



**CO L O R A D O**

**Department of  
Regulatory Agencies**

Division of Insurance

## **A Report Regarding SB17-300:**

# **Colorado High-Risk Health Coverage Study**

Submitted to the Colorado Legislature:

Joint Budget Committee of the General Assembly  
Health and Human Services Committee of the Senate  
Health, Insurance, and Environment Committees of the  
House of Representatives

October 2, 2017

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**COLORADO**

**Department of  
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Marguerite Salazar  
Commissioner of Insurance

Members of the Joint Budget Committee of the General Assembly, the Health and Human Services Committee of the Senate, and the Health, Insurance, and Environment Committee of the House of Representatives  
c/o the Office of Legislative Legal Services  
State Capitol Building  
Denver, Colorado 80203

Dear Members of the Committees:

Please find attached the study conducted in response to SB17-300, which directed the Division of Insurance (Division) to:

***"... explore the feasibility of maintaining health care coverage for high-risk individuals and reducing premiums through a reinsurance program or other high-risk programs..."***

The findings of that study are to be submitted the Joint Budget Committee of the General Assembly, the Health and Human Services Committee of the Senate, and the Health, Insurance, and Environment Committee of the House of Representatives, no later than October 1, 2017.

Accordingly, the Division is pleased to transmit its completed study on the feasibility of maintaining health care coverage for high-risk individuals and reducing premiums through a reinsurance program or other high risk programs, as directed.

The study includes an overview of the Division's stakeholder-involvement process, the range of high-risk coverage options explored, and an evaluation of strategies utilized by other states. This study also includes a discussion of stakeholder perspectives on program preference and structure, program funding options, and the findings of the preliminary actuarial analysis on the impact of a state-run reinsurance program.

This report is a beginning of a process to potentially develop and implement a state-run reinsurance program, but it is only a beginning. It is hoped that this study will lead to further discussions of possible approaches to address the increasing insurance premiums experienced by the citizens of Colorado. The Division looks forward to an ongoing partnership with legislators and stakeholders on this issue, and continuing the

conversation with the goal of reaching consensus on how best to proceed and make a meaningful impact for consumers in Colorado.

Sincerely,

A handwritten signature in black ink that reads "Marguerite Salazar". The signature is written in a cursive style with a large, stylized initial 'M'.

Marguerite Salazar  
Commissioner of Insurance

## **Introduction**

The Legislature passed and the Governor signed SB17-300, a law that requires the Division of Insurance (DOI) to study potential high-risk coverage solutions for Colorado's individual market (Appendix A). This study was prompted by ongoing discussions among policymakers regarding escalating health care costs and related premium increases across the state.

For the SB17-300 study, the DOI evaluated actual and potential avenues to address escalating premiums under the Affordable Care Act (ACA) and bills before Congress, including current federal requirements for a 1332 State Innovation Waiver. The study also included an evaluation of other states' strategies to address coverage for high-risk individuals and facilitated stakeholder meetings to gather input on a potential Colorado strategy.

Stakeholders generally are opposed to establishing a segregated high-risk pool and generally prefer a reinsurance model that allows high-risk enrollees to maintain coverage with the health plan of their choice. There is less agreement regarding the operational structure and funding mechanism for a reinsurance program. The DOI has contracted for an actuarial analysis to study and analyze the potential effects on premiums and the costs involved in the establishment of a state high cost/risk reinsurance program, and to provide actuarial support for establishment of such a program, including a federal waiver application if required.

This study occurred while national leaders have begun evaluating potential funding for a new federal reinsurance program and expanded federal waiver authorities. This aligns with the Governor's bipartisan proposal released in August that would allow a rapid pass-through of federal funds to support a reduction in individual market premiums nationally.<sup>i</sup> While our analysis is based on waiver requirements under current law, developments at the federal level should guide the upcoming evaluation by policymakers of a possible high-risk coverage solution for Colorado.

## **Our Charge**

During the 2017 legislative session the Colorado Legislature approved and Governor John Hickenlooper signed the “Colorado High-Risk Health Care Coverage Study Act” (SB17-300), a law that requires the Commissioner of Insurance to study methods of providing health coverage to high-risk individuals and reducing premiums in the individual health insurance market. The Act defines high-risk individuals as “an individual who has a medical condition that is likely to result in high health care costs.”

In conducting the study, the law requires the DOI to take into consideration:

- Requirements imposed under federal law and regulation to qualify for federal funds,
- Potential financial impacts to consumers and the business community,
- Potential funding mechanisms and other measures to promote long-term sustainability of a high-risk coverage program, and
- Procedural requirements that must be met in order to apply for a federal waiver or other federal program to seek funds for a high-risk coverage solution.

SB17-300 requires the DOI to submit a report to the Joint Budget Committee, the Senate Health and Human Services Committee and the House Health, Insurance and Environment Committee by October 1, 2017. The DOI must also present study findings during committee hearings held prior to the 2018 session under the State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act. This report fulfills the requirements of SB17-300, outlining study findings as required by the law.

## **Background**

Most states that have evaluated high-risk coverage solutions have done so in the context of their unique market conditions. Should Colorado pursue such a strategy, any approach must be guided by individual market dynamics balanced with available funding.

While Colorado's uninsured rate has dropped significantly to 6.5% since passage of the Patient Protection and Affordable Care Act (ACA) and is at a historic low, underlying health care costs continue to be a challenge.<sup>ii</sup> According to the 2017 final report of the Colorado Commission on Affordable Health Care (Cost Commission), provider and carrier competition is decreasing while geographic variation and significant utilization and cost increases continue.<sup>iii</sup>

As outlined in the Cost Commission report, health care service costs have been a significant driver of premium increases in Colorado including rising charges by hospitals, physicians, and pharmaceutical and medical device companies. The report also found that the number of carriers has almost no correlation with lower unit costs in some cases (for example as related to imaging and laboratory services).

These rising costs have resulted in elevated carrier loss ratios and subsequent premium rate increases in the individual market. The loss ratio is the calculation of the amount of premium revenues spent on clinical services.<sup>iv</sup> In recent years, the average loss percentage for many Colorado individual market carriers has risen to over 100 percent, meaning that carriers are spending more on services than they are taking in through premiums. While small group market loss ratios are more stable, overall these trends are unsustainable.

These trends are directly tied to recent individual market premium increases averaging 20 percent in 2017 and will average nearly 27 percent for the 2018 benefit year.<sup>v</sup> They have also increased consumer cost-sharing and have prompted the expansion of more limited networks. Although the state has a fairly large number of carriers compared to other states considering high-risk coverage programs, 14 counties will have only one carrier offering coverage on the Connect for Health Colorado exchange in the upcoming year.

## **Applicable Federal Laws and Regulations**

The Patient Protection and Affordable Care Act or ACA (Public Law 111-148) includes provisions that allow states to develop a customized coverage system to account for local market challenges while continuing to fulfill the overall goals of the law. These provisions are found in the Section 1332 State Innovation Waiver of the ACA and became effective in January of 2017. Federal waiver rules permit states to receive pass-through funds as a result of any reductions in

federal spending that result from 1332 state waiver implementation. The law permits waivers for up to five years and waivers can be renewed.

To qualify for federal financial support under a 1332 waiver states must meet the following basic requirements:

- Cover at least the same number of people as under the ACA,
- Ensure that coverage is at least as affordable and comprehensive as provided absent a waiver,
- Cannot increase the federal deficit, and
- Must be guided by state authority.

States that want to apply for a 1332 waiver must pursue the following procedural steps:

- Enact legislation authorizing pursuit of a federal waiver,
- Identify specific provisions to be waived and rationale,
- Provide a notice and public comment period and conduct public hearings related to a state's application,
- Conduct a separate notice and comment process for federally recognized Native American tribes,
- Obtain an actuarial analysis and certification demonstrating a 10-year budget plan that is deficit neutral to the Federal government, and
- Develop a timeline for waiver implementation.

Detailed regulatory guidance is provided by the Centers for Medicare and Medicaid Services including a checklist for states to help guide waiver development (Appendix B).<sup>vi</sup> The Departments of Health and Human Services (HHS) and Treasury will conduct a preliminary review of the waiver application within 45 days of submission to determine completeness. A final determination of the waiver's approval or denial will be made within 180 days of the completeness review.

In addition to complying with the basic requirements and procedural steps outlined above, states seeking to establish a high-risk coverage solution and requesting related federal pass-through funding must provide an actuarial certification of how the state's plan will reduce federal spending and comply with the basic requirements for coverage, comprehensiveness and affordability. States must also specify the ACA provisions they wish to waive.



## **Our Process**

The Division began its evaluation of high-risk coverage options in June 2017 and held a series of stakeholder meetings to solicit input. Six in-person meetings were widely attended by a variety of stakeholders including health insurance carriers, consumer organizations, provider groups, and actuarial firms. The Governor's office, legislators, and representatives from the Department of Health Care Policy and Financing were also in attendance. Meetings covered a variety of topics including: federal regulatory framework, other states' high-risk coverage strategies, and options for program design, funding, and operational structure. Stakeholder meetings also included presentations by Alaska and Minnesota divisions of insurance on their 1332 waiver submissions.

The DOI also released a formal Request for Proposals during this period to identify an actuarial firm to evaluate the financial impacts to consumers and the business community for a high-risk coverage solution. Due to the short time period between passage of SB17-300 and the report deadline, we have outlined an initial set of financial impact estimates in this report and will provide detailed actuarial findings prior to the DOI's SMART hearing later this year.

## **Guiding Principles**

At the outset of our stakeholder process we sought to gain consensus around a set of principles to guide the process for evaluating potential high-risk coverage solutions. These agreed-to principals supported stakeholder discussions and ground this report. Principles include:

- Any high-risk coverage framework must:
  - Clearly identify the problem we are trying to solve,
  - Segment out short and long-term solutions, and
  - Set clear and realistic timelines for implementation.
- Selection of a model should be backed by analysis that:
  - Accounts for Colorado's unique market conditions,
  - Ensure consumers have affordable, non-discriminatory coverage, and
  - Evaluates financial and administrative impacts.
- State funding mechanisms and estimated costs will drive decisions about program design and must be a priority for discussion.
- A high-risk coverage solution will not fully address premium challenges due to the underlying costs of care. Options to address cost drivers must also be considered.

## **Overview of High-Risk Coverage Options**

All high-risk coverage options serve the same general purpose, to reduce premiums by providing funds to counterbalance the highest cost claims in a given market.<sup>vii</sup> Our analysis and stakeholder process was guided by a common understanding of the key elements of three primary high-risk coverage solutions: high-risk pools, traditional reinsurance, and an “invisible” high-risk reinsurance program (also referred to as a hybrid approach). These models usually leverage assessments and fees to cover high-claims costs (see Figure 1).

Traditional Reinsurance - Traditional reinsurance programs provide payment to insurers for high-cost claims and companies often purchase this type of insurance to protect themselves. The federal government emulated the private model by operating an ACA reinsurance program from 2014 to 2016.<sup>viii</sup> Eligibility for reinsurance in this model can be based on a total dollar threshold for all claims or an individual dollar threshold per enrollee. This threshold or “attachment point” is the point at which reinsurance is provided and requires carriers to pay a portion of the claims costs. A cap is also put in place at which point reinsurance discontinues and the carrier is again responsible for total claims costs.

Traditional High-Risk Pool – This model prospectively assigns high-risk patients into a segregated insurance program and enrollees are selected for participation based on their condition. In this model risk is pooled separately from the risk of the broader market, helping to drive down premiums outside the segregated pool. Prior to the ACA, consumers who experienced a coverage denial or were quoted extremely high rates were eligible for a high-risk pool program. Under current law there is a prohibition on medical underwriting and coverage denials and therefore any new high-risk pool mechanism would need to account for these changes.

Hybrid/Invisible Pool - This approach can prospectively or retrospectively identify high-risk enrollees and provides a mechanism for carriers to recover a portion of extraordinary high-cost claims. Similar to a traditional reinsurance program, enrollees receive coverage from their insurer of choice. A condition-based or dollar threshold may be used in this approach to identify eligible enrollees or claims.

While all of these models seek to reduce premiums, some critics believe that high-cost coverage solutions only mask the underlying costs of health care and simply redistribute the costs of coverage through fees and assessments on carriers and sometimes providers. It is recognized that underlying costs are a driver of premiums, and the Division supports trying to address the cost issue, but anticipate that these issues will need to be addressed separately from any reinsurance program.

Figure 1. High-Risk Coverage Models Comparison Chart

	<b>ACA transitional reinsurance</b>	<b>Traditional high risk pool</b>	<b>Invisible high risk pool (hybrid)</b>
<b>Summary</b>	Retrospective program paying insurers for a portion of high-cost claims. No segregated program.	Prospective program where high-risk patients are assigned to segregated insurance.	Prospective* or retrospective program where issuers are reimbursed for high-cost claims. No segregated program.
<b>Pooling</b>	Single risk pool	Separate risk pool	Single/separate risk pool depending on design
<b>Eligibility</b>	Dollar threshold	Condition-based or dollar threshold	Condition-based (Prospective) and/or dollar threshold (Retrospective)

\*In a prospective hybrid model carriers must cede premium to the program for enrollees with pre-selected conditions.

## Evaluation of State Strategies

The SB17-300 study began with a review of efforts by a number of other states to address escalating premiums and coverage of the high-risk enrollees.<sup>ix</sup> The kick-off stakeholder meeting included a review of five states, evaluating their unique market conditions compared to Colorado's market as well as the elements of their high-risk coverage solutions. These state evaluations were key to identifying a potential framework and design for a high-risk coverage solution for Colorado. Our evaluation sought to understand state approaches to: program design, financing, and operational structure. Alaska and Minnesota were the primary focus of our review and leaders from both states' insurance divisions presented at stakeholder meetings.

To inform funding discussions, the DOI also provided an overview of the state's prior high-risk pool, Cover Colorado that was offered from 1991 through September 2013.<sup>x</sup> This program averaged approximately 13,700 members with annual incurred claims averaging \$117 million. The program was funded through monthly premium fees (50%), assessments on state regulated plans including stop loss and reinsurance (25%), and unclaimed property funds (25%). While many states are using existing high-risk pool authorities to apply for 1332 waivers, Colorado sunset its program in 2014 and therefore must enact new legislation to establish a coverage entity if the state intends to pursue a waiver. During stakeholder discussions of Cover Colorado there was universal agreement that a return to a high-risk pool was not a feasible option. Consumer advocacy organizations were especially concerned that segregating high-risk individuals could lead to discriminatory practices.

Alaska and Minnesota 1332 waivers both seek to establish reinsurance programs to cover high-cost enrollees and mitigate premium increases (Appendix C and D). Both also leverage dormant high-risk pool programs and did not require the states to establish a new entity to administer reinsurance. The states also requested to waive the "single risk pool" requirement in the ACA, allowing high-cost enrollees to be invisibly covered through the reinsurance program. This mechanism will help drive down premiums for the rest of the pool and subsequently reduce federal spending for Advanced Premium Tax Credit (APTC) subsidies.<sup>xi</sup> Both waivers request pass-through funds related to these federal APTC reductions to help fund their reinsurance programs.

Alaska's approved waiver relies on a condition-based program while Minnesota has proposed a claims-based reinsurance model. Conditioned-based programs are more administratively complex than a claims-based approach due to the need to prospectively identify enrollees based on condition. Alaska has only one carrier in the individual market, which simplifies operations in this model. Minnesota's market is more similar to Colorado's having more carrier competition

and a larger enrollee population. Figures 2 and 3 below provide an overview of these states' markets and waiver programs:

Figure 2. Alaska 1332 State Waiver Overview

<p><b>Market Snapshot:</b> Alaska participates in the federal exchange and has 36,000 individual market enrollees. Only one insurer offers coverage and the average monthly premium is \$904. The state established a reinsurance program in 2017 reducing premium increases from 42% to 7.3%. The waiver has been approved.</p>	
<p><b>Waiver Summary</b></p>	<p>Prospective hybrid program providing reinsurance (2018-2022). Individuals remain in traditional insurance.</p>
<p><b>Eligibility</b></p>	<p>Condition based (30 high-cost conditions are covered).</p>
<p><b>Financing</b></p>	<p>\$59.9 million (2018) – 81% federal pass-through and the remaining by state appropriation.</p>
<p><b>Estimated Impact</b></p>	<p>Twenty percent lower increases absent a waiver (2018), \$48.9 million federal APTC savings, and a 1,460 enrollment increase.</p>
<p><b>Entity</b></p>	<p>Alaska Comprehensive Insurance Association</p>

Figure 3. Minnesota 1332 State Waiver Overview

**Market Snapshot:** Minnesota operates a state exchange with total individual market enrollment of 250,000. Seven plans offer coverage in the individual market and all counties offered at least 2 health plans in 2017 with average approved rate increases from 50% to 66.8%. Enabling legislation repurposes a dormant high-risk pool. The state's waiver has received a completeness review, but at this time federal waiver approval has not been granted.

<b>Waiver Summary</b>	Retrospective hybrid program providing reinsurance (2018-2020). Individuals remain in traditional insurance.
<b>Eligibility</b>	Claims-based. Attachment point of \$50,000, a coinsurance rate of 80%, and a reinsurance cap of \$250,000.*
<b>Financing</b>	Legislation authorizes: \$200 million from a health access fund & \$71 million in general fund annually (2018/2019). Waiver also requests federal pass-through for APTC savings.
<b>Estimated Impact</b>	Twenty percent lower premium than without waiver, \$139 – \$167 million APTC savings, and enrollment increase of 50,000.
<b>Entity</b>	Minnesota Comprehensive Health Association

\*See Figure 4 for additional details.

## Stakeholder Perspectives

Throughout implementation of the SB17-300 study stakeholders have been invited to provide verbal and written comments on a variety of issues including program design, operational structure, and financing of a potential high-risk coverage program (Appendix E). Carriers, providers, and consumer advocacy organizations all participated in the DOI's facilitated stakeholder meetings and provided input.

