# HB 21-1232

Legislative Council Staff

*Nonpartisan Services for Colorado's Legislature*

## Revised Demographic Note

(replaces demographic note dated April 8, 2021)

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| **Drafting Number:** | LLS 21-0050 | **Date:** | May 17, 2021 |
| **Prime Sponsors:** | Rep. Roberts; Jodeh<br>Sen. Donovan | **Analyst:** | Elizabeth Ramey \| 303-866-3522<br>Elizabeth.ramey@state.co.us |

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| **BILL TOPIC:** | **STANDARDIZED HEALTH BENEFIT PLAN COLORADO OPTION** |
| **Demographics Analyzed:** | • Socioeconomic Status • Race/Ethnicity • Sex • Disability • Geography |
| **Direct Impact(s):** | ☒ Economic ☒ Employment ☒ Health ☐ Education ☐ Public Safety |
| **Bill Impact:** | If the bill expands access to health care or lowers insurance premiums, economic and health outcomes will improve for several populations in the state, including but not limited to lower income, uninsured, and rural populations. If health care providers reduce services in response to reduced premiums required under the bill, the bill may impact economic, employment, and health outcomes for the populations or health care providers affected. |
| **Report Status:** | This demographic note reflects the introduced bill. |

## Demographic Impact Summary

This demographic note[1] analyzes potential impacts of HB 21-1232 on disparities in economic and health outcomes based on available data, including by sex, ethnicity, race, education, disability, geography, age, and income.[2] HB 21-1232 directs the Commissioner of Insurance to develop a standardized health insurance plan that private health insurance carriers are required to offer at reduced premium rates in individual and small group markets starting in 2023. Economic and health outcomes for those who elect to use the reduced premium plan are expected to improve, potentially reducing economic and health disparities by ethnicity, race, education, geography, age, and income. Demographic characteristics of existing and potential consumers of standardized health plans suggest that the following demographics are more likely to be impacted by HB 21-1232 through reduced health insurance premiums:

[1]Pursuant to Section 2-2-322.5, C.R.S., this demographic note uses available data to outline the potential impacts of proposed legislation on disparities within the state. Disparities are defined by statute as the difference in economic, employment, health, education, or public safety outcomes between the state population as a whole and subgroups of the population, as defined by socioeconomic status, race, ethnicity, sex, gender identity, sexual orientation, disability, geography, or any other relevant characteristic for which data are available. It is beyond the scope of this analysis to examine each of the varied causes contributing to a given disparity. For further information on the contents of demographic notes, see "Demographic Notes Overview" Memorandum available at https://leg.colorado.gov/sites/default/files/images/lcs/demographic_notes_overview.pdf.

[2] Terminology used to distinguish demographic groups (e.g., black/African American, Hispanic or Latina/Latino) is based on the terminology used in the data sources referenced. These terms may differ from the self-identification of these populations.

- persons who are Hispanic or non-white;
- those of lower socioeconomic status as measured by education and income;
- persons living in rural communities; and
- adult Coloradans under the age of 65.

To the extent that reduced-premium health plans result in lower reimbursement rates for health care providers, the bill will have economic impacts for affected health care providers. To the extent that these health care providers respond by reducing the provision of health care services, employment and health outcomes for those in the provider's service region may be reduced. Many of these impacts depend on how the bill is implemented and cannot be determined at this time.

## Key Provisions Impacting Demographic Disparities

The bill directs the Commissioner of Insurance to develop a standardized health insurance plan that private health insurance carriers must offer in individual and small group markets beginning January 1, 2023. The plan must be designed to improve affordability and access as well as to improve racial health equity and reduce racial health disparities. Beginning January 1, 2023, insurance carriers must offer the standardized plan at a premium rate that is below the 2021 rate for health insurance plans offered by the carrier by at least 6 percent in 2023, 12 percent in 2024, and 18 percent in 2025, adjusted for medical inflation. Beginning in 2026, premiums may increase by no more than medical inflation. Cost-shifting from the standardized plan to another plan that requires state approval is prohibited, and cost shifting to self-funded plans may be monitored by the Commissioner.

