligible individuals.

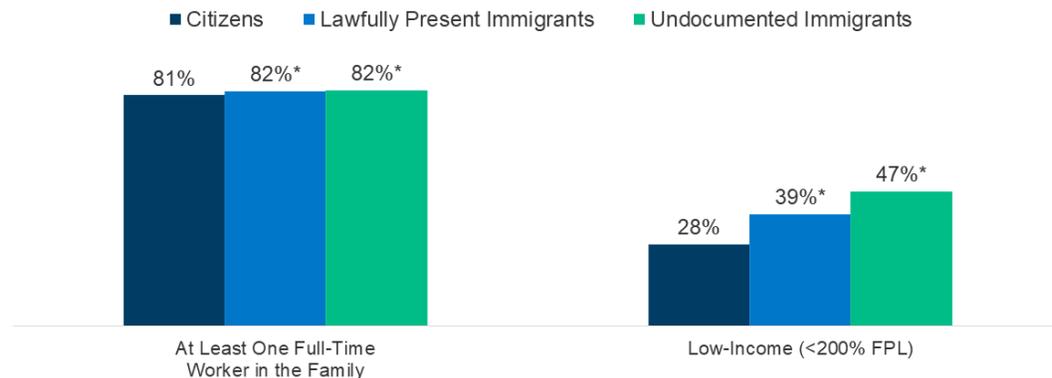
Limited Access to Coverage

Although most nonelderly noncitizens live in a family with a full-time worker, they face gaps in access to private coverage. Nonelderly noncitizens are more likely than nonelderly citizens to live in a family with at least one full-time worker, but they also are more likely to be low-income (Figure 5). They have lower incomes because they are often employed in low-wage jobs and industries that are less likely to offer employer-sponsored coverage. Given their lower incomes, noncitizens also face increased challenges affording employer-sponsored coverage when it is available or through the individual market.

Lawfully present immigrants may qualify for Medicaid and CHIP but are subject to certain eligibility restrictions. In general, lawfully present immigrants must have a “qualified” immigration status to be eligible for Medicaid or CHIP, and many, including most lawful permanent residents or “green card” holders, must wait five years after obtaining qualified status before they may enroll. Some

Figure 5

Employment and Income Among Nonelderly Population by Immigration Status, 2019



NOTE: * Indicates a statistically significant difference from citizens at the $p < 0.05$ level.
SOURCE: KFF analysis of 2019 American Community Survey, 1-Year Estimates.

KFF

Figure 5: Employment and Income Among Nonelderly Population by Immigration Status, 2019

immigrants with qualified status, such as refugees and asylees, do not have to wait five years before enrolling. Some immigrants, such as those with temporary protected status, are lawfully present but do not have a qualified status and are not eligible to enroll in Medicaid or CHIP regardless of their length of time in the country (Appendix A). For children and pregnant women, states can eliminate the five-year wait and extend coverage to lawfully present immigrants without a qualified status. As of 2021, 35 states (<https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>) have taken up this option for children and half have elected the option for pregnant women.

In December 2020, Congress restored Medicaid eligibility for citizens of Compact of Free Association (COFA) communities.

Compacts of Free Association are agreements between the U.S. government and the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. Certain citizens of these nations can lawfully work, study, and reside in the U.S., but they had been excluded from federally-funded Medicaid since 1996, under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). As part of a COVID-relief package, Congress restored Medicaid eligibility for COFA citizens who meet other eligibility requirements for the program effective December 27, 2020.

Lawfully present immigrants can purchase coverage through the ACA

Marketplaces and may receive subsidies for this coverage. These subsidies are available to people with incomes from 100% to 400% FPL who are not eligible for

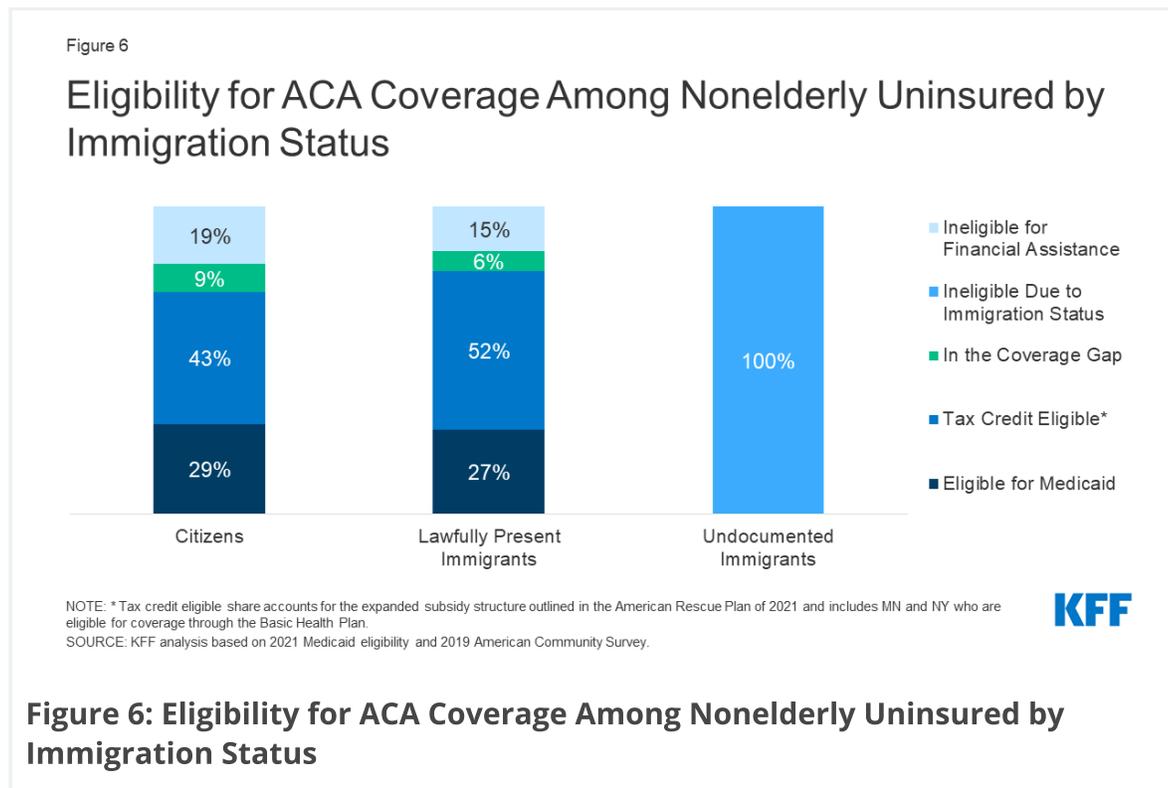
other coverage. In addition, lawfully present immigrants with incomes below 100% FPL may receive subsidies if they are ineligible for Medicaid based on immigration status. This group includes lawfully present immigrants who are not eligible for Medicaid or CHIP because they are in the five-year waiting period or do not have a “qualified” status.

Undocumented immigrants are not eligible to enroll in Medicaid or CHIP or to purchase coverage through the ACA Marketplaces. Medicaid payments for emergency services may be made on behalf of individuals who are otherwise eligible for Medicaid but for their immigration status. These payments cover costs for emergency care for lawfully present immigrants who remain ineligible for Medicaid as well as undocumented immigrants. Since 2002, states have had the option to provide prenatal care to women regardless of immigration status by extending CHIP coverage to the unborn child. In addition, some states have state-funded health programs that provide coverage to some groups of immigrants regardless of immigration status. There are also some locally-funded programs that provide coverage or assistance without regard to immigration status. Under rules issued by the Centers for Medicare and Medicaid Services, individuals with Deferred Action for Childhood Arrivals (<https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf>) (DACA) status are not considered lawfully present and remain ineligible for coverage options.

Enrollment Barriers among Eligible Individuals

Many uninsured lawfully present immigrants are eligible for coverage options under the ACA but remain uninsured, while uninsured undocumented immigrants are ineligible for coverage options. Prior to the pandemic many uninsured lawfully present immigrants were eligible for ACA coverage. The American Rescue Plan Act (ARPA) enacted in 2021 further increased access to health coverage through temporary increases and expansions in eligibility for subsidies (<https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>) to buy health insurance through the health insurance marketplaces. It also includes incentives to states that have not yet adopted the ACA Medicaid (<https://www.kff.org/medicaid/issue-brief/medicaid-provisions-in-the-american-rescue-plan-act/>) expansion to do so and provides a new option for states to extend the length of Medicaid coverage for postpartum women (<https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/>). With the temporary changes under ARPA, nearly eight in ten (79%) uninsured lawfully present immigrants were eligible for ACA coverage, including 27% who were eligible for Medicaid and 52% who were eligible for tax credit subsidies (Figure 6). Many lawfully present immigrants who are eligible for coverage remain uninsured because immigrant families face a range of enrollment barriers, including fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges. Uninsured undocumented immigrants are ineligible for

coverage options due to their immigration status. In the absence of coverage, they remain reliant on safety net clinics and hospitals for care and often go without needed care.



Research (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/>) **suggests that changes to immigration policy made by the Trump administration contributed to growing fears among immigrant families about enrolling themselves and/or their children in Medicaid and CHIP.** The Trump administration implemented a range of policies to curb immigration, enhance immigration enforcement, and limit use of public assistance programs among immigrant families. Research shows that, amid this policy climate, some immigrant families avoided enrolling themselves and/or their children in public programs, including **Medicaid** (<https://www.kff.org/medicaid/issue-brief/impact-of-shifting-immigration-policy-on-medicare-enrollment-and-utilization-of-care-among-health-center-patients/>). In particular, changes to **public charge policy** (<https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/>) that allowed federal officials to consider the use of certain non-cash programs, including Medicaid for non-pregnant adults, when determining whether to provide certain individuals a green card or entry into the U.S., likely contributed to decreases in participation in Medicaid among immigrant families and their primarily U.S.-born children. The Biden administration has since reversed many of these changes, including the changes to public charge policy.

Impact of the Pandemic on Immigrant Health Coverage

The pandemic has likely contributed to increased health and financial needs

(<https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-financial-risks-noncitizen-immigrants-covid-19-pandemic/>) **and declines in health coverage among immigrant families.** Immigrants' work, living, and transportation situations put them at increased risk for potential exposure to coronavirus. Noncitizen immigrants also face risk of financial difficulties due to the pandemic, as many are working in service industries, such as restaurants and food services, that have suffered cutbacks. **Initial job losses** (<https://www.migrationpolicy.org/research/covid-19-unemployment-immigrants-other-us-workers>) amid the pandemic were particularly high among immigrants. Given their low incomes, job loss could lead to significant financial pressures for them and their families and may increase the share who are uninsured, as people lose access to employer-sponsored insurance or are no longer able to afford coverage.

Restrictions limit immigrants' access to COVID-19 relief, and ongoing immigration-related fears are making some reluctant to access assistance, services, and COVID-19 vaccines.

Although noncitizen immigrants face increased risks associated with the pandemic, restrictions limit immigrants' eligibility for federal health and financial relief provided in response to COVID-19. Moreover, even though the Biden administration has **reversed** (<https://www.uscis.gov/sites/default/files/document/notices/SOPDD-Letter-to-USCIS-Interagency-Partners-on-Public-Charge.pdf>) many immigration policy changes made by the Trump administration, recent data suggest that ongoing immigration-related fears are contributing to reluctance to access assistance and services as well as COVID-19 vaccines. For example, surveys of **Hispanic adults** (<https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-access-information-experiences-hispanic-adults/>) and **Asian community health center patients** (<https://www.kff.org/coronavirus-covid-19/issue-brief/asian-immigrant-experiences-with-racism-immigration-related-fears-and-the-covid-19-pandemic/>) show some are continuing to avoid participating in assistance programs for health, housing, or food due to immigration-related fears. **Data** (https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-access-information-experiences-hispanic-adults/?utm_campaign=KFF-2021-polling-surveys&utm_source=hs_email&utm_medium=email&utm_content=2&hsenc=p2ANqtz--FVEMWa0HoaHj0OH1tUH96kqd08xwChxhc2s4i4I3iux5j5uFexuXsLOCRX5ZZqw8vKcA0zSfhIIW9OZEjQKOnkOeJbW) also suggest that immigration-related fears are contributing to reluctance to access COVID-19 vaccines among Hispanic adults even though all individuals are eligible for the vaccine regardless of immigration status.

Appendix A: Lawfully Present immigrants by Qualified Status

Qualified Immigrant Categories	Other Lawfully Present Immigrants
<ul style="list-style-type: none"> • Lawful permanent resident (LPR or green card holder) • Refugee • Asylee • Cuban/Haitian entrant • Paroled into the U.S. for at least one year • Conditional entrant granted before 1980 • Granted withholding of deportation • Battered noncitizen, spouse, child, or parent • Victims of trafficking and his/her spouse, child, sibling, or parent or individuals with pending application for a victim of trafficking visa • Member of a federally recognized Indian tribe or American Indian born in Canada • Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories (referred to as Compact of Free Association or COFA migrants) (Effective December 27, 2020 COFA migrants are considered “qualified noncitizens” and are eligible for Medicaid, if they meet all of the eligibility criteria for their state.) 	<ul style="list-style-type: none"> • Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Individual with Non-Immigrant Status, includes worker visas, student visas, U-visa, and other visas, and citizens of Micronesia, the Marshall Islands, and Palau • Temporary Protected Status (TPS) • Deferred Enforced Departure (DED) • Deferred Action Status, except for Deferred Action for Childhood Arrivals (DACA) who are not eligible for health insurance options • Lawful Temporary Resident • Administrative order staying removal issued by the Department of Homeland Security • Resident of American Samoa • Applicants for certain statuses • People with certain statuses who have employment authorization

SOURCE: “Coverage for lawfully present immigrants,” HealthCare.gov, <https://www.healthcare.gov/immigrants/lawfully-present-immigrants/> (<https://www.healthcare.gov/immigrants/lawfully-present-immigrants/>).

