Colorado Consumer
Health Initiative

July 6, 2015

Commissioner Marguerite Salazar
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202

Re: Market Considerations for 2016 Health Insurer Rate Filings in Colorado

Dear Commissioner Salazar:

Attached is a report prepared for the Colorado Consumer Health Initiative by former Missouri Commissioner of Insurance and Health and Human Services Region 7 Director Jay Angoff. This report examines several market-wide factors in Colorado, occurring due to the continued implementation of the Affordable Care Act, that are creating downward pressure on the cost of health insurance.

We believe that health insurers' filings should explicitly address how they factored the impact of these market trends into the development of their rates. Failure to explicitly address the trends could result in excessive and unjustified costs being passed onto consumers in Colorado.

Thank you for the opportunity to comment on the proposed health insurance rate increases.

Sincerely,

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Considerations Regarding Health Insurers' Rate Filings in Colorado for 2016

I. Introduction

The proposed rate increases for 2016 in Colorado are not as high as they are in many other states. Nevertheless, several assumptions insurers have made regarding their 2016 rates for Colorado are unreasonable, and have resulted in higher proposed rates than the Commissioner should approve. Most significant, several insurers have assumed that the health status of those they will insure in 2016 will be worse than that of those they insured in 2014. This assumption is at odds with the industry's consistently having said that the least healthy people would sign up first, since if the least healthy sign up first--i.e. in 2014--it necessarily follows that those who sign up in later years will be more healthy than those who signed up in 2014. Some insurers acknowledge this point in theory, but then do not meaningfully apply it in their filings; other insurers disregard it entirely.

While less significant, the insurers' assumptions regarding trend; the 3 R's--the risk-adjustment, reinsurance, and risk corridor programs; contribution to surplus or risk margin; and the ACA's health care delivery reforms can also contribute to unreasonably high proposed increases.

Finally, the insurers generally do not explain the rationale for the assumptions they've made, or for the specific numbers they have chosen. In order for the public, and the Commissioner, to evaluate the reasonableness of those assumptions, the rationale on which they are based must be disclosed.

II. 2016 Enrollee Health Status v. 2014 Enrollee Health Status

A. Failure to recognize the factors causing the health status of 2016 insureds to be more favorable than that of 2014 insureds, and to quantify the effect of those factors in the rate filing

The industry has unanimously and reasonably expressed the view that the least healthy people would sign up first--i.e., in 2014--thus necessarily resulting in a healthier and less expensive pool of enrollees in 2015 and 2016. For example, the American Academy of Actuaries advised in 2014 that "In general, higher-cost individuals are more likely to enroll early during the open enrollment period and in the first year of the program."[1] Similarly, Wakely Consulting Group, which prepares rate filings for several insurers, concluded in a white paper it issued in March 2015 that "there is general consensus that the remaining uninsured population who may take-up insurance in 2016 is generally healthier than the population of previously uninsured individuals who have already entered the market…."[2] The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) also agree: in a 2014 report they say they "anticipate that exchange enrollees in the future will be healthier, on average, than the smaller number of people who are obtaining such coverage in 2014."[3]

Moreover, not only are those signing up in 2016 likely to be healthier, on average, than those signing up in 2014, but many more people--and thus many more healthy people--are likely to sign up in 2016 than 2014: the CBO projects that under the ACA enrollment will increase from 6 million in 2014 to 25 million in 2016, thus resulting in the percentage of people with

[1] Amer. Academy of Actuaries, Drivers of 2015 Health Insurance Premium Changes, at 2 (2014).

[2] Wakely Consulting Group, Considerations for 2016 Health Insurance Rate Development, Rate Filing, and Rate Review, March 2015, at 6.