If a carrier is unable to meet the premium or network adequacy requirements for a standardized plan, the Division of Insurance (DOI) may establish provider and hospital reimbursement rates, which may be no less than 135 percent of Medicare rates for providers and 155 percent for hospitals, with adjustments and exceptions for certain hospitals including small, rural, critical access hospitals, among others. Reimbursement rates are required to take into account employment costs for health-care employees. A health care provider or hospital may be required to participate in a standardized plan and accept the reimbursement rate. Requiring carriers to offer the standardized plan is contingent upon the federal government granting a state innovation waiver allowing the state to capture federal government savings as a result of the implementation of the standardized plan.

The commissioner must hire a consultant to prepare a report on the impact of the standardized plan on employment conditions and compensation for hospital workers and a second report on the impacts of the standardized plan on health plan enrollment, insurance affordability, and health equity disaggregated by race, ethnicity, immigrations status, sexual orientation, gender identity, age, and ability if such data are available.

**Similar legislation in other states.** Seven states, including California, Connecticut, Massachusetts, New York, Oregon, Vermont, and Washington, along with the District of Colombia, currently require insurers to offer standardized health benefit plans.

## Background

**Existing health disparities.** Existing health disparities, or differences in health status experienced by different groups, are well-documented, both in the U.S. and Colorado. Many factors contribute to disparities including inadequate access to care, quality of care, poor air quality, language barriers, community features such as poverty, access to healthy foods, and availability of safe and stable housing, and individual factors such as genetics and personal behavior. Racial and ethnic minority communities, rural communities, people with disabilities, populations with a lower socioeconomic status, and LGBTQ communities are often disproportionately exposed to adverse conditions, environments, and health risks and more likely to experience health disparities.[3]

For example, people living in rural areas are more likely to die from heart disease, stroke, cancer, chronic lower respiratory disease, and unintentional injury than their urban counterparts.[4] These disparities are tied to individual, environmental, economic and social factors: rural Americans tend to be older, have higher rates of cigarette smoking, opioid abuse, high blood pressure, and obesity, and lower physical activity levels and seatbelt use. They also tend to have higher levels of poverty, less access to health care and longer travel distances to emergency and specialty care, and are less likely to have health insurance.

Among Coloradans, most residents (85.2 percent) report good, very good, or excellent health, yet among lower income residents (those with incomes at or below 100 percent of the federal poverty level), only 73.3 percent report excellent, very good, or good health.[5] Among Hispanic/Latinx and black Coloradans, 80.6 percent and 81.7 percent report excellent, very good, or good health, respectively, compared to 87 percent of white Coloradans who do so. Non-white Coloradans are more likely than white non-Hispanic Coloradans to experience food insecurity, poverty, and uninsurance, and to suffer from chronic disease such as diabetes and childhood asthma, disability, poor mental health and higher infant mortality.[6]

The COVID-19 pandemic has highlighted health disparities across demographic groups, with risk of COVID-19 exposure correlated to differences in employment and housing conditions and socioeconomic status, among other factors. In Colorado, for example, white non-Hispanic residents were infected at lower rates and experienced lower rates of hospitalization and death from the disease than black/African American, Hispanic/Latinx, or American Indian/Alaska Native residents.[7]