Endnotes

1. The estimate of the total number of non-citizens in the US is based on the 2018 American Community Survey (ACS). The ACS does not include a direct measure of whether a non-citizen has legal status or not. We impute documentation status by drawing on methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et al. This approach uses the second wave of the 2008 Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status for each person in the sample; it then applies the model to a second data source, controlling to state-level estimates of total undocumented population as well as the undocumented population in the labor force from the Pew Research Center. See, "5 facts about illegal immigration in the U.S.," available here: <https://www.pewresearch.org/fact-tank/2019/06/12/5-facts-about-illegal-immigration-in-the-u-s/> (<https://www.pewresearch.org/fact-tank/2019/06/12/5-facts-about-illegal-immigration-in-the-u-s/>).

[← Return to text \(https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/#endnote-link-527709-1\)](https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/#endnote-link-527709-1)

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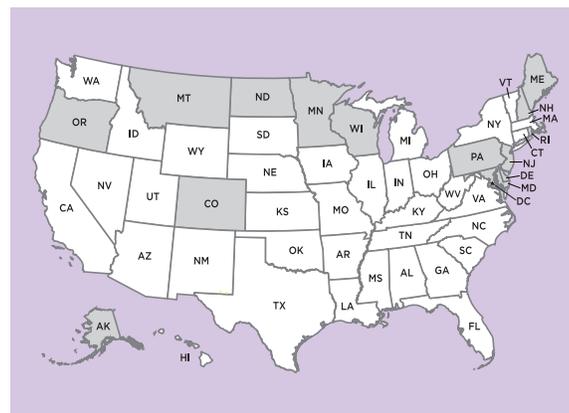
CCIIO DATA BRIEF SERIES

State Innovation Waivers: State-Based Reinsurance Programs

AUGUST 2021

BACKGROUND

Section 1332 of the Affordable Care Act (ACA) permits states to apply for waivers from certain ACA requirements to pursue innovative and individualized state strategies that provide their residents with access to affordable, quality health care, subject to approval by the Department of Health and Human Services (HHS) and the Department of the Treasury (collectively, the Departments). In order for a section 1332 waiver to be approved, the Departments must determine that the waiver will provide coverage that is at least as comprehensive as the coverage provided without the waiver; will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver; will provide coverage to at least a comparable number of residents as without the waiver; and will not increase the federal deficit. States were first able to apply for section 1332 waivers beginning on January 1, 2017, and to date, the Departments have approved 16 states' waivers.



As of Plan Year (PY) 2021, 14 states with approved section 1332 waivers operate state-based reinsurance programs by waiving the single risk pool requirement under section 1312(c)(1) of the ACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate.ⁱ

The data presented below provide an overview of the state-based reinsurance programs implemented as of PY 2021 under currently approved section 1332 waivers (referred to throughout this report as section 1332 state-based reinsurance waivers), including relevant information about premiums, issuer participation, plan offerings, and enrollment.ⁱⁱ

CURRENTLY APPROVED SECTION 1332 STATE-BASED REINSURANCE WAIVERS

Funding Sources and Program Design Elements

Tables 1 and 2 summarize state funding sources and programmatic elements for currently operating section 1332 state-based reinsurance waivers.ⁱⁱⁱ Through section 1332 waivers, states have designed and implemented different reinsurance models, including: a claims cost-based model, where issuers are reimbursed for a portion of the costs of enrollees whose claims exceed an attachment point (CO, DE, MD, MN, MT, ND, NH, NJ, OR, PA, RI, WI); a conditions-based model, where insurers are reimbursed for costs of individuals with one or more of pre-determined high-cost conditions (AK); or a hybrid conditions and claims cost-based model (ME).

ⁱ State-based reinsurance programs are distinct from the temporary federal reinsurance program that was effective for the 2014 through 2016 benefit years, the latter having been established via section 1341 of the ACA. The goal of the ACA's temporary reinsurance program was to stabilize individual market premiums during the early years of the federal market reforms that took effect beginning in 2014.

ⁱⁱ The information contained in this report does not reflect the American Rescue Plan Act of 2021, or other factors that may have led the states to update their PY 2021 parameters since submitting rate filings for the 2021 plan year (e.g., the Departments' 2021 pass-through estimates).

ⁱⁱⁱ State legislation authorizing states' funding sources are listed in the endnotes.

TABLE 1
State Funding Sources for Section 1332 State-Based Reinsurance Waivers

State	First Year of Operation Under a Waiver	State Funding Sources ^{iv}
Alaska	2018	Alaska funds the state portion of its section 1332 state-based reinsurance waiver through a separate fund called the Alaska Comprehensive Health Insurance Fund. This fund is established within Alaska's general fund and financed by the state's premium tax that applies to all lines of insurance (not just health insurers) in Alaska. ¹ Premium tax rates vary from 0.75% to 6% depending on insurer type.
Colorado	2020	Colorado funds the state portion of its section 1332 state-based reinsurance waiver through the Colorado Health Insurance Affordability Enterprise (Enterprise). The Enterprise was established under Colorado Senate Bill 20-215 in June 2020. ² The main source of funding for the Enterprise is drawn from a fee on health insurers who would otherwise be subject to the now repealed federal Health Insurance Provider Fee under Section 9010 of the ACA. For PYs 2022 and 2023 only, Colorado will administer a special assessment on hospitals. A portion of the state's health insurance premium tax revenue will also go to the Enterprise. Money from the state's general fund is available for section 1332 state-based reinsurance waiver administration only.
Delaware	2020	Delaware funds the state portion of its section 1332 state-based reinsurance waiver through an assessment on carriers and any person or entity subject to state regulation that provides either 1) products that would otherwise be subject to the federal Health Insurance Providers Fee under Section 9010 of the ACA; or 2) products subject to a state assessment. The state assessment is 2.75% of premium annually in years that the Health Insurance Providers Fee is waived, and 1% of premium annually in years that the Health Insurance Providers Fee is assessed. ³
Maine	2019	Maine funds the state portion of its section 1332 state-based reinsurance waiver through 1) a market-wide assessment (\$4 per member/per month), and 2) a ceding premium equal to 90% of premiums received from consumers for all policies ceded, whether on a mandatory or discretionary basis. ⁴
Maryland	2019	In PY 2019, Maryland funded the state portion of its section 1332 state-based reinsurance waiver through a 2.75% state assessment on certain health insurance carriers. ⁵ The assessment equals the amount carriers otherwise would have been subject to under the now-repealed federal Health Insurance Providers Fee of Section 9010 of the ACA. Maryland extended and reduced the assessment to 1% for PYs 2020-2023. ⁶
Minnesota	2018	Minnesota funds the state portion of its section 1332 state-based reinsurance waiver through its general fund and a portion of past accumulations of the state's 2% provider tax, which applies to hospitals and other providers. ⁷
Montana	2020	Montana funds the state portion of its section 1332 state-based reinsurance waiver through a 1.2% annual state assessment on major medical health insurance premiums. ⁸
New Hampshire	2021	New Hampshire funds the state portion of its section 1332 state-based reinsurance waiver through a premium assessment of 0.6% of the previous year's second lowest cost silver plan without waiver rate across all licensed health insurance issuers in the state's individual and group health insurance markets with some exceptions. ^{9,10}
New Jersey	2019	New Jersey funds the state portion of its section 1332 state-based reinsurance waiver from revenue raised by shared responsibility payments per the state individual mandate, ¹¹ and if necessary, the state general fund.
North Dakota	2020	North Dakota funds the state portion of its section 1332 state-based reinsurance waiver through a state assessment on insurers writing in the small and large group health insurance markets. North Dakota allows insurers to deduct the assessment from the state premium tax. ¹² The PY 2020 assessment on the insurers was approximately \$22M. Assessments were suspended in the third quarter of PY 2020 and the suspension is expected to continue through PY 2021.
Oregon	2018	For PYs 2018 through 2019, Oregon funded the state portion of its section 1332 state-based reinsurance waiver through a phased-in 1.5% state premium assessment levied on major medical premiums and, for PY 2018 only, Oregon also used excess fund balances held in two state programs, the Oregon Health Insurance Marketplace (OHIM) fund and the Oregon Medical Insurance Pool (OMIP) account. ¹³ Starting in PY 2020, Oregon made two changes to the assessments: 1) increased the premium assessment to 2%, and 2) expanded the assessment to apply to premiums derived from "insurance described in ORS 742.065" (stop loss insurance). ^{14,15}
Pennsylvania	2021	Pennsylvania funds the state portion of its section 1332 state-based reinsurance waiver through a portion of a user fee that is 3.0% of premiums and assessed on issuers participating in the Pennsylvania Health Insurance Exchange and other available state sources. This fee only affects individual market issuers, as there are currently no participating SHOP issuers. ¹⁶
Rhode Island	2020	Rhode Island funds the state portion of its section 1332 state-based reinsurance waiver through a state appropriation for the Health Insurance Market Integrity Fund to support operation and administration of the program, and from penalties collected from the state individual mandate. ^{17,18}
Wisconsin	2019	Wisconsin funds the state portion of its section 1332 state-based reinsurance waiver through state general purpose revenue (GPR), which consists of general taxes, miscellaneous receipts, and revenues collected by the state. The state is able to appropriate GPR for the Wisconsin Healthcare Stability Plan (WIHSP) through a sum sufficient appropriation. ¹⁹

^{iv} Unless otherwise indicated, the state funding sources presented reflect all active years to date of a given state's reinsurance program.

TABLE 2, cont.
Program Design Elements of Section 1332 State-Based Reinsurance Waiver

State	Type of Reinsurance Program	Program Parameters		
Maryland	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid: \$462M*/\$352.8M (2019) \$416.8M* (2021) \$400M* (2020)		
		Attachment point: \$20,000 (2019-2021)	Coinsurance rate: 80% (2019-2021)	Cap: \$250,000 (2019-2021)
Minnesota	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid: Up to \$271M** (2018/2019) \$165.8M* (2020) \$136.1M (2018) \$204.5M* (2021) \$149.7M (2019)		
		Attachment point: \$50,000 (2018-2021)	Coinsurance rate: 80% (2018-2021)	Cap: \$250,000 (2018-2021)
Montana	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$32.9M* (2020) \$39.5M* (2021)		
		Attachment point: \$40,000 (2020/2021)	Coinsurance rate: 60% (2020/2021)	Cap: \$101,750 (2020/2021)
New Hampshire	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$45.5M* (2021)		
		Attachment point: \$60,000 (2021)	Coinsurance rate: 74% (2021)	Cap: \$400,000 (2021)
New Jersey	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid: \$295M*/\$267.7M (2019) \$397.5M* (2021) \$320M* (2020)		
		Attachment point: \$40,000 (2019/2020) \$35,000 (2021)	Coinsurance rate: 60% (2019/2020) 50% (2021)	Cap: \$215,000 (2019/2020) \$245,000 (2021)
North Dakota	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$47.3M* (2020) \$24.7M* (2021)		
		Attachment point: \$100,000 (2020/2021)	Coinsurance rate: 75% (2020/2021)	Cap: \$1M (2020/2021)
Oregon	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid: \$90M*/\$90M (2018) \$101.8M* (2020) \$95.4M*/\$94.5M (2019) \$104.3M* (2021)		
		Attachment point: \$95,000 (2018) \$90,000 (2019/2020) \$83,000 (2021)	Coinsurance rate: 59.2% (2018) 50% (2019-2021)	Cap: \$1M (2018-2021)
Pennsylvania	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$133.9M* (2021)		
		Attachment point: \$60,000 (2021)	Coinsurance rate: 60% (2021)	Cap: \$100,000 (2021)

TABLE 2, cont.
Program Design Elements of Section 1332 State-Based Reinsurance Waiver

State	Type of Reinsurance Program	Program Parameters		
Rhode Island	Claims Cost Based	Total Amount of Reinsurance Payments Planned*:		
		\$14.7M* (2020) \$19.3M* (2021)		
		Attachment point:	Coinsurance rate:	Cap:
		\$40,000 (2020) \$30,000 (2021)	50% (2020) 50% (2021)	\$97,000 (2020) \$72,000 (2021)
Wisconsin	Claims Cost Based	Total Amount of of Reinsurance Payments Planned*/Paid:		
		\$200M*/\$174.3M (2019) \$200M* (2020/2021)		
		Attachment point:	Coinsurance rate:	Cap:
		\$50,000 (2019) \$40,000 (2020/2021)	50% (2019/2020) 48% (2021)	\$250,000 (2019) \$175,000 (2020/2021)

^v In Table 2 for **Total Amount of Reinsurance Payments**, values marked with one asterisk (*) indicate the total planned cost of the reinsurance payments for eligible claims, which is the state’s estimated total reinsurance reimbursements for a given reporting year for eligible claims expected to be incurred in the individual market.

Values marked with two asterisks (**), in the case of Minnesota, indicate the maximum program size (\$271M) for PYs 2018 and 2019, such that the actual program size will fully cover reimbursements to carriers for 80% of the costs between \$50,000 and \$250,000 for individual claims. However, there is general agreement between the state’s model and carriers’ models that an approximate 20% reduction in premiums is the result of the state’s program parameters (i.e., attachment point, coinsurance rate, and cap), which are the most relevant information the carriers need and use to develop rates.

Values without any asterisks indicate the total actual amount paid out by the state for reinsurance payments in the individual market for a given reporting year where known. The final total amount paid out by the state for a given reporting year is typically available in the following PY. Furthermore, the total actual amount does not include the expected operational costs associated with running the state-based reinsurance program.

The average premium reduction rates in the with waiver scenario compared to the without waiver scenario for a given PY (as seen in Table 3) reflect the total planned cost of the reinsurance payments for eligible claims. Note that the total planned costs for PYs 2020 and 2021 do not yet reflect potential cost changes due to COVID-19 or the American Rescue Plan Act of 2021. States may update their program budgets and payment parameters as more claims and enrollment data are received.

Premiums

Table 3 presents the actual impact of the section 1332 state-based reinsurance waiver on statewide average premiums each year of the waiver's operation compared to the estimated impact on statewide average premiums in the first year of the waiver (i.e., as estimated in the original state waiver application). From PYs 2018 to 2021, states that have implemented section 1332 state-based reinsurance waivers for the individual market have reduced statewide average second-lowest-cost silver plan premiums by a range of 3.75% to 41.17% relative to premiums absent the waiver, as shown in Table 3.

