Health Law and Policy Update:
March 8, 2013

This week's updates:

Medicaid Expansion bill will be heard on Thursday

Senate Bill 13-200, that increases eligibility for Medicaid, will have its first hearing on March 14th at 1:30 p.m. in the Old Supreme Court Chambers on the second floor of the Capitol. See the CCLP fact sheetfor more information about the bill. We encourage organizations that support SB200 to sign on to a support letter by e-mailing Marykathryn Hurd, legislative liaison for the Department of Health Care Policy and Financing, at mk.hurd@state.co.us.

What's New

HHS releases final regulations - crash course in insurance rating in 2014

The US Department of Health and Human Services has recently released a slew of regulations regarding the implementation of the Affordable Care Act (ACA). Most recently, HHS released its final regulations concerning how health insurance companies may rate and price their products given the many consumer protections present in the ACA. As many of our readers know, the ACA requires that health insurance companies, starting in January 2014, no longer base insurance rates on health status or gender. The only rating factors allowed in the reformed market are age, family unit size (only applicable for family coverage), geographic area and tobacco use.

- Age rating shall not exceed a 3:1 ratio for adults - meaning that insurance rates for the oldest adults shall not exceed three times that of the youngest adults. The final rule requires a single age band for children ages 0 to 20 and one-year age bands for adults ages 21 through 64 (within the 3:1 ratio

maximum), which will be determined annually at the time of plan enrollment or renewal.

- Tobacco rating shall not exceed a 1.5:1 ratio for tobacco using adults - meaning that insurance rates for tobacco using adults shall not exceed one and a half times that of non-tobacco users. The rule defines tobacco use as use of any tobacco products (including smokeless tobacco) on average of four or more times per week within the past six months. The rule also includes an important consumer protection that prohibits insurers from canceling a policy for misrepresentation of tobacco use. Consumer advocates have raised significant concerns that higher health insurance rates for tobacco users could make coverage much less affordable thereby making it difficult to access the services they need. In response to these concerns, the final rule requires small employer plans to offer a discount for smoking cessation wellness programs. However, we are concerned that this discount may not be adequate. Moreover, this discount is not available for individual policies sold through the exchange.
- Health insurers may charge higher rates from one geographic area to another. States are limited to creating geographic rating areas based on counties, zip codes or metropolitan statistical areas and the rating differences must be actuarially justified. However, states can establish different geographic rating areas with the approval of HHS. As a 2012 Robert Woods Johnson Foundation report explains, insurance rates for rural residents are typically higher than urban residents. However, it is not clear whether this is due to higher administrative costs required for health coverage in rural areas, higher costs of delivering care in rural areas, unhealthier rural populations, or some combination of these factors.
- Finally, the rule clarifies that insurance rates for family policies will vary on the family unit size. Family policy rates will be calculated by adding up all of the individual rates, adjusted for the factors above, for each covered family member over 21 and for the oldest three covered children under age 21. If a family has more than three children under 21, they do not count towards the family rate. This method of calculating family policy rates is meant to address the potential that certain family members may obtain coverage from different sources. For example, children in a family may be covered under CHIP, young adults may obtain student health insurance through their college or university, and adults may have varying options through their employers. Of course, the devil lies in the details with respect to how this rating methodology will translate into actual premiums, deductibles, cost-sharing requirements and overall affordability.

Legislation would provide funding for the Colorado Health Benefit Exchange

On March 1, Colorado State Representative Beth McCann and Senator Pat Steadman introduced House Bill 13-1245, which would provide funding for the Colorado Health Benefit Exchange (COHBE) between 2014-2016. The bill would transition existing health insurance carrier assessments to COHBE to support its operations, sustainability and ability to generate reserves. The existing carrier assessment is currently used to support CoverColorado, Colorado's state-based insurance plan for individuals with pre-existing conditions. HB 1245 would cap the assessment at $1.80 per plan sold in the individual and small group markets. Based on financialmodeling performed by COHBE, this assessment would generate revenue in the amount of $14.7 million per year. Moreover, HB 1245 would transfer a $5 million premium tax credit, which is also part of the existing CoverColorado assessment structure, to the exchange, resulting in a total of nearly $20 million in revenue for years 2014, 2015 and 2016. COHBE projects their annual operating budget to be $26 million.

The assessment prescribed in HB 1245 would sunset after 2016 and COHBE would then have to rely on other funding mechanisms, including administrative fees on carriers participating in the exchange, which would be passed on to consumers in form of higher premiums. COHBE projects that these administrative fees could range from 1%-3.4% of premiums per plan sold in the exchange, depending largely on whether HB 1245 passes. Based on 2010 data from the Colorado Division of Insurance, this administrative fee could range from to $11 to $38 per month for a family health insurance policy.

Advancing the Debate

Commonwealth Fund profiles Colorado Accountable Care Collaborative

For those interested in what states are doing around delivery and payment system reform, The Commonwealth Fund released case studies this week of efforts underway in Colorado, Minnesota and Vermont. The profile of Colorado's Accountable Care Collaborative program is very positive, highlighting Colorado

results, lessons learned and opportunities for further federal action to support states.

Sequester corner

We thought we would pick out one way in which the Sequester will impact health care services in Colorado. First, for those looking for an overview of the Sequester, we were very impressed with thispiece from the Washington Post's Wonk Blog. The Denver Post wrote a story about Colorado specific impacts.

Impact on Community Health Centers

We wanted to highlight the effect of sequester related cuts on Community Health Centers. CHCs are critical primary care access points for lower income people in Colorado and across the nation. George Washington University's School of Public Health and Health Services released an analysis this week of what a 5% across the board cut would mean to Community Health Centers. According to the report, the nation's 1,200 community health centers are expected to experience a $120 million loss in grant funding. That cut would result in approximately 3 million fewer patient visits than expected during 2013.

Specifically, the report says that "depending on the type of personnel considered (salaries and support costs vary, of course), a loss of $120 million represents 450 physicians, 300 dentists, 900 nurses and physician assistants, or 90 mental health providers.

Of those patients impacted, 72% (648,000) will live in families with incomes below 100% of the federal poverty level. 32% (288,000) will be children. The report also notes that every dollar spent on Medicaid generates, on average, $5 dollars in economic activity. Therefore, a loss of $120 million in health center funding will cost the communities they serve $600 million overall in direct and indirect economic benefits.

When we examine Colorado impacts, a 5% across the board cut to the particular funding stream subject to sequester means that Colorado CHCS will lose $3 million. The impact on Colorado communities will vary depending in part, on how long each CHC has to prepare and implement anticipated cuts. A 5% cut can be

much higher if it has to be implemented almost half-way through the federal fiscal year, as is the case with the Sequester. HRSA has not yet determined how these cuts will be implemented.

What You Can Do

Connect for Health Assistance Network - Q&A session

The Colorado Health Benefit Exchange, soon to be doing business as Connect to Health Colorado, will host its final Q&A session regarding the Assistance Network (Navigator Program) request for proposals. The meeting will take place on Tuesday, March 12, 2013, 10:30 am to Noon. More information is available on the COHBE website.