

Date: JULY 15, 2015

TO: Senator Ellen Roberts, Chair, Colorado Health Insurance Exchange Oversight Committee

CC: Elizabeth Haskell, Colorado Legislative Council, Research and Committee Staff

From: Kevin Patterson, Interim CEO, Connect for Health Colorado

RE: Responses to Committee Members Questions from 6/05

The Colorado Health Benefit Exchange Oversight Committee asked Connect for Health Colorado the following questions during the June 5 meeting. Below are Connect for Health Colorado's responses.

1. How does Connect for Health Colorado's retention rate (66%) compare to other states? What is your retention goal and do you have plans to improve? (Asked by Senator Roberts)

Our retention goal for Fiscal Year 2016 is 66 percent for the Individual and Small Group Marketplaces. We exceeded our retention goal in Fiscal Year 2015 with a retention rate of 67 percent (Our goal in 2015 was 70 percent, an industry standard).

For the 2015 plan year, other state based Marketplace retention rates were: 92 percent in California, 97 percent in Kentucky, 82 percent in Rhode Island, and 80% in Washington¹.

2. What is the ripple effect on consumers if the Colorado HealthOp becomes insolvent? (Asked by Senator Roberts)

Connect for Health Colorado does not regulate carriers. Our partners at the Division of Insurance (DOI) are responsible for regulating carriers and Commissioner Salazar addressed this issue in her testimony to the committee on June 5.

3. What is the budget impact to Connect for Health Colorado of receiving effectuated enrollments at different times? (Asked by Representative Landgraf)

Connect for Health Colorado enrollment projections are based on projected, effectuated enrollments and used for revenue forecasts and budget development. The number of effectuated enrollments changes month over month as enrollees leave and enter the market. Given this fluidity, the Marketplace has implemented monthly reconciliation processes with

¹ Ahn, S. (personal communication, June 10, 2015)

its insurance carriers to ensure accurate effectuations are captured for revenue forecasts and federal reporting. Our budgeting takes into account this fluid process, which traditionally has been a part of the individual insurance market.

4. Do you have a work plan in place for activities underway on each of the key learnings identified in the presentation (i.e. 1095-A, streamlining eligibility, etc.)? (Asked by Senator Martinez-Humenik)

Yes, the Marketplace has a work plan for the Shared Eligibility System improvements and for Open Enrollment 3.0 activities. The Shared Eligibility system improvements are jointly managed by the Office of Information Technology, Department of Healthcare Policy and Financing, and Connect for Health Colorado. This project has a dedicated team and project manager.

Connect for Health Colorado manages Open Enrollment 3.0 activities. Similar to the eligibility project, this activity has a dedicated team and project manager.

5. Is Connect for Health Colorado prepared to make changes that might be necessary related to the King v. Burwell decision? (Asked by Senator Martinez-Humenik)

As you now, the Supreme Court of the United States voted 6-3 to uphold the Affordable Care Act's premium tax credit (subsidies), regardless of what state you reside in. The majority reasoned that Congressional intent was clear: qualified enrollees in all exchanges, whether state or federal, are entitled to tax credits to help defray the cost of health insurance. This decision is good news to consumers in states participating in the federal exchange as it resolves the uncertainty surrounding the support they have relied on to ensure their financial security and ability to receive healthcare. Here in Colorado, we continue to stay focused on the activities identified in our 2015-2016 Strategic Plan, which was reviewed by the Committee on June 5, 2015.

6. Regarding the state audit, is there any chance the Exchange will be required to refund any of the federal grant? (Asked by Senator Martinez-Humenik)

Connect for Health Colorado entered into contractual arrangements with various vendors to supply services. As needs dictated that additional services were required to launch the Marketplace, vendors provided these services and Connect for Health Colorado paid for them. However, the documentation associated with the additional services in the form of additional "statements of work" was not adequate. Absent this context, the Office of the State Auditor's report makes it appear that there were overpayments on contracts resulting in "questioned costs." In fact, Connect for Health Colorado received all services paid for on its contracts, but did not present adequate documentation (from an audit perspective) to reflect that the payments were related to services provided. In that the services were provided, no requests for "refunds" is appropriate; rather Connect for Health Colorado's vendor and procurement documentation policies and procedures have been materially revised to avoid future documentation inadequacies.

