Colorado Option Strike Below Overview

Removal of Phase 1
Creation of standardized plan requirements
- Created through a stakeholder engagement process; finalized by January 1, 2022
- Standardized plan offered in individual and small group markets in bronze, silver, and gold metal levels
- Standardized plans must be offered starting in 2023 by all commercial carriers, in the geographic areas (counties) and markets where they are currently offering plans
- Individual market plans will be offered on-exchange and through public benefit corporation (PBC)

Provisions include:
- Enhanced network adequacy requirements that aim to improve equity and ensure access to culturally responsive care
- To the extent possible, provider networks, for the standardized plan, should reflect the diversity of its enrollees;
- Network access plans need to include a description of the carrier's efforts to address equity and reduce health disparities;
- If the carrier is unable to achieve the network adequacy requirements with respect to diversity and/or cultural responsiveness of providers, the carrier files an action plan that describes their efforts to achieve greater diversity and cultural responsiveness in their networks
- Access to some pre-deductible, high-value services

Premium reduction targets
- Phased in premium reductions in both individual and small group:
    - 10% in year 1,
    - 20% in year 2, and
    - Limit future increases to CPI-U plus 1%
    - Use 2021 as benchmark year, allow for inflation (CPI-U)
- Premium targets applied prior to reinsurance and account for any health insurance mandates and/or changes to the standardized plan
- DOI consult with an advisory committee in developing the methodology for evaluating the premium rate reduction targets; advisory committee will include representation from consumers, providers, hospitals, and carriers, and be limited to 11 members

Public hearings
- If a carrier fails to meet the premium reduction target for the standardized plan or is unable to build an adequate network at the premium reduction target, the Division is compelled to call a rate hearing (only for those entities that failed to meet the targets; the "bad actors")
- If evidence is presented during the hearing that indicates that carriers cannot achieve the premium reduction target or network adequacy requirements, the Division may compel providers to participate at a rate that achieves the premium reduction target by:

- Establishing a fee schedule for hospitals and/or providers for categories of services, as long as it covers the costs of hospitals and providers; and
- In the case of a bare county, requiring carriers to offer the standardized plan in specific counties, after considering the carrier's structure, number of covered lives (and which lines of business), their existing service area, and alternatives available (like purchasing alliances).
- Orders issued by the DOI may be appealed to the district court

Consumer ombudsman
- There is a consumer ombudsman position created that is independent of the department or division where they're created; recommendations or decisions of the ombudsman will not be reflective of the state agency in which they're located.
- The ombudsman will field consumer concerns regarding standardized plans and represent consumer interests (generally), including:
  - Interacting with consumers regarding their access, affordability, and coverage issues with the standardized plan
  - Evaluating data to assess the standardized plan's network and affordability; and
  - Representing the interests of consumers in public hearings (as described above)

1332 waiver language
- The Division applies for a 1332 waiver; pass through funding is directed toward the health insurance affordability enterprise to preserve affordability for subsidized and low- income populations

Creation of a Hospital Standardized plan and a Provider Standardized plan
- This section is missing a lot of details but will cover mandatory participation and repercussions if facilities and providers refuse to participate