There was general consensus across stakeholders that a high-risk coverage solution is needed for Colorado to respond to escalating premiums but that any program should try to address the underlying costs of coverage that are driving those increases. Stakeholders also made it clear from the outset that a clear state funding mechanism must be identified before Colorado applies for a federal waiver and that state funding sources will drive several key decisions regarding the scope and operational structure of a high-risk coverage program. Many participants also indicated that the actuarial analysis is critical to these decisions. While many stakeholders would like to see a program put in place as soon as possible, there was broad acknowledgement that 2019 would be the earliest year implementation could occur.

Most stakeholders agreed that a claims-based invisible reinsurance program that allows individuals to maintain coverage in the individual market is the best approach for a high-risk coverage program in Colorado. Many indicated that this model would best leverage carrier infrastructure already in place due to the ACA's former transitional reinsurance program and would also allow greater predictability in estimating program costs.

There was broad opposition to the idea of the condition-based reinsurance model. Some stakeholders stated that this approach would be more administratively complex for both the state and carriers due to the need to prospectively identify individuals with high-risk conditions for participation in a program. Reaching consensus on a list of conditions for eligibility was also identified as a challenge.

There was universal agreement that any program should leverage federal funds including the federal risk adjustment program that in the 2018 benefit year will provide carriers with reimbursement for 60% of high-risk individual claims costs above \$1 million dollars.<sup>xii</sup> Stakeholders also agreed that state policymakers should take into consideration any Congressional action impacting the individual market, including any action establishing a new or reconstituted federal reinsurance program.



## Areas for Future Discussion

While our stakeholder engagement process did yield areas of consensus regarding the design of a high-risk coverage program, there are several outstanding issues that will require further discussion and analysis before a 1332 waiver application can be pursued. Decisions regarding program design, operational structure, and state funding sources will be supported by the findings in the detailed actuarial analysis and driven by debate among policymakers.

### Program Design

As mentioned, there is general agreement that a Colorado high-risk coverage program should utilize a retrospective claims-based reinsurance model. A reinsurance program design should strike the right balance between available funds and the need to significantly reduce premiums. Any reinsurance design will rely on selection of an attachment point, coinsurance and cap<sup>xiii</sup>:

Figure 4. Reinsurance Model Design Overview

Program Elements	Definition	Example*
<b>Attachment Point</b>	Dollar amount of insurer costs, above which they are eligible for reinsurance.	\$100,000
<b>Coinsurance</b>	The percent of costs above the attachment point and below the reinsurance cap that are reimbursed.	80% of claims
<b>Cap</b>	The dollar amount at which the insurer is no longer eligible for reinsurance.	\$1million

\*Using the thresholds outlined above, if an enrollee incurred \$1.5 million in medical claims in a benefit year the carrier would be responsible for the first \$100,000 in claims. The reinsurance program would reimburse the plan \$720,000 (80% of claims between the attachment point and the cap). The carrier is then responsible for the remaining \$500,000 above the cap.

The Division anticipates that the detailed actuarial analysis, to be provided later, will provide some cost estimates for various attachment points, coinsurance levels and cap scenarios and evaluate their impact on rates in the individual market. While a low attachment point will allow for coverage of more claims, this may quickly exhaust available funds that would otherwise be available for higher costs claims. The coinsurance level should be set at a point that provides some “skin in the game” for carriers. Without this cost sharing, carriers will have little incentive to manage high-cost enrollee care once reinsurance is providing reimbursement. As was mentioned previously, some stakeholders are recommending that the cap level be set to align with the federal risk adjustment program that provides reinsurance funds to carriers for claims over \$1 million.

### Operational Structure

Should Colorado pursue a high-risk coverage solution, a supervising entity must be created to administer the program. While the DOI is not recommending a particular location for a program, there are several key requirements that should guide entity selection: 1) a clear statutory construct that ensures a regulatory oversight role for the DOI, 2) entity audit capability to ensure carrier compliance with program requirements, and 3) expertise or ability to contract out key functions to collect carrier data and design and adjust payment parameters. If a quasi-governmental entity is selected, policymakers must also identify a governance structure.

Additional key questions that should guide development of an operational structure include:

Figure 5. Operational Structure

Key Questions	
<b>Entity Location &amp; Governance</b>	<ul style="list-style-type: none"><li>• What is the regulatory construct?</li><li>• Where is entity housed and what is relation to DOI?</li><li>• Who selects/approves governance?</li></ul>
<b>Management &amp; Decision-making</b>	<ul style="list-style-type: none"><li>• Who collects data from carriers to determine payments?</li><li>• Who designs/adjusts payment parameters?</li><li>• Who collects funds and disburses payments?</li></ul>
<b>Accounting &amp; Auditing</b>	<ul style="list-style-type: none"><li>• Who maintains an account of funds?</li><li>• Who manages administrative expenses?</li><li>• Who handles audits and public reporting?</li></ul>

While stakeholders provided limited comments on the operational structure for an entity there was disagreement regarding whether a new statutory entity should be created with the sole purpose of running a reinsurance program or whether a program should rely on an existing entity for administration. Some stakeholders believe that the entity should be quasi-governmental with a governance structure that includes experts in a variety of areas including health insurance, actuarial science and other relevant areas. At least one stakeholder commented that the DOI should have a key role in adjusting payment parameters for the program, working closely with the entity that would administer reinsurance.

### Funding Options

While some states intend to use assessments within health care to help cover a portion of their reinsurance program costs, it is important to consider that these funding sources will be built back into premium rates. During the SB17-300 stakeholder discussions there was general consensus that any health care market assessments must be broad-based and that additional funding outside of health care will provide the greatest impact on individual market premiums. Some stakeholders have also suggested that funding sources be tied to cost drivers that have a direct impact on premium increases.

While stakeholders provided very limited feedback on potential funding sources many indicated that it would be important that the funding mechanism must be protected from future budget shortfalls and that TABOR implications must also be evaluated.

While the DOI is not recommending any specific funding framework, we offer the following potential sources for consideration by policymakers:

Figure 6. Considerations for Potential Funding Options

Potential Funding Source	Considerations
Health insurance assessment*	<ul style="list-style-type: none"> <li>• Circulates dollars within health system.</li> <li>• Broad-based assessment across individual, small group and large group markets (including self-funded plans) will have greater impact on individual market premiums.</li> <li>• Breadth of the population the assessment covers will influence impact on the market.</li> </ul>
Premium tax	<ul style="list-style-type: none"> <li>• Applies to all insurance premiums including non-health premiums.</li> <li>• Diversion of existing funds collected or tax increase required.</li> </ul>
Provider assessment	<ul style="list-style-type: none"> <li>• Circulates dollars within health system.</li> <li>• Diversion of existing funds collected or tax increase required.</li> </ul>
Foundation grant	<ul style="list-style-type: none"> <li>• Possibly short-term, one-time only funding likely. May not address long-term funding needs.</li> <li>• Could constitute a letter of credit as guaranty of state funding to qualify for federal pass-through funds.</li> <li>• Significant timing uncertainty.</li> <li>• Slow process to access funds.</li> </ul>
Unclaimed property interest	<ul style="list-style-type: none"> <li>• Portion of funds are currently dedicated to Medicaid adult dental.</li> <li>• Diversion of existing funds collected would be required.</li> </ul>
State individual mandate penalty	<ul style="list-style-type: none"> <li>• Requires a ballot initiative.</li> <li>• Administrative burden may be significant.</li> <li>• May address underlying costs by driving young/healthy to market.</li> </ul>
Non-health insurance assessments	<ul style="list-style-type: none"> <li>• Broadens funding pool taking some burden off health insurance market.</li> <li>• Non-health premium increases may occur.</li> </ul>
Marijuana tax	<ul style="list-style-type: none"> <li>• Requires tax increase or diversion of funds from other initiatives.</li> <li>• Possible TABOR implications.</li> </ul>
Third Party Administrators	<ul style="list-style-type: none"> <li>• Not currently regulated by DOI, would require legislation to expand authority.</li> </ul>
Tobacco tax	<ul style="list-style-type: none"> <li>• Requires tax increase or diversion of funds from other initiatives.</li> <li>• Possible TABOR implications.</li> </ul>

\*Assessment may include all DOI regulated markets including: small group, individual, and stop loss. May also include state employee coverage. The DOI has regulatory authority over approximately 27% of the health care market. ERISA self-funded plans are exempt from state regulation.

## **Preliminary Actuarial Analysis**

A key component of the analysis and discussion of High-Risk Health Care Coverage Study is the actuarial analysis of the parameters of such a program, including the overall cost for such a program, the anticipated effect on individual market premiums, balanced against the potential funding sources (both state and federal, public and private). To this end, the Division of Insurance contracted with Milliman, Inc. to produce an actuarial analysis to provide some estimates of potential reinsurance program parameters; potential impact to premiums in the individual market; and estimated state-based costs and available Federal funding for a state-based reinsurance program. As there remain a variety of potential options on how to structure and fund a reinsurance program, the Division chose to ask for a preliminary actuarial analysis based on the state seeking a Section 1332 waiver, which is intended to supply the foundational information upon which policymakers and stakeholders can continue discussions on how to proceed. Milliman will follow this preliminary analysis with a more in-depth analysis of Colorado-specific claims, enrollment and population data to finalize reinsurance parameters, estimate program costs with greater precision, and evaluate funding options more thoroughly. It is anticipated that this more detailed analysis will be completed later in the fall for discussion with policymakers and stakeholders.

The Milliman high level actuarial analysis is attached to this report as Appendix F. They summarized their preliminary analysis as follows:

Increasing unsubsidized enrollment through increased access to coverage by improving affordability should be an important policy goal for the State of Colorado and as high of a priority as increasing subsidized Marketplace enrollment. A state-funded reinsurance program can provide some amount of price relief that may improve the perceived value of insurance for a portion of the population currently forgoing coverage.

The introduction of a reinsurance program would have at least two beneficial impacts to Colorado's individual market. First, the direct infusion of funds from outside the Affordable Care Act (ACA) compliant market will likely lower prices for those members who are not receiving Federal premium assistance. Second, the morbidity of the individual market risk pool may improve from additional enrollment of health members not receiving premium assistance that may have otherwise forgone health insurance. The

magnitude of both effects will be directly correlated with the funding amount included in the reinsurance program. However, a reinsurance program cannot, by itself, solve the challenges related to underlying cost of care or delivery system issues.

Based on Colorado individual market impacts from the Federal government's Transitional Reinsurance Program from 2017 through 2014, we modeled state-based reinsurance scenarios for the 2018 individual market. The 'High', 'Medium', and 'Low' scenarios illustrated in the below table correspond closely to the 2014, 2015 and 2016 percentage reduction in insurer paid claims achieved by the Federal reinsurance program. The table illustrates the total reinsurance fund size, estimated premium rate reduction, the division of state-based and Federal funding for the program.

<b>State of Colorado</b>			
<b>2018 Illustrative Reinsurance Scenarios – Estimated Market Impact and Funding Requirements</b>			
	<b><u>High</u></b>	<b><u>Medium</u></b>	<b><u>Low</u></b>
Reinsurance Fund Size (\$ Millions)	\$296	\$177	\$59
Individual Market Premium Rate Reduction	-21%	-12%	-4%
Federal Pass-Through Percentage with Margin	40%	40%	40%
Federal Pass Through-Funding (\$ Millions)	\$119	\$71	\$24
State-Based Revenue Requirement (\$ Millions)	\$177	\$106	\$35

Based on a high-level projection for 2018 individual market enrollment, we estimate a reinsurance fund of nearly \$300 million would achieve a 21% premium rate reduction. Federal pass through-funding under this scenario is estimated at \$119 million dollars, leaving the state of Colorado's cost at \$177 million. To the extent the size of the reinsurance program is smaller, the corresponding premium rate reduction and state-funding requirements also decrease. Relative to other states, Colorado will tend to have less of its reinsurance program's costs paid by the Federal government due to a lower than average amount of premium paid with APTC [advance premium tax credit] dollars relative to the total ACA market.

As noted, Milliman will be refining this high-level analysis with more in-depth review of Colorado-specific claims, enrollment and population data

to advance the discussion of a reinsurance program in the context of the multiple potential avenues which may be available through the Federal government or by state action or participation.

## **Next Steps**

The SB17-300 study has fulfilled its charge to evaluate potential high-risk coverage solutions and gather input from the stakeholder community. Most agree that a retrospective claims-based reinsurance model is the best approach but design details will be dependent on how much funding is available both federally and at the state level. The actuarial analysis will drive future discussions about these issues and will inform policy development.

Once the actuarial analysis is completed, if policymakers decide to move forward with pursuit of a 1332 waiver, under current law Colorado's next procedural steps include drafting and advancing state legislation that would permit Colorado to apply for a waiver. Legislation is also needed to establish a program, identify funding sources, and outline an operational framework to administer a reinsurance program.

While these procedural steps are underway, it will also be important for policymakers and stakeholders to continue to evaluate any regulatory changes to the ACA's 1332 waiver authority and monitor developments in Congress regarding federal reinsurance. Any overarching policy changes should guide Colorado's efforts to address coverage for high-risk enrollees. Given federal uncertainty, any solution will likely be short-term and will require a revisiting of the strategy for future years.

Finally, as suggested in our guiding principles, this process should be driven by an ongoing exploration of how to address cost drivers in health care. Without this critical lens, any high-risk coverage solution will only serve to mask rising system costs in Colorado.



## **Acknowledgements**

The DOI would like to thank all of the contributors to the SB17-300 study process. We were pleased to have numerous stakeholders provide input including insurers, providers and consumer advocacy organizations (Appendix E).

We also acknowledge participants from the state staff including the Governor's office and at the Department of Health Care Policy and Financing, as well as participants from Connect for Health Colorado.

Report was drafted under the direction of Chief Deputy Commissioner Peg Brown by Mara Baer, President of AgoHealth, and Matt Mortier, Director of Compliance, Colorado Division of Insurance

## **Appendices**

- **Appendix A** – SB17-300 Legislative Text
- **Appendix B** – 1332 Waiver Checklist
- **Appendix C** – Alaska 1332 Waiver Request Summary
- **Appendix D** – Minnesota 1332 Waiver Request Summary
- **Appendix E** – Stakeholder Organizations Participating
- **Appendix F** – Preliminary Actuarial Analysis

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- <sup>i</sup> <https://www.colorado.gov/governor/news/gov-hickenlooper-shares-bipartisan-blueprint-stabilize-individual-health-insurance-market>
- <sup>ii</sup> <https://www.coloradohealthinstitute.org/research/colorado-health-access-survey>
- <sup>iii</sup> <https://www.colorado.gov/pacific/sites/default/files/Cost%20Commission%20June%202017%20report%20FINAL%206.30.17.pdf>
- <sup>iv</sup> <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html>
- <sup>v</sup> <https://www.coloradohealthinstitute.org/research/insurance-prices/2018-preliminary>
- <sup>vi</sup> [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section\\_1332\\_State\\_Innovation\\_Waivers.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers.html)
- <sup>vii</sup> <http://www.actuary.org/content/using-high-risk-pools-cover-high-risk-enrollees>
- <sup>viii</sup> <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html>
- <sup>ix</sup> <http://www.statenetwork.org/more-states-looking-to-section-1332-waivers/>
- <sup>x</sup> Cover Colorado was put in place with the enactment of House Bill 90-1305.
- <sup>xi</sup> <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit>
- <sup>xii</sup> <http://www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/insights/actuarial/2017/NYC-ADM90101-246%202018%20NOTICE%20OF%20BENEFIT%20FINAL%20RULE.pdf>
- <sup>xiii</sup> <http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>



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**Appendix A: SB17-300 Legislative Text**

# An Act

SENATE BILL 17-300

BY SENATOR(S) Lambert, Aguilar, Crowder, Donovan, Guzman, Kefalas, Lundberg, Martinez Humenik, Moreno, Williams A., Grantham; also REPRESENTATIVE(S) Kennedy, Buckner, Danielson, Esgar, Ginal, Hamner, Hansen, Hooton, Kraft-Tharp, Lontine, Michaelson Jenet, Pettersen, Singer, Weissman, Young, Duran.

CONCERNING THE AUTHORITY OF THE COMMISSIONER OF INSURANCE TO IMPLEMENT PROGRAMS TO ADDRESS THE RISING COSTS OF PROVIDING HEALTH CARE COVERAGE TO HIGH-RISK INDIVIDUALS IN THE STATE, AND, IN CONNECTION THEREWITH, DIRECTING THE COMMISSIONER TO STUDY ISSUES RELATED TO THE IMPLEMENTATION OF SUCH PROGRAMS.

*Be it enacted by the General Assembly of the State of Colorado:*

**SECTION 1.** In Colorado Revised Statutes, **add** article 22.5 to title 10 as follows:

## **ARTICLE 22.5**

### **Colorado High-risk Health Care Coverage Study**

**10-22.5-101. Short title.** THE SHORT TITLE OF THIS ARTICLE 22.5 IS THE "COLORADO HIGH-RISK HEALTH CARE COVERAGE STUDY ACT".

*Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.*

**10-22.5-102. Legislative declaration.** THE GENERAL ASSEMBLY HEREBY DECLARES THAT, WITH RISING RATES IN THE INDIVIDUAL HEALTH INSURANCE MARKET AND THE CHALLENGES FACED BY CARRIERS IN ANTICIPATING COSTS OF CARE FOR INDIVIDUALS WHO ARE CONSIDERED HIGH RISK DUE TO A MEDICAL CONDITION, IT IS IMPORTANT FOR COLORADO TO EXPLORE INNOVATIVE WAYS TO REDUCE COSTS WHILE MAINTAINING ACCESS TO CARE. ACCORDINGLY, THE PURPOSE OF THIS ARTICLE 22.5 IS TO AUTHORIZE THE COMMISSIONER OF INSURANCE AND THE DIVISION OF INSURANCE TO STUDY NEW POLICY SOLUTIONS THAT MAY INVOLVE APPLYING FOR AUTHORIZATION OR WAIVERS AVAILABLE UNDER FEDERAL LAW.

**10-22.5-103. Definitions.** AS USED IN THIS ARTICLE 22.5, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "CARRIER" HAS THE SAME MEANING AS SET FORTH IN SECTION 10-16-102 (8).

(2) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE OR THE COMMISSIONER'S DESIGNEE.

(3) "DIVISION" MEANS THE DIVISION OF INSURANCE ESTABLISHED IN SECTION 10-1-103.

