COLORADO
Health Insurance
Affordability Enterprise

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Evaluation of the Colorado Health Insurance Affordability Enterprise FY 2022/23

Final Evaluation Report

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Executive Summary

Colorado's Health Insurance Affordability Enterprise (HIAE), established by the state's legislature through Senate Bill 20-215 in 2020 and designed to address the affordability of health insurance on the individual market, provides subsidized health insurance for residents not eligible for federal subsidies, in addition to enhancing the subsidies already available to Marketplace enrollees. In particular, it is the first statewide program in the nation to offer subsidized health insurance coverage to people with undocumented immigration status.

This report contains findings from an independent evaluation of the first two open enrollment periods since the HIAE made subsidies available: 2022 and 2023. The goal was to assess the effectiveness of the outreach and enrollment efforts of the Colorado Division of Insurance (DOI), HIAE, and other organizations for people who were eligible for HIAE subsidies and to determine whether the HIAE reduced uninsurance, decreased movement from insured to uninsured status, lowered health insurance costs, and improved the overall stability of the state's individual health insurance market. To this end, we conducted key informant interviews with state officials, staff at partner organizations, and frontline workers who helped consumers enroll in individual health insurance plans. We also analyzed enrollment and premium data from the first two open enrollment periods since the HIAE subsidies were available as well as health insurance market data. Below, we summarize our findings and key takeaways.

A. Implementation of the HIAE

Colorado's HIAE statute established two state-based subsidy streams, and the HIAE Board, which provides oversight and guidance for the HIAE, made policy recommendations to the Commissioner of Insurance regarding the implementation of the HIAE subsidies for the 2022 and 2023 plan years. The on-exchange subsidy started with open enrollment for plan year 2022 and provides state funded cost sharing reductions to people with incomes between 150 percent and 200 percent of the federal poverty level (FPL) who qualify for federal advance premium tax credits (APTC). Cost sharing reductions lower the amount of out-of-pocket spending for health care services. People who qualify for this subsidy sign up for coverage through the state's health insurance exchange. We refer to this HIAE component as the APTC–eligible enrollee subsidy.

OmniSalud started with open enrollment for plan year 2023. It allows Colorado residents regardless of immigration status to purchase Colorado Option plans available at Colorado Connect, which is administered by, but a separate entity from the state's health insurance exchange to ensure consumer confidentiality. Individuals can access SilverEnhanced Savings which provide premium subsidies and cost sharing reductions for people who do not qualify for Medicaid, the Children's Health Insurance Program, or Medicare (so-called qualified individuals) with incomes below 150 percent of the FPL through Colorado Connect. Due to a limited budget, DOI capped enrollment in subsidized insurance through OmniSalud at 10,000 individuals in 2023. Qualified individuals with incomes below 150 percent of the FPL can enroll after the cap is reached, but they do not receive subsidies. Further, qualified individuals whose income is above 150 percent of the FPL can also enroll but do not receive subsidies.

Key informants mentioned both advantages and drawbacks of the HIAE subsidy design. They noted that the alignment of APTC–eligible enrollee subsidies with the existing health insurance marketplace structure, the simplicity of the OmniSalud subsidy, and the ease of consumer access for both components as advantages. However, timing can be a challenge for the HIAE Board as it needs to make decisions about subsidies before full information about the budget is available. Further, OmniSalud benefits are

similar but not identical to Medicaid benefits, which caused some confusion for frontline workers. Respondents identified potential ways in which the OmniSalud subsidy cap could be implemented more equitably.

DOI collaborates with partners across the state to ensure the HIAE's success. Connect for Health Colorado (C4HCO) operates the state's health insurance exchange and is an important partner with the DOI in conducting outreach and enrollment efforts. Interview respondents from both entities credited the close collaboration between the two organizations as instrumental to the HIAE's initial success. DOI also collaborates with other partners, such as consumer advocacy organizations, to provide information to consumers about the HIAE. However, the HIAE could benefit from deepened partnerships with health care providers and local community organizations, according to interview respondents.

B. Outreach and enrollment in OmniSalud SilverEnhanced Savings

Throughout 2022, DOI and its partners used dedicated resources and staff to spread awareness of the new OmniSalud program and SilverEnhanced Savings benefit among qualified individuals across the state. These efforts relied upon building partnerships with trusted organizations. Interview respondents reported that the most effective outreach model was to lean on trusted community messengers. DOI and its community partners relied upon online resources and in-person presentations to inform people about OmniSalud and asked them to spread the word within their networks. Interview respondents suggested that DOI could use more social media outreach to inform eligible populations in future years.

A network of frontline workers, including health coverage guides, certified application counselors, and health insurance agents or brokers, assisted eligible populations with enrolling in OmniSalud plans. Interview respondents perceived assisters and other frontline workers as helpful in making enrollment as easy as possible for a population that often had no prior experience with signing up for health insurance. Consumers faced some challenges with enrollment such as making enrollment appointments due to a lack of appointment slots, language barriers due to the English-only application, and some households' mixed immigration status that frontline workers could not always resolve. According to interview respondents, HIAE could further improve enrollment efforts by providing ongoing education, materials, and support to frontline workers and by recruiting staff from local communities to receive assister certification from C4HCO.

Qualified individuals signed up for OmniSalud quickly, and the program reached its cap of 10,000 enrollees on December 6, 2022. After this date, eligible people were unable to receive subsidies. By the end of the open enrollment period, 9,689 people had enrolled in a plan with OmniSalud subsidies. Fewer than 10,000 people enrolled in subsidized plans because C4HCO had to trigger the enrollee cap when 10,000 people had started their application. Most of them used the help of frontline workers to enroll and all of them paid a $0 net premium for their coverage. Enrollment in SilverEnhanced Savings plans relative to the number of qualified individuals predicted to reside in each part of the state varied within the state, suggesting that the first-come-first-served enrollment process may lead to geographical inequities. Interview respondents also noted equity challenges related to the first-come-first-served approach. Ideas for a more equitable approach include setting aside slots for certain groups of qualified individuals (for example, by disability status or region) and increasing the subsidy cap to allow more qualified individuals to access subsidized coverage by collecting small premiums on a sliding scale. In making policy recommendations about HIAE subsidies to the Commissioner of Insurance, the HIAE Board has to balance operational feasibility and a limited subsidy budget with equity considerations and other stakeholder priorities.

C. Outreach and enrollment in the APTC–eligible enrollee subsidy

C4HCO conducted outreach with the support of DOI to educate eligible consumers about available subsidies under the APTC–eligible enrollee subsidy. These outreach and enrollment efforts were less comprehensive than for OmniSalud because many APTC–eligible consumers eligible for the HIAE subsidy were already familiar with enrolling in health insurance plans on the marketplace and the benefit was integrated into the exchange. However, the cost sharing reductions made the APTC–eligible enrollee subsidy benefit more difficult to understand for consumers but also more generous than the subsidy these enrollees would otherwise receive. In addition, interview respondents cited high premiums as a potential factor that deterred eligible consumers from enrolling in the subsidized plan.

Compared to previous years, enrollment in Silver plans among eligible consumers increased when the APTC–eligible enrollee subsidy started in 2022 and enrollment rates were relatively similar across the state. Net premiums for Silver plans declined with the start of the APTC–eligible enrollee subsidy in 2022, although this could be due to factors other than the HIAE. Movement from insurance to uninsurance status (churn) was slightly higher among APTC–eligible enrollees eligible for the HIAE subsidy compared to other on-exchange consumers during plan year 2022. These findings suggest that the APTC–eligible enrollee subsidy reduced uninsurance overall but not churn. However, there is further potential for increased enrollment: about one-quarter of eligible consumers have not yet signed up for coverage.

D. Health insurance market stability

The APTC–eligible enrollee subsidy and OmniSalud had a neutral impact on the stability of the individual insurance market. We analyzed statewide data on premiums, number of insurers, and insurer financials to assess the effect of the HIAE on the stability of the individual health insurance market. Average premiums did not change significantly from 2021 to 2022 and increased similarly to the national average in 2023. Two insurers left the individual market in 2023, but these market exits were due to their national strategy and unrelated to the HIAE. Insurer financials did not change consistently in 2022, when the APTC–eligible enrollee subsidy was rolled out. Colorado's experience indicates state-based subsidies can be introduced into the individual market to increase affordability for consumers while maintaining market stability. Colorado's individual market was a healthy, stable market prior to the introduction of the HIAE and continues to be a strong market post implementation of the HIAE with competitive options for consumers and relatively stable prices from year to year.

E. Lessons learned

Overall, the first two open enrollment periods showed initial success of the HIAE in achieving its short-term goals. Nearly 10,000 qualified individuals enrolled in OmniSalud subsidized plans, an achievement that is largely due to the outreach and enrollment efforts of the DOI and its partners. Interview respondents had several recommendations for continued success and further improvement of the HIAE:

- Allocate OmniSalud enrollment more equitably across parts of the state
- Build in further data collection to better understand who enrolls in the APTC–eligible enrollee subsidy and OmniSalud
- Engage more deeply with health care providers and local on-the-ground organizations to improve outreach
- Focus on health insurance literacy to enable new enrollees to fully benefit from their coverage

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I. Introduction

The Colorado legislature established the Health Insurance Affordability Enterprise (HIAE) through Senate Bill (SB) 20-215 in 2020 to reduce the number of Coloradans without health insurance, decrease movement (churn) between insured and uninsured status, lower premiums, and stabilize the insurance market.[1] Starting with plan year 2022, certain residents with low incomes have qualified for cost sharing reductions, which increase the actuarial value of health plans and reduce out-of-pocket costs. We refer to this HIAE component as the advance premium tax credit (APTC)–eligible enrollee subsidy. Importantly, through the second component of the HIAE, known as OmniSalud or Colorado Option SilverEnhanced Savings, in 2023 Colorado became the first state to provide subsidized health insurance to residents with low incomes regardless of their immigration status (so-called qualified individuals [QIs]). Up to 10,000 QIs who enrolled in a SilverEnhanced Savings plan would receive coverage with $0 premium. The 11-member HIAE Board oversees the HIAE and makes recommendations about the subsidies to the Insurance Commissioner, while the Colorado Division of Insurance (DOI) is responsible for administering HIAE subsidies and managing outreach and enrollment efforts with partner organizations.

This report provides findings from an independent evaluation of the HIAE and covers the first two years of the HIAE subsidies: two years of the APTC–eligible enrollee subsidy (plan years 2022 and 2023) and one year of OmniSalud (plan year 2023).[2] Overall, the aim of the evaluation was to assess how effectively the HIAE has been implemented. Specifically, the evaluation addressed four key goals:

1. Assessing the impact of the HIAE APTC–eligible enrollee subsidy on health insurance coverage and insurance churn among eligible consumers—that is, individuals with incomes between 150 percent to 200 percent of the federal poverty level (FPL)
2. Assessing the effectiveness of DOI and other Colorado organizations' outreach to and enrollment of QIs who were eligible for OmniSalud or for the APTC–eligible enrollee subsidy, and how the allocation of HIAE funds influenced these efforts
3. Assessing how the HIAE affected the overall stability of the individual health insurance market in Colorado and the financials of health plan issuers
4. Informing DOI activities and strategies for subsequent plan years, as well as for other states considering similar initiatives to provide subsidized health insurance to their residents

Our evaluation followed a mixed-methods approach consisting of qualitative data collection and analysis of key informant interviews and document review, as well as quantitative analysis of enrollment and insurance market data. By synthesizing findings from our qualitative and quantitative analyses, this report provides a comprehensive picture of the effectiveness of the HIAE during open enrollment for 2022 and 2023. Exhibit I.1 lists the research questions we address and the evaluation hypotheses we assess in this report.

[1] The HIAE has additional goals—namely, to offset high-cost claims, create a healthier risk pool, reduce cost shifting, reduce uncompensated care, and expand access to care for low-income and uninsured Coloradans. We only address the four goals mentioned in the text in this report.

[2] For plan year 2023, we only observed enrollment during the open enrollment period through the end of February.

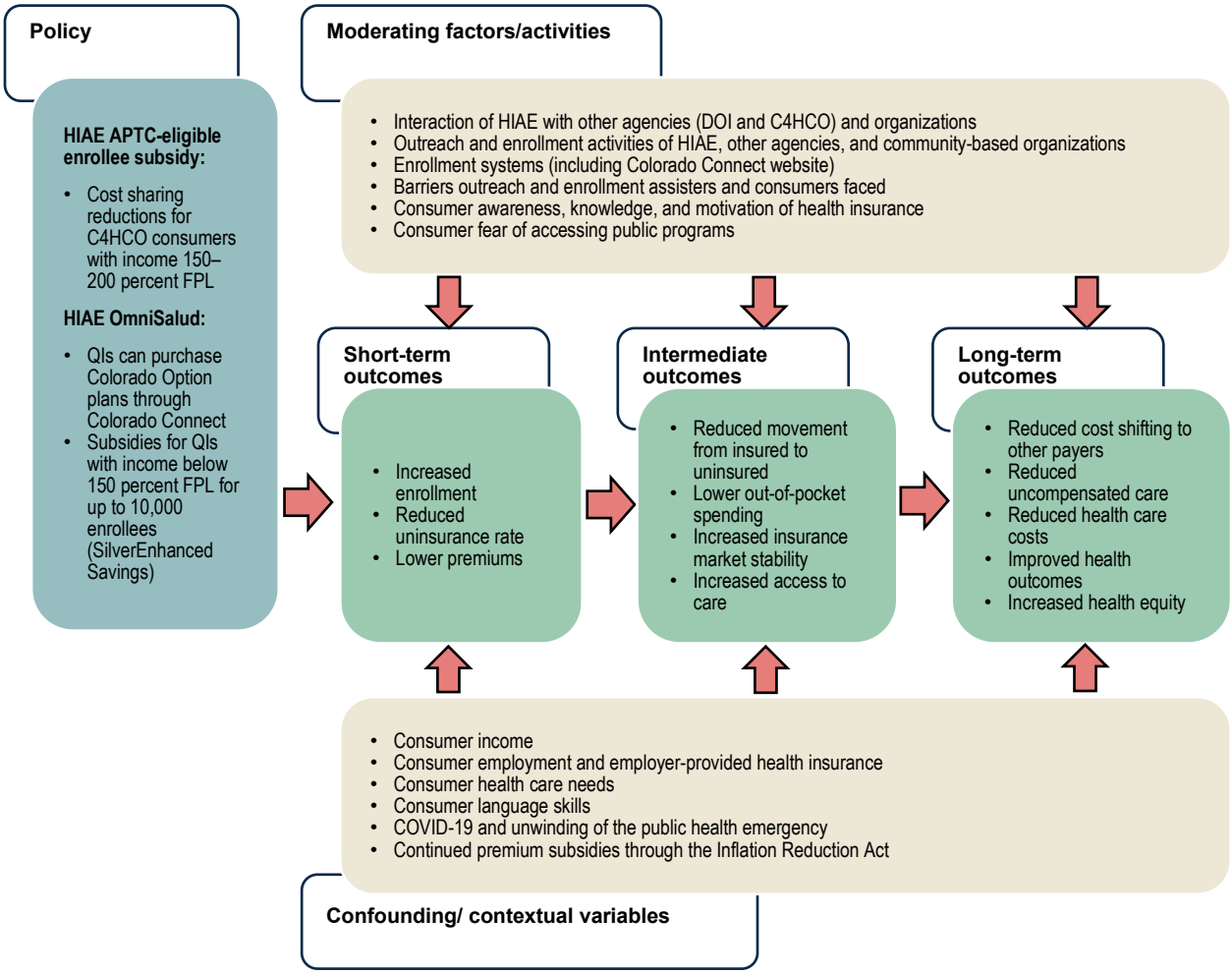
Exhibit I.1. Key research questions and hypotheses

Research question or hypothesis
Research questions for the implementation evaluation
What were the strengths and challenges of how HIAE subsidies were structured?
How did HIAE interact with partners in its outreach and enrollment work?
What strategies did Colorado DOI plan and implement to reach and enroll the APTC–eligible enrollee subsidy and OmniSalud populations?
What were the barriers to and facilitators of reaching and enrolling the APTC–eligible enrollee subsidy and OmniSalud populations?
What lessons did Colorado learn for the future and for other states that might seek to enroll similar populations?
Evaluation hypotheses for the outcome evaluation
Providing payments to further subsidize coverage for consumers enrolled under the APTC–eligible enrollee subsidy and OmniSalud SilverEnhanced Savings is an effective method to …
• Reduce the number of uninsured
• Increase stability in insurance markets
• Reduce movement between insured and uninsured status
• Lower health insurance costs

APTC = Advance Premium Tax Credit

The logic model in Exhibit I.2 illustrates how the HIAE APTC–eligible enrollee subsidy and OmniSalud may lead to short-term, intermediate, and long-term outcomes. Moderating factors, which include activities by DOI and other participating organizations, also affect these outcomes. Confounding and contextual variables play a role in affecting the outcomes but cannot be changed directly through HIAE policies. This report explains how the moderating factors may have affected short-term outcomes and some intermediate outcomes (such as reduced churn from insured to uninsured and increased insurance market stability) of APTC–eligible enrollee subsidy and OmniSalud and assesses the hypotheses related to these outcomes.

Exhibit I.2. HIAE logic model



APTC = Advanced Premium Tax Credit; C4HCO = Connect for Health Colorado; DOI = Division of Insurance; FPL = federal poverty level; HIAE = Health Insurance Affordability Enterprise; QI = qualified individual.

The logic model also guides the organization of this report. Chapter II describes the APTC–eligible enrollee subsidy and OmniSalud policies. Chapter III explains the interaction of HIAE with other organizations. Chapter IV and V combine findings from key informant interviews with quantitative evidence on enrollment of consumers eligible for APTC–eligible enrollee subsidy subsidies and SilverEnhanced Savings to assess how effectively the HIAE has been implemented. The key informant interviews cover outreach and enrollment activities, barriers faced by enrollment assisters and consumers, and secondhand insights into the consumer experience. Chapter IV covers OmniSalud, while Chapter V covers the HIAE APTC–eligible enrollee subsidy. Although the full implications of the HIAE for health equity will only materialize in the longer term, we tentatively assess equity implications in Chapters IV and V. Chapter VI concludes the report with actionable recommendations to help DOI and partner organizations further improve their outreach, enrollment, data collection, and engagement activities in future years of the HIAE. We also highlight more general lessons learned that may be informative for policymakers and interested partners in Colorado as well as other states considering similar policies.

To assess how participating organizations implemented the HIAE and to learn about facilitators and barriers, we conducted interviews and a document review. We interviewed 33 key informants: seven state officials, including DOI and HIAE staff; four HIAE Board members; nine staff at partner organizations, including Connect for Health Colorado (C4HCO); and 13 frontline workers who helped consumers enroll in individual health insurance plans. In these interviews, we asked key informants about perceived strengths and limitations of the HIAE subsidies, what kind of outreach and enrollment activities their organizations undertook, how successful these activities were, what kind of system barriers they faced, their perception of consumers' experience with enrollment in HIAE coverage, and lessons learned and recommendations for future years of the HIAE and for other states seeking to enroll similar populations. (Appendix A describes key informant interviews in more detail.) Our qualitative evaluation also involved a thorough document review of HIAE Board meeting materials, budget documents, and outreach and enrollment plans, all provided by HIAE staff.

Our quantitative evaluation components relied on enrollment data from Colorado's health insurance exchange (C4HCO) and the newly established platform where consumers who qualify for OmniSalud subsidies can enroll (Colorado Connect). With these data, we tracked enrollment over time of consumers who qualified for the HIAE APTC–eligible enrollee subsidies and assessed how their enrollment decisions changed as APTC–eligible enrollee subsidies became available in 2022 and 2023. We also described the characteristics of consumers who signed up for coverage under OmniSalud, to understand who qualified for the SilverEnhanced Savings. Finally, we used health insurance plan filing and financial data to assess changes in the number of issuers and plans as well as in issuers' financials with the introduction of the HIAE APTC–eligible enrollee subsidy and OmniSalud. (See Appendix B for a more detailed description of the data sources used in this report.)

The findings in this report were based on data available in March 2023, so we cannot assess any long-term effects of the HIAE on access to care, health care service use, out-of-pocket spending, or consumers' health outcomes. This evaluation was also limited by not having direct qualitative evidence on consumers' experience with enrolling in the HIAE APTC–eligible enrollee subsidy or OmniSalud plans. Instead, we relied on interviews with frontline workers who assist consumers in enrolling for this information. The findings in this report are nevertheless informative about the effectiveness of the HIAE during the first two years of its implementation.

II. The HIAE Design

The HIAE was established to make health insurance on Colorado's individual market more affordable. Its goals include to reduce the number of Coloradans without health insurance, decrease churn between insured and uninsured status, lower health insurance costs, and stabilize the insurance market. The HIAE was implemented within the context of Colorado's individual health insurance market, a relatively small market of individuals who do not have health insurance coverage through their employer or through public coverage. In this chapter, we describe the HIAE's financing and structure and provide an overview of the HIAE subsidies, including what key informants saw as their strengths and drawbacks. Finally, we share reflections on the equity implications of the HIAE subsidy design. Findings in this chapter were based on our document review and key informant interviews.

Key takeaways about the HIAE design

- SB 20-215 established the HIAE during the 2020 legislative session to reduce the number of Coloradans without health insurance, decrease churn between insured and uninsured status, lower premiums, and provide stability to the insurance market, among other goals. HIAE is governed by an 11-member Board, which makes policy recommendations to the Insurance Commissioner.
- HIAE has two primary mechanisms for achieving its goals: (1) payments to carriers that improve plan affordability for individuals already eligible for federal financial assistance (the HIAE APTC–eligible enrollee subsidy) and (2) an affordable, state-subsidized coverage option for residents with undocumented status (OmniSalud).
- Strengths of the HIAE design include the APTC–eligible enrollee subsidies' alignment with existing benefit programs, the simplicity of the OmniSalud design, and the overall customer experience.
- The main challenge to the HIAE structure is the mismatch of when decisions need to be made regarding subsidy structures and eligibility thresholds and when budget information for future plan years is known. The evaluation also identified equity implications related to the cap of 10,000 for OmniSalud enrollees who can receive SilverEnhanced Savings subsidies.

A. Description of the HIAE

SB 20-215 established the HIAE in the 2020 legislative session.[3] The legislation outlines eight key goals of the HIAE, some of which are addressed in this evaluation (Colorado Revised Statutes [CRS] §§ 10-16-1202(1)(d) and (e)): (1) reduce the number of Coloradans without health insurance, (2) stabilize the insurance market, (3) reduce churn between insured and uninsured status, (4) offset high-cost claims, (5) create a healthier risk pool, (6) reduce cost shifting between payers, (7) reduce uncompensated care, and (8) expand access to care for low-income and uninsured Coloradans.[4]

1. Governance and staff

The 11-member Health Insurance Affordability Board (the Board), established under SB 20-215, provides guidance for the HIAE. As stipulated in CRS § 10-16-1207, the Board consists of the executive director of C4HCO or their designee; the Insurance Commissioner or their designee; and nine members appointed by the governor, with the consent of the Senate, including representatives of an insurance carrier, primary health care providers, and consumers and rural, critical access, or independent hospitals, among others.

[3] See https://leg.colorado.gov/bills/sb20-215.

[4] See https://drive.google.com/drive/folders/1ybCNxK3Vrr9M-d7hv87JZe-iStypp5o5.

The legislation stipulates that, to the extent possible, the Board should reflect the diversity of the state regarding race, ethnicity, immigration status, income, wealth, ability, and geography. The Board has a number of duties, including making policy recommendations to the Insurance Commissioner for the distribution of HIAE funds. The Board generally meets eight times per year, including a two-day retreat. Members of the public can register in advance to attend virtual Board meetings.

The HIAE is housed within DOI at the Colorado Department of Regulatory Agencies (DORA) and is led by the reinsurance program director. The HIAE has several staff who perform outreach, enrollment, program management, and administrative functions. As described in Chapter III, HIAE staff work closely with C4HCO, which is responsible for the information technology (IT) development and implementation required for the Board's decisions.

2. Financing

SB 20-215 outlines the financing of the HIAE and specifies how the available funds will be allocated each year. To finance the HIAE, DOI draws from multiple revenue sources to contribute to the Colorado Health Insurance Affordability Fund: (1) an annual health insurance affordability fee from health insurers (CRS § 10-16-1205(1)(a)(I)), (2) a special assessment fee from hospitals (2022 and 2023 only; CRS § 10-16-1205(1)(a)(II)), (3) a portion of the annual health insurance premium tax revenue, and (4) federal pass-through funds from Colorado's Section 1332 State Innovation Waiver.[5] The statute also stipulates how the HIAE must allocate these revenues. Specifically, funding is allocated to (CRS § 10-16-1205(1)(b)): (1) HIAE administrative costs; (2) reinsurance program cash funds; (3) outreach, enrollment, and education activities; (4) increasing subsidies for consumers receiving federal tax credits; and (5) providing state subsidies for QIs.[6] QIs are Colorado residents, regardless of immigration status, who have a household income of not more than 300 percent of the FPL and who are not eligible for a federal premium tax credit, Medicaid, the Children's Health Insurance Program (CHIP), or Medicare (CRS § 10-16-1203(12)).

B. The HIAE subsidies

The HIAE subsidies were rolled out in two phases, as required by statute: the APTC–eligible enrollee subsidy and OmniSalud. The Board carefully deliberated and reached consensus on policy recommendations for setting parameters and eligibility for the subsidies for the DOI Commissioner's consideration. As a result, the Commissioner formulated regulations to translate recommendations into action. The public had an opportunity to provide informal and formal comments on the regulations. The key DOI regulations that implement the HIAE include 4-2-78 and 4-2-83.[7] Both were effective November 14, 2022. Exhibit II.1 summarizes the implementation of HIAE in these two phases.

[5] Under Colorado's 1332 Innovation Waiver, Colorado operates a reinsurance program that lowers the amount of money the federal government spends on Affordable Care Act tax credits. The federal government passes money saved through Colorado's reinsurance program through to the state to fund the reinsurance program and support HIAE's state-based subsidies for individuals who may find out-of-pocket costs unaffordable or who are not eligible for premium tax credits under the Affordable Care Act.

[6] See https://drive.google.com/drive/folders/15N_rF97hZGD2LYg509WXAs05jo0DFEmY.

[7] See DOI regulation 4-2-78 (https://drive.google.com/file/d/1HWNBWjjhmMXtaAq6JV7H4vBDL6dqBWTN/view) and 4-2-83 (https://drive.google.com/file/d/1vRBuJjYAytW_TrkzrD-tEBRcUPyQrU28/view).

Exhibit II.1. HIAE implementation overview

	APTC–eligible enrollee subsidy	OmniSalud
Implementation date	Open enrollment for 2022	Open enrollment for 2023
Eligible consumers	Subsidized enrollees with incomes of 150–200 percent FPL	QIs with income ≤ 150 percent FPL, up to 10,000 SilverEnhanced Saving enrollees
Subsidy type	Cost sharing reduction enhancement	Premium wrap and cost sharing reduction enhancement
Subsidy application platform	C4HCO	Colorado Connect
Funding	**2022:** 30 percent of remaining funds after administrative and reinsurance are allocated **2023+:** Lesser of 10 percent of total or remaining fund after administrative, reinsurance, and $18M QI subsidies allocated	**2022:** 70 percent of remaining funds after administrative, reinsurance, and APTC–eligible enrollee subsidy are allocated **2023+:** $18M+ remaining funds after all other allocations

C4HCO = Connect for Health Colorado; FPL = federal poverty level; QI = qualified individual.

1. Structure

Although HIAE subsidy financing and eligibility limits are defined in statute (SB 20-215), the Board recommends how subsidies should be structured and how the allocated funding should be distributed to enrollees. According to respondents, the Board weighed whether subsidies should be given through a premium wrap or cost sharing reduction enhancements (see Box II.1) and whether all eligible enrollees or only a subset would receive subsidy dollars. Focusing subsidy dollars on a subset of eligible enrollees would allow for more generous subsidies, while giving subsidy dollars to all enrollees would allow for more enrollees to receive partial savings.