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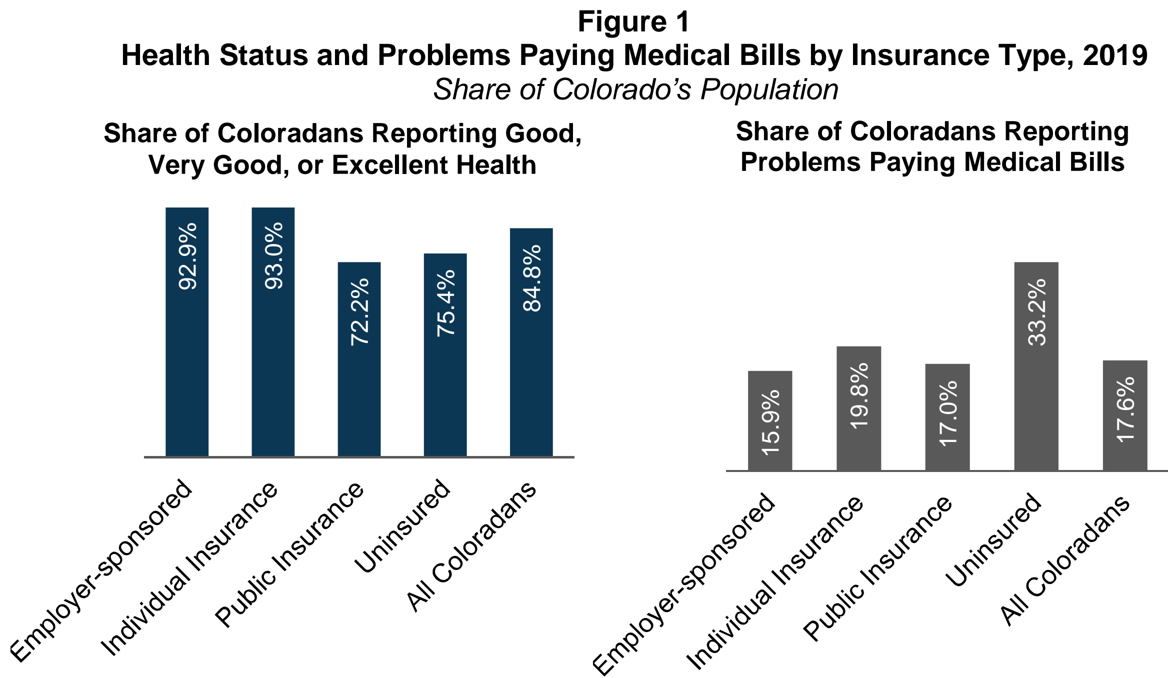
[3] NCSL. 2020. "Health Disparities Overview." Available at: https://www.ncsl.org/research/health/health-disparities-overview.aspx
[4] Centers for Disease Control and Prevention. 2017. "Rural Americans at Higher Risk of Death from Five Leading Causes." Available at: https://www.cdc.gov/media/releases/2017/p0112-rural-death-risk.html
[5] Colorado Health Institute. 2020. "2019 Colorado Health Access Survey: Health of Coloradans." Available at: https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-coloradans
[6] Colorado Department of Public Health and Environment. 2019. Health Inequities Impacting Colorado Communities of Color." Available at: https://cdphe.colorado.gov/inequity-fact-sheets
[7] Colorado School of Public Health. 2020/2021. "Regional Models for Colorado." Available at: https://coloradosph.cuanschutz.edu/resources/covid-19/modeling-results

**Health disparities, access to health care, and health insurance.** Differences in health insurance coverage are one factor in health disparities. Research suggests that health insurance coverage can increase access to health care and improve health outcomes.[8] Health insurance may translate into better health outcomes and less health-related financial risk, but the relationship is complex and many other factors influence access to health care as well as health outcomes.

As shown in Figure 1, compared to the statewide population as a whole, uninsured Coloradans are less likely to report good, very good, or excellent health (75.4 percent versus 84.8 percent) and are at greater risk for experiencing problems paying medical bills (33.2 percent versus 17.6 percent). However, health disparities persist even with insurance coverage, reflecting socioeconomic and other factors. For example, almost one in five Coloradans with individually purchased insurance report problems paying medical bills, while fewer than three quarters of Coloradans with public insurance, including Medicare and Medicaid, report good, very good, or excellent health.

**Figure 1**
**Health Status and Problems Paying Medical Bills by Insurance Type, 2019**
*Share of Colorado's Population*




*Source: Colorado Health Institute, 2019 Colorado Health Access Survey,*

[8] Sommers, B., A Gawande, and K. Baicker. 2017. "Health Insurance Coverage and Health – What the Recent Evidence Tells Us." *New England Journal of Medicine.* 377: 586-593. McWilliams, J. M. 2009. "Health Consequences of Uninsurance among Adults in the United States. *Milbank Quarterly.* 87(2): 443-494. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881446/pdf/milq0087-0443.pdf .