(4) "FEDERAL ACT" MEANS THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT", PUB.L. 111-148, AS AMENDED BY THE "HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010", PUB.L. 111-152, AND AS MAY BE FURTHER AMENDED, AND INCLUDING ANY FEDERAL REGULATIONS ADOPTED UNDER THE FEDERAL ACT.

(5) "HIGH-RISK INDIVIDUAL" MEANS AN INDIVIDUAL WHO HAS A MEDICAL CONDITION THAT IS LIKELY TO RESULT IN HIGH HEALTH CARE COSTS.

(6) "REINSURANCE" MEANS A SYSTEM IN WHICH A CARRIER MAY ARRANGE WITH ANOTHER ENTITY FOR PAYMENT OF SERVICES FOR HIGH-RISK INDIVIDUALS ENROLLED IN THE CARRIER'S HEALTH PLAN, AND IN WHICH ALL COVERED PERSONS, HEALTHY AND SICK, ARE IN A SINGLE POOL AND HAVE THE SAME CHOICE OF HEALTH PLANS.

**10-22.5-104. High-risk health care coverage study - commissioner to conduct - report.** (1) THE COMMISSIONER SHALL STUDY METHODS OF PROVIDING HEALTH CARE COVERAGE TO HIGH-RISK INDIVIDUALS AND REDUCING HEALTH INSURANCE PREMIUMS IN THE INDIVIDUAL MARKET. IN CONDUCTING THE STUDY, THE COMMISSIONER AND THE DIVISION SHALL ENGAGE WITH AND SEEK ONGOING INPUT FROM CARRIERS, CONSUMER GROUPS, AND OTHER INTERESTED STAKEHOLDERS.

(2) AS PART OF THE STUDY, THE COMMISSIONER SHALL EXPLORE THE FEASIBILITY OF MAINTAINING HEALTH CARE COVERAGE FOR HIGH-RISK INDIVIDUALS AND REDUCING PREMIUMS THROUGH A REINSURANCE PROGRAM OR OTHER HIGH-RISK PROGRAMS AND SHALL TAKE INTO CONSIDERATION:

(a) ANY REQUIREMENTS IMPOSED UNDER THE FEDERAL ACT OR OTHER APPLICABLE FEDERAL LAWS AND REGULATIONS TO QUALIFY FOR FEDERAL FINANCIAL SUPPORT;

(b) POTENTIAL FINANCIAL IMPACTS TO CONSUMERS AND THE BUSINESS COMMUNITY;

(c) POTENTIAL FUNDING MECHANISMS AND OTHER MEASURES TO ENSURE THE LONG-TERM FINANCIAL SUSTAINABILITY OF A HIGH-RISK OR REINSURANCE PROGRAM; AND

(d) THE NECESSARY PROCEDURAL REQUIREMENTS THAT THE STATE MUST FULFILL IN ORDER TO APPLY FOR AND SEEK APPROVAL OF ANY WAIVER OR OTHER AUTHORIZATION THAT MAY BE REQUIRED UNDER THE FEDERAL ACT OR OTHER APPLICABLE FEDERAL LAW.

(3)(a) UPON COMPLETION OF THE STUDY, THE COMMISSIONER SHALL SUBMIT A REPORT ON THE STUDY TO THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY, THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE, AND THE HEALTH, INSURANCE, AND ENVIRONMENT COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES, BY OCTOBER 1, 2017, WHICH REPORT MAY BE CONSIDERED, AS NECESSARY, IN THE BUDGETING PROCESS. THE COMMISSIONER SHALL REPORT, AT A MINIMUM, ON THE AREAS INCLUDED IN THE STUDY, AS SPECIFIED IN SUBSECTION (2) OF THIS SECTION.

(b) IN ADDITION TO SUBMITTING THE REPORT AS REQUIRED BY THIS SUBSECTION (3), THE COMMISSIONER SHALL PRESENT THE REPORT TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE AND THE HEALTH, INSURANCE, AND ENVIRONMENT COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES, DURING THE COMMITTEES' HEARINGS HELD PRIOR TO THE 2018 REGULAR SESSION UNDER THE "STATE MEASUREMENT FOR ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2 OF ARTICLE 7 OF TITLE 2.

**10-22.5-105. Gifts, grants, donations, and federal funding - authority to accept and expend.** THE COMMISSIONER MAY SEEK, ACCEPT, AND EXPEND GIFTS, GRANTS, AND DONATIONS FROM PRIVATE OR PUBLIC SOURCES OR ANY FEDERAL FUNDING TO DEFRAY THE COSTS OF CONDUCTING THE STUDY PURSUANT TO SECTION 10-22.5-104.

**10-22.5-106. Repeal.** THIS ARTICLE 22.5 IS REPEALED, EFFECTIVE JUNE 30, 2018.

**SECTION 2. Act subject to petition - effective date.** This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 9, 2017, if adjournment sine die is on May 10, 2017); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2018

and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.



Kevin J. Grantham  
PRESIDENT OF  
THE SENATE



Crisanta Duran  
SPEAKER OF THE HOUSE  
OF REPRESENTATIVES



Effie Ameen  
SECRETARY OF  
THE SENATE

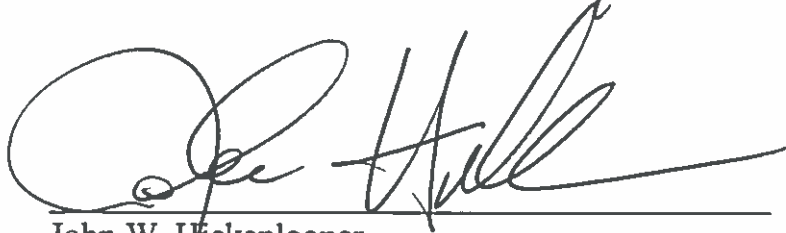


Marilyn Eddins  
CHIEF CLERK OF THE HOUSE  
OF REPRESENTATIVES

APPROVED

11:39 am

8/2/17



John W. Hickenlooper  
GOVERNOR OF THE STATE OF COLORADO





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**Appendix B: 1332 Waiver Checklist**

## **Checklist for Section 1332 State Innovation Waiver Applications, including specific items applicable to High-Risk Pool/State-Operated Reinsurance Program Applications**

**Introduction:** Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (Section 1332 waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health coverage.<sup>1</sup>

To receive approval for a Section 1332 waiver, the state must demonstrate that the waiver will provide access to quality health care that is at least as comprehensive and affordable as would be provided without the waiver, will provide coverage to at least a comparable number of residents of the state as would be provided coverage without a waiver, and will not increase the federal deficit. Before submitting its Section 1332 waiver application, the state must also provide a public notice and comment period, including public hearings, sufficient to ensure a meaningful level of public input, and enact a law providing for implementation of the waiver. Under a Section 1332 waiver, a state may receive pass-through funding associated with the resulting reductions in federal spending on Marketplace financial assistance consistent with the statute.

The Department of Health and Human Services and the Department of Treasury (the Departments) are interested in working with states on Section 1332 waivers that would lower premiums for consumers, improve market stability, and increase consumer choice. In particular we welcome the opportunity to work with states to pursue Section 1332 waivers incorporating a high-risk pool/state-operated reinsurance program. State-operated reinsurance programs have a demonstrated ability to help lower premiums, and if the state shows a reduction in federal spending on premium tax credits a state could receive Federal pass-through funding to help fund the state's reinsurance program.

**Checklist:** This checklist is intended to help states pursuing Section 1332 waivers as they develop and complete the required elements of the application. In completing a Section 1332 waiver application, states are asked to submit the items described below. More information can be found in regulations<sup>2</sup> and guidance<sup>3</sup>. We encourage states interested in applying for Section 1332 Waivers to reach out to the Departments promptly for assistance in formulating an approach that meets the requirements of Section 1332. If you have further questions please contact [StateInnovationWaivers@cms.hhs.gov](mailto:StateInnovationWaivers@cms.hhs.gov).

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<sup>1</sup> Provisions that may be waived include the following: Part I of Subtitle D of Title I of the Affordable Care Act (relating to establishing qualified health plans (QHPs)); Part II of Subtitle D of Title I of the ACA (relating to consumer choices and insurance competition through health insurance marketplaces); Sections 36B of the Internal Revenue Code and 1402 of the ACA (relating to premium tax credits and cost-sharing reductions for plans offered within the marketplaces); Section 4980H of the Internal Revenue Code (relating to employer shared responsibility); and Section 5000A of the Internal Revenue Code (relating to individual shared responsibility).

<sup>2</sup> <https://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf>

<sup>3</sup> <https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>

	HHS Citation and Description	Comments
1	<p><b>45 CFR 155. 1308(a),(b), (c), (d)</b></p> <p>Submit application States should submit application with enough time to allow for an appropriate implementation timeline</p>	<p>E-mail applications to <a href="mailto:StateInnovationWaivers@cms.hhs.gov">StateInnovationWaivers@cms.hhs.gov</a>.</p> <p>Note that HHS/Treasury will conduct a preliminary review of the application for completeness within 45 days of receipt of the application. The final decision of HHS/Treasury will be issued no later than 180 days after the application completeness determination is made.</p>
2	<p><b>45 CFR 155.1308(f)(2)</b></p> <p>Written evidence of the State’s compliance with the public notice and comment requirements, set forth in 45 CFR 155.1312.</p>	<p>Include:</p> <ol style="list-style-type: none"> <li>1. A copy of the web page and/or notice that was posted. The notice must include a comprehensive description of the Section 1332 waiver application, where the application is available, how to submit written comments, and the timeframe to submit comments (minimum of 30 days). The notice should include the location, date, and time of public hearings.</li> <li>2. Report on the issues raised during the public comment process.</li> </ol>
	<p>Public Hearings</p>	<p>Include:</p> <ol style="list-style-type: none"> <li>1. Evidence that a minimum of 2 public hearings were convened on separate dates and locations (i.e., notice or agenda).</li> <li>2. Report on the issues raised during public hearings.</li> </ol>
	<p>Tribal Consultation and evidence of meaningful consultation (if the state has one or more Federally-recognized Indian tribes)</p>	<p>Include:</p> <ol style="list-style-type: none"> <li>1. Evidence of an official meeting between the state and Tribal representatives.</li> <li>2. Report of the issues raised during official meeting.</li> </ol>

3	<p><b>45 CFR 155.1308(f)(3)(i), (ii)</b></p> <p>Comprehensive description of State’s enacted legislation and program to implement a plan meeting the requirements for a Section 1332 waiver and a copy of the state’s enacted legislation</p>	<p>Include legislation establishing authority to pursue a Section 1332 waiver and/or for the program to implement a state plan for a waiver.</p> <p><i>If submitting a Section 1332 waiver application implementing a high-risk pool/state-operated reinsurance program and seeking a pass through of funding, the legislation must provide that the high-risk pool/state-operated reinsurance program is contingent upon federal approval of the waiver (or become effective only if the Section 1332 waiver is approved). This could be accomplished by making appropriations or funding for the program or the authorization for the reinsurance program contingent on approval of the Section 1332 waiver, or by otherwise structuring the legislation so that the program cannot operate without an approved Section 1332 waiver in place.</i></p>
4	<p><b>45 CFR 155.1308(f)(3)(iii)</b></p> <p>List of provision(s) of the law that the state seeks to waive and reason for the specific request(s).</p>	<p>Include a description of the provision the seeking to be waived and how it will facilitate the state’s plan.<sup>4</sup></p> <p>If the state is seeking pass-through funding, include an explanation of how, due to the structure of the state plan, the state anticipates that individuals would not qualify for premium tax credits, small business tax credits, or cost-sharing reductions for which they would otherwise be eligible. Also explain how the state plans to use that funding.</p> <p><i>For a high-risk pool/state-operated reinsurance Section 1332 Waiver a state should request a waiver of one or more related provisions of the ACA<sup>5</sup> and explain how that will facilitate the state’s plan to implement a state-operated reinsurance program for</i></p>

<sup>4</sup> Per ACA Section 1332, these provisions include: Part I of Subtitle D of Title I of the Affordable Care Act (relating to establishing qualified health plans (QHPs)); Part II of Subtitle D of Title I of the ACA (relating to consumer choices and insurance competition through health insurance marketplaces); Sections 36B of the Internal Revenue Code and 1402 of the ACA (relating to premium tax credits and cost-sharing reductions for plans offered within the marketplaces); Section 4980H of the Internal Revenue Code (relating to employer shared responsibility); and Section 5000A of the Internal Revenue Code (relating to individual shared responsibility).

<sup>5</sup> For example, a state could waive Section 1312(c)(1) related to the individual market single risk pool in connection with implementation of a state-operated reinsurance program. Section 1312(c)(1) requires a health insurance issuer to consider “all enrollees in all health plans....offered by such issuer in the individual market...to be members of a single risk pool.” In its waiver application, the State would be required to explain how waiver of the single risk pool provision would facilitate the operations of and/or requirements for participation in the State’s reinsurance program or high risk pool and/or mechanism for a high risk pool in its individual insurance market in terms of its decision to implement its reinsurance program. For example, a state might explain how in order to maximize the rate-lowering impact of their proposal, the state would like to waive the single risk pool provision at 45 CFR 156.80 to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market wide index rate.

		<p>2018 and/or future years. The state should further explain how the provision(s) of the ACA that the state is seeking to waive are connected to and/or relate to the state’s plan for a reinsurance program. The state should also state how the high-risk pool/state-operated reinsurance program would result in a reduction in federal spending on premium tax credits, if the state expects to receive pass-through funding, and how the state wants to use that funding to implement the state plan under the Section 1332 waiver.</p>
5	<p><b>45 CFR 155.1308(f)(4)(i)-(iii)</b></p> <p>Actuarial analyses and actuarial certifications</p> <p>Economic analyses</p> <p>Data and assumptions</p> <p><i>*Note a state can combine the elements of an actuarial analysis and economic analysis into one report or submit separate actuarial and economic reports.</i></p>	<p>Include:</p> <ol style="list-style-type: none"> <li>1) An actuarial analysis and certification to support the state’s finding that the waiver complies with the coverage, comprehensiveness, and affordability requirements in each year of the waiver.</li> <li>2) An economic analysis to support the state’s finding that the waiver will not increase the federal deficit over the five-year waiver period or in total over the ten-year budget period.</li> <li>3) The data and assumptions that the state relied upon to determine the effect of the waiver on coverage, comprehensiveness, affordability and deficit neutrality requirements.</li> </ol> <p>The actuarial and economic analyses must compare coverage, comprehensiveness, affordability and net Federal spending and revenues under the waiver to those measures absent the waiver (the baseline) for each year of the waiver.</p> <p>The deficit analysis should show yearly changes in the federal deficit (that is, revenues less spending) due to the waiver. It should include a description of all costs associated with the program, including federal administrative costs, foregone tax collections, and any other costs that the federal government might incur.</p> <p>For states considering establishing a <i>high-risk pool/state-operated reinsurance Section 1332 waiver</i>, the state should use a baseline in which there is no state or federal funding for a state reinsurance program, and should compare premiums and coverage under the baseline for each year to those projected under the waiver (i.e. with a reinsurance program with funding). Data used to produce these projections might</p>

		<p>include overall and Second Lowest Cost Premium (SLCSP) and enrollment information for a recent plan year. The actuarial and/or economic analyses must include:</p> <ul style="list-style-type: none"> <li>• A comprehensive description of the parameters of the reinsurance arrangement, including projected funding levels.</li> <li>• A projection of the following items separately under both a ‘without-waiver’ scenario and a ‘with-waiver’ scenario: <ul style="list-style-type: none"> <li>• Number of non-group market enrollees by income as a share of FPL (0% - 99%, ≥100% to ≤150%, &gt;150% to ≤200%, &gt;200% to ≤250%, &gt;250% to ≤300%, &gt;300%- ≤400%, and greater than 400% of FPL), by PTC-eligibility, and by plan.</li> <li>• Overall average non-group market premium rate.</li> <li>• Second Lowest Cost Silver Plan rate for a representative consumer (e.g., a 21-year old non-smoker), by rating area.</li> <li>• Aggregate premiums and PTC amounts.</li> <li>• Aggregate shared responsibility payments, health insurance provider fee, and exchange user fee for FFE or SBE-FP states.</li> </ul> </li> <li>• Documentation of the assumptions and methodology used in the projections.</li> </ul> <p>Additional information may be required to facilitate evaluation of state estimates and calculation of pass-through amounts by the Departments.</p>
6	<p><b>45 CFR 155.1308(f)(4)(iv)</b></p> <p>Draft timeline for implementation of the proposed waiver</p>	<p>Include a timeline and discussion of implementation of the waiver plan. <i>If applicable</i>, include an explanation as to how the state will provide the federal government with all information necessary to administer the waiver at the federal level.</p> <p>If a <i>high-risk pool/state-operated reinsurance program Section 1332 waiver</i>, <u>include</u>:</p> <ol style="list-style-type: none"> <li>1. How the state will implement a reinsurance program.</li> <li>2. The data collection timing and mechanism for collecting claims information and generally for pay-out.</li> <li>3. Whether the state is using conditions-based list for reinsurance and/or an attachment point model.</li> <li>4. Whether the reinsurance program includes incentives for providers, enrollees, and plan issuers to continue managing health care cost and utilization for individuals eligible for the described reinsurance (if any).</li> </ol>

		<ol style="list-style-type: none"> <li>5. Whether the state is specifying a co-insurance amount, or a cap, based on available funds, similar to the federal program.</li> <li>6. Any legislation and/or regulations related to the state reinsurance program.</li> </ol>
7	<p><b>45 CFR 155.1308(f)(4)(v)(A)(B)(C)(D) and (E)</b></p> <p>Additional Information</p>	<p>Additional Information that is pertinent to your waiver plan. This may include:</p> <ol style="list-style-type: none"> <li>1) Explanation of whether the waiver increases or decreases the administrative burden on individuals, insurers, or employers.</li> <li>2) Explanation of whether the waiver will affect the implementation of ACA provisions which are not being waived. <ul style="list-style-type: none"> <li>Note: The state should identify if any section of the ACA would be adversely affected by the proposed waiver.</li> </ul> </li> <li>3) Explanation of how the waiver will affect residents who need to obtain health care services out of the state. <ul style="list-style-type: none"> <li>Please include whether the state health plans provide for coverage out of state.</li> </ul> </li> <li>4) If applicable, an explanation as to how the state will provide the Federal government with all information necessary to administer the waiver at the Federal level.</li> <li>5) Explanation of how the state’s proposal will address potential compliance, waste, fraud, and abuse.</li> </ol>
8	<p><b>45 CFR 155.1308(f)(4)(vi)</b></p> <p>State’s suggested reporting targets for the four statutory requirements</p>	<p>States must propose a plan for quarterly and/or annual reporting of data to demonstrate that the waiver remains in compliance with the scope of coverage, affordability, comprehensiveness and deficit requirements. For example, a state might meet this requirement by proposing to continue to report the same data used to support the application findings as required under <b>45 CFR 155.1308(f)(4)</b>.</p> <p>For comprehensiveness, if there is no change to the provision of the ten Essential Health Benefits (EHB) identified in the benchmark plan, the state can indicate that it will report on any modifications from federal or state law on an annual basis.</p> <p>For a <i>high-risk pool/state-operated reinsurance program Section 1332 waiver</i>, the state must provide each year the actual Second Lowest Cost Silver Plan premium under the waiver and an estimate of the premium as it would have been without the waiver, for a</p>

		representative consumer in each rating area. Coverage and affordability metrics may be also reported on an annual basis.
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**Appendix C: Alaska 1332 Waiver Request Summary**

## **Alaska: State Innovation Waiver under section 1332 of the PPACA**

*July 11, 2017*

The U.S. Department of Health and Human Services and the U.S. Department of the Treasury (the Departments) approved Alaska's application for a State Innovation Waiver under section 1332 of the Patient Protection and Affordable Care Act (PPACA) (the waiver). Alaska's application seeks to implement the Alaska Reinsurance Program (ARP) for 2018 and future years. As a result of the waiver approval, more consumers in Alaska may have coverage, consumers will see lower premiums, and the State will receive federal funds to cover a substantial portion of State costs for the ARP.