Box II.1. Types of subsidies available under the HIAE

Premium wrap: State subsidy dollars supplement the premium subsidy provided by the federal government, through tax credits, which lowers net premiums for consumers.

Cost sharing reduction enhancements: State subsidy dollars lower the consumer cost sharing amounts in plans that are eligible for Affordable Care Act subsidies. This lowers out-of-pocket amounts paid by the consumer. The HIAE cost sharing reduction enhancement increases the value of a Silver plan for HIAE enrollees from 87 percent actuarial value to 94 percent actuarial value.

The Board recommended structuring the subsidies for Coloradans who receive federal premium tax credits (under the APTC–eligible enrollee subsidy) as a cost sharing reduction enhancement and structuring the subsidies for QIs (under OmniSalud) as premium subsidies and cost sharing reduction enhancements. The Board recommended distributing both HIAE subsidies to a subset of eligible enrollees through plan year 2023. Specifically, the Board recommended: (1) focusing cost sharing reduction enhancements to APTC–eligible individuals with income between 150 percent to 200 percent FPL, and (2) focusing QI subsidies to those with incomes up to 150 percent FPL. The Board recommendations were approved and established by the Insurance Commissioner by rulemaking.[8]

[8] See DOI regulation 4-2-78 and 4-2-83.

2. Implementation

The HIAE subsidies rolled out in two separate phases. The APTC–eligible enrollee subsidy began with open enrollment for 2022 coverage and included new subsidies for consumers who were eligible for premium tax credits and who purchased coverage through C4HCO, Colorado's health insurance marketplace. The increased subsidies under the first phase were available through cost sharing reductions, which decreased deductibles, co-pays, and coinsurance, and increased the actuarial value of a Silver plan from 87 percent—the current actuarial value for this income level under federal cost sharing reductions—to 94 percent. Like federal cost sharing reductions, consumers must enroll in a Silver plan to receive these subsidies. The subsidy is automatically applied at renewal for consumers who qualify and enroll in Silver plans. There is no limit to the number of enrollees who could receive this benefit.

OmniSalud began with open enrollment for 2023 coverage. Through OmniSalud, QIs can purchase Colorado Option plans (see Box II.2) at Colorado Connect, C4HCO's new separate and secure online platform. Colorado Connect is a public benefit corporation owned and operated by C4HCO, but it has its own application and shopping platform, which allows applicant information to be stored in its own secure database. QIs can access SilverEnhanced Savings, which is the HIAE subsidy available for eligible OmniSalud enrollees, in the form of premium subsidies and cost sharing reductions, if their household income is 150 percent FPL ($20,385 per year for a one-person household in 2023) or below. Cost sharing reductions available to OmniSalud enrollees include lower deductibles and co-pays. The Board recommended narrowing the income eligibility threshold from 300 percent FPL or below to 150 percent FPL or below to accommodate the limited budget for subsidies and to align with the income threshold for $0 APTC subsidies available in the C4HCO marketplace.[10] These subsidies lower premiums to $0 per month and reduce costs for health care services through cost sharing reductions. To access SilverEnhanced Savings, consumers must purchase a Silver plan through Colorado Connect. This is the first time that a state-subsidized health plan is available to these individuals. Given the limited funding for the program, up to 10,000 eligible QIs have access to the SilverEnhanced Savings in 2023. After the subsidy cap was met, QIs were able to purchase Bronze, Silver, and Gold Colorado Option plans, but at full price. QIs with incomes of 151 percent FPL and above could enroll in regular-priced plans at any time during open enrollment.

Box II.2. Colorado Option

The Colorado Option is a state-designed, standardized insurance plan sold by private insurance companies.[9] The standardized plans are available to all Coloradans who buy their health insurance on the individual market. Colorado Option plans are sold on Colorado Connect and are available to all OmniSalud enrollees. Colorado Option plans are required to reduce premiums by 15 percent by 2025 and include standardized coverage to make plan comparisons straightforward. Colorado Option plans cover all essential health benefits required by the Affordable Care Act, provide free primary care and mental health visits, and are designed to reduce racial health disparities and improve health equity.

[9] See https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/colorado-option.

[10] SB 20-215 stipulates the $0 premium plan be available for the "lowest income group," which the Board defined as at 150 percent FPL or below.

3. Benefits to the HIAE structure and subsidy design

a. APTC–eligible enrollee subsidy alignment with existing marketplace structures

The HIAE Board decided to align the APTC–eligible enrollee subsidy and OmniSalud with existing health insurance subsidy structures as closely as possible, which helped shape and focus the Board's analysis and discussions. Because the HIAE authorizing legislation does not specify the structure of the subsidies, respondents said that the Board began by considering the strategies the Affordable Care Act uses to subsidize health insurance and reduce the cost of health insurance for consumers. The Affordable Care Act accomplishes this in two ways: (1) through a premium reduction in the form of an APTC and (2) through a cost sharing reduction for residents whose incomes are under 250 percent of the FPL. The Board opted to align the on-exchange subsidy (the APTC–eligible enrollee subsidy) with these two forms of federal financial assistance. While the Board was deliberating on the APTC–eligible enrollee subsidy structure, Congress passed the American Rescue Plan Act in March 2021 and increased the generosity of the premium subsidy under the Affordable Care Act and set a cap of 8.5 percent of income that consumers could pay for health insurance. With these changes, the federal government effectively provided the premium wrap that the Board had considered; thus, the Board decided to offer the cost sharing reduction to complement the premium subsidy provided through the American Rescue Plan Act and extended through the Inflation Reduction Act. An important goal of the HIAE was to enhance the value of APTC–eligible enrollee subsidy plans to help ensure residents with low incomes could afford the health care benefits available to them. Without cost sharing reduction enhancements, consumers may not be able to afford deductible and coinsurance payments and therefore forgo health care despite having a low-premium plan. As one respondent from a community organization explained, "Coverage is only good if you can actually use it to access the care that you need."

Importantly, aligning the APTC–eligible enrollee subsidy with on-exchange subsidy structures ensured that C4HCO and insurance carriers were equipped to implement the APTC–eligible enrollee subsidy. A few respondents mentioned that implementation considerations required restricting possible actuarial values (AV) to existing values for the benefit of insurance carriers and C4HCO. The Board raised the AV from 87 percent to 94 percent, rather than raising it to 95 percent or 96 percent, because carriers already had that AV built into their plan benefit structures and C4HCO was already working with the 94 percent AV plan variant.

b. Simplified OmniSalud design

For the OmniSalud program, many respondents noted that offering one benefit to individuals who were not eligible for federal subsidies and a single eligibility criterion—income—simplified communicating about it. One respondent suggested that including other components, such as geography or age, would have added complexity for customers, assisters, and the technological implementation. Several respondents also underscored the importance of reducing consumer burden by allowing self-attestation of income as opposed to requiring customers to send in documentation. One respondent from a partner organization described similar documentation requirements for Medicaid and CHIP as "incredibly onerous" and a potential roadblock to an individual's ability to enroll.

Respondents were proud of how quickly the HIAE made OmniSalud available for consumers. Most respondents also underscored that the statutory requirement that enacted a $0 premium wrap for the lowest income group will ensure that Coloradans could truly access the health care they need. One HIAE Board member described the implications of the $0 premium wrap as "something that people, when

they're shopping, can really see and feel the difference of." Almost universally, respondents supported the $0 premium wrap and felt that requiring anything higher would be cost-prohibitive for many in the OmniSalud population. However, a few respondents also noted that providing a $0 premium wrap and rich benefit design came at the cost of limiting the number of enrollees.

Most respondents thought the OmniSalud subsidy provided the health care access that the OmniSalud population desperately needed. Respondents described several problems with the patchwork of health care options available to people with undocumented status before OmniSalud, which generally included emergency departments, federally qualified health clinics or lookalikes, or other community health centers. For example, one frontline worker said, "I spoke with many customers who had put off surgeries, needed examinations, things that go beyond the scope of just the community health clinic, and so I think it will be very beneficial."

c. Customer experience

According to key informants, a significant benefit to the APTC–eligible enrollee subsidy structure is that customers do not need to do anything additional to access the savings available to them. They are presented with Silver metal level plans on the exchange with the cost sharing reductions already built into the plan benefit design, without needing to see or understand factors and intricacies on the back end. This is important because describing cost sharing is complex, and the process of shopping for and purchasing insurance already comes with many decision points. (See also Section V.B.)

For OmniSalud, the Colorado Connect platform emphasizes that consumers are accessing state-sponsored insurance, as opposed to a federal program. Several respondents identified this as a key distinction to assuage consumers' fears or concerns about sharing personal information with the government. (See also Section IV.B.)

4. Drawbacks to the HIAE structure and subsidy design

a. Timing and Board decisions

The HIAE Board had to develop recommendations for subsidy structures and eligibility thresholds before knowing the final budget for the year, which presented a challenge. The Board needs to make decisions about one year in advance of the start of the subsidy program year to give C4HCO, carriers, and the DOI sufficient time for implementation. However, this timing is often before the HIAE Board has final information on its budget and before other critical guidance from the federal government is available for the next year. For example, the Board made recommendations for plan year 2024 in December 2022, even though the final budget for plan year 2024 was not available until late Spring 2023. When deliberating on the subsidies for plan year 2023, the Board also had information gaps related to federal subsidies through the Affordable Care Act, American Rescue Plan Act, and Inflation Reduction Act. The Board created different strategies for various federal subsidy scenarios to prepare for a range of outcomes. This compressed the timeline and created some operational challenges, as C4HCO needed to move quickly to adapt subsidies to reflect the Inflation Reduction Act, which passed on August 16, 2022.

Decisions about subsidy design require time and coordination with insurance carriers, C4HCO, and DOI. For plan year 2024, the Board has more time—until the summer of 2023—to set the subsidy cap for OmniSalud. Moving forward, OmniSalud subsidy funding will depend largely upon how much the state receives from the federal government through its 1332 State Innovation Waiver. The placeholder in the budget until that funding amount is known is based on rigorous actuarial modeling for the state's 1332

waiver conducted by Wakely Consulting Group in 2021. DOI staff reported that the federal government is updating its 1332 pass-through funding methodology in 2023, due to the addition of the Colorado Option to Colorado's 1332 waiver. Once the federal government finalizes its 1332 funding methodology, the HIAE Board should have more timely budget estimates to support its decision making for future years.

Some respondents expressed concerns that funding uncertainties could impact the consistency of available subsidies. They noted that budget changes that impact eligibility or the amount of financial help available from year to year could be detrimental to maintaining trust with consumers and the OmniSalud population. The HIAE Board recognized this challenge. As one state official shared, "We really tried to build the structure so that folks can, year after year, come back and have those subsidies available to them." An HIAE Board member underscored another important component of consistency: "Anything that's going to cause more administrative headaches for insurers and for C4HCO means more money is lost to administration and not going to the populations we're trying to help serve."

b. Challenges in aligning OmniSalud with existing Medicaid structures

The Board attempted to design the OmniSalud program benefits to mirror Medicaid by implementing a $0 premium wrap with low-cost sharing; however, the alignment is not perfect. For example, one frontline respondent indicated that household size for OmniSalud differed from Medicaid. If an individual was pregnant at enrollment, it did not increase the household size for purposes of income eligibility under OmniSalud as it would for Medicaid. Respondents also highlighted potentially expensive out-of-pocket cost sharing for pregnant people and for emergency services under OmniSalud as examples, compared to no cost sharing for pregnant people on Medicaid who deliver or beneficiaries who qualify for emergency Medicaid.[11] Several respondents also discussed the need for access to dental care among the OmniSalud population.

c. Equity implications of the OmniSalud enrollee cap on SilverEnhanced Savings subsidies

As noted earlier, OmniSalud implemented a 10,000-enrollee cap on SilverEnhanced Savings due to budget constraints. Open enrollment began on November 1, 2022, and the subsidy cap was reached on December 6, 2022. Most respondents emphasized that how quickly the cap was reached indicated that, although OmniSalud is an important first step, demand for the subsidies far outweighed their supply, indicating that there is still a long way to go to provide equitable health care across Colorado. Many respondents shared concerns about people who did not enroll before the cap was reached. One respondent from a community organization said, "If they didn't get it, they felt even more defeated or even more let down than if they hadn't known about it in the first place." We discuss enrollment before and after the cap was reached in more detail in Section IV.C.

[11] House Bill 22-1289 will address these concerns in the future. See https://leg.colorado.gov/sites/default/files/2022a_1289_signed.pdf.

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III. Partnerships

To design, plan for, and implement the HIAE and ensure its success, the DOI relied on and strengthened several critical partnerships. In this chapter, we first describe the relationship between DOI and C4HCO and then the relationships between DOI and other non-state government organizations, including policy, consumer advocacy, and community-based organizations. We discuss how the various partnerships functioned in terms of what worked well and what was challenging. We also provide actionable recommendations for strengthening the partnerships. Most of the discussion in this chapter focuses on OmniSalud because key informants viewed that program as the primary motivation for the partnerships with other organizations.

Key takeaways on partnerships

- DOI and C4HCO collaborate regularly to carry out the mission of the HIAE. Respondents from both entities described a mutually beneficial, collaborative, and transparent working relationship, although some challenges have arisen around timeline and resource constraints. Creating longer-term strategic plans to allow more time for implementation and planning could improve the partnership.
- HIAE partners with many organizations within Colorado that contribute vital work benefiting the HIAE, including consumer advocacy input and outreach and enrollment support. Some respondents suggested that HIAE could do more to engage local on-the-ground community organizations; build mutually beneficial relationships; and incorporate more opportunities for public comment and community engagement in its decision making.
- HIAE could benefit from deepening partnerships with health care providers and local on-the-ground community organizations to spread awareness of OmniSalud.

A. HIAE partnership with C4HCO

DOI and C4HCO collaborate regularly to carry out the mission of the HIAE. This strong collaboration has been viewed as a critical component to the success of the HIAE. C4HCO is a public, non-profit entity that operates the health insurance exchange and Connect Colorado, where consumers sign up for coverage under the HIAE APTC–eligible enrollee subsidy and OmniSalud, respectively. IT development is a major task for C4HCO. DOI and C4HCO work together to weigh technology and feasibility considerations of policy options and pool their outreach and communication resources. The work between DOI and C4HCO is twofold: first, the two entities work together to figure out and improve the nuts and bolts of the programs; second, the two organizations collaborate in implementing the policy for the state. In its capacity of implementing the HIAE, C4HCO is a contractor of DOI. In FY 2021/22, DOI paid C4HCO $2.5 million (APTC–eligible enrollee subsidy only), and the proposed budget for FY 2022/23 included payment of $3.5 million (APTC–eligible enrollee subsidy and OmniSalud).[12] These payments were for technology and outreach support. DOI and C4HCO staff have regular, semimonthly meetings to discuss operational matters related to program implementation as well as broader policy considerations. The CEO of C4HCO sits on the HIAE Board as a voting member, which is another point of collaboration between the two entities. Other C4HCO staff also regularly attend the

[12] These amounts are based on the proposed HIAE budget for FY 2022/23 as reflected in Board meeting materials, see https://drive.google.com/drive/folders/1voCo9DIxbXbJb9A1Bco282POqrwExsdt and communication from DOI.

HIAE Board meetings to provide input on the feasibility of the Board's ideas and recommendations as well as updates on implementation progress. C4HCO staff provide critical insight to the Board as to what is possible from a technology standpoint, and what will be possible to implement within the given time frame and resource constraints. Additionally, as described further in Chapters IV and V, C4HCO and DOI outreach teams work closely to spread awareness of the programs and build partnerships with community-based and consumer advocacy organizations. A respondent described C4HCO's primary role as "operationalizing the decisions or preparing for the decisions the HIAE Board is going to be making." For example, C4HCO teams designed the web-based application for OmniSalud and developed the guidance and training for frontline workers (such as the health coverage guides, assisters, and brokers) who receive certification to help others enroll.

Respondents from DOI and C4HCO described a mutually beneficial, collaborative, and transparent working relationship across entities. One described the relationship as a "pick up the phone relationship," highlighting the collaborative nature of the partnership and the willingness of both groups to communicate openly with one another. Many respondents noted that frequent interaction and regular meetings helped the teams swiftly address issues as they arose. C4HCO staff appreciated that HIAE Board members were receptive to their feedback: "I get the sense that they are really interested and eager to learn more and use that information to ultimately guide the program towards the kind of the best decisions and the best outcomes possible."

Several challenges surfaced regarding DOI and C4HCO's partnership, mostly related to timeline and resource constraints; however, respondents perceived these challenges as natural and not interfering with the success of the work. Most respondents noted that there was tension between the policy goals of the HIAE and what was operationally feasible for C4HCO to create and implement within the allotted time frame and resource constraints. For example, offering the application only in English for the first year was a difficult decision driven by time constraints and what was feasible for C4HCO to build.[13] Additionally, budget constraints and how much time C4HCO requires to build new technology led both entities to focus on changes for one year at a time. Both entities indicated that mapping out a long-term strategy would be ideal. One respondent also noted that they believe most members of the HIAE Board lack experience with IT development. Thus, C4HCO needs to explain the IT language and frameworks so that Board members understand what is and is not technologically feasible and the trade-offs being made.

> *"The partnerships that we have with consumer advocates are really important to our work up and down the Division, and as we look to evolve this program…we will absolutely be looking to the advocates to help inform those decisions because they're the ones working with the communities that are benefiting from this policy…I can't overstate how important those partnerships are in this work."*
>
> — State official

Respondents suggested that building in more time between when the HIAE Board makes decisions and when they are expected to be implemented could improve the partnership, as could creating a longer-term strategic plan. This would allow operations to be consistent from year to year. Making recommendations several years in advance, where possible, also would give C4HCO more time to build out the necessary technological elements. In recommending a two-year horizon for planning, one respondent explained, "I

[13] Reportedly, the OmniSalud application for plan year 2024 is already available in both English and Spanish.

think that will help us reach better decisions that are based on what we actually want to see the program do rather than compromise decisions based on a really short runway that we have to make the best of."

Box III.1. Key non-governmental partners to the HIAE

Center for Health Progress canvassed low-income housing communities to share information about OmniSalud, among other programs consumers might be eligible for.

Colorado Center on Law and Policy supported HIAE's initial authorizing legislation and continues to support access and eliminate barriers to federal tax credits and other financial assistance available to consumers.

Colorado Community Health Network hosted webinars to inform the 20 community health centers it represents about OmniSalud, inviting DOI and C4HCO staff to field questions about Colorado Option plans, OmniSalud, how to bill claims, and how to make sure the health centers were in-network for OmniSalud plans.

Colorado Consumer Health Initiative (CCHI) a consumer-based health advocacy organization, provided presentations and trainings to community organizers and community networks, including an in-depth series of webinars in collaboration with Colorado Immigrant Rights Coalition (see below). In addition, CCHI provided mini grants of approximately $8,000 to organizations to support OmniSalud outreach; technical assistance and coaching; and materials in English, Spanish, Korean, Chinese, and Vietnamese to four organizations across the state to support their work to reach immigrant populations. CCHI also created one-pagers and communications materials and conducted targeted digital advertising about OmniSalud in English and Spanish through Facebook and Google ads.

Colorado Immigrant Rights Coalition partnered with CCHI to provide a series of eight in-depth webinars with community organizers from late July 2022 through early December 2022. Content for the webinars was provided bilingually in Spanish and English and included information on insurance basics, such as defining premiums and deductibles, and explaining current resources and OmniSalud.

Colorado Organization for Latina Opportunity and Reproductive Rights promoted open enrollment to ensure that eligible Latinas could access the coverage.

Doctors Care is a provider organization that offered bilingual enrollment assistance.

Healthier Colorado leveraged its listserv and social media following to generate awareness.

Vuela for Health provided health information and resources to members of the Latino community.

B. HIAE partnerships with other organizations

The HIAE partners with many organizations within Colorado that represent the communities that the HIAE seeks to reach. These organizations contribute vital work benefiting the Enterprise (see Box III.1). Several of these organizations were early partners of the DOI and helped pass the legislation that created the HIAE. The organizations include consumer advocacy groups, immigrant rights organizations, policy organizations, and community-based health promotion organizations. Partner organizations and DOI staff alike lauded the important role of these non-governmental partners, noting that each organization plays a different role. For example, respondents said that some of the state's consumer advocacy organizations meet with one another monthly ahead of the HIAE Board meetings. They then attend Board meetings to provide feedback and suggestions and to ensure that consumer interests are represented. In general, the partner organizations "are really subject matter experts in their community," as one DOI respondent stated, "and that's so necessary, because we can't launch a government program without knowledge of what's needed on the ground." Another state official noted that HIAE consulted with community organizations on the creation of the OmniSalud application and that

it made "all the difference in the world" to developing a readable and culturally competent application. Respondents from several advocacy organizations said they appreciated the Board's openness to public comments and its ability to incorporate advocacy perspectives into its decision making. As discussed later in Chapter V, many partner organizations collaborate with HIAE on outreach and enrollment efforts.

Some respondents suggested that the HIAE Board could do more to build mutually beneficial relationships with its partners. The Board has engaged partners throughout its existence, including hosting discussions with advocates and frontline workers in immigrant communities before OmniSalud's open enrollment. However, some perceived this engagement to be short term and limited to the organizations providing information to the HIAE, with little effort put into mutual relationship-building. As one advocate stated, "What I see is a bit lacking is some additional efforts from the Board to really connect at that community level." For example, this respondent suggested more interaction between the Board and the populations that they are serving, so that the Board is aware of the needs, goals, and challenges facing immigrant communities when making decisions. Some of the challenges are structural. Several respondents noted that it is challenging and inconvenient for the Board meetings to be the main way for partners to keep abreast of HIAE happenings. One respondent identified language accessibility at Board meetings as problematic, although the Board has begun offering real-time Spanish translation and Spanish-language materials on its website. Several respondents suggested that there is a need for more easily accessible updates and sources of information from the Board, such as an email newsletter.

C. Potential partners

Many respondents suggested that the HIAE establish and/or deepen its partnerships with hospitals and community health centers and do more to engage local on-the-ground community organizations, especially among those that are already serving communities of people with undocumented status. Respondents described opportunities for the HIAE to work with hospitals and community health centers to help enroll potential consumers during open enrollment. Because many people with undocumented status seek care at emergency departments (ED), offering on-site enrollment support could be beneficial. Respondents suggested that partnerships with hospitals would allow ED visits to serve as an opportunity to inform patients with undocumented status of their eligibility for OmniSalud, or even go a step further and facilitate enrollment if the ED visit occurs during open enrollment. "Somebody that's there in the hospital that can offer the insurance to people that are hospitalized," one respondent said.

Further, outside of open enrollment, some respondents thought more could be done to educate safety net health care providers about OmniSalud to ensure that they recognize it as a Colorado Option plan and bill claims appropriately. "The hospitals don't seem to know a whole lot about the insurance or about the audience. I think maybe that would be a really big help if there was somebody in there that would know more [about OmniSalud]." This frontline worker added that if hospitals are not able to staff

> *"I think from the OmniSalud program implementing this year, it was clear that needing to work with providers is something new for the vision. There were a lot of providers that personally worked with the undocumented community who weren't necessarily credentialed in commercial insurance, because they were doing self-pay or, they had grants that would help them provide low to no cost care for that population. Now that this is a commercial product… [it is] more important to be reaching out to providers and working with them."*
>
> — State official

these activities, "I know that our company would be more than happy to send somebody in like once or twice a week." A partnership between local community assister and broker organizations or with the Enterprise itself could be a potential model for engaging hospitals and their patients with undocumented status with OmniSalud. Building partnerships and recognition of OmniSalud with clinics, health centers, and other providers could also facilitate continuity of care for populations with undocumented status. One respondent highlighted the need to partner with community health centers, an important source of care for some people with undocumented status that may not have experience billing commercial insurance, to help them understand what it means to work with a commercial insurance company and get reimbursed through that mechanism. For consumers who previously received care through community health centers, this would allow them to continue seeing their established providers after being enrolled in OmniSalud. Helping such patients get coverage through OmniSalud helps the providers financially as well.

Several respondents recommended continued and deepened engagement with local community-based organizations as well as establishing new partnerships with organizations that the HIAE has not yet engaged. The HIAE hired a bilingual health care equity and outreach specialist to promote OmniSalud and establish relationships with partners, and respondents reported the HIAE's partnerships with many organizations across Colorado as strong. Some respondents perceived that, while the HIAE had effective relationships with consumer advocacy and state-level organizations, there are additional opportunities for the HIAE to work with the local frontline organizations that interact directly with the consumers of these two programs. One respondent noted that these relationships, while acknowledged as important, had been slower to take root, likely due to limited staff resources. Several frontline worker respondents noted that their organizations did not actively work with or communicate with DOI at all. Working to make contact and share resources through an email listserv could be an easy first step. One respondent perceived that the partnerships between DOI and the community-based organizations have been "Denver-centric" and suggested building partnerships in other areas of the state. The respondent acknowledged the impact of COVID-19 on creating this dynamic, because it was challenging to build new relationships with organizations located in other regions through virtual means during the pandemic.

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IV. OmniSalud Outreach and Enrollment

HIAE sought to reach and enroll residents eligible for OmniSalud by designing and implementing a statewide outreach and enrollment plan. In this chapter, we describe the efforts conducted by DOI and its partners to reach and enroll the OmniSalud population, including what the facilitators and barriers were to these efforts. We then share findings from our analysis of enrollment data from the first open enrollment period. Finally, we discuss the consumer experience and equity implications for the program. Findings presented in this chapter were based on key informant interviews and Mathematica's analysis of Colorado Connect enrollment data.

Key takeaways on outreach and enrollment in OmniSalud

- DOI invested in staff and resources that were dedicated specifically to reaching and enrolling people in OmniSalud. The HIAE's outreach approach sought partnership with trusted community organizations. Almost universally, respondents reported that the most effective outreach model was to lean on trusted community messengers.
- A network of frontline enrollment workers, including certified assisters and brokers, provided one-on-one enrollment assistance to OmniSalud consumers, seeking to make enrollment as easy as possible. Respondents cited how quickly the 10,000-enrollee subsidy cap was reached as evidence of this approach's success.
- Frontline workers described a compressed time frame, confusion from frontline workers and consumers about the program's branding, and technological challenges as the primary barriers to their OmniSalud outreach and enrollment work and noted that the application process itself presented challenges to some consumers.
- The subsidy cap was reached on December 6, 2022—before the end of the open enrollment period—when 10,000 consumers had started an application for coverage. Ultimately, 9,689 consumers enrolled in a SilverEnhanced Savings plan. Most enrollees received help from assisters or other frontline workers. Those who qualified for SilverEnhanced Savings and signed up before December 6 had $0 net premiums.
- Grassroots outreach was an essential component of building awareness and providing guidance to the OmniSalud population. However, these efforts varied in intensity and reach across the state, which can present equity concerns due to unequal access to information. Several respondents suggested strategies to make the enrollment process more equitable in the future, as opposed to the first-come-first-served system.

A. Outreach and enrollment strategies and related barriers and facilitators

1. Outreach strategies

DOI hired a bilingual health care equity and outreach specialist to promote OmniSalud across the state. Respondents cited this investment as critical to OmniSalud's first-year success. This specialist worked closely with C4HCO outreach staff, built partnerships with organizations conducting enrollments such as Vuela for Health and Doctors Care, developed OmniSalud messaging and materials, hosted bilingual presentations, and directly enrolled consumers into the program. The specialist also developed and implemented an outreach plan with the explicit goals of extending access to health care to all Coloradans regardless of immigration status; created bridges between community members and DOI; educated community organizations and consumers on health insurance benefits; and empowered

consumers to face their insurance company with knowledge and confidence.[14] The bilingual health care equity and outreach specialist worked closely with C4HCO outreach staff and tracked all outreach activities using an Excel spreadsheet and shared them in a monthly DOI-wide report of outreach work. When planning for outreach and enrollment, it was difficult to predict what consumer uptake of OmniSalud might be. DOI commissioned the Colorado Health Institute to develop a demographic analysis of people eligible for SilverEnhanced Savings; however, the extent to which eligible consumers might apply for and enroll in coverage remained unknown.

