America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway, #110
Denver, CO 80202

RE: Comments Regarding the Draft Report for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway:

I write today on behalf of America's Health Insurance Plans (AHIP)[1] to provide feedback on behalf of our member companies regarding the draft report for Colorado's State Coverage Option. We appreciate the opportunity to comment and look forward to working with the Department of Health Care Policy and Financing (HCPF) and the Division of Insurance (DOI) to find the best path forward to provide access to affordable health care to all Coloradans.

As the draft report recognizes, our members have the knowledge and infrastructure to achieve the best value for their enrollees. We applaud the DOI and HCPF's willingness to address plan affordability while protecting market stability. We are similarly appreciative of the draft proposal's contemplation of the incorporation of innovative, value-based payment reforms. Our members have been leaders in developing payment arrangements that align reimbursement with enhanced quality.

However, we have significant concerns regarding several other aspects of the proposal. We believe that the draft proposal will not meet the state's goals of improving affordability, access, plan choice, and competition. The implementation of a coverage option, as proposed, would actually decrease competition, innovation, and choice overall as well as reduce the total federal premium subsidies available for Colorado consumers. We appreciate the state's effort to address

[1] AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers. Our members provide a range of products to millions of consumers, including major medical coverage, disability income insurance, dental insurance, LTCI, reinsurance, pharmacy benefits, and administrative services for self-funded health plans.

affordability, and we want to work with the state to develop policy alternatives that will further bolster market stability, increase coverage rates, and improve overall affordability. To that end, we offer the following feedback on several of our concerns.

Mandated Carrier Participation Will Have an Adverse Effect on all Aspects of Colorado's Health Insurance Market

Overall competition in Colorado's individual market is strong; however, mandated participation runs the risk of destabilizing the market by making continued participation in Colorado's market less sustainable for some plans and less feasible for plans that may otherwise wish to enter. Each individual plan is in the best position to decide if its financial and market position can sustain adding a state option plan offering to its existing offerings. Our members have spent years pursuing strategies to enable them to compete in the regions in which they operate, and to address the needs of consumers within those regions. This proposal would undercut those efforts. It would require carriers to go beyond areas of traditional experience and expertise to invest in networks and services in new areas and develop strategies to address consumer needs that they may not be familiar with. All of this would entail significant costs. While the thresholds for mandated carrier participation in the state option plan have not yet been established, we are concerned this proposal may have significant unintended consequences, including reductions in market participation and significant added cost.

Additionally, we are concerned that the proposed state plan offering risks creating an unlevel playing field. Fundamentally, compelling participation — especially into new markets and regions — risks creating market disruption and the reduction of consumer choice in Colorado — exacerbating a problem which the state option proposal seeks to remedy.

Capped Reimbursement Rates Reward Volume Over Value and Risks Destabilizing the Non-State Option Markets

Adding products to the market that include price controls on health care providers poses a danger to both choice and competition in the individual market. The well-documented phenomenon of cost-shifting makes it likely that consumers of non-state option plans will bear the cost of the rate reductions mandated in the state option plans. This will likely to raise prices for consumers of those plans and threaten the viability of such plans going forward.

The combination of these factors is likely to create a textbook example of an unlevel playing field, with state option plans having the advantage of government-controlled rates, and the non-state-option plans bearing ever higher costs shifted by providers away from such plans. For consumers to benefit from choice and competition, there needs to be a level playing field for all

carriers in all markets who want to offer products to individuals and families purchasing coverage.

The market damage caused by capped reimbursement in the state option plans will not be limited to the individual market. Higher reimbursement rates charged by facilities and providers seeking to shift lost revenue will place upward pressure on premiums for small and large employer groups, and self-insured plans — where the vast majority of the state gets coverage. Any health care solution, including the state option plan, should not increase rates for those remaining in individual, small group, large group, or ERISA plans.