Alaska's State Innovation Waiver under section 1332 of the PPACA is approved subject to the State accepting the specific terms and conditions (STCs). This approval is effective for January 1, 2018, through December 31, 2022.

### ***Summary of Alaska's State Innovation Waiver under section 1332 of the PPACA Application***

Alaska's application for a State Innovation Waiver under section 1332 of the PPACA seeks to waive section 1312(c)(1) of the PPACA, the requirement to consider all enrollees in a market to be part of a single risk pool, to the extent it would otherwise require excluding total expected State reinsurance payments when establishing the market-wide index rate in order to implement the ARP for 2018 and future years. Specifically, the ARP is a state-operated reinsurance program which covers claims in the individual market for individuals with one or more of 33 identified high cost conditions to help stabilize premiums. The ARP is administered by the state of Alaska and the Alaska Comprehensive Health Insurance Association (ACHIA).

As a result of the waiver approval, more consumers in Alaska may have coverage, consumers will see lower premiums, and the state will receive pass-through funding to help offset a substantial portion of state costs for the state-operated reinsurance program. Alaska projects that under the ARP and 1332 waiver, premiums will be 20 percent lower in 2018 than they would be without the waiver. In addition, Alaska predicts that an average of 1,460 additional individuals will have health insurance coverage due to the lower cost of healthcare through stabilization of the individual market. These projections were certified by independent actuaries and reviewed by the Departments. Alaska is waiving section 1312(c)(1) of the PPACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate for the purposes described in the State's application.

Because the ARP will lower premiums, the second lowest cost silver plan premium is reduced, resulting in the Federal government spending less in premium tax credits. As such, the State shall receive pass-through funding based on the amount of premium tax credits (PTC) that would have been provided to individuals under section 36B of the Internal Revenue Code in the State of Alaska absent the waiver, but will not be provided under the waiver, while considering all Federal revenue. As required by Federal law, Alaska's 1332 waiver will not increase the Federal deficit.

The Departments have determined that Alaska's application for a State Innovation Waiver under section 1332 of the PPACA meets the requirements outlined in Section 1332(b)(1) of the PPACA and related [guidance](#). Specifically, the waiver is projected:

- to provide coverage at least as comprehensive as the coverage defined in section 1302(b) of PPACA;
- to provide coverage as affordable as would otherwise be provided;
- to provide coverage to at least a comparable number of Alaska residents; and
- to not increase the deficit.

***Section 1332: State Innovation Waivers***

Section 1332 of the PPACA permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance. The Departments are promoting these waivers to give states the opportunity to develop strategies that best suit their individual needs. Through innovative thinking, tailored to specific state circumstances, states can lower premiums for consumers, improve market stability, and increase consumer choice.

State Innovation Waivers allow states to implement innovative ways to provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver and provide coverage to a comparable number of residents of the state as would be covered absent a waiver, while not increasing the Federal deficit.

State Innovation Waivers are available beginning January 1, 2017. State Innovation Waivers are approved for five-year periods and can be renewed. The Departments welcome the opportunity to work with states on Section 1332 State Innovation Waivers. Read more about State Innovation Waivers [here](#). States interested in Section 1332 waivers for state-operated reinsurance programs can find a checklist to help states complete their application [here](#).

The letter to Alaska can be found here: [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section\\_1332\\_state\\_Innovation\\_Waivers-.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html).



**COLORADO**

**Department of  
Regulatory Agencies**

Division of Insurance

A Report Regarding SB17-300:

Colorado High-Risk Health Coverage Study

**Appendix D: Minnesota 1332 Waiver Request  
Summary**

# Minnesota Premium Security Plan & Section 1332 State Innovation Waiver

## What is the Minnesota Premium Security Plan?

Minnesota has enacted a new law that creates the Minnesota Premium Security Plan, a state-based reinsurance program to stabilize premiums in Minnesota's individual health insurance market in 2018 and beyond.

The new law authorizes \$271 million per year for the reinsurance program in 2018 and 2019. These funds would be used to partially reimburse insurers for especially high-cost claims. Specifically, reinsurance would cover 80 percent of an individual's annual claims costs between \$50,000 and \$250,000. As a result of this financial protection against high-cost claims, insurers would be able to reduce premiums for all consumers in Minnesota's individual health insurance market.

## How will the Minnesota Premium Security Plan affect me?

If you buy your own health insurance, the Minnesota Premium Security Plan will lower the premiums you pay. The Commerce Department projects that insurers will be able to reduce premiums in 2018 by an average of 20 percent from what they would be without reinsurance.

Aside from this impact on premiums, reinsurance will not affect the consumer health care experience – and its actual operation will be invisible to consumers, with no paperwork required.

The Minnesota Premium Security Plan will have no impact on you if you receive health insurance coverage through an employer or a public program such as Medicare, Medicaid or MinnesotaCare.

## What is a Section 1332 State Innovation Waiver?

Section 1332 of the Affordable Care Act permits a state to apply for a State Innovation Waiver to pursue innovative strategies to provide access to more affordable health insurance while retaining the basic protections of the Affordable Care Act.

The new state law calls for the Minnesota Commerce Department to submit a waiver application to the federal government for the Minnesota Premium Security Plan. If approved, the waiver would allow Minnesota to obtain federal funding for the new reinsurance program, without affecting the federal funding that helps support the MinnesotaCare public health insurance program.

The waiver application is designed to maintain access to comprehensive health insurance for Minnesotans through more affordable premiums. It does not seek to waive any of the consumer protections in the Affordable Care Act, such as coverage for essential health benefits or pre-existing conditions.

## **How would the waiver affect federal health insurance funding for Minnesota?**

Reinsurance would directly reduce the premium for the second-lowest cost silver plan in Minnesota's individual health insurance market. In turn, this would reduce the federal premium tax credits that Minnesota consumers receive and it would lower federal funding for MinnesotaCare.

With the waiver, Minnesota seeks to retain federal funding equal to the amount of the forgone assistance for premium tax credits and MinnesotaCare that would have otherwise been spent on Minnesotans without reinsurance.

## **Where can I get more information and read the draft waiver application?**

More information, including the draft waiver application and the public information meeting schedule, is available on the Minnesota Commerce Department website:

<https://mn.gov/commerce/industries/insurance/reinsurance/>

## **How can I comment on the draft waiver application?**

Comments may be submitted in writing or presented orally at a public information meeting. Written comments (which will be available for public review) will be accepted until the close of business on May 26, 2017. Please submit comments via mail or email to:

Minnesota Department of Commerce  
Attn: 1332 Waiver Draft Application  
85 7th Place East, Suite 280  
Saint Paul, MN 55101  
[WaiverComments@state.mn.us](mailto:WaiverComments@state.mn.us)



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A Report Regarding SB17-300:

Colorado High-Risk Health Coverage Study

**Appendix E: Stakeholder Organizations Participating**

## **Appendix E – Stakeholder Organizations Participating**

Aetna  
America's Health Insurance Plans  
Anthem  
Bright Health  
Chronic Care Collaborative  
CIGNA  
Colorado Association of Commerce and Industry  
Colorado Association of Health Plans  
Colorado Center for Law and Policy  
Colorado Consumer Health Initiative  
Colorado Department of Health Care Policy and Financing  
Colorado Hospital Association  
Colorado Medical Society  
Colorado Psychiatric Society  
Connect for Health Colorado  
Denver Health  
Governor's Office  
Kaiser Permanente  
Members of the General Assembly  
Milliman  
National Association of Insurance and Financial Advisors  
Oliver Wyman  
PCG  
United Health Group/Rocky Mountain Health Plans  
Wakely





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A Report Regarding SB17-300:

Colorado High-Risk Health Coverage Study

**Appendix F: Preliminary Actuarial Analysis**



**Actuarial report to the  
Colorado High-Risk Health  
Care Coverage Task Force**

**Preliminary findings**

Prepared for:  
**Colorado Division of Insurance**

Prepared by:  
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### APPENDIX A: COLORADO SILVER PLAN RATES

### APPENDIX B: CALCULATION OF ESTIMATED 2018 PASS-THROUGH FUNDING

## I. EXECUTIVE SUMMARY

The Colorado Division of Insurance (Division) has engaged Milliman to evaluate certain aspects of a claims-based reinsurance program for the individual health insurance market for the potential submission of a Section 1332 State Innovation Waiver (Section 1332 waiver). Key components of the requested analysis include:

- Reinsurance program parameters.
- Impact to premiums in the individual market.
- Estimated state-based costs and available federal funding for the reinsurance program.

This preliminary report details our initial evaluation of these aspects of the program. Our final report will use detailed claims and enrollment data from 2016, along with updated financial and other public source data if needed. *Estimates provided in this report should be considered preliminary and subject to material changes.*

Our review of the Colorado individual market shows that, despite the requirement that all transitional business be moved into the Patient Protection and Affordable Care Act (ACA) single risk pool in 2016 (which should have improved pool morbidity and helped reduce rate increases), high premium rate increases continue to plague the market. However, for consumers purchasing coverage with federal premium assistance through the Marketplace (Connect for Health Colorado), net out-of-pocket premiums experienced by the consumer have felt little impact because rate increases have been absorbed by the federal government as a result of greater levels of premium assistance being paid. This stands in contrast to consumers who are not eligible for subsidies. These unsubsidized consumers must absorb the full impact of premium rate increases. Three years of annualized increases in excess of 20% have caused some unsubsidized consumers to view health insurance as unaffordable, driving decreases in market enrollment in 2017, and likely into 2018. Individuals not eligible for subsidies in 2017 (either on- or off-Marketplace) are paying premiums nearly equal to group premiums. Yet individual buyers do not get an employer contribution, nor do they have any favorable tax treatment of the premiums they pay.

Given these dynamics, a narrow focus on the subsidized Marketplace enrollment alone could be short-sighted. To the extent the State of Colorado desires to improve the individual market risk pool, increasing unsubsidized enrollment through increased access to coverage by improving affordability should be an important policy goal and as high of a priority as increasing subsidized Marketplace enrollment. A state-funded reinsurance program can provide some amount of price relief that may improve the perceived value of insurance for a portion of the population currently forgoing coverage.

The introduction of a reinsurance program would have at least two beneficial impacts to Colorado's individual market. First, the direct infusion of funds from outside the ACA-compliant market will likely lower prices for those members who are not receiving federal premium assistance. Second, the morbidity of the individual market risk pool may improve from additional enrollment of healthy members not receiving premium assistance who may have otherwise forgone health insurance. The magnitude of both effects will be directly correlated with the funding amount included in the reinsurance program. However, a reinsurance program cannot, by itself, solve the challenges related to underlying cost of care or delivery system issues.

We modeled three state-based reinsurance scenarios for the 2018 individual market, corresponding to varying premium rate reductions. For each scenario, Figure 1 illustrates the total reinsurance fund size, estimated premium rate reduction, and the division of state-based and federal funding for the program.

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**Figure 1:  
State of Colorado  
2018 Illustrative Reinsurance Scenarios – Estimated Market Impact and Funding Requirements**

	<b>High</b>	<b>Medium</b>	<b>Low</b>
Reinsurance Fund Size (\$ millions)	\$296	\$177	\$59
Individual Market Premium Rate Reduction	-21%	-12%	-4%
Federal Pass-Through Percentage With Margin	40%	40%	40%
Federal Pass-Through Funding (\$ millions)	\$119	\$71	\$24
State-Based Revenue Requirement (\$ millions)	\$177	\$106	\$35

Based on a high-level projection for 2018 individual market enrollment, we estimate that a reinsurance fund of nearly \$300 million would achieve a 21% premium rate reduction. Federal pass-through funding under this scenario is estimated at \$119 million dollars, leaving the State of Colorado's cost at \$177 million. To the extent the size of the reinsurance program is smaller, the corresponding premium rate reduction and state-funding requirements also decrease. Relative to other states, Colorado will tend to have less of its reinsurance program's costs paid by the federal government, which is due to a lower-than-average amount of premium paid with Advanced Premium Tax Credit (APTC) dollars relative to the total ACA market.

State-based funding sources for a potential Colorado reinsurance program have yet to be determined and are heavily dependent on the magnitude of the reinsurance program, with potential sources including (in no particular order) provider assessments, carrier assessments based on commercial membership (similar to funding for the ACA's Transitional Reinsurance Program), and general revenues. If Colorado instituted a carrier assessment based on group market membership only (including self-funded coverage), for example, the charges per group market member would tend to be higher in Colorado than in many other states because Colorado has a comparatively larger than average individual market relative to its group market. A similar relationship occurs with general revenues because Colorado's individual market is a larger percentage of the state's population relative to ratios observed in other states, resulting in the per citizen assessments being larger. These relationships should be considered in Colorado's funding strategies or combinations of strategies relative to other states for a potential Section 1332 waiver.

*It should be emphasized that the funding estimates in this report could change materially in subsequent reports.* Additional analysis of Colorado-specific detailed claims and enrollment and population data will be needed to finalize reinsurance parameters, estimate costs with greater precision, and evaluate funding options more thoroughly. We specifically note that our projections of enrollment and premium rates in the individual market assume Federal funding of cost sharing reduction (CSR) subsidies continue, and the individual mandate is enforced in a manner similar to the 2014 through 2016 time period. Moreover, pending and future legislation that is being proposed by Congress could drastically affect funding available under a Section 1332 waiver. Even without the impact of proposed legislation, our report and conclusions assume that the federal government will continue payments for any pass-through funding under Section 1332 of the ACA.

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## II. INTRODUCTION

Milliman was engaged by the Division to evaluate a claims-based reinsurance program under an ACA Section 1332 waiver and to assist the Division with its application by performing the actuarial and financial modeling required for federal government approval. This report is a preliminary report based on high-level data and modeling that is Colorado-specific. It will be followed with a final report based on more detailed analysis from available historical insurer claims data, enrollment data supplied by the Division, and updated publicly available data.

The primary objectives of our preliminary report are to:

- Gain a better understanding of the history and current condition of the Colorado individual market, with breakdowns of enrollment and premium rate changes for those purchasing coverage through the state-based exchange, Connect for Health Colorado, as well as those purchasing outside of Connect for Health Colorado.
- Understand the general magnitude of potential impacts of a reinsurance program on individual premiums and the corresponding state-based and federal pass-through funding necessary to support a program.
- Examine potential state-based funding strategies for a reinsurance program.
- Briefly discuss reinsurance program impacts on risk adjustment and outline possible remedies for these impacts.

This report is part of a larger report being prepared for the legislature by the Division, pursuant to Senate Bill 17-300. The main body of the report covers other broader topics related to the overall process of designing and implementing a reinsurance program under a Section 1332 waiver. Our report will not cover any of these items except insofar as they are related to the actuarial aspects of the reinsurance program. Specifically, we will not address in any material detail:

- Various types of reinsurance models and their advantages and disadvantages.
- Details of other state reinsurance programs that have already been implemented.
- Stakeholder perspectives and comments.

Note that, throughout this document, we will refer to Advanced Premium Tax Credits as either APTCs, premium assistance, or premium subsidies. We also will refer to Connect for Health Colorado as the Marketplace.

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### III. COLORADO COMMERCIAL MARKETS OVERVIEW

As background to understanding the need and impact of a reinsurance program on Colorado's ACA-compliant individual market, we have compiled an enrollment and premium rate history by major segment of commercial business. We have provided an analysis of the number of Marketplace enrollees receiving an APTC and the associated federal spending on premium assistance.