## Demographic Comparisons

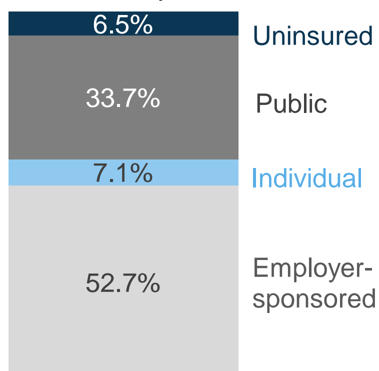
The following analysis compares the population affected by the bill to the statewide population across different demographic groups. Among consumers, the affected populations include existing consumers of health insurance in individual and small-group markets, as well as potential consumers of these products (i.e., the uninsured population); among businesses, the affected populations include small businesses served in the small group insurance market, health insurance carriers and health care providers, and their employees. Pursuant to statute and based on available data on demographic differences between affected and statewide comparison populations, this analysis identifies potential effects of the bill on existing disparities. For detailed information on the data used, see Appendix A.

**Data limitations.** Due to constraints on the availability and applicability of data, the demographic comparisons presented below are focused on consumers of individual insurance and the uninsured. Demographic data on persons served in the small group market is not readily available. If additional data become available, the analysis may be updated and expanded.

According to the Colorado Department of Regulatory Agencies Division of Insurance 2019 Colorado Health Cost Report, of a statewide population of 5.76 million, 494,000 Coloradans, or 8.6 percent, were uninsured. There were 204,000 individually insured and 267,000 small-group-insured individuals, accounting for 3.5 percent and 4.6 percent of the statewide population, respectively. Small businesses are less likely to offer insurance coverage, with 29 percent of companies with fewer than 50 employees offering coverage compared to 98 percent of larger firms, with 50 or more employees, doing so.

As shown in Figure 2, using data from the Colorado Health Institute's Colorado Health Access Survey, persons insured through employer-sponsored plans account for the largest share of the population (52.7 percent), followed by those insured through public or government plans including Medicare, Medicaid and Children's Health Plan Plus (CHP+) (33.7 percent). The uninsured and individually insured account for the remaining 13.6 percent of the statewide population.[9]

**Figure 2**
**Colorado Population by Insurance Type**
*Share of the Population, 2019*




*Source: Colorado Health Institute, 2019 Colorado Health Access Survey.*

The impact of COVID-19 and related economic stimulus packages on health insurance markets and health care providers is likely to be substantial. The extent of these impacts is still unknown and may limit the applicability of the most recent data to provide meaningful analysis of policy changes.

[9] The individually insured population includes people who purchase coverage through the state's health benefit exchange, Connect for Health Colorado, as well as from private insurers outside the exchange. According to Connect for Health Colorado, 188,000 Coloradans are enrolled through the exchange in 2021.

**Demographics of individually insured and uninsured Coloradans.** Figure 3 presents a comparison of the two affected populations for which data are available, those who are uninsured and the individually insured, with the statewide population as a whole by sex, ethnicity, race, education, disability, geography, age, and income.

The data suggest that individually insured individuals are more likely than the statewide population to be female, non-Hispanic, white, 55 to 64 years old, with a high school education or more, living in rural areas, and with income between 101 and 301 percent of the federal poverty level. Uninsured individuals are more likely to be male, Hispanic, non-white, 19 to 54 years old, without a high school education, living in rural areas, without a disability, and with income below 301 percent of the federal poverty level. For example, while rural Coloradans constitute only 13.9 percent of the state's population, they are 20.1 percent of the uninsured population and 18.1 percent of the individually insured (middle, right). Likewise, Coloradans who identify as Hispanic or non-white account for 20.1 percent and 30.3 percent of the statewide population, respectively, but 31.4 percent and 37.8 percent of the uninsured population, respectively (top, middle and right).

