

DOI Remarks to Legislative Health Insurance Exchange Review
Committee – July 15, 2015

Thank you for permitting the Division of Insurance to return with answers to the questions asked at your June 5th meeting.

Exchange User Fees

Senator Lundberg asked whether spreading the Exchange user fee across all carriers is legal?

- There are two user fees which partially fund Connect for Health Colorado – a special fee under HB13-1245 and a federally authorized Exchange user fee under 45 CFR 156.50. As the fees are measured and calculated differently, I will briefly explain each:
- In May, 2013, HB 13-1245 concerning mechanisms for funding Connect for Health Colorado was signed into law. That bill followed precedent from the CoverColorado high risk pool program of assessing a special fee to carriers to provide funding to the Exchange. Under CRS 10-22-109(2), the fee cannot exceed \$1.80 per number of lives insured per month and is assessed against all carriers providing individual or small group coverage, including stop-loss coverage for self-funded plans. Under the statute, this fee is not considered premium for any purpose, but an insurer who fails to pay the fee may be subject to suspension or revocation of its certificate of authority to transact business in Colorado. The Division issued Regulation 4-2-52 which

sets forth the process for accessing and collecting this fee.

This fee expires on December 31, 2016.

- The second fee is one authorized under federal regulation 45 CFR 156.50. This is the 3.5% fee for 2016 which is assessed against carriers on the Exchange. In contrast to the HB13-1245 fee, the amount a carrier owes for this fee is based on the total premiums of its Exchange enrollment, but then is assessed as part of the premium across the carrier's "book of business" for that market – individual or small group. The federal government's rationale for this action was to create a level-playing field inside and outside the Exchanges, and to further protect against adverse selection.
- To be clear, this 3.5% assessment only applies to carriers offering coverage on the Exchange but is spread over all of the carrier's business. Carriers not offering products on the Exchange are not subject to the fee. This process helps maintain a level playing field across the entire marketplace in Colorado by keeping the premiums for a plan offered through Connect for Health at the same price a consumer would pay to buy the same plan off the Exchange.

Carrier Consumer Service Costs

Rep. Primavera asked whether the carrier's cost for providing consumer assistance services and IT upgrades are part of a carrier's administrative costs.

- Yes, customer service and IT upgrades are part of a carrier's administrative costs.
- Under federal and state law, carriers are required to meet a calculation called the medical loss ratio or MLR. If they do not meet these requirements they must rebate the excess back to consumers.
- The calculation for the MLR is:
$$\frac{\text{Health care claims plus Quality Improvement Expenses}}{\text{Premiums minus Licensing and Regulatory Fees}}$$
- Carriers must meet a MLR of 80% in the individual and small group markets, and 85% in the large group market. Because customer service and IT upgrades are not claim or quality improvement expenses, they fall into the administrative cost category and the 20% that is not the MLR.

Transition Plan Termination

Sen. Martinez-Humenik asked whether the Division of Insurance is prepared to deal with the shift of consumers from non-ACA compliant plans in 2015.

- Health carriers which are exiting from a market segment are required to give the Division, and consumers, notice 180 days in advance under CRS 10-16-105.1(1)(h). Three carriers, covering almost 12,400 people, have provided this notice for policies to end December 31, 2015. These three carriers must stay out of the Colorado individual market for 5 years pursuant to statute.
- Carriers who elect to discontinue a particular individual or small group plan, must provide consumers, and the Division, notice at least 90 days prior to non-renewal of the coverage. The Division has received notices of this, primarily, but not exclusively, for transition plans.
- Because the bulk of cancellations are by carriers who are remaining in the marketplace and are required to offer consumers the option of purchasing any other plan offered by the carrier, as well as the opportunity to use a special enrollment period to seek coverage from another carrier, we expect any disruption in the market to be manageable by the carriers as they compete for market share.

Formatted

Adverse Selection due to Specialty Drug Coverage

Senator Aguilar asked whether we are seeing adverse selection due to specialty drug coverage.