Nearly universally, respondents reported that the most effective outreach model for OmniSalud was to lean on trusted community messengers. The HIAE and C4HCO sought partnerships with trusted organizations, provided them with outreach materials, and allowed them to reach their individual communities as they saw fit. Recognizing that OmniSalud consumers might be more receptive to messages from organizations they knew and trusted (rather than a government entity), beginning in November 2021, the HIAE and C4HCO staff shared information with and made presentations about OmniSalud to consumer advocacy organizations, community organizations, immigrant rights groups, and service providers that were known and trusted in communities of people with undocumented status. Several of these organizations became critical contributors to outreach and enrollment efforts (see Box III.1 for a description of key partners' outreach and enrollment efforts). The HIAE leaned on its staff members' existing networks and on the C4HCO network of assisters and brokers to establish connections and build these outreach and enrollment partnerships. As open enrollment grew closer, the footprint expanded, and the number of events grew. Beyond existing partnerships, the HIAE and C4HCO sought to engage with assisters and brokers who had relevant lived experience or connections to immigrants, because frontline workers who could relate to eligible individuals might be more likely to engage with the program. The bilingual health care equity and outreach specialist cold-called and emailed community-based organizations to share information about the new benefit and to seek opportunities to work together. The specialist also offered hands-on support to organizations presenting or sharing information about OmniSalud to ensure communication was accurate and clear. Throughout its efforts, the HIAE sought to provide education using effective teaching methods that were responsive to the priority populations' cultural, educational, linguistic, and literacy needs.

> *"It's a community that has had reasons to not trust government entities… We knew that we were going to have to overcome some barriers of trust, and the best way for us to do that was to make sure that organizations that already had that [trust] established understood the program and believed in it, and then could ultimately vouch for it."*
>
> — Respondent from a partner organization

OmniSalud outreach materials and media communication focused on affirmative messaging, including that the program was new, affordable, and confidential. The bilingual health care equity and outreach specialist, with the help of C4HCO's in-house graphics designer, developed OmniSalud's outreach materials, such as flyers, leaflets, and posters. In addition, C4HCO developed an online and printed toolkit. All of these materials were shared widely across partner networks. Respondents from partner organizations reported that the state materials were simple, clear, and complete and that they used them to support their outreach and enrollment work. However, several noted that it took too long to roll

[14] DOI outreach plan document shared with Mathematica.

out the materials and that there was initial confusion around program branding (that is, the language changed from originally calling the program Phase II, to referring to consumers as QIs, and finally landing on OmniSalud). Some would have appreciated materials in languages other than Spanish and English (for example, Mandarin and Native languages spoken by Guatemalan immigrants), and several would have appreciated opportunities to engage in material development. For example, some respondents identified the need for even more visuals and graphics, such as a graphic showing exactly how the insurance product works, or examples about what certain procedures or tests would cost with and without subsidized coverage. Another requested that future materials leave room for local organizations to add a sticker with their phone number so consumers know how to reach local help.

"What I think would have been more beneficial was for DOI and Connect for Health Colorado to engage community organizations more proactively in, okay, how can this best be framed to inform the community? We did provide them a lot of feedback throughout the lead up to open enrollment and during, but it was mostly at our doing, it was not necessarily them initiating that kind of outreach and engagement…I think we were in many cases out of the gate already on those fronts and it made it a little more challenging at times, particularly around Connect for Health Colorado to make sure that we were communicating the same information in a similar way."

— Respondent from a partner organization

Media outreach about OmniSalud consisted of Spanish radio, social media, TV interviews, and a billboard.[15] Some frontline workers did not think there was sufficient public advertising and would have liked to see posters in grocery stores, libraries, and bus stations; however, several noted that this lack of public advertising was not detrimental because the program reached its cap on the number of enrollees who could receive SilverEnhanced Savings early. Further, a few respondents shared that although radio and internet ads can build awareness, people with undocumented status may need direct contact with someone to alleviate concerns and build trust in the system. The HIAE did not have active social media accounts (such as Facebook or Instagram), which some respondents saw as a missed opportunity to engage consumers online.

"I always tell our organizers after we have a meeting that it's really important to follow up and make sure that that person that is coming to that meeting spreads the word to their family, to anybody that they know is impacted. So, following up and making sure that we're building it like a tree. And so, it's like yes, this one person is coming to this meeting, but you need to make sure that they are telling five other people about this new resource, this new benefit."

— Respondent from a partner organization

Local, community-based organizations sought to reach the OmniSalud population creatively by establishing a presence in the community and online. Respondents said asking people to spread the word to their networks was an effective outreach strategy. Armed with materials and information from HIAE, C4HCO, and some of the key partners listed in Chapter III, local community-based organizations conducted a range of outreach efforts. Examples included hosting tables at health fairs; handing out flyers at

[15] Based on document review, the total marketing budget for OmniSalud was $150,000, with about two-thirds spent on radio ads in the Denver metro area and the rest spread between Weld County, Colorado Springs/Pueblo, and developing print materials such as full-color ads in two bilingual/Spanish newspapers.

back-to-school and community events; working with churches to host educational forums and to motivate church leaders to share information about the program among their congregations; funding radio ads and text message campaigns; visiting farms with migrant workers; and receiving referrals from other organizations, such as food banks, who helped identify people with undocumented status who were also uninsured. Across all these outreach efforts, organizations tried to build trust, share clear and accurate information, and, when possible, schedule enrollment appointments. Organizations reported leveraging social media, email newsletters, and WeChat (specifically for the Chinese community), seeking to reach their existing networks of contacts and asking them to share the information more broadly. Several noted the difficulty of conducting outreach to people with undocumented status, because their organization was concerned about protecting people's immigration status and privacy. Beyond formal outreach methods, many organizations reported that, for every interaction they had with a potentially eligible consumer, they encouraged that person to share information about OmniSalud with their family and friends to help spread information about the program. One frontline worker proactively reached out to managers of local restaurants and encouraged them to share information with their employees who might not have immigration documentation

2. Enrollment strategies

A network of frontline enrollment workers—including, health coverage guides, certified application counselors, promotoras, and health insurance agents and brokers—provided one-on-one enrollment assistance to OmniSalud consumers, seeking to make enrollment as easy as possible. Respondents cited how quickly the 10,000-enrollee cap on receiving SilverEnhanced Savings was reached as evidence of this approach's success. From the beginning, assisters played an important role in working with OmniSalud consumers and encouraging potential enrollees to get assistance when applying for coverage. Respondents generally perceived this to be a positive decision, citing the complexity of the program, the required technology, and the need for follow-up assistance after enrollment. C4HCO played an integral role in OmniSalud enrollment by increasing funding to its Assistance Network and training all

Box IV.1. Types of frontline workers

In this report, we use the term frontline worker to refer to the various types of professionals who provided enrollment assistance to consumers, including the following:

Health coverage guides are analogous to health insurance navigators in federally facilitated marketplace states. Health coverage guides receive funding from Connect for Health Colorado and are certified to help consumers review their health coverage options and assist them with completing eligibility and enrollment forms. These individuals are required to be unbiased. Their services are free to consumers.

Certified application counselors or **assisters** are trained to help consumers review their health coverage options and assist them with completing eligibility and enrollment forms. These individuals are required to be unbiased. Their services are free to consumers. They do not receive funding from Connect for Health Colorado.

Promotoras are Hispanic and Latino community health workers, some of whom received training to help consumers review their health coverage options and assist them with completing eligibility and enrollment forms. These individuals are required to be unbiased. Their services are free to consumers. Promotoras generally have additional community health worker responsibilities.

Health insurance agents or brokers are certified to help consumers enroll in health insurance plans. They can make specific recommendations about which plan consumers should enroll in and typically get payments from the issuer for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers.

frontline workers, regardless of their funding sources, on how to enroll consumers in OmniSalud.[16] During C4HCO's CoverCO conference from October 11 to 13, 2022, which virtually convened between 700 and 800 frontline workers, one session focused on the new OmniSalud program. C4HCO also incorporated information about OmniSalud into the trainings required for frontline workers to become certified.

Frontline workers provided enrollment support during in-person enrollment events, either at their offices or public locations such as libraries and churches, as well as virtually and over the phone. Responses regarding consumers' preferences for in-person versus virtual appointments varied. Many said they were most successful in scheduling appointments with consumers, although they appreciated building flexibility into their schedules and thus would take occasional walk-in or on-the-spot appointments. Frontline workers reported varying preferences for in-person versus virtual enrollment appointments, pointing to the importance of offering consumers both options. Some said most of their consumers opted for virtual or phone appointments, particularly on weekends, after working hours, or when the consumer lived far away. Others said that many consumers tended to prefer in-person assistance because it helped build trust and was easier to talk through plan options when looking at the same screen.

Respondents reported varying strategies to encourage and support consumers when applying for coverage as well as challenges:

- To help prioritize appointments, several reported prescreening consumers to make sure they were only scheduling appointments with those who would qualify for coverage.
- Regarding conducting enrollments in public spaces, one frontline worker noted the importance of making people feel comfortable, such as by using folding screens or dividers to protect confidentiality and privacy.
- One frontline worker noted that their offices were housed within the county public health department, which may have been off-putting for some consumers who mistrusted the government.
- Building people's trust in the program and ensuring that their information would be kept confidential was a challenge. However, several frontline workers noted that once word of mouth spread within a particular community, requests for enrollment appointments increased.

Frontline workers developed innovative approaches to deal with the unique challenges this population faces when attempting to enroll in coverage. Respondents saw these approaches as successful and thought they could be standardized and shared on a broader scale in future years. Common approaches included the following:

- Providing consumers with additional documentation about out-of-pocket costs for services on an OmniSalud plan (that is, how much they would be charged for emergency room and specialty care visits) and definitions of frequently used terms (that is, premiums, coinsurance, co-pays, and in network versus out of network).
- Offering take-home packets with basic information about the program, the enrollment assister's phone number for follow-up questions, information about how to contact the insurance plan, and a

[16] C4HCO funds 77 Assistance Network and Enrollment Center partners across the state. The grant program is analogous to the federal Navigator program. Organizations had to apply by April 25, 2022. Their contract funding period runs from July 1, 2022, through June 30, 2024. Thirteen organizations were newly certified this year, some of which represented organizations that people with undocumented status accessed for support and care.

secure place to store the consumer's email address and password. This was particularly useful for consumers who needed to create email addresses and passwords to sign up for coverage.

- Because all subsidized plans offered the same benefit,[17] the most important decision for consumers to make during enrollment was which carrier to select—because provider networks differ from carrier to carrier. Frontline workers reported encouraging people to consider distance from their house to the doctors in the carriers' network and what provider or clinic they currently use. Some even encouraged consumers to call the carrier to confirm that they could continue seeing their current doctors.
- Some groups created at-a-glance lists to help consumers make educated plan selections. They thought the state could play a role in developing and distributing those lists in the future.

3. Barriers to outreach and enrollment

Frontline workers and community organizations described a compressed time frame, insufficient background on the program, and technological challenges as the primary barriers to their OmniSalud outreach and enrollment work. While community organizations were generally aware of the new subsidy program, they nonetheless described a scramble to obtain training and get clarification on specific questions in time for open enrollment. Community organizations wanted to feel confident in the program and have a clear understanding of how Colorado Connect would protect the OmniSalud population's information before they encouraged their communities to enroll. These organizations have built trust within communities of people with undocumented status. They wanted to honor that trust by making sure they understood and had confidence in the program themselves. As one respondent from a community organization explained, "That's why we had to be very careful and to search a lot of information." One frontline worker reflected, "If we had had that information on time, if it were well organized, if it were prepared by professionals or by leaders and experts from DORA, preparing us earlier, explaining that to us, it would have been better." The branding for the program was one area of confusion. In addition, one frontline respondent shared that, though C4HCO's certification coursework offered comprehensive information, it did not include hands-on, interactive components to prepare for enrolling people through the online platform.

A few frontline workers discussed technology challenges, such as poor internet connectivity in more rural locations and occasional problems with the online platform. Frontline workers also indicated that they needed to support many individuals who were eligible for OmniSalud with a basic orientation to technology by helping them create an email address so that they could enroll on Colorado Connect.

Respondents shared several challenges related to equity. Challenges included issues with the infrastructure and application process itself, including the lack of language access; the high demand for enrollment appointments; and the specific concerns facing households with mixed immigration status. The OmniSalud application was only available in English, which presented a barrier to both consumers and frontline workers, particularly in instances where frontline workers were assisting a consumer with whom they did not share a common language. One respondent from a partner organization reflected on the customer experience, "It's not the same as just immediately being able to speak in your preferred language." Because the application was not translated into Spanish or other languages, many people could not complete it on their own. The solution to this problem was for consumers to find an assistance center and make an enrollment appointment. Although many frontline

[17] The only plan feature that can differ across plans is drug formularies. While cost-sharing is standardized, formularies may vary.

workers were bilingual and spoke Spanish or other languages, consumers could not assume that a frontline worker who spoke their preferred language would be available in their area, in which case interpreter services were needed. Requiring a translator adds complexity because, as one frontline worker noted, "[It's] another barrier and another obstacle that they had to overcome. And also, it's another person they have to place their trust in that the information is being put in correctly." Several respondents also noted that some consumers reportedly received English-only copies of their new member packets from the insurance companies, which included important insurance information that they could not understand. According to one respondent, "Some people threw them away."

Frontline workers also had capacity challenges in trying to meet appointment demand. Some sites offered evening or weekend hours, but many did not. The ease of scheduling and completing an appointment also varied. Some sites had online appointment scheduling, which required consumers to have a level of technology and knowledge. Other sites scheduled appointments by phone, but this often required very long waits. Some people had appointments canceled by the assister organization repeatedly, which caused them to miss the opportunity to enroll before the subsidy cap was reached.

One respondent shared that it was challenging to enroll members of households with mixed immigration status, such as a household in which one spouse does not have documentation and one has legal permanent resident status. Although both would be eligible for OmniSalud based on income, the partner without documentation would qualify for OmniSalud while the partner with legal permanent resident status would not. This could create confusion about eligibility.

One HIAE Board member highlighted a federal requirement regarding insurers' collection of Social Security numbers that might deter people without legal documentation from enrolling in coverage. According to the respondent, "Under federal rules, health insurance companies have to ask three times for a Social Security number." The respondent worried that if this was not clear to consumers, who had been assured elsewhere that they did not need a Social Security number to enroll in an OmniSalud plan, this could make them uneasy or discourage them from enrolling.

Frontline workers commonly noted that the OmniSalud population required education on health insurance topics, such as how to use their coverage to access care, and that frontline workers were often the best resources available to fill that gap. Several frontline workers noted that they tried to help individuals understand how to use their health insurance and explained terms such as co-pays, coinsurance, and deductibles, to ensure that individuals knew how to start using their health insurance. One frontline respondent said, "People are enrolling in health insurance maybe for their first time ever and they don't know what an insurance card is, and they don't know how to tell the doctor that they have health insurance." Because OmniSalud plans have $0 premiums, there was confusion around how individuals would effectuate their coverage, the process that makes coverage go into effect and usually occurs when consumers pay the initial premium. This process varied from carrier to carrier, so providing guidance and answers for when to expect insurance cards and when individuals could begin using their health insurance was a challenge for frontline workers.

Respondents noted that helping consumers understand insurance networks was also important. Many consumers wanted to continue to receive care through their existing providers, and frontline workers found it challenging to explain the concept of a provider network and to look through the different provider directories to determine which providers participated in which networks. As one respondent reported, frontline workers were tasked with "making sure that the providers that they want are in the network that they're enrolling into and that they can still access coverage at some of the community

clinics that they trust and have been accessing for years." The respondent concluded, "I think there's still a gap there with many of the safety net and community clinics not being fully integrated into these plans." As discussed in Chapter III, some health care providers that traditionally worked with people with undocumented status were not credentialed in commercial insurance and therefore needed to take this step to continue seeing patients who were now covered through OmniSalud. Some frontline workers discovered that consumers did not understand that the frontline workers and their organizations were not insurance providers. Therefore, when consumers received a bill or experienced an issue with their plan, they lost trust in the organization that provided the enrollment assistance.

Some brokers were uncertain about when and how they could expect payments for enrolling consumers into OmniSalud plans. Brokers receive payment from carriers for conducting enrollments. However, some broker respondents reported that they did not have clarity about when or if they would be paid for signing up OmniSalud consumers. Brokers may need additional education and engagement, potentially from health insurance carriers, to clarify their compensation. Without this knowledge, some broker respondents said they might not feel incentivized to enroll this population in the future.

One respondent described an additional challenge in the way that the Colorado Connect platform, which was designed to provide OmniSalud consumers with additional data privacy and confidentiality, is set up to communicate status updates to consumers, as compared to the regular C4HCO platform that is used for other populations. As this respondent described it, "Some of our tools are less built out than they are on the Connect for Health Colorado side, so our ability to mail these customers or email these customers is a little bit constrained by our need to keep their data on a different side of the firewall." The respondent noted that C4HCO needs to improve upon this issue in order to have "better and easier communication with these Colorado Connect customers," but that this may have caused challenges in the first year of the program.

Enrollment in OmniSalud SilverEnhanced Savings occurred more quickly and at a greater volume than expected. When planning for open enrollment, respondents noted that they were concerned not enough consumers would seek to enroll in OmniSalud and be eligible for SilverEnhanced Savings. Thus, they were focused on maximizing enrollment, not on what to do if enrollment exceeded expectations. When it became clear that the 10,000-enrollee subsidy cap would be met early, the HIAE and C4HCO needed to quickly update policies and procedures to ensure that they did not enroll more people than the program could support. These quick adjustments presented several barriers to both frontline workers and those eligible for SilverEnhanced Savings under OmniSalud, particularly because awareness of the subsidy cap varied. Several community organizations and frontline workers said they needed more communication updates about enrollment numbers and proximity to reaching the subsidy cap. Many were

> *"I don't think anyone came in really knowing that there were only 10,000 spaces…. If they happened to come after the 10,000 cap was filled, for me, it was mainly confusion or disappointment. Them knowing like, 'Oh, if I would have come earlier, I might have gotten one of those spots.' Or … 'Now I'm going to have to stay without insurance because I can't afford to pay the full cost.' Or just people being confused and saying like, 'Well, my income is within those limits, why can't I get one of those $0 plans?' I'm just having to explain that there were only 10,000 spaces, and unfortunately you came after those 10,000 spots were already filled."*
>
> — Frontline worker

caught off guard when the cap was reached on December 6—more than a month before the end of open enrollment. Many community organizations explained that this put them in a difficult situation with their community: after encouraging individuals to enroll and spread the word about the benefit to their friends and families, trusted organizations then had to communicate that the opportunity was closed and, in many instances, cancel appointments scheduled after December 6. One respondent from a community organization explained, "[Frontline worker organizations] had to call and cancel a hundred appointments and that didn't feel great to them because it's their reputation. They're this trusted person and now they're letting their community down is how it felt to them." Although C4HCO and DOI prepared messaging once the subsidy cap was reached, some respondents did not receive that guidance and reported that they struggled with how to inform the community that they could continue to receive coverage but that the SilverEnhanced Savings subsidy was no longer available. Often, community organizations and frontline workers felt responsible for providing clear communication, yet they did not have the information they needed to project how quickly the subsidy cap would be met. A respondent from a community organization described, "There was essentially a communication vacuum around that. While Connect for Health communicated that to assisters and brokers, it was not communicated publicly in a way that the community would know and trust."

Awareness about nearing the subsidy cap and subsequent action on the local level varied. Some community organizations and frontline workers learned about climbing enrollment numbers, and they felt a sense of urgency to enroll as many people as possible. One frontline respondent explained: "We made a decision in December to basically contact everybody who had an appointment with us in January and try to get them in before January." The respondent shared several strategies of "doing these enrollment events where we enrolled 20 people at a time in a group setting, doing weekend appointments, doing evening appointments, because we just knew that cap was going to be hit and we wanted everybody that had already scheduled with us to get on."

Some respondents expressed concerns about future enrollments because individuals may not be automatically re-enrolled, and demand will be higher. One HIAE Board member summarized the challenge as "just really making sure that if we built all of this trust through all of these groups who did outreach that we don't violate it in Year 2 in any way." Several respondents shared that they are keeping lists of individuals to reach out to at the next open enrollment. One frontline worker said, "We've all started keeping notes or keeping a particular file of who lost out this year."

Frontline workers did not have clear guidance about how to proceed with applications that were in process, or whether they could redesignate a spot if someone chose not to enroll after their initial application counted toward the cap on SilverEnhanced Savings subsidies. Some only learned that the subsidy cap was reached when they helped an individual complete and submit an application and it did not go through. Other frontline workers learned about individuals who counted toward the cap but then chose not to complete their applications. When frontline workers inquired whether they could fill the vacant slot with someone else who was trying to access the program, they were told no. In efforts to make the enrollment process as fair as possible, Colorado Connect implemented a policy to hold OmniSalud subsidized spots for people who had begun applications, rather than offer those spots to new people who tried enrolling later.

Community organizations and frontline workers indicated very few individuals they worked with purchased plans at full price. Several respondents mentioned that, once the subsidy cap was reached, many people canceled or did not show up for their enrollment appointments. One frontline respondent reflected that some people did keep the appointments, "We did have quite a few folks who did still want

to see what it looked like and what it would cost, but they either couldn't afford it or didn't see the value in paying that much money for health insurance." One frontline worker explained, "Once those savings went away, it was just too expensive for people. People were very interested, but they just could not afford that."

B. Consumer experience

Most frontline workers indicated that consumers learned about OmniSalud and their eligibility for health insurance coverage through word of mouth and trusted messengers in the community. However, some consumers remained hesitant to enroll and some required significant education to understand the benefit. Many respondents specified fear of deportation and lack of trust in government as a distressing factor for this population, which helped explain why they perceived word of mouth by trusted members in the community to be the most effective method of outreach. As one frontline worker stated, "I'm sure there was advertising…. But it was word of mouth. Everyone learned because their friend called them, their neighbor told them, their doctor told them about it. There was so much word of mouth and so many trusted messengers." Another noted, "They communicated it to each other. Someone came to enroll, a few minutes later another person came, and it turned out they were relatives or neighbors. They communicated to each other."

Frontline workers used key messages such as "$0 premiums," "affordable insurance plans," "protected personal information," and "medical attention" to help motivate consumers to enroll. One frontline worker mentioned that most of the consumers that enrolled in OmniSalud came to appointments with their mind set on signing up for a plan and did not require any information to try to convince or sell them on the program. The benefit offered to consumers was compelling because people with undocumented status have not had access to coverage for health care services and they were eager to have a fully subsidized plan with affordable co-pays for the first time.

> *"Many people really didn't trust the system. What if I give them all this information and next week they show up at my house and they want to deport us? … From previous work with those families, I knew who was suffering a hand surgery, a knee surgery, cancer. And they didn't have the resources to take care of the elderly or ill members in their family that are undocumented. Still, I was surprised—not shocked, but surprised—at the fact that more than one family said, No, I don't trust the system."*
>
> — Frontline worker

Most organizations working with OmniSalud consumers had created an environment of trust with this community. If they didn't, they had to develop it. According to frontline workers, consumers prioritized the safety and privacy of their family, which meant they may have been reluctant to share information with a person or organization they didn't fully trust. A frontline worker shared that many of the consumers they came across worried about public charge[18] and how their information could be used against them in the future. Working with trusted organizations helped overcome this fear for some, as did creating an environment for consumers to feel secure and understand that personal information would not be shared with government agencies.

[18] "Public charge" is a ground of inadmissibility for which a person can be denied a green card, visa, or admission into the United States. In deciding whether to grant some applicants a green card or a visa, an immigration officer must decide whether that person is likely to become dependent on certain government benefits in the future, which would make them a "public charge."

Despite these assurances, some frontline workers noted that some consumers hesitated to enroll. In these instances, the workers would remind the consumers that this was a once-in-a-lifetime opportunity that would allow them to access health services and help prevent future illnesses. One respondent recalled enrolling an individual who had broken their hand but did not pursue medical care because they did not have insurance. The frontline worker used this incident to explain that having health insurance would have allowed them to seek medical care for this injury. Finally, the enrollment process asked for minimal personal information and did not require proof of immigration status or income. Respondents shared that the overall enrollment process was easy and fast because the actual application process was brief.

Overall, most frontline workers expressed a moderate level of difficulty (on a scale from 1 to 5) with explaining the new benefit to consumers. While the insurance plan itself may have been relatively straightforward, many OmniSalud enrollees had no prior experience with or education around health insurance. The OmniSalud population is composed of immigrants from various countries, with different health systems, and many are not familiar with the U.S. health care system. This is the first time they have had access to health insurance in the United States. Respondents said that many consumers did not understand health insurance terminology such as premiums, co-pays, out-of-pocket costs, and referrals. Therefore, frontline workers needed to explain benefits multiple times and get creative with examples, charts, and pamphlets to educate consumers. As one frontline worker stated, "OmniSalud is not difficult to explain. The health system in general is difficult to explain."

Since this was the first time the majority of OmniSalud consumers had enrolled in health insurance, many frontline workers indicated that they embedded health insurance literacy into their enrollment processes, which consisted of sharing pamphlets or discussing basic insurance terminology. One respondent urged HIAE to consider a mailing to all OmniSalud enrollees with a pamphlet, similar to what Colorado sent after consumers began enrolling on the exchange for the first time, that includes resources that explain health insurance terms and how to schedule a doctor's appointment as part of an educational campaign on health insurance literacy. This type of education could help overcome consumer confusion. For example, one respondent shared that some consumers did not realize they would be receiving an insurance card in the mail. When it arrived, they thought it was junk mail and threw it away. Others would seek medical care and would be asked for a Social Security card, which would cause them to panic. Then, when they were asked if they had health insurance, they would respond that they did not have insurance or did not know, when in fact they did.

Not all frontline workers and organizations had time to educate consumers about health insurance. Some shared that they focused on "casting a wide net" for enrollments and squeezing in as many appointments as possible to not leave anyone behind. This left little time to explain health insurance concepts and terms with each person.

Several respondents thought there could be more opportunities for the HIAE Board to engage with community members. Some respondents noted that the opportunities for public comment during Board meetings could be made more accessible to gather and incorporate feedback from community members. One respondent suggested that Board meetings should be scheduled at times that are more accessible to individuals in the communities being served (that is, residents with low incomes and undocumented status). One respondent suggested that Board members try to better understand and engage with the populations they're serving through increased community engagement: "Many [Board members] do not have much interaction or experience, particularly with immigrant populations, and I think that occasionally stunts their perspectives as they're making decisions." It will be especially important to consult community voices as the program grows and evolves. Several respondents suggested that partners

should be engaged with the Board on a more regular basis, perhaps with a monthly check-in to exchange information, ideas, and answer questions, as well as to gather community advocates' input when weighing challenging decisions.

C. Quantitative analysis of OmniSalud 2023 open enrollment

We used enrollment and premium data from Colorado Connect provided by C4HCO to analyze how many people qualified for SilverEnhanced Savings, when they enrolled, and what their demographic characteristics were (including the part of the state where they lived).[19] See Appendix B for a more detailed description of this data source.

