HB 21-1232

Legislative Council Staff

Nonpartisan Services for Colorado's Legislature

Final Fiscal Note

Drafting Number: LLS 21-0050
Prime Sponsors: Rep. Roberts; Jodeh
Sen. Donovan

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Bill Status: Signed into Law
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Bill Topic: **STANDARDIZED HEALTH BENEFIT PLAN COLORADO OPTION**

Summary of Fiscal Impact:

☒ State Revenue
☒ State Expenditure
☒ State Diversion
☐ TABOR Refund
☐ Local Government
☒ Statutory Public Entity

The bill directs the Commissioner of Insurance to develop a standardized health insurance plan that private health insurance carriers must offer; sets targets for premium rate reductions under the plan; and creates a process by which providers may be required to accept rates established by state regulators. It increases state expenditures and creates a General Fund diversion on an ongoing basis.

Appropriation Summary: For FY 2021-22, the bill requires and includes appropriations of $1.5 million to multiple state agencies.

Fiscal Note Status: The fiscal note reflects the enacted bill.

Table 1
State Fiscal Impacts Under HB 21-1232

		Budget Year FY 2021-22	Out Year FY 2022-23
Revenue		-	-
Expenditures	General Fund	$78,993	$159,282
	Cash Funds[1]	$1,409,637	$1,589,307
	Centrally Appropriated	$227,941	$269,998
	Total Expenditures	**$1,716,571**	**$2,018,587**
	Total FTE	**7.3 FTE**	**8.8 FTE**
Diversions	General Fund	($1,618,394)	($1,825,137)
	Cash Funds	$1,618,394	$1,825,137
	Net Diversion	**$0**	**$0**
TABOR Refund		-	-

[1]The standardized health insurance plan will be funded initially from the Division of Insurance Cash Fund, possibly to be supplanted by federal funds starting in FY 2022-23.

Summary of Legislation

The bill directs the Commissioner of Insurance to develop a standardized health insurance plan that private health insurance carriers are required to offer. It sets targets for premium rate reductions under the plan and creates a process by which health care providers and hospitals may be required to accept the plan and rates established by state regulators.

Standardized health insurance plan. By January 1, 2022, the commissioner must establish, by rule, a standardized health insurance plan that private health insurance carriers will be required to offer in the individual and small group market segments. The plan must be developed through a stakeholder engagement process, must offer coverage at the bronze, silver, and gold coverage levels, and must include pediatric care and all essential health benefits. It may be updated annually. An advisory board made up of 11 governor appointees is created to advise and assist with implementation.

Carrier participation. Beginning January 1, 2023, insurance carriers are required to offer the standardized plan in any county where they offer coverage in the individual and/or small group markets. In addition, the commissioner may require a carrier to offer the standardized plan in specific counties where no carrier is offering the plan. Standardized plans must be offered at premium rates at least 6 percent less than the plans that carrier offered in the 2021 calendar year, adjusted for medical inflation. For 2024 and 2025, the plans must be offered at premium rates at least 12 percent and 18 percent less, respectively. Beginning in 2026, premiums may increase by no more than medical inflation.

Rate and network hearings. If a carrier is unable to meet the premium or network adequacy requirements for the standardized plan, the Division of Insurance (DOI) must hold a public hearing to examine why the carrier failed to do so. The hearing is open to affected parties throughout the health care system. Based on evidence presented at the hearing and actuarial analysis, the commissioner may establish provider and hospital reimbursement rates as needed to meet the requirements. Rates may not be less than 135 percent of Medicare rates for providers and 155 percent for hospitals, with further adjustments for certain classes of hospitals detailed in the bill.

Provider participation and reimbursement. Following a rate and network hearing, the commissioner may require a health care provider or hospital to participate in a standardized plan and accept the reimbursement rate if deemed necessary to achieve premium and network adequacy requirements. A hospital refusing to participate is subject to fines of up to $10,000 per day, increasing to $40,000 per day after 30 days, and state regulators may suspend or impose conditions on its license.

Ombudsman. The Office of the Insurance Ombudsman is created to act as an advocate for consumer interests in matters related to access and affordability of the standardized plan. Duties include representing the interests of consumers in rate and network hearings. The ombudsman is housed in the Department of Health Care Policy and Financing, though acts independently of the department.

