KAISER PERMANENTE.

October 25, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St.
Denver, CO 80203

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Sent via email to hcpf_1004affordableoption@state.co.us

Re: Draft Report for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway:

Thank you for the opportunity to comment on the *Draft Report for Colorado's State Coverage Option* (the "Report"). As the largest issuer serving Colorado's individual market, Kaiser Permanente appreciates the Department of Health Care Policy and Financing and Division of Insurance (collectively, the "Agencies'") ongoing commitment to stabilize Colorado's individual market. We are concerned that the Report's recommendations would reverse Colorado's market stability gains and undermine competition and consumer choice across all of Colorado's commercial markets. As drafted, the Report compels issuer participation in a new system providing minimal premium reductions to a relatively small number of Colorado consumers at the expense of significant reimbursement cuts to Colorado's rural hospitals. It focuses on unit prices instead of total costs, and does not factor in quality and value.

At its core, the public option seeks to achieve premium reductions through artificial price controls; Kaiser Permanente opposes government-led approaches to capping or setting reimbursement rates without addressing the underlying costs of health care. The proposal also compels statewide coverage, antithetical to Kaiser Permanente's integrated model of coverage and care that serves more Coloradans in the individual market than any other carrier statewide.

The public option proposal, as discussed below, is unlikely to achieve its premium reduction goals for most Coloradans and could eventually significantly disrupt coverage for state residents – including those who currently carry employer-sponsored insurance. Rather than potentially jeopardizing consumer choice and access to coverage and care, we recommend that the Agencies build upon existing, proven approaches (such as Colorado's reinsurance program, consumer-directed subsidies and an individual mandate) to expand access to affordable coverage for more

Coloradans. Kaiser Permanente is committed to working on and providing alternative solutions that advance the State's agenda to reduce costs, without relying on government-set rates.

Kaiser Permanente commissioned the actuarial firm Milliman to review the impact of a public option on Colorado's health care market and consumers.[1] Based upon that work and our experience in the Colorado individual market, we are concerned that the Report's premium savings estimates may be overstated, particularly for urban areas. For the reasons explained below, Kaiser Permanente finds Milliman's analysis more compelling than the analysis in the Report, but we welcome further discussion on the relative merits of the competing analyses. Our primary concerns about the analysis in the Report, as contrasted with the analysis performed by Milliman, are as follows:

- First, the Report apparently assumes a uniform level of facility reimbursement across the state at 289 percent of Medicare. Milliman, based on its methodology, notes that facility reimbursements materially vary by geographic region.[2] It is not disputed that there are generally lower baseline reimbursement rates for urban markets where more providers and issuers already compete for individual market consumers versus less-competitive rural markets. Because the Report's conclusion about the uniform level of facility reimbursement does not reflect any geographical weighting, we believe that number is simply not an accurate reflection of the market. Milliman's premium reduction projections reflect geographic differences and the relative percentage of the population in the different areas.

- Second, the Report evaluates the hypothetical public option's performance against a statewide average individual market premium, whereas Milliman compares the public option against actual facility reimbursement rates under the current second lowest-cost silver plan ("SLCS") offered through Connect for Health Colorado. In the highly price-sensitive individual market, participants often choose one of the lower-priced plans, and issuers are therefore incentivized to limit facility payments to achieve a lower price point. Kaiser Permanente believes projections should therefore compare the public option's performance against premiums and products a vast majority of individuals actually purchase. SLCS is the better measurement for this behavior than a statewide average due to the fact that it is the basis for federal subsidies available to (and actual buying power of) subsidy-eligible consumers in a price-sensitive market. More than half of Colorado's individual market consumers receive subsidies; modeling changes to SLCS rates therefore

[1] *Evaluation of a Colorado Public Option*, Milliman (Oct 21, 2019) (attached).
[2] The commercial employer group reimbursement rates assumption is based on Milliman analysis of the IBM Marketscan® database, proprietary Milliman claims databases, and publicly available data sources. The assumption that the provider reimbursement underlying plans available on CFHC is better than standard commercial employer group reimbursement in certain counties is based on Milliman experience and work with previous, similar studies in other states. *Id.* at 19.

better estimates probable premium savings to current and potential individual market participants. While a single, publicly-available individual market reimbursement value (potentially between the analyses) is unavailable, we believe Milliman's geographic weighting and SLCS-based framework more closely reflects the actual value.

Below, we discuss in more detail Kaiser Permanente's specific concerns with the Report, referencing Milliman's findings where applicable.

- **Few Colorado consumers would benefit from the public option, and any benefit comes at the expense of rural hospitals.**

The Agencies' stated primary objective for a public option is to provide more Colorado consumers with lower-cost individual market coverage. The proposal presumes to accomplish this by limiting what private insurers would reimburse Colorado's hospitals. Milliman concluded that "the competitive advantage obtained by a public option is borne entirely by the provider community."[3] Limiting facility reimbursements to between 175-225 percent of Medicare fee-for-service rates, the Report projects, will generate monthly premium reductions of at least 9 to 18 percent.[4] Based upon the Milliman analysis, Kaiser Permanente believes these premium reductions are overly optimistic. Further, Milliman concludes that the benefit of any premium reductions under the public option would apply to a relatively small number of Colorado's individual market consumers, who reside outside the state's major urban areas. Overall, Milliman concludes that the public option will provide little to no price relief for urban consumers, even at very low percentages of Medicare.[5] The competitive market in urban areas has generally succeeded at keeping rates lower. The public option can only succeed in reducing premiums for rural customers by imposing an effective assessment on rural hospitals in the form of reimbursements capped at very low percentages of Medicare rates compared to current reimbursement levels.