#### Enrollment

As observed on a national level, Colorado is experiencing relative stability in employer group markets but enrollment losses in the individual market<sup>1</sup> Figure 2 illustrates these enrollment trends by insurance market. For the individual market, enrollment has been split into four separate segments:

1. On-Marketplace ACA, APTC-eligible: Consumers purchasing coverage through the marketplace and receiving an APTC. The majority of these consumers have income less than 250% of the federal poverty level (FPL), but includes a portion of consumers with income up to 400% FPL<sup>2</sup>
2. On-Marketplace ACA, Non-APTC-eligible: Consumers purchasing coverage through the marketplace and not receiving an APTC. These consumers are likely to have income approaching or above 400% FPL.
3. Off-Marketplace ACA: Consumers purchasing ACA-compliant coverage outside of the Marketplace. Premium assistance is not available outside of the Marketplace.
4. Non-ACA: Consumers with grandfathered (GF'd) or transitional coverage that is not in compliance with ACA requirements<sup>3</sup>

**Figure 2:  
State of Colorado Health Insurance Market Enrollment Changes, 2014 Through 2018  
(in thousands)**

Market Segment	2014	2015	2016	Est. 2017	Est. 2018
1. Individual <u>On-Marketplace</u> ACA	80	102	133	133	132
1.a. Individual APTC-eligible	56	65	84	86	87
1.b. Individual Non-APTC-eligible	24	37	49	47	45
2. Individual <u>Off-Marketplace</u> ACA	60	112	141	115	95
3. Individual ACA	140	214	274	248	227
4. Individual Non-ACA (transitional and GF'd)	171	105	27	24	22
5. <b>Total Individual</b>	311	319	301	272	249
6. <b>Insured Group</b>	908	906	921	935	944
7. <b>Self-Funded</b>	1,692	1,764	1,803	1,824	1,870
8. <b>Commercial Total</b>	2,911	2,989	3,025	3,031	3,063
9. <b>Commercial Total (w/o self-funded)</b>	1,219	1,226	1,223	1,208	1,193

<sup>1</sup> National Q2 individual market enrollment reported by health insurers in the NAIC Exhibit of Premium, Enrollment, and Utilization has decreased by 13% from 2015 to 2017.

<sup>2</sup> Dollar amounts associated with the 2017 federal poverty level may be found at <https://aspe.hhs.gov/poverty-guidelines>.

<sup>3</sup> See <https://www.colorado.gov/pacific/dora/Non-ACA-Health-Insurance-Plans-Phase-Out> for additional description of grandfathered and transitional plans.

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Figure 2 sources: 2014-2016 figures from Centers for Medicare and Medicaid Services (CMS) and U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) reports, census survey data, commercial medical loss ratio (MLR) filings, and National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibits. 2017 and 2018 values have been estimated based on historical trends, quarterly insurer financial data through the second quarter of 2017, and reported 2018 premium rate changes.

The following are key observations from Figure 2:

- On-Marketplace, APTC-eligible enrollment (line 1.a) is stable and projected to grow slightly from 2016 to 2018. As shown in Figure 5 below, these enrollees represent individuals and families who receive federal premium assistance that caps out-of-pocket premium expenditures for the second-lowest-cost silver plan offered through the Marketplace. These consumers are generally not impacted by premium rate changes, due to the ACA premium subsidy structure capping the maximum they pay for coverage at a specified percentage of their incomes, which for the majority of enrollees is well below ACA premium rates<sup>4</sup> Further discussion of premium subsidy calculation is provided in Section IV of this report.
- ACA-compliant enrollment outside the Marketplace (line 2) is estimated to decrease from 141,000 to 95,000 persons between 2016 and 2018, an approximately 33% decrease. As a result of average annual premium rate increases in 2017 and 2018 exceeding 20%<sup>5</sup> in the individual market, we believe a material number of consumers not qualifying for APTCs may view premium rates as unaffordable and elect to forgo insurance coverage. Some of this estimated enrollment loss may also be driven by expanding enrollment, as a result of job growth, in the employer group segments (lines 6 and 7).
- Finally, by contrast, the insured group and self-funded categories (lines 6 and 7) have seen and are projected to see increases in enrollment that is due to job growth in Colorado coupled with a stable insurance market environment. As nonfarm employment has increased by more than 200,000 from July 2014 through July 2017<sup>6</sup> it is assumed this has driven a corresponding growth in the number of persons with access to employer-sponsored insurance.

It is important to note that the portion of the ACA-compliant market that purchases coverage off of the Marketplace and is therefore unsubsidized (as well as unsubsidized enrollees purchasing coverage on the Marketplace) is critical to the *long-term* health of the overall ACA individual market. For ACA-compliant enrollment segments, the percentage of insured individuals not receiving an APTC is estimated to be more than 60% in 2018. Continued enrollment deterioration among consumers not receiving premium assistance will put upward pressure on ACA gross premium rates (that is, premium rates before the application of the APTC), as healthier consumers, on average, are assumed to be less likely to maintain coverage relative to consumers with greater healthcare needs. This phenomenon, known by the term "adverse selection," likely also occurs among APTC-eligible Marketplace enrollees. However, due to the APTC capping out-of-pocket premium cost, the degree of adverse selection in the future is less likely to vary on

*It is important to note that the significant portion of the ACA-compliant market that does not receive premium assistance is critical to the long-term health of the ACA market.*

<sup>4</sup> Note, APTC consumers may need to switch plans or insurers, as the subsidy benchmark plan can vary from year to year.

<sup>5</sup> Information about 2018 premiums may be found at <https://www.colorado.gov/pacific/take5dora/news/division-insurance-approves-health-insurance-premiums-2018>. Information about 2017 premiums is available at <https://drive.google.com/file/d/0BwguXutc4vbpcnl6Qk9LSzJza0U/view>.

<sup>6</sup> U.S. Bureau of Labor Statistics. State and Area Employment, Hours, and Earnings: Colorado. Retrieved September 26, 2017, from [https://data.bls.gov/timeseries/SMS0800000000000001?amp%253bdata\\_tool=XGtable&output\\_view=data&include\\_graphs=true](https://data.bls.gov/timeseries/SMS0800000000000001?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true).

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a year-to-year basis (as observed by our estimate of steady APTC-eligible enrollment in the Marketplace from 2016 to 2018).

Premium rates and premium PMPM trends

Figure 3 shows historical and projected premium rates (for 2017 and 2018) by the same market segments as illustrated in Figure 2 above. Premium rates are shown on a per member per month (PMPM) basis. Additionally, the monthly value of APTC assistance is shown for Marketplace enrollees qualifying for premium assistance. Figure 3 illustrates the annual trend rates for the premium PMPM and APTC values. Premium PMPM values and corresponding trend rates shown in Figure 3 are affected by premium rate changes for a given plan, as well as the mix of insured lives by metallic level, insurer, geographical area and age, and regulatory changes.

<b>Figure 3: State of Colorado Health Insurance Market PMPM Premium Changes, 2014 Through 2018</b>					
<b>Market Segment</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>Est. 2017</b>	<b>Est. 2018</b>
1. Individual On APTC-Eligible, Gross	\$400	\$391	\$441	\$502	\$607
1.a less APTC Premium Subsidy	<u>\$272</u>	<u>\$234</u>	<u>\$307</u>	<u>\$369</u>	<u>\$470</u>
1.b Individual On APTC-Eligible, Net	\$128	\$157	\$134	\$133	\$137
2. Individual Off and On Non-APTC-Eligible	\$316	\$304	\$335	\$389	\$471
3. Individual ACA-Compliant	\$350	\$330	\$368	\$428	\$523
4. Individual Non-ACA-Compliant	\$252	\$267	\$271	\$282	\$293
<b>5. Total Individual</b>	<b>\$296</b>	<b>\$309</b>	<b>\$359</b>	<b>\$415</b>	<b>\$503</b>
<b>6. Insured Group</b>	<b>\$423</b>	<b>\$439</b>	<b>\$437</b>	<b>\$448</b>	<b>\$466</b>
<b>7. Self-Funded</b>	<b>\$431</b>	<b>\$446</b>	<b>\$450</b>	<b>\$460</b>	<b>\$479</b>
<b>8. Commercial Total</b>	<b>\$414</b>	<b>\$430</b>	<b>\$437</b>	<b>\$453</b>	<b>\$471</b>
<b>9. Commercial Total (w/o self-funded)</b>	<b>\$371</b>	<b>\$383</b>	<b>\$418</b>	<b>\$441</b>	<b>\$489</b>

Notes:

1. Line 4 includes grandfathered and transitional plans in 2014 and 2015. For 2016 and forward it includes only grandfathered coverage.
2. Values rounded to the nearest dollar.
3. Sources identical to Figure 2 above.
4. The 2018 premium estimates assume a portion of consumers will shift to less expensive plans, resulting in an average premium rate change less than the approved average for the market.

Important conclusions from Figure 3 include:

- Average premium rates, including silver plans, decreased from 2014 to 2015. This resulted in lower average monthly APTC payments for APTC eligible enrollees and higher net premiums relative to 2014.
- For individuals receiving APTC, the federal government’s average monthly APTC amount has increased from \$272 in 2014 to an estimated \$470 in 2018. This has resulted in net premium rates for APTC-eligible enrollees increasing very little between the two years.
- For consumers not receiving federal premium assistance (line 2), the average premium PMPM is significantly lower relative to the APTC enrollees gross premium (line 1). While we are in the process of collecting detailed enrollment data from insurers, this is likely due to demographic differences between nonsubsidized and subsidized enrollees as well as nonsubsidized enrollees purchasing a

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higher proportion of bronze-level plans relative to subsidized consumers. For APTC enrollees with income below 250% FPL, there is a very high prevalence of silver-level coverage purchased, which is due to the availability of cost-sharing reduction (CSR) subsidies.

- Total ACA-compliant premiums (line 3) are expected to exceed insured group premiums (line 6) on average in 2018. Premium rates for individuals not receiving federal subsidies (line 2) are estimated to be very near average group premiums (line 6). While individual market enrollees are estimated to have leaner health insurance coverage relative to employer-sponsored plans, consumers in the individual market are likely to be older, have lower incomes, and have greater healthcare needs.
- The 2018 estimated APTC per enrollee (line 1.a) is equal to the *entire premium paid by an unsubsidized enrollee* (line 2) in the ACA-compliant market.

Trend rates illustrated in Figure 4 document the relative stability of premium rates in the group markets (line 6 and line 7), with average annual per capita premium rate changes estimated at 0% to 4% from 2014 to 2018. For group plans, plan design changes may be made on an annual basis to limit premium growth. Conversely, while premium rates in the ACA-compliant market decreased from 2014 to 2015<sup>7</sup> significant premium rate increases have occurred in the remaining three years, with the largest increase estimated to be in 2018.

<b>Figure 4: State of Colorado Health Insurance Market PMPM Premium Changes,* 2014 Through 2018</b>				
<b>Market Segment</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
1. Individual On APTC-Eligible, Gross	-2%	13%	14%	21%
1.a. APTC Premium Subsidy**	-14%	31%	20%	27%
1.b. Individual On APTC-Eligible, Net	23%	-15%	-1%	3%
2. Individual Off and On Non-APTC-Eligible	-4%	10%	16%	21%
3. Individual ACA-Compliant	-5%	11%	16%	22%
4. Individual Non-ACA-Compliant	6%	2%	4%	4%
<b>5. Total Individual</b>	<b>5%</b>	<b>16%</b>	<b>16%</b>	<b>21%</b>
<b>6. Insured Group</b>	<b>4%</b>	<b>0%</b>	<b>2%</b>	<b>4%</b>
<b>7. Self-Funded</b>	<b>4%</b>	<b>1%</b>	<b>2%</b>	<b>4%</b>
<b>8. Commercial Subtotal</b>	<b>4%</b>	<b>2%</b>	<b>4%</b>	<b>4%</b>
<b>Commercial Total (w/o self-funded)</b>	<b>3%</b>	<b>9%</b>	<b>5%</b>	<b>11%</b>

\* Percentage changes include mix effects such as plan, age, and rating area.

\*\* APTC is directly correlated with silver plan rate changes.

Sources identical to Figure 2 above.

Rate increases for the average silver plan, by region, are shown in Appendix A. The values in Appendix A are comparing similar benefit levels for the same age and therefore give an apples-to-apples comparison. After a decrease in rates in 2015, Colorado’s Marketplace has experienced annualized premium increases between 20% and 30%, depending on the region of the state. Moreover, the cumulative increases in most regions are approximately 100% (i.e., rates have doubled).

<sup>7</sup> Insurers had very limited ACA-compliant experience available to develop 2015 premium rates.

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### Aggregate premiums, premium equivalents and federal APTC revenue

Figure 5 shows the growth in premium volume (the product of enrollment and monthly premium rates) by segment, including the percentage of ACA market premium being paid by the federal government through APTCs to subsidy-eligible enrollees (line 2). The amount of APTCs paid as a percentage of estimated ACA premium has grown in the last three years, which is due to the large rate increases in 2016, 2017, and 2018. Note that this percentage is highly correlated with the share of a state-based reinsurance program's funding that Colorado would receive via federal pass-through funding. Further discussion of the pass-through calculation is provided later in this report.

As seen in both the Figure 2 enrollment numbers above and the Figure 5 premium volume numbers below, the self-funded employer group market is approximately two-thirds of the total employer group market and approximately 60% of the total commercial market. To our knowledge, this is not significantly different from other states. However, the large share of self-funded enrollment does have implications for the funding of the reinsurance program should an employer group charge (either on a PMPM or percentage-of-claims basis) be put into effect. In particular, the PMPM charge or percentage-of-claims charge would have to be significantly higher if self-funded groups were not included.

<b>Figure 5:</b>					
<b>State of Colorado Aggregate Premium Changes 2014 Through 2018 (\$ millions)</b>					
<b>Market Segment</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>Est. 2017</b>	<b>Est. 2018</b>
1. (a) Individual ACA-Compliant	\$588	\$850	\$1,212	\$1,275	\$1,426
2. (b) Pct. of Premium Paid by Fed. Gov.	31%	22%	26%	30%	34%
3. (c)=(a)*(b) Individual APTC Assistance	\$184	\$183	\$311	\$380	\$492
4. Individual Non-ACA-Compliant	\$516	\$337	\$87	\$82	\$76
<b>5. Total Individual</b>	<b>\$1,105</b>	<b>\$1,187</b>	<b>\$1,300</b>	<b>\$1,357</b>	<b>\$1,502</b>
<b>6. Insured Group</b>	<b>\$4,609</b>	<b>\$4,780</b>	<b>\$4,834</b>	<b>\$5,027</b>	<b>\$5,281</b>
<b>7. Self-Funded</b>	<b>\$8,751</b>	<b>\$9,453</b>	<b>\$9,725</b>	<b>\$10,080</b>	<b>\$10,746</b>
<b>8. Commercial Subtotal</b>	<b>\$14,465</b>	<b>\$15,420</b>	<b>\$15,859</b>	<b>\$16,464</b>	<b>\$17,529</b>
<b>9. Commercial Total (w/o self-funded)</b>	<b>\$5,714</b>	<b>\$5,967</b>	<b>\$6,134</b>	<b>\$6,384</b>	<b>\$6,783</b>

### Market overview conclusion

While fully insured and self-funded group markets have seen enrollment increases and relative stability in premium rates, the individual market has shown much greater instability. Enrollment by APTC-eligible consumers appears stable, but there is significant concern for the perceived affordability of individual market coverage for the nonsubsidized population. For these consumers, the premium rate increases must be fully paid with after-tax income or wages. As observed in other state insurance markets, a material portion of consumers purchasing coverage in the individual market may view current or 2018 rates as unaffordable, resulting in additional uninsured persons and greater adverse selection in the risk pool.

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## IV. ACA SECTION 1332 WAIVERS: ACTUARIAL PERSPECTIVES

Section 1332 of the ACA permits the Secretary of Health and Human Services and the Secretary of the Treasury to approve a state's proposal to waive specific provisions of the ACA (known as a "State Innovation Waiver"), provided that the waiver proposal meets the following criteria, known as the "four guardrails"<sup>8</sup>

1. Health insurance coverage (coverage): The waiver would provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver.
2. Health insurance affordability (affordability): The waiver would provide coverage as affordable as would be provided absent the waiver.
3. Health insurance comprehensiveness (comprehensiveness): The waiver would provide coverage that is at least as comprehensive as would be provided absent the waiver.
4. Deficit neutrality: The waiver would not increase the federal deficit.

To the extent the State of Colorado pursues a Section 1332 waiver application, these measures will be evaluated by an actuarial and economic analysis of Colorado's health insurance markets under the waiver and in the absence of the waiver. The measures are not evaluated relative to a baseline year or historical period. For example, premium rates under a waiver may still be projected to increase on an annual basis. However, the measurement of premium affordability under the waiver is based on costs in absence of the waiver in the same year. To the extent premium rates were estimated to increase by 10% in absence of the waiver, but only by 5% under the waiver, the waiver would be deemed as meeting the affordability standard.

Under a state-run reinsurance program, it is likely that Colorado could develop a waiver that would meet the guardrails for coverage, affordability, or comprehensiveness. However, for policy makers, it is important to understand how certain consumer segments of Colorado's individual market may see very little impact from a state-run reinsurance program, whereas other segments may have more direct benefits. Additionally, having a firm comprehension of the federal pass-through calculation under a Section 1332 waiver is necessary to properly evaluate state-based funding requirements. The following are key considerations for each of the four guardrails.

*For policymakers, it is important to understand how the subsidized consumer segment of Colorado's individual market may see very little impact from a state-run reinsurance program.*

### Coverage

The number of consumers purchasing coverage in the individual market is largely a function of premium cost. In general, premium rate increases result in coverage losses, while premium decreases result in coverage gains. However, under the ACA, the impact of premium rate increases is more varied as a result of available federal premium assistance in the Marketplace for qualifying consumers with incomes up to 400% FPL.

As discussed in the previous section, consumers qualifying for federal premium assistance will have their costs capped at a specified percentage of household income and be largely insulated from premium rate increases, as the federal government absorbs premium rate increases through higher APTCs. APTC value is tied to the cost of the second-lowest-cost silver plan, also known as the "subsidy benchmark plan." For example, if the premium assistance structure caps a consumer's cost for the subsidy benchmark plan at \$50 per month, the consumer's premium will not vary from \$50 regardless if the gross premium rate is \$200, \$500, or \$1,000 per month. However, the value of the monthly APTC will vary from \$150 (\$200 - \$50), \$450 (\$500 - \$50), or \$950

<sup>8</sup> Full details of the regulation may be found at <https://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf>.

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(\$1,000 - \$50). This is also demonstrated in the historical changes in APTC and net consumer premium as illustrated in Figure 3 above.

For consumers not qualifying for an APTC, the consumer must either fully absorb the premium rate increase, purchase a less expensive health insurance plan, or forgo health insurance coverage. As evident by enrollment changes outside the insurance marketplace (refer to Figure 2 in Section III above), these consumers are estimated to be the most adversely impacted by Colorado's individual health insurance market premium rate increases since 2016.