Federal waiver. The commissioner must seek a State Innovation Waiver from the federal Department of Health and Human Services to implement the bill and to identify savings to the federal government attributable to the bill. Upon approval by the federal government, a portion of the savings generated may be passed through to the state. This pass-through funding may be used for the implementation of the standardized plan and for the Colorado Health Insurance Affordability Enterprise to increase

the value, affordability, quality, and equity of health care coverage in Colorado. The requirement that carriers offer the standardized plan is conditional upon approval of the waiver and receipt of federal funds.

Reports. The commissioner must hire a consultant to prepare five reports. First, a report describing how the standardized plan affects hospital staffing, wages, benefits, training, and working conditions, which may include policy recommendations. The report must be submitted each July for three years beginning in 2023. Next, a report summarizing how the standardized plan impacts health plan enrollment, insurance affordability, and health equity, due January 1, 2026. Lastly, a report evaluating how to phase in to a hospital's reimbursement methodology, due December 31, 2022.

Background

Colorado's individual and small group markets. In 2019, an estimated 204,000 individuals received health insurance coverage in Colorado's individual market. Another 267,000 individuals received coverage in the small group market, which consists of plans for employers that have fewer than 100 employees. About 375,000 Coloradans are estimated to be uninsured.

Federal premium subsidies. In 2019, Coloradans received about $749 million in federal advance premium tax credits to purchase health insurance through Connect for Health Colorado, the state's health insurance exchange. These subsidies, established in the federal Affordable Care Act, are based on household income, premium amount paid, and the cost of a benchmark health plan. Subsidies are available to persons with income between 133 and 400 percent of the federal poverty level. Adults with income up to 133 percent of the federal poverty level are eligible for Medicaid. Children, the elderly, and persons with disabilities are also eligible for Medicaid at various income levels.

State innovation waivers. Section 1332 of the federal Affordable Care Act allows states to apply for waiver of various requirements of the federal law to pursue innovative strategies for providing residents with access to high-quality, affordable health care. These waivers allow states to receive federal "pass-through" funds based on estimated savings to the federal budget from reduced advance premium tax credits or other federal spending.

Health insurance coverage levels. Plans sold on the health insurance exchange are differentiated based on how costs are split between the insurer and covered individual. Bronze, silver, and gold levels indicate plans that provide benefits actuarially calculated to be sixty, seventy, and eighty percent, respectively, of the full value of benefits provided under the plan.

State Revenue

State revenue is likely to increase from fines issued to health facilities that fail to accept patients enrolled in a standardized plan. Revenue is not estimated due to insufficient data on which to base an estimate and the discretionary nature of the fines. Fine revenue is deposited into the General Fund and is subject to state revenue limits under TABOR.

State Diversions

The bill diverts an estimated $1.6 million from the General Fund to the Division of Insurance Cash Fund in FY 2021-22, and $1.7 million in FY 2022-23. This revenue diversion occurs because the bill increases costs in the DOI, which is funded with premium tax revenue that would otherwise be credited to the General Fund.

State Expenditures

The bill is estimated to increase state expenditures by $1.7 million and 7.3 FTE in FY 2021-22, and $1.9 million and 8.8 FTE in FY 2022-23. In subsequent years, all costs continue at the FY 2022-23 level, except for the reports with statutory deadlines, which continue through FY 2025-26 only. These costs are shown in Table 2 and described below.

Table 2
Expenditures Under HB 21-1232

Cost Components	FY 2021-22	FY 2022-23
Department of Regulatory Agencies		
Personal Services	$451,167	$451,167
Operating Expenses	$7,290	$7,290
Capital Outlay Costs	$31,000	-
Actuarial Consultant	$400,000	$400,000
Healthcare Consultant	$97,500	$60,000
Reports	$210,000	$300,000
Legal Services	$212,680	$265,850
Centrally Appropriated Costs[1]	$208,757	$235,830
FTE – Personal Services	5.4 FTE	5.4 FTE
FTE – Legal Services	1.1 FTE	1.4 FTE
DORA Subtotal	**$1,618,394**	**$1,720,137**
Department of Health Care Policy and Financing		
Personal Services	$65,243	$156,582
Operating Expenses	$1,350	$2,700
Capital Outlay Costs	$12,400	-
Centrally Appropriated Costs[1]	$19,184	$34,168
FTE – Personal Services	0.8 FTE	2.0 FTE
HCPF Subtotal	**$98,177**	**$193,450**
Total	**$1,716,571**	**$1,913,587**
Total FTE	**7.3 FTE**	**8.8 FTE**

[1] Centrally appropriated costs are not included in the bill's appropriation.