While customers in the state's rural areas – with higher reimbursement rates due to lower or non-existent hospital competition and limited coverage options – would benefit from greater price relief, it is important to consider the broader impact of introduction of a public option. Any price relief attributable to rural consumers would be at the cost of lower reimbursements to providers that are already financially stressed.[6] Further, the state's existing reinsurance program features differentiated coinsurance rates designed to provide the state's rural consumers with additional, premium relief. We recommend that the Agencies evaluate the success of the reinsurance program at reducing the cost of coverage before introducing a new, unproven approach that could threaten the financial viability of the state's rural providers.

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[3] *Colorado Public Option: Evaluating Potential Implications, Milliman (Oct. 18, 2019) at 3 (attached).*at 3.
[4] *Draft Report for Colorado's State Coverage Option*, Colorado Division of Insurance and the Colorado Dep't of Health Care Policy & Financing (Oct. 7, 2019) at 3.
[5] *See supra* n.2 at 3.
[6] *See Id.*at 4.

- **The proposal does not meaningfully reduce underlying costs of care.**

At its core, the public option achieves premium reductions through artificial price controls, without addressing the underlying costs of health care. The Report does not address issues such as rising pharmaceutical prices, costly benefits mandates and third-party payment mechanisms that drive increases in insurance premiums. The Report's recommendations instead attempt to impose additional restrictions on issuers by increasing the minimum medical loss ratio ("MLR") from 80 to 85 percent. This proposal may discourage participation in the individual market, which features administrative challenges given its high turnover and acquisition costs, combined with significant member engagement and higher-than-typical risk profile.

- **Maintaining current coverage could become more expensive following introduction of a public option.**

The Report apparently requires all carriers above a market share threshold (to-be-determined) in Colorado's commercial markets to offer the public option in order "to spread both the opportunity and the risk."[7] To the extent that the Report's plan reduces premiums, Colorado's rural individual market consumers could lose any effective alternative to public option coverage. Milliman concludes that many subsidized Colorado consumers will see no reduction in total coverage costs under the public option plan, and would pay substantially more to remain in the same plan.[8] This is largely because the Affordable Care Act's advanced premium tax credit ("APTC") subsidy, pegged to the second-lowest cost silver plan in a given market, diminishes as premiums artificially decrease due to the presence of the public option in that market. To the extent the subsidy decreases, total out-of-pocket costs for Colorado consumers who wish to keep their current coverage – or any form of individual market coverage that is not the public option – increases. Overall, Milliman concludes that many subsidized enrollees would pay more to maintain current coverage.[9]

- **Costs may rise across Colorado's commercial insurance markets to benefit a small number of consumers.**

Colorado's individual market covers just over 200,000 lives statewide, or 4 percent of the state's entire population.[10] The cost for providing premium relief to a small selection of these consumers, however, could increase costs and jeopardize current coverage for the nearly 3 million Coloradans receiving coverage through their employers. If the public option succeeds in lowering rates, hospitals, particularly rural facilities, would be forced to make up financial losses sustained

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[7] *Supra* n.4 at 3.
[8] *Supra* n. 3 at 3.
[9] *Id.*
[10] *Supra* n. 1 at 13.

through reduced individual market reimbursements, from other payers – particularly group and self-funded payers. Health costs on self-insured Colorado employers will increase, because the proposal only regulates contracting between hospitals and fully-insured plans. Because states lack significant tools to regulate self-insured employers, any such action may offer little marginal benefit.

- **Other alternatives better promote market stability in Colorado without imposing government-set rates.**

Colorado policymakers can build upon existing reforms to stabilize Colorado's individual market without the risks of imposing broader market disruption and limiting consumer choice. Kaiser Permanente recommends:

Improvements to Reinsurance

The Agencies could expand and improve upon Colorado's new reinsurance program, to extend the benefits to more Coloradans. First, reinsurance could better mitigate the overlap between the reinsurance program and federal risk adjustment to improve program efficiency. A promising option is to replace the traditional reinsurance structure, which potentially biases toward high-risk carriers, with a flat per-member-per-month or flat percentage market subsidy made payable to issuers, which would then be used to reduce premiums. Under a traditional reinsurance structure, the overlap between reinsurance and risk adjustment should continually be monitored, as any change in parameters may have a significant impact on the level of overlap, and dampening factors should be applied to address any determined overlap. Second, if maintaining a traditional reinsurance program, equalizing coinsurance rates across urban and rural areas could offer Colorado's urban consumers meaningful premium relief.

Direct Subsidies to Consumers

Colorado could direct new subsidies to help currently APTC-ineligible consumers better afford coverage. This approach would not require significant changes to existing exchange operations and would not require a Section 1332 waiver for implementation. The state could target relief to individuals, families and small business owners currently lacking federal premium assistance available to other Colorado consumers.

Individual Mandate

Other states, such as California, New Jersey and Washington, D.C., have pursued state-level individual mandate policies that replicate the ACA's federal requirement to stabilize the risk pool.

Such an approach could encourage more issuers to offer individual market coverage in more places across Colorado.

- **The report's prescription drug recommendations require further clarity.**

The Report recommends requiring "all prescription drug rebates and compensation paid by manufacturers to insurance carriers" to be used to "reduce the price of individual policies." Very few additional details about this proposal were provided in the Report.

Kaiser Permanente appreciates what the Agencies are trying to accomplish by requiring use of rebates to lower premiums. We currently recognize price concessions from manufacturers in our premiums and cost-sharing. Depending on how the Agencies intend to implement this recommendation, it could create significant operational challenges, disrupt plans' ability to use drug discounts to lower cost-sharing, and lead to burdensome new reporting requirements in addition to what we must already report to the All Payer Claims Database. Health plans should instead retain flexibility over rebate use, which could lead to more plan choices that better meet patients' variant health care and financial needs.

With this context in mind, we request that the Agencies provide more details about this recommendation and encourage them work closely with insurance carriers and pharmacy benefit managers to ensure any new requirements do not create an undue burden.

Thank you for your time and consideration. Please do not hesitate to contact us if you have any questions or require additional information. We look forward to discussing how proven approaches to market stabilization can expand access to affordable coverage and care to more Coloradans.