TABLE 3
Statewide Average Premium Impact of Section 1332 State-Based Reinsurance Waivers^{vi}

State	First Year of Operation Under a Waiver	Estimated Statewide Average Premium Reduction in First Year of Waiver ^{vii}	Actual Statewide Premium Reduction from Waiver Compared to No Waiver ^{viii}			
			2018	2019	2020	2021
Alaska	2018	Up to a 20% reduction	30.18%	33.95%	37.12%	41.17%
Minnesota	2018	Up to a 20% reduction	16.78%	20.16%	21.29%	21.31%
Oregon	2018	Up to a 7.5% reduction	7.15%	6.71%	8.00%	8.05%
Maine	2019	Up to a 9% reduction		13.86%	7.24%	9.11%
Maryland	2019	Up to a 30% reduction		39.63%	35.83%	34.0%
New Jersey	2019	Up to a 15% reduction		15.49%	16.93%	16.02%
Wisconsin	2019	Up to an 11% reduction		9.92%	11.04%	13.04%
Colorado	2020	Up to a 16% reduction			22.44%	18.47%
Delaware	2020	Up to a 20% reduction ^{ix}			13.78%	15.80%
Montana	2020	Up to an 8% reduction			8.89%	9.38%
North Dakota	2020	Up to a 20% reduction			20.03%	12.14%
Rhode Island	2020	Up to a 5.9% reduction			3.75%	6.40%
Pennsylvania	2021	Up to a 4.6% reduction				4.92%
New Hampshire	2021	Up to a 16% reduction				13.90%
Overall State Average Premium Reduction Among States with Approved Section 1332 State-Based Reinsurance Waivers^x			12.73%	17.84%	17.65%	14.13%

^{vi} The statewide average premium is an average of premiums among rating areas in the state, with each rating area given an equal weight. Enrollment data by rating area are unavailable.

^{vii} The estimated statewide average premium reduction for the first year of the waiver is provided by each state as part of its waiver application.

^{viii} The actual statewide average premium reductions are calculated using per person per month premium information submitted by each state for pass-through calculations pertaining to each year of the approved waiver. Consistent with the specific terms and conditions of its waiver, each state provides to the Departments: (1) the final second lowest cost silver plan (SLCSP) rates for a representative individual (e.g., a 21-year-old nonsmoker) in each rating area with the approved waiver; and (2) the state's estimate of what the final SLCSP rates for a representative individual in each rating area would have been absent approval of the waiver for each year of the approved waiver.

^{ix} Delaware estimated a 13%-20% average premium reduction, depending on the level of funding expected to be available for each plan year, plus any additional assumed morbidity improvement, as explained in its application.

^x Overall average premium reduction uses 2018 risk adjustment premium to weight each state's premium reduction and estimate an overall premium reduction across states with approved section 1332 state-based reinsurance waivers.

Issuer Participation

Table 4 shows changes in individual market Exchange issuer participation among states with section 1332 state-based reinsurance waivers. Figures 1 and 2 illustrate the change in individual market Exchange issuer participation in these states comparing PYs 2017 (before any reinsurance waivers were operational)^{xi} and 2021 on national maps. Table 5 presents a summary of the percentage of enrollees with access to 1, 2, or 3+ individual market Exchange issuers in states with operational section 1332 state-based reinsurance waivers, compared to the percentage of individual market Exchange enrollees in all states across the U.S.

TABLE 4
Individual Market Issuer Exchange Participation in States with
Section 1332 State-Based Reinsurance Waivers^{xii}

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation ^{xiii}				
		2017	2018	2019	2020	2021
Alaska	2018	1	1	1	2 [^] Re-entry: Moda	2
Minnesota	2018	4	4	4	4	5 [^] Entry: Quartz Health Solutions
Oregon	2018	6	5 Exit: ATRIO Health Plans	5	5	6 [^] Entry: Cambia Health Solutions (additional HIOS ID)
Maine	2019	3	2 Exit: Anthem	3 [^] Re-entry: Anthem	3	3
Maryland ^{xiv}	2019	3	2 Exit: Cigna	2	2	3 [^] Re-entry: UnitedHealth Group
New Jersey	2019	3	4 [^] Entry: Mulberry Health (Oscar)	4	4	4
Wisconsin	2019	15	11 Exits: Anthem, Franciscan Health Solutions, Gundersen Health System, Molina Healthcare	12 [^] Re-entry: Molina	13 [^] Re-entry: WPS Health Plan, Inc.	14 [^] Re-entry: Anthem
Colorado	2020	7	7	7	8 [^] Entry: Oscar Health	8
Delaware	2020	3	1 Exits: Aetna (two separate HIOS IDs)	1	1	1
Montana	2020	3	3	3	3	3
North Dakota	2020	3	2 Exit: Medica	3 [^] Re-entry: Medica	3	3
Rhode Island	2020	2	2	2	2	2

TABLE 4, cont.
Individual Market Issuer Exchange Participation in States with
Section 1332 State-Based Reinsurance Waivers^{xii}

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation ^{xiii}				
		2017	2018	2019	2020	2021
Pennsylvania	2021	8	9 [^] Entry: Highmark (additional HIOS ID)	11 [^] Entry: Centene Re-entry: Geisinger Health (additional HIOS ID)	12 [^] Entry: Mulberry Health (Oscar)	12
New Hampshire	2021	4	3 Exit: Minuteman Health	3	3	3

TABLE 5
Percent of Enrollees with Access to 1, 2, 3+ Individual Market Exchange Issuers,
Compared to Overall U.S.^{xv}

Section 1332 State-Based Reinsurance Waiver States	1 Issuer		2 Issuers		3+ Issuers	
	2020	2021	2020	2021	2020	2021
	4%	3%	14%	9%	82%	88%
Overall U.S.	9%	3%	18%	15%	73%	82%

^{xi} Note that Alaska began operating a state reinsurance program in 2017, prior to the first year of its approved section 1332 state-based reinsurance waiver.

^{xii} For states with a Federally-facilitated Exchange (FFE), CMS issuer counts are based upon the number of unique Health Insurance Oversight System (HIOS) IDs. Issuers represent the organization within an insurance company that is responsible for insurance offerings in a given state. Registering an entity as an Issuer within HIOS will generate a unique Issuer ID. FFE 2021 data reflected in this table are point in time as of October 2, 2020. State-Based Exchange (SBE) 2021 data reflected in this table are self-reported from the Exchanges to CMS. These data are point in time as of October 30, 2020 for the following 1332 waiver states: Colorado, Maryland, Minnesota, New Jersey, and Rhode Island, and August 30, 2020 for Pennsylvania. Note that New Jersey and Pennsylvania transitioned from FFEs to SBEs in PY 2021. Issuers offering partial county coverage are considered participating in a county and are included in the total number of issuers in a county. Issuers that partially cover counties do not cover every zip code in the county.

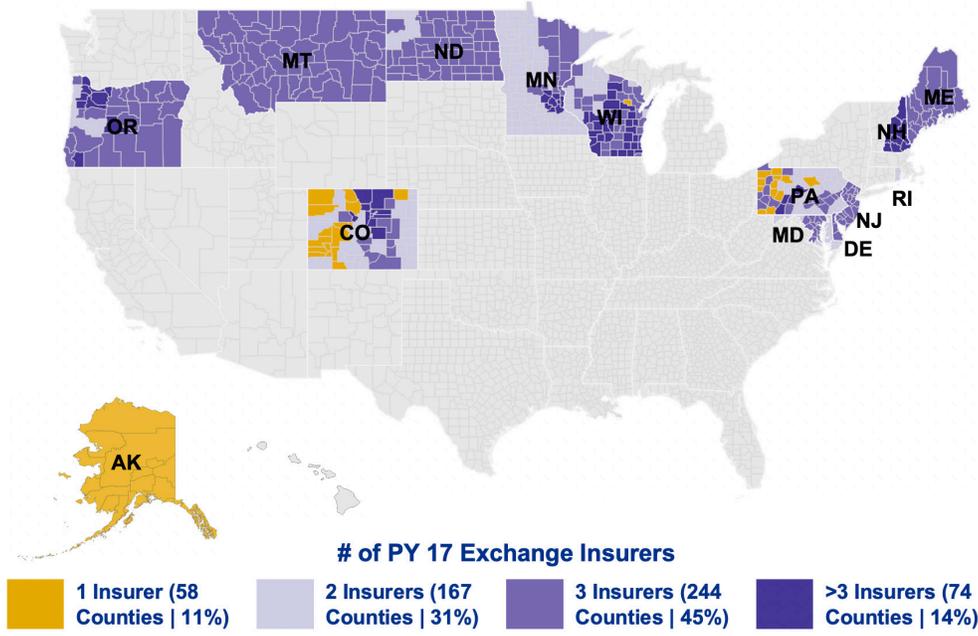
^{xiii} [^]Denotes a new issuer participating (entry or re-entry) in the individual market from the previous year.

^{xiv} To ensure that the total counts of issuers within a state or county are consistent with SBE reporting BlueChoice (HIOS 28137), CFMI (HIOS 45532), and GHMSI (HIOS 94084) in Maryland have been aggregated to the parent company level (CareFirst BlueCross BlueShield).

^{xv} Methodology note for Table 5: The number of issuers in each county was counted and weighted by the county enrollment. That weighted issuer count was then divided by the total enrollment. Because data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019), only PYs 2020 and 2021 are shown, which account for all states with operational section 1332 state-based reinsurance waivers for those particular years. To calculate national trends, Los Angeles County, California has two rating areas where issuers could possibly participate on the State's Exchange in the individual market. Since Los Angeles County has a very large number of enrollees, the two rating areas in the county are treated as separated counties for purposes of these calculations.

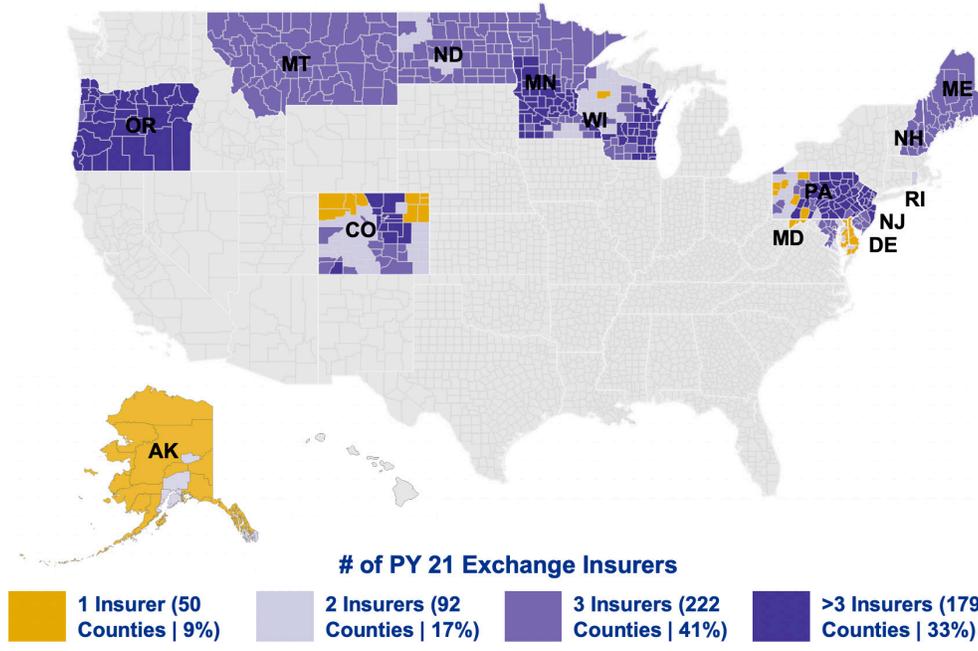
FIGURES 1 and 2
Individual Market Issuer Participation on the Exchanges in States with
Section 1332 State-Based Reinsurance Waivers^{xvi}

2017



Map is as of 11/02/2017 for FFE states and as of 11/17/2017 for SBE states

2021



Map is as of 10/02/2020 for FFE states, as of 10/30/2020 for SBE states, and as of 08/30/2020 for PA

^{xvi} For illustrative purposes, PY 2017 is provided as a comparison year to PY 2021 because section 1332 waivers were not yet operational in PY 2017, and the first waivers went into effect in PY 2018. Note that for some states, issuers exited the state's individual marketplace prior to the state's implementation of a section 1332 state-based reinsurance waiver, and some states' waivers began operating as recently as PY 2021. For each state's first year of operation and issuer count across PYs 2017 through 2021, please refer to Table 4 above.

Plan Offerings

Table 6 shows the average number of qualified health plans (QHPs) by metal level per county, weighted by enrollment in states with section 1332 state-based reinsurance waivers. Table 7 summarizes the average number of QHPs weighted by enrollment available in states with section 1332 state-based reinsurance waivers, compared to the average number of QHPs available in all states across the U.S.