1. Enrollment

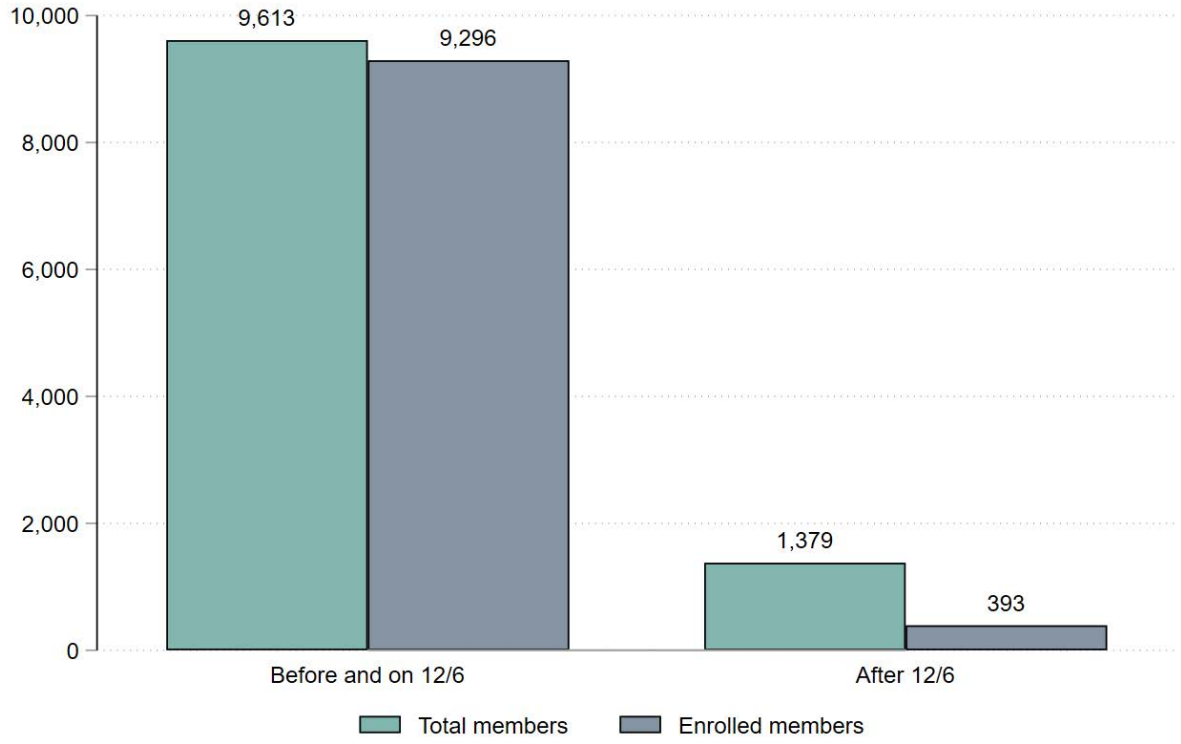
During open enrollment for plan year 2023, 9,689 QIs enrolled in a plan with SilverEnhanced Savings through Colorado Connect. The vast majority enrolled before December 6, 2022, when C4HCO triggered the 10,000-enrollee cap. By that date, 10,000 people had started their application for coverage although only 9,613 individuals had submitted their application and 9,296 had enrolled in a plan (Exhibit IV.1).[20] After December, another 1,370 qualified individuals submitted their application, of whom 393 enrolled in a plan. Although these people were eligible for SilverEnhanced Savings based on their income, they were not able to enroll in a SilverEnhanced Savings plan because the enrollee cap had been triggered. Overall, 10,992 SilverEnhanced Savings-eligible QIs submitted their application for OmniSalud coverage, suggesting that demand for subsidized OmniSalud plans exceeded the enrollee cap. Qualitative findings suggest that this number likely would have increased even more had the cutoff not been executed when it was, because many frontline workers reported cancelling enrollment appointments with eligible individuals after the cutoff date. Although consumers were still able to sign up for plans without subsidies after the cutoff date, the cutoff possibly discouraged them from ultimately enrolling. Among those who submitted their application for coverage before the cutoff, 3 percent subsequently did not enroll, compared to the 72 percent who applied after December 6 and subsequently did not enroll. Not everyone who enrolled in a plan also effectuated coverage, that is, their coverage did not go into effect by the time we conducted this analysis.[21]

[19] We only included QIs with incomes below 150 percent of the FPL because C4HCO did not provide data on people who enrolled through Colorado Connect but did not qualify for SilverEnhanced Savings. 150 percent FPL was the eligibility cutoff established by the HIAE Board (see DOI regulation 4-2-83).

[20] Of the 9,296 who enrolled by December 6, only 14 did not enroll in a SilverEnhanced Savings plan.

[21] Mathematica received the Colorado Connect data used in this report on March 23, 2023.

Exhibit IV.1. Enrollment of QIs eligible for SilverEnhanced Savings, before and after December 6, 2022



Source: Mathematica analysis of Colorado Connect data.

Notes: Green bars ("Total members") show the number of members who were eligible for SilverEnhanced Saving and submitted an application for coverage through Colorado Connect, and blue bars ("Enrolled members") show the numbers of members who enrolled into a plan.

2. Sociodemographic characteristics

OmniSalud enrollees predominantly spoke Spanish, almost half were employed, and more than half had household incomes between 100 percent and 150 percent of the FPL. Among those who enrolled in OmniSalud plans, 81 percent reported Spanish as their preferred language (when given the option between English and Spanish). This is clear evidence that more materials—from outreach resources to the coverage application—should be provided in Spanish and likely other non-English languages. Among those who enrolled, 46 percent reported being employed. One frontline worker from a rural region of the state reported that local places of employment for OmniSalud-eligible individuals where the enrollment organization had previously built relationships—particularly agricultural centers—were effective enrollment sites. Additional demographics can be found in Exhibit IV.2, including gender (54 percent female), age (majority 35 to 54), and mean household size (3 people).

Exhibit IV.2. Sociodemographic characteristics of OmniSalud enrollees

Enrollee characteristic	Percentage of enrollees
Preferred language: Spanish	81%
Employed	46%
Income < 100% FPL	45%
Income 100–150% FPL	55%
Female	54%
Male	46%
Ages 0–17	11%
Ages 18–25	8%
Ages 26–34	15%
Ages 35–44	24%
Ages 45–54	25%
Ages 55–64	11%
Ages 65+	6%
Mean household size	3

Source: Mathematica analysis of Colorado Connect data.

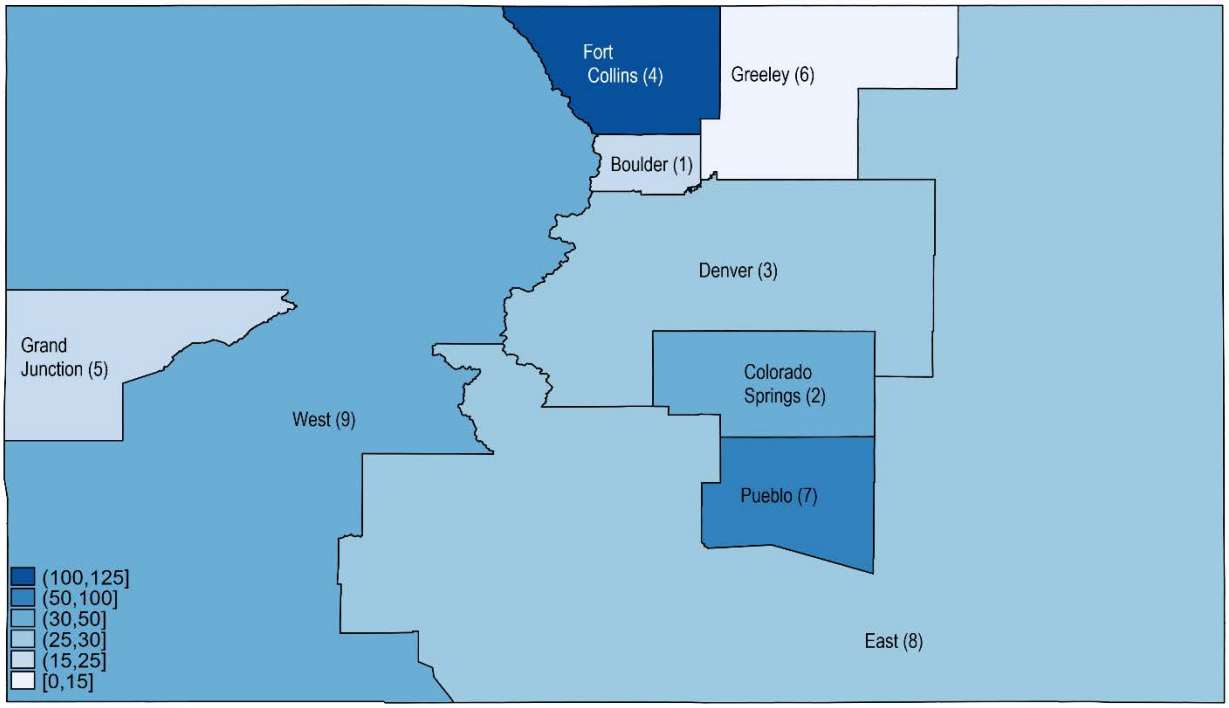
3. Geography

There was some variation in enrollment in OmniSalud plans across regions when compared with the projected number of QIs, but rural areas of the state did not exhibit consistently lower enrollment. Some respondents were concerned that a first-come-first-served system would allow large urban areas—namely Denver—to take up a disproportionate number of enrollment slots under the 10,000-enrollee cap and leave rural areas underserved. One respondent, a community organizer in Fort Morgan, felt that key organizations leading outreach and enrollment were not well prepared to support rural areas, noting that "if they would have done the proper research into communities like Fort Morgan, they would know that those are the communities that need the most support." We compared enrollment in OmniSalud plans during open enrollment in each DOI rating area to the projected number of QIs.[22] Overall, enrollment was lower than the projected number of QIs, which was expected because the total number of QIs in the state (36,000) far exceeded the 10,000-enrollee cap. If enrollment were proportional to the projected number of QIs across the state, the ratio of enrolled to projected QIs would about 28 percent in all areas. However, there was some variation in the percentage of projected QIs enrolled in OmniSalud. In one rating area, Fort Collins, more than the projected number of people enrolled, while only 13 percent of projected QIs enrolled in the Greeley rating area (Exhibit IV.3). Generally, there was no consistent difference in the percentage of QIs enrolled between urban and rural parts of the state, as a fraction of total QIs in those respective areas. For example, in the West and East rating areas, 32 percent and 27 percent, respectively, of projected QIs enrolled, while in the Denver rating area, 25 percent enrolled. Regions where multiple events were held in person before open enrollment tended to enroll a larger proportion of the projected QI population. For example, eight in-person outreach and enrollment events—42 percent of all in-person events conducted by DOI in 2022—were held in the West rating area. Although there is no evidence of a causal relationship between on-the-ground efforts and enrollment,

[22] The Colorado Health Institute estimated these projections using data from the 2019 American Community Survey, according to a memo provided by DOI.

qualitative findings suggest that areas where frontline workers spend time building trust with communities see positive results when it comes to engaging and enrolling the QI population. It could have been necessary to focus outreach activities in the West area to reach QIs living there while fewer outreach events may have been sufficient in other parts of the state; however, we cannot draw definitive conclusions with the available data.

Exhibit IV.3. Percentage of OmniSalud enrollees out of projected QI population, by DOI rating area



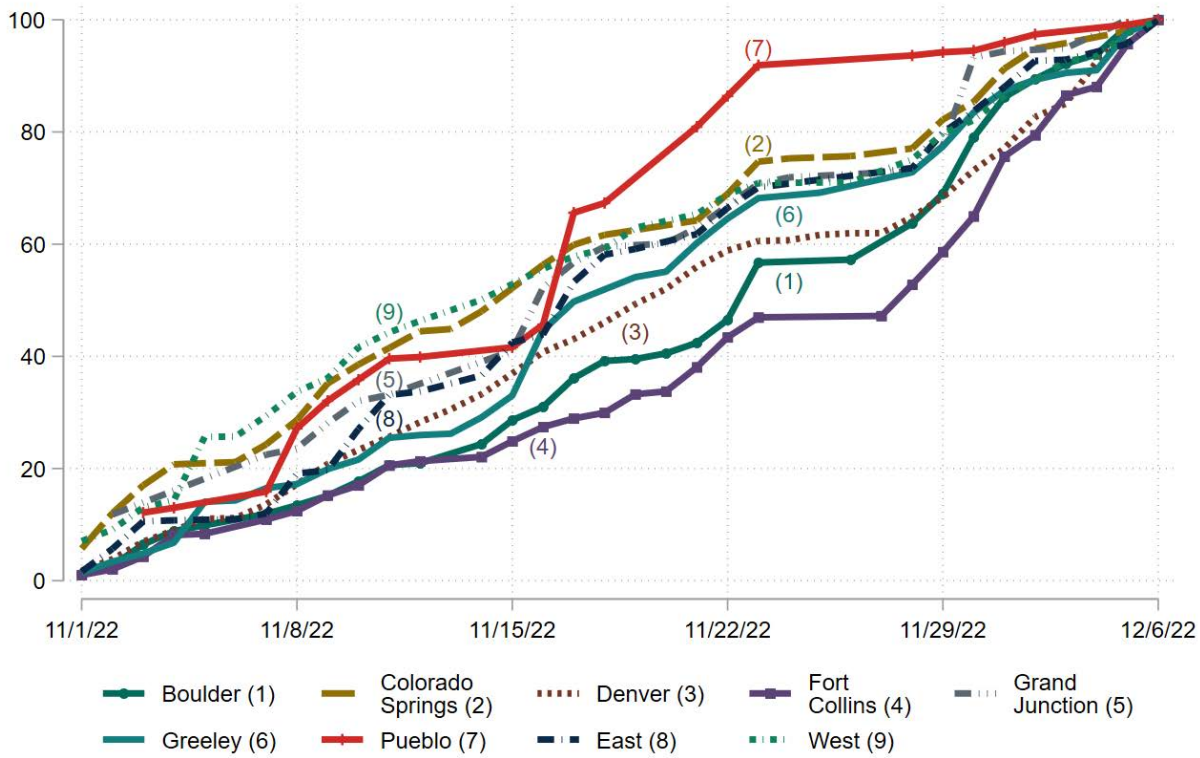
Source: Mathematica analysis of Colorado Connect data; Colorado Health Institute projections.

Notes: The map shows the percentage of QIs who enrolled in an OmniSalud plan with SilverEnhanced Savings out of the total number of QIs with income below 150 percent FPL who were projected to reside in each DOI rating area.

Analysis of regional enrollment dates over time suggests that conducting virtual events during open enrollment might have been a successful and equitable approach to outreach and enrollment. For each DOI rating area, we calculated cumulative enrollment for each day of the open enrollment period up to December 6.[23] Areas differed in the speed of enrollment. Some areas, such as West, had early enrollment spikes; others, such as Fort Collins, only saw significant enrollment activity later during open enrollment (Exhibit IV.4). Overall, enrollment in most areas spiked around the same times throughout November and early December, up until the enrollment cutoff was triggered. This suggests that enrollment spikes may have occurred after virtual enrollment events that were not geographically specific. Thus, they could have impacted the rate of enrollment equally across regions. The only exception to this was Pueblo, where there were uniquely large spikes in enrollment in mid to late November that cannot be explained by existing DOI outreach data.

[23] C4HCO did not provide enrollment dates after December 6.

Exhibit IV.4. Enrollment under OmniSalud over time, by DOI rating area



Source: Mathematica analysis of Colorado Connect data.

Note: The figure shows the cumulative percentage of enrollees who applied for coverage by each date given on the horizontal axis, for each DOI rating area, with cumulative enrollment on December 6, 2022, normalized to 100 percent for each area.

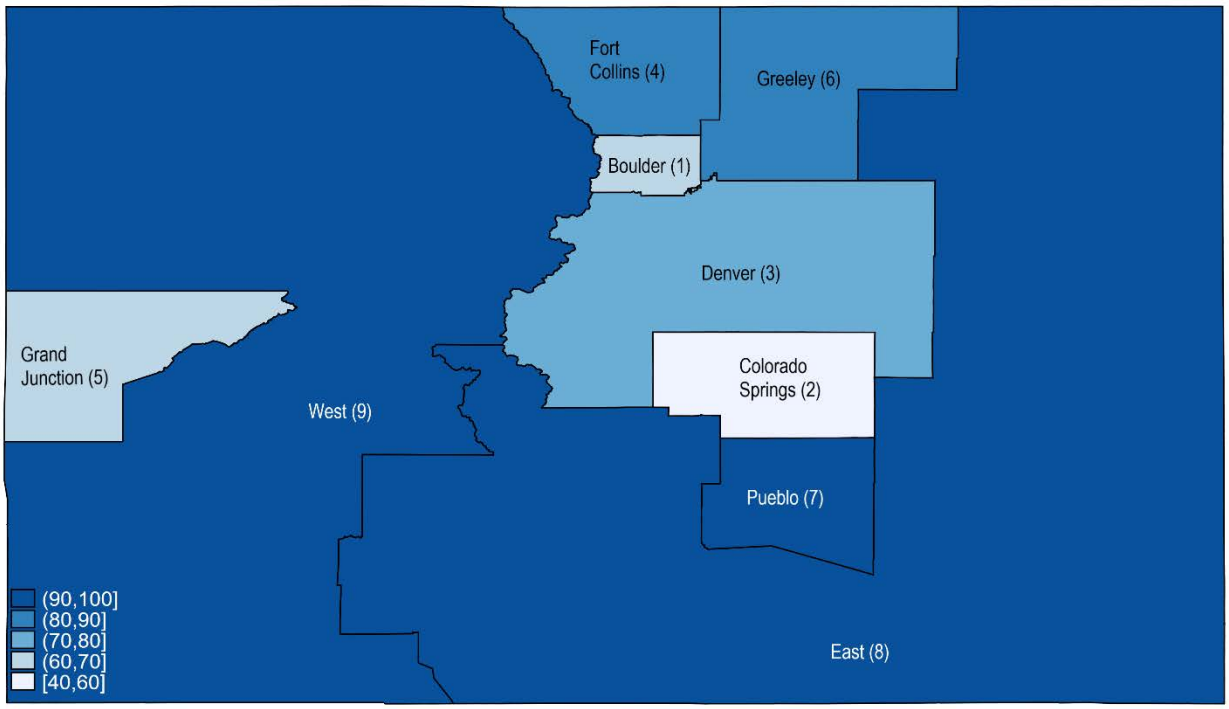
4. Enrollment assistance

Most consumers who signed up for coverage through OmniSalud used the help of assisters or brokers who were popular across all regions. Even in the DOI rating area with the lowest percentage of enrolled individuals seeking assistance, Colorado Springs, 46 percent sought assistance (Exhibit IV.5). Although some community organizers were concerned that rural regions were underserved when it came to enrollment staff, the enrollment data showed that consumers in rural regions sought out assisters and brokers the most: in Pueblo, West, and East, 97 percent, 94 percent, and 93 percent of applicants sought assistance, respectively. These findings suggest that there are opportunities for DOI to partner with and provide resources to frontline workers whose services are heavily used. For example, DOI could invite assisters and brokers from Pueblo, East, and West to share their best practices, work with DOI on developing outreach strategies, and support networks of assisters and brokers in regions that seek to increase community engagement and enrollment.

Rates of assistance in Boulder and Pueblo run counter to qualitative findings suggesting that Boulder and Pueblo were prepared for higher and lower levels of support from assisters and brokers, respectively. A respondent discussing resources in Boulder suggested that assisters and brokers in that region were prepared to support enrollment and were testing innovative approaches to enroll consumers. Conversely, a

community organization representative in Pueblo had concerns regarding the effectiveness and availability of the local enrollment center.

Exhibit IV.5. Percentage of QIs who sought help from assisters or brokers, by DOI rating area



Source: Mathematica analysis of Colorado Connect data.

5. Plan selection

Nearly all eligible individuals who enrolled through Colorado Connect by the December 6, 2022, cut-off date selected SilverEnhanced plans, suggesting that there was clear guidance about which plans were subsidized (Exhibit IV.6). The number of individuals who enrolled in non-SilverEnhanced plans was nominal and may be attributable to error. Although few people enrolled in non-SilverEnhanced plans, comparison of mean net premiums between SilverEnhanced and non-SilverEnhanced plans showed significant savings for individuals who received the subsidy (Exhibit IV.6). While the mean net premium for those enrolled in non-SilverEnhanced plans was $400.20, the mean net premium for SilverEnhanced plans was $0.

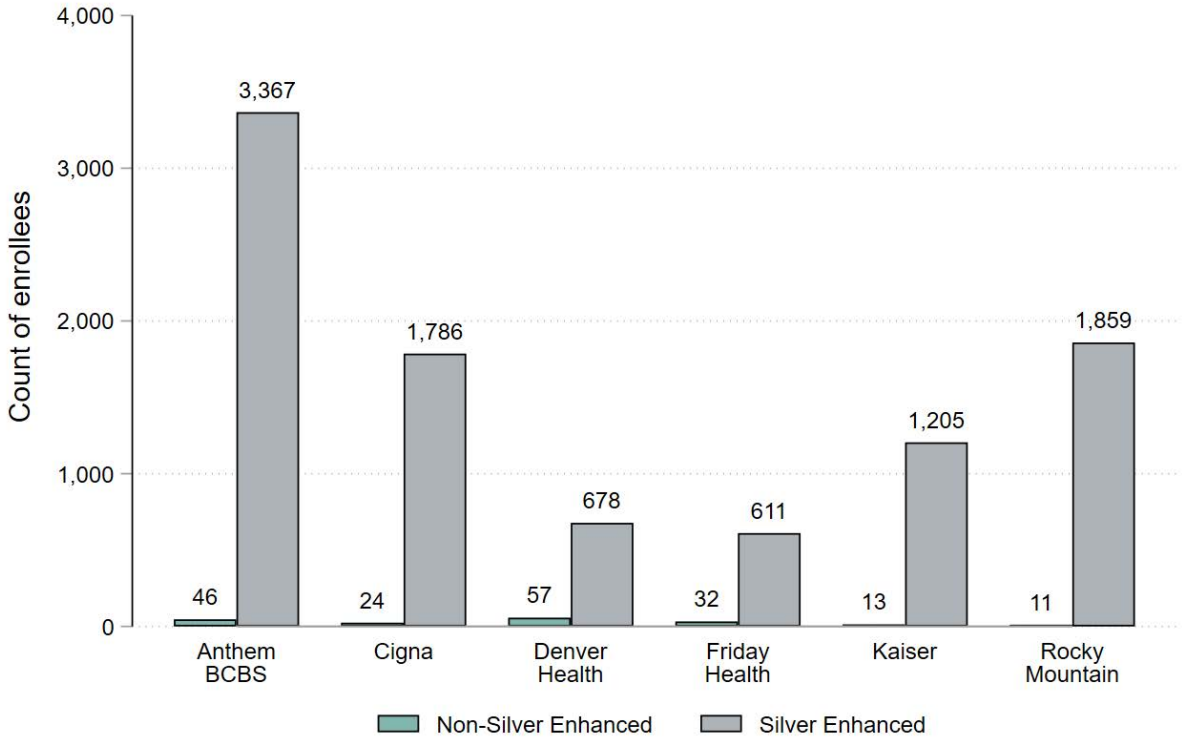
Exhibit IV.6. Number of enrollees and net premium, by level of coverage

Level of coverage	Number of enrollees	Mean net premium
SilverEnhanced	9,282	$0
Bronze	5	$400.20
Silver	8	
Gold	1	
Total	9,296	

Source: Mathematica analysis of Colorado Connect data.

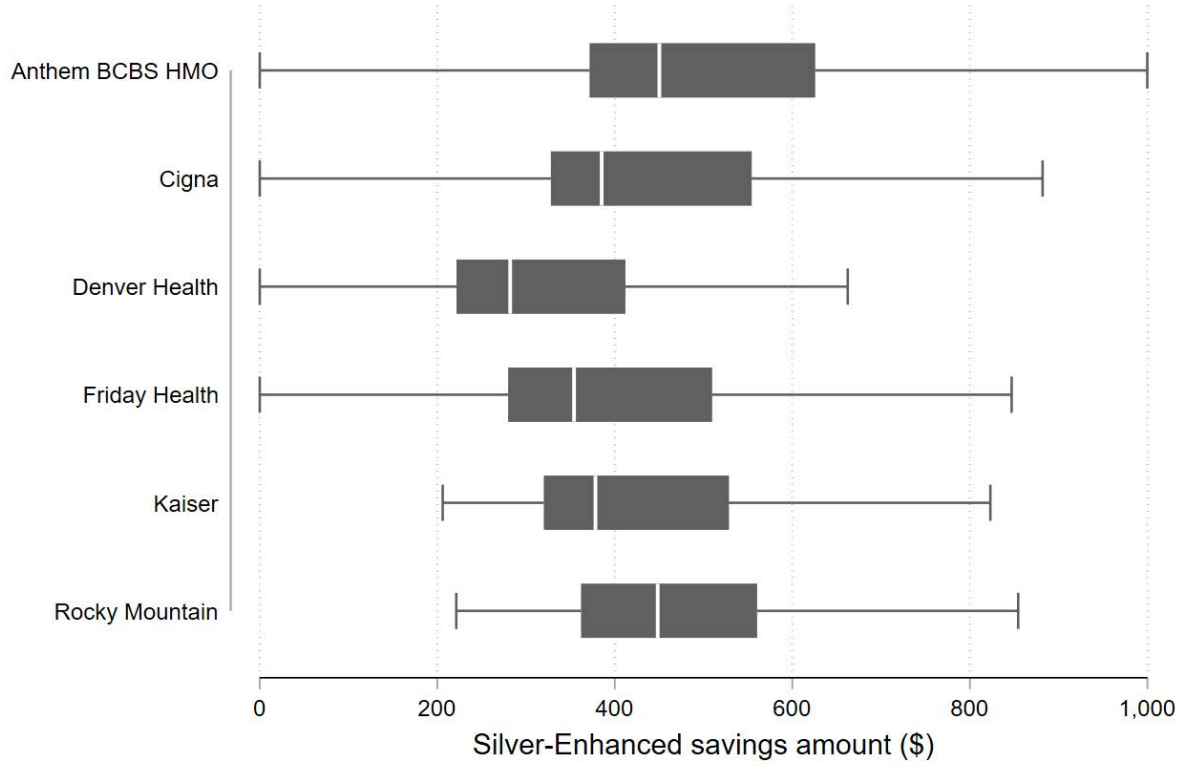
The carriers with the highest enrollment were Anthem BCBS HMO (35.2 percent), Rocky Mountain HMO (19.3 percent), and Cigna (18.7 percent) (Exhibit IV.7). Issuers with the highest enrollments also had the highest average (median) amounts of Silver Enhanced Savings: Anthem BCBS HMO ($518), Rocky Mountain ($493.40), and Cigna ($449.60) (Exhibit IV.8).

Exhibit IV.7. Number of enrollees, by insurer



Source: Mathematica analysis of Colorado Connect data.

Exhibit IV.8. Distribution of SilverEnhanced Savings amount, by insurer



Source: Mathematica analysis of Colorado Connect data.

Notes: The figure shows the median SilverEnhanced Savings amount (white vertical line) for each insurer, the 25th and 75th percentiles (left and right end of the "box"), and the highest and lowest amount observed in the data (right and left "whisker"). For some insurers the lowest amount is $0 because a few members have a gross premium of $0, so their SilverEnhanced Savings amount is also $0.

D. Equity implications

Grassroots outreach efforts were an essential component of building awareness and providing guidance to the OmniSalud population. However, these efforts varied in intensity and reach across the state, which could present equity concerns if certain geographic or demographic populations were more likely to hear about the program than others. One respondent from a community organization shared, "It means that people with the most information get the coverage, and are those the people who most need it or not?" Other frontline workers shared that they enrolled more young people than older adults. They worried that older adults either did not learn about the program in time or that they lacked the technology or ability to schedule an appointment for enrollment assistance. Many frontline workers and community organizations shared that word of mouth drove enrollment. As enrollees use their OmniSalud benefits this year, they likely will encourage family members, neighbors, and friends to enroll in the 2024 open enrollment period, which will spur even higher demand.

Although most respondents viewed routing enrollment through frontline workers as helpful, a few pointed out limitations to this approach that might have prevented people from successfully enrolling in time. For example, this strategy required people to get connected to an assister or broker and schedule an

appointment, often during typical working hours. Some respondents from community organizations shared that some frontline workers were difficult to contact. In some instances, frontline workers canceled and rescheduled an individual's appointments repeatedly. Some community organizations and frontline workers showed ingenuity by shifting to an all-hands-on-deck approach, with extended hours and group enrollment events to sign up as many people as quickly as possible. Other local organizations might have lagged in enrollment because they did not realize enrollment was nearing the 10,000-enrollee cap so quickly or they simply did not have the capacity to do more. Therefore, local factors could have positively or negatively influenced a person's ability to enroll before the cap was reached. A few respondents requested a more streamlined and accessible online application form, with translations in multiple languages, so that individuals could self-enroll in the future.