The state option plan discusses the need for carriers to utilize value-based payments to reward providers who achieve quality and pricing targets. AHIP supports improving quality through value-based payments. However, under a Medicare-linked capped reimbursement model, there is no room to negotiate or reward quality because the payment rate is linked to a fee-for-service methodology. A capped rate in a fee-for-service system, as this option proposes, drives up overall health care costs while at the same time leaving no room to provide the right incentives to improve quality of care or lower overall costs. This is not mere conjecture as we have seen this in other markets. For example, in the state of Montana:

> *Montana's State Employee Plan implemented a flat-fee pricing methodology for medical services at a payment rate of approximately 234% of Medicare rates for reimbursement of hospital claims and the majority of hospitals in the state contracted to accept this rate.*[2] *This policy initially resulted in savings for the state plan. However, in the years since the state plan implemented this reimbursement model, costs have continued to rise. Overall, 2018 resulted in a $2.3 million loss and plan expenses are expected to exceed revenues in 2020 and 2021.*[3] *Per member per month (PMPM) spending on medical claims in 2018* ***increased by 11.2%*** *over 2017.*[4] *These increases in medical cost trend for the state plan are in stark contrast to the national medical cost trend, which has remained steady at 5.7% in 2018 and 2019.*[5] *Additionally, the average high cost claim was approximately* ***$235,000, which is higher than the previous 6 years' average***.[6]

[2] NAIC Health Innovations (B) Working Group 2019 Summer National Meeting, page 35. August 3, 2019. Available at https://www.naic.org/meetings1908/cmte_b_health_inn_wg_2019_summer_nm_materials.pdf.
[3] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, May 22, 2019, page 3.
[4] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, March 28, 2019, page 2.
[5] "Medical cost trend: Behind the numbers 2020," page 3. June 2019. PricewaterhouseCoopers' Health Research Institute. Available at https://www.pwc.com/us/en/industries/health-industries/assets/pwc-hri-behind-the-numbers-2020.pdf.
[6] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, May 22, 2019, page 3.

While more is to be learned to fully understand the Montana story, it is clear that simply capping rates has not resulted in long-term savings. Given the critical nature of assuring the lowest cost and highest quality care be available to Colorado residents, we are deeply concerned that a similar fact pattern would result from the proposed state option.

Raising the Medical Loss Ratio (MLR) Could Raise Costs and Reduce Vital Consumer Services

The Affordable Care Act (ACA) included requirements for carriers to spend 80 cents of every premium dollar in the individual market on medical care and quality improvement activities. The ACA's MLR requirements are working, and consumers have benefited from MLR rebates in instances when a carrier does not meet the required MLR threshold. Carriers are also required to meet state and federal regulatory requirements and provide important consumer services that improve customer care – nearly all of which are not counted as medical care under the MLR.

Examples of these "administrative costs" include (varies by market segment):

- Network engagement with provider recruitment and retention, negotiations with doctors, hospitals, and pharmaceutical companies, and timely payment of claims;
- Customer services, including call centers, interactive websites, mobile apps, cost transparency tools, provider directories, medical interpreters, and translation services;
- Clinical experts to ensure patients receive evidence-based care and cost-effective treatments, 24/7 nurse advice lines, and Pharmacy & Therapeutics Committees to review drug safety and use; and
- National certifications and accreditations (NCQA, URAC, etc.), quality reporting, regulatory audits and surveys, and other regulatory requirements such as rate filings, annual reports, actuarial analyses, and fraud, waste, and abuse prevention, detection, and correction.

Recognizing that, on average, only 2.7 cents of every premium dollar goes to net profit,[7] carriers would still be required to meet all their statutory obligations under a higher MLR. Premium rates must be actuarially sound and account for total health plan spending. Raising the MLR does not automatically equate to lower overhead costs, it just changes the ratio between the delivery of medical care and the amount available to provide high-quality customer service, meet accreditation and regulatory requirements, and meet state mandated solvency requirements.

[7] "Where Does Your Premium Dollar Go?" America's Health Insurance Plans. March 2, 2017. Available at https://www.ahip.org/health-care-dollar/.

Additionally, federal regulations require states to demonstrate why a lower MLR would be necessary for market stabilization, but they also require states seeking to enact a ***higher*** MLR to demonstrate the need for and impact of such a change:

> *In adopting a higher minimum loss ratio than that set forth in §158.210, a State must seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.*[8]

As drafted, we do not believe the state option meets these prerequisites. By making it more difficult for carriers to perform their required administrative functions, this proposal discourages, rather than encourages, innovation, competition, and choice. We strongly urge the state to maintain the MLR requirements outlined in the ACA.

The Underlying Drivers of Health Care Costs Need to be Adequately Addressed

Rather than capping the reimbursement rate to certain providers, the state's solutions should focus on the underlying cost drivers and market dynamics driving premium increases — prescription drug pricing, third party payments, monopolistic market behavior — including hospital acquisition of provider practices and provider consolidation, and other tactics that game the system to drive up costs. For example, recent research has shown that there is a correlation between increased provider and facility consolidation and integration and higher prices for physician and hospital services.[9] In addition, private equity firms are implementing business strategies to consolidate physician groups to generate higher revenue through market consolidation and aggressive contracting tactics.