Sincerely,

Mike Ramseier
President
Kaiser Foundation Health Plan of Colorado

Margaret Ferguson

Margaret Ferguson, MD, MBA
President and Executive Medical Director
Colorado Permanente Medical Group

Colorado Public Option: Evaluating potential implications

Commissioned by Kaiser Permanente

Fritz Busch, FSA, MAAA
Paul Houchens, FSA, MAAA

October 21, 2019

Kaiser Permanente (Kaiser) engaged Milliman to assist in analyzing various aspects of the potential introduction of a Public Option in Colorado. In determining the scope, methodology and assumptions for our analysis, we relied in part on the text of Colorado HB19-1004 which laid out the public policy objectives and analysis requirements of a state-sponsored proposal that outlines the most effective implementation of Public Option in Colorado. One of those objectives was to estimate premium rates under a Public Option and the required provider reimbursement levels required underlying those rates.[1]

A major variable in any Public Option scenario is provider reimbursement. Any changes in professional and / or facility reimbursement have significant cost implications. Since the text of the bill did not define "provider," we assumed a broad definition of the word. Given that broadest possible definition of the word "provider," our analysis assumed changes in both professional and facility reimbursement.

On October 7, 2019 and concurrently with finalizing our report, the Colorado Department of Regulatory Agencies and the Colorado Department of Health Care Policy and Financing released their joint report on a Public Option (the joint report).[2] The analysis in the joint report assumes that only facility reimbursement will be reduced in order to achieve the desired rate impacts. By contrast, our analysis assumes that both professional and facility reimbursement levels would be modified in order to obtain the needed premium rates for the Public Option to be competitive.

Despite this key difference, we present our analysis in full, under our original assumption, using a provider reimbursement structure that includes changes to both facility and professional providers. While this difference is significant, the overall conclusions drawn related to market impacts are still directionally consistent. Where they are not comparable, however, is in terms of premium rate impact. To facilitate cleaner comparisons between our report and the joint report, we have calculated two scenarios that assume only facility reimbursement is affected in addition to our original four scenarios that assume both facility and professional are affected.

MILLIMAN AND JOINT REPORT PROVIDER REIMBURSEMENT ASSUMPTIONS

- In order to achieve meaningfully lower consumer-facing prices in the individual market for non-subsidized consumers, a Public Option includes mandated reimbursement for facility and professional providers (or for just facilities alone, as in the joint report) that is lower than what underlies current Connect for Health Colorado (CFHC) participating plan offerings. In particular, the *provider payment level for a Public Option would need to be lower than payment levels underlying the current second-lowest-cost silver (SLCS) plan on Connect for Health Colorado (CFHC).*
- There are significantly different reimbursement-related assumptions made between the analyses in our report versus the joint report, specifically:
  - The joint report assumes that facility reimbursement is at a uniform percentage of Medicare across the entire state. Our analysis, based on Milliman research, assumes that there are material variations by geographical region.
  - The joint report assumes a reimbursement level as a percentage of Medicare of 289%[3], which is much higher than what we assume currently underlies premium rates on CFHC, and in particular, for the second lowest cost silver plan.

In Figure 1 we detail these assumptions for current reimbursement for five representative counties compared to the state-wide assumption used in the joint report.

FIGURE 1: COMPARISON OF ASSUMED PREVAILING REIMBURSMENT MILLIMAN VS. STATE REPORT ANALSYSIS

	MILLIMAN REIMBURSEMENT ASSUMPTIONS BY CLAIM TYPE AND COUNTY, PERCENTAGE OF MEDCIARE BASIS			
County	INPATIENT	OUTPATIENT	PROFESSIONAL	TOTAL
Boulder	142%	142%	120%	134%
Denver	130%	167%	116%	138%
Larimer	208%	246%	120%	189%
Mesa	214%	241%	140%	196%
Gunnison	216%	345%	180%	250%
State Report	289%	289%	NA	NA

[1] https://leg.colorado.gov/sites/default/files/documents/2019A/bills/2019a_1004_01.pdf Section1 (4)(a) & (b)
[2] Colorado Department of Regulatory Agencies & Colorado Department of Health Care Policy and Financing (October 7, 2019). DRAFT Report for Colorado's State Coverage Option. Retrieved October 17, 2019, from http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf.
[3] Ibid.

As Figure 1 shows, our research indicates that significantly lower reimbursement currently exists in highly populated and competitive counties such as Boulder and Denver. Reimbursement is higher in rural counties for facilities, but is generally still lower than 289%. *The difference in overall reimbursement and the material variations by geography lead to very different projections of premium savings coming from a Public Option.*

MILLIMAN AND JOINT REPORT PUBLIC OPTION PREMIUM SAVINGS IMPACTS FROM PROVIDER REIMBURSEMENT ASSUMPTIONS

- The impacts of provider reimbursement assumptions on the estimated premium savings of a Public Option relative to the SLCS are illustrated in Figure 2 below[4].

FIGURE 2: COMPARISON OF PREMIUM SAVINGS FROM PUBLIC OPTION

	MILLIMAN ANALYSIS						JOINT REPORT	
	FACILITY AND PROFESSIONAL AT MEDICARE %				FACILITY ONLY AT MEDICARE %		FACILITY ONLY AT MEDICARE %	
County	SCENARIO A 180% OF MEDICARE	SCENARIO B 150% OF MEDICARE	SCENARIO C 120% OF MEDICARE	SCENARIO D 100% OF MEDICARE	SCENARIO E 225% OF MEDICARE	SCENARIO F 175% OF MEDICARE	225% OF MEDICARE	175% OF MEDICARE
Boulder	21.7%	5.6%	-9.6%	-19.1%	25.7%	9.5%	NA	NA
Denver	22.8%	5.8%	-10.2%	-20.3%	25.9%	8.5%	NA	NA
Larimer	-4.9%	-18.1%	-30.8%	-39.0%	-1.5%	-15.2%	NA	NA
Mesa	-8.1%	-20.1%	-31.6%	-39.0%	-1.4%	-15.6%	NA	NA
Gunnison	-25.0%	-35.1%	-44.6%	-50.7%	-12.4%	-22.8%	NA	NA
Composite	12.9%	-2.5%	-17.0%	-26.3%	16.8%	1.0%	-9.6%	-18.2%