Several respondents suggested strategies to make the enrollment process more equitable in the future, as opposed to the first-come-first-served system. Suggestions included a lottery system, priority criteria, a waiting list for individuals with high medical needs (such as cancer), and a geographic distribution of slots. Several respondents also recommended considering a tiered approach to offer some financial assistance to people over 150 percent FPL. Each of these options would require C4HCO to make significant, labor-intensive modifications to the current system. However, absent statewide processes or guidance, access to OmniSalud slots might depend even more upon localized efforts and action, or lack thereof. For example, frontline workers and community organizations might develop their own organic systems to prioritize which people they reach out to proactively to schedule enrollment appointments (not based on recommendations from the HIAE Board), such as people in their communities that they know have health conditions or who were not able to receive the subsidy before the subsidy cap was reached in 2023. Several respondents shared that they took down people's contact information and assured them that they would reach out to them first when new funding became available. Though OmniSalud individuals may not be automatically re-enrolled, those who secured the $0 premium plans this year will have the experience of applying and using the health plan, which might make them more likely to be aware and sign up early when compared to individuals who did not receive SilverEnhanced Savings subsidies this year. It is reasonable to expect that current OmniSalud members, community organizations, and frontline workers will approach open enrollment with more urgency, which could amplify access inequities across lower-resourced communities and underserved populations.

V. APTC–Eligible Enrollee Subsidy Outreach and Enrollment

In this chapter, we describe the strategies that DOI and C4HCO implemented to reach and enroll consumers who were eligible for the APTC-eligible enrollee subsidy, including the facilitators of and barriers to these efforts. We also discuss our analysis of enrollment and premium data from the first two open enrollment periods. Findings presented in this chapter were based on key informant interviews and Mathematica's analysis of C4HCO enrollment data.

Key takeaways on outreach for and enrollment in plans with the APTC–eligible enrollee subsidy

- With financial support from the HIAE, C4HCO conducted outreach to the population eligible for the HIAE subsidy to educate them about the new subsidies and support their enrollment into Silver-level plans. Respondents reported that advertising focused on APTC–eligible consumers eligible for the state subsidy as well as direct email marketing were effective outreach strategies.
- Compared to their outreach and enrollment efforts for the OmniSalud population, DOI and its partners reported putting fewer resources into such efforts for the population eligible for the HIAE subsidy. This was largely because of APTC–eligible consumers' existing experience with the marketplace and the way the benefit was integrated into C4HCO's existing system.
- Respondents commonly cited three key barriers that consumers faced about APTC–eligible enrollee subsidies: (1) understanding the benefit and their eligibility, (2) high premiums, and (3) structural challenges within the C4HCO platform.
- Frontline workers described moderate challenges when explaining the new benefit to consumers.
- Enrollment of consumers eligible for the HIAE subsidy in a Silver plan increased after the start of the HIAE. The percentage of eligible consumers who enrolled in and effectuated coverage also increased. Net premiums declined, although this could be due to factors other than the HIAE. Movement from insurance to uninsurance status during plan year 2022 was slightly higher among enrollees eligible for the HIAE subsidy compared to other on-exchange consumers, but this was not necessarily a causal impact of the subsidy.

A. Outreach and enrollment strategies and related barriers and facilitators

1. Outreach and enrollment strategies

With support from DOI, C4HCO conducted outreach to the population eligible for the HIAE subsidy to educate them about the new subsidies and support their enrollment into Silver-level plans. Respondents reported that advertising focusing on APTC–eligible consumers and direct email marketing were effective outreach strategies. In the first year that cost sharing reductions under the APTC–eligible enrollee subsidy were available, the HIAE Board awarded C4HCO over $1.1 million to supplement its existing consumer marketing and outreach budget to perform marketing and outreach for the APTC–eligible enrollee subsidy. C4HCO used these funds to (1) advertise through digital and social media beginning in summer 2021, (2) increase funding to a subset of C4HCO's Assistance Network

> *"I think that we not only got kind of a boost in enrollments for the rest of that plan year but that then translated into seeing higher enrollment in our open enrollment that year."*
>
> — Respondent from a partner organization

locations to provide enrollment support to customers eligible for the HIAE subsidy, and (3) conduct an email marketing campaign from October 2021 through January 2022 to educate current cost sharing reductions-eligible customers and encourage their enrollment into Silver-level plans. Respondents involved in the campaign reported that the HIAE funds supported the effectiveness of the outreach campaign in terms of enrollments for plan year 2022. According to the January 21, 2022, HIAE Board presentation, the email open rates for these materials ranged from 38 percent to 49 percent, which is above the standard marketing email open rates of 20 percent to 25 percent.

C4HCO did not have the additional funding from the HIAE for APTC–eligible enrollee subsidy outreach for plan year 2023. However, C4HCO respondents reported that their organization continued to support outreach to this population, including direct email marketing to customers eligible for the state subsidy in their database. These emails included customized messaging about the benefits of enrolling in Silver-level plans. Respondents involved in this effort found that email marketing allowed them to communicate to eligible individuals more directly and effectively, because they were able to share more details about the cost sharing reductions than they could through other marketing approaches.

Across both open enrollment periods, the HIAE leveraged its network of partners by including information about the APTC–eligible enrollee subsidy in its email newsletters to them, suggesting that they could amplify the message among their constituents. Some organizations reported sharing information about the cost sharing reductions under the APTC–eligible enrollee subsidy with their members through their own email lists and social media channels.

Compared to their outreach and enrollment efforts for the OmniSalud population, DOI and its partners reported putting fewer resources into outreach and enrollment efforts for the population eligible for the HIAE subsidy—largely because of APTC–eligible consumers' existing experience with the Marketplace and the way the benefit was integrated into C4HCO's existing system. Unlike efforts to reach the OmniSalud population (discussed in Chapter IV), those eligible for the APTC–eligible enrollee subsidy have been eligible to enroll in health plans through C4HCO for nearly 10 years. As one respondent explained, "you don't have to start from scratch" with the APTC–eligible population because they are "used to shopping on the exchange and know that there are other resources available to them." Another respondent noted that DOI tried to strike a balance in its communication with the population eligible for the HIAE subsidy because they were concerned that excessive outreach could lead to irritation and concerns about the validity of the messages. Some respondents familiar with the C4HCO enrollment system suggested that the population eligible for the HIAE subsidy was easier to enroll than OmniSalud because the HIAE benefit was integrated into the C4HCO platform, which this population was used to using (unlike OmniSalud, which required enrollment through Colorado Connect, a new platform). However, consumers may not be aware of the state subsidy under the HIAE because it is embedded into the C4HCO platform.

> *"We do a lot through social media and electronically because people don't read snail mail the same way and we don't want to over-communicate with them, because then they start blocking you because it just feels like spam to them. So, we're just trying to figure out when there's an opportunity to do something, we'll hit them a few times but we just won't inundate them, so it's just trying to figure out what's that right balance. It's just kind of a dance."*
>
> — HIAE Board Member

Frontline workers' experiences with outreach and enrollment among the population eligible for the state subsidy varied, potentially due to different levels of available resources. Some frontline workers reported experiences consistent with those of the HIAE, C4HCO, and their partner organizations: getting the word out about the HIAE benefit required less work than outreach for the OmniSalud population because the benefit was naturally embedded within the existing enrollment process. However, others described using similar outreach and enrollment efforts for the HIAE APTC–eligible and OmniSalud populations, suggesting that limited resources did not allow for differentiated approaches. One frontline worker explained that, because they represent a small organization, they "just kind of lumped it up together" when reaching out to APTC–eligible and OmniSalud populations. In general, frontline workers reported using social media and in-person events such as health fairs to promote the availability of state subsidized plans for the population eligible for the state subsidy.

2. Common barriers

Respondents commonly cited three key barriers that consumers faced with regard to the APTC–eligible enrollee subsidy: (1) understanding the benefit and their eligibility, (2) high premiums, and (3) structural challenges within the C4HCO platform. In general, some respondents thought that shopping for health care on the marketplace felt overwhelming for some consumers, regardless of whether they were receiving a subsidy, so this was a concern not specific to the HIAE. Frontline workers said they sometimes needed to explain key eligibility concepts such as FPL qualifications, which some consumers found confusing. Multiple respondents noted that adding the description of a cost sharing reduction on top of those other complicated topics can be an added challenge. As one respondent explained, "From a marketing lens, the cost sharing reduction is hard to talk about. And until people are kind of in it and closely considering options and … comparing plans … it's a little bit wonky, and it's more information than the average shopper is ready for or interested in." Because of these complications, consumers may not be aware they are receiving state benefits in the form of cost sharing reduction enhancements.

> *"I hear from people that healthcare and insurance shopping is just really complicated and really challenging and there's a lot of things to weigh. It's expensive, it's stressful for families to do and to think about."*
>
> — Respondent from a partner organization

Even with the cost sharing reduction, some consumers avoid Silver-level plans because they perceive the premiums to be too high. Some respondents believe that consumers' perception that premiums are too high can be a contributing factor for who are eligible for the APTC–eligible enrollee subsidy to enroll in suboptimal plans (that is, plans with a lower actuarial value), exit the market, or switch carriers from one year to the next in pursuit of the lowest possible premiums. In 2022 and 2023, respectively, 15 percent and 12 percent of consumers eligible for the state subsidy enrolled in a Bronze plan, suggesting enrollment in a suboptimal plan occurs but is uncommon (see Section B.3 below). Finally, one respondent familiar with the C4HCO platform noted that some consumers struggled with a structural disconnect between the C4HCO online browsing tool that allows people to determine their eligibility for a cost sharing reduction plan and the online shopping platform through which people enroll in plans. Although the tools are initially helpful, "it can be a little bit cumbersome to make sure that you find the same plan that you're interested in [as identified through the browsing tool]."

B. Consumer experience

According to frontline workers, consumers eligible for the state subsidy were used to shopping for marketplace coverage and were attracted to the affordability of the Silver plans. Frontline workers whom we interviewed shared limited information about consumer experiences with the new cost-sharing reductions, because these consumers were generally not new to individual market coverage and were enrolling in plans akin to what had been offered to them in the past, with the addition of the state cost-sharing reductions. In general, frontline workers described consumers' motivation for enrollment as interest in access to an affordable health plan, including an interest in greater affordability than what had been available previously. In general, these workers did not share specific messages that were used to reach this population, because most of these consumers were not new to individual market coverage.

When asked about the level of difficulty frontline workers experienced while explaining the new benefit to consumers, frontline workers described it as "medium." This ranking was based on their efforts to educate consumers on the plans and having to repeat their explanation multiple times to consumers. One respondent noted that changes in insurance carriers for 2023 resulted in some confusion among consumers who purchased insurance through one carrier in prior years and then needed to select a new plan under a different carrier. In this respect, the respondent thought the APTC–eligible enrollee subsidy was slightly more confusing to explain to consumers than OmniSalud, because there were more variables for them to consider.

C. Enrollment of consumers eligible for the state subsidy over time

We used enrollment and premium data from C4HCO to assess quantitatively how effectively DOI and its partners—in particular, C4HCO—implemented the APTC–eligible enrollee subsidy and to corroborate interview findings. Although the APTC–eligible enrollee subsidy started in 2022, we used data from plan years 2019 through 2023. This allowed us to compare (potential) HIAE-eligible consumers before and after the start of the APTC–eligible enrollee subsidy. Specifically, we used the same income thresholds for 2019 to 2021 as were used in 2022 and 2023 (150 percent to 200 percent of the FPL per DOI regulation 4-2-78). We used enrollment in any Silver plan among consumers who were eligible for the HIAE subsidy for comparison purposes for 2019 to 2021 (that is, before the start of the APTC–eligible enrollee subsidy). (See Appendix B for a detailed description of this data source.)

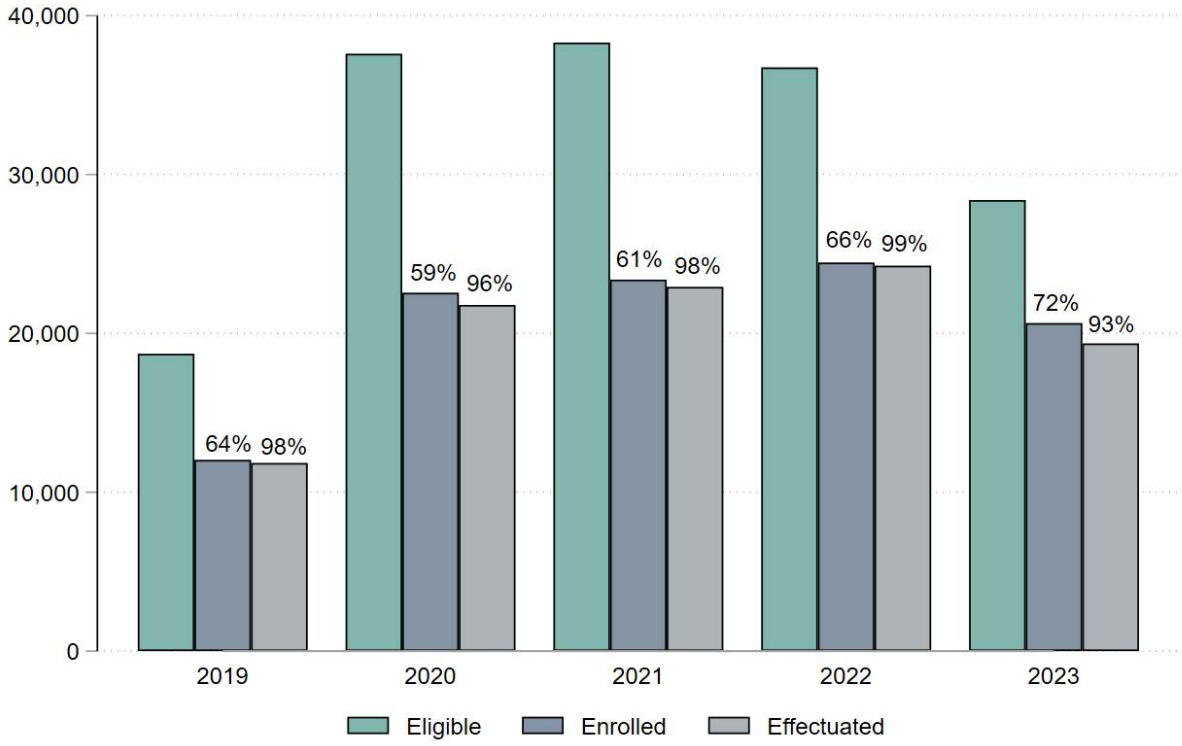
1. Eligibility and enrollment

The percentage of consumers eligible for the HIAE subsidy who enrolled in a Silver plan increased after HIAE was rolled out and was higher in the second year, suggesting that consumers were potentially motivated by the new benefit (Exhibit V.1). While between 59 percent and 64 percent of consumers with income between 150 percent and 200 percent of the FPL who submitted an application for coverage enrolled in Silver plans for plan years 2019 to 2021, this percentage increased to 66 percent in 2022 and 72 percent in 2023.[24] The first year of the HIAE benefit (2022) saw a 8.2 percent increase in the percentage of eligible consumers who enrolled from the previous year. The number of eligible consumers increased from 2019 to 2020 and was stable between 2020 and 2022. (The 2023 data are incomplete.) Comparison of enrollment after 2020 is complicated by the subsidies under the American Rescue Plan Act (ARPA) and the Inflation Reduction Act (IRA) that came into effect partway through

[24] The 2023 data are provisional because we did not have full-year enrollment. Enrollment during plan year 2023 may increase as consumers enroll due to life events or decrease as some consumers disenroll.

2021 and 2022, respectively.[25] Most eligible consumers who enrolled ultimately effectuated, with a small increase in effectuation in 2022. From 2019 to 2021, between 97 percent and 98 percent of enrolled consumers effectuated their coverage. This percentage increased to 99 percent in 2022. (The 2023 data are missing effectuation for some insurers.) Overall, Exhibit V.1 suggests that the APTC–eligible enrollee subsidy increased take-up of coverage by eligible consumers. However, there is still potential for enrolling about one-quarter of qualifying consumers who enrolled in Bronze, Gold, or Catastrophic plans in plans with cost sharing reductions under the HIAE instead.

Exhibit V.1. Eligibility, Silver plan enrollment, and effectuation in the HIAE APTC–eligible enrollee subsidy, 2019–2023



Source: Mathematica analysis of C4HCO data.

Notes: Green bars represent to total number (100 percent) of APTC–eligible consumers, that is, consumers with household income between 150 and 200 percent FPL who submitted an application for on-exchange coverage. Blue bars represent the number of APTC–eligible consumers who enrolled in a Silver plan, and the percentages above these bar indicate percent enrolled out of eligible consumers. Gray bars represent the number of consumers with Silver plans whose coverage went into effect (effectuated), and percentages over these bars indicate percent effectuated out of enrolled consumers.

Data for 2023 were incomplete at the time of this analysis and should be interpreted cautiously. Effectuation for 2023 was missing for one issuer, which biases the effectuated percentage downward.

[25] The available data did not allow us to disentangle the effects of the HIAE state subsidies from the ARPA or IRA. Because the HIAE subsidy changed out-of-pocket spending while ARPA and IRA affected premiums, an analysis of health care use would be informative for distinguishing the impacts of federal and state policies.

Enrollment of eligible consumers did not vary substantially across geographic regions within the state. The distribution of eligible consumers who enrolled in a Silver plan closely tracked the distribution of consumers who were eligible for APTC–eligible enrollee subsidies in 2022 and 2023 (Exhibit V.2). For each year, the table shows what percentage of consumers lived in each DOI rating area among consumers who were eligible for APTC–eligible enrollee subsidies (first column) and enrolled in a Silver plan with cost saving reductions (second column). This finding suggests that there were no meaningful differences in enrollment by geographic region and that the outreach and enrollment efforts of DOI, C4HCO, and frontline workers performed similarly across all parts of the state.

Exhibit V.2. Eligibility and enrollment in state subsidy by DOI rating area, 2022 and 2023

DOI rating area	2022		2023	
	Eligible (%)	Enrolled (%)	Eligible (%)	Enrolled (%)
Boulder	7.75	7.55	7.47	7.61
Colorado Springs	8.94	9.04	8.87	9.01
Denver	50.66	50.21	50.24	49.16
East	4.72	4.76	5.04	5.02
Fort Collins	7.45	7.65	7.24	7.31
Grand Junction	2.69	2.65	2.82	2.82
Greeley	3.73	3.71	3.79	3.84
Pueblo	1.57	1.62	1.67	1.76
West	12.50	12.81	12.87	13.48
Total	**100**	**100**	**100**	**100**

Source: Mathematica analysis of C4HCO data.

Note: The table entries show what percentage (out of state totals) of APTC–eligible and enrolled consumers lived in each DOI rating area.

2. Consumer demographics

Consumers eligible for the HIAE subsidy were older, much less likely to have Spanish as their preferred language, and more likely to live in smaller households than OmniSalud enrollees. Consumers' characteristics did not change markedly over time. The majority of eligible consumers were female; most were ages 26 to 34 and ages 55 to 64 (Exhibit V.3). There was a slight increase in the 55 to 64 age group in 2023. The relatively large share of enrollees in this age group may suggest the cost sharing reductions available under the HIAE are particularly valuable for consumers with higher age-related health care use but who are too young to be eligible for Medicare. Overall, consumers eligible for the state subsidy skewed older than the OmniSalud population. Mean household size grew slowly year over year but was quite low (1.6 in 2019 to 1.9 in 2023). The average enrollee eligible for the HIAE subsidy reported not having children living in their household, which is notable compared to the OmniSalud population (among whom the average household size is closer to 3). Filling out race and ethnicity information is optional, so the data were difficult to interpret and insufficient for statistical significance. Among the 97 percent of non-missing values, APTC–eligible enrollees predominantly preferred English and only a small percentage preferred Spanish, which was opposite the OmniSalud population. The percentage of consumers who reported being employed increased notably year over year, from 37 percent in 2020 to 73 percent in 2023. Although the fraction of employed consumers increased

with the start of the APTC–eligible enrollee subsidy, this continued an existing trend. Because these data were self-reported they should be interpreted with caution.

Exhibit V.3. Demographic characteristics of consumers eligible for the state subsidy, 2020–2023 (percentages)

	2020	2021	2022	2023
Female	55.06	54.1	53.4	53.43
Ages 0–17	1.36	1.07	1.13	1.11
Ages 18–25	8.90	9.46	9.38	8.79
Ages 26–34	23.37	24.57	23.95	21.55
Ages 35–44	15.65	15.63	15.94	15.94
Ages 45–54	17.00	16.59	16.96	16.88
Ages 55–64	31.26	30.24	29.94	32.63
Ages 65+	2.45	2.44	2.69	3.1
White	33.66	37.89	40.28	43.83
Black	0.87	0.89	1.08	1.16
Asian	4.61	5.58	6.68	8.23
American Indian/Alaska Native	3.27	0.10	0.14	0.13
Multiple or other race	13.79	23.46	18.54	15.57
Unknown race	43.80	32.08	33.27	31.07
Hispanic	4.32	5.07	5.6	6.4
Not Hispanic	48.1	61.27	60.02	61.13
Hispanic status unknown	47.58	33.65	34.38	32.48
Spanish is preferred language	1.41	1.81	2.27	2.63
Mean household size	1.79	1.92	1.89	1.91
Employed	37.48	63.33	68.08	73.00

Source: Mathematica analysis of C4HCO data.

Sociodemographic characteristics overall did not differ substantially between consumers who were eligible for the HIAE subsidy and consumers who enrolled in a plan with the APTC–eligible enrollee subsidy, suggesting the benefit was implemented equitably. We compared sociodemographic characteristics of consumers who were eligible for the APTC-eligible enrollee subsidy in 2022 and 2023 to those who actually enrolled in a Silver plan with cost sharing reductions. For example, 52.3 percent of eligible consumers in 2022 were female while 53.4 percent of enrolled consumers were female, indicating that women were slightly overrepresented among enrolled consumers (Exhibit V.4). We did not find substantial differences between the characteristics on eligible and enrolled consumers, overall, although there were a few exceptions. One notable difference was by age: older consumers (ages 55–64) were overrepresented among enrolled consumers. In 2023, 27 percent of eligible consumers were in this age range versus 33 percent of enrolled consumers. Race and ethnicity did not differ meaningfully between eligible and enrolled consumers although Asian consumers were slightly overrepresented among the enrolled in 2023.

Exhibit V.4. Demographic characteristics of consumers eligible for the state subsidy and enrolled consumers, 2022 and 2023 (percentages)

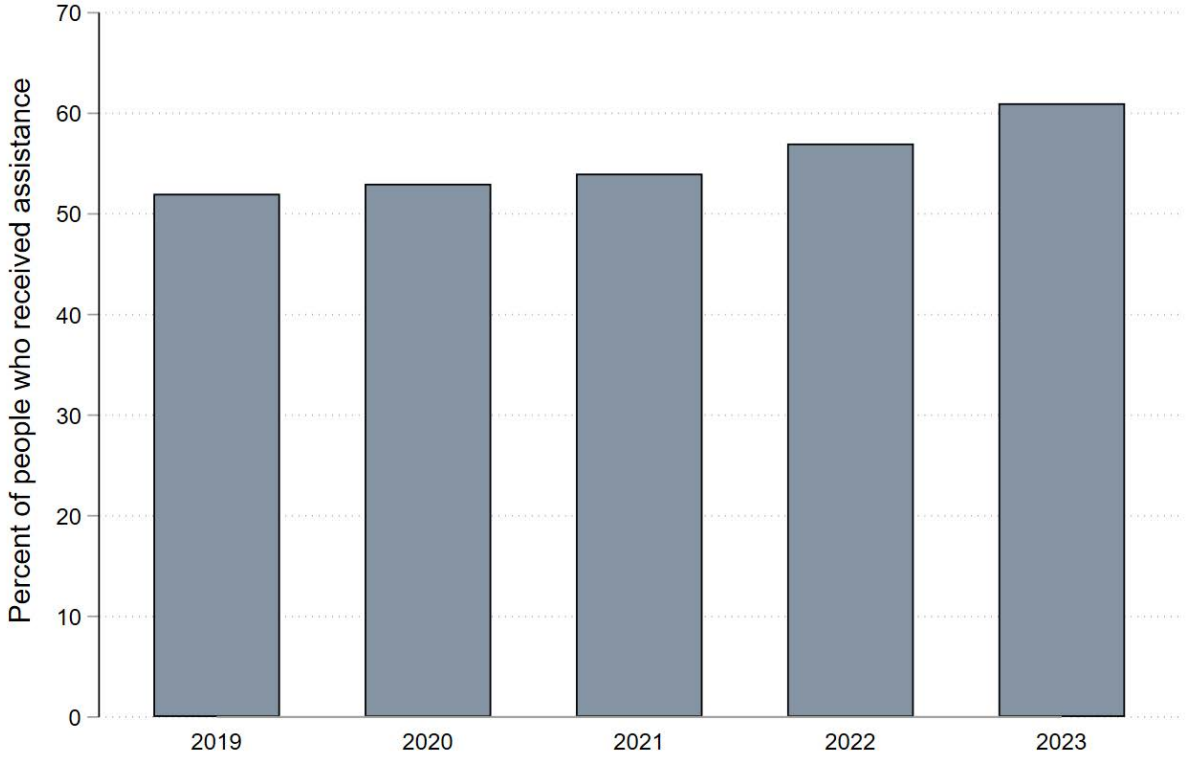
	2022		2023	
	Eligible (%)	Enrolled (%)	Eligible (%)	Enrolled (%)
Gender				
Female	52.28	53.41	51.00	53.55
Age				
Ages 0–17	1.03	1.12	1.12	1.09
Ages 18–25	9.85	9.35	9.67	8.85
Ages 26–34	26.09	24.06	23.76	21.58
Ages 35–44	17.63	15.83	16.81	15.91
Ages 45–54	16.34	16.85	17.01	16.76
Ages 55–64	23.54	30.07	26.58	32.78
Ages 65+	5.50	2.72	5.05	3.03
Race				
White	42.39	40.24	44.18	43.56
Black	1.61	1.08	1.73	1.16
Asian	5.5	6.69	6.05	8.29
American Indian/Alaska Native	0.14	0.14	0.19	0.13
Multiple or other race	40.41	43.39	42.03	42.46
Unknown race	9.96	8.46	5.81	4.4
Ethnicity and preferred language				
Hispanic	7.04	5.62	6.88	6.37
Not Hispanic	61.10	60.00	60.05	60.88
Hispanic status unknown	31.86	34.38	33.07	32.75
Spanish is preferred language	1.92	2.27	2.22	2.66
Household size and employment				
Mean household size	2.00	1.87	2.05	1.90
Employed	65.77	68.17	72.7	73.03

Source: Mathematica analysis of C4HCO data.

3. Enrollment assistance

The majority of consumers eligible for the HIAE subsidy used the help of assisters or brokers when enrolling. This percentage increased further after the state subsidies became available in 2022. The percentage of consumers who qualified or would have qualified for the APTC–eligible enrollee subsidy and enrolled using the help of a frontline worker was between 52 percent and 55 percent from 2019 to 2021. This figure increased to 58 percent in the first year of the APTC-eligible enrollee subsidy and then to 61 percent in 2023 (Exhibit V.5). The increase in assistance suggests that consumers took advantage of the resources available to them, possibly because they were aware that the cost sharing reductions under the APTC–eligible enrollee subsidy, which are in addition to federal cost sharing reductions, made insurance plan choice more complex. Nevertheless, the percentage of consumers using enrollment assistance was lower than among OmniSalud enrollees (see Section IV.C.4).