Coloradans with a disability and those aged 65 and over or 18 and under are less likely to be uninsured than the statewide population as a whole due largely to Medicare, Medicaid, and CHP+ programs, as well as private health plans that cover dependents into their twenties. Women are also less likely than men to be uninsured due to these programs, as women have been more likely to qualify for Medicaid coverage under one of Medicaid's eligible categories: pregnant women, parents of children under 18, disabled, or over 65.[10] In Colorado, 22.3 percent of women and 17.7 percent of men are enrolled in Medicaid or CHP+.

[10] Kaiser Family Foundation. 2021. "Women's Health Insurance Coverage." Available at: https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/#

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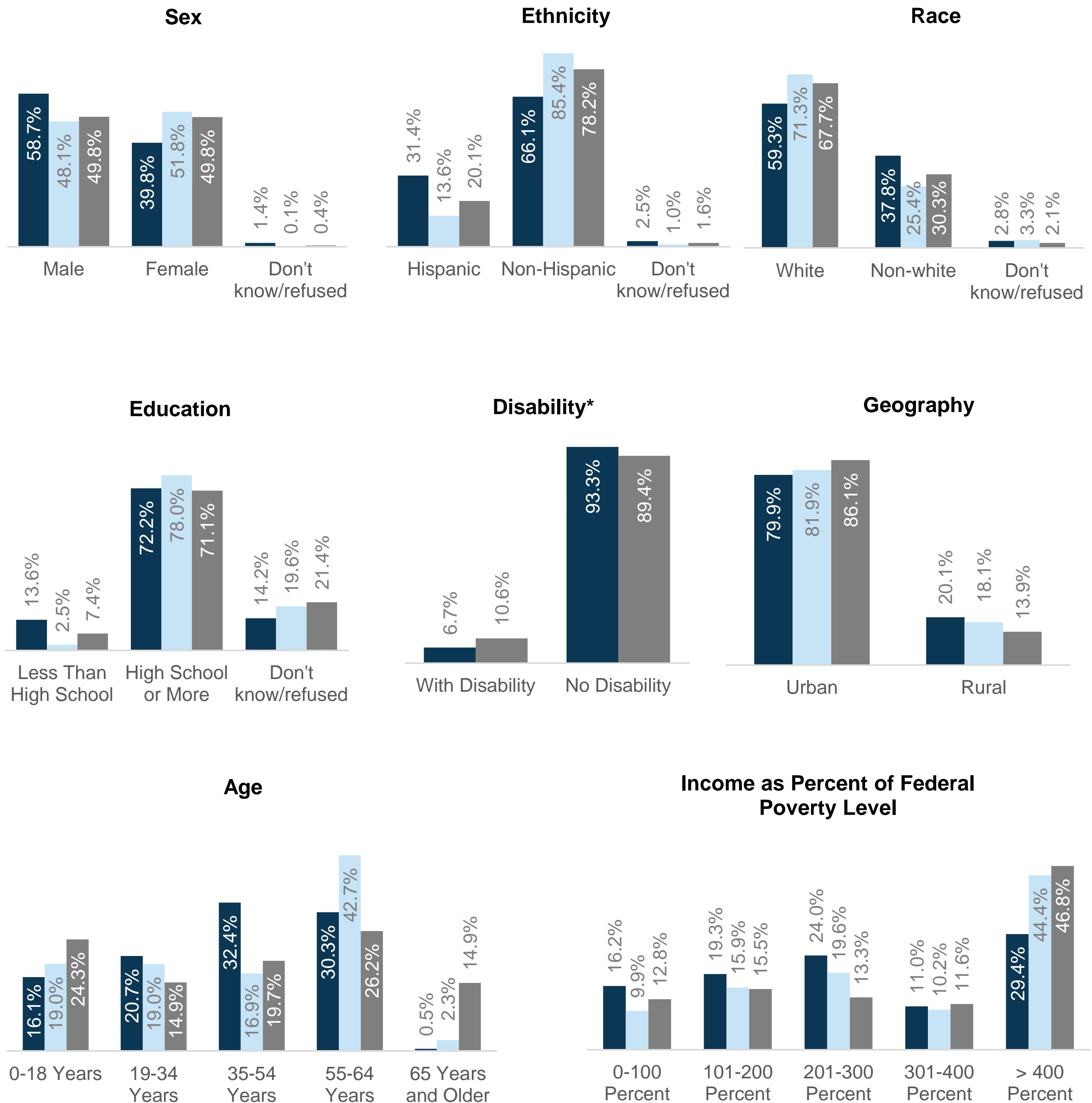
**Figure 3**
**Population Comparisons**
*Share of Total Population*