Scenarios A through D shown in Figure 2 assume that both professional and facility reimbursement are at the percent of Medicare level indicated. In high-density population areas such as Denver and Boulder, which are competitive markets with five or six carriers offering coverage on CFHC, we estimate current reimbursement for the SLCS to be much lower than in rural counties, which leads to smaller premium savings and, under scenarios A & B, premium rates actually above the current SLCS. *Thus our analysis indicates that a Public Option may bring little to no price relief to a large portion of Colorado consumers (those residing in urban areas) even when reimbursement as low as 120% of Medicare applies to both facility and professional providers.*

Scenarios E and F of Figure 2, along with the corresponding columns for the joint report, illustrate that our estimates of premium savings are less favorable relative to those in the joint report when put on a comparable basis. For example, while the joint report estimates a state-wide *decrease* in the price of the SLCS of 9.6% under a 225% of Medicare scenario, our analysis produces a population-weighted average *increase* of 16.8%. Again, this is a result of our assumption of much lower provider reimbursement which, at 225% of Medicare, actually produces *higher Public Option premium rates* in the heavily-weighted urban areas.

In summary, we find that the ability of the Public Option to provide lower prices for Coloradans purchasing coverage on CFHC, particularly the unsubsidized, is highly dependent on three factors:

- the actual level of reimbursement that currently exists for the SLCS,
- how that reimbursement varies by geography, and
- at what level of reimbursement the Public Option will ultimately contract with providers.

EFFECTS ON CONSUMER PRICES AND CARRIER COMPETITION

- Current carriers (or potential new entrants) may not be able to obtain the same reimbursement terms on non-Public Option offerings as those related to Public Option plans, making a private carrier's CFHC non-Public Option offerings uncompetitive (and possibly irrelevant). This is particularly true after considering the effect of federal premium subsidies on a consumer's net premium. Depending on the degree of price advantage held by a Public Option, individual carriers may be forced to participate in the Public Option program or simply exit the individual ACA-compliant market, thereby accomplishing the opposite effect intended and actually decreasing carrier competition and consumer choice. The leveraged impact of the introduction of a lower priced Public Option on post-subsidy premiums is illustrated in Figure 3 for a single 40-year-old with income equivalent to 150% Federal Poverty Level (FPL).

[4] An additional impact report was done by the REMI Partnership (September 2019). Anticipating a State Option for Health Care: Will Businesses Face Higher Costs or Will Quality and Access Be Cut? Retrieved October 9, 2019, from https://www.commonsensepolicyroundtable.org/wp-content/uploads/2019/09/REMI-Partnership-Anticipating-a-State-Option-for-Health-Care-FULL-REPORT-.pdf.

Figure 3: Denver County 2019 SLCS Premium - 150% FPL

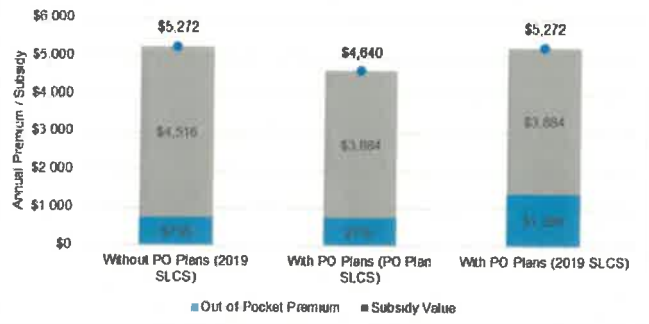
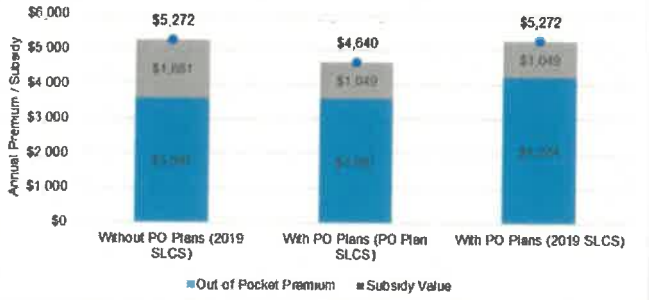


Figure 4: Denver County 2019 SLCS Premium - 300% FPL



In this example, the introduction of Public Option plan causes the gross annual premium for a 40 year old for the SLCS plan to decrease by 12% ($5,272 to $4,640). The person can switch to the Public Option (middle column), with the net out-of-pocket annual premium remaining at $756. However, to the extent the person wanted to stay on the same plan (right column), then the annual out-of-pocket premium increases from $756 to $1,388, an *84% increase*. This effect is the result of the premium subsidy value decreasing from $4,516 to $3,884, which in turn is a result of the Public Option becoming the SLCS.

We estimate approximately 36% of the ACA-Compliant Individual market has subsidy levels comparable with those illustrated in Figure 3 (incomes less than 250% of FPL). An additional 24% of the individual ACA-compliant market will have lighter subsidies because there income is between 250% and 400% of FPL and, therefore, will have a lower leveraging affect, as illustrated in Figure 4. In this case, while gross premium declined, the out-of-pocket premium *increases 17%* (from $3,591 to $4,224), if they want to keep their current plan.

Therefore, under a Public Option, a subsidized person will see no reduction in out-of-pocket premiums and must pay substantially higher out-of-pocket premiums to remain in their same plan.