Exhibit V.5. Enrollment assistance among APTC–eligible consumers, 2019–2023 (percentages)

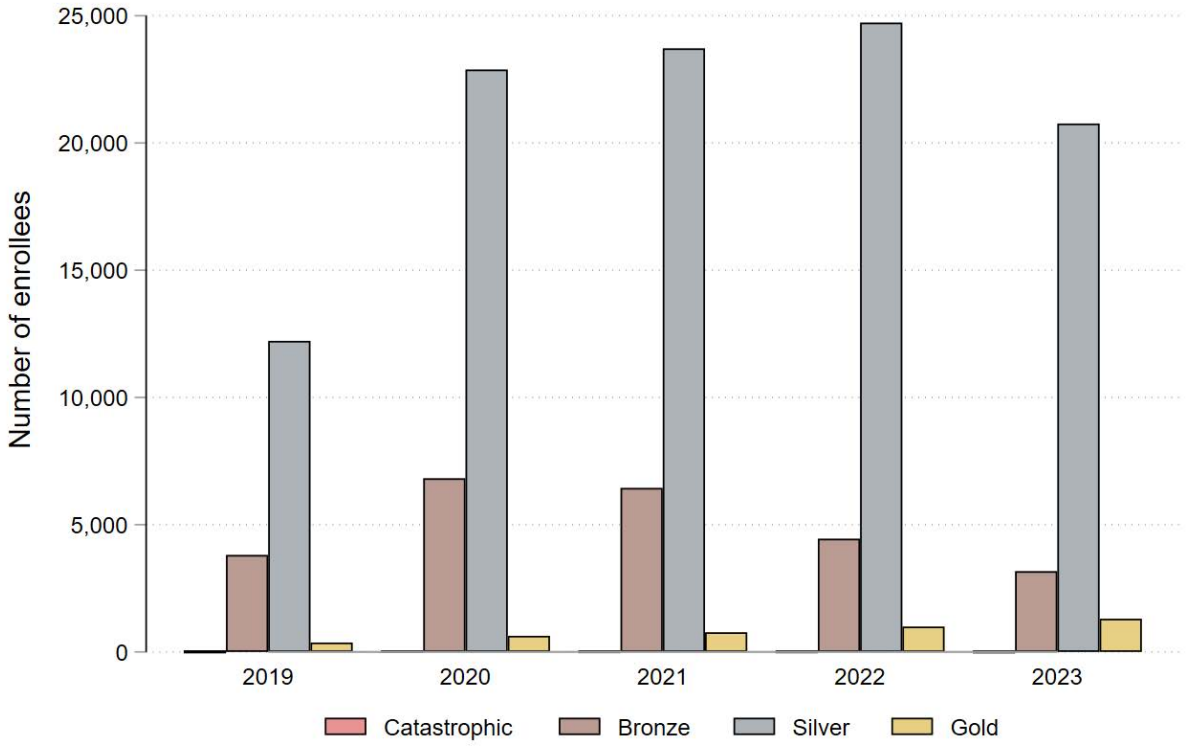


Source: Mathematica analysis of C4HCO data.

4. Level of coverage

Once the APTC–eligible enrollee subsidy became available for Silver-level plans, more consumers chose those plans over Bronze plans. However, 12 percent of consumers eligible for the HIAE subsidy still chose a Bronze plan in 2023. Before the start of the APTC–eligible enrollee subsidy, between 20 percent and 24 percent of consumers who would have been eligible for subsidized state coverage if the HIAE had existed selected a Bronze plan. This percentage declined to 15 percent in 2022 and then to 12 percent as consumers moved to Silver plans with cost sharing reductions under the APTC–eligible enrollee subsidy (Exhibit V.4). Only small fractions selected Catastrophic or Gold plans in all years. Although the relative increase in consumers selecting Silver plans suggests that they were being educated successfully about the benefits of enrolling in these plans (see above), there are opportunities to educate additional consumers eligible for the HIAE subsidy that a Silver plan with cost sharing reductions is a better choice based on actuarial value than a Bronze plan, despite a higher premium. Bronze plans have a lower actuarial value than Silver plans for these consumers, because although Bronze plan premiums are lower than Silver plan premiums, the cost saving reduction enhancement under the HIAE leads to much lower out-of-pocket costs under Silver plans compared to Bronze plans.

Exhibit V.6. Level of coverage of consumers eligible for the state subsidy, 2019–2023



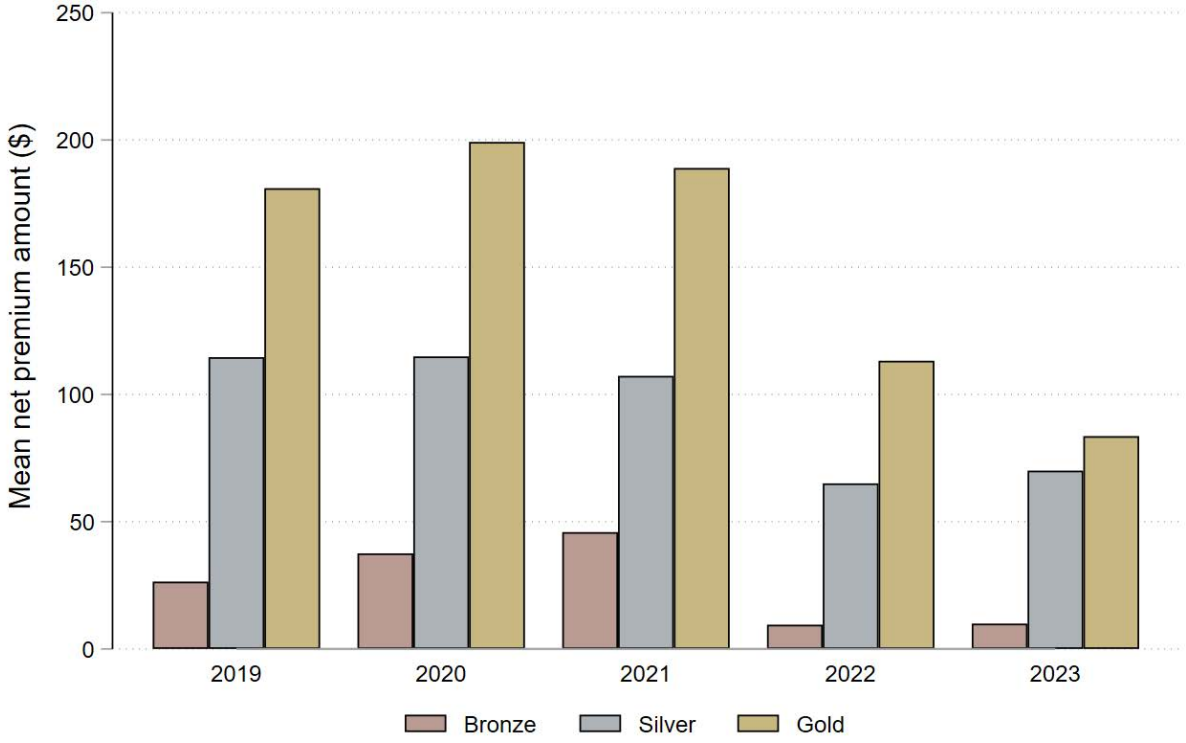
Source: Mathematica analysis of C4HCO data.

Notes: Data for 2023 were incomplete at the time of this analysis and should be interpreted cautiously.

5. Premiums

Average net premiums for Silver plans declined with the start of the APTC–eligible enrollee subsidy, but premiums for other coverage levels decreased as well. Silver plan premiums were stable between 2019 and 2021, at about $115 per month, and declined to $67, on average, in 2022 when the APTC–eligible enrollee subsidy started, although this decline is not causally related to the HIAE. In 2023, they increased slightly to $74 per month (Exhibit V.6). Overall, consumers who qualified for the APTC–eligible enrollee subsidy paid substantially less for their insurance coverage after the start of the HIAE, in addition to paying lower out-of-pocket costs due to cost sharing reductions. However, net premiums for Bronze and Gold plans also declined between 2021 and 2022, so we cannot attribute the drop in net premiums to the HIAE. Instead, general health insurance market factors and federal legislation may have driven the premium declines. The decline in Bronze and Gold plan premiums may also explain why some consumers eligible for the HIAE subsidy chose those plans over Silver plans despite Silver plans providing a better actuarial value (see above).

Exhibit V.7. Average net premium by level of coverage, 2019–2023

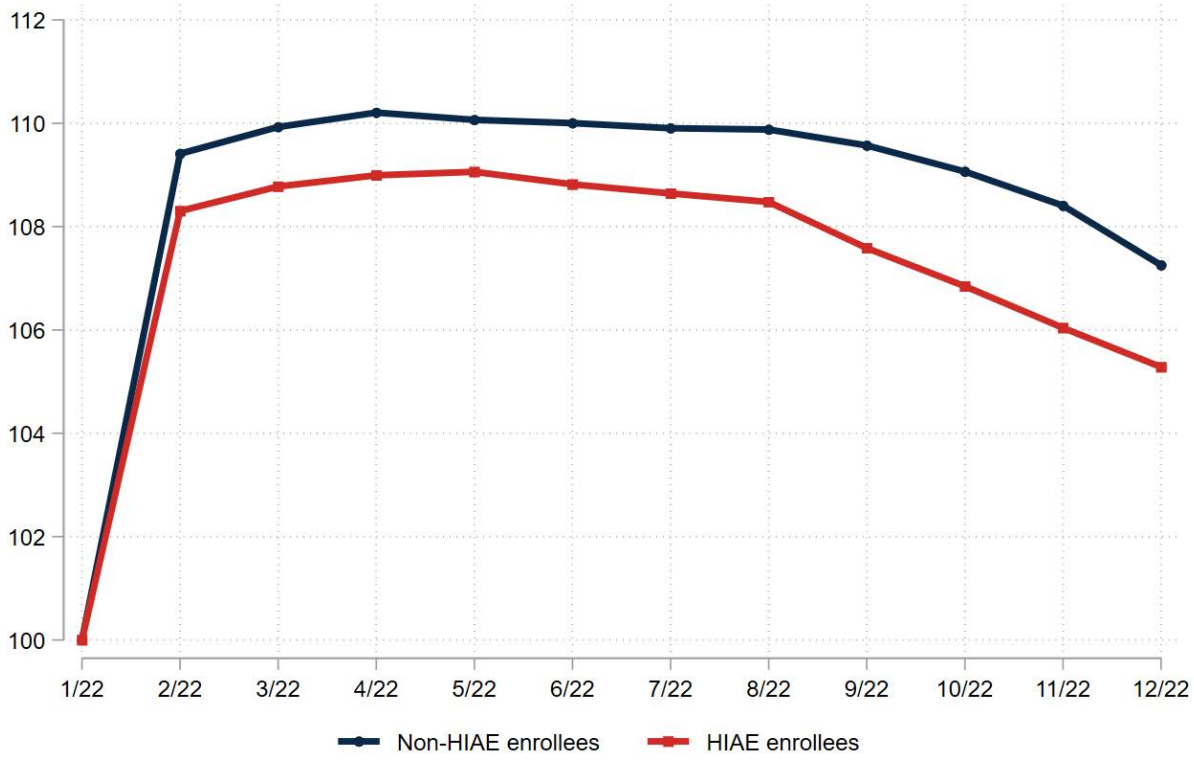


Source: Mathematica analysis of C4HCO data.

6. Changes in insurance status

Churn during plan year 2022 among enrollees in plans with the APTC–eligible enrollee subsidy was higher compared to other consumers on the exchange. We tracked enrollment and disenrollment during plan year 2022 of consumers who enrolled in a plan with the APTC-eligible enrollee subsidy during open enrollment and compared them with enrollment and disenrollment of all other on-exchange consumers. After normalizing enrollment on January 1, 2022, to 100, we found an increase in enrollment of about 8 percent among HIAE enrollees on February 1, with relatively stable enrollment until August and a slight decline in net enrollment thereafter (Exhibit V.8). The enrollment trajectory of HIAE consumers was about one to two percentage points lower than among other consumers on the exchange. This suggests that churn (that is, movement from insurance to uninsurance status) was slightly higher among enrollees eligible for the HIAE subsidy. However, we cannot causally attribute this difference to the HIAE subsidy as the available data do not show why consumers enroll in or drop on-exchange coverage during the plan year.

Exhibit V.8. Changes in enrollment throughout plan year 2022 (in percentage of January 1 enrollment)



Source: Mathematica analysis of C4HCO data.

VI. Health Insurance Market Stability

While the preceding two chapters assess how the HIAE subsidies affected individual enrollment, this chapter investigates the impact of the HIAE on the individual health insurance market in Colorado overall. One of the main purposes of the HIAE, as stated in statute (SB 20-215), is to improve the stability of the individual health insurance market. To assess whether the HIAE achieved this goal, we examined Colorado's individual health insurance market and whether there were any notable changes to it since the implementation of the HIAE (see box for an overview of the methods used). Market stability is of particular concern because the individual market has a history of volatility, even after the Affordable Care Act market reforms. This volatility was improved significantly in Colorado following the implementation of the state's reinsurance program in 2020. The state aimed to continue reducing volatility and stabilizing the market through the HIAE subsidy program and other individual market reforms.

Methods: Understanding changes in health insurance market stability

Data. We used insurer-reported plan filing and financial data from Colorado insurers and state-level premium data. We used Kaiser Family Foundation's health insurance marketplace analysis to compare Colorado to other states and the national landscape.

Outcomes. The primary outcomes of interest included: (1) individual market premiums, (2) the number of issuers offering plans on the individual market, (3) the number of plans offered, and (4) medical loss ratios and issuer gross margins.

Analytic methods. To assess the relationship between the implementation of HIAE and changes in key measures of insurance market stability measures, we compared outcomes before and after the start of the HIAE subsidies in 2022. We also compared the individual market in Colorado to other, similar states and national averages.

See Appendix C for details.

The HIAE should strengthen Colorado's individual health insurance market, given the availability of increased financial assistance to current consumers as well as the expansion of financial assistance to consumers who previously could not buy subsidized health plans through the Affordable Care Act. These reforms could bring new individuals to the individual market and improve the risk pool of the market. To the extent that these new consumers are healthier, on average, than existing consumers, the HIAE may enable carriers to reduce premiums.

Key takeaways on health insurance market stability

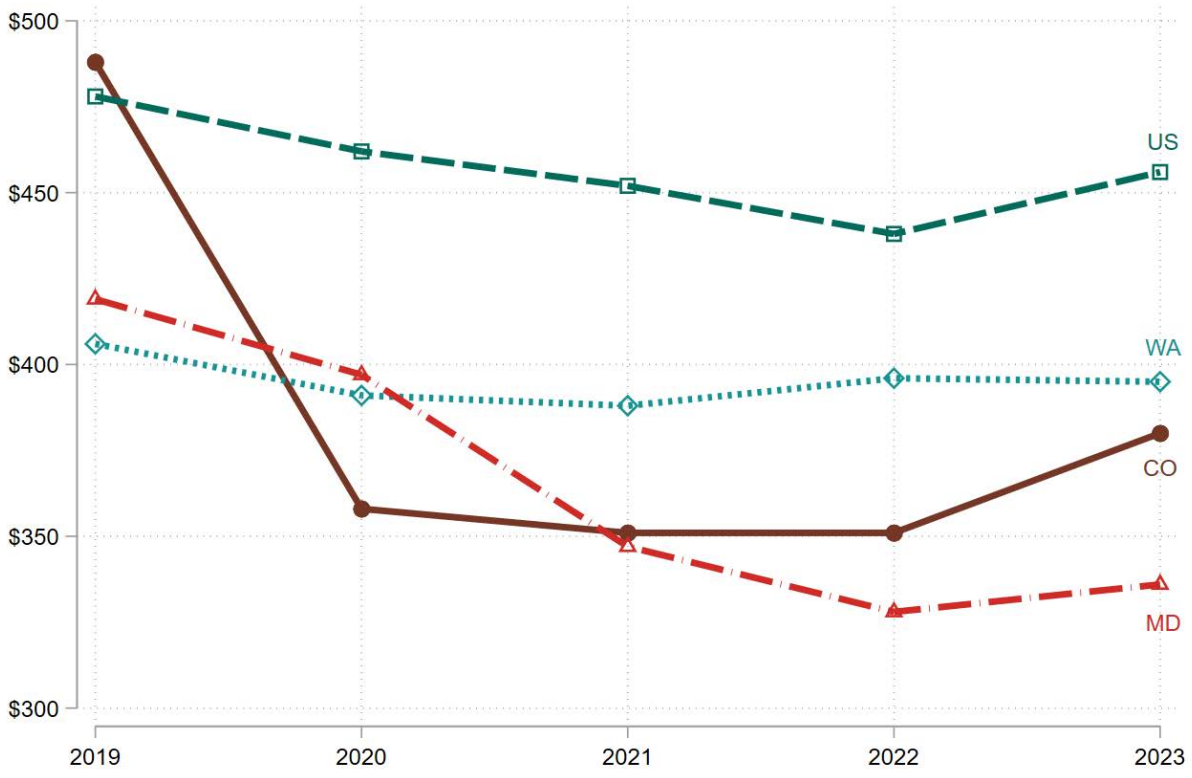
- HIAE APTC–eligible enrollee subsidies and OmniSalud had a neutral impact on the stability of the individual insurance market, based premiums, number of insurers, and insurer financials.
- Premiums changed little from 2021 to 2022 and increased similarly to the national average in 2023.
- Insurer market exits were unrelated to the HIAE. In addition, changes in insurer financials did not all go in the same direction in 2022 when the APTC-eligible enrollee subsidy was rolled out.

A. Premiums

Benchmark plan premiums did not meaningfully change after the introduction of the HIAE in 2022, when comparing premiums in Colorado with nationwide averages or similar states. We compared benchmark premiums (that is, the statewide average of second-lowest-cost Silver premiums) in

each county for a 40-year-old in Colorado with average premiums nationwide and in Maryland and Washington State.[26] This analysis of benchmark premiums looks at base premium prices and does not analyze tax credits or net premiums. In the two years preceding the HIAE, the Colorado marketplace already had competitive premiums compared to the nationwide average, after a large drop from 2019 to 2020, due to reinsurance. Colorado's 2019 average benchmark premium was slightly higher than the national average ($475 versus $454) (Exhibit VI.1). Colorado's benchmark premiums were more competitive (that is, premiums were lower) than Washington's after 2019 and less competitive than Maryland's after 2020. Benchmark premiums did not meaningfully change after the introduction of the APTC–eligible enrollee subsidy under the HIAE in 2022 ($345 in 2022 compared to $346 in 2021). In 2023, when OmniSalud was introduced, Colorado did see a more notable increase in the average benchmark premium ($376), but this appears to mirror nationwide trends. Maryland and Washington experienced a smaller increase and a decline in premiums, respectively, from 2022 to 2023. The lack of change in premiums in 2022 is not surprising because the APTC–eligible enrollee subsidy was not intended to impact premiums due to the HIAE Board's recommendation to implement a cost sharing reduction subsidy instead. Even a premium wrap for this population would not have lowered premiums across the market.

Exhibit VI.1. Colorado, Maryland, Washington, and U.S. average benchmark premiums, 2019–2023

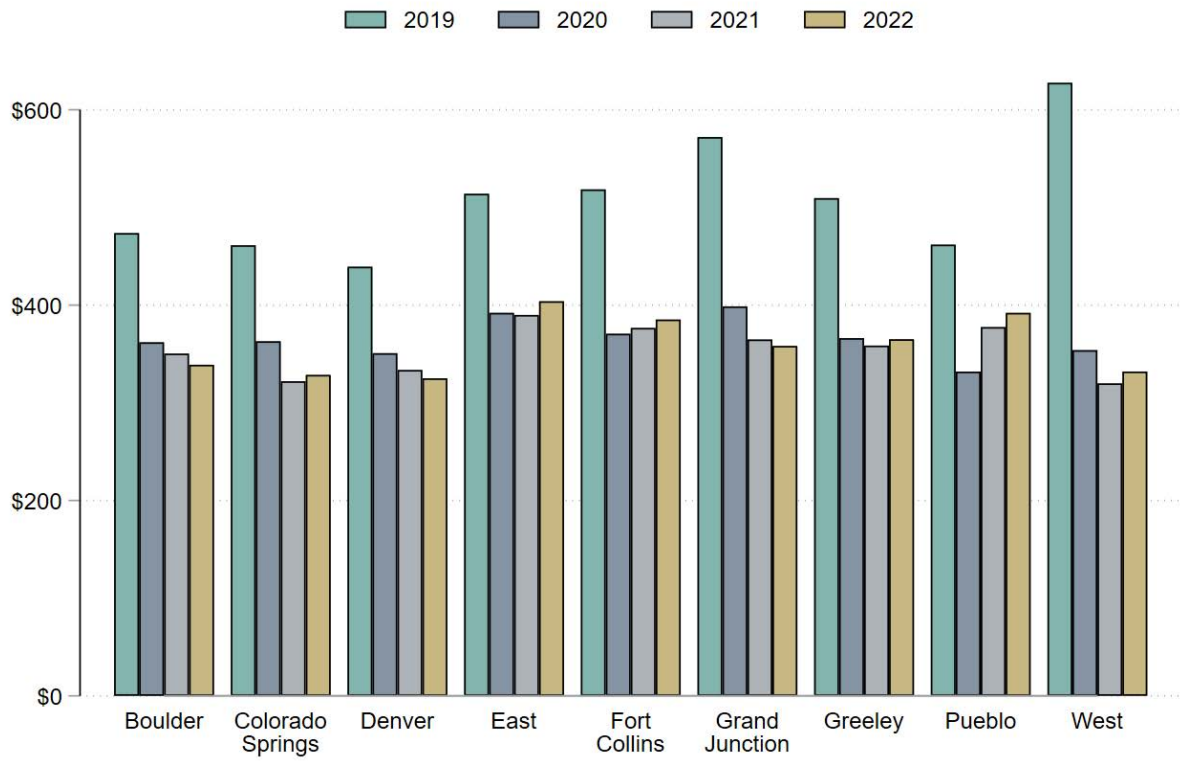


Source: Kaiser Family Foundation.

[26] We chose these two states as comparators because they both have their own state-based marketplaces, have adopted individual market affordability initiatives, and their individual markets are similar in size to Colorado's market.

No region of the state was disproportionately affected by the APTC–eligible enrollee subsidy under the HIAE. We examined Colorado benchmark premiums for a 40-year-old by DOI rating area to understand the variation in prices. Given the large number of enrollees in metropolitan areas, overall state averages may not be indicative of the market for coverage in rural areas of the state. The near-constant statewide premiums in 2021 and 2022 mask some variation across rating areas. There were small premium decreases in Denver, Boulder, and Grand Junction, while the other areas experienced small increases. Variation across rating areas declined over time, largely due to the state's reinsurance program, although there was still variation in the average benchmark premiums. Although reinsurance significantly decreased the premium variation between the Front Range and the rural eastern and western parts of the state, the Front Range continues to have a more competitive market and pricing - due mainly to its large population. No DOI rating area experienced a large change in premiums from 2021 to 2022.

Exhibit VI.2. Colorado average benchmark premium by DOI region, 2019–2022

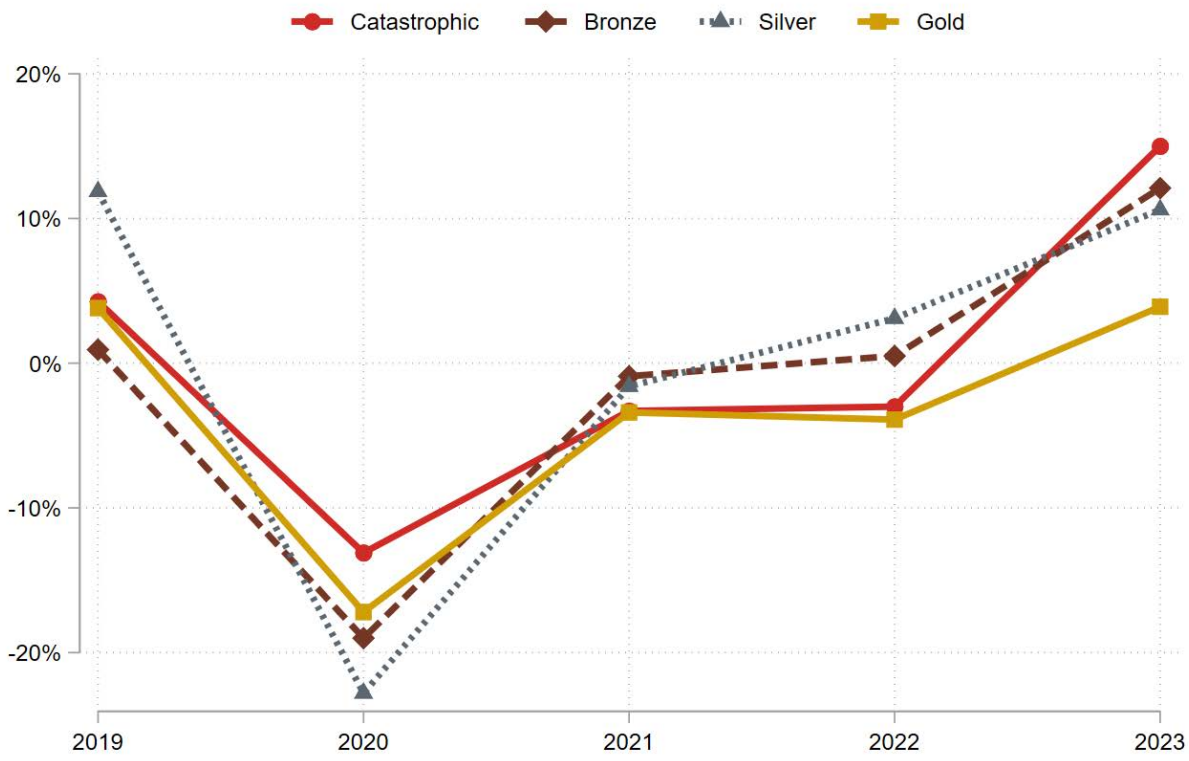


Source: Mathematica analysis of Colorado DOI data.

Premiums across all metal tiers changed little in 2022 and increased slightly in 2023. In addition to examining benchmark premiums, we examined Colorado average premium changes across metal tiers for the study period. Consumers who are eligible for subsidies under the APTC-eligible enrollee subsidy or OmniSalud must enroll in Silver plans to receive the subsidy, but there could be spillovers into other metal tiers. Mainly due to the introduction of reinsurance in 2020, Silver premiums saw the biggest change from the 2019 to 2020 plan years, but other metal tiers saw similar decreases leading into 2020. There were only small changes in premiums from 2021 to 2022, when the APTC-eligible enrollee subsidy

was rolled out, suggesting that the HIAE did not have a meaningful impact on premiums, as expected. In 2023, average premiums increased across all metal tiers, but Gold coverage average premiums increased the least.

Exhibit VI.3. Colorado average premium changes by metal tier, 2019–2023



Source: Mathematica analysis of Colorado DOI data.

Exhibits VI.1 to VI.3 suggest HIAE did not have any major impact on individual market premiums. Because the market had already undergone large decreases in premiums in 2020, due to reinsurance, it would be difficult for HIAE to make any additional improvements, especially in the short term.

B. Number of insurers

The number of insurers offering individual coverage in Colorado is high. The market exits in 2023 were unrelated to HIAE implementation. Colorado has a large number of insurers participating in the individual market compared to other states. Colorado had eight insurers offering on the exchange from 2020 to 2022, which was above the national average. Colorado had a similar number of insurers as Washington and was well above Maryland's three insurers on the exchange (Exhibit VI.4).