7. How much Medicaid churn is happening and how is it affecting enrollment? (Asked by Senator Aguilar)

Churn is a topic that needs further research to quantify and to understand the impact on individual households in Colorado. Generally, churn is considered as moving from public health insurance to private health insurance coverage and then back to public insurance. This is an area where the Department of Health Care Policy and Financing (HCPF) may seek additional research funding in order to quantify and understand impacts on coverage and care. Nationwide churn is an ongoing policy discussion for state Medicaid agencies, Marketplaces and private insurers.

Anecdotally, we know there is churn. As such, HCPF and the Marketplace have implemented policies to mitigate its impact. One example is HCPF's implementation of continuous eligibility for kid²s. HCPF has had this policy in place for just over a year, and is in the process of analyzing what impact this policy has had on Medicaid and CHP+ kids.

HCPF can track changes in Medicaid and CHP+ caseload on a monthly basis and the Marketplace can track enrollees who become newly eligible for public insurance. Unfortunately, there is not an automated way to identify churn between programs. Measuring churn is further complicated by the fact that an individual can have private coverage and Medicaid, where Medicaid becomes the payer of last resort.

8. How successful has the Exchange been in addressing the under-insured? (Asked by Senator Kefalas)

For families earning at least twice the federal poverty level (FPL), the Colorado Health Institute defines underinsurance as spending at least 10 percent of annual income on out-of-pocket medical expenses. For families below that threshold, underinsurance is defined as spending at least five percent of annual income on out-of-pocket medical expenses. The Colorado Health Institute captures the number of Coloradans who are underinsured in their biennial Colorado Health Access Survey (CHAS). Results from the 2013 CHAS showed that Colorado's underinsured and uninsured rates have been similar since 2009 at about 14 percent and that the underinsured tend to be older³.

The Affordable Care Act (ACA) addresses affordability and underinsurance in the following ways:

² HCPF does not have this policy in place for adults.

³ When Insurance Is Not Enough: How Underinsurance Impacts Health and Finances. (2014, June 1). Retrieved June 29, 2015, from http://www.coloradohealthinstitute.org/uploads/postfiles/CHAS/CHAS_Underinsurance_brief_2014.pdf

1. *Minimum Standard of Coverage: Requires a standard set of benefits all health insurance companies must offer(at a minimum) in the individual and small group markets regardless of whether the plan is purchased on or off the Marketplace. This standard set of benefits is called the Essential Health Benefits and includes 10 categories of services such as prescription drugs, rehabilitative/habilitative services, mental health and substance use disorder services, and preventative/wellness services.*
2. *Minimum Standards for Cost-Sharing: Requires a standard for “plan generosity” in the individual and small group markets regardless of whether the plan is purchased on or off the Marketplace. This plan generosity is categorized in to metal tiers—Bronze, Silver, Gold, and Platinum. If a customer purchases a Silver-level plan, their plan generosity (also called Actuarial Value, AV) is 70 percent. This means that their health insurance company will cover 70 percent of the covered services, and the enrollee will pay for 30 percent. If a customer purchases a Platinum-level plan, their plan generosity is 90 percent. This means their health insurance company will cover 90 percent of covered services, and the enrollee will pay for 10 percent. A Bronze plan has a plan generosity of 60 percent and will have lower premiums and higher cost-sharing requirements (co-pays/deductibles); whereas, a Gold plan at 80 percent will have a higher premium than a Bronze plan but lower cost-sharing requirements.*
3. *Free Preventative Services: Requires health insurance companies to pay for preventative health services. This means the individual has no co-pay when they access these services.*
4. *Help Paying for the Up-Front Cost of Insurance: Allows eligible individuals to use a tax credit in advance to lower their monthly premiums in plans purchased in the individual market through the Marketplace.*
5. *Help Paying for Accessing Services: Allows eligible individuals to purchase a plan in the individual market through the Marketplace that has lower cost-sharing requirements (out of pocket costs) such as copays and deductibles.*
6. *Expanding Coverage to More Residents: Allows a State to expand Medicaid eligibility to cover more people, and requires health insurance companies to accept enrollees regardless of health status.*

At the end of the Open Enrollment Period for the 2015 plan year, 54 percent of Marketplace customers were receiving financial help in the form of cost sharing reductions and/or the advance premium tax credit. The majority of Marketplace enrollees are enrolled in Bronze and Silver-level plans, 41.48% and 45.13% respectively.