The market dynamics illustrated in Figures 3 and 4 are magnified in regions where there is potentially a larger spread between existing plans and Public Option premiums. As Figure 2 illustrates, estimated current provider reimbursement in rural areas is higher relative to urban areas; therefore, it is projected that a Public Option (assuming uniform, statewide reimbursement levels are implemented) would have a larger price advantage to existing CFHC plans in rural areas and, therefore, a heavy post-subsidy leveraging effect on out-of-pocket premiums. Corresponding out-of-pocket increases for 150% of FPL and 300% of FPL for high cost rural areas are 218% and 46%, assuming those consumers want to keep their current plan.

EFFECTS ON INDIVIDUAL AND EMPLOYER-SPONSORED MARKET ENROLLMENT

- We assume that a Public Option would be a qualified health plan (QHP) offered on CFHC. Given the price sensitivity of individual consumers and their acclimation to narrow network products already common on CFHC, the movement to a lower-priced Public Option would make the most economic sense. A large share of the individual market would likely switch to a Public Option under several of the price scenarios we modeled, especially given the leveraged post-subsidy rate increases consumers would experience if they do not switch.

- Just over 50% of Coloradans receive their healthcare coverage through employer-sponsored plans. This is the largest single share of healthcare coverage by market (Medicaid is second, covering approximately 21% of the State of Colorado's population). Depending on reimbursement level and geography, a Public Option could have premium rates that employers currently offering traditional group coverage might find attractive.

  Assuming eligibility for a Public Option would include employees currently covered under employer-sponsored plans, significant migration to the Public Option might occur under certain scenarios. Along with attractive prices, the availability of tax-favored vehicles, such as the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) and the Integrated Individual Health Reimbursement Arrangement (IIHRA) allows employers to fund premium payments for individual health insurance coverage. That could make an employer's decision to fund coverage on CFHC in lieu of a traditional plan much easier. This migration from group segments (small group, large group insured, and self-funded) could increase if product features such as an adequate provider network are satisfactory to employers.

EFFECTS ON COLORADO'S PROVIDER COMMUNITY

- A potentially large membership movement from both the individual and group markets to a Public Option with materially lower provider reimbursement is possible, depending on the Public Option's price. Because of the size of employer group segment (50% of Coloradans), small percentage movements in this segment can have large impacts on Public Option enrollment. The movement of members to a Public Option is anticipated to have at least two effects.

  First, because the cost of the competitive advantage obtained by a Public Option is borne entirely by the provider community, movement to it will reduce provider revenue for each individual purchaser or employee who chooses it.

  Figure 5 illustrates the interplay between lower premium rates, higher enrollment, and reduced provider reimbursement. In short, the relationship becomes nonlinear as each effect compounds the other. For example, under the 150% of Medicare scenario, enrollment is modest at approximately 250,000 and a reduction in provider revenue is seen of slightly above $63 million. However, under the 120% of Medicare scenario, enrollment nearly doubles in the Public Option, but provider revenue losses increase nearly ninefold (from a loss of $63 million to $578 million).

  Second, in response to revenue pressures, providers could react in a variety of ways and most likely in a combination of ways. These potential reactions include (but are not limited to):

- Choosing not to contract with the Public Option, depending on the level of reimbursement. This could cause network adequacy challenges and result in access issues for Public Option enrollees.
- Changing patient mix, accepting fewer patients with lower reimbursement coverage, such as Medicaid patients. This will cause access issues for the affected populations.
- Contracting with the Public Option but attempting to increase revenues on other commercial contracts they may have with payers (cost shifting). Figure 5 shows the impact to commercial contracts under various reimbursement levels (in the "Cost Shift to Commercial Group" line) if providers were able to shift *all* of the costs of the Public Option revenue loss to those contracts.

FIGURE 5: ESTIMATED PUBLIC OPTION MEMBERSHIP, PROVIDER REVENUE IMPACT, AND COST SHIFTING

	LEVEL OF PROVIDER REIMBURSEMENT FOR PUBLIC OPTION			
SCENARIO	**SCENARIOS A** **180%OF MEDICARE**	**SCENARIOS B** **150% OF MEDICARE**	**SCENARIO C** **120% OF MEDICARE**	**SCENARIO D** **100% OF MEDICARE**
PUBLIC OPTION MEMBERSHIP	31,200	249,600	466,000	619,900
PROVIDER REVENUE CHANGE $ (MILLIONS)	$116	-$63	-$578	-$1,115
PROVIDER REVENUE CHANGE %	0.4%	-0.2%	-1.9%	-3.7%
COST SHIFT TO COMMERCIAL GROUP	-0.8%	0.5%	4.3%	8.7%

As an example, if providers under a Public Option were to accept 120% of Medicare state-wide *and* attempted to recoup all the lost revenue of the 466,000 enrollees by cost shifting to commercial payer contracts, they would need to increase reimbursement levels by 4.3% on the remaining commercial group coverage to be made whole.

Providers could also respond to lower revenues by changing patient mix. One example of this might be by accepting fewer Medicaid patients. Finally, providers could employ a combination of the various strategies mentioned above, improving their efficiency, increasing patient volume, and / or merging with another provider. In extreme cases, physicians may also choose to retire and exit private practice, or close their independent practices and work for a health system.

UNIQUE CONSIDERATIONS FOR RURAL COUNTIES

- HB19-1004 notes specifically the lack of carrier choice in the individual market in 14 Colorado counties. These counties also typically have much higher premium rates due to a combination of lower provider competition (i.e., a single hospital or health system serves the area) and minimal carrier competition.[5] One of the purposes stated for considering a Public Option in the bill is to address these specific issues. As shown in Figure 3 above, rural areas could see significant premium rate relief under a Public Option. However, this price relief comes at the cost of reduced reimbursement to providers (professional and facility) that may be already financially stressed.[6,7]
- Additional financial stress of lower provider reimbursement may induce provider consolidation or even closing of facilities.[8] These actions may exacerbate access issues for rural patients.
- Finally, overall carrier competition in the State of Colorado, as noted above, may not be enhanced with a Public Option. If a private carrier is competing against a Public Option that has a competitive advantage (legislatively mandated lower reimbursement) that it may not be able to match, it may not make business sense to continue offering coverage in that county. The exit of that carrier would leave the county with a single carrier again,[9] but this time it would be the Public Option, which given its lower reimbursement, may or may not have been successful at contracting an adequate network.