*Sources: Colorado Health Institute, 2019 Colorado Health Access Survey; * American Community Survey, 1-Year Estimates, 2019; data for individually insured Coloradans by disability is not available.*

## Analysis and Findings

Economic and health outcomes for those who elect to use the reduced premium plan are expected to improve, potentially reducing economic and health disparities by ethnicity, race, education, geography, age, and income. To the extent that reduced-premium health plans result in reduced reimbursement rates for health care providers, the bill will have economic impacts for affected health care providers. If these health care providers respond by reducing the provision of health care services, employment and health outcomes for those in the provider's service region may be reduced. Impacts depend on how standardized plans are designed and implemented and how premium reductions are achieved.

**Current consumers of health insurance.** HB 21-1232 is expected to reduce health insurance premiums for those who elect to use the reduced premium plans in individual and small group markets, thus improving economic outcomes for individuals in these markets. The bill prohibits health insurance carriers from shifting costs onto consumers of other types of state-regulated health insurance plans.[11] Based on a comparison between the statewide and affected populations, HB 21-1232 may reduce existing economic disparities for women, Coloradans living in rural areas, and low-income Coloradans who currently purchase health insurance in individual markets. If standardized plans at reduced premiums result in greater access to care, for example by lowering deductibles for preventative medical services or other high value forms of care, health outcomes may also improve for these groups. These impacts depend on the design and implementation of these plans.

**Uninsured Coloradans.** HB 21-1232 is expected to result in lower-premium options for health insurance coverage for uninsured Coloradans and to increase enrollment of previously uninsured Coloradans sensitive to premium changes.[12] Based on a comparison between the statewide and affected populations, HB 21-1232 may reduce existing disparities by race, ethnicity, age, education, geography, and income by increasing health insurance coverage and therefore reducing exposure to health-related financial risk for affected populations. Relative to the statewide population as a whole, data suggest that these impacts may improve existing disparities in economic outcomes for male, Hispanic, non-white, younger, less-educated, rural, and low-income Coloradans. To the extent that insurance coverage for the previously uninsured results in greater access to care, health outcomes for these groups may also improve.

**Health care providers.** To the extent that reduced premiums for standardized plans in individual and small group markets impact health care providers' reimbursement rates for health services, HB 21-1232 is expected to have economic impacts for health care providers. These impacts will vary across regions and type of health care facility. Hospitals and other providers may experience conflicting and offsetting impacts depending on their mix of payer type, reimbursement rates, and other financial factors. Previously uninsured individuals or those with high deductible health plans switching to standardized plans are likely to reduce the costs to health care providers of uncompensated care, while premium reduction targets for standardized plans may reduce reimbursement rates for individual and small-group payers with these plans.

[11] The Division of Insurance does not regulate self-insured employer plans, Medicare, or Medicaid, which are federally regulated. Self-insured plans covered 3.5 million lives in Colorado in 2019, according to the Division of Insurance.
[12] Gavel, D. 2017. "Up and Out: Price Sensitivity in Health Care Insurance Market." Harvard University Kennedy School Policy Topics. Available at: https://www.hks.harvard.edu/research-insights/policy-topics/health/price-sensitivity-health-care

To the extent that reduced-premium health plans result in reduced reimbursement rates for health care providers, the bill may impact economic and health outcomes depending on the financial circumstances and decisions made by individual providers. Specifically, to the extent that health care providers respond to financial changes that accompany the bill by reducing the provision of health care services or closing facilities, these impacts may offset economic and health outcomes resulting from reduced health insurance premiums or may increase existing disparities depending on the demographic make-up of a provider's service region. Potential impacts depend on how the bill is implemented and cannot be determined at this time.