TABLE 6
Average Number of QHPs per County Weighted by Enrollment in States with Section 1332 State-Based Reinsurance Waivers^{xvii}

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
AK	2018	All	5	5	7.7	8.3	0	2.7	0.6	3.3
		Bronze	2	2	3.4	3.6	0	1.4	0.2	1.6
		Silver	2	2	2.7	2.8	0	0.7	0.1	0.8
		Gold	1	1	1.7	1.8	0	0.7	0.1	0.8
		Platinum	0	0	0	0	0	0	0	0
CO	2020	All	N/A	39	47.2	60.8	N/A	8.2	13.6	N/A
		Bronze	N/A	14.6	17.8	24.1	N/A	3.2	6.3	N/A
		Silver	N/A	15.7	20.2	25.6	N/A	4.5	5.4	N/A
		Gold	N/A	8.7	9.2	11.1	N/A	0.5	1.9	N/A
		Platinum	N/A	0	0	0	N/A	0	0	N/A
DE	2020	All	6	7	8	11	1	1	3	5
		Bronze	2	2	3	3	0	1	0	1
		Silver	3	3	2	3	0	-1	1	0
		Gold	1	1	2	3	0	1	1	2
		Platinum	0	1	1	2	1	0	1	2
MD	2019	All	15.5	13.6	16.6	25.4	-1.9	3	8.8	9.9
		Bronze	4.6	3.7	5.7	8.3	-0.9	2	2.6	3.7
		Silver	5.4	4.5	4.5	8.1	-0.9	0	3.6	2.7
		Gold	4.6	4.5	5.5	8.2	-0.1	1	2.7	3.6
		Platinum	0.9	0.8	0.8	0.9	-0.1	0	0.1	0
ME	2019	All	15.2	25.5	29.2	31	10.3	3.7	1.8	15.8
		Bronze	6	10	12	13	4	2	1	7
		Silver	7.2	12.5	14.2	14.2	5.3	1.7	0	7
		Gold	2	3	3	3.7	1	0	0.7	1.7
		Platinum	0	0	0	0	0	0	0	0
MN	2018	All	N/A	N/A	28.1	44.7	N/A	N/A	16.6	N/A
		Bronze	N/A	N/A	12.5	17.6	N/A	N/A	5.1	N/A
		Silver	N/A	N/A	10.2	18.5	N/A	N/A	8.3	N/A
		Gold	N/A	N/A	5.3	8.5	N/A	N/A	3.2	N/A
		Platinum	N/A	N/A	0	0	N/A	N/A	0	N/A

TABLE 6, cont.
Average Number of QHPs per County Weighted by Enrollment in States with
Section 1332 State-Based Reinsurance Waivers^{xvii}

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
MT	2020	All	15.8	17.8	20.9	20.9	2	3.1	0	5.1
		Bronze	7.5	8.5	9.3	9.3	1	0.8	0	1.8
		Silver	4.7	5.7	7.3	7.3	1	1.6	0	2.6
		Gold	3.7	3.7	4.3	4.3	0	0.6	0	0.6
		Platinum	0	0	0	0	0	0	0	0
ND	2020	All	8.2	20.6	20.7	21.9	12.4	0.1	1.2	13.7
		Bronze	2.6	9.3	9.3	9.9	6.7	0	0.6	7.3
		Silver	3.2	7	7.1	6.9	3.8	0.1	-0.2	3.7
		Gold	2.3	4.3	4.3	5.1	2	0	0.8	2.8
		Platinum	0	0	0	0	0	0	0	0
NH	2021	All	13.7	14.8	23.4	32.4	1.1	8.6	9	18.7
		Bronze	3	4	9.8	10.8	1	5.8	1	7.8
		Silver	7.9	7.9	10.7	16.6	0	2.8	5.9	8.7
		Gold	2.9	2.9	2.9	4.9	0	0	2	2
		Platinum	0	0	0	0	0	0	0	0
NJ	2019	All	18.6	19.4	20.4	23.4	0.8	1	3	4.8
		Bronze	4.5	4.5	4.5	6.6	0	0	2.1	2.1
		Silver	10.3	10.3	11.3	12.2	0	1	0.9	1.9
		Gold	3.8	4.6	4.6	4.7	0.8	0	0.1	0.9
		Platinum	0	0	0	0	0	0	0	0
OR	2018	All	20.5	25.5	30.4	49.1	5	4.9	18.7	28.6
		Bronze	7	9.8	12.1	20.3	2.8	2.3	8.2	13.3
		Silver	7.2	8.6	10.1	16.3	1.4	1.5	6.2	9.1
		Gold	6.2	7.1	8.2	12.5	0.9	1.1	4.3	6.3
		Platinum	0	0	0	0	0	0	0	0
PA	2021	All	13.5	16.1	26.3	34.7	2.6	10.2	8.4	21.2
		Bronze	3	3.9	8.3	10.5	0.9	4.4	2.2	7.5
		Silver	5.4	6.7	10.7	15.1	1.3	4	4.4	9.7
		Gold	3.7	4	6.5	9	0.3	2.5	2.5	5.3
		Platinum	1.4	1.4	0.7	0	0	-0.7	-0.7	-1.4

TABLE 6, cont.
Average Number of QHPs per County Weighted by Enrollment in States with Section 1332 State-Based Reinsurance Waivers^{xvii}

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
RI	2020	All	18	18	19	20	0	1	1	2
		Bronze	4	4	4	4	0	0	0	0
		Silver	7	7	7	7	0	0	0	0
		Gold	7	7	7	7	0	0	0	0
		Platinum	0	0	1	2	0	1	1	2
WI	2019	All	31.2	27.6	35.4	49.7	-3.6	7.8	14.3	18.5
		Bronze	9.4	9.2	12.8	19.9	-0.2	3.6	7.1	10.5
		Silver	12.6	11.3	13.8	18.8	-1.3	2.5	5	6.2
		Gold	8.2	6.6	8.3	10.5	-1.6	1.7	2.2	2.3
		Platinum	1.1	0.5	0.5	0.5	-0.6	0	0	-0.6

TABLE 7
Average Number of QHPs Weighted by Enrollment Available in States with Section 1332 State-Based Reinsurance Waivers Compared to Overall U.S.^{xviii}

Section 1332 State-Based Reinsurance Waiver States	Bronze		Silver		Gold		Platinum		TOTAL	
	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
	10.0	13.2	11.3	15.0	6.3	8.2	0.2	0.2	27.8	36.6
Overall U.S.	12.3	19.3	15.0	22.9	7.0	9.1	2.2	2.3	36.6	53.6

^{xvii} Methodology note for Table 6: The number of plans in each county and metal level was counted and weighted by the county enrollment. That weighted plan count was then divided by the total enrollment. Data only reflects states with operational section 1332 state-based reinsurance waivers for that year, with some exceptions where state data was unavailable. Data are only available going back to 2018, and data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019, so their values are set to N/A for those years). Highlighted cells indicate years when a state's section 1332 state-based reinsurance waiver is operational.

^{xviii} Methodology note for Table 7: The number of plans in each county and metal level was counted and weighted by the county enrollment. That weighted plan count was then divided by the total enrollment. Because data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019), only PYs 2020 and 2021 are shown, which account for all states with operational section 1332 state-based reinsurance waivers for those particular years. To calculate the national trends, Los Angeles County, California has two ratings areas where issuers could possibly offer a different number of plans. Since Los Angeles County has a very large number of enrollees, the two rating areas in the county are treated as separated counties for the purposes of these calculations.

Enrollment

Table 8 displays individual market enrollment both on and off-Exchange for states that began implementing section 1332 state-based reinsurance waivers in PYs 2018 and 2019.

TABLE 8
Individual Health Insurance Market Subsidized^{xix} and Unsubsidized Average Monthly Enrollment for Select States with Section 1332 State-Based Reinsurance Waivers, Compared to Overall U.S.^{xx}

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment
Alaska ^{xxi}	2018	Total	17,596	15,898	16,761	16,533
		<i>Percent Change^{xxii}</i>		<i>-10%</i>	<i>+5%</i>	<i>-1%</i>
		Subsidized	14,065	13,442	14,125	13,254
		<i>Percent Change</i>		<i>-4%</i>	<i>+5%</i>	<i>-6%</i>
		Unsubsidized	3,531	2,456	2,636	3,279
		<i>Percent Change</i>		<i>-30%</i>	<i>+7%</i>	<i>24%</i>
Minnesota	2018	Total	240,312	155,471	148,943	150,950
		<i>Percent Change</i>		<i>-35%</i>	<i>-4%</i>	<i>1%</i>
		Subsidized	42,631	61,932	62,832	59,219
		<i>Percent Change</i>		<i>+45%</i>	<i>+1%</i>	<i>-6%</i>
		Unsubsidized	197,681	92,539	86,111	91,731
		<i>Percent Change</i>		<i>-53%</i>	<i>-7%</i>	<i>7%</i>
Oregon	2018	Total	224,670	210,384	190,899	177,715
		<i>Percent Change</i>		<i>-6%</i>	<i>-9%</i>	<i>-7%</i>
		Subsidized	87,436	95,919	98,489	95,106
		<i>Percent Change</i>		<i>+10%</i>	<i>+3%</i>	<i>-3%</i>
		Unsubsidized	137,234	114,465	92,410	82,609
		<i>Percent Change</i>		<i>-17%</i>	<i>-19%</i>	<i>-11%</i>
Maine	2019	Total	82,158	77,897	72,801	67,260
		<i>Percent Change</i>		<i>-5%</i>	<i>-7%</i>	<i>-8%</i>
		Subsidized	63,402	57,984	57,883	52,589
		<i>Percent Change</i>		<i>-9%</i>	<i>-0.2%</i>	<i>-9%</i>
		Unsubsidized	18,756	19,913	14,918	14,671
		<i>Percent Change</i>		<i>6%</i>	<i>-25%</i>	<i>-2%</i>
Maryland	2019	Total	255,560	227,207	193,227	191,824
		<i>Percent Change</i>		<i>-11%</i>	<i>-15%</i>	<i>-1%</i>
		Subsidized	95,084	98,261	110,632	114,189
		<i>Percent Change</i>		<i>3%</i>	<i>13%</i>	<i>3%</i>
		Unsubsidized	160,476	128,946	82,595	77,635
		<i>Percent Change</i>		<i>-20%</i>	<i>-36%</i>	<i>-6%</i>

TABLE 8, cont.

Individual Health Insurance Market Subsidized^{xix} and Unsubsidized Average Monthly Enrollment for Select States with Section 1332 State-Based Reinsurance Waivers, Compared to Overall U.S.^{xx}

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment
New Jersey	2019	Total	336,605	342,903	312,923	303,808
		<i>Percent Change</i>		2%	-9%	-3%
		Subsidized	186,444	185,258	178,312	162,892
		<i>Percent Change</i>		-1%	-4%	-9%
		Unsubsidized	150,161	157,645	134,611	140,916
		<i>Percent Change</i>		5%	-15%	5%
Wisconsin	2019	Total	246,712	299,302	206,934	197,421
		<i>Percent Change</i>		-7%	-10%	-5%
		Subsidized	174,641	166,310	164,999	157,413
		<i>Percent Change</i>		-5%	-1%	-5%
		Unsubsidized	72,071	62,992	41,935	40,008
		<i>Percent Change</i>		-13%	-33%	-5%
Total U.S. ^{xxiii}		Total	14,517,542	13,018,351	12,128,447	11,718,848
		<i>Percent Change</i>		-10%	-7%	-3%
		Subsidized	8,248,839	8,025,959	8,356,247	8,272,321
		<i>Percent Change</i>		-3%	+4%	-1%
		Unsubsidized	6,268,703	4,992,392	3,772,200	3,446,527
		<i>Percent Change</i>		-20%	-24%	-9%

^{xix}Subsidized and unsubsidized in terms of eligibility for Advance Payments of the Premium Tax Credit (APTC).

^{xx} Enrollment data for 2016, 2017, 2018, and 2019 sourced from: Trends in Subsidized and Unsubsidized Enrollment October 9, 2020. Data includes average monthly enrollment in the ACA individual market (on and off-Exchange), and does not include enrollment in grandfathered or transitional (“grandmothered”) plans. Available online at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf>.

^{xxi} Alaska began operating its reinsurance program in 2017, prior to the first year of its approved section 1332 state-based reinsurance waiver.

^{xxii} Percent changes in enrollment are for 2016 to 2017, 2017 to 2018, and 2018 to 2019.

^{xxiii} Total U.S. enrollment excludes data on plans from Massachusetts and Vermont, because both states have merged their individual and small group markets.

TABLE 1 ENDNOTES:
**Legislation Authorizing State Funding Sources for States
with Section 1332 State-Based Reinsurance Waivers**

Alaska

¹ SB 165 was signed into law on June 29, 2018. (Chapter 46 SLA 18). Available online at <http://www.akleg.gov/basis/Bill/Detail/30?Root=SB%20165>

Colorado

² SB20-215 was signed into law on June 30, 2020. Available online at https://leg.colorado.gov/sites/default/files/2020a_215_signed.pdf

Delaware

³ HB 193 was signed into law on June 20, 2019. Available online at <http://legis.delaware.gov/BillDetail/47632>

Maine

⁴ SP 221 LD 659 was signed into law on June 2, 2017. Available online at <https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0221&item=3&snum=128>

Maryland

⁵ SB 387 was signed into law on April 10, 2018. Available online at https://www.marylandhbe.com/wp-content/uploads/2018/04/Ch_38_sb0387E.pdf

⁶ HB 258 was signed into law on May 25, 2019. Available online at http://mgaleg.maryland.gov/2019RS/Chapters_noln/CH_597_hb0258t.pdf

Minnesota

⁷ HF No.5 was signed into law on April 3, 2017. Available online at https://www.revisor.mn.gov/bills/text.php?number=HF5&version=0&session=ls90&session_year=2017&session_number=0&type=ccr&format=pdf

Montana

⁸ SB 125 was signed into law on April 30, 2019. Available online at <https://leg.mt.gov/bills/2019/BillPdf/SB0125.pdf>

New Hampshire

⁹ HB 4 (Chaptered Law 346 of 2019) was signed into law on October 2, 2019. Available online at http://gencourt.state.nh.us/bill_status/billText.aspx?id=1336&txtFormat=html&sy=2019

¹⁰ RSA 404-G:3. Available online at <http://www.gencourt.state.nh.us/rsa/html/xxxvii/404-g/404-g-mrg.htm>

New Jersey

¹¹ A3380 was signed into law on May 30, 2018. Available online at https://www.njleg.state.nj.us/2018/Bills/A3500/3380_R1.PDF

North Dakota

¹² HB 1106 was signed into law on April 18, 2019. Available online at <https://www.legis.nd.gov/assembly/66-2019/documents/19-8068-05000.pdf>

Oregon

¹³ HB 2391 was signed into law on July 5, 2017. Available online at <https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/HB2391>

¹⁴ Oregon Revised Statutes, 743B.800 (2019). Available online at https://www.oregonlegislature.gov/bills_laws/ors/ors743b.html

¹⁵ HB 2010 was signed into law on March 13, 2019. Available online at <https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/HB2010/Enrolled>

Pennsylvania

¹⁶ Act 42 was signed into law on July 2, 2019. Available online at <https://www.insurance.pa.gov/Documents/Act%2042%20Codified.pdf>

Rhode Island

¹⁷ S 2934 was signed into law on July 3, 2018. Available online at <http://webserver.rilin.state.ri.us/BillText/BillText18/SenateText18/S2934A.pdf>

¹⁸ H 8351 was signed into law on July 3, 2018. Available online at <http://webserver.rilin.state.ri.us/BillText/BillText18/HouseText18/H8351.pdf>

Wisconsin

¹⁹ 2017 Wisconsin Act 138 was signed into law on February 27, 2018. Available online at <https://docs.legis.wisconsin.gov/2017/related/acts/138>

February 2, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Colorado Section 1332 Innovation Waiver Amendment

Dear Administrator Brooks-LaSure and Secretary Becerra:

Centennial State Prosperity (CSP) is submitting the following comment strongly urging CMS to approve Colorado's Section 1332 Innovation Waiver Amendment. CSP is a Colorado-based organization that believes good wages, cost-effective and quality healthcare, and jobs that offer opportunities to balance hard work and family responsibilities are the keys to a good life. Colorado has led the way over the last several years in making healthcare more affordable and accessible and can continue to make progress towards those goals if the waiver amendment is approved.