OTHER POLICY OPTIONS

Our review of various policy alternatives finds that there are other available options that could be more efficient means to reducing prices in the individual market, particularly for those above 400% FPL. Although a Public Option could set eligibility standards that would allow current employer group members to enroll and employers might benefit from moving employees to the Public Option, current reform strategies, including a Public Option, are largely targeted at the *unsubsidized, individual market*. The individual market is only about 3.8% of Colorado's 2019 health benefits marketplace and the unsubsidized portion is even smaller (approximately 105,000 persons or less than 2% of the State of Colorado's total population). Geographically, the current market challenges lie predominantly in rural regions that are not densely populated, and have limited carrier and healthcare delivery system competition.

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[5] See Appendix B of the full report for rates by geographic region and carrier counts.
[6] National Rural Health Association. Advocacy: NRHA Save Rural Hospitals Action Center. Retrieved October 9, 2019, from https://www.ruralhealthweb.org/advocate/save-rural-hospitals.
[7] U.S. Senate Committee on Finance (May 24, 2018). Statement of Konnie Martin: "Rural Health Care in America: Challenges and Opportunities." Retrieved October 9, 2019, from https://www.finance.senate.gov/imo/media/doc/24MAY2018MartinSTMNT.pdf.
[8] Ingold, J. (July 4, 2017). In Colorado's drumbeat of medical mergers, rural hospitals often trade independence for better care. Denver Post. Retrieved October 9, 2019, from https://www.denverpost.com/2017/07/04/colorado-rural-hospitals-merge-with-big-city-health-economic-concerns/.
[9] Colorado currently has 14 one-carrier counties. Please see Appendix B for more information.

Thus, it is important to consider the potentially broad ramifications of an ambitious proposal that is intended to primarily benefit a relatively small sub-segment of the population.

Hence, the discussion of more targeted and efficient solutions to improve Colorado's individual health insurance market relative to a Public Option may include:

- *A state-based program that extends subsidies based on income beyond the federal limit of 400% FPL.* This would not require a 1332 Waiver and could be built off of existing CFHC infrastructure. It can be designed to achieve the same effect as a reinsurance program or Public Option in terms of net premium decreases. Finally, it can eliminate the subsidy cliff that exists at 400% FPL.

  If implemented in lieu of an existing reinsurance program, state-based subsidies eliminate the structural weaknesses that may be inherent in reinsurance programs (such as high-cost carriers receiving disproportionate shares of program funding and duplicative payment by the federal risk adjustment). State-based subsidies could also complement a reinsurance program, achieving even greater out-of-pocket premium rate reductions for targeted populations.

- *A per member per month (PMPM) or flat percentage market subsidy.* These types of market subsidies (received by carriers) can achieve the same price reductions as a Public Option (or reinsurance program), but reduce or eliminate the potential high-cost carrier bias and overpayment issue (double payment by risk adjustment and reinsurance) that are both inherent to a reinsurance program. A market subsidy is much easier to implement than a Public Option and can build off the existing reinsurance infrastructure. Like state-based subsidies, these options can be implemented in lieu of a reinsurance program or as a complementary program.

- *Enhancing the reinsurance program.* A Public Option would be a large investment for the State of Colorado, with both business and insurance risks associated with it. For example, a stand-alone, risk-bearing Public Option entity would have significant startup costs, ongoing and likely increasing capital needs, and other associated expenses. Moreover, it is not entirely clear that a Public Option would achieve the desired policy ends without significant drawbacks. These same funds could be used more efficiently and with less risk to the State of Colorado by simply increasing the funding and, therefore, the rate impact of Colorado's reinsurance program.

  These policy options also come with the additional advantage that there is either no need of a 1332 Waiver to reclaim savings (state-based subsidies) or a low risk of not getting an application approved (reinsurance or market subsidy). Yet these policy options can have virtually the same effects on consumer premiums as a Public Option, without the potential detrimental effect on consumer choice.

The full report can be found at: http://www.milliman.com/insight/2019/Evaluation-of-a-Colorado-Public-Option/

CAVEATS AND LIMITATIONS

The services provided for this report were performed under the Consulting Services Agreement between Milliman Inc. (Milliman) and the Kaiser Foundation Health Plan dated August 1, 2019. Kaiser Permanente is the organization's trade name.

The information contained in this report has been prepared for the Kaiser Permanente to provide data and analysis related to the evaluation of potential health benefits market impacts from the introduction of a Public Option in Colorado. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report could be released publicly in summary form. Any distribution of the summary information should be done so in conjunction with access to the full report. 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 Kaiser Foundation Health Plan 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.

Milliman has relied upon certain data and information that is publicly available from the Connect for Health Colorado, Colorado Insurance Commissioner, and the Centers for Medicare and Medicaid Services (CMS). Additionally, we relied on statutory financial statement information downloaded from S&P Global Market Intelligence (formerly SNL Financial). Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data provided are not accurate, the estimates provided in this report would need to be modified to reflect revised information.

It should be noted that there is significant uncertainty surrounding future enrollment and premiums in health benefits programs, particularly the individual 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.

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

Contact:

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DENVER METRO CHAMBER OF COMMERCE

By email: Director Bimestefer, Commissioner Conway and HCPF_1004AffordableOption@state.co.us

October 25, 2019

Director Kim Bimestefer and Commissioner Conway:

Today we write on behalf of the Denver Metro Chamber and its 3,000 members to express concerns with the proposal for Colorado's State Coverage Option. Our organization represents almost 400,000 employees across the state. We work every day to ensure more Coloradans can get to work in great jobs at great companies through advocacy, education, leadership training, small business resources and economic development.

