Summary of Standardized Health Benefit Plan Colorado Option

During the 2021 legislative session, Democratic Governor Jared Polis signed the Standardized Health Benefit Plan Colorado Option (Colorado Option) (House Bill 21-1232) into law. While the new law stops short of establishing a state-administered public option program, it provides the Colorado Division of Insurance (DOI) with various regulatory levers to increase access to affordable health coverage. Most notably, insurance carriers will be required, beginning in plan year 2023, to offer the standardized health benefit plan with mandatory premium reductions in the individual and small group markets.

Under the enacted legislation, carriers must reduce premiums by five percent, as adjusted for inflation, in each of the first three plan years in which the standardized plan is offered, resulting in a 15 percent premium reduction by 2025. If at any point carriers are unable to meet premium reduction requirements or network adequacy requirements, DOI is authorized to establish, through public hearings, and implement the necessary reimbursement rates for hospitals to achieve savings targets.

Regarding next steps, DOI must establish, through rulemaking, the standardized health benefit plan by January 1, 2022.

Standardized Health Benefit Plan

The law requires DOI to establish, through rulemaking by January 1, 2022, the standardized health plan to be offered by insurance carriers through the Exchange (i.e., Connect for Health Colorado; individual and small group markets) and through the Public Benefit Corporation (individual market).[1] The standardized health benefit plans must offer coverage at the gold, silver, and bronze levels and include, at a minimum, all pediatric and other essential health benefits required by the Affordable Care Act (ACA).

The standardized benefit design must be developed through a stakeholder engagement process with a targeted focus on soliciting input from a diverse cross-section of organizations and communities. Additionally, the standardized health plan must be designed, with input from consumer stakeholders, to improve racial health equity and decrease racial health disparities. Improving perinatal health care coverage and providing first-dollar, pre-deductible coverage for certain high-value services, such as primary and behavioral health care, are among the health equity-focused strategies delineated in the law.

Insurance Carrier Participation Requirements

At a minimum, an insurance carrier is required to offer the standardized plan in each county and market (individual and/or small group) that the carrier operates in, beginning January 1, 2023. DOI may update the standardized plan annually through rulemaking that entails a stakeholder engagement process.

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[1] The Public Benefit Corporation is a subsidiary of Connect for Health Colorado through which residents affected by the "family glitch" could receive a state-funded subsidy beginning in 2023.

The insurance carrier must offer the standardized plan at a premium rate that is at least five percent less than the premium rate offered in 2021 in each of the first three years of offering the standardized plan, resulting in a 15 percent premium reduction in plan year 2025 compared to plan year 2021. If a carrier seeks to offer coverage in a county in which the carrier did not operate in 2021, the carrier must offer the standardized health benefit plan at a premium that is at least five percent less than the average rate for that market. For plan year beginning 2026 and subsequent years, the carrier must limit any annual premium rate increase to no more than medical inflation relative to the prior year.

Table 1. Premium Rate Controls

Plan Year	Rate Control
2023	5% reduction from plan year 2021
2024	10% reduction from plan year 2021
2025	15% reduction from plan year 2021
2026 and beyond	Increase to no more than medical inflation relative to prior year

Likely as an attempt to minimize market disruption and premium costs for non-standardized plans, the law requires the Insurance Commissioner to disapprove a requested rate increase for a non-standardized plan if the increase is due to the insurance carrier shifting costs from the standardized plan to the non-standardized plan in order to meet the premium reduction requirements.

Provider Network Adequacy Requirements

The standardized plan must have a network that is not narrower than the most restrictive network that the carrier is offering for non-standardized plans in the individual market for the metal tier for that rating area. Carriers must also include a majority of the "essential community providers" (ECP) in its network (similar to the ACA's ECP standard for qualified health plan (QHP) issuers) and pursue "efforts to construct a diverse, culturally responsive network." If a carrier is unable to meet the network adequacy requirements, the carrier must file an action plan with DOI that details how the carrier will come into compliance. DOI must issue, through rulemaking, the network adequacy requirements and the action plan requirements.

Procedures to Resolve Reimbursement Disputes and Carrier Participation Issues

The law prescribes procedures for resolving issues relating to carrier participation and provider network adequacy:

- **Nonbinding Arbitration** – If a carrier or health care provider anticipates that the carrier will be unable to meet the network adequacy standards or the premium rate requirement due to a reimbursement rate dispute, the carrier or health care provider may enter into nonbinding arbitration to resolve the dispute. The carrier is still obligated to submit its rate filing by the deadline. At this point, the carrier may, or may not, submit a rate filing that meets the network adequacy standards or the premium rate requirements.