**Health insurance carriers.** This analysis assumes that economic impacts in the form of premium reductions are largely passed by carriers to health care providers. Health insurance carriers may experience increased administrative costs, for example, from the costs of forming a provider network for standardized plans. The impact of these costs on health insurance carriers and existing disparities is unknown and will depend on several factors, including the timing and implementation of the bill's provisions.

**Disparities in context.** While HB 21-1232 may reduce disparities in health insurance coverage, it is unlikely to influence other factors that contribute to health or other disparities. It is important to note that economic and health disparities such as those discussed here have multiple and interacting causes, including not only individual behavior and choices, but also historical and structural factors that can shape or constrain individual choices and distribute economic and other opportunities unevenly to individuals on the basis of their membership in particular demographic groups.

## Demographics Not Analyzed

Some demographic groups have not been included in the analysis due to data limitations. Data on the relevant populations delineated by gender identity and sexual orientation were not available at the time of the analysis. Should data become available, this analysis may be updated.

## Data Sources and Agencies Contacted

Connect For Health Colorado
Health Care Policy and Financing
Colorado Health Institute
Regulatory Agencies
Public Health and Environment

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## Appendix A
## Population Data Used in Analysis
## Demographics of Coloradans by Health Insurance Type, 2019

### Sex

| | *Uninsured Coloradans* | | *Coloradans Insured through Individual Market* | | *All Coloradans* | |
|---|---|---|---|---|---|---|
| **Sex** | Population | Share of Total | Population | Share of Total | Population | Share of Total |
| Male | 211,736 | 58.7% | 189,576 | 48.1% | 2,759,496 | 49.8% |
| Female | 143,677 | 39.8% | 204,207 | 51.8% | 2,756,671 | 49.8% |
| Don't know/refused | 5,199 | 1.4% | 206 | 0.1% | 22,288 | 0.4% |
| **TOTAL** | **360,612** | **100.0%** | **393,989** | **100.0%** | **5,538,455** | 100.0% |

*Source: Colorado Health Institute.*

### Ethnicity

| | *Uninsured Coloradans* | | *Coloradans Insured through Individual Market* | | *All Coloradans* | |
|---|---|---|---|---|---|---|
| **Ethnicity** | Population | Share of Total | Population | Share of Total | Population | Share of Total |
| Hispanic | 113,134 | 31.4% | 53,630 | 13.6% | 1,114,690 | 20.1% |
| Non-Hispanic | 238,544 | 66.1% | 336,327 | 85.4% | 4,333,557 | 78.2% |
| Don't know/refused | 8,934 | 2.5% | 4,032 | 1.0% | 90,208 | 1.6% |
| **TOTAL** | **360,612** | **100.0%** | **393,989** | **100.0%** | **5,538,455** | 100.0% |

*Source: Colorado Health Institute.*

### Race

| | *Uninsured Coloradans* | | *Coloradans Insured through Individual Market* | | *All Coloradans* | |
|---|---|---|---|---|---|---|
| **Race** | Population | Share of Total | Population | Share of Total | Population | Share of Total |
| White | 213,867 | 59.3% | 280,816 | 71.3% | 3,747,311 | 67.7% |
| Non-white | 136,475 | 37.8% | 99,986 | 25.4% | 1,676,106 | 30.3% |
| Don't know/refused | 10,270 | 2.8% | 13,186 | 3.3% | 115,038 | 2.1% |
| **TOTAL** | **360,612** | **100.0%** | **393,988** | 100.0% | **5,538,455** | **100.0%** |

