ISSUE BRIEF | House Bill 21-1232

Standardized Health Benefit Plan Colorado Option

Background

The affordability of health insurance continued to be a key focus of the General Assembly in 2021. Following the passage of a public option study bill in 2019 and a failed public option bill in 2020, CHA engaged with stakeholders and legislators to negotiate on key provisions in one of the primary health care bills this legislative session, the "public option" or "Colorado Option," at the direction of the CHA Board of Trustees.

HB 21-1232: Standardized Health Benefit Plan Colorado Option

House Bill (HB) 21-1232 allows the state to develop a standardized health insurance plan that private health insurance carriers are required to offer in the individual and small group markets starting in 2023. These standardized plans must achieve a 15 percent premium reduction, phased in over three years (2023-25), and can only grow at the rate of medical inflation after 2025. The bill also creates a process by which health care providers and hospitals may be required to accept the plan and rates established by the state if private negotiations do not achieve premium reduction targets.

What You Need to Know

The bill requires the Commissioner of Insurance to establish a standardized health plan offered by carriers in the individual and small group markets and include coverage at the gold, silver, and bronze levels by Jan. 1, 2023. The standardized plan must:

- Be offered in all counties where a carrier currently does business;
- Have a network that is no 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;
- Include a majority of essential community providers and a description of efforts to construct a diverse, culturally responsive network;
- Include all essential health benefits required by the Affordable Care Act; and,
- Provide first-dollar, pre-deductible coverage for certain high-value services.

The standardized plan is being developed through a stakeholder engagement process run by the Division of Insurance (DOI). Meetings begin on July 29 and will run through the summer and fall of 2021. The DOI will be accepting stakeholder input from hospitals, insurers, other industry professionals, and consumer advocates.

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For questions or more information, contact Joshua Ewing, CHA vice president, legislative affairs, at joshua.ewing@cha.com.

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Colorado Hospital Association

DOI Rate Hearing and Fee Schedule Process

If an insurer believes they will not be able to meet network adequacy standards or the premium rate reductions specified in statute, an insurer or health care provider may enter non-binding arbitration prior to filing rates, which typically occurs in April or May of the preceding year. If insurers are unable to meet premium reductions or network adequacy requirements, the DOI will hold a public hearing prior to approval of the insurers' final rates.

Following a public hearing, the Commissioner of Insurance may establish reimbursement rates based on evidence presented at the hearing to meet the premium rate requirements or network adequacy standards. DOI-imposed reimbursement rates may not exceed one year and are limited to a specific plan within a single county, and evidence at the hearing must demonstrate that the provider for whom rates are being set was a contributor to the plan's inability to meet the premium reduction target.

The DOI must follow a "higher of" methodology for establishing rates that examines:

1) A Medicare base rate formula calculated from a threshold of 155 percent of provider-specific Medicare rates with specific increases calculated from financial data reported to the state, as follows:
   - 20 percent increase for an essential access hospital;
   - 20 percent increase for an "independent" hospital not part of a health system (defined as three or more hospitals);
   - 30 percent increase for a hospital with a Medicare/Medicaid payer mix that exceeds the statewide average; and,
   - 40 percent increase for a 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.
   - Under this formula, there are some exceptions:
     - No hospital shall receive less than 165 percent of Medicare.
     - A pediatric specialty hospital with a Level 1 pediatric trauma center will receive a 55 percent increase, but they may not receive other increases specified above.
     - The state shall adopt a special Medicaid conversion factor for pediatric and obstetric services, as well as other small-volume Medicare services.
2) Maximum reduction of 20 percent below the prior year negotiated rate between a specific hospital and a specific carrier.
3) If a hospital's rates are less than 10 percent below the statewide median (for individual or small group), a maximum reduction of one-third of the difference between their current rate and the formula output from option one above or 165 percent of Medicare, whichever is higher.

After the determination of reimbursement rates, the Commissioner may require a health care provider to participate in the standardized plan and accept the reimbursement rate. Carriers and provider may appeal the decision by the Commissioner to the district court.

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Implementation Timeline

- **Summer/fall 2021:** DOI stakeholder processes on standardized health benefit plan and network adequacy standards.
- **Jan. 1, 2022:** Deadline for DOI to establish standardized health benefit plan and network adequacy standards; in setting premium reduction targets, DOI must take into account medical inflation and benefit design differences for the standardized plan compared with 2021 plans.
- **May 1, 2022:** Carriers must notify DOI if they cannot meet premium or network adequacy requirements for 2023.
- **July 1, 2022:** Deadline for Governor to appoint advisory board to consult with DOI, consider utilization management processes, consider alternative payment methods, and other duties.
- **Plan Year 2023:** Carriers must offer standardized plans 5 percent less than 2021 plan premiums.
  - DOI may begin holding public hearings in 2023.
  - March 1, 2023, and March 1 in subsequent years: deadline for insurers to notify DOI of inability to meet premium or network adequacy targets.
- **Plan Year 2024:** Carriers must offer standardized plans 10 percent less than 2021 plan premiums.
- **Plan Year 2025:** Carriers must offer standardized plans 15 percent less than 2021 plan premiums.
- **Plan Year 2026 and beyond:** Carriers must offer standardized plans that have not increased more than U.S. medical inflation of the previous years' plan premiums.

Additional Resources

- HB21-1232 and Fiscal Note

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