To the extent that the Section 1332 waiver is limited to a state-run reinsurance program, the waiver proposal does not modify the structure of the ACA's federal premium assistance available for qualifying consumers through the insurance marketplaces. Assuming the reinsurance program is successful in decreasing insurers' premium rates, the consumers receiving the most benefit will be those *not qualifying for federal premium assistance*. Consumers qualifying for an APTC are unlikely to see changes in the cost of the subsidy benchmark plan (unless the premium rate decreases below the maximum required under the ACA).

*For those not qualifying for an APTC, premium rate increases must absorb the full increase, purchase a cheaper plan or forgo coverage.*

The most significant gains in health insurance coverage under a state-run reinsurance model are anticipated to be attributable to consumers not qualifying for premium assistance. The majority of such consumers are likely to have income above 400% FPL. A portion of these consumers may be young adults with income below 400% FPL who do not qualify for an APTC because the cost of the subsidy benchmark plan does not exceed the maximum specified under the ACA. For example, the ACA may cap the subsidy benchmark plan for a young adult with income below 400% FPL at \$300 per month, but if the actual premium rate is only \$250, the individual does not receive an APTC.

For consumers qualifying for an APTC prior to the introduction of a reinsurance program and who continue to receive federal premium assistance after the program is implemented, there are unlikely to be material coverage changes driven by the introduction of the reinsurance program. For example, if the consumer's subsidy benchmark premium is capped at \$100 per month, the consumer's net premium remains at \$100 per month even if premium rates decrease by 15% as a result of the reinsurance program. Without a change in net premiums, we do not anticipate additional low-income consumers purchasing coverage in the Marketplace.

As it relates to other health insurance markets (i.e., public programs, employer-sponsored coverage), we would not anticipate material enrollment changes resulting from a state-run reinsurance program. To the extent the State of Colorado elects to fund the reinsurance program through an assessment on a segment of the commercial health insurance market, such assessments would be assumed to be passed through to the employer or individual consumer, rather than absorbed by the insurer. To the extent the amount of such an assessment reached a certain level, it may be possible that employers terminate offering coverage or individual consumers may forgo health insurance coverage. However, historical evidence indicates that large employers (50 or more employees) have continued to offer health insurance coverage at a nearly identical rate in the last decade despite significant cost increases<sup>9</sup>

### Affordability

Affordability for health insurance coverage under the Section 1332 waiver guardrails is measured by changes in both premium and cost-sharing expenses for consumers (deductibles, copays, coinsurance). By itself, a state-run reinsurance program does not change the actuarial value (the percentage of the costs paid by the insurer) of plan designs offered in the individual market. It does not change CSR plans available to low-income consumers. To the extent the reinsurance program reduces premiums, it may be possible that some

<sup>9</sup> Agency for Healthcare Research and Quality. Percent of private-sector establishments that offer health insurance by firm size and selected characteristics (Table I.A.2), year 1996-2016.

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consumers elect to purchase a richer benefit plan (e.g., a silver plan rather than a bronze plan). As cost-sharing changes under a reinsurance program are estimated to be immaterial, the Section 1332 waiver affordability measure will be focused on premium rate changes. As discussed in the prior section, *out-of-pocket* premium changes under a state reinsurance program will be limited to consumers not qualifying for federal premium assistance. Consumers qualifying for an APTC, with or without a reinsurance program in place, are unlikely to see material changes in net premiums.

### Comprehensiveness

As stated in regulations for Section 1332 waivers, comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs)<sup>10</sup> By itself, a state-run reinsurance program does not make any changes to required EHBs for insurers offering coverage in the individual and small group markets. Therefore, by default, a Section 1332 waiver for a state-run reinsurance program would meet the comprehensiveness requirement.

### Deficit neutrality

The last guardrail for Section 1332 waiver approval is deficit neutrality. Deficit neutrality is evaluated over the period of the waiver (which may not exceed five years unless renewed) and in total over the 10-year budget plan submitted by the state as part of the waiver application<sup>11</sup> To the extent a state did not request any federal funding for a reinsurance program, it would likely result in federal deficit savings, as the federal government would have reduced outlays for APTC expenditures in the state. For example, if a consumer's premium for the subsidy benchmark plan was capped at \$100, and the monthly premium was reduced from \$500 to \$450 by a state-based reinsurance program, the federal government would realize \$50 in monthly savings from the reinsurance program (as the APTC, the difference between the consumer net premium and total premium, was reduced from \$400 to \$350).

Rather than a reinsurance program only accruing savings to the federal government, a state may receive federal pass-through funding based on the difference between federal marketplace expenditures with and without the waiver. Under a state-based reinsurance program, the most significant change will be APTC expenditures. For consumers qualifying for an APTC, who do not realize net premium changes from the reinsurance program, these savings are accrued by the federal government. However, available federal pass-through funding under Section 1332 of the ACA provides a mechanism to return these savings to a state implementing a waiver.

At a high level, discounting other offsets, the amount of pass-through funding under a reinsurance program waiver will be the difference in aggregate APTC expenditures with and without the waiver. As discussed further in Section VI of this report, the proportion of funding for a state-based reinsurance program derived from federal pass-through funding is highly dependent on the proportion of individual market enrollees receiving an APTC. For example, if 100% of individual market enrollees received an APTC and did not experience any change in net premium resulting from the reinsurance program, the reinsurance program may be nearly fully funded by the federal government. Conversely, if 0% of the individual market were APTC enrollees, no federal pass-through funding would be available.

Figure 6 provides an illustrative example of how a reinsurance program impacts consumers differently based on qualification for premium assistance, as well as the corresponding change in the federal government's APTC expenditures (which becomes pass-through funding under a Section 1332 waiver).

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<sup>10</sup> Federal Register (December 16, 2015). Waivers for State Innovation. Retrieved September 26, 2017, from <https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>.

<sup>11</sup> Waivers for State Innovation, *ibid*.

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**Figure 6:  
Illustrative Example of Reinsurance Program Pass-Through Funding: Impact by Level of Subsidy**

Household	Pre-Reinsurance Program Implementation			Post-Reinsurance Program Implementation			Consumer Premium Savings	Federal Pass-Through Amount
	Full Premium	Premium Subsidy	Net Premium	Full Premium	Premium Subsidy	Net Premium		
A	\$500	\$300	\$200	\$450	\$250	\$200	\$0	\$50
B	\$500	\$25	\$475	\$450	\$0	\$450	\$25	\$25
C	\$500	\$0	\$500	\$450	\$0	\$450	\$50	\$0

Household A. Consumers qualifying for federal premium assistance with greater value than the premium reduction resulting from a reinsurance program are unlikely to see a reduction in net premium cost (federal government retains 100% of premium savings).

Household B. For consumers qualifying for limited premium assistance, such as Household B, premium savings will be shared by the consumers and the federal government. Household B does not qualify for premium assistance under the reinsurance program, but experiences a \$25 reduction in monthly net premiums (federal government retains 50% of premium savings in this example).

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

As documented in the prior section of this report, we estimate more than 60% of consumers purchasing ACA-compliant coverage in 2018 will not receive premium assistance. As shown in Figure 6, these "Household C"-type consumers will directly benefit from a state-based reinsurance program, with the federal government not realizing any savings.

In addition to changes in APTC expenditures, the pass-through calculation, as noted in the Section 1332 Waiver Checklist released by the Centers for Medicare and Medicaid Services (CMS), also considers changes in federal exchange user fees (not applicable to Colorado as it has a state-based exchange), shared responsibility payments (individual mandate penalties), and federal revenue related to the health insurer provider fee<sup>12</sup> To the extent that the reinsurance program results in additional consumers having health insurance, it may reduce federal revenue from shared responsibility payments. However, this projection should also consider that the reinsurance program may change the number of individuals who are exempted from the individual mandate as a result of having unaffordable coverage. The net change in federal expenditures for these additional items is included with the aggregate federal APTC savings in the final determination of pass-through funding.

An important distinction in the federal pass-through calculation is that the actual Section 1332 waiver application only serves as an *estimate* of federal pass-through funding received. As stated in Alaska's Section 1332 waiver approval letter, a state must provide on an annual basis the following information to support the final pass-through funding calculation:<sup>13</sup>

<sup>12</sup> CMS. Checklist for Section 1332 Waivers, item 5. Retrieved September 26, 2017, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf>.

<sup>13</sup> HHS (July 7, 2017). Section 1332 Waiver Approval Letter, Alaska, p. 5, item 14. Retrieved September 26, 2017, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter.pdf>.

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- For a representative age (e.g., 21 years old), the subsidy benchmark nontobacco premium in each rating area under the waiver.
- An estimated premium for the same plan in absence of the waiver.
- Documentation of assumptions and methodologies to determine the premium in absence of the waiver.

*By itself, a reinsurance program does not change the underlying cost of healthcare. Rather, it subsidizes the cost of individual health insurance market coverage.*

#### Long-term impact of reinsurance program

In addition to the four guardrails, it is also important to consider the long-term impact of a state-based reinsurance program. Insurer premiums under a reinsurance program are likely to remain lower relative to without the waiver through two means:

1. *The direct impact of the reinsurance program subsidy provided to the individual market.* The reinsurance program will reduce the amount of insurer-paid claims in the market, which should result in lower premium rates offered by insurers.
2. *Improvement in individual market risk pool morbidity.* As a secondary impact, the reinsurance program may improve the overall individual market risk pool morbidity by resulting in a healthier mix of individuals enrolling in coverage. The magnitude of this impact is directly correlated with the size of the premium rate change generated by the reinsurance program. A reinsurance program that only has a minimal impact on premium rates will be unlikely to materially change enrollment. The potential for risk pool morbidity improvement is also dampened by stagnant enrollment changes occurring among low-income consumers (as net premium rates are not impacted by the reinsurance program).

By itself, a reinsurance program does not change the underlying cost of healthcare. Rather, it subsidizes the cost of individual health insurance market coverage. A state introducing a reinsurance program will have to consider how the size of the reinsurance program changes with healthcare inflation. To the extent the fund size was kept static, it is likely to have a diminished effect over time as a result of healthcare inflation. Conversely, if the fund size grows, a state may need to evaluate changes in state-based assessments or funding to generate the necessary funding for the program.

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## V. STARTING POINTS: ACA TRANSITIONAL REINSURANCE 2014-2016

The federal Transitional Reinsurance Program (TRP) provided reinsurance payments to individual ACA plans for the 2014 through 2016 coverage periods. The program paid a portion (coinsurance) of a high-dollar claim between a threshold (attachment point) and \$250,000 (cap). The attachment point and coinsurance varied each year, with the federal government adjusting the parameters to target estimated insurer payments equal to planned annual funding levels.

Reinsurance payments were funded through a fixed PMPM contribution required from all individual and small group plans, whether ACA, grandfathered, or transitional, as well as self-funded and fully insured large group plans<sup>14</sup> Figure 7 provides the parameters for the TRP during the three-year period.

<b>Figure 7:</b>			
<b>2014 Through 2016 Federal Transitional Reinsurance Program Parameters</b>			
<b>Reinsurance Payment Parameters:</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Attachment Point	\$45,000	\$45,000	\$90,000
Coinsurance	100%	55%	53%
Cap	\$250,000	\$250,000	\$250,000
Maximum Payments per Claim	\$205,000	\$112,750	\$84,800
Contribution Amount PMPM	\$5.25	\$3.67	\$2.25

The Division requested that we model a parameter-based reinsurance program (identical in nature to the TRP). Therefore, we have used the TRP experience in Colorado as a starting point to estimate impacts from a potential state-based reinsurance program. Figure 8 provides the 2014 to 2016 Colorado-specific TRP experience, as reported by the federal government.

<b>Figure 8:</b>			
<b>2014 Through 2016 Federal Transitional Reinsurance Program Payments in Colorado</b>			
	<b>2014</b>	<b>2015</b>	<b>2016</b>
Individual ACA Member Months	1,682,886	2,571,524	3,298,546
Individual ACA Claims (\$ millions)	\$720.1	\$1,089.6	\$1,271.1
Individual ACA Claims PMPM	\$427.89	\$423.72	\$385.35
Reinsurance Receipts (\$ millions)	\$157.6	\$132.3	\$77.2
Reinsurance Receipts PMPM	\$93.67	\$51.44	\$23.39
Reinsurance as a % of Claims	21.9%	12.1%	6.1%

*Note: Member adjustments as reported by the federal government have been adjusted by a 1% factor to reflect unbillable member months.*

We developed individual ACA claims estimates from analyzing Statutory Supplemental Health Care Exhibit premium and enrollment data, ACA loss ratios implied by 2014 and 2015 Colorado individual ACA risk corridor payments, statewide premium PMPM amounts from risk adjustment summary reports, and 2014 through 2016 TRP payments provided by CMS. Our analysis estimated that ACA individual market insurer claims expense (gross of TRP payments) decreased slightly from 2014 to 2015, with a significant decrease from 2015 to 2016, as healthier transitional members enrolled in the ACA market.

<sup>14</sup> Certain self-funded plans were exempted from making contributions in 2015 and 2016. For more information, see the webinar at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/Module-1-Transitional-Reinsurance-Program-Contributions-Overview-for-2015-Benefit-Year.pdf>.

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There are a number of differences between the claims costs underlying Colorado's 2014 through 2016 TRP experience, and later projected reinsurance costs for 2019 and beyond, including:

- Charge levels and trend
- Morbidity and demographics
- Carrier mix and member movement
- Metallic level mix

The following paragraphs provide a discussion of each of these items and potential impacts for future costs associated with a reinsurance program.

#### Charge levels and trends

Healthcare costs are directly correlated to healthcare providers' billed charges and carrier discounts off those billed charges. Provider-billed charges, whether on a fee-for-service basis, a capitated amount, or some variation thereof, typically increase each year. Prescription drug costs also change over time, generally at a higher trend than medical costs. Prescription drug costs increase for new specialty and brand drugs, may decrease for brand drugs coming off patent (thus becoming available as cheaper generic drugs), and change with brand/generic mixes and increased pharmacy rebates.

In addition, narrow networks have become more prevalent in the ACA market. Carriers may limit their network in order to:

- Funnel members to fewer providers in hopes of getting improved discounts.
- Remove higher-cost providers from their networks.
- Limit networks to providers with whom they have better working relationships.
- Perhaps to be less attractive to enrollees who are high utilizers of care.

Carriers adjusting network breadth over time (either narrowing or widening) will result in different claims costs from year to year.

Finally, new technologies, in the form of procedures and equipment, can also increase costs by generating additional utilization of healthcare services.

#### Morbidity and demographics

The health status of the ACA single risk pool is a key factor in determining the impact of a reinsurance program, as a less healthy population will have more frequent large-dollar claims. It has been generally assumed that the size of the ACA single risk pool is a good indicator of the risk pool's morbidity. Early enrollees into the ACA were likely the unhealthiest. As the risk pool has grown, it is assumed that new enrollees were healthier. In 2016, Colorado moved transitional plan members into the ACA single risk pool, which likely improved the ACA single risk pool morbidity. However, with declining enrollment among non-APTC enrollees, it is possible the risk pool will deteriorate between 2016 and 2018.

#### Carrier mix and member movement

Carrier market share can change significantly in the ACA market as carriers enter and exit the Marketplace, or the entire market. Because carriers have different cost levels, based on their networks and provider discounts, changing carrier market share can impact costs. Carrier market share can be particularly volatile in the individual ACA market, as members go through open enrollment each year, and the structure of the ACA's premium subsidy (tied to the second-lowest-cost silver plan) can provide added incentive to switch carriers (i.e., an enrollee may have a choice that includes a plan with no premium).

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Metallic level mix

Reinsurance payments are based on the actual claims dollars incurred by an ACA enrollee that are paid by the carrier. The enrollee’s plan benefits and cost-sharing provisions will impact the carrier’s paid claims expense. The most impactful cost sharing on high-dollar claims is the maximum out-of-pocket (MOOP) amount. The highest allowable individual MOOP has increased from \$6,350 in 2014 to \$7,350 in 2018. Enrollees with high-dollar claims will typically have their cost sharing capped at the MOOP, leaving the remaining claims dollars to be the responsibility of the carrier, the amount upon which reinsurance payments are based. Platinum and gold plans typically have lower MOOPs, resulting in less member cost sharing and higher incurred claims for the carrier, and a higher reinsurance payment. Decreasing individual ACA platinum and gold membership decreases reinsurance payments.

Claims cost increases are leveraged when assessing the attachment point impact on high-dollar claims. Figure 9 demonstrates how claims trends of 10% and 20% actually result in 18% and 36% higher reinsurance costs, respectively.

<b>Figure 9: Illustrative Example of Deductible Leveraging \$90,000 Attachment Point and 100% Coinsurance</b>			
	<b>Original Claim</b>	<b>10% Higher</b>	<b>20% Higher</b>
High Claim Cost	\$200,000	\$220,000	\$240,000
Reinsurance Payments	\$110,000	\$130,000	\$150,000
% Above Original Reinsurance Claim		18%	36%

In our follow-up analysis, we will analyze the most recent Colorado-specific detailed claims experience and enrollment and population data, along with various adjustments for the factors noted above, to develop and calibrate future projected Colorado claims from Colorado historical claims experience. This calibrated projected Colorado experience will then be used to create a claims probability distribution (CPD) model to estimate costs under various reinsurance parameters.

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## VI. PRELIMINARY FUNDING CONSIDERATIONS

Funding for a state-based reinsurance program through a Section 1332 waiver will come from federal pass-through funding, but will also need a Colorado-based revenue source. In this section, we first discuss the calculation of federal pass-through funding under a Section 1332 waiver, and then key considerations for Colorado-based revenue sources.

### Federal pass-through funding

When a state implements a Section 1332 waiver that reduces federal spending related to ACA health insurance financial assistance in the Marketplace, the state is eligible to receive these savings in the form of pass-through funding from the federal government. The amount of federal pass-through funding that is available directly depends on the degree to which APTCs are funding total ACA-compliant individual market premium. APTC expenditures as a percentage of the total ACA-compliant market premium are, in turn, driven by the income distribution of individuals not qualifying for public programs or without access to employer-sponsored insurance who then buy subsidized coverage through the Marketplace.