  If a carrier is unable to offer a standardized health benefit plan, the carrier must notify DOI of the reasons why the carrier is unable to meet the network adequacy standards or premium requirements by May 1, 2022 for plan year 2023. For plan year 2024 and subsequent years,

the carrier must notify DOI by March 1 of the preceding year. The carrier is still obligated to submit its rate filing by the deadline. Presumably, at this point, the carrier may submit a rate filing that does not comply with the premium rate requirement or network adequacy standard.

- **Public Notice and Hearing** – If, on or after January 1, 2023, (1) the carrier is unable to offer a standardized health benefit plan, or (2) DOI determines that the carrier has not met the premium rate requirements, then DOI will convene a public hearing at which the Insurance Commissioner will determine the additional measures necessary to facilitate approval of the carrier's final rates.

  The Insurance Commissioner must consider the following factors into their decision:

  - **Evidence and testimony** from all involved parties – including carriers, hospitals, health care providers, and consumer advocacy organizations;
  - **Any actuarial differences** between the standardized plan and the health benefit plans the carrier offered in plan year 2021;
  - **Any changes to the standardized plan**;
  - **State or federal health benefit coverage mandates** implemented after the 2021 plan year;
  - **Exemption for carriers that file an action plan**. A carrier that files an action plan detailing how it will come into compliance with the network adequacy requirements will be considered compliant with those requirements; and
  - **Exemption for health care coverage cooperatives that have achieved and maintain premium rate reductions of at least 15 percent.** A health care coverage cooperative, and a carrier participating in a health care coverage cooperative agreement, that has achieved and maintained at least 15 percent reduction in premiums, "regardless of the first year the health benefit plans were offered," will be considered compliant with the premium rate reduction requirements. Of note, the nonspecific timeline for when the premium rate reduction must have been achieved provides broad leeway to health care coverage cooperatives. For example, the premium rate reduction could have been achieved over a single year or multiple years.

  As discussed below, the Insurance Commissioner must consult with the newly established advisory board. The Insurance Commissioner may also consult with health care trade associations and consider the expenses of hospitals and health care providers (e.g., wages, benefits, staffing, training) needed to provide continuous quality care.

Regulatory Levers to Promote Affordability and Accessibility

Through the public hearing process, the Insurance Commissioner may decide additional cost-control measures must be implemented in order to approve a carrier's rate filing. The law authorizes the Insurance Commissioner to:

- **Establish reimbursement rates and require certain hospitals and health care providers to accept such rates.** These reimbursement rates only apply to hospitals or health

care providers that "prevented a carrier from meeting the premium rate requirements for a standardized plan being offered in a specific county; or caused the carrier to fail to meet network adequacy requirements."

The new authority, if exercised, would alter the negotiation dynamics between hospitals, and health care providers, and insurance carriers. Essentially, hospitals and health care providers that wish to contract with an insurance carrier will have to accept the negotiated reimbursement rate, presumably lower due to premium rate reduction, or the reimbursement rates set by the Insurance Commissioner. As discussed below, the law sets guardrails to prohibit the reduction of reimbursement rates by more than 20 percent from the 2021 plan year.

Table 2. Floors for Reimbursement Rates Established by the Insurance Commissioner

Provider	Percent of Medicare Reimbursement[2] or Equivalent Rate[3]
Independent hospital that is not part of a health system	175%
Essential access hospital that is part of a health system	175%
Essential access hospital that is not part of a health system	195%
Pediatric specialty hospital with a level one pediatric trauma center	210%
Hospital that serves more than the statewide average of Medicaid or Medicare	Up to 185%
Hospital that is efficient in managing the underlying costs of care as determined by the hospital's total margins, operating costs, and net patient revenue.	Up to 195%
Other hospitals	165%
Health care providers	135%
Hospitals with a negotiated reimbursement rate that is lower than 10% of the statewide hospital median reimbursement rate[4]	Greater of: (1) Commercial rate minus one-third of the difference between the 2021

[2] "Medicare reimbursement rate" means the facility-specific reimbursement rate for a particular health care service provided under Medicare. For a hospital that is reimbursed through the Medicare prospective systems rate for a critical access hospital, the "Medicare reimbursement rate" means the rate based on allowable costs as reported in Medicare cost reports and the historical cost-to-cost ratios for the specific hospital."

[3] An "equivalent rate" applies to health care facilities that are not reimbursed through Medicare. For a pediatric specialty hospital with a level one trauma center, the "equivalent rate" is the most recent payment rate determined by the Medicaid fee schedule multiplied by a conversion factor equal to the ratio of the statewide payment to cost ratio for Medicare to the hospital's specific payment-to-cost ratio for the most resent set of publicly available hospital financial data. For other settings, the "equivalent rate" will be set through rulemaking.