Colorado is requesting a waiver of the following provisions in the amendment:

- Continued waiver of Section 1312(c)(1) – Single Risk Pool – for the purpose of supporting and continuing Colorado's reinsurance program;
- Waiver of Section 1312 (c)(1) and Section 1312(c)(2) – Single Risk Pool – for the purpose of supporting the premium reduction requirements of the Colorado Option in the individual and small group markets.

The 1332 waiver that was recently reapproved by CMS has been essential to lowering healthcare costs after the creation of Colorado's Health Insurance Affordability Enterprise (HIAE), which funded the state's reinsurance program, enhanced CSRs through Connect for Health Colorado, and created a first-in-the-nation mechanism to provide financial assistance for private insurance for those who cannot qualify under the Affordable Care Act.

In order to move Colorado's groundbreaking work of effectively increasing healthcare access and affordability forward, Centennial State Prosperity supported HB21-1232, the Standardized Benefit Plan Colorado Option, to improve affordability and equity in coverage. Centennial State Prosperity worked with consumer and health equity advocates in Colorado to pass this legislation to reduce insurance premiums, create standardized plans, improve affordability in the individual and small group markets, and build on Colorado's HIAE.

The proposed waiver amendment will lead to savings for the federal government based on the premium reductions required through the Colorado Option (growing to an estimated \$147 million in additional savings on top of reinsurance by 2027), and seeks to draw down those savings as passthrough dollars. These passthrough funds will be reinvested through Colorado's HIAE to enhance existing CSRs through Connect for Health Colorado, which is already helping roughly

24,000 Coloradans by making it more affordable to access care with marketplace coverage. Colorado has been deliberate in how the HIAE, the Colorado Option, and this waiver are structured to continue to improve access to affordable healthcare. This waiver amendment will allow more Coloradans to afford the care they need to take care of their health and the health of their families.

The Section 1332 Innovation Waiver Amendment is crucial for Colorado to meet the goals and requirements set out in the Colorado Option. We urge CMS to approve this waiver amendment so Colorado can continue to increase access to affordable healthcare for people across our state.

Thank you for your consideration,

Beka Whitson
Executive Director
Centennial State Prosperity
beka@centennialstateprosperity.org

February 1, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Colorado Section 1332 Innovation Waiver Amendment

Dear Administrator Brooks-LaSure and Secretary Becerra:

The Colorado Center on Law and Policy (CCLP) appreciates the opportunity to comment on Colorado's Section 1332 Innovation Waiver Amendment. CCLP is a nonprofit, nonpartisan organization that advocates to advance the needs and legal rights of Coloradans facing economic insecurity. We pursue policy objectives that mitigate the effects of poverty, support the health and economic security of Coloradans struggling to make ends meet, and move our state toward greater economic and racial equity. We are submitting comments strongly urging CMS to approve this waiver amendment.

In this waiver amendment, Colorado is seeking waiver of the following provisions:

- Continued waiver of Section 1312(c)(1) – Single Risk Pool – for the purpose of supporting and continuing Colorado's reinsurance program;
- Waiver of Section 1312 (c)(1) and Section 1312(c)(2) – Single Risk Pool – for the purpose of supporting the premium reduction requirements of the Colorado Option in the individual and small group markets.

Colorado's waiver amendment aims to integrate with innovative state level efforts to improve access to coverage for populations that face the greatest obstacles to affordable care. Colorado created the state-based Health Insurance Affordability Enterprise (HIAE) in 2020, establishing funding for the state's reinsurance program, enhancing cost-sharing reductions (CSRs) in 2022 through Connect for Health Colorado, and creating a mechanism to provide financial assistance for private insurance for those that cannot qualify under the ACA beginning in 2023. "Qualified individuals" (QI) include those who fall into the "family glitch" – partners and children who can't afford employer coverage despite the coverage meeting ACA requirements – and people living without documentation.

Through this waiver, we seek to integrate the Standardized Benefit Plan Colorado Option ("Colorado Option") with the HIAE. CCLP, along with many other consumer and health equity advocates in Colorado, worked diligently to craft and pass Colorado Option legislation (HB21-1232) to reduce insurance premiums, create standardized plans that are structured to improve equity, improve affordability in the individual and small group markets, and build on Colorado's HIAE to expand access to financial assistance and coverage for those that have been left out of current coverage systems and assistance.

The Colorado Option requires insurance carriers to offer standardized plans that, with the help of a broad stakeholder group that included carriers, providers, and consumers, were designed to improve racial and health equity. These plans will be required to offer more primary, behavioral, and perinatal care with no cost-sharing, provide more benefits to patients living with diabetes at low or no additional costs, and shift more cost-sharing structures like those for prescription drugs to copays instead of coinsurance. These structures, along with networks that include more essential community providers and incentivize cultural competency, will benefit all Coloradans but particularly those with lower incomes,¹ a group that is disproportionately Black and Latinx as a result of structural racism.

Insurance carriers will be required to offer these standardized plans in the individual and small group markets, and the plans will be offered through Connect for Health Colorado and the Colorado Public Benefit Corporation (the latter of which will be used by the QI population). Through this waiver, Colorado will require insurance carriers to meet premium reductions of 15% from 2023-2025 (5% each year) and control costs thereafter based on medical inflation. Those targets are appropriate and achievable, considering the financial health of Colorado hospitals during the last decade of hospital consolidation of inpatient facilities and outpatient practices,² as well as the ability of the standardized plans to improve access to high-value care.

The waiver amendment will lead to savings for the federal government based on the premium reductions required through the Colorado Option, growing to an estimated \$147 million in additional savings on top of reinsurance by 2027. Drawing down those dollars as passthrough funds will allow reinvestment through Colorado's HIAE, which currently supports enhanced CSRs for about 24,000 Coloradans, and, beginning in 2023, will provide financial assistance through the Public Benefits Corporation to Coloradans without documentation and those in the "family glitch."

The additional populations that will access plans through the Public Benefits Corporation are a significant portion of Colorado's remaining uninsured population,³ as is the case nationally,⁴ because they are ineligible for APTCs and have no viable affordable coverage options to protect their health and financial security. We know that particularly those Coloradans living without documentation, who are integral parts of our communities, experience health disparities at high rates, are less likely to have employer-based coverage,⁵ and rarely access health care services because they cannot afford coverage or care.

Colorado has been thoughtful and deliberate in how we have structured the HIAE, the Colorado Option, and this waiver to improve affordable access to coverage and care and make important strides to address health inequities that have persisted for decades. This component of the waiver will significantly advance

¹ Gross, T., Layton, T., Prinz, D. "Liquidity Sensitive of Health Consumption: Evidence from Social Security Payments," National Bureau of Economic Research, October 2020. Available at: <https://www.nber.org/papers/w27977>

² "Hospital Cost, Price and Profit Review," Colorado Department of Health Care Policy and Financing, August 2021. Available at: https://hcpf.colorado.gov/sites/hcpf/files/Hospital%20Cost%20Price%20and%20Profit%20Review%20Full%20Report_withAppendices-0810ac.pdf

³ "ACA at 10 Years: Colorado's Remaining Uninsured," Colorado Health Institute, Jan. 2020. Available at: <https://www.coloradohealthinstitute.org/research/aca-ten-years-colorados-remaining-uninsured>

⁴ "Key Facts about the Uninsured Population," Kaiser Family Foundation, Nov. 2017. Available at: <https://files.kff.org/attachment/Fact-Sheet-Key-Facts-about-the-Uninsured-Population>

⁵ "Health Coverage of Immigrants," Kaiser Family Foundation. July 2021. Available at: <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/>

Colorado's ability to provide assistance to these populations that have been left out of coverage and is a crucial element in our state's overall efforts to improve racial and health equity in Colorado. This will allow Colorado to put coverage within reach of tens of thousands more Coloradans and help tens of thousands more afford the care they need to take care of their health.

The 1332 waiver, with the amendments proposed, meets federal requirements for improved affordability, coverage, and access, and builds on current successes. We strongly urge CMS to approve this waiver amendment so we can continue our work to improve health equity and affordability in Colorado.

For any questions regarding these comments, please contact Bethany Pray at bpray@cclponline.org.

Very truly yours,



Bethany Pray
Legal Director

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February 2, 2021

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Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Colorado Section 1332 Innovation Waiver Amendment

Dear Administrator Brooks-LaSure and Secretary Becerra:

The Colorado Consumer Health Initiative (CCHI) appreciates this opportunity to comment on Colorado's Section 1332 Innovation Waiver Amendment. CCHI is a nonprofit, consumer-oriented, membership-based health advocacy organization that serves Coloradans whose access to health care and financial security are compromised by structural barriers, affordability, poor benefits, or unfair business practices of the health care industry. We are submitting comments strongly urging CMS to approve this waiver amendment.

In this waiver amendment, Colorado requesting waiver of the following provisions:

- Continued waiver of Section 1312(c)(1) – Single Risk Pool – for the purpose of supporting and continuing Colorado's reinsurance program;
- Waiver of Section 1312 (c)(1) and Section 1312(c)(2) – Single Risk Pool – for the purpose of supporting the premium reduction requirements of the Colorado Option in the individual and small group markets.

Colorado's waiver amendment is designed to integrate with state level efforts to improve affordability. In 2020, Colorado created our state-based Health Insurance Affordability Enterprise (HIAE) to fund the state's reinsurance program, to enhance CSRs through Connect for Health Colorado, and create a first-in-the-nation mechanism to provide financial assistance for private insurance for those that cannot qualify under the ACA - those that fall in the "family glitch" and people living without documentation (referred to as "qualified individuals" or QI population). Continued affordability and access challenges are also why we supported the Standardized Benefit Plan Colorado Option (hereinafter, Colorado Option) and through this waiver, have sought to integrate it with the HIAE.

This waiver amendment builds on the 1332 waiver that was recently reapproved by CMS and incorporates innovative efforts to improve affordability and equity in coverage initiated through state legislation HB21-1232 - Standardized Benefit Plan Colorado Option (from here on referred to as the Colorado Option). We, along with many other consumer and health equity advocates in Colorado, worked diligently to craft and pass this legislation to reduce insurance premiums, create standardized plans that are structured to improve equity, improve affordability in the individual

and small group markets, and build on Colorado's HIAE to expand access to financial assistance and coverage for those that have been left out of current coverage systems and assistance.

The Colorado Option requires insurance carriers to offer standardized plans that are designed to improve racial and health equity. These plans have been designed through an extensive stakeholder process and will be required to offer more primary, behavioral, and perinatal care with no cost-sharing, shift more cost-sharing structures like those for prescription drugs to copays instead of coinsurance, and provide more benefits to patients living with diabetes at low or no additional costs. Insurance carriers are required to offer these standardized plans in the individual and small group markets, and they will be offered through Connect for Health Colorado and the Colorado Public Benefit Corporation (which will be used by the QI population). Through this waiver, Colorado is requiring insurance carriers to meet premium reductions of 15% from 2023-2025 (5% each year) and control costs thereafter based on medical inflation.

The waiver amendment will lead to savings for the federal government based on the premium reductions required through the Colorado Option (growing to an estimated \$147 million in additional savings on top of reinsurance by 2027), and seeks to draw down those savings as passthrough dollars. These passthrough funds will be reinvested through Colorado's HIAE to enhance existing CSRs through Connect for Health Colorado, which is already helping roughly 24,000 Coloradans by making it more affordable to access care with marketplace coverage. Beginning in 2023, the HIAE will provide financial assistance through the Public Benefits Corporation to Coloradans living without documentation and those that fall in the "family glitch." These populations are a significant portion of Colorado's remaining uninsured population because they are ineligible for APTCs and have no viable affordable coverage options to protect their health and financial security. We know that particularly those Coloradans living without documentation, who are integral parts of our communities, experience health disparities at high rates, are overwhelmingly people of color, and rarely access health care services because they cannot afford coverage or care.

Colorado has been thoughtful and deliberate in how we have structured the HIAE, the Colorado Option, and this waiver to improve affordable access to coverage and care and make important strides to address health inequities that have persisted for decades. This component of the waiver will significantly advance Colorado's ability to provide assistance to these populations that have been left out of coverage and is a crucial element in our state's overall efforts to improve racial and health equity in Colorado. This will allow Colorado to put coverage within reach of tens of thousands more Coloradans, and help tens of thousands more afford the care they need to take care of their health.

This 1332 waiver amendment is vital to implementing the requirements and fulfilling the goals and values laid out through the Colorado Option. We strongly urge CMS to approve this waiver amendment expediently so we can continue our work to improve health equity and affordability for Coloradans.

For any questions regarding these comments, please contact Adam Fox, afox@cohealthinitiative.org.

Adam Fox
Deputy Director
Colorado Consumer Health Initiative
afox@cohealthinitiative.org
303-563-9108



Feb. 2, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Administrator Brooks-LaSure:

On behalf of Colorado Hospital Association (CHA) and its 100-plus member hospitals and health systems statewide, I am writing to provide comment on the Colorado Division of Insurance (DOI)'s [Final-Colorado Section 1332 Innovation Waiver Amendment- 11/30/21](#).