- In 2014, very few plans had a specialty drug copay. These plans were adversely selected against, and for 2015, changed from a copay to a coinsurance requirement.
- Beginning in May 2014, the Division of Insurance facilitated a number of meetings regarding specialty drug issues – primarily the impact high deductible health plans have on consumers using specialty drugs in the early months of a new year requiring the satisfaction of a new deductible before benefits are payable. At these meetings were consumer advocacy groups, carriers, pharmacy representatives, among others.
- Based on these discussions, the Division published a bulletin (B-4.82) which asked carriers to ensure that at least 25% of their 2016 array of plans include the specified copay parameters for specialty drugs without a deductible. This will provide consumers with more choices and minimize the financial impact. It should also help minimize adverse selection for carriers.

Third Party payment of premiums

Senator Aguilar asked whether there is law to address the issue of providers paying for, or contributing to the payment of, a consumer's premiums.

- At this point, there is not in Colorado health insurance law, an “insurable interest” requirement to prohibit a provider from paying for or contributing to the payment of a patient’s premium.
- The federal government has put out FAQs (frequently asked questions) in which they “discourage this practice and encourage insurers to reject such third party payments.”
- It later qualified this by saying the prior FAQ does not apply to payments from private, not-for-profit foundations on behalf of an enrollee if they “satisfy defined criteria that are based on financial status and do not consider enrollee’s health status.” This “exception” was to recognize payments made by the Ryan White program, Indian tribes and tribal organizations, and State and Federal government programs.
- On the particular issue of ESRD (end stage renal disease requiring dialysis), the Federal Government issued another FAQ which provides:
 - Individuals with ESRD are not required to sign up for Medicare;
 - Individuals who do not have Medicare Part A or Part B can enroll or maintain individual commercial coverage;

- Individuals may be eligible for Advance Payment Tax Credits (APTC) if they have not yet requested or received a determination of eligibility for Medicare due to a diagnosis of ESRD; and
- Individuals with ESRD who are currently enrolled in Medicare generally cannot disenroll from Medicare prospectively.

How the Guaranty Fund Works

Senator Roberts asked for information about how the guaranty fund works in the event a company becomes insolvent.

- The guaranty fund protects all Colorado residents, regardless of where they lived when they purchased the policy, so long as they are currently a Colorado resident and the insurer was licensed to sell products in Colorado.
- For basic hospital, medical-surgical or major medical insurance, there is a \$500,000 limit on what the guaranty fund will pay for any one individual.
- The guaranty fund can arrange to continue the coverage and pay claims, and the consumer will still need to pay premiums.
- If there were to be a shortfall in the available funds, the guaranty fund can assess its members (all the other carriers writing hospital, medical-surgical or major medical insurance) to cover the bills not covered by the insolvent carrier.
- For major medical plans, if a carrier becomes insolvent, the involuntary loss of coverage would trigger a special enrollment period for policyholders. The guaranty fund would cover, if needed, the claims incurred up to the termination date or while it continues the coverage.

Colorado Health Op (Co-op)

Senator Sias asked for information about Colorado Health OP.

- The Health-OP currently meets the minimum capital and surplus requirements of the Division and State law.
- From the Division's discussions with the Health-Op, it is on track with its growth projections, with 85,000 members.
- It was necessary for it to grow, as it needed a larger pool of members to spread the risk.
- The Health-Op updates its projections monthly as new data comes in.
- For the Health-Op, their claims experience has been very different for 2015, thus far, than in 2014. Their membership has grown in 2015 while per member claim amounts have decreased from what they were in 2014.
- The Division is meeting with the Health-Op regularly to ensure everything is staying on track. The Division would have such a relationship with any start-up health insurance company.

Premium Increases

Anticipating questions about the 2016 rates:

- Rates filed for 2016 are proposed rates. The Division of Insurance is currently reviewing the rates to ensure they comply with Colorado law.
- We received comments on a number of rate filings from individuals and groups. As part of our rate review, rates are reviewed in conjunction with the carrier's financial statements. One commentator questioned a large rate increase for a carrier. When we looked at the carrier's financial statements, we found that the carrier had a loss ratio of 135%, meaning for every dollar it received in premium it paid out an average of \$1.35 in claims. We also found that in the last 2 years it has lost money, and not insubstantial sums. We factor these considerations into our analysis of the rate request before making a decision on it.