[4] This calculation uses data from the Colorado All Payer Claims Database

	commercial reimbursement rate and the otherwise established rate (2) 165% of the hospital's Medicare reimbursement rate; or (3) Otherwise established rate

- **Impose penalties on a hospital that refuses to participate in a standardized health benefit plan if required to do so.** The Insurance Commissioner is permitted to take the following enforcement actions: (1) issue a warning; (2) levy a fine up to $10,000 per day for the first 30 days of noncompliance and up to $40,000 per day for each subsequent day of noncompliance; and (3) suspend or impose conditions on the hospital's license. The hospital's financial circumstances will be taken into account to determine the appropriate fine or action.

- **Require carrier participation in markets with limited competition** – The Insurance Commissioner may require a carrier to offer the standardized plan in specific counties and markets where no carrier is offering the standardized plan that year. The Commissioner must consider (1) the carrier's structure and the number of covered lives; and (2) alternative health care coverage available in each county. The Commissioner must promulgate rules to ensure that there is not an unfair competitive advantage for carriers that intend to offer the standardized plan in a county where it has not previously offered plans.

Additionally, the law provides guardrails to premium and reimbursement rate reduction:

- **Limit on reimbursement rate reduction** – The Insurance Commissioner is prohibited from setting a reimbursement rate that is 20 percent lower than the negotiated rate for the previous plan year; and

- **Appeal process** – An insurance carrier or health care provider is permitted to appeal the Commissioner's decision to the district court in their jurisdiction.

New Entities: Advisory Board and Insurance Ombudsman

The law establishes an advisory board that will advise the Insurance Commissioner with decisions at public hearings. In addition, the advisory may:

- Consider recommendations to streamline prior authorization and utilization management processes for the standardized plan;
- Recommend ways to keep health care services in the communities where patients live; and
- Consider whether alternative payment models may be appropriate for particular services, accounting for the impact of these models on health outcomes for people of color.

The advisory board will be composed of up to 11 members appointed by the governor by July 1, 2022. The governor is directed to appoint a diverse membership "with regard to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, and geography" as well as experience and expertise, such as in health equity and health benefits for small businesses.

Additionally, the law creates the Office of the Insurance Ombudsman, which will be tasked with advocating for consumer interests related to access to and affordability of the standardized health benefit plan. The ombudsman's responsibilities include evaluating data to assess the standardized plan's network and affordability and representing the interests of consumers in public hearings.

Federal Waiver Authority

The law directs, but does not require, the Commissioner to submit an application to waive certain requirements of Section 1332 of the Affordable Care Act (ACA) to secure the applicable savings as a result of implementing the standardized plan, referred to as pass-through funding.

Upon approval of the waiver by the Centers for Medicare and Medicaid Services (CMS), the law specifies that the Commissioner may use the savings for Colorado's reinsurance program, administered by the Colorado Health Insurance Affordability Enterprise, which was established in the 2020 legislative session (Senate Bill 20-215). Savings must be used to increase the value, affordability, quality, and equity of health care coverage for all Coloradans, and will be deposited to the newly created Health Insurance Affordability Case Fund.

Oversight and Transparency

The Insurance Commissioner is required to submit several reports on a periodic basis regarding implementation of the standardized health benefit plans.

Table 3. Required Reports

Due Date	Description
January 2022 and annually thereafter*	Report on the implementation and operation of the standardized plan, including provider network adequacy and premium reductions
December 31, 2022 January 2024 and annually through 2026*	Evaluation of how to phase in hospital's reimbursement rate methodology, including a quality metric adjustment and acuity adjustment (prepared by a third-party contractor)
July 1, 2023 and annually through 2025 January 2024 and annually through 2026*	A series of three reports on how the implementation of the standardized plan affects staffing, wages, benefits, training, and working conditions of hospital workers (prepared by a third-party contractor)
January 2024 and annually thereafter*	A report on the insurance carrier's efforts to develop diverse, culturally responsive networks that are well-positioned to address health equity and reduce health disparities; and to include a majority of the essential community providers in the service area in its network
January 1, 2026	A report on the impact of the standardized plan on health plan enrollment, health insurance affordability, and health equity; and include disaggregated data to the extent possible (prepared by a third-party contractor)

January 1, 2026	A survey on the experience of consumers who purchased the standardized benefit plan (conducted in collaboration with the Exchange)

* Required for Insurance Commissioner to report during hearings conducted pursuant to the State Measurement for Accountable, Responsive, and Transportation (SMART) Government Act

Implementation: Start-Up Funding and Rulemaking

Roughly $1.4 million for the 2021-22 state fiscal year is appropriated for implementation of standardized health benefit plans. With regard to next steps, DOI must establish, through rulemaking, the standardized health benefit plan by January 1, 2022. DOI must also promulgate rules on the following:

- Provider network adequacy requirements and action plan;
- Requirements to ensure an insurance carrier does not face an "unfair competitive advantage" if it choose to offer a standardized plan in a market in a county where it has not previously operated or with a hospital with which the carrier has not previously contracted with; and
- Requirements to align with federal program requirements.