[3] Congressional Budget Office, Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014, at 7.

health insurance coverage rising from 80% prior to the ACA taking effect to 84% in 2014 and 89% in 2016.[4]

Some insurers have acknowledged that the health status of the insured pool will improve in 2016. For example, in its Missouri rate filing for 2016, Blue Cross of Kansas City projects that in 2016 its "morbidity will improve by approximately 24% as compared to the 2014 experience."[5] The Colorado carriers, however, have generally not assumed that the health status of their enrollees will improve in 2016 but instead have assumed that morbidity would remain unchanged or deteriorate.[6] So assuming is not reasonable, and is inconsistent with the industry's continued insistence that the less healthy would sign up first in a guarantee-issue environment. In addition, some insurers have declined to disclose their morbidity assumptions.[7]

Further, improvement in the health status of the insured pool between 2014 and 2016 should be greater in Colorado than in many other states, since Colorado is one of the minority of states which permitted insurers to continue to renew plans that did not comply with the ACA, and many of those people will be entering the Exchange market in 2016. The 74,811 Coloradans currently enrolled in non-ACA compliant individual plans should be overwhelmingly healthy, since at the time they bought their policies – prior to 2014, when the ACA's guarantee-issue mandate kicked in – insurers were permitted to decline people based on health status. In addition, some of the people who have been insured under grandfathered policies--those in effect

[4] Id. at 6.

[5] Blue Cross of Kansas City Individual Rate Filing, at 11, available at ratereview.healthcare.gov.

[6] E.g., Rocky Mountain: "There are no new anticipated changes in the population morbidity"; Humana: proposed a -1% adjustment for new enrollees.

[7] E.g., Kaiser: Exhibit 6 detailing changes in morbidity was confidential; Colorado HealthOP: Exhibit D Morbidity Assumption was confidential; CIGNA: Morbidity adjustments redacted in filing.

when the ACA was enacted and which did not materially change their benefits--will be buying insurance through the Exchange in 2016. Those people, too, will be predominantly healthy because at the time they bought their policies insurers were permitted to decline the unhealthy.

A just-released study strongly supports the proposition that post-2014 enrollees have lower health care costs than 2014 enrollees. Express Scripts reported last week that Exchange plan costs were 36% lower per member per month in the first quarter of 2015 than they were in the first quarter of 2014.[8] Express Scripts also found that the number of new Exchange plan enrollees who used at least one prescription drug in 2015 declined by 18% compared to Q1 2014; that new Exchange enrollees in Q1 2015 had 34% fewer adjusted specialty pharmacy claims than did enrollees in Q1 2014; and that new enrollees in 2015 were four years younger than were 2014 enrollees. Insurers' assumptions that claims costs in 2016 will be higher than they were in 2014 are particularly difficult to justify in the face of this study.

B. The effect of the substantially increased penalty for not buying insurance in 2016

The Colorado carriers also generally disregard the effect of the substantially higher penalty for not buying insurance that kicks in in 2016.[9] In 2014, people who didn't buy insurance had to pay a penalty of the greater of $95 or 1% of income; that penalty was widely dismissed as insufficient to have any real effect.[10] In 2016, however, the penalty increases

[8] http://lab.express-scripts.com/Insights/Government-Programs/First-Look-2015-Public-Exchange-Plan-Rx-Trends; see also http://www.bloomberg.com/news/articles/2015-07-01/obamacare-customers-get-younger-as-drug-costs-fall-study-finds.

[9] Filings in the individual market that do not mention the strengthened individual mandate include Kaiser, Colorado HealthOP, Rocky Mountain HMO, United, and Anthem.

[10] *See e.g.*, http://www.miamiherald.com/news/local/community/miami-dade/article21105861.html ("The Obamacare fee is still small enough this year [in 2014]…to make it worthwhile for people…to opt out of health coverage."); http://www.thefiscaltimes.com/Articles/2014/02/11/Obamacare-Penalty-4-Things-

substantially: people who don't buy insurance will have to pay a penalty of either $695 or 2.5% of income – $875 on an income of $35,000.[11] Thus, due to the generous subsidies available through the Exchange, many healthy young people will have a choice between paying a penalty of $700 or $900 or so and getting nothing, or paying only a little more and getting decent insurance. The latter is the economically rational decision, and a substantial percentage of healthy young people can reasonably be expected to make that decision. Moreover, based on the new Express Scripts data, it appears that they have in fact been making that decision in 2015, during which the penalty for not buying insurance--the greater of $325 or 2% of income--has been higher than it was in 2014, but not nearly as high as it will be in 2016.