Our Brokers, Health Coverage Guides, Customer Service Representatives, carriers, stakeholders, volunteers, and online tools have had an instrumental role in educating Colorado consumers about health insurance basics and coverage options post-ACA. Our enrollment assisters and online tools will continue to be a major part of our health literacy strategy. As more Coloradans are covered, it is vital that the Marketplace help consumers understand what co-pays and deductibles are. We are lucky to be a part of the Colorado Health Foundation’s health literacy consortium with our state partners and look forward to collaborating and creating new ways to educate consumers on the value of health insurance.

9. What is the plan for persons that received a subsidy but now the IRS says they owe money back? (Asked of the Department of Healthcare Policy and Financing but more appropriately assigned to the Marketplace)

When an applicant applies for coverage in the Marketplace, the Marketplace will estimate the amount of the premium tax credit that an applicant may be able to claim for the tax year, using information he or she provides about family composition and projected household income. Based upon that estimate, an applicant can decide if he or she wants to have all, some, or none of the estimated credit paid in advance directly to his or her insurance company and applied to the monthly premium. If an applicant chooses to have all or some of the credit paid in advance, he or she will be required to reconcile on their income tax return the amount of advance payments that the government sent on the enrollee's behalf with the premium tax credit that an enrollee may claim based on their actual household income and family size.

If an enrollee's circumstance changes during the plan year, he or she is responsible for notifying the Marketplace and updating his or her eligibility. Each month and at year-end, the Marketplace provides enrollment data to the IRS so the IRS can appropriately pay insurance companies.

Once a tax filer has filed his or her federal taxes, the IRS will take the three actions below, called "reconciliation:"

- I. The IRS will check to see if the income the filer reported to the Marketplace is the same as the income reported on the federal tax return*
- II. The IRS will also check to see if the filer's tax household size is the same as when they applied for health insurance with the Marketplace*
- III. The IRS will then compare the financial assistance already paid to the health plan with the financial assistance that the filer should qualify for (as determined by the IRS)*

If the household income on the tax return is lower than the income estimated on the Marketplace application for financial assistance, the filer may not have gotten enough financial assistance. At tax time, the filer may get that extra financial assistance to lower the taxes he or she owes, or even as a refund.

If the household income on your tax return is higher than the household income, you estimated on your application for financial assistance, the IRS might have paid too much financial assistance on your behalf. In this case, you may have to pay some or all of the premium assistance back when you file.

To educate customers on the importance of updating income and household size information throughout the year, the Marketplace gives reminders in its customer newsletter, on its website, and through Brokers, Health Coverage Guides, and Service Center Representatives.

10. How could a person receive a subsidy then owe the IRS money? (Asked of the Department of Healthcare Policy and Financing but more appropriately assigned to the Marketplace)

The premium tax credit is an advanceable, refundable tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through the Marketplace beginning in 2014. The Marketplace estimates the amount of premium tax credit that an applicant may be able to claim for the tax year based on information provided by the applicant in the application for financial assistance. An eligible applicant can choose to have the credit paid in advance to his or her insurance company to lower what he or she pays in monthly premiums, or an eligible applicant can claim all of the credit when he or she files a tax return for the year. If an applicant chooses to have the credit paid in advance, he or she will reconcile the amount paid in advance with the actual credit computed when he or she files a federal tax return.

The actual premium tax credit for the year will differ from the advance credit amount estimated by the Marketplace if your family size and household income as estimated at the time of enrollment are different from the family size and household income you report on your return. The more your family size or household income differs from the Marketplace estimates used to compute your advance credit payments, the more significant the difference will be between your advance credit payments and your actual credit. If your actual allowable credit on your return is less than your advance credit payments, the difference, subject to certain caps, will be subtracted from your refund or added to your balance due. If your actual allowable credit is more than your advance credit payments, the difference will be added to your refund or subtracted from your balance due.

Notifying the Marketplace about changes in circumstances allows the Marketplace to update the information used to determine the expected amount of the premium tax credit and adjust the advance payment amount. This adjustment will decrease the likelihood of a significant difference between the advance credit payments and the actual premium tax credit determined by the IRS. Changes in circumstances that can affect the amount of the actual premium tax credit include:

- *Increases or decreases in household income.*
- *Marriage*
- *Divorce*
- *Birth or adoption of a child*
- *Other changes to your household composition*
- *Gaining or losing eligibility for government sponsored or employer sponsored health care coverage (such as Medicaid or CHP+)*
- *Deciding that your filing status will be Married Filing Separately*