Department of Regulatory Agencies. Beginning in FY 2021-22, the DOI requires additional staff to develop and implement the standardized plan. Initial workload includes development of the plan structure, reviewing additional rate and form filings, coordinating work to analyze whether carriers meet premium requirements, and submitting the federal waiver. In addition, staff are needed to conduct public rate and network hearings, and following these hearings, to develop provider reimbursement rates. In addition, the fiscal note includes costs for the following:

- *Actuarial consultant.* This work includes contributing to the development the standardized plan, conducting premium target reduction analysis, and developing a fee schedule. This is estimated to require 1,000 hours per year at a rate of $400 per hour on an ongoing basis.

- *Health care consultant.* This work includes developing the federal waiver application and designing standardized plan benefits. This is estimated to require 325 hours in the first year and 200 hours in subsequent years on an ongoing basis at a rate of $300 per hour.

- *Reports.* First, a report on phasing in hospital reimbursement methodology requires 700 hours at a rate of $300 per hour in FY 2021-22 only. After that, various consultants are needed to complete the annual hospital workforce reports for three years and a 2026 report on the impact of the standardized plan on health plan enrollment, insurance affordability, and health equity. These reports will be released once per year from FY 2022-23 through FY 2025-26. For each of these four fiscal years, this is estimated to require 1,000 hours at a rate of $300 per hour.

- *Legal services.* In the first year, legal services are required for rulemaking and stakeholder work. In year 2 and beyond, this work also includes rate and network hearings and enforcement activities. This is estimated at 2,000 and 1.1 FTE and 2,500 hours and 1.4 FTE, respectively, at the standard legal services rate of $106.34 per hour.

Initial administrative costs are paid from the DOI Cash Fund. The fiscal note assumes these costs will be paid from federal funds if available. Though the receipt and timing of federal funds is uncertain, they potentially may be received as soon as FY 2022-23.

Federal pass-through funding. If Colorado is granted a State Innovation Waiver, the state is expected to receive federal funds based on savings to the federal budget attributable to this initiative. The bill specifies that pass-through funds can be spent at the discretion of the commissioner for two purposes: (1) to administer the standardized plan, and (2) through the Colorado Health Insurance Affordability Enterprise for value, affordability, quality, and equity related objectives. It is estimated that the state could receive up to $88 million in federal pass-through funding per year.

Department of Health Care Policy and Financing. The Office of the Insurance Ombudsman is created in the department and requires two staff members to fulfill the duties of this office, prorated to reflect the General Fund paydate shift and a start date of January 1, 2022.

Centrally appropriated costs. Pursuant to a Joint Budget Committee policy, certain costs associated with this bill are addressed through the annual budget process and centrally appropriated in the Long Bill or supplemental appropriations bills, rather than in this bill. These costs, which include employee insurance and supplemental employee retirement payments, are estimated to be $227,941 in FY 2021-22 and $269,998 in FY 2022-23.

TABOR refunds. The bill increases state revenue subject to TABOR. For FY 2022-23, the March 2021 LCS forecast projects revenue to fall short of the TABOR limit by $28.6 million, or 0.2 percent of the limit. If actual revenue exceeds the limit, the bill will increase the amount required to be refunded to taxpayers from the General Fund in FY 2023-24.

Statutory Public Entity

Connect for Health Colorado, the state's health insurance exchange, is funded primarily through a health insurance carrier fee charged on plans purchased through the marketplace. The fee is set at 3.5 percent of premiums for 2021. To the extent that the bill decreases some premiums and increases the number of policies purchased, this will have an offsetting impact on revenue to the exchange; the net impact of these effects is not estimated. In addition, the exchange will incur one-time costs to conduct a survey and update marketing materials, technology, data collection, and reporting practices.

Effective Date

The bill was signed into law by the Governor and took effect on June 16, 2021.

State Appropriations

For FY 2021-22, the bill requires the following appropriations:

- $1,409,637 to the Department of Regulatory Agencies from the Division of Insurance Cash Fund, and an allocation of 5.4 FTE. Of this amount, $212,680 is reappropriated to the Department of Law for legal services, with an additional allocation of 1.1 FTE.

- $78,993 to the Department of Health Care Policy and Financing from the General Fund, and an allocation of 0.8 FTE.

State and Local Government Contacts

Connect For Health Colorado
Regulatory Agencies
Health Care Policy and Financing
Information Technology
Public Health and Environment
Governor
Judicial
Higher Education
Law
Personnel

Demographic Note

Legislative Council Staff prepared a Demographic Note for the introduced version of this bill. To access the note, please visit the General Assembly website using the link below.

https://leg.colorado.gov/agencies/legislative-council-staff/demographic-notes