A New England Journal of Medicine study has quantified the effect of the increasing penalty. That study looked at the effect on enrollee health status of the penalty for not buying insurance that was phased in under the Massachusetts health reform law, which is the model for the ACA. Specifically, it looked at the health status of the people buying coverage through the Massachusetts Exchange before July 1, 2007, when there was no penalty; between July and November 2007, when there was a $219 penalty; and from December 2007 through mid-2008, when the law was fully effective and there was a $900 penalty, pro-rated for the number of months of coverage the insured had during the year. The study found that those who signed up when there was no penalty for not signing up "were nearly 4 years older, were almost 50% more likely to be chronically ill, and had about 45% higher health care costs than those who signed up once the program was fully effective." It also concluded, "when the mandate became fully

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You-Don-t-Know ("Since the cost of the Obamacare penalty is relatively low this year [2014], more Americans may choose to forego insurance and simply pay the fee.")

[11] "Income" for purposes of calculating the penalty is defined as adjusted gross income in excess of the threshold for mandatory tax filing.

effective at the end of 2007, there was an enormous increase in the number of healthy enrollees and a far smaller bump in the enrollment of people with chronic illness."[12]

Notably, each of the three stages of penalty in Massachusetts – no penalty, $219, and $900 pro-rated monthly – is in the same general range as its corresponding penalty under the ACA. Moreover, because the subsidies people receive under the Massachusetts system are substantially greater than those authorized by the ACA, the study concluded that mandating coverage, and thus penalizing the failure to obtain coverage, "might well play an even larger role in encouraging the healthy to participate in health insurance markets nationally than it has in Massachusetts."[13] In other words, the ACA penalty might have an even greater effect on getting healthy people to sign up for insurance than it did in Massachusetts.

Reasonable people can certainly disagree about the magnitude of the effect of the higher penalty in 2016, and about the implications of the differences between the Massachusetts system and the ACA. To ignore the entire issue, however, as the Colorado carriers appear to have done, is not reasonable.

C. Pent-up demand

The industry has also assumed, and reasonably so, that the people enrolling in 2014 who were previously uninsured not only had relatively poor health status resulting in higher than average costs over the long run, but also had declined to get treatment for their health conditions in the past because they had no insurance to cover the cost of such treatments. In seeking to justify the increase it was seeking for 2014, for example, Blue Cross of Arkansas noted that "it is clear that a pent up demand existed for medical services – most likely from individuals who

[12] The Importance of the Individual Mandate – Evidence from Massachusetts, http://www.nejm.org/doi/pdf/10.1056/NEJMp1013067, at 295.

[13] *Id.*

previously couldn't afford such care."[14] Therefore, as the former CCIIO Chief Actuary explained in 2014, "Most actuaries priced for this higher utilization when they set 2014 premiums, but they are likely to project a smaller impact from this factor for 2015. Consumers with these high initial needs would have obtained services early in 2014 and there should be disproportionately fewer enrollees with unmet health needs in 2015, assuming those with the most pressing needs enrolled in 2014."[15] Or as the Society of Actuaries advised in a new report published in April 2015, "A facet of pent-up demand is that it does not persist. Once the initial surge in use has passed, the behavior of the population should subside into a more persistent, long-term pattern."[16] The claims costs of the people the Colorado carriers insured in 2014 should therefore not be as high after 2014 as they were in 2014.

A 2014 UCLA study quantifies the effect of pent-up demand on Emergency Room visits by people in California's Low Income Health Program who had not previously used county services. In the first three months they were in the program, there were 600 ER visits per 1,000 employees. That rate declined rapidly during the first year of the program, remained relatively constant during the second year, and reached a low of 183 per 1,000 at the end of the second year. Over the first two years of the program, therefore, ER visits per 1,000 declined from 600 to 183 per 1,000, or by 70%.[17]

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[14] Arkansas Blue Cross and Blue Shield Part II, Reason for Requesting Rate Increase, http://www.arkansasbluecross.com/doclib/documents/members/rate%20increase%20notification%20for%20metallic%20policies.pdf.

[15] John Bertko, What to Expect for 2015 ACA Premiums: An Actuary Opens the Black Box, at 2, NIHCM Foundation (May 2014).

[16] Society of Actuaries, Indications of Pent-up Demand, April 2015, at 5.