The average income level, and the resulting level of subsidization, of these individuals can be affected by state Medicaid policy. For example, in states such as Colorado that have expanded Medicaid under the ACA, the population with household income between 100% and 138% FPL is eligible for Medicaid, rather than premium assistance in the Marketplace. However, in states that have not expanded Medicaid, the population with this level of income are eligible for premium assistance, generating significant Marketplace enrollment and APTC expenditures.

On a broader basis, a population with a higher-income distribution will result in a lower degree of individual market enrollment for APTC-eligible consumers, as well as a lower APTC per capita for qualifying consumers. Colorado's median household income is higher than the national average<sup>15</sup> which contributes to Colorado citizens receiving less per capita APTC dollars relative to other states.

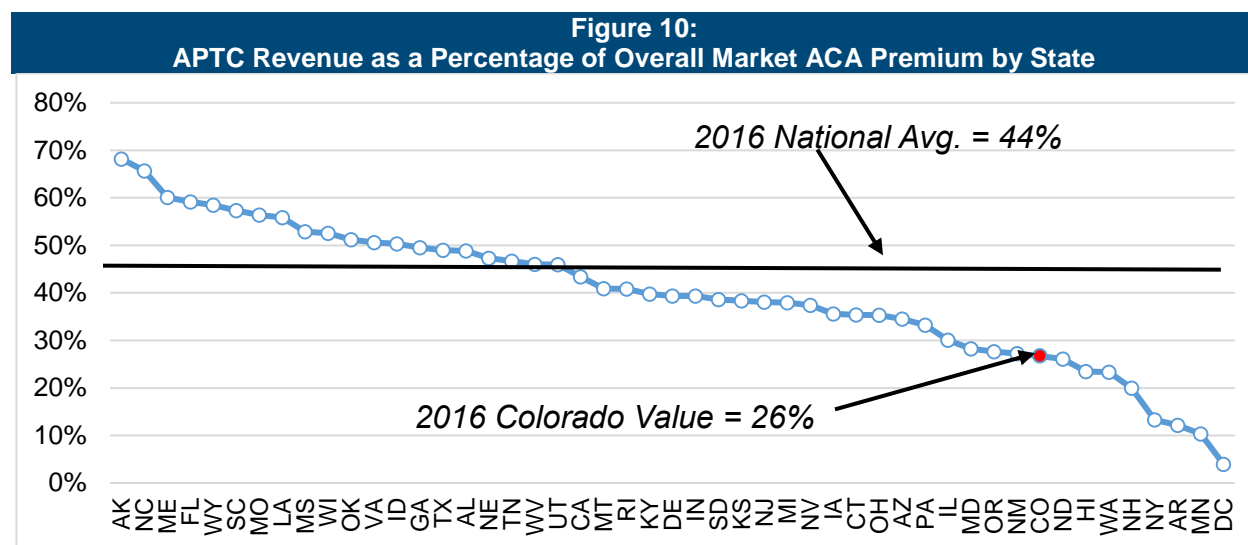
Figure 10 illustrates the calendar year 2016 state variation in APTC funding as a percentage of total individual market ACA-compliant premium revenue. Note that, with the significant premium increases that have occurred in many states in 2017 and 2018, these percentages are likely to vary significantly on both national and state levels in 2018.

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<sup>15</sup> For a discussion of household income variation by state in 2016, see <https://www.census.gov/content/dam/Census/library/publications/2017/acs/acsbr16-02.pdf>.

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As shown in Figure 10, Colorado’s 2016 APTC revenue percentage of 26% was significantly below the national average of 44%.

For state-based reinsurance programs, it is important to understand that the degree of federal pass-through funding will vary significantly by state, largely based on APTC funding as a percentage of the total ACA-compliant market premium. The degree of available federal pass-through funding for Colorado may be significantly less than other states that have applied for a Section 1332 waiver. As a result, the feasibility of certain strategies to fund a state’s share of the reinsurance program’s cost may vary on a state-specific basis. For example, Alaska’s 2016 APTC revenue percentage was 68%, much greater than the national average of 44% and more than double Colorado’s 26% value. This will tend to drive higher levels of federal funding for Alaska relative to Colorado. Accordingly, Colorado may likely have completely different strategies than Alaska for funding the state’s share of the program’s costs.

Moreover, the magnitude of pass-through funding may change over time as markets change in response to the reinsurance program itself. Somewhat paradoxically, a successful reinsurance program (as measured by lower premium rates and higher nonsubsidized enrollment) will actually drive lower APTC revenue per individual market insured life.

[General considerations for state-based funding](#)

The State of Colorado should consider the following key questions as it evaluates potential funding options for a state-based reinsurance program:

**1) To what degree should the state-based funding directly impact the individual market?**

As discussed in the prior section, the contributions to fund the ACA’s TRP applied to the ACA-compliant individual market, even though carriers offering coverage ultimately received the contributions back (as well as significantly more funding) in the form of reinsurance payments. The argument against having any funding coming from the individual market is that it is “dollar swapping,” i.e., contributions collected to fund the reinsurance program will cycle back to insurers in the form of reinsurance payments.

The argument in favor of collecting contributions from the individual market is that both the TRP and a state-based reinsurance program are not simply market subsidies, although there is a heavy emphasis on subsidization. The reinsurance structure also contains a pooling and insurance element that could be beneficial for plan offerings in the individual market in any given year. For example, if two insurers had

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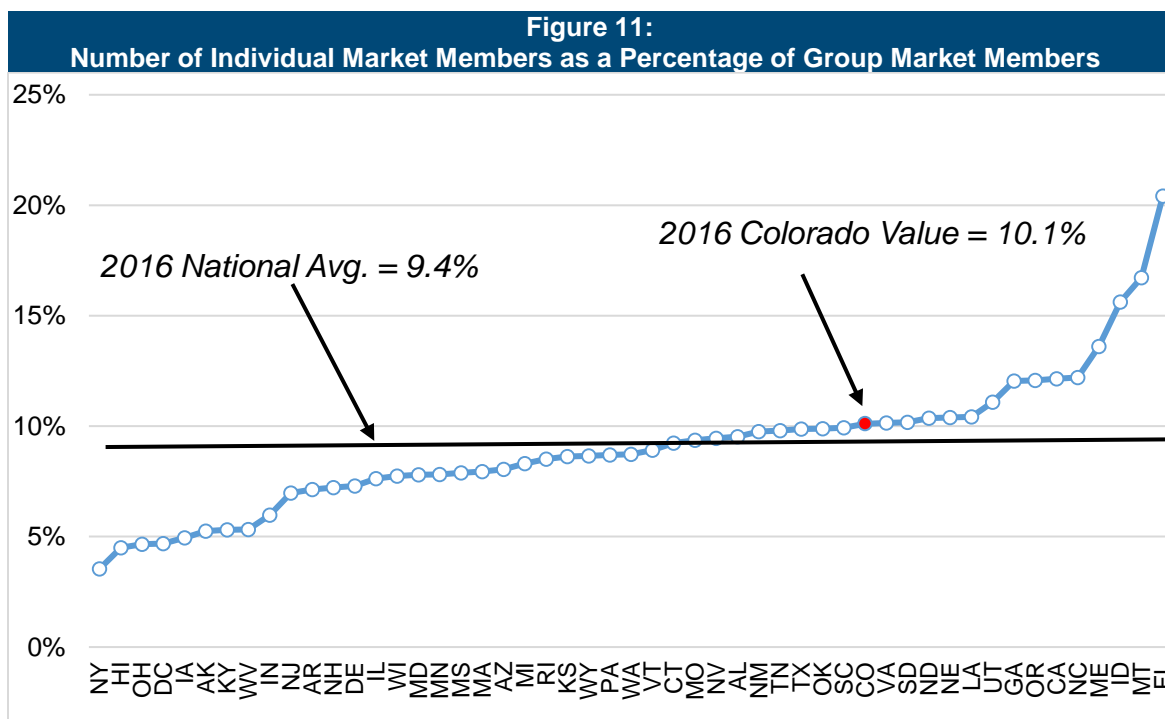
equal market share, but one insurer had a disproportionate number of high-cost individuals, then this insurer would also receive a disproportionate amount of reinsurance payments. For smaller carriers offering coverage in the individual market, a reinsurance program to some degree may limit the potential volatility of net insurer-paid claims expenses.

**2) What is the financial feasibility of imposing an assessment on the broader group insurance market?**

An assessment on the employer group market could take at least the following forms:

- PMPM charge on commercial health insurance enrollees.
- Percentage of health insurance premium, premium equivalents, or claims on commercial health insurance enrollees.

The number of ACA-compliant members in the individual market as a percentage of the group insurance market serves as a reasonable indicator of the potential feasibility of deriving state-based funding for an individual market reinsurance program from the broader commercial health insurance market. For example, if a state's group insurance market was roughly the same size as its individual market, it may be difficult to introduce an assessment to the group market to fund the nonfederal portion of the reinsurance program's cost, as the necessary per capita assessment may be viewed as a financial burden by employers and their employees. Conversely, if the group insurance market had enrollment that was 10 times greater in size than the individual market, a group assessment may not be viewed as a significant cost. As a benchmark, the TRP required a PMPM assessment ranging from \$2.25 to \$5.25 (illustrated in Figure 7 above) for nearly all group health insurance coverage. As shown in the chart in Figure 11, Colorado has a larger than average individual market relative to its group insurance market compared to other states. This means that assessments introduced to the group market to fund a state-based reinsurance program will tend to be proportionally larger on a PMPM basis than in most other states.



Note: Values based on ACA-compliant individual market member months as reported by CMS and estimated employer-sponsored coverage enrollment derived from the American Community Survey.

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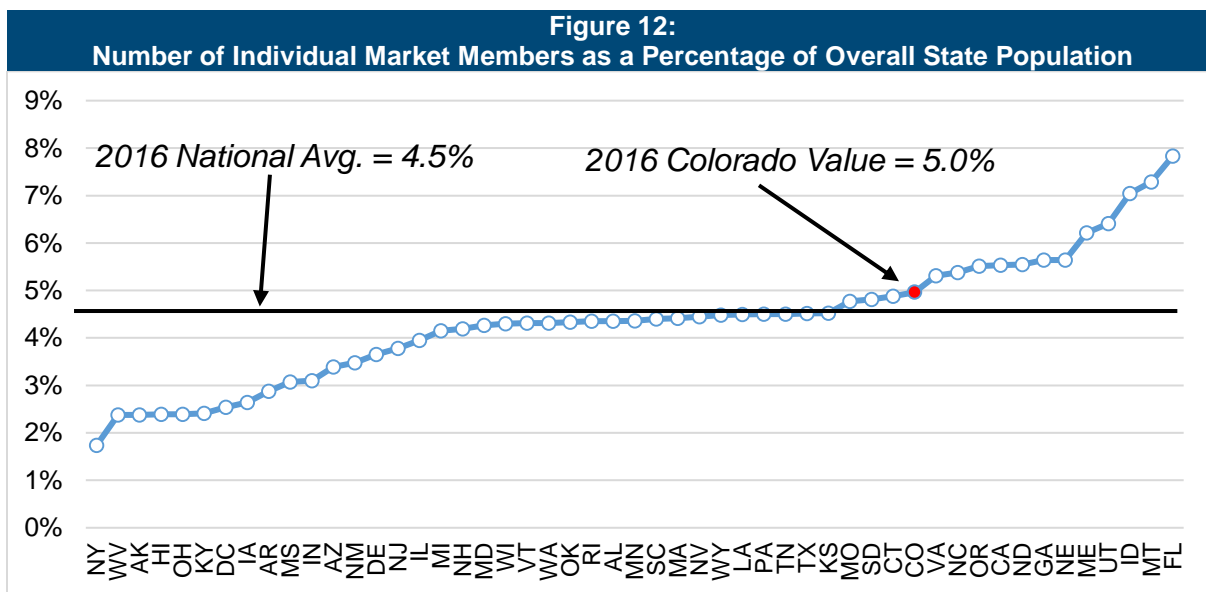
Variations on an employer group assessment include assessing the individual market and varying degrees of assessments of self-funded group markets and stop-loss markets. The merits of including the individual market in the assessment base has already been discussed above.

To the extent an assessment on commercial market or group coverage is desired, it may be more administratively efficient to use a PMPM, rather than percentage of premium, premium equivalent, or claims. The State of Colorado should consider the ability to collect and audit assessment funding from the defined contributing entities.

**3) To what degree should funding come from completely outside the healthcare system itself?**

Funding that comes from completely outside of the healthcare system, such as general revenues, has the advantage of putting no additional cost pressure on a system in which cost is the primary problem. Additionally, to the extent funding came from the State of Colorado’s general revenue, funding for the reinsurance program may be viewed as more progressive, as households or corporations paying a greater amount of state income tax would be implicitly paying a greater share of the program’s cost. Conversely, a flat PMPM assessment on the commercial market would require the same amount of funding from every insured consumer, regardless of income.

The number of members in the individual insurance market as a percentage of the entire state population can serve as a simple but reasonable indicator of the potential value of general revenue funding for the State of Colorado, at least relative to other states. As shown in the chart in Figure 12, Colorado has a larger than average individual market relative to its overall state population compared to other states. This means that assessments that are proportional to the population will need to be larger in Colorado than they would need to be in most other states.



**4) Which entities will have direct and indirect benefits from a state-based reinsurance program?**

An argument can be made that commercial group markets (and employers) have a vested interest in a robust individual market. For one, employer groups often hire persons insured through the individual market prior to beginning employment. For an employer-sponsored health plan, a more robust individual market may lessen the likelihood of pent-up demand for healthcare services from new employees, who may be otherwise uninsured. In addition, a greater number of insured individuals through a healthy

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individual market will theoretically reduce uncompensated care, which in turn puts less pressure on providers to raise fees to cover this cost. For example, a Society of Actuaries analysis of Kansas individual market data found newly enrolled persons had greater use of preference-sensitive services relative to the previously insured population<sup>16</sup>. In addition, the higher provider reimbursement needed to cover uncompensated care is generally borne by the commercial markets, of which the employer group segment is the lion's share. A state-based reinsurance program for the individual market may reduce the amount of uncompensated care. This reduction in uncompensated care should result in less pressure on providers to increase reimbursement rates on commercial markets to cover the costs of uncompensated care, however, the degree to which this will actually translate into low commercial costs or lower cost trends over time is uncertain.

It should be noted that the largest reductions in the uninsured population under a state-based reinsurance program are likely to come from the population with income above 400% FPL. As this population has higher income and is likely healthier than a low-income uninsured population, the reduction in uncompensated care may not be significant.

Providers may also directly benefit from a reinsurance program. Insofar as the program is successful at increasing the number of people that are insured, providers will likely see an increase in utilization of services as well as revenue. However, consistent with an assessment on commercial health insurance, a provider assessment, such as a hospital bed tax or claims tax, would add cost *within* the healthcare system. Providers may increase reimbursement rates as a result of the assessment, which in turn raises costs for insurers and self-funded plans. This may result in higher premium or contribution requirements for employers and individual consumers.

**5) Will available funding vary significantly in either amount or timing on an annual basis?**

Provision for the funding should be appropriated by law from a source or sources with minimal variability year to year. Uncertainty in funding could translate into uncertainty in carrier pricing (i.e., higher margins) and possibly fewer carriers willing to take the risk that the program will be underfunded or not funded at all. In addition, funding for the program needs to be determined well in advance of the benefit year. To the extent funding varied significantly on an annual basis, it may also impact the effect of the reinsurance program on enrollment and premium rates in the individual market, particularly the population not qualifying for federal premium assistance.

**6) Should funding come from a single source or from a combination of sources?**

A combination approach to funding could decrease the variability of total funding and could help ease the financial burden on any one party or constituency. Combination strategies could also increase the perception that all affected parties are doing their part to fund the program.

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<sup>16</sup> Owen, R. & Maeng, D. (April 2015). Indications of Pent-up Demand, Table 2. Society of Actuaries. Retrieved September 26, 2017, from <https://www.soa.org/research-reports/2015/2015-pent-up-demand-health/>.

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## VII. REINSURANCE SCENARIOS

In order to provide the State of Colorado with an understanding of the potential premium rate impact and funding requirements of a state-based reinsurance program, we have created reinsurance scenarios with "High," "Medium," and "Low" impact, illustrated in Figure 13. These scenarios correspond to insurer-paid claims cost reductions of 25%, 15%, and 5%, respectively. Insurers' non-benefit expenses are assumed to be not impacted by the reinsurance program. The combination of claims cost reductions and constant non-benefit expenses results in estimated premium rate reductions for the three scenarios of 21%, 13%, and 4%, respectively.

In our analysis, we have estimated Colorado's pass-through funding percentage at 40% (the federal government would contribute 40% of the necessary funding for the reinsurance program). As discussed, this low percentage relative to other states is primarily driven by Colorado's non-APTC-eligible population being a significant portion of individual market enrollment. Our detailed methodology for this estimate is found in Appendix B.

Additionally, we have calculated the PMPM assessment for group coverage that will generate the necessary amount of state-based funding for each scenario. Assessment values have been calculated with and without self-funded coverage in the assessment base.

This exercise is intended to provide the State of Colorado with high-level estimates of federal pass-through funding and premium rate impacts. More in-depth analysis of a potential reinsurance program will be described in our final report.