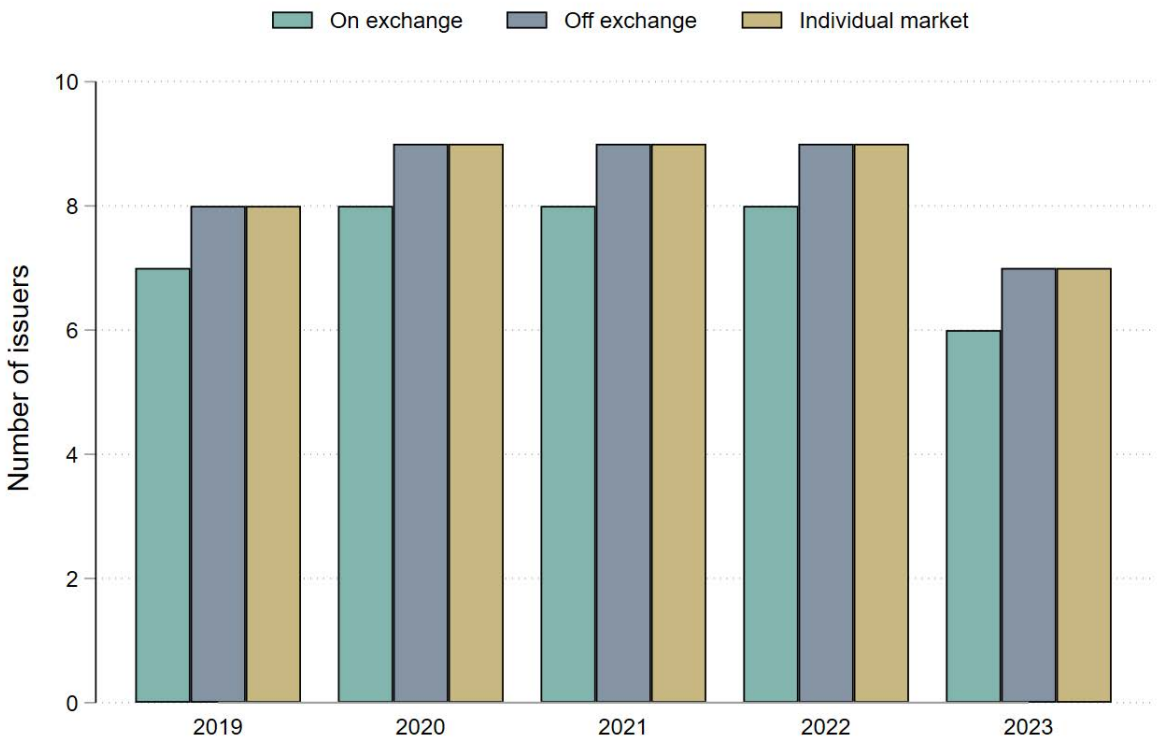
Exhibit VI.4. Average number of exchange insurers in Colorado, Maryland, Washington, and the U.S., 2019–2022

	2019	2020	2021	2022
United States	4	4.5	5	5.9
Colorado	7	8	8	8
Maryland	2	2	3	3
Washington	5	7	9	8

Source: Kaiser Family Foundation.

Colorado saw two insurers (Bright Health and Oscar Health) exit the individual market in 2023, both on and off the exchange (Exhibit VI.5). Although this decrease in insurers occurred after HIAE implementation, these decisions were part of the insurers' national individual market strategy and were not specific to the Colorado market. Bright Health withdrew from all individual markets where it had offered coverage.[27] Similarly, Oscar Health withdrew from Colorado and Arkansas.[28]

Exhibit VI.5. Colorado individual market insurers, 2019–2023



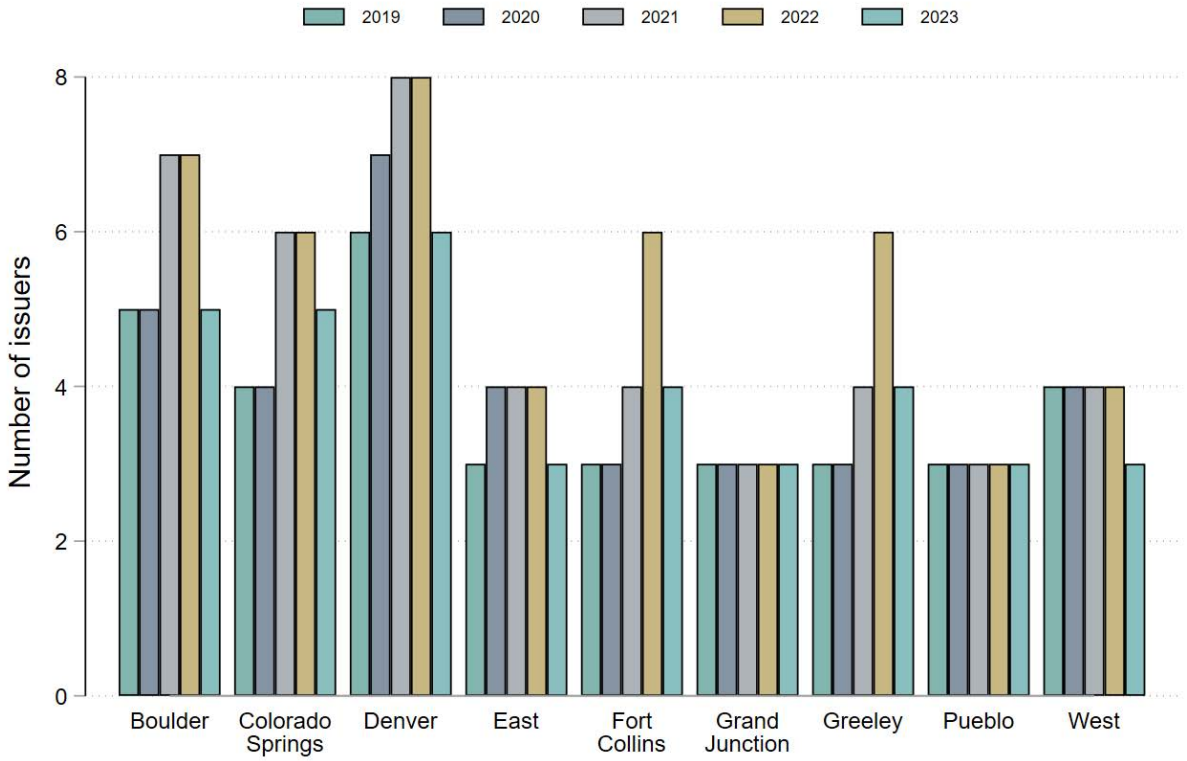
Source: Mathematica analysis of Colorado DOI data.

[27] See https://doi.colorado.gov/news-releases-consumer-advisories/bright-health-will-not-offer-individual-health-plans-for-2023.

[28] See https://doi.colorado.gov/news-releases-consumer-advisories/consumer-advisory-former-individual-market-bright-health-oscar.

Although some insurers do not offer individual coverage in all parts of the state, Colorado consumers have a good choice of exchange issuers across the state. Further, some rating areas saw an increase in the number of insurers in 2022, when the APTC-eligible enrollee subsidy was rolled out. We examined the number of insurers offering plans on the exchange across DOI rating areas to understand the variation in insurer availability across Colorado and to examine whether rural regions of the state were lacking in insurer choice. Denver had the largest amount of choice of exchange insurers in all years, peaking with eight insurers in 2021 and 2022 before declining to six insurers in 2023. The Boulder and Colorado Springs regions also had more insurers than other rating areas, with at least four or more insurers for every plan year we examined (2019 to 2023). None of the DOI regions saw fewer than three issuers in any plan year. No rating area experienced market exits in 2022. The market exits in most areas in 2023 were unrelated to the HIAE, as discussed above.

Exhibit VI.6. Number of Colorado exchange insurers by DOI region, 2019–2023



Source: Mathematica analysis of Colorado DOI data.

C. Insurer financials

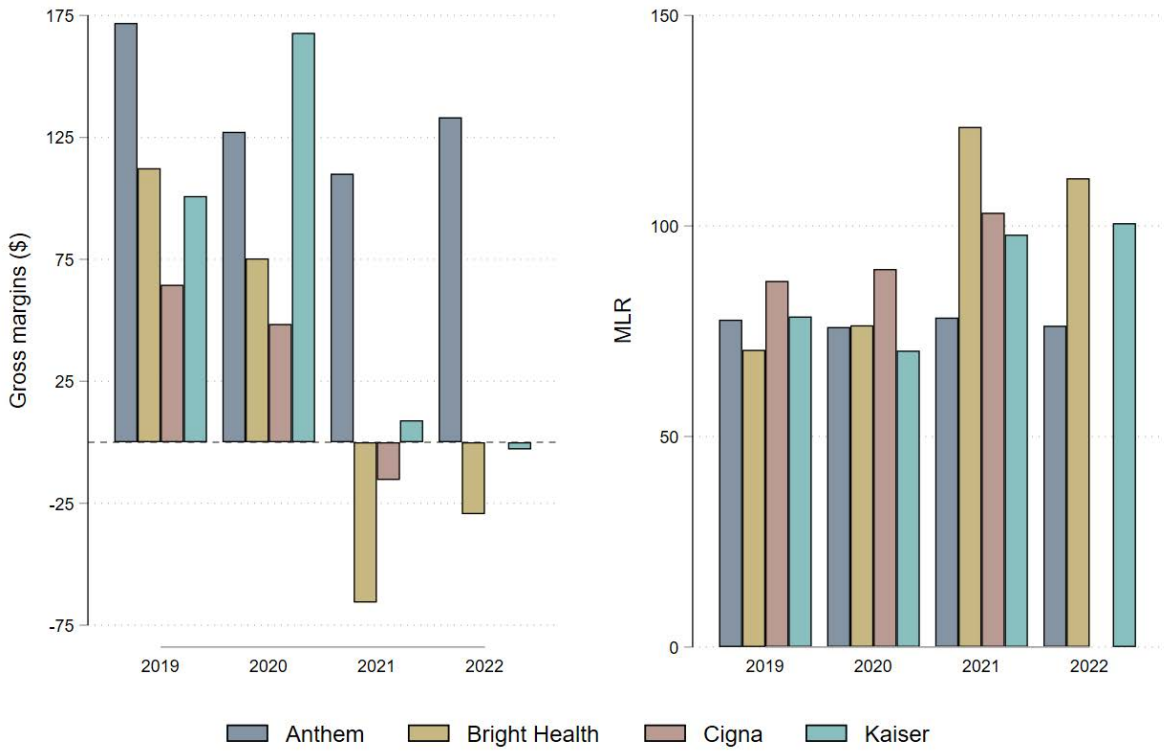
Insurer financials give insight into individual market stability through key metrics such as gross margins and medical loss ratios (MLR).[29] When monitoring insurer financials, we examined whether there were

[29] The calculation of MLRs for this analysis differs from the MLR in the Affordable Care Act, which includes adjustments for quality improvements and taxes. The MLRs included in this report are simple loss ratios, or the share of premium income that insurers pay out for claims.

any large differences in year-to-year claims and enrollment. Large market movements can be disruptive to insurer stability, especially if insurers have not priced their products appropriately. A stable individual market means that insurers will make predictable and reasonable margins. The COVID-19 pandemic disrupted trends in use and spending in all health insurance markets starting during the 2020 plan year with elective procedures being delayed and increases in hospitalizations, which may produce atypical financial results.

We did not observe consistent changes in gross margins and MLRs across the largest insurers in Colorado between the three years before the HIAE and 2022, when the APTC–eligible enrollee subsidy started. While the four largest insurers (Anthem, Bright Health, Cigna, and Kaiser) had sizeable gross margins in 2019 and 2020, only Anthem retained sizeable positive margins in 2021 and 2022. Bright Health and Cigna had losses in those years (left panel of Exhibit VI.7). Colorado insurers' MLRs increased in 2021 and 2022 compared with 2019 and 2020. Notably, some insurers had MLRs close to or even above 100, indicating that some Colorado insurers' claims costs exceeded the premiums they collected. Between 2021 and 2022, there was little change in MLRs, except for a decline in Bright Health's MLR (right panel of Exhibit VI.7).

Exhibit VI.7. Gross margins and medical loss ratios of the four largest insurers, 2019–2022



Source: Mathematica analysis of Colorado DOI data.

Notes: Data for Cigna were not available for 2022.

MLR = medical loss ratio.

D. Conclusion and limitations

HIAE implementation did not result in meaningful changes in market stability in 2022 and 2023. The Colorado individual market has seen some significant changes over the past few years, with issuers exiting the market, premiums first decreasing and then slightly increasing, and insurer margins decreasing. However, most of these mirror national trends. The nationwide trends are likely due to consumers avoiding care use in 2020, due to the COVID-19 pandemic, which led to an uptick in claims in 2021. Higher premiums could also be attributed to higher health care costs.

Because HIAE policies impact a small percentage of the individual market and the APTC–eligible enrollee subsidy is focused on impacting out-of-pocket costs for consumers rather than premiums, it is not surprising that we have not seen evidence of changes in several key market stability characteristics. Individual market planning and decision making often happens at least a year in advance of a plan year due to plan filing process and timeline. Given this timing, the individual market may be slow to reflect policy changes. The impacts of HIAE on individual market stability may not be visible until both phases of the HIAE have been in effect for multiple plan years. Even then, the impact may not be large because enrollment in plans with the APTC–eligible enrollee subsidy and OmniSalud only accounted for about 13 percent of the individual market.

This examination of Colorado individual market stability has limitations. There were several individual market changes that occurred during the implementation of the HIAE that we could not control for. This included broader environmental changes and policy changes specific to the individual market, such as the introduction of the Colorado Option in 2023. Other notable policy changes during HIAE implementation were the Medicaid continuous coverage provision, which required states to keep Medicaid enrollees in coverage during the public health emergency for COVID-19, and the expansion of premium tax credits by the American Rescue Plan Act, which has since been extended until 2025 by the Inflation Reduction Act.

VII. Lessons Learned and Recommendations

When establishing the HIAE in 2020, Colorado made a substantial investment in the health and well-being of its residents by seeking to reduce the number of Coloradans without health insurance, increase continuous health insurance coverage, lower premiums, and further stabilize the insurance market. This evaluation sought to understand the implementation and effectiveness of the HIAE to date by seeking qualitative and quantitative evidence from a variety of sources. In this chapter, we present final reflections on specific recommendations that the HIAE Board and DOI may want to consider for future years. We also present lessons that other states seeking to increase affordability and enroll similar populations may want to consider.

A. Final reflections and recommendations for the HIAE Board and DOI

In this section, we provide recommendations related to changing the allocation of limited OmniSalud enrollment slots, gathering more data about the populations enrolled in HIAE programs, enhancing outreach and enrollment efforts, and improving health insurance literacy.

1. Allocation of limited OmniSalud enrollment slots

If demand for OmniSalud continues to outweigh the available subsidies, the HIAE Board should carefully consider how to allocate OmniSalud enrollment in future years with an eye toward equity. The current allocation approach of providing subsidized OmniSalud coverage to consumers on a first-come-first-served basis places certain consumers at a disadvantage, including those who may not have heard about the opportunity for coverage until later, did not realize the number of consumers who could receive SilverEnhanced Savings would be capped, live farther away from a frontline worker and/or lack the technology to request and attend a virtual appointment, or have inflexible schedules. It also places substantial burden on frontline workers who faced high demand for early enrollment appointments and who, once the subsidy cap was reached, had to deliver to consumers the difficult message that subsidized plans were no longer available. These challenges are likely to grow in future years. Early appointment slots are likely to be valued even more, given that current enrollees may need to re-enroll; consumers who sought but did not receive coverage this year will likely try to enroll earlier; and general awareness about the program will likely be higher, as consumers see their friends and family benefiting from the program. Further, the end of the public health emergency and Medicaid unwinding mean that frontline workers may be busier, because their attention will also be on helping with Medicaid renewals and because APTC–eligible enrollee subsidy consumers may continue to increase their reliance on assistance when enrolling, as the analysis of C4HCO data showed.

> *"Once they're able to access care and use the insurance, they're a little more trustworthy about it. A lot of people in our initial enrollment dates, we did have quite a few people that absolutely did not want anything to do with it. But we're hoping, because word of mouth is always the best thing, once they witnessed that people have actually been able to access care with it, that they'll be a little more open to it next year."*
>
> — Frontline worker

Respondents offered several recommendations that the HIAE Board, DOI, and their partners could consider to more equitably allocate OmniSalud enrollment or offset the costs of increasing the

subsidy cap, although implementation and C4HCO's operating capacity would likely remain a barrier:

- The HIAE could implement the program on a sliding scale basis, which was the most common recommendation. In this model, enrollees at the higher end of the income distribution (consumers with income close to 150 percent of the FPL) would make small financial contributions to the program, which could then subsidize additional OmniSalud slots.
- C4HCO could implement a waiting list so that if some consumers fail to effectuate or disenroll, those who sought coverage could be notified and potentially enrolled as part of a special enrollment period.
- The HIAE could allocate OmniSalud slots on a geographic basis, because quantitative analysis showed that enrollment by region as a percentage of projected enrollment differed somewhat within the state, or on a weighted lottery system where certain higher risk or disadvantaged counties receive priority (for example, using Census Bureau Community Resilience Estimates[30]).
- The HIAE could prioritize enrollments for people with chronic conditions or reserve a certain number of OmniSalud spaces for individuals who could benefit the most from coverage, such as transplant patients or those on dialysis, although this would be a difficult decision to make.
- The HIAE could offer a less rich benefit package than the Colorado Option plans, which are more generous than standard Affordable Care Act plans, to reduce the costs of the OmniSalud plan and allow more people to be covered. However, higher out-of-pocket costs would make coverage less attractive, and consumers would be less likely to use it. Moreover, this option would require a change in state statute governing HIAE benefits for QIs.

All of these options would require extensive analysis and consideration of the pros and cons, associated costs, implied trade-offs, and how to implement them.

2. Data collection and analysis

The HIAE could recommend to C4, DOI, and insurers additional data collection and analysis capabilities to better understand the populations engaging in OmniSalud and the APTC–eligible enrollee subsidy. Despite the successes of the APTC–eligible enrollee subsidy and OmniSalud enrollment, much remains unknown about who is enrolling in the programs and why. Collecting more comprehensive demographic information on enrollees could help the HIAE better understand the populations covered by these programs, address health disparities, and serve the cultural and linguistic needs of the populations. For example, respondents suggested gathering information on race and ethnicity, sexual orientation, gender identity, health status, and disability status for both OmniSalud and the APTC–eligible populations.[31] Collecting and monitoring data that are broken down by these types of demographic factors is an essential first step in assessing health disparities and identifying strategies for improvements. Collecting additional information would require a significant IT build by C4HCO, and monitoring and using it to inform program policies and initiatives would require

> *"I think there's a newfound realization that if we're really going to talk about equity, we need to have the demographic data, and we don't necessarily have all those tools in place to get that kind of data."*
>
> — State official

[30] See https://www.census.gov/programs-surveys/community-resilience-estimates.html.

[31] Health insurance carriers collect some of these data for Colorado Option plans.

substantial investment. Given potential concerns that people with undocumented status might have about providing this additional information, making the questions optional or requiring them but offering an option not to answer might be necessary to avoid a chilling effect on enrollment. Engaging enrollees and frontline workers on the importance of answering demographic questions could also be helpful. It would also be helpful to gather information on people who attempt to enroll after the subsidy cap is reached, either to add them to a waiting list or to get a better sense of the full scope of demand for OmniSalud. In addition, linking enrollment data from C4HCO with claims data from Colorado's all-payer claims database, which is maintained by the Center for Improving Value in Health Care (CIVHC), could yield valuable insights into how the HIAE affects health care use of enrollees.

Gathering demographic and other data from frontline worker organizations could provide additional insights about the populations covered by the APTC–eligible enrollee subsidy and OmniSalud. Frontline workers reported collecting information from people that they helped enroll in coverage in case they needed help later, but the amount of information collected and method for gathering this information varied by organization. C4HCO requires the 77 organizations funded as health coverage guides to collect and report data on appointment information, number of people in the household, enrollment status, reasons for not enrolling, and preferred language. The HIAE could request access to these data as well as request additional data collection from other frontline workers who are not included in C4HCO's Assistance Network to get a fuller picture of enrollees. The HIAE could explore opportunities to share data and collaborate on messaging with enrollment organizations.

Beyond frontline workers, the HIAE Board could leverage additional opportunities to gather and incorporate feedback from community members. Some respondents would appreciate making Board meetings more accessible for people wanting to publicly comment or convening community forums, where community members could share information, ideas, and questions with Board members or their representatives in a less formal setting.

The HIAE should continue to monitor and analyze enrollment and potentially utilization trends. Quantitative analysis showed increasing enrollment trends of consumers eligible for APTC–eligible enrollee subsidies and quick uptake of OmniSalud benefits. Even though the quantitative enrollment analyses presented in this report did not result in major recommendations, continuing to conduct them will also be important to monitor trends over time. In future years, it will be important to continue tracking changes in enrollment, in particular with a focus on equity, for example, by exploring to what extent demographic characteristics, including area of residence, of APTC–eligible and OmniSalud enrollees change over time. As people enrolled in OmniSalud use their coverage, HIAE can also begin to analyze how OmniSalud affects consumers' access to care, health care service use, out-of-pocket spending, and overall health, using all-payer claims data from CIVHC.

3. Outreach and enrollment efforts

The HIAE and C4HCO could further enhance existing outreach and enrollment efforts by engaging more deeply with providers and local on-the-ground community organizations. Across both the APTC–eligible enrollee subsidy and OmniSalud, respondents cited a gap in the knowledge of safety net hospitals and community health clinics about the new programs. Offering education to staff and providers to preview the programs, providing them with resources to understand how to contract with insurers, and understanding the various names the programs might go by could prevent miscommunication when consumers call their provider to ask questions.

Engaging staff at provider organizations to help with outreach could be a further avenue for uninsured patients to hear about the programs. Safety net hospitals and larger health centers often have staff who focus on helping people apply for coverage; however, smaller clinics without that type of in-house support may be reluctant to add responsibilities to existing staff members' workloads. The HIAE could encourage connections with local frontline worker organizations to support enrollment in clinical settings. Insurance carriers communicate with their provider networks regularly. The HIAE could engage with carriers to support and clarify those communications about the APTC–eligible enrollee subsidy and OmniSalud.

The HIAE could encourage frontline workers from local communities to receive assister certification. Although respondents made this suggestion, the lack of funding to support these frontline workers would likely be a challenge. During the first open enrollment, some new frontline workers came on board from community organizations, but there may be an opportunity to engage beyond the current set of health coverage guides, assisters, and brokers, who may not be the most trusted messengers within the new community that OmniSalud is trying to reach. If additional demographic data are collected and analyzed, these insights could be used to identify less represented groups or geographic areas that could benefit from local assistance and focused recruiting efforts. Further, the outreach this year was primarily focused on Spanish-speaking populations. The HIAE could reach other communities of people with undocumented status through materials translated for immigrants who speak languages other than English or Spanish and through partnerships with organizations that work with these communities.

Providing more ongoing education, materials, and support to frontline workers before and during open enrollment could add value. Frontline workers deal with many special circumstances and need help navigating some of them, particularly during periods of high volumes of appointments. One respondent noted that the required training for frontline workers was challenging to complete, particularly for those for whom English is not their first language. Specific recommendations include offering OmniSalud-specific training provided by C4HCO for those focusing on that population, replacing existing examples with more examples more relevant to the community, and conducting the training in Spanish. Perceived delays from community organizations in sending partner organizations materials and messaging may have been due to it being the first year of OmniSalud. Next year, it would be helpful to ensure that partners and community organizations are equipped early. In addition, offering opportunities for partner organizations to weigh in on materials development could be useful. One respondent noted that breaking the messaging down according to stage of open enrollment could help frontline workers tailor their communications accordingly, such as preparing for open enrollment, early open enrollment, and after open enrollment. Several frontline workers noted that it would be helpful to have a better sense of when the subsidy cap would be reached, such as an online tracker that clearly shows how close the program is to reaching its limit.

For both the APTC–eligible enrollee subsidy and OmniSalud, social media outreach has untapped potential. Partners reportedly used Facebook live events and Instagram stories effectively during open enrollment. HIAE could

> *"It would be ideal to have the Enterprise be interested in wanting to get more community members involved in the actual process, and maybe even doing a training with community members that are interested in it to become [health coverage guides] or people that are helping with enrollment. That to me would be so ideal, because who better than the people that are actually a part of the community than to help?"*
>
> — Respondent from a partner organization

also use social media to promote more active engagement. This would require updating its social media accounts. For the next open enrollment period, using social media to amplify the stories of consumers who have benefited from the programs to date could be quite powerful.

4. Health insurance literacy

As the HIAE emerges from the initial implementation phase of OmniSalud and the APTC–eligible enrollee subsidy, additional focus on health insurance literacy education for both populations will be necessary. This shift has already begun and should continue as new consumers begin engaging with their health insurance. Offering clear messaging for OmniSalud enrollees and the public at large, including simple graphics and definitions of critical terms, would be a helpful start. Many frontline workers said they offer support for newly enrolled consumers, which often involves helping them get their insurance cards and helping them navigate where and how to seek care. Whereas this year, some frontline organizations created materials on their own to distribute, the HIAE could play a bigger role in creating and standardizing tools to help consumers understand and navigate these processes more independently. Finally, it could be worthwhile to continue encouraging additional messaging to APTC–eligible enrollees eligible for the state subsidy, who may not be aware of changes to their benefits. Although these consumers are mostly familiar with enrolling on the exchange, they may not realize they need to enroll in a Silver plan to qualify for state and federal subsidies, especially when their income changes.

B. Lessons for other states

Establishing the HIAE was an important step to make health insurance more affordable for Coloradans and to expand access to coverage to people without immigration documentation. Findings from this evaluation demonstrate early implementation successes and challenges and offer recommendations for Colorado and other states as they continue to pursue equitable coverage and health for all. Key informants offered the following suggestions to other states seeking to enroll similar populations. These include recommendations on politics and process, community engagement, financial planning, and the structure of the enrollment platform:

- **States interested in replicating these programs or creating similar programs should first seek to determine which populations to focus on and what benefits to offer.** Colorado chose to focus on residents with undocumented status, which may be where other states choose to focus as well. However, it may be important for other states to assess which of its populations need coverage and to understand what the barriers to coverage are and how they might be broken down. In some states, it may not be feasible to cover residents who are undocumented, but opportunities may still exist to make gains in insurance coverage. Colorado's decision to standardize the structure of the Colorado Option plans so that they were all the same in terms of what benefits were offered and how much they cost was seen as a major strategic win because they were easy to explain to consumers. Further, the affordability structure of the OmniSalud plans, which offered no-cost premiums as well as copay–free primary care and prescription drugs, meant that consumers received benefits that aligned with commonly needed services.
- **States need to consider their own political circumstances and program structures when making decisions about how to set up their coverage programs.** Colorado's politics are such that their legislature passed this legislation with support from nearly all Democrats and a handful of Republicans. Proponents of the legislation were able to make reasonable arguments that spoke to

politicians of different parties. For example, they focused on the fact that the legislation would help vulnerable populations receive better care as well as on the actualized long-term savings that the health care system should see. The presence of established partnerships across government entities also benefited the program. Other states may want to consider the strength and depth of their partnerships with any government entities that would need to be engaged. The presence of a strong and robust health care advocacy community within Colorado contributed to the programs' success. Advocates helped push through the legislation authorizing the HIAE and continued to engage on a regular basis. Having a state-based exchange greatly facilitated Colorado's ability to offer these benefits, because the state had already built the general infrastructure for the platform. The way Colorado structured OmniSalud resulted in pros and cons that other states may want to consider. Carving out a separate organization to support the community of people with undocumented status added a lot of complexity to the program. Other states may want to consider allowing this population to enroll through the marketplace, Medicaid, or other means. However, securing privacy and creating separate systems gave many consumers peace of mind when enrolling.

- **When building programs for new populations, states should engage impacted communities through each step of the process.** Finding ways to authentically engage and connect with people is important, particularly when seeking to enroll populations that have reason to be wary of government programs. Authentic community engagement could include working with community groups as trusted messengers (potentially by offering them additional funding to reach and enroll consumers in their area), incorporating community voices into decision making, hosting work groups for impacted persons to share feedback on government decisions, ensuring staff members are speaking the language of those they are trying to reach, and carefully considering the membership of the Board so that it includes a wide range of partners and community voices. Finally, enrolling the OmniSalud-eligible population (or similar populations) will not work unless frontline workers are viewed as trusted messengers by the community.
- **States considering similar programs—both APTC–eligible enrollee subsidies and OmniSalud—should carefully consider how their program budgets and operational capacity may impact subsidy implementation.** Respondents noted the importance of using comprehensive budgeting that acknowledges the price of all needed services, such as actuarial consulting, language translation, and technology build-outs. For other states that may need to engage multiple government entities, building a runway of funding and time is important for implementing additional technology components. To the extent possible, budgets should also be built to accommodate other state and federal policy changes that may impact state subsidy programs.

Appendix: Detailed Study Description

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A. KII recruitment and interview guide

Key informants. From January through March 2023, we conducted 33 semi-structured telephone interviews with key informants across the state of Colorado, consisting of 60-minute interviews with 32 respondents (one DOI staff member was interviewed twice). We worked collaboratively with DOI staff to develop the initial list of key informants for interviews. Appendix Exhibit A.1 describes the types of respondents with whom we spoke.