*Source: Colorado Health Institute.*

### Education

| | *Uninsured Coloradans* | | *Coloradans Insured through Individual Market* | | *All Coloradans* | |
|---|---|---|---|---|---|---|
| **Education** | Population | Share of Total | Population | Share of Total | Population | Share of Total |
| Less Than High School | 49,031 | 13.6% | 9,684 | 2.5% | 412,517 | 7.4% |
| High School or More | 260,223 | 72.2% | 307,202 | 78.0% | 3,940,023 | 71.1% |
| Don't know/refused | 51,358 | 14.2% | 77,103 | 19.6% | 1,185,915 | 21.4% |
| **TOTAL** | **360,612** | **100.0%** | **393,989** | **100.0%** | **5,538,455** | 100.0% |

*Source: Colorado Health Institute.*

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### Disability

| | Uninsured Coloradans | | All Coloradans | |
|---|---|---|---|---|
| **Disability** | Population | Share of Total | Population | Share of Total |
| With Disability | 30,340 | 6.7% | 599,748 | 10.6% |
| No Disability | 423,135 | 93.3% | 5,064,451 | 89.4% |
| **TOTAL** | **453,475** | **100.0%** | **5,664,199** | 100.0% |

*Source: American Community Survey, 1-Year Estimates, 2019.*

### Geography

| | *Uninsured Coloradans* | | *Coloradans Insured through Individual Market* | | *All Coloradans* | |
|---|---|---|---|---|---|---|
| **Geography** | Population | Share of Total | Population | Share of Total | Population | Share of Total |
| Urban | 288,151 | 79.9% | 322,821 | 81.9% | 4,766,460 | 86.1% |
| Rural | 72,461 | 20.1% | 71,168 | 18.1% | 771,995 | 13.9% |
| **TOTAL** | **360,612** | **100.0%** | **393,989** | 100.0% | **5,538,455** | **100.0%** |

*Source: Colorado Health Institute.*

### Age

| | *Uninsured Coloradans* | | *Coloradans Insured through Individual Market* | | *All Coloradans* | |
|---|---|---|---|---|---|---|
| **Age** | Population | Share of Total | Population | Share of Total | Population | Share of Total |
| 0-18 Years | 58,134 | 16.1% | 74,997 | 19.0% | 1,347,369 | 24.3% |
| 19-34 Years | 74,802 | 20.7% | 74,695 | 19.0% | 827,451 | 14.9% |
| 35-54 Years | 116,730 | 32.4% | 66,708 | 16.9% | 1,091,413 | 19.7% |
| 55-64 Years | 109,269 | 30.3% | 168,361 | 42.7% | 1,448,444 | 26.2% |
| 65 Years and Older | 1,677 | 0.5% | 9,227 | 2.3% | 823,777 | 14.9% |
| **TOTAL** | **360,612** | **100.0%** | **393,989** | 100.0% | **5,538,455** | **100.0%** |

*Source: Colorado Health Institute.*

### Income
*Percent of Federal Poverty Level*

| | *Uninsured Coloradans* | | *Coloradans Insured through Individual Market* | | *All Coloradans* | |
|---|---|---|---|---|---|---|
| **Income** | Population | Share of Total | Population | Share of Total | Population | Share of Total |
| 0-100 Percent | 58,479 | 16.2% | 39,009 | 9.9% | 710,932 | 12.8% |
| 101-200 Percent | 69,540 | 19.3% | 62,554 | 15.9% | 855,923 | 15.5% |
| 201-300 Percent | 86,615 | 24.0% | 77,159 | 19.6% | 736,601 | 13.3% |
| 301-400 Percent | 39,780 | 11.0% | 40,325 | 10.2% | 643,757 | 11.6% |
| > 400 Percent | 106,198 | 29.4% | 174,942 | 44.4% | 2,591,241 | 46.8% |
| **TOTAL** | **360,612** | **100.0%** | **393,989** | 100.0% | **5,538,455** | **100.0%** |

*Source: Colorado Health Institute.*