[17] Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California's Low Income Health Program, http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/Demand_PB_FINAL_10-8-14.pdf, pg. 3.

Alone among the major Colorado carriers, the Colorado HealthOP reflects in its rate filing some effect due to the fulfillment of pent-up demand, although it is much less significant than that found by the UCLA study: it assumes that the release of pent-up demand in 2014 will reduce 2016 claims costs by 15%, relying on a study (which it doesn't cite) of the Massachusetts health care reform that showed 18% pent-up demand in the first year of reform.

Just as with the effect of the higher penalty for not having insurance in 2016, reasonable people can disagree about the magnitude of the effect of pent-up demand, and about the extent to which the results of any given study may properly be extrapolated to Colorado's insureds who would be affected by the proposed increase. But completely disregarding the effect of pent-up demand and any studies that have quantified it – as the major Colorado carriers with the exception of the Colorado HealthOP appear to have done – is unreasonable.

III. Trend

Trend is the rate of change in health care costs, and it includes both the change in cost per service and the change in utilization of services, i.e., the extent to which people are using more or fewer services. The trends used by the major Colorado carriers are fairly close to each other. Humana uses trends of between 5.9% and 6.2%; Colorado HealthOp uses 6.6%, which it says is the average of the trends used by Colorado Choice, Denver Health, Kaiser, and New Health Ventures; and Rocky Mountain uses 10.7% for two years, which equals about 5.2% annually. Kaiser is slightly lower, at 4.3%, which one would expect based on Kaiser's greater ability to control costs due to its status as a staff-model HMO.

These trends can be criticized, because they are all higher than the 4% annual increase in national health expenditures that has occurred since the ACA was enacted, and because all but Kaiser's trend are above the average medical trend rates in the individual market in 2012

(5.02%) and 2013 (4.56%) reported in the 2014 Colorado Health Care Cost Report. A greater concern, however, is whether the combination of trend and increased morbidity results in double counting: specifically, part of the increase in the insurers' projected claims costs may be attributed to the insurers' enrollees being in worse health, and thus should not also be included in trend. The Department should therefore closely scrutinize the basis for the insurers' morbidity- and trend-related assumptions to determine the extent, if any, to which trend has already been accounted for by the increase in morbidity the insurer has assumed.

V. The 3 R's

The so-called "3R's" (risk-adjustment, reinsurance, and risk corridors) ensure that if an individual market insurer pays out more than it had projected, taxpayers and other insurers will end up paying for most, if not all, of the difference. Under the risk-adjustment program, an individual-market insurer that receives worse risks than average gets paid by other insurers in the individual market; under the reinsurance program all individual-market insurers get paid by individual and group insurers and self-insured group administrators for a substantial portion of their large claims; and under the risk corridor program all individual-market insurers get paid by the taxpayers if their claims costs turn out to be significantly higher than they projected.

Insurers generally reflect in their rate filings both the payments they say they are likely to receive under the reinsurance program, and the payments they say they are likely to either receive or make under the risk-adjustment program. However, they generally disregard entirely the effect of the risk-corridor program, which pays for 50% of any losses above 3% of the company's target amount, and 80% of any losses above 8% of that amount. The argument in favor of disregarding any such effect is that Congress has passed a resolution prohibiting HHS

from making risk corridor payments to the extent that those payments would exceed what HHS has collected in such payments.[18]

As enacted, however, the risk-corridor program clearly is not revenue neutral: i.e., if the government owes insurers more than the insurers owe the government under it, the government is on the hook for the difference.[19] Moreover, HHS has stated several times that one way or another insurers will be paid what they are owed under the program--and that if for any year HHS owes insurers more than they owe HHS, HHS will pay the insurers by borrowing against the next year's funds or using money from another account.[20] Thus, while reasonable people can disagree about the likely effect of the risk-corridor program, it is unreasonable to take the position that the program definitely will have no effect, as the Colorado carriers have been doing in disregarding it in their rate filings.

The carriers may also be understating the benefits they will receive as a result of the reinsurance program--not intentionally, necessarily, but because HHS has a record of ultimately establishing a reinsurance threshold lower than the one it originally announced, thus enabling the carriers to receive higher reinsurance payments than they would under the originally-announced threshold. For example, for 2014 HHS originally established a reinsurance threshold of $60,000

[18] Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113-235, §227. Available at https://www.congress.gov/bill/113th-congress/house-bill/83.