**Figure 13:  
State of Colorado 2018 Individual Market Illustrative Reinsurance Scenarios**

	<b>High</b>	<b>Medium</b>	<b>Low</b>
ACA-Compliant Average Monthly Members (thousands)	227	227	227
Estimated 2018 Insured Paid Claims (\$ millions)	\$1,183	\$1,183	\$1,183
Total Reinsurance Funding (\$ millions)	\$296	\$177	\$59
Insurer-Paid Claims Expense Reduction Percentage	25%	15%	5%
Reinsurance Funding per ACA-Compliant Member Month	\$108.60	\$65.16	\$21.72
<b>State's Share (%) after Federal Pass-Through Funding</b>	<b>60%</b>	<b>60%</b>	<b>60%</b>
State's Share (\$ millions)	\$177	\$106	\$35
State's Share per ACA-Compliant Member Month	\$65.16	\$39.09	\$13.03
<b>Individual-to-Group Ratio (includes self-funded)</b>	<b>9%</b>	<b>9%</b>	<b>9%</b>
Group PMPM Charge If Applied to FI and Self-Funded	\$5.81	\$3.49	\$1.16
<b>Individual-to-Group Ratio (excludes self-funded)</b>	<b>29%</b>	<b>29%</b>	<b>29%</b>
Group PMPM Charge If Applied to FI Group	\$18.97	\$11.38	\$3.79

*Notes:*

1. Values are rounded.
2. FI = Fully insured small and large group insurance.

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To generate claims cost savings of 25%, 15%, and 5%, respectively, we estimate the State of Colorado will need to create a reinsurance fund (based on 2018 dollars and enrollment) with total funding amounts of \$296 million, \$177 million, and \$59 million, respectively. In establishing the size of the reinsurance fund, the State of Colorado should consider historical premium rate increases and their effect on enrollment. For example, the Division recently approved 2018 average individual market premium rate increases of nearly 27%<sup>17</sup>. Therefore, even a reinsurance fund of nearly \$300 million (and corresponding 21% premium rate decrease) is estimated to still result in individual market premiums above 2017 levels. While a reinsurance program may slow erosion of non-APTC enrollment in the State of Colorado's individual market, incremental enrollment gains relative to prior years may be more difficult to achieve.

The size and means of state-based funding is also an important consideration. We have illustrated the collection of the state-based share of the reinsurance program's cost through two funding options:

1. Funded by all group business including self-funded, resulting in a range of \$1.16 PMPM to \$5.81 PMPM.
2. Funded by all group business excluding self-funded, resulting in a range of \$3.79 PMPM to \$18.97 PMPM.

As previously stated, the self-funded employer group market is approximately two-thirds of the total employer group market. When self-funded employer groups are excluded from paying reinsurance program contributions, those contributions from other group members roughly triple. Moreover, in this scenario, if there is a subsequent migration of group sponsors from fully insured to self-funded, then the aggregate assessments will be eroded over time, thereby causing a funding shortfall for the reinsurance program.

Additional funding scenarios can be interpolated between those laid out above to account for applying the charge to stop-loss coverage. For example, assume hypothetically that approximately 50% of self-funded membership is covered by stop-loss. The corresponding assessment PMPMs for each of the high, medium, and low scenarios would be halfway between the two options proposed above.

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<sup>17</sup> DORA (September 6, 2017). Division of Insurance approves health insurance premiums for 2018. Retrieved September 26, 2017, from <https://www.colorado.gov/pacific/dora/news/division-insurance-approves-health-insurance-premiums-2018>.

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## VIII. REINSURANCE IMPACTS ON RISK ADJUSTMENT

### Risk adjustment in the commercial individual market

Under the ACA, the commercial individual market is subject to specific rules including guaranteed issue and renewal, adjusted community rating, prohibition on health status rating, and pricing across a single risk pool. These rules limit a health insurer's ability to select or price for health status risk in its enrolled populations. Risk adjustment is a permanent program intended to offset adverse selection in a market by transferring funds from health plans enrolling healthier-than-average members to those enrolling sicker-than-average members. This is intended to result in health insurers behaving more or less agnostically with respect to the relative health status of their members, instead focusing on competing over healthcare quality and outcomes. Risk adjustment is not a perfect science and requires continual refinement both methodologically and operationally to ensure market balance. CMS appears to be committed to a process that gathers stakeholder feedback on risk adjustment and regularly refines and improves the federal program based on these best practices.

However, risk adjustment does not address the challenges related to the overall high morbidity of the risk pool or the resulting steep premium rate increases filed in Colorado over the last three years. Risk pool acuity and selection against the individual market as a whole can be addressed, at least in part, within a reinsurance framework, such as the one being considered by the State of Colorado. However, the introduction of a permanent state-based reinsurance program necessitates the consideration of how that program would interact (or fail to interact) with risk adjustment.

### Tailoring risk adjustment to state-specific market conditions

Risk adjustment is designed to be paired with rules of the market. As such, when the rules of the market change, the existing risk adjustment mechanism should be reevaluated for whether or not it is still effective and compatible with the updated market rules, necessary modifications, and implementation requirements for any modifications.

The current federal risk adjustment methodology for the commercial individual market does not adjust for the presence of a reinsurance program, including during the time the Transitional Reinsurance program was in effect. The risk adjustment model assigns high risk scores to high-cost members, and the methodology will result in health plans enrolling sicker-than-average members receiving a transfer payment from the rest of the market. A reinsurance program also reimburses high-cost members. It is conceivable that health plans may get payments from both programs, resulting in plans receiving overcompensation for high-risk members.

*The current federal risk adjustment methodology does not assume the presence of a reinsurance program...it is conceivable that certain high claims will be over-reimbursed.*

In a report to the Minnesota State Legislature<sup>18</sup> we modeled several market reform scenarios, including a *state-based reinsurance program*, and the direction and magnitude of risk adjustment funds transfers. Specifically, we modeled a state-based reinsurance program with a \$90,000 attachment point, 50% coinsurance, and a cap at \$250,000. Using data from Minnesota, we found that under the given hypothetical reinsurance configuration<sup>19</sup> the federal risk adjustment model, which does not account for state-based reinsurance, would

<sup>18</sup> Minnesota Department of Health (October 2016). State-Based Risk Adjustment System Assessment and Feasibility Study. Report to the Minnesota Legislature. Retrieved September 26, 2017, from <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/raLegislativeRpt2016.pdf>.

<sup>19</sup> As noted, the reinsurance model implemented by HHS in 2014 differed from the specifications in this scenario in the following ways: The attachment point was at \$45,000 (instead of \$90,000) and the coinsurance amount was 80% (instead of 50%). The cap in the federal reinsurance program was, like the specification for this report, set to \$250,000. Parameters varied over the three years of the federal program based on differing enrollments and appropriated funds each year.

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have potentially transferred premium payments of \$13 per member per month (PMPM) for the entire individual market (\$663 per member per month for high-cost members receiving reinsurance proceeds) without an equivalent plan liability, i.e., overcompensation. This could create economic inefficiencies in both the reinsurance program and in risk adjustment. As a next step, we demonstrated how to correct the overcompensation by recalibrating a risk adjustment model to reflect the plan claims liability after reinsurance.

*The adoption of a state-based risk adjustment program may not be administratively or financially feasible for the State of Colorado.*

However, because the federal program does not support state-based variations, this recalibration of the federal risk adjustment coefficients means essentially establishing a Colorado-specific risk adjustment program, complete with data gathering, calculations, transfer formulas, and administration. This represents a significant turn in strategy and investment for the State of Colorado.

### State flexibility in risk adjustment

HHS provides states the flexibility to design their own risk adjustment methodologies tailored to market rules that may be different from those existing in the federal default. For example, in Massachusetts, the Massachusetts Health Connector implemented a federally certified state alternative methodology<sup>20</sup>, to fit its unique market conditions.

A state-based risk adjustment methodology can differ from the federal methodology in the following areas, and a state may choose to deviate from any or all of these areas:

- The risk adjustment model that calculates member-level risk scores.
- The calculation of plan average actuarial risk, which includes the member risk scores and a set of other actuarial factors such as plan actuarial value, allowable rating factor, induced demand, and geography.
- The calculation of payments and charges at the plan level.
- The data collection approach.
- The schedule for implementation.

In terms of accounting for the interaction between reinsurance and risk adjustment, model recalibration is an important consideration. Other state options are less likely to be consequential to a state-based reinsurance program.

To the extent that it pursues a state-based risk adjustment methodology, the State of Colorado may wish to engage CMS and involve the market and all stakeholders in this process to reach consensus and ensure a balanced design, while conducting actuarial modeling and stress testing the program operations. The risk adjustment methodology would be published by CMS in the federal annual Notice of Benefit and Payment Parameters (federal NBPP) in the first quarter of the year preceding the program year, and the State of Colorado would be required to publish its own state NBPP within 30 days from the official publication of the federal NBPP. In our experience, this process can take at least nine months from inception to final federal approval.

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<sup>20</sup> Massachusetts Health Connector (March 27, 2015). Massachusetts Notice of Benefit and Payment Parameters 2016. Retrieved September 26, 2017, from <https://betterhealthconnector.com/wp-content/uploads/Massachusetts-Notice-of-Benefit-and-Payment-Parameters-2016.pdf>.

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### Advantages and disadvantages of a state-based risk adjustment program

Risk adjustment methodologies are highly technical, and the program operations are complex. There are clear advantages associated with state-based risk adjustment, including:

- Without recalibration of risk-adjustment coefficients, the issue of overpayment on high claims opens up the possibility of gaming by carriers or a random concentration of overcompensation (or under-compensation) in one or more carriers. Smaller carriers may be particularly vulnerable to this.
- State-based risk adjustment would provide the state the unique opportunity to design risk adjustment to align with state market reforms while balancing key stakeholders' perspectives. To the extent that the state's market reform initiatives differ significantly from that of the federal, both in terms of market rules and implementation timelines, administering risk adjustment at the state level can provide the state with needed flexibility and the potential for improved implementation timelines.
- A state-based methodology that is calibrated using the state's own data can be more accurate and better represent the state's own population characteristics and market conditions.
- The state may be able to provide more timely insight on risks and selection for the health plans and other stakeholders by conducting interim statewide risk adjustment simulations. In our experience, these interim simulations provide valuable information for pricing, reserving, and regulatory reporting, etc., as well as serving as a check for risk adjustment data quality.

There are also significant challenges associated with adopting a state-based risk adjustment methodology:

- By adopting a state-based risk adjustment methodology, the state automatically assumes the responsibility of operating the program, which includes data collection, annual funds settlement, regulatory reporting, program integrity and oversight, and risk adjustment data validation (RADV). The cost for administering the program can be significant. Currently CMS charges a risk adjustment user fee to the health insurers on a per member per year basis. A state may not be able to achieve the same level of economy of scale, and may require higher user fees to finance the program.
- Risk adjustment requires high levels of expertise in actuarial modeling, statistical analysis, data management, and clinical practice. As is the case with any statistical and actuarial tool, it also has inherent limitations in predicting or explaining the relationship between health status and healthcare service use or costs. Even the most sophisticated models may have some form of prediction bias for certain populations or fail to accurately predict the effect of changes in clinical practice, technological development, and demand for health services. Changing from the federal methodology to a state methodology will lead to a different funds transfer result, creating different "winners" and "losers" in risk adjustment. The state needs to have the technical skills and policy insight to anticipate the impact of risk adjustment on the local market, effectively communicate with the stakeholders, and adapt the methodology as needed going forward.

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## IX. METHODOLOGIES AND DATA RELIANCE

In preparing this report, we relied on data, information, and assumptions provided by the Colorado Department of Regulatory Agencies (DORA) along with public data sources. Data sources utilized in our analysis include, but are not limited to, the following:

- Health plan financial information downloaded from S&P Global Market Intelligence.
- Health insurer rate review information available at <https://ratereview.healthcare.gov/>
- Insurer rate filing information.
- Medical Loss Ratio Reporting Form data, 2014 through 2015.
- Historical Medical Expenditure Panel Survey data.
- HHS Marketplace Open Enrollment reports.
- Reports released by the federal government related to premium stabilization programs, APTC amounts, and effectuated marketplace coverage.
- Connect for Health Colorado Dashboard reports.

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

It should be noted there is significant uncertainty surrounding future enrollment and premiums in health insurance programs, particularly the individual market. Uncertainty arises from inability to predict individual behavior as well as the inability to predict the business decisions of carriers in the market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. *Federal pass-through funding will be based on actual premiums filed by insurers offering coverage in Colorado's non-group market, final funding amounts may differ significantly from the high-level, preliminary estimates provided in this report.*

The actuarial analyses presented in this report solely reflect the estimated incremental impacts from a potential state-run reinsurance program in the State of Colorado. Other state or federal policy changes may impact actual amounts presented in this report.

We specifically note that our projections of enrollment and premium rates in the individual market assume that federal funding of cost-sharing reduction (CSR) subsidies continues, and that the individual mandate is enforced in a manner similar to the 2014 through 2016 time period. To the extent judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted by a significant degree.

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## X. LIMITATIONS AND QUALIFICATION STATEMENT

The services provided for this report were performed under the contract between Milliman and the Department of Regulatory Agencies (Department) dated September 8, 2017.

The information contained in this report has been prepared for the Department and their consultants and advisors to provide data and information related to the potential development of a state-based reinsurance program under a Section 1332 waiver. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be released publicly. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

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

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

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## APPENDIX A

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**Colorado Silver Plan Rates and Increase, 2014-2018**

<b>Rating</b>		<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>Est. 2018</b>	<b>Annualized Increase 2015-2018</b>	<b>Cumulative Increase 2015-2018</b>
Area 1	Premium	\$191.83	\$158.00	\$208.51	\$247.02	\$312.43	26%	98%
	Change		-17.6%	32.0%	18.5%	26.5%		
Area 2	Premium	\$189.49	\$152.13	\$201.09	\$240.52	\$304.21	26%	100%
	Change		-19.7%	32.2%	19.6%	26.5%		
Area 3	Premium	\$191.83	\$161.65	\$189.71	\$238.75	\$301.97	23%	87%
	Change		-15.7%	17.4%	25.8%	26.5%		
Area 4	Premium	\$182.24	\$172.34	\$218.94	\$271.72	\$343.67	26%	99%
	Change		-5.4%	27.0%	24.1%	26.5%		
Area 5	Premium	\$223.20	\$223.61	\$291.35	\$364.75	\$461.34	27%	106%
	Change		0.2%	30.3%	25.2%	26.5%		
Area 6	Premium	\$182.24	\$173.16	\$218.94	\$271.72	\$343.67	26%	98%
	Change		-5.0%	26.4%	24.1%	26.5%		
Area 7	Premium	\$230.20	\$211.93	\$243.96	\$287.49	\$363.62	20%	72%
	Change		-7.9%	15.1%	17.8%	26.5%		
Area 8	Premium	\$206.22	\$162.79	\$214.48	\$289.01	\$365.54	31%	125%
	Change		-21.1%	31.8%	34.7%	26.5%		
Area 9	Premium	\$272.26	\$195.00	\$271.06	\$321.12	\$406.15	28%	108%
	Change		-28.4%	39.0%	18.5%	26.5%		
<b>Average</b>	<b>Premium</b>	<b>\$207.72</b>	<b>\$178.96</b>	<b>\$228.67</b>	<b>\$281.34</b>	<b>\$355.84</b>	<b>26%</b>	<b>99%</b>
	<b>Change</b>		<b>-14%</b>	<b>28%</b>	<b>23%</b>	<b>26%</b>		

Sources: The 2014-2017 rates are from the Colorado State Exchange at <http://connectforhealthco.com/>. The 2018 rates are estimated based on the statewide average individual market increase reported by the Division in September 2017.

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## APPENDIX B

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Calculation of 2018 Estimated Pass-Through Funding %		
a)	2018 Aggregate ACA-Compliant Individual Market Premium (\$ Millions)	\$1,426
b)	2018 Estimated Aggregate Claims Expense (\$ Millions)	\$1,183
(c)=(a)-(b)	Non-Benefit Expense <sup>1</sup> (\$ Millions)	\$242
(d)= 25% * (b)	Claims Impact of High Reinsurance Scenario (\$ Millions)	\$(296)
(e)=(b)+(c)+(d)-(a)	Premium Impact of High Reinsurance Scenario (\$Millions) <sup>2</sup>	\$(296)
(f)=(e)/(a)	% Premium Impact of High Reinsurance Scenario	-21%
(g)=(a) * (f)	2018 Aggregate ACA-Compliant Individual Market Premium (\$ Millions)	\$1,130
		PMPM
(h)	Baseline 2018 Gross Premium per APTC Enrollee	\$607.42
(i)	Baseline 2018 Net Premium per APTC Enrollee	\$137.00
(j)=(h)-(i)	APTC Pre-Reinsurance per Enrollee	\$470.42
(k)=(h)*(f)	Gross Premium After Reinsurance per APTC Enrollee	\$481.38
(l)	Baseline 2018 Net Premium per APTC Enrollee <sup>3</sup>	\$137.00
(m)=(k)-(l)	APTC Post-Reinsurance per Enrollee	\$344.38
(l)	APTC Enrollees <sup>4</sup>	87,114
(m)=(l)*(j)	Aggregate APTC Expenditure Pre-Reinsurance (\$ Millions)	\$492
(n)=(l)*(m)	Aggregate APTC Expenditure With Reinsurance (\$ Millions)	\$360
(o)=(m)-(n)	Aggregate APTC Savings from Reinsurance (\$ Millions)	\$132
(p)	Reinsurance Fund (\$ Millions)	\$296
(q)=(o)/(p)	Initial Pass-Through Percentage	44.5%
(r)	Margin for Federal revenue offsets, enrollment changes <sup>5</sup>	-4.5%
(s)=(q)-(r)	<b>Final Preliminary Federal Pass-Through Estimate</b>	<b>40.0%</b>

**Notes:**

1. Non-benefit expense estimate assumes an 83% individual market medical loss ratio (not adjusted for quality improvement expenses or fees and taxes).
2. Aggregate non-benefit expenses are assumed to not change as a result of the reinsurance program.
3. We have assumed that the average net premium paid by APTC enrollees does not vary as a result of the reinsurance program. This is due to APTC members having their out-of-pocket premiums capped through the ACA's premium assistance structure. Small changes may occur as a result of APTC enrollment changes discussed in item 4.
4. Our preliminary modeling assumes no changes in APTC enrollment. Theoretically, the reinsurance program may slightly reduce the number of APTC enrollees. Because of premium rate reductions resulting from the reinsurance program, young adults may have a greater likelihood of being able to purchase the second-lowest-cost silver plan for less than the maximum amount under the ACA premium subsidy structure.
5. This modeling exercise does not account for additional nonsubsidized enrollment resulting from the reinsurance program. Additional enrollment may slightly dampen the premium rate impact (and corresponding change in federal APTC expenditures) from the reinsurance program, as available funding must be spread across a larger enrollment base. Margin is also assumed for a reduction in federal shared responsibility payments, offsetting APTC savings.

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