In our 152-year history we've seen how well our market works – it responds to demand, it innovates and it advances with technology. Our experience has been that many of the challenges we face are best addressed through market-based solutions. Health care is no exception to this, and Coloradans agree. In 2016, more than 80 percent of Colorado voters opposed a state-run health insurance program, indicating a lack of support for an increased role of government in health care.

For example, we oppose mandatory participation in the program for carriers and hospitals because we believe requiring a company to compete in a market (whether based on geography or niche) that they aren't equipped to serve (whether lacking the expertise or resources) only adds costs and inefficiencies, costing our companies and employees more money. And, frankly, employers and their employees across our state are struggling to pay for health care already. We've seen that market pressure can positively influence rates faster than any other strategy – which was proven in Summit County with the launch of PEAK Health.

Last legislative session we saw major reforms to our health care system, including the introduction of a reinsurance program, estimated to reduce individual-plan premiums between 10 and 25 percent, and a law to end surprise billing, affecting about one-third of private-insurance customers. We will continue to work with legislators to explore additional market strategies that could help even more.

We appreciate and share your commitment to decreasing health care costs in Colorado but cannot allow our smallest businesses and their employees to continue to be expected to carry the burden of the unintended consequences from regulations like this.

Thank you for your consideration of our concerns. Please reach out to Laura Giocomo Rizzo at Laura.Rizzo@denverchamber.org with any questions.

Sincerely,

Kelly J. Brough

Kelly J. Brough

San Luis Valley HEALTH
CONEJOS COUNTY HOSPITAL

Oct. 28 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

I am proud to submit comments on behalf of San Luis Valley Health Conejos County Hospital for the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019. We agree that our state needs to take proactive steps to address health care access and affordability to ensure that Coloradans have access to the care they need and can afford it when they do seek care. Unfortunately, we are concerned that this proposal, as drafted, would have serious ramifications for our community, our local hospital and our state as a whole.

Specifically, we don't believe this proposal will help enough Coloradans and may actually jeopardize access to care and affordability for those who are already covered. With nearly 400,000 Coloradans currently uninsured, we are disappointed that this new option doesn't prioritize those individuals. We are also concerned that it will increase health insurance costs for many Coloradans, as costs will be shifted to the nearly half of Coloradans who have employer-sponsored insurance. Finally, we believe that the government rate setting for hospitals that funds this proposal could be incredibly detrimental to hospitals across our state.

Conejos County Hospital, our local hospital, is a vital part of our community. It is one of the largest employers in our community and provides significant community benefit beyond the traditional patient care offered within the hospital. While the draft proposal doesn't examine the financial impact to hospitals, we must assume that this type of government rate setting for hospitals will be significant – especially since hospitals cuts are the only funding mechanism for these significantly reduced health care plans.

The proposal purports to protect rural hospitals, but doesn't give any specific details about how that will happen. Our hospital, like most in rural Colorado, works incredibly hard to make ends meet in order to ensure access to care in our community. Without the benefit of the detail, this is too risky to our local hospital.

Please consider the impact this proposal could have on communities like ours, on hospitals like ours and on access to affordable care for patients like me, my family, friends and neighbors. We agree that there is still more work to do to improve our health care system, but this proposal as drafted is not the solution.

Sincerely,

Kelly Gallegos RN, BSN
Administrator
San Luis Valley Health Conejos County Hospital

National Jewish Health®
Breathing Science is Life®

Michael Salem M.D., FACS
President and CEO

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Oct. 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Dear Director Bimestefer and Commissioner Conway:

We appreciate the opportunity to provide feedback on the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019.

National Jewish Health is the #1 Respiratory Care hospital in the nation and we have been proud to be a part of Colorado for 121 years. We provide a unique patient care experience (and provide a great deal of time for each patient and their families with their provider) in respiratory, cardiac, immune and related disorders for adults and children. We have always been an organization that serves all patients on a first-come, first-serve basis. We have no restrictions on the number of Medicaid or uninsured patients we see. Many patients come to the institution having had a number of medical opinions previously; with serious unsolved medical issues; misdiagnoses; tertiary and quaternary medical problems; and, in many cases, a lack of education about their acute or chronic illnesses. We do all we can to keep patients from being hospitalized and work closely with Saint Joseph Hospital, a part of the SCL Health system, and a high quality/low cost provider.

We offer many services that are beyond essential hospital care, but are needed by our community. For example, we run an on-site, free school for up to 90 chronically ill children – the Morgridge Academy. This school serves Colorado children in kindergarten through 8th grade. The school serves the medical needs of the children while providing a solid education for children who are unable to succeed in their neighborhood schools due to their illnesses. While we receive some funding from the state for designated facility schools, the bulk of the cost is willingly borne by National Jewish Health. We also invest substantially in and conduct extensive biomedical research to ensure that we advance science and medicine to bring leading edge treatments and solutions to our patients and others around the world - a critical part of our mission.

We see over 130,000 patients each year. We know how important it is for people to get the health care they need at the time they need it. We have been a steadfast advocate for the expansion of health care coverage and access.

We have watched the conversation around the proposed public option legislation and the stakeholder process used to develop a plan required by House Bill 19-1004. Despite considerable input from the Colorado Hospital Association on behalf of all hospitals, including us, and input from many individual hospitals, community members and others, the process seems to have lacked substantive discussion about genuine solutions. As hospitals shared during the stakeholder process, we believe a state public option should:

- Prioritize coverage and affordability for Colorado's remaining uninsured
- Protect patient choice through competitive insurance markets
- Safeguard access to high-quality care through sufficient payments for providers and hospitals

Because the proposal does not include details in its actuarial analysis about the impact on hospitals like ours, it places the responsibility for that analysis on us. The proposal does not consider the unique issues of caring for the chronically ill or the patients that have failed treatment elsewhere. These patients require a higher level of clinical support, the costs of which are not reimbursed by Medicare and cannot be financially supported at the rates proposed in House Bill 19-1004.