Exhibit A.1. Study interviews by respondent type

Respondent type	Number of interviews
State officials[a]	7
HIAE Board members	4
Other organizations[b]	9
Frontline workers[c]	13
Total	**33**

[a] Includes DOI and HIAE staff

[b] Includes Connect for Health Colorado staff

[c] Includes assisters, brokers, health Coverage Guides, promotoras, and AmeriCorps members

IRB and study materials. On January 13, 2023, Health Media Lab Independent Review Board Research & Ethics approved our study materials, including recruitment emails, informed consent language, and interview questions (available as Appendices A–C in our Evaluation Plan). We then created separate interview protocols for each type of respondent to guide our interviews. We translated many of these materials into Spanish to facilitate Spanish-language interviews with frontline workers.

KII recruitment. We began recruiting respondents via email on January 17, 2023, using two distinct approaches

1. For recruiting HIAE staff and Board members, we scheduled directly with those we already knew and had contact information for. For those HIAE staff and Board members that we did not have a relationship with and for other state informants, Public Health AmeriCorps members, and other organizations HIAE staff had a relationship with, we utilized a "warm handoff" approach, which involved an HIAE staff member introducing Mathematica staff to respondents via email. We provided recruitment language for HIAE staff to send for this handoff that requested the individual's participation in the study. Within 24 hours of HIAE staff's initial email, Mathematica staff followed up to schedule an interview with the respondent. We leveraged HIAE staff's existing relationships with these colleagues to get their buy-in on the study and encourage them to participate in interviews. This multimodal approach worked well to recruit respondents.
2. To recruit key informants from organizations that HIAE staff did not have a relationship with, and for frontline navigators, assisters, and brokers who were not members of Public Health AmeriCorps, we drafted recruitment language for our own staff to send directly to respondents, without the initial HIAE staff email described above. With the exception of the Public Health AmeriCorps members, we offered informants from this group $75 as an incentive for participating. This outreach method proved to work well for recruiting consumer advocates, who we reached with ease and were eager to participate. However, this method proved challenging for reaching frontline workers. Ultimately, Connect for Health Colorado sent an email to its network of assisters and brokers, requesting their

participation in our evaluation. We received responses from 13 frontline workers. We recruited three additional frontline workers by connecting with organizations that had been recommended to us by staff at DOI. Our sample of frontline workers included individuals who work in varying geographic regions across the state, for diverse organizations, in a variety of titles and roles.

Recruitment emails for both groups 1 and 2 described above included a description of the study and a Doodle poll to facilitate efficient scheduling of interviews. Once a respondent agreed to participate, we scheduled the interview and sent an email invitation that included the confirmed date, time, WebEx log-in information, and a copy of the informed consent that later reviewed during each call. If a respondent did not reply to an initial email and a follow-up, we reached out a third time by phone if a number was available, otherwise we reached out a third time by email. If a respondent was unreachable after these three attempts, we moved on to alternate respondents as appropriate. We offered interviews in Spanish, and four participants took advantage of this option.

Data collection. An experienced interviewer conducted each interview and took high-level notes throughout. Before interviews began, the qualitative team hosted a training for all team members to ensure they all understood the interview protocols and the topics to cover, the research questions, and the purpose of the data collection. Interviewers followed the structure of the interview guide closely to ensure we obtained the most important content from all respondents within the time allotted for each interview. Although we asked respondents all the questions found in Appendix Exhibit A.2, they were not always able to answer all of them during this evaluation given the timing of our interviews and the people we were interviewing. The qualitative team met regularly while fielding interviews to discuss issues and comments as they arose. These procedures helped to ensure the data collected from these interviews were as consistent as possible across interviewers. After each call, the interview recordings were professionally transcribed by an external firm and securely delivered to Mathematica. A team member reviewed all transcriptions for accuracy and clarity. Interviews conducted in Spanish were transcribed and then translated into English by the external firm.

Exhibit A.2. Qualitative interview questions

	Colorado DOI	Other organiza-tions	Frontline outreach and enrollment workers
Program design and processes			
1. What are the strengths of the way the HIAE subsidies are structured (e.g., in terms of who is eligible, the subsidy amount, the timing of when the subsidy is received, and/or mode of accessing subsidies)? Are there any challenges with the subsidy structure (e.g., in terms of the subsidy amount, the timing, and/or communication of the subsidy, or other)? *If so:* Please describe. From your perspective, what are the pros and cons to offering a larger subsidy to fewer people vs. offering a smaller subsidy to more people? In your view, are there ways that the HIAE subsidy structure could be improved? *If so:* Please describe.	✔	✔	✔
2. How and why does HIAE interact with other state agencies (e.g., C4HCO) and other community partners? What information or resources does HIAE find most useful from these partners? What	✔	✔	

	Colorado DOI	Other organiza-tions	Frontline outreach and enrollment workers
information or resources does HIAE provide to them? What aspects of those organizational interactions are working particularly well? What, if anything, is challenging about those interactions?			
3. How could HIAE be a better partner to the other state agencies and organizations with which it works? How could HIAE be a better partner to consumer advocacy groups and frontline outreach and enrollment organizations? Are there potential new partners within the state that HIAE should seek to build relationships with? *If so:* Which groups and what geographic areas do they cover?	✔	✔	✔
4. What data does your agency/organization collect about its work with the P population (e.g., outreach metrics, enrollment metrics)? What is the process for collecting those data? How are those data used? Are there any opportunities for improvement in data collection?	✔	✔	✔
Outreach and enrollment activities			
5. What strategies/activities did HIAE and other outreach and enrollment organizations undertake to reach and enroll the Phase I population? What strategies/activities did HIAE and other outreach and enrollment organizations undertake to reach and enroll the OmniSalud population? Were any of these strategies/activities different from what had been planned? *If so:* How and why did the strategies/activities evolve? Were any of these strategies different for different locations (e.g., rural vs. urban, digital vs. low-tech, or other differences based on local community characteristics)? To what extent did the strategies/activities for reaching and enrolling the Phase I and OmniSalud populations differ from strategies/activities for reaching and enrolling other Marketplace populations, or Medicaid and CHIP populations?	✔	✔ (if relevant)	✔
6. Which organizations were critical partners in conducting outreach and enrollment to the Phase I population? Which organizations were critical partners in conducting outreach and enrollment to the OmniSalud population? Were those organizations focused on specific subpopulations (e.g., geographic areas, those working in specific industries, those from specific countries)? How did those partners work with HIAE, other state agencies, and/or AmeriCorps? What strategies/activities did they undertake?	✔	✔	✔
7. What outreach/communication materials were developed specifically to reach the Phase I population? What outreach/communication materials were developed specifically to reach the OmniSalud population? Please describe the messages, materials, language(s), and how they were distributed and used. Are there any opportunities for improving the outreach/communication materials?	✔	✔	✔
8. What were the most effective strategies for *reaching* the Phase I population? What were the most effective strategies for *reaching* the OmniSalud population? How do you know (e.g., data collected, analysis, general impressions)?	✔	✔	✔
9. What were the most effective strategies for *enrolling* the Phase I population? What were the most effective strategies for *enrolling* the OmniSalud population? How do you know (e.g., data collected, analysis, general impressions)?	✔	✔	✔

	Colorado DOI	Other organiza-tions	Frontline outreach and enrollment workers
10. What, if any, *system barriers* did outreach and enrollment assisters face in their work to reach and enroll Phase I consumers or OmniSalud consumers (e.g., knowledge about the new benefit, use of the website, the 10,000-enrollee cap for OmniSalud)? How could those system barriers be overcome?	✔	✔	✔
11. Are there groups of consumers eligible for coverage that were not effectively reached and/or enrolled during this most recent open enrollment period (e.g., geographic areas, those working in specific industries, those from specific countries)? How do you know (e.g., data collected, analysis, general impressions)? What made those consumers particularly challenging to reach and enroll in coverage? How might they be reached and enrolled in the future?	✔	✔	✔
Consumer awareness and experiences			
12. In general, how did the Phase I population of consumers hear about their eligibility for coverage? In general, how did the OmniSalud population of consumers hear about their eligibility for coverage? Did Phase I and OmniSalud consumers appear to be aware of the benefits available to them? On a scale of 1 to 5 with 1 being very difficult and 5 being very easy, how easy or difficult was it to explain this new benefit to consumers? What types of messages seemed to influence enrollment the most (e.g., you are now eligible for coverage, coverage is affordable, assistance is available, other)? From your interactions with OmniSalud consumers, were consumers aware that here was a 10,000-enrollee cap? Once the cap was reached, how did the messaging to the OmniSalud population change? What could make outreach more effective to the Phase I and/or OmniSalud populations?		✔	✔
13. What motivated the Phase I and OmniSalud populations to seek out and enroll in coverage? What, if anything, made enrolling in coverage easy for the Phase I and OmniSalud populations?		✔	✔
14. What barriers did Phase I and OmniSalud consumers face when trying to enroll in coverage? How were those barriers overcome? How did OmniSalud consumers who tried to enroll after the 10,000-enrollee cap was reached behave (e.g., did they choose not to enroll once they learned subsidies were no longer available, or enroll in different plans)?		✔	✔
15. Once enrolled, what barriers do Phase I consumers face when using their coverage (e.g., understanding their benefits, difficulty finding culturally competent care)? Once a consumer is enrolled, do you provide them with any additional services (e.g., assistance with finding a provider, paying their premiums, health insurance literacy)? *If applicable, given the timing of interviews:* How did the Phase I population use the new coverage to obtain health care services? Do you think Phase I consumers are noticing a difference in their out-of-pocket health care costs? *If so:* Does that difference appear to impact their health care utilization?		✔	✔
16. Among consumers eligible for coverage through Phase 1, but not yet enrolled, what do you think prevents them from enrolling (e.g., lack of awareness, concerns about costs or immigration, other)?		✔	✔

	Colorado DOI	Other organiza-tions	Frontline outreach and enrollment workers
17. Is this health insurance benefit and the way it is structured what members of the Phase I and OmniSalud populations need, based on your observations and interactions with them? *If not:* What type of benefit do you think would better meet the needs of this population?		✔	✔
18. How could open enrollment be improved for consumers in the Phase I population? How could open enrollment be improved for consumers in the OmniSalud population?		✔	✔
Lessons learned			
19. What lessons can Colorado learn for the future as a result of the first years of reaching and enrolling the Phase I and OmniSalud populations (e.g., lessons on the subsidy or program design, outreach methods, enrollment methods, other)? What advice would you give to another state that might seek to enroll similar populations?	✔	✔	✔
20. Given the benefit of hindsight, is there anything you would change about the design or implementation of the program? *If so:* Please describe.	✔	✔	✔
21. What resources, supports, or policies would be needed to improve outreach and enrollment to the Phase I and/or OmniSalud populations? Are there any additional partner groups that could be engaged?	✔	✔	✔

Coding and data analysis. To organize data from the key informant interviews and identify themes and key findings, we used an Excel spreadsheet and NVivo qualitative software to code interview transcripts. We developed a coding framework that documented the main topics from the interview protocols as codes and defined which data fit into each code. We applied the coding framework to each interview transcript, which enabled us to objectively organize the qualitative data collected through key informant interviews into categories and themes. The research team held a training session to discuss the definitions included in the coding framework to ensure all the team members understand them before beginning to code. Throughout the coding process, the team met regularly to discuss questions or concerns, and one team member served as an internal quality assurance reviewer.

After completing coding, we pulled queries for each code that showed the data on each topic across all transcripts, allowing us to identify the key findings and most prevalent themes from the interviews. We analyzed data across respondents and drafted analytic summary statements to synthesize the main findings for each topic, or code, which we used to answer the primary research questions.

B. Quantitative data sources used

This appendix describes the quantitative data sources we used in this report.

1. Connect for Health Colorado

Connect for Health Colorado (C4HCO) for plan years 2019–2023 was the data source for eligibility and enrollment information on people who apply for individual marketplace coverage. In addition to looking at the eligibility of those who enrolled into a qualified health plan (QHP) under HIAE Phase I, Mathematica also requested eligibility data for people who applied but did not enroll, along with their eligibility status. Appendix Exhibit A.3 describes the variables we used.

Exhibit A.3. Description of Connect for Health Colorado data

Data variable	Data definition
Plan year	12-month period during which a health plan provides coverage for health benefits
Gender	Male or female
Age category	Calculated based on January 1st of the plan year: birth–17; 18–25; 26–34; 35–44; 45–54; 55–64; 65+
Household size	Number of individuals from the eligibility application who are in the same household.
Rating county	Rating county based on a member's enrollment. Note this is NOT based on their eligibility application.
Employment flag	Yes (Y) or No (N). If Y, they indicated they were employed on the Eligibility application.
Federal poverty level (FPL) category	FPL categories: ≤100%; 100%–150%; 151%–200%; 201%–250%; 251%–300%; 301%–350%; 351%–400%; 401%+; Unknown
Race	Data from eligibility application
Ethnicity	Data from eligibility application
QHP eligible	Yes (Y) or No (N). Reflects whether the eligibility determination allows the member to shop for a Qualified Health Plan (QHP) on C4HCO.
HIAE eligible	Yes (Y) or No (N). Reflect whether the eligibility determination qualified the member for the HIAE benefit while shopping for a QHP and potentially enrolling in a Cost Share Reduction Silver Plan.
Policy start date	Coverage start date at the member level. Defines the span of coverage
Policy end date	Coverage end date at the member level. Defines the span of coverage
Financial start date	The financial start date at the member level. This may result in additional rows for the member because there are different financial periods under the same policy if their eligibility changed mid-year.
Financial end date	The financial end date at the member level. This may result in additional rows for the member because there are different financial periods under the policy if their eligibility changed mid-year.
Effectuated flag	Yes (Y) or No (N). Reflects whether the coverage span was ever effectuated.
Member submission date	Submission date at the member level. This defines when the member submitted for coverage.

Data variable	Data definition
Broker assisted	Yes (Y) or No (N). Reflects whether the account authorized a broker to potentially help them complete eligibility and enroll
Assistance site	Yes (Y) or No (N). Reflects whether the account authorized someone at an assistance site to potentially help them complete eligibility and enroll.
Rating area	Region of the state used for rating rules
Issuer ID	5-digit unique Issuer ID
Issuer name	Name of issuer
HIOS plan ID	The unique ID for the medical plan. Format will be 17 digits, with the last two after the dash being the cost sharing reductions level; for example, 31070CO0010066-03.
Plan type	HMO; PPO; EPO
Level of coverage	Catastrophic; Bronze; Silver; Gold; Platinum
HIAE enrollment flag	Yes (Y) or No (N). Reflects whether the member enrolled in a "06" Silver Plan, which includes the HIAE benefit. For Plan Years 2018–2021, this flag indicates that someone could have been enrolled in a HIAE Plan if the HIAE benefit had been available at that point in time.
Member premium amount	The gross monthly premium for each member during the plan year
Eligible advanced premium tax credit (APTC) amount	The amount of APTC the household was awarded based on the application
Member applied APTC amount	The amount of APTC applied monthly at the member level towards their premium.
Date of last eligibility determination	The last date a member was determined eligible for APTC
Net premium amount	This is the monthly amount the member is responsible for paying the issuer for their premium. It is the premium amount minus the applied APTC amount.
Preferred language	Preferred language as indicated by member
Tobacco usage	Yes (Y) or No (N). Reflects whether the member use tobacco.

EPO = exclusive provider organization; HIOS = Health Insurance Oversight System; HMO = health maintenance organization; PPO = preferred provider organization.

2. Colorado Connect

Anyone who applies to Colorado Connect had their data stored in a separate database from C4HCO data. Mathematica received a separate report on them to evaluate OmniSalud. Appendix Exhibit A.4 describes the variables we used. Note that the data do not contain member race and ethnicity because these fields were not mandatory according to C4HCO.

Exhibit A.4. Description of Colorado Connect data

Data variable	Data definition
Plan year	12-month period during which a health plan provides coverage for health benefits
Gender	Male or female
Age category	Calculated based on January 1st of the plan year: birth–17; 18–25; 26–34; 35–44; 45–54; 55–64; 65+
Household size	Number of individuals from the eligibility application who are in the same household.

Data variable	Data definition
Rating county	Rating county based on a member's enrollment. Note this is NOT based on their eligibility application.
Employment flag	Yes (Y) or No (N). If Y, they indicated they were employed on the Eligibility application.
Policy start date	Coverage start date at the member level. Defines the span of coverage
Policy end date	Coverage end date at the member level. Defines the span of coverage
Financial start date	The financial start date at the member level. This may result in additional rows for the member because there are different financial periods under the same policy if their eligibility changed mid-year.
Financial end date	The financial end date at the member level. This may result in additional rows for the member because there are different financial periods under the policy if their eligibility changed mid-year.
Member submission date	Submission date at the member level. This defines when the member submitted for coverage.
Eligibility determination date	Defines when the member was determined eligible for coverage.
Broker assisted	Yes (Y) or No (N). Reflects whether the account authorized a broker to potentially help them complete eligibility and enroll
Assistance site	Yes (Y) or No (N). Reflects whether the account authorized someone at an assistance site to potentially help them complete eligibility and enroll.
Rating area	Region of the state used for rating rules
Issuer ID	5-digit unique Issuer ID
Issuer name	Name of issuer
HIOS plan ID	The unique ID for the medical plan. Format will be 17 digits, with the last two after the dash being the cost sharing reductions level; for example, 31070CO0010066-03.
Plan type	HMO; PPO; EPO
Level of coverage	Bronze; Silver; Gold
Member premium amount	The gross monthly premium for the member during the plan year
SilverEnhanced Savings eligibility flag	Yes (Y) or No (N). Reflects whether the member is eligible for SilverEnhanced Savings
SilverEnhanced Savings amount	The amount of SilverEnhanced Savings provided to the member
Member net premium amount	The net monthly premium for the member during the plan year
Enrollment flag	Yes (Y) or No (N). Reflects whether the member is enrolled in a plan
Preferred language	Preferred language as indicated by member
Tobacco usage	Yes (Y) or No (N). Reflects whether the member use tobacco.

EPO = exclusive provider organization; HIOS = Health Insurance Oversight System; HMO = health maintenance organization; PPO = preferred provider organization.

3. Health Insurance Affordability Enterprise

The Health Insurance Affordability Enterprise (HIAE) has information on the establishment, implementation, and administration of HIAE that will inform the evaluation. We used budget data to assess how HIAE resource allocation, budget, and spending decisions impacted the overall goals and desired outcomes. Appendix Exhibit A.5 shows which data elements are available for fiscal years 2022 and 2023.

Exhibit A.5. Description of Health Insurance Affordability Enterprise data by fiscal year

Data variable
Budgeted amounts
Projected year-end spending
Funding amounts
Fund allocation amounts

4. Colorado Division of Insurance

a. Plan filing data

The Division of Insurance (DOI) has critical information on health insurance issuers and plans in the individual market that will inform the evaluation. Individual market issuers are required to file rates and forms with DOI. DOI reviews the insurance plans, making sure policies conform to state laws and regulations, and reviews rate filings to make sure the premiums are appropriate and not discriminatory. We used this information to assess the market dynamics, including companies offering coverage, types of plans available, and the pricing of the plans. Issuers are required to report financial data to the National Association of Insurance Commissioners (NAIC) on a quarterly basis and at year end. These financial data serve several different functions, including ensuring compliance and preventing insolvencies. NAIC provides DOI with financial filing information for issuers regulated by DOI. This information was used to assess each issuer's performance and stability in the individual market, along with the stability of the total market. Appendix Exhibit A.6 shows the variables we will use to assess the hypothesis that the HIAE increases stability in insurance markets.

Exhibit A.6. Description of DOI issuer and plan filing data by year

Data variable
Individual market plan count, by metal level
Plan count, by issuer
Base premium, by issuer
Participating individual market issuers by plan year
Count of individual market issuers by plan year, by county

b. Financial data

Two measures to assess issuer financial performance are gross margins and medical loss ratios (MLRs). We used NAIC financial data to calculate both measures. In their filings, issuers break their financial information down into markets, which will allow us to examine each issuer's individual market

performance. We calculated gross margins by subtracting the sum of total incurred claims from the sum of unadjusted health premiums earned and dividing the resulting number by the total number of member months. Member months are equivalent to the cumulative number of members in a period multiplied by the number of months in that period. We calculated MLRs by dividing each issuer's individual market sum of total incurred claims by the sum of all unadjusted health premiums earned. MLRs in this analysis are simple loss ratios and are not adjusted for quality improvement expenses, taxes, or risk program payments, like the MLRs defined by the Affordable Care Act. The simpler MLRs are nevertheless a good proxy for the actual MLRs. Appendix Exhibit A.7 shows the variables we used.

Exhibit A.7. Description of Division of Insurance issuer and plan financial data

Data variable
Total members at end of first quarter, individual
Total members at end of current year, individual
Current-year member months
Health premiums earned
Amount incurred for provision of health care services
Member ambulatory encounters (physician and non-physician encounters)
Physician encounters
Non-physician encounters
Hospital patient days incurred
Inpatient admissions

c. Off-exchange enrollment data

People can enroll into individual coverage directly through an issuer. Data on these off-exchange enrollments are collected by DOI for reinsurance purposes. We will use individual market, off-exchange enrollment for plan years 2019–2023 in the evaluation to measure the size of the total individual market in assessing the hypothesis that the HIAE reduces the number of uninsured. We will also use these data to examine any shifting in the proportion of enrollees who enroll off exchange versus on exchange due to HIAE initiatives.

5. Kaiser Family Foundation

Kaiser Family Foundation (KFF) tracks data on average health insurance marketplace premiums across all states.[32] These benchmark data examine the premium level for a 40-year-old in each county and weight the premium by county plan selections to produce an overall state average premium, which reflects the average premium before any tax credits are applied. We used these benchmarks to track base health insurance premiums in the Colorado market from year to year and to compare these prices with other markets and market trends. We examined marketplace base premiums for plan years 2019–2023. Appendix Exhibit A.8 shows the variables we used.

Exhibit A.8. Description of Kaiser Family Foundation data

Data variable
Average benchmark premium
Average premium: Lowest-cost bronze
Average premium: Lowest-cost silver
Average premium: Lowest-cost gold

C. Methodology for analysis of insurance market stability

There are several methods of assessing the strength of the Colorado individual market. Insurers are required to submit annual financial statements to the Colorado Division of Insurance (DOI) for review. We analyzed this insurer-reported financial data for the evaluation of issuer market performance.[33] Insurer financial statements include several datapoints that can be examined to assess financial performance. We calculated medical loss ratios (MLRs) and gross margins using the insurer's "Exhibit of Premiums, Enrollment, and Utilization." MLRs show the percent of premium income that issuers are spending on medical claims. Lower MLRs show that issuers have adequate money to cover medical claims and more money to spend on administrative costs and profits. The ACA requires that insurers in the individual market have a MLR of at least 80 percent or they must issue health premium rebates to their consumers. The calculation of MLRs for this report differs from the MLR in the ACA, which includes adjustments for quality improvements and taxes. The MLRs included in this report are the share of premium income that insurers pay out for claims.

Gross margins measure whether the premiums that insurers collected from consumers cover their medical claim costs. However, it should be noted that gross margins should be considered carefully as positive margins do not necessarily translate to profitability given insurers still need to account for administrative expenses and tax liabilities. These margins can be viewed year-over-year to consider how much issuers are spending and collecting on a per enrollee basis.

In addition to health insurer financials, other measures to assess the strength of the Colorado individual market include health insurance premium prices and the number of insurers offering coverage. Health insurance premiums can be examined because large changes in prices from year to year could indicate instability in the market. Large changes in prices could also lead to similar shifts in consumer movement as consumers react to these prices. We also examined Colorado's individual market premiums compared to other individual market prices in the United States as higher prices may indicates a less healthy overall

[32] https://www.kff.org/state-category/affordable-care-act/health-insurance-marketplaces/.

[33] https://doi.colorado.gov/annual-financial-statements-colorado-domestic-insurers.

risk pool. Lastly, we examined the number of insurers participating in the individual market as well as insurers are entering or exiting the market. Individual markets have previously struggled in having insurers participate, especially in counties with smaller populations, with some states worried about having counties where no insurance carriers are offering coverage. Ideally, counties should have at least two insurers offering coverage, so consumers have choice in selecting a health plan. Few health insurers in the market can drive prices up because of the lack of competition. When an individual market has insurers leaving the market altogether, this can be a sign of instability and could also drive consumers from the market. We utilized Kaiser Family Foundation (KFF) state health facts data to compare the Colorado individual market and marketplace data to other states and nationwide averages.[34]

This examination of Colorado individual market stability uses data from 2019 to 2023. To analyze the Colorado individual market prior to the HIAE, we examined 2019-2021 data. We looked at 2022-2023 data to examine the market after the HIAE. While we can examine certain market stability data elements from 2019 to 2023, like number of individual market insurers and premiums, other data elements are only available up to 2022 since the 2023 plan year is not complete. Health insurer financials are published the calendar year after the plan year is completed so gross margins and MLR are not available for 2023.

D. Alternative text for line graphs in the report

Exhibit A.9. Alternative text for Exhibit IV.4

Date	Boulder	Colorado Springs	Denver	Fort Collins	Grand Junction	Greeley	Pueblo	East	West
11/1/2022	1	6	2	1		1		2	7
11/2/2022	3	12	4	2	12	3		6	9
11/3/2022	6	17	7	4		5	12	11	13
11/4/2022	9	21	9	8		7	13	11	14
11/5/2022	10		11	8		14			26
11/6/2022		21	11			14		11	26
11/7/2022	12	24	14	11	22	17	16	12	29
11/8/2022	13	29	17	12	24	17	27	19	34
11/9/2022	15	35	21	15	28	20	32	20	36
11/10/2022	18	39	23	17	32	22	36	27	42
11/11/2022	21	42	26	21	33	25	40	33	44
11/12/2022	21	44	28	21		26	40	34	46
11/13/2022		45	31			26			
11/14/2022	24	48	33	22		29		37	50
11/15/2022	29	52	37	25	41	33	42	42	53
11/16/2022	31	56	41	27	52	45	46	44	56
11/17/2022	36	60	43	29	57	50	66	53	58
11/18/2022	39	62	46	30	60	52	67	58	59
11/19/2022	40		49	33		54		59	63
11/20/2022	41		52	34	60	55			

[34] https://www.kff.org/state-category/affordable-care-act/health-insurance-marketplaces/.

Date	Boulder	Colorado Springs	Denver	Fort Collins	Grand Junction	Greeley	Pueblo	East	West
11/21/2022	42	64	56	38	63	60	81	62	65
11/22/2022	47	69	59	43		65	86	66	69
11/23/2022	57	75	61	47	71	68	92	70	71
11/24/2022		75	61		72				
11/25/2022			62			69			
11/26/2022	57	76	62						71
11/27/2022			62	47					
11/28/2022	64	77	65	53	73	73	94	74	75
11/29/2022	69	82	68	59	78	77	94	80	80
11/30/2022	79	85	73	65	93	83	95	84	82
12/1/2022	86	91	77	76	94	87	96	88	86
12/2/2022	89	95	83	79		89	97	93	89
12/3/2022	92	96	85	87	95	91		93	93
12/4/2022	94		93	88		91			93
12/5/2022	99	98	98	96	100	98	99	96	98
12/6/2022	100	100	100	100		100	100	100	100

Exhibit A.10. Alternative text for Exhibit V.8

Date	Non-HIAE enrollees	HIAE enrollees
January 2022	100	100
February 2022	109	108
March 2022	110	109
April 2022	110	109
May 2022	110	109
June 2022	110	109
July 2022	110	109
August 2022	110	108
September 2022	110	108
October 2022	109	107
November 2022	108	106
December 2022	107	105

Exhibit A.11. Alternative text for Exhibit VI.1

Year	US	WA	CO	MD
2019	478	406	488	419
2020	462	391	358	397
2021	452	388	351	347
2022	438	396	351	328
2023	456	395	380	336

Exhibit A.12. Alternative text for Exhibit VI.3

Year	Catastrophic	Bronze	Silver	Gold
2019	4.26	0.94	11.86	3.81
2020	-13.1	-19	-22.8	-17.2
2021	-3.3	-0.9	-1.6	-3.4
2022	-3	0.5	3.1	-3.9
2023	15	12.1	10.6	3.9

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