CHA strongly supports affordability and accessibility for Coloradans and is committed to partnering with the DOI on a smooth implementation of the enabling statute for the Colorado Option ([HB 21-1232](#)). Through negotiations with sponsors, proponents, and the DOI during the bill's consideration, CHA ultimately took a neutral position on the legislation. That said, CHA has serious concerns about the technical details informing the state's waiver application. Specifically, the calculations and estimates being used to request federal pass-through funding have deficiencies which, if not addressed, may have destabilizing effects on Colorado's health care landscape. CHA requests that the Centers for Medicare & Medicaid Services (CMS) take an oversight role in evaluating and correcting discrepancies to ensure a successful implementation of the Colorado Option in 2023 and beyond.

Overview of the Colorado Option

HB 21-1232 established the creation of a new Colorado Option standardized benefit plan for all carriers in the individual and small group market. By law, premiums in the Colorado Option plan must be 5% lower in 2023, 10% lower in 2024, and 15% lower in 2025, when compared to the 2021 plan year. As drafted, these premium reductions would significantly reduce the federal government's Colorado premium tax credit expenditures. In the DOI Colorado Section 1332 Innovation Waiver Amendment (on page 4), the DOI requests that the federal government provide these projected savings to the State of Colorado in the form of pass-through payments to support health care subsidies.

To achieve the premium reduction targets without destabilizing the health care industry, HB 21-1232 required the commissioner to account for *"any actuarial differences between the standardized plan and the health benefit plans [carriers] offered in the 2021 calendar year."* The law further requires that the standardized benefit plan be *"actuarially sound and allow a carrier to continue to meet the financial requirements of [state law]."* CHA has serious concerns that the state actuarial analysis, both with regard to implementation of the Colorado Option rate reduction target methodology, standard plan, and ultimately the amount of request to the federal government, seriously disregards confounding factors and existing mandates. These are concerns that need to be addressed for program feasibility and sustainability.

Actuarial Impact of Recent Benefit Additions

Essential to the framework of HB 21-1232 is the concept that independent adjustments to the underlying value of the standardized benefit plan – such as new benefit mandates – would not undercut the potential for carriers and providers to successfully achieve the premium reduction targets specified in the legislation. Based on the statutory requirement, it is deeply concerning to CHA that analysis, even using rigid actuarial industry standards, have yielded impact differences that could be as little as 0.88% and as great as 2.45%. These mathematical differences must be accounted for in any actuarial estimate of the savings anticipated by this waiver.

Colorado received approval from the federal government in 2021 to update its Essential Health Benefits (EHB) package beginning in 2023. This will materially change the level of benefits offered in 2023 relative to the 2021 EHB package. Added benefits include acupuncture, gender affirming care, mental health wellness exams, and changes to drug coverage. The Division’s actuaries estimated the total cost of these benefit changes at 0.16% of premium. However, other independent actuaries’ analysis of the same benefits yielded remarkably different results – equating to potentially a nine-fold difference in impact to premiums, as outlined below. Additionally, recent legislation (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 in plan year 2023.

EHB Addition	DOI Estimate	Outside Estimate
Acupuncture, gender affirming care, mental health wellness exams, and changes to drug coverage	0.16% of premium	0.28% to 1.45% of premium
Additional infertility and reproductive services	Not addressed	0.6% to 1.0% of premium
Total	0.16% of premium	0.88% to 2.45% of premium

CHA and other stakeholders have flagged these concerns in writing and on stakeholder meetings with the DOI numerous times without them being addressed. These discrepancies cause significant concerns both for implementation of the Colorado Option plan at the state level as well as failure to achieve projected cost savings at the federal level, due to the richer benefit requirements currently unaccounted for.

Actuarial Basis

CHA deeply values both affordability and additional coverage options for Coloradans. Maintaining a stable marketplace throughout the implementation of the Colorado Option is a key priority for the Association. The timing surrounding the funding presents a number of confounding factors related to the COVID-19 crisis that could impact enrollment and subsequent costs.

Section 5 of the proposed waiver amendment notes that the Wakely model utilizes the 2019, 2020, and emerging 2021 base data experience to inform the potential savings intended for use as potential pass-through funding. Both the 2020 and 2021 plan year were significantly impacted by COVID-19 benefit utilization factors, as well as federal interventions to prevent loss of coverage. Appendix E of the Wakely

model acknowledges significant uncertainty regarding the impact of COVID-19 and the Public Health Emergency with regard to both future premiums and enrollment (*page 77-78 of the waiver amendment request*). Namely, the Wakely estimate assumes that an additional 15,000 subsidy eligible enrollees would enroll in the individual market over the course of 2023 following the end of the Public Health Emergency (*page 46*). The model assumes that these increases will be offset by transitions from the individual market to employer-sponsored coverage. This analysis does not account for a potential scenario in which costs shift to employers and employers reduce their coverage offerings, shifting employees to the public option and increasing cost.

To ensure that this proposal conservatively accounts for the impact of current market disruptions, on actuarial assumptions, CHA recommends that CMS perform additional actuarial analysis to confirm that the projected savings are accurate. Specifically, CMS should evaluate the following questions:

- Does the Department's actuarial analysis consider a range of potential savings?
 - If so, would the Department's approach be considered conservative or aggressive with regard to requested savings?
- Are there other steps the Department is or should be taking to ensure that the projected savings are not an overestimate?
- What happens if the Department is provided with pass-through funding based on savings that are not realized? Does CMS have requirements for a potential recoupment process?

In general, CHA requests that CMS take a strong oversight role to ensure operational success of this program. Specifically, CHA requests that CMS obtain additional independent actuarial analysis to gain understanding of the impact of COVID-19 on key variables and provide better insight into the significant differences of estimates for recent benefit changes and account for the fact that differing actuarial assumptions may exist and choose model outputs that reflect more conservative or midpoint estimates.

Regards,

/s/ Megan Axelrod
Megan Axelrod
Manager, Regulatory Policy



Feb 1, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201
RE: Colorado Section 1332 Innovation Waiver Amendment

Dear Administrator Brooks-LaSure and Secretary Becerra:

Good Business Colorado (GBC) thanks you for your attention to these comments on Colorado's Section 1332 Innovation Waiver Amendment. GBC is a grassroots organization of 410 business owners in 31 counties advocating for a prosperous economy, equitable communities, and a sustainable environment. Our members believe that business success cannot be measured by profit alone and that true success means that our planet, communities, and bottom lines are all thriving. We strongly urge CMS to approve the Colorado Section 1332 Innovation Waiver Amendment.

In this waiver amendment, Colorado is requesting a waiver of the following provisions:

- Continued waiver of Section 1312(c)(1) – Single Risk Pool – for the purpose of supporting and continuing Colorado's reinsurance program;
- Waiver of Section 1312 (c)(1) and Section 1312(c)(2) – Single Risk Pool – for the purpose of supporting the premium reduction requirements of the Colorado Option in the individual and small group markets.

GBC's business owner members have struggled to find affordable small group insurance for themselves and their employees. This has made it difficult for them to provide a needed benefit, and puts them at a disadvantage with relation to larger companies who can access more affordable large group plans. Colorado's state level efforts to improve affordability include our state-based Health Insurance Affordability Enterprise (HIAE) that funds the state's reinsurance program, enhances CSRs through Connect for Health Colorado, and creates a mechanism to provide financial assistance for private insurance for those that cannot qualify under the ACA.

Last year, we worked hard alongside consumer and health equity advocates in Colorado, to pass state legislation HB21-1232 - Standardized Benefit Plan Colorado Option (aka the Colorado Option) to reduce insurance premiums, create standardized plans that are structured to improve equity, improve affordability in the individual and small group markets, and build on Colorado's HIAE to expand access to financial assistance and coverage for those that have been left out of current coverage systems and assistance.

This waiver amendment builds on the 1332 waiver that was recently reapproved by CMS and incorporates innovative efforts to improve affordability and equity in coverage initiated through the Colorado Option. Colorado is requiring insurance carriers to meet premium reductions of 15% from 2023-2025 (5% each year) and control costs thereafter based on medical inflation, and requires insurance carriers to offer standardized plans that are designed to improve racial and health equity. The waiver amendment will lead to savings for the federal government based on the premium reductions required through the Colorado Option (growing to an estimated \$147 million in additional savings on top of reinsurance by 2027), and seeks to draw down those savings as passthrough dollars. These passthrough funds will be reinvested through Colorado's HIAE to enhance existing CSRs through Connect for Health Colorado, providing financial assistance through the Public Benefits Corporation to Coloradans living without documentation and those that fall in the "family glitch."

The HIAE, the Colorado Option, and this waiver have been designed to work together to put affordable healthcare in reach of all individuals and small businesses in our state, including those who have always been left behind. Our small business members care deeply about addressing health inequity, and this waiver amendment is critical to making that possible. That is why we are asking CMS to approve the Colorado Section 1332 Innovation Waiver Amendment as soon as possible.

Thank you for your thoughtful consideration.

Angelique Espinoza
Policy Director
Good Business Colorado
angelique@goodbusinessco.org



February 2, 2022

Ms. Ellen Montz, Ph.D.
Director, Center for Consumer Information & Insurance Oversight
Deputy Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Sent via email to: stateinnovationwaivers@cms.hhs.gov

Re: Colorado’s ACA Section 1332 State Innovation Waiver Amendment Request

Dear Director Montz:

Kaiser Permanente offers the following comments in response to Colorado’s 1332 Waiver Amendment Request (the “Request”) to include the Colorado Option program alongside the existing reinsurance program. Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering care to 12.2 million members in eight states and the District of Columbia. Kaiser Permanente Colorado provides and coordinates complete health care services for over 550,000 members through 30 medical office buildings in the state.

Kaiser Permanente supports the goals of reducing premiums and out-of-pocket costs, increasing enrollment, and improving the individual and small group markets in Colorado. However, we have significant concerns with the Colorado Option program because it could negatively disrupt existing coverage options, commercial health plan affordability, and access to quality health care by artificially constraining necessary medical expenditures.

We believe that the Request is incomplete and does not meet mandatory Affordable Care Act (“ACA”) Section 1332 waiver requirements as outlined by the Center for Consumer Information and Insurance Oversight (“CCIIO”).¹ Specifically, the Request does not include the following required elements: (1) an adequate assessment of the program’s impact on ACA Section 1332 statutory guardrails; (2) a description of state activities that are outside the Request but impact the baseline; (3) a complete actuarial and economic analysis for both the individual and small group markets; and (4) an explanation of the Request’s impact on projected federal pass-through funding.

The Request is not aligned with federal requirements because of the underlying requirements of the Colorado Option law. This new law and the ongoing state regulatory activity call for conflicting outcomes by prescribing robust plan benefits beyond the ACA’s Essential Health Benefits, new and onerous requirements related to provider networks and directories, additional cost-sharing restrictions, mandatory annual premium reductions, and specified provider and hospital reimbursement rates (but with limits on reductions in hospital rates year-over-year).

¹ Specific Requirements for Colorado’s Waiver Amendment Application, available at <https://www.cms.gov/files/document/1332-co-lol-amendment-response-letter.pdf/>.

Carriers are required to meet these conflicting, mathematically impossible standards or face potential consequences, including nonbinding arbitration, public rate hearings, government rate-setting, or potentially face orders to enter new services areas.² These requirements discourage new entrants into the Colorado individual and small group markets and may force existing carriers to consider changes to current service area offerings, reducing carrier participation in the state.

We respectfully recommend CCIIO deny the Request. At a minimum, CCIIO should require additional analyses from the state for the following reasons:

1. The state has not demonstrated that the premium reduction targets in the individual and small group markets satisfy all required ACA Section 1332 statutory guardrails.
2. Colorado's actuarial and economic analyses contain significant gaps, including insufficient analysis of several state programs that could impact the baseline and an inadequate analysis of the impacts to the small group market.
3. While the state provided updated information about state subsidy concepts, the state has not adequately demonstrated how it will use new pass-through funding associated with the Colorado Option program and how it will successfully ensure funds from that program and the reinsurance program will be separated and fairly distributed to approved purposes.
4. Colorado's timeline does not provide sufficient detail as required by federal rules and does not provide stakeholders enough time for implementation efforts on new, robust requirements.
5. The state's public comment procedures do not satisfy federal rules because the state provided insufficient time to review and respond to initial and updated drafts of the application given the complexity of the Request and the programs involved.

We discuss these issues in more detail below.

Premium Reduction Targets

Kaiser Permanente supports efforts to achieve greater health care affordability. However, we have significant concerns with Colorado's approach to accomplish this goal using mandatory premium reduction targets. These premium reduction targets are one of three primary carrier requirements under the Colorado Option program. To satisfy this requirement, all carriers currently offering individual or small group plans must offer a Colorado Option plan with a robust, standardized benefit design at a premium that meets the reduction target relative to its lowest-premium plan at each metal level. Premiums in a county must be 15% lower than 2021 premiums offered in that county by that carrier adjusted for national medical inflation over three years. After three years, premiums in a county are still limited – they must not be higher than premiums offered by that carrier in that county in the previous year.

² See Colo. Rev. Stat. § 10-16-1306.

These arbitrary targets do not account for the actual costs of providing care, competing state and federal requirements like actuarial soundness, rich standardized benefit designs and associated adverse selection issues, and – over time – potential for carrier service area and market changes.

Colorado has not yet finalized the standard benefit designs for the Colorado Option plans, but the new law and draft regulations indicate the plans will include a more robust set of benefits than what is currently required under the ACA, additional cost-sharing restrictions, and new, onerous requirements related to provider networks and directories. This plan design will make it even more difficult for carriers to meet the premium reduction targets while still establishing actuarially sound rates and could have significant impacts to enrollees' access to care and coverage if carriers abandon other plan offerings or service areas.