We believe the current proposal will have significant negative impact on our organization. We operate on small margins and invest any income back into care and research to meet the needs of our patients. We do believe that the proposed plan is unworkable as it penalizes the very organizations that provide the care. We also believe that that the financial burden imposed by the proposed plan will be unsustainable and will ultimately lead to reimbursement reductions that our hospital cannot bear. And, we believe that reducing services or reducing the health care workforce – which are likely outcomes of this measure – are not in the best interest of Colorado.

This proposal is not an acceptable solution for our community or our hospitals, which is why we believe revisions must be made to this proposal before it is finalized. We urge you to look closely at the options provided by CHA.

We look forward to working with you and your staff on this and other issues as we all seek to maintain and improve Coloradan's access to high-quality, affordable health care.

Sincerely,

Michael Salem, M.D.

To Whom It May Concern:

My name is Melissa Shields. I live in [REDACTED] and I am an Oncology Certified Registered Nurse at Sky Ridge Medical Center.

I am submitting comments about my opposition to the State Option, which proposes to establish a public option for health insurance that would reimburse hospitals and healthcare providers at lower rates.

I'd like to start off by providing some background. In Colorado, the percentage of patients insured by Medicare or Medicaid increased from 20% in 2008 to 34% in 2017. That means that one-third of insurance payments for healthcare services in the State of Colorado are reimbursed at only $0.69 for every $1. The remaining $0.31 does not just disappear. These lost costs are, in effect, picked up by reimbursements from commercial insurance plans. In other words, hospitals and healthcare providers rely on reimbursements from commercial insurance plans to stay afloat to continue to provide vital and high-quality services to the community. The reimbursement constraints in this bill would force healthcare providers and hospitals to accept payments do not cover the cost of care. They will face pressure to cut services or close their doors, effectively cutting off access to healthcare to those who need it most – our patients.

I am a Registered Nurse. But I am also a wife, a friend, and daughter. I have hugged a young cancer patient knowing that was the last time I would see them alive. I have held and kissed the new baby of my best friend who tried for 4 years to get pregnant and then ended up having a high-risk, complicated & scary pregnancy. I have seen my father undergo brain surgery and rehab to treat a hemorrhagic stroke. I have stayed awake for 36 hours to stay with my husband as he prepared to undergo an emergency appendectomy. How can that happen if the lights are off and the doors closed and locked?

Like you, I want everyone to have affordable health insurance and access to high-quality care. But, doctors, nurses and hospitals did not cause these problems. So, they should not be punished. The State Option is well-intentioned, but it is the wrong way to go.

Thank you for your time and consideration.

Melissa Shields, RN, BSN, OCN, ONN-CG

To whom it may concern:
My name is Spencer Way. I'm from [REDACTED] and I work in administration at Littleton Adventist Hospital.
My office is adjacent to the surgery waiting area. I heard parents in the hallway calling friends and family to provide updates about their children in surgery after the STEM shooting in Highlands Ranch. I see nurses come in on their only day off for staff meeting on cost reduction, surgeons volunteer to change practice habits and schedules to create access and lower cost and I meet with clinicians who are bent and bowed by the pressure to do the right thing in the face of constantly shrinking resources and support on daily basis.
I believe we have a responsibility to lower the cost of care and create healthcare that every person in this country can access. But the State Option, a public option, unintentionally accomplishes the opposite.
This is a funding reduction for the front lines of healthcare. Forcing providers to accept below cost reimbursement threatens our ability serve everyone.
Economics in this case are simple. When we reduce the resources available to provide a service, the service will in turn be reduced. The connection between access and quality has been studied time and time again and the link is clear. When we reduce services, limit access or constrain the ability for people to seek care, the quality of care declines despite the best efforts of the clinicians I support every day.
I deeply appreciate the intention of the State Option but we can and we must do better.

Spencer Way

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Director Bimestefer and Commissioner Conway:

As a Registration Educator at University of Colorado Hospital in Aurora, I am writing to share my concerns about the "Draft Report for Colorado's State Coverage Option," released Oct. 7, 2019.

In my job, I meet patients and their families at an incredibly difficult time. We provide support and guidance as they make decisions ranging from end-of-life and final wishes to long-term care. More than 70 percent of the patients I work with are receiving either Medicaid or Medicare benefits. The rest are wither those who have private health insurance through their employer or those who have no coverage at all. At UCHealth, I am proud that each patient receives my best efforts and those of my colleagues, regardless of their income, insurance status, or ability to pay for care.

I am proud of UCHealth's commitment to our community. As the largest provider of Medicaid, we are dedicated to caring for every patient who walks through our doors. We also support programs that improve health in the communities we serve, keep kids healthy, prevent distracted driving, provide healthy food options for seniors, provide a free nurse advice line, free flu shots, programs to address postpartum depression, treat substance use disorders, and so much more. We've just started a program that will dedicate at least $100 million to treat behavioral health in a more comprehensive and integrated way.

While I applaud your desire to improve health care, I disagree with the plan's proposal to use government rate setting to cut reimbursements for hospitals. I believe such actions will force a dramatic reduction of services provided by hospitals like mine, as well as reducing or eliminating our community programs. Our largest payer is Medicaid, which is already reimbursing at a rate of .69c per dollar, and further reimbursement cuts will demand that as a hospital system we re-allocate budget funding to cover this greater gap in payment reimbursements. In times of crisis our patients should not be worried about the cost of care and I feel that further cuts to hospital reimbursements could have a negative impact on our top priority, the patients.

I care about my patients and the community we share. I am concerned that some hospitals will not be financially solvent enough to weather these cuts and will be forced to permanently close, especially in rural areas where healthcare resources are already stretched thin. I strongly believe that this proposal will cause serious harm to our patients, our communities, and our hospitals.

Please note that these are my personal comments and views, which don't necessarily represent those of my employer.

Respectfully,

Megan Smith
[REDACTED]
[REDACTED]