[19] See ACA §1342(a)(b)(1)(A)-(B), which requires the Secretary to reimburse insurers that have qualifying losses regardless of whether other insurers have qualifying gains. ("If a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and if a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.")

[20] See, e.g., 79 Fed. Reg. 30243; HHS Guidance "Risk Corridors and Budget Neutrality" 4/11/14. *Available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

but then reduced it to $45,000; and for 2015 HHS originally authorized an increase in the threshold to $70,000, but then decided to keep it at $45,000.[21] And just two weeks ago HHS announced that the reinsurance program would pay insurers 100% of all claims they paid in 2014 between the $45,000 threshold and $250,000, rather than the 80% HHS had originally announced and that insurers had assumed in their filings.[22] The Commissioner may wish to require insurers to issue refunds to their enrollees to the extent that the premiums they paid included amounts that the insurers have now received reinsurance payments for. Those refunds would include both the additional amount any insurer received because it assumed a higher reinsurance threshold than HHS actually implemented, and the additional 20% payment from the reinsurance program that HHS just announced.

V. Contribution to surplus or risk margin

Insurers routinely include a specific provision for profit in their rates, which they often characterize as "contribution to surplus" or "risk margin." The rationale for including an extra provision for risk margin is that the insurer should include in the rate an extra allowance in case it ends up paying out more than it assumed it would in its rate filing. As explained in the preceding section, however, the 3 R's ensure that if an insurer pays out more than it had projected, taxpayers and other insurers will end up paying for most, if not all, of the difference. Thus, even if an additional factor for risk margin were acceptable in the past, it is clearly not acceptable today: the 3R's essentially guarantee that insurers will not suffer significant losses.

[21] HHS Notice of Payment and Benefit Parameters for 2016. 80 Fed. Reg. 10777 (February 27, 2015). *Available at* http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

[22] CMS, Transition Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year, June 17, 2015, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RI-Payments-National-Proration-Memo-With-Numbers-6-17-15.pdf.

Relatedly, to what extent should a contribution to surplus be permissible in today's insurance market? Surplus is the extra cushion an insurer holds above and beyond the amount it has set aside to pay claims, and including a provision characterized as "contribution to surplus" serves the same purpose as a provision characterized as a risk margin: it is an extra amount to protect policyholders if the insurer pays out more than it has projected. The NAIC has developed a formula that produces a minimum level of surplus for each insurer. The states have traditionally required insurers to hold 200% of that minimum level – in insurance jargon, to have an RBC ratio (for "risk-based capital") of 200% -- and the Blue Cross Association requires all Blue plans to have an RBC ratio of at least 375%. These are minimums, not maximums; the NAIC has never established maximum RBC ratios. Nevertheless, beyond some point additional surplus is not necessary to protect policyholders. Moreover, while in for-profit companies surplus is presumably reflected in the value of the company's stock, non-profit carriers have no shareholders, and thus beyond the level at which surplus is necessary to protect policyholders its accumulation by a non-profit serves no legitimate policy goal. There is therefore a strong argument that the Commissioner should not approve any contribution to surplus factor for any non-profit insurer whose surplus is already at a sufficient level.

VI. The ACA's health-care delivery system reforms

The ACA contains several delivery system reforms designed to reduce underlying healthcare costs, including mandatory penalties for hospitals with high readmission rates, Accountable Care Organizations (ACOs), bundled payments, value-based purchasing, Patient-Centered Medical Homes, and the Comprehensive Primary Care Initiative. In addition, the ACA established the HHS Prevention and Public Health Fund, which has made grants of

more than $5 billion to support various prevention and immunization programs. While the long-term effect of these reforms and grant programs won't be known for several years, the ACA has been in effect now for five years, and studies have been done on the effectiveness of its delivery system reforms and programs.[23] Based on the available evidence, there is a credible argument that at least some of these reforms and programs have already reduced healthcare costs in certain areas and/or are likely to do so in the near future.

[23] See, e.g., Commonwealth Fund, The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years, May 2015.