Federal regulations require that a waiver application establish that the waiver will provide coverage that is at least as comprehensive as the coverage provided without the waiver; provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver; provide coverage to at least a comparable number of residents as without the waiver; and not increase the federal deficit.³

We do not believe this Request meets the coverage and affordability guardrails because the Request includes unsupported assumptions and incomplete analyses. For example, the Request assumes that all carriers will meet the premium reduction targets in every county, without exception. However, even if a carrier applied the Colorado Option law's hospital and provider reimbursement rate floors,⁴ which may be imposed by the Insurance Commissioner as part of the rate hearing process when a carrier fails to meet the premium reduction requirements, it is extremely unlikely that a carrier would obtain a 15% premium reduction in every service area over three years. In addition, the Colorado Option law imposes a limit on hospital reimbursement rate reductions (no more than 20% annually). Carriers must also abide by actuarial soundness standards and other state health plan pricing requirements as well as carrier solvency and capital rules, and these requirements likely conflict with the premium reduction targets.

In addition, the Request outlines that the premium reduction targets are expected to be derived from lower provider rates, reductions in profits, and reduced utilization through effective care management. Existing federal and state requirements permit carriers to lower premiums through lower provider rates and reduced utilization. What is novel is that the state seeks to waive the ACA's single risk pool requirements for the individual and small group markets to enable carriers to run negative profit margins on Colorado Option plans if necessary to meet the premium reduction targets. This is actuarially unsound, does not comport with the broader goals of the ACA and violates the mandatory ACA Section 1332 statutory guardrails.

The state's assessment of the ACA Section 1332 guardrails does not address any of these issues. For example, the Request assumes no impact to existing carrier participation and coverage options. This assumption is based on prior experience of an unrelated purchasing alliance in the state. However, the purchasing alliance negotiates with health plans through a bidding process –

³ 31 C.F.R. § 33.108(f)(3)(iv); 45 C.F.R. § 155.1308(f)(3)(iv).

⁴ See Colo. Rev. Stat. § 10-16-1306.

it does not utilize aggressive premium targets and is not evidence that the Colorado Option program satisfies the required coverage and affordability guardrails.

We respectfully request that CCIIO carefully analyze the potential impacts of the Colorado Option program, and specifically the premium reduction targets, on the ACA Section 1332 coverage and affordability guardrails. We recommend CCIIO deny the Request or alternatively require that Colorado conduct a more thorough analyses to ensure the Colorado Option program would not have negative impacts on the state's individual and small group markets.

Actuarial and Economic Analyses

Kaiser Permanente believes this Request fails to include the required actuarial and economic analyses. Federal rules require that a waiver application include an updated actuarial and economic analysis demonstrating how the proposed amended waiver will meet the ACA Section 1332 statutory guardrails.⁵ For waivers that impact the small group market, the analysis must include the applicable information for that market, including the average small group premium rate.⁶ A waiver amendment request must also include a description of state activities that are outside the waiver amendment but could impact the baseline calculations.⁷

The actuarial and economic analyses in this Request do not adequately examine several relevant state programs or potential policy changes. While the analyses were updated from prior versions to include more information about the state's subsidy programs, they do not include finalized parameters for each program, duration of each program, or indicate whether parameters would change if federal premium subsidy levels change. The state's actuarial firm acknowledges that state subsidy parameters are not yet finalized and any changes to those programs could affect the overall analyses – including the determination related to the ACA Section 1332 statutory guardrails.

In addition, the analyses do not address the potential end of the federal public health emergency, Medicaid redeterminations, and corresponding impacts to the individual market. All of these are intertwined with the Colorado Option program and could have significant effects on baseline calculations and thus on coverage and affordability guardrail assessments. The analyses also assume that the premium reduction targets will be realized, without exception, and that rates for non-standardized plans will not increase to cover any losses associated with Colorado Option plans. In other words, the analyses do not outline potential outcomes if carriers are unable to reduce rates in standardized plans to the extent required by the Colorado Option law – one outcome being pass-through funds will be less than estimated.

Furthermore, the Request does not provide adequate analysis related to the small group market. It does not include the required average and aggregate small group premium rates or overview of enrollees by income and plan. The small group analysis does not include state-specific information and instead cites to broad statements about small employer behaviors regarding

⁵ 31 C.F.R. § 33.108(f)(4)(i)–(iii); 45 C.F.R. § 155.1308(f)(4)(i)–(iii).

⁶ Specific Requirements for Colorado's Waiver Amendment Application, ¶ 4(a)(iii); available at <https://www.cms.gov/files/document/1332-co-lol-amendment-response-letter.pdf>.

⁷ *Id.* at ¶ 1(f).

coverage options for their employees. This is insufficient to determine whether the small group portion of the Request satisfies the ACA Section 1332 statutory guardrails.

Finally, Kaiser Permanente is concerned that the Request and associated analyses were prepared and submitted prior to completion of the state regulatory process. The state is still in the process of finalizing the benefit design for Colorado Option plans, including promulgating regulations related to the more onerous network adequacy requirements, additional cost-sharing restrictions, and required actuarial values. The state’s actuarial firm acknowledged the incomplete plan design and ongoing regulatory process as an issue that could potentially affect the results of the analyses. We recommend CCIIO deny the Request or alternatively require the state to update the actuarial and economic analyses after the state finalizes these rules to include a more complete review of how the Colorado Option program may impact the ACA Section 1332 statutory guardrails.

Pass-through Funding

Kaiser Permanente supports state efforts to make health care more affordable. However, the Request does not provide adequate details about proposed uses for new pass-through funding.

A waiver amendment application must include an explanation of the expected impact of the proposed amendment on federal pass-through funding and any new proposed uses for pass-through funding.⁸ The Request asks for pass-through funding in the amount of federal premium tax credit savings associated with the Colorado Option program, in addition to the approved pass-through request associated with the state’s reinsurance program. The Request indicates that the pass-through funding attributable to the reinsurance program will continue to be used to support the reinsurance program. Separately, the pass-through funding attributable to the Colorado Option program will be used to support a new state subsidy program. However, we are concerned that the Request does not explain how the pass-through funds associated with the Colorado Option program will be kept separate from pass-through funds associated with the reinsurance program to ensure that the federal funds will be utilized only for the approved purposes. In other words, it is unclear how the state will ensure that pass-through funds associated with the reinsurance program will not be used for any portion of the Colorado Option program and the associated new state subsidies.

In addition, the Request does not provide adequate detail about how the new pass-through funds associated with the Colorado Option program will be used. As discussed above, the state does not provide sufficient information about how new federal pass-through funding will be distributed to various state subsidy programs. The Request also indicates some of the new subsidies will be available to Coloradans that are ineligible for federal subsidies or coverage assistance due to immigration status or lack of documentation and those ineligible for assistance due to the so-called “family glitch.” Kaiser Permanente supports efforts to provide more affordable coverage options for these populations, but we want to ensure this is accomplished through programs that comply with state and federal laws – including requirements for the collection and use of federal pass-through funding.

⁸ Specific Requirements for Colorado’s Waiver Amendment Application, ¶ 5; available at <https://www.cms.gov/files/document/1332-co-lol-amendment-response-letter.pdf/>.

We recommend CCIIO deny the Request or alternatively require the state to provide additional information about the use of new pass-through funding associated with the Colorado Option program and how those funds will be separated from pass-through funds associated with the state's reinsurance program.

Timeline

Kaiser Permanente does not believe the Request meets federal requirements regarding implementation timelines. Federal rules require that ACA Section 1332 waiver applications include a detailed implementation timeline.⁹

This Request includes a timeline that lacks sufficient detail and includes unrealistic milestones. For example, the timeline indicates the state will provide carriers with the premium reduction targets in the first quarter of 2022 and, in turn, carriers must have rate and form filings for Colorado Option plans ready by the second quarter of 2022. This turnaround is unreasonable because hospital and provider contract negotiation often takes several months, and carriers will need the premium reduction targets to inform contract negotiations. At the time of this letter, the state has not finalized the methodology that will be used to calculate the targets.¹⁰ The state is requesting federal approval of a program that is not yet fully designed – making it impossible to determine whether the new program will meet all ACA Section 1332 statutory guardrails. In addition, Colorado's timeline is organized broadly by quarter, which does not provide stakeholders enough detail to prepare for specific requirements and implementation deadlines.

We recommend CCIIO deny the Request or alternatively require the state to produce a detailed implementation timeline that gives stakeholders time to appropriately prepare for the robust new requirements.

Public Comments

Federal law and regulations require that states provide a comment period for a Section 1332 waiver application sufficient to ensure a meaningful level of public input.¹¹ These state comment periods must generally be at least 30 days, but federal regulators have acknowledged that a longer period may be more appropriate for complex waiver plans.¹²

Colorado's Request is novel, lengthy, and extremely complex. Even so, Colorado only provided the minimum 30 days for public comment. In a clear violation of this requirement, the state also released a substantially revised Request just five business days prior to the comment deadline

⁹ 31 C.F.R. § 33.108(f)(4)(iv); 45 C.F.R. § 155.1308(f)(4)(iv).

¹⁰ [Request for Comment on DRAFT Proposed Emergency Regulation 22-E-XX - Concerning the Methodology for Calculating Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans | DORA Division of Insurance](#). The state is utilizing emergency rulemaking processes to establish this rule, making it even more difficult for carriers and other stakeholders to meaningfully engage and provide feedback. For example, on this initial draft, stakeholders had just one week to respond with comments.

¹¹ 42 U.S.C. § 18052(a)(4)(B)(i); 31 C.F.R. § 33.112; 45 C.F.R. § 155.1312.

¹² Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53412, 53474 (Sept. 27, 2021).



without providing stakeholders additional time to review and prepare feedback on the new portions of the Request.¹³ Finally, Colorado submitted this Request to CCIIO just six business days after the close of the comment period, an inadequate time for the state to meaningfully consider recommendations from public commentors.

In sum, Kaiser Permanente believes the state's actions fail to meet federal standards for public input on ACA Section 1332 waiver proposals. We recommend CCIIO deny the Request or alternatively require the state to conduct new notice and public comment procedures that correspond to the complexity of the changes to the waiver plans, giving stakeholders adequate time to review and provide feedback on the Request, and allowing ample time for the state to review and consider this feedback.

We appreciate your attention to our recommendations and are happy to provide additional information. Please feel free to contact Anthony Barrueta (510-271-6835; Anthony.Barrueta@kp.org) or Jessica Fjerstad (510-220-3371; Jessica.L.Fjerstad@kp.org) with any questions or concerns.

Sincerely,

A handwritten signature in black ink that reads "Anthony A. Barrueta".

Anthony A. Barrueta
Senior Vice President
Government Relations

¹³ The day *after* comments were due, Colorado announced a very short extension of the comment period which did not remedy the abbreviated timeline because it was announced after the initial deadline.



**PARTNERSHIP FOR AMERICA'S
HEALTH CARE FUTURE
ACTION**

February 2, 2022

VIA ELECTRONIC MAIL

The Honorable Janet Yellen
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to provide comments regarding the waiver amendment application submitted by Colorado's Division of Insurance on November 30, 2021, which requests permission to amend the state's currently approved waiver under section 1332 of the Patient Protection and Affordable Care Act (PPACA).

The Partnership for America's Health Care Future Action ("The Partnership") recently engaged NovaRest, a well-respected, independent actuarial consulting firm with extensive experience supporting state and federal insurance regulators, to perform an actuarial review of Colorado's waiver amendment application.

NovaRest's report – which builds on a previous in-depth analysis of the potential impact of Colorado HB 21-1232 by the actuarial firm Milliman, Inc. and provides a deeper analysis of some of the aspects of HB 21-1232 that the Milliman report did not address – exposes substantial flaws within Colorado's waiver amendment request and the underlying policy it seeks to enable.

The new analysis warns that the state's proposed reimbursement reduction floors and limitations for hospitals and physicians, combined with actuarial issues in the allowed adjustments, will make it difficult for health insurance carriers to achieve the targeted premium reductions throughout Colorado while still offering actuarially sound premiums. Specifically, NovaRest finds:

- Hospital and physician reimbursement reductions likely will not be sufficient to reduce premiums by 15 percent by 2025 in several regions in the state, a conclusion that Milliman's actuaries also reached in their earlier analysis.

- The state government’s use of the Federal Actuarial Value Calculator (AVC) to adjust for plan design differences between the Colorado Option and the 2021 benchmark plans is inappropriate, and the state’s premium reduction requirements will be more difficult to achieve if the resulting standardized plan premiums are required to be actuarially sound.
- The state government’s use of the Medical Component of the Consumer Price Index (CPIM) is not an appropriate proxy for medical cost trend and could contribute to an overall result of premiums that are not actuarially sound in that the premiums will not be sufficient to cover claims, administrative costs and risk margins.
- The state government’s benefit mandate adjustments are inadequate, failing to account for all applicable benefit mandates, and “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.”
- The state government’s waiver analysis fails to account for all of the above factors and likely significantly overstates the size of the federal passthrough savings they expect to receive. As NovaRest finds, “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 in place of a pricing actuarial value significantly impact the federal passthrough projections in the CO 1332 Amendment.”

Additionally, NovaRest’s analysis demonstrates that the creation of the Colorado Option carries significant risk for the health coverage market in Colorado, with potentially serious negative consequences regarding Coloradans’ access to coverage choices. The ability for carriers to meet the state government’s premium reduction requirements is tied to their ability to offer non-standard plans in the market, and the state government’s unrealistic requirements could force some carriers to exit certain counties.

Based on these facts and the risk the state government’s proposed actions pose to Coloradans’ access to affordable, high-quality health coverage and care throughout the state, we urge you to deny the state government’s waiver amendment request.

However, if the state government’s application is ultimately approved, we strongly recommend that federal regulators develop a process that accurately reflects and separates premium reductions achieved via Colorado’s existing reinsurance program from what we suspect will be very slight, if any, premium reductions achieved via the creation of the Colorado Option. It would be highly inappropriate to co-mingle federal passthrough funding between these two programs, and therefore is critical that any federal passthrough funding for the state’s reinsurance program be fully accounted for and directed to that program only.

The full report of NovaRest’s actuaries, who have previously worked with state regulators, the National Association Of Insurance Commissioners (NAIC), and the Department of Health and Human Services (HHS) to implement the PPACA, is enclosed with this letter.

We thank you again for the opportunity to provide comment on this matter and we welcome any questions, feedback or additional discussion that may aid your departments in reaching a conclusion concerning this waiver amendment application.

Sincerely,

A handwritten signature in black ink that reads "Kelley McCullough Robertson". The signature is written in a cursive, flowing style.

Kelley McCullough Robertson
Executive Director
The Partnership for America's Health Care Future Action

Enclosure



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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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 21-1232¹

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



- 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 Realized¹⁹](#)

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.

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 actuarially 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 Plan²⁵ requires the use of the AVC to set the actuarial values of the Standardized Plans for the purpose of adjusting the carriers' 2021 benchmark plans²⁶ 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 actions²⁷ 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 Plans³⁸ 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.

⁴⁰Emergency 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 year⁴², 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% *12 visits	0.08% *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 Rule⁴³. 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 actions⁴⁴ 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 – Individual⁴⁵

	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 Proposed 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.



Appendix I – Provider Reimbursement Rate Restrictions

(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.



February 2, 2022

Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Colorado Section 1332 Innovation Waiver Amendment - Colorado Option

Dear Secretary Becerra and Administrator Brooks-LaSure:

United States of Care appreciates the opportunity to comment on Colorado's application to amend its existing 1332 waiver to further implement the Colorado Option. We strongly urge the Centers for Medicare & Medicaid Services (CMS) to approve this waiver amendment; it is a critical component of successful implementation of the Colorado Option, which aims to provide affordable coverage and advance health equity for Coloradans.

[United States of Care](#) (USofC) is a non-partisan non-profit founded in 2018 with a mission to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We were established by a diverse [Board of Directors](#) and [Founders Council](#) to advance state and federal policies that solve the challenges people face with our health care system. We seek to [understand people's unique needs](#) to drive health policy innovation and partner with elected officials and stakeholders to pass and implement those ideas.

At USofC, we have a vision of a better, more equitable, accessible, and affordable health care system that is centered on peoples' needs. We recognize that only by putting the needs of people at the forefront of our research and policy solution design work can we ensure that the policies we create and champion work for people. Across the country, people have a desire for a health system that works when, where, and how they need it - at an [affordable cost](#). Our people-centered research has identified that Colorado is no different. Across all demographics, there are commonalities in the [problems people identify](#) within their health care system including cost, access to care, and equity.



Over the past two years, we have worked closely with a coalition of advocates in support of the Colorado Option and know just how critical this approach is to improve equity, reduce disparities, and increase affordability and access to care for Coloradans. This waiver amendment, along with requirements around standardized plan design and implementation of culturally responsive networks, will support affordability, increase care access, and advance health equity. We urge CMS to approve this waiver amendment so Colorado can continue its efforts to meaningfully improve affordability and advance health equity for Coloradans.

Colorado's Continued Commitment to Reducing Health Disparities

Throughout the ongoing COVID-19 pandemic, Colorado has passed legislation aimed at making tangible improvements to its health system and patient experiences. The [Colorado Option](#), the most recent in a [series of bills](#), strengthens the state's commitment towards improving health outcomes and reducing health disparities through several measures that will make health insurance more accessible, affordable, and equitable.

The burdens often experienced by our health care system, however, are not experienced uniformly in [Colorado](#). Black, Hispanic, Asian, American Indian/Alaska Native, and multiracial Coloradans experience a [greater risk of major health crises](#) and disproportionate burden of health conditions that lead to worse overall health than their white peers. The longstanding disparities affecting Coloradan health care have been exacerbated by the COVID-19 pandemic. The design of the Colorado Option provides a major [opportunity](#) to reduce health disparities and build health equity within the system by developing [culturally responsive provider networks](#) that can better [validate, understand, and affirm](#) the different cultures within a diverse population.

Many Coloradans [experience](#) barriers in accessing care that reveal inequities in the current system that need to be addressed, including insufficient distribution of providers, transportation barriers, language access challenges, communication barriers due to hearing loss, lack of trust in providers who do not share lived experiences, and a lack of flexible provider hours, among others. A key component of the Colorado Option in increasing access to care is the choice that it provides to consumers. Colorado Option plan networks must include the majority of Essential Community Providers as a means of better providing access to and sustaining care for populations who have been historically underserved by the health care system. This is a key step in strengthening provider networks that can help address the inequities that exist [across the current health care system](#).

The Colorado Option seeks to reduce the outsized costs of health care in Colorado while increasing access to care and centering equity as a key health system goal. The state's application for an amendment, if approved, will result in federal pass-through funding that can further these goals and tangibly improve health outcomes in Colorado, including through the creation of additional financial assistance for those who have previously been ineligible and have therefore gone without coverage.

Promoting Affordability and Choice for Coloradans

From our work [listening to people](#), we know that cost is their first concern when discussing the health care system. Our research reveals that the cost burden was the reason [42%](#) of people said they have gone without health insurance and [41%](#) of people under 30 chose to refrain from seeking medical care. In 2019, before the creation of the Colorado Option, USofC also conducted public opinion research in Colorado. From that research, we found that [Coloradans are disappointed in the cost of their health care](#). High premiums, out-of-pocket costs, travel costs, and the cost of taking time off work to seek care have presented a burden for Colorado consumers and resulted in Coloradans spending up to [20% of their income](#) on health care.

Furthermore, Colorado has some of the [highest health care costs](#) in the nation. Colorado hospitals rank first in total profit margin at [16%](#), which is more than double the national average of [7%](#). Colorado hospitals also rank 6th in terms of highest per-patient costs at a level [23% higher](#) than the national median. Exacerbating these concerns is Colorado's [under-65 uninsurance rate of 9%](#), which is higher than the [national average](#). To this end, we believe the premium reduction targets and the state's effort to address the underlying costs of care are a critical component of the Colorado Option plan.

Colorado Option issuers will be required to meet premium reductions totaling [15% between 2023 and 2025](#), and then limit growth based on medical inflation beyond 2025. If this waiver is approved, achieving these premium reduction targets will generate considerable savings for the federal government, which can be passed down to the state to provide more affordable coverage to enrollees¹. However, these premium reduction targets going into effect are contingent on this waiver's approval, making approval of this waiver amendment critical for success.

State Oversight to Promote Achievement of Premium Reduction Targets

If plans do not meet the premium reduction targets, they will be subject to rate reviews and may be required to participate in public hearings held by the Commissioner of Insurance. USofC supports this enforcement mechanism of the State to ensure the 15% premium reduction targets are met. The Commissioner's authority to set provider rates hold public hearings, and potentially institute fines or disciplinary action if the premium reduction targets are not met will support both plan and provider accountability to meeting these targets and promote affordability.

¹Pass-through funds will be reinvested in the state's Health Insurance Affordability Enterprise (HIAE), created in [2020 as part of an initiative](#) to support improved access to coverage for individuals who do not qualify for financial assistance under the ACA. The HIAE houses the state reinsurance program which has significantly reduced premiums in the state, and also provides financial assistance, outreach, and enrollment help to certain qualified individuals, including people in the [family glitch](#) and Coloradans without documentation. This population is 88% people of color, compared to 34.8% of Coloradans statewide. If approved, this waiver would allow pass-through funds generated through the premium reduction targets to be reinvested in the HIAE, sustaining the state's existing affordability mechanisms and allowing the state-only funding to focus where federal funding may be prohibited.



Increasing Plan Choice and Competition

We commend Colorado’s commitment to increasing plan choice and competition through the development of the Colorado Option’s standardized plan, offering an additional plan choice for Coloradans to select an affordable coverage option that aligns with their care needs. The standardized plans have been designed through an [extensive stakeholder process](#), with an emphasis on improving health equity, and will be required to offer primary, behavioral health, and perinatal services with no cost-sharing. In addition, cost-sharing structures will be shifted to promote greater affordability of high-value services that drive better health outcomes and increase equity, including reasonable co-pay amounts for prescription drugs. The addition of these standardized plans to the individual and small-group markets will not inhibit people from choosing a plan currently available on the state’s Marketplace but will broaden the choices available to Coloradans. It will also help reduce confusion among individuals shopping for and comparing coverage options, as standardized plans encourage carriers to compete on quality of network and customer services, rather than cost alone.

Advancing Equity through the Colorado Option

As described above, Colorado has worked diligently to ensure people have access to affordable coverage, yet disparities remain. In the years after the Affordable Care Act and before the COVID-19 pandemic, Colorado maintained an insured rate of [94%](#) of the population. However, the [7%](#) of Coloradans who were uninsured were disproportionately people of color. Black, Hispanic, Asian, American Indian/Alaska Native, and multiracial Coloradans have a [greater risk of major health crises](#) as well as an outsized burden of underlying health conditions.

The [Colorado Health Access Survey](#) has illuminated disparities in health insurance coverage across the state over the past several years. Between 2019 and 2021, the survey found that for White Coloradans, coverage increased during the COVID-19 pandemic, while the uninsured rate grew for the state’s Hispanic population. In 2019, [6%](#) of White Coloradans and [11%](#) of Hispanic Coloradans reported being uninsured; by 2021, only [4%](#) of White Coloradans reported being uninsured, while [13%](#) of Hispanic Coloradans reported being uninsured. Additionally, the premium reduction targets referenced above would promote the affordability of coverage in the small-group market where several [small businesses owned by people of color](#) have faced disproportionate financial challenges in the wake of the COVID-19 pandemic.

The same survey also found in 2021 that nearly [150,000 Coloradans](#) reported that a healthcare professional had treated them disrespectfully. The majority of these respondents attribute the disrespect to their disability, race, or language barrier. Coloradans of color, those living with a disability, and LGBTQ+ individuals also reported [higher levels of distrust](#) and difficulty finding a provider who fits their needs or shared lived experiences. Colorado has the opportunity to address these disparities in care through the [culturally responsive network requirements](#).

Culturally Responsive Networks in the Colorado Option

Colorado’s efforts represent a precedent-setting approach to developing provider networks that are “culturally responsive and, to the greatest extent possible, [reflect] the diversity of their] enrollees in terms of race, ethnicity, gender identity, and sexual orientation in the area that the network exists,” serving to advance health equity and address disparities in access. The state’s Division of Insurance (DOI) has engaged in a robust stakeholder engagement process and has committed to establishing a diverse advisory board with expertise in health equity to assist with network development.² We commend the Colorado Division of Insurance for facilitating this intentional process as they develop regulations to implement these equity-focused network requirements within the Colorado Option.

Even for those who are insured, affordability continues to be a barrier for those in need of care. While all Coloradans are worried about the cost of care, this burden falls disproportionately on Hispanic and Black Coloradans. People of color in the state were [twice as likely](#) to report that they were struggling to pay a medical bill compared to their white counterparts. In addition to racial barriers to affordable health care, there are also regional inequities throughout the state. Coloradans living in rural parts of the I-70 corridor have an uninsured rate of [14%](#), more than [double](#) the statewide average. Additionally, [16% of Coloradans](#) in the I-70 corridor reported having trouble paying a medical bill in 2021 in comparison to the statewide average of [11%](#). These discrepancies highlight both racial and geographic disparities in affordability and access.

There are clear inequities in Colorado regarding who has access to affordable care based on factors such as race and region. Reinvesting the pass-through savings generated under this waiver amendment in the HIAE, as described above, will allow the state to further increase affordability, improve access to coverage, and reduce these inequities. Successful implementation of the Colorado Option, as allowed by this waiver, will ensure Coloradans not only have more affordable options but have access to one of the most equitable insurance products in the country.

Investing in Outreach and Enrollment

The HIAE fund also provides for outreach and enrollment assistance to ensure people enroll in these new coverage options. While not explicitly included in the 1332 waiver request, we support the HIAE-funded effort to expand outreach and enrollment activities that will undoubtedly help individuals enroll in public option coverage. Further, as noted in the waiver request, supporting outreach presents a greater opportunity for the state to reduce uninsurance rates for Colorado altogether, particularly for people of color. By directing the pass-through funding to the HIAE,

² The Colorado DOI has been diligently working to develop regulations [implementing the Colorado Option](#), including the culturally responsive provider networks. The current provider network [draft regulations](#), set to be finalized in early 2022, outlines specific network requirements.



Colorado will be able to leverage the state dollars allocated to the HIAE for outreach and enrollment to provide both mass marketing campaigns and localized grassroots efforts, maintain outreach efforts outside of open enrollment, and target outreach and enrollment efforts to harder to reach communities (e.g., BIPOC, those experiencing homelessness, LGBTQ+, minority-owned small businesses, and immigrants.)

We also commend the Administration’s commitment to increasing access by investing additional resources in outreach and enrollment efforts at the federal level. For example, CMS made its [largest-ever investment](#) in the federal Navigator program ahead of the 2021 open enrollment period for the 2022 plan year, with a particular focus on underserved communities, including racial and ethnic minorities, people in rural communities, LGBTQ+, American Indians, and Alaska Natives, refugee and immigrant communities, low-income families, pregnant women and new mothers, people with transportation or language barriers or lacking internet access, veterans, and small business owners. We appreciate the Administration’s recognition of the need for increased Navigator funds and the importance of robust outreach and enrollment efforts to assist uninsured individuals to obtain affordable and comprehensive coverage. These investments have proved successful in increasing enrollment, as is demonstrated by the [historic number of people](#) who signed up for coverage during this open enrollment period, which was partially driven by these investments. This success at the federal level can be replicated in Colorado under this approved 1332 waiver amendment by generating pass-through funds to reinvest in outreach and enrollment efforts.

Thank you for the opportunity to provide comments on Colorado’s 1332 waiver amendment in support of the successful implementation of the Colorado Option. This waiver amendment is critical to implementing the requirements under the Colorado Option to achieve affordability and health equity goals outlined by the state, as demonstrated by its commitment to a robust, diverse stakeholder engagement process to ensure the needs of all Coloradans are addressed. If you have any questions or are interested in further discussion of the waiver amendment application, please do not hesitate to reach out to our Director of Policy Solutions, Liz Hagan, at ehagan@usofcare.org.

Sincerely,

A handwritten signature in black ink that reads "Natalie Davis". The signature is fluid and cursive, with a long horizontal stroke at the end.

Natalie Davis
Co-Founder and CEO
United States of Care