Most importantly, this proposal ignores the single largest driver of health care costs – prescription drug prices. Nationally, prescription drugs represent the largest segment of commercial health care spending, making up more than 23% of commercial premiums.[10] These recommendations have no levers aimed at lowering the prices that drug makers set, which continue to increase year over year. There are no requirements on drugmakers to do anything under these proposals to be accountable for the prices they set. Regulating drug prices or cost-sharing through health plans or their PBM partners will not bring down prices, and in fact could increase drug prices and their impact on premiums.

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[8] 45 C.F.R. § 158.211

[9] Polyakova, Maria, M. Kate Bundorf, Daniel Kessler, and Laurence Baker. "ACA Marketplace Premiums and Competition Among Hospitals and Physician Practices." The American Journal of Managed Care, February 2018. Available at https://www.ajmc.com/journals/issue/2018/2018-vol24-n2/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices.

[10] "Where Does Your Premium Dollar Go?" America's Health Insurance Plans. March 2, 2017. Available at https://www.ahip.org/health-care-dollar/.

There are a number of alternative approaches that could more efficiently and directly address rising health care costs. For example, Colorado has already joined with private entities to address costs. Colorado's community-based purchasing alliance will be offering plans for the first time in 2020. Additionally, the state has been promoting an employer-based purchasing alliance, an effort that is in its infancy. AHIP's members are not necessarily endorsing these approaches, but we have yet to see the full impact of these programs and would urge the state to allow time for such programs to take effect before implementing anther significant reform. We are concerned that any positive gains achieved by these programs may be jeopardized by the implementation of a state option.

To tackle access and affordability issues, we need to build upon what works in Colorado and expand choice and competition through free-market solutions. For example, we know that well-crafted reinsurance programs can help stabilize the individual market. Colorado's newly implemented reinsurance program is being credited with lowering premiums for plan year 2020 by an average of 20.2% across Colorado. We must also seek to address the drivers of unit costs and overall consumer out-of-pocket costs, which increasingly create a barrier to accessing care. We look forward to working with the state on opportunities to address these affordability concerns without compromising market stability and consumer choice. To that end, we offer the following proposed solutions to lower premiums.

These proposals are adapted from a comprehensive list of 12 proposed solutions[11] supported by our members, and are based on three tested and proven methods for driving down the costs of premiums for consumers: reducing the cost of health care, offering premium savings to consumers, and increasing enrollment and retention to balance the pool of enrollees in the insurance marketplace.

The proposals in which Colorado policymakers can play a role include:

- **Reduce Surprise Medical Billing** by protecting patients from surprise medical bills and preventing unnecessary premium increases related to out-of-network care. The Colorado Legislature recently adopted surprise medical billing legislation that has not been fully implemented. This measure will save consumers money and bring predictability to carriers and consumers when fully implemented.
- **Curb Inappropriate Third-Party Premium Payments** by limiting the list of third-party entities from which carriers must accept premium and cost-sharing payments. Colorado

[11] "12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage." America's Health Insurance Plans. November 2018. Available at https://www.ahip.org/wp-content/uploads/2018/11/AHIP_AffordabilityWorkgroup-111518.pdf.

may also prohibit the use of copay coupons for brand-name drugs if there is a less expensive, equally effective alternative. These marketplace schemes seek to increase overall health care costs, thus increasing premiums for all.

- **Increase Drug Competition and Transparency** by requiring manufacturers to publish true R&D costs and explain price setting and price increases.
- **Create a State Premium Assistance Program** for individuals and families earning more than 400 percent of the federal poverty level.

AHIP shares your goals to make health care more affordable for Colorado residents. However, government rate setting, MLR adjustments, and mandatory participation are not solutions to address the underlying costs of health care in the state. Our members stand ready and eager to work with policymakers and other stakeholders to inform policy approaches to make coverage more affordable, but such efforts can and should be done in a way that strengthens the market and does not pose the risk of higher costs to consumers.

We appreciate this opportunity to comment and welcome the opportunity to remain engaged as this proposal is developed. Please contact Leanne Gassaway at lgassaway@ahip.org or (202) 861-6365 if you have any questions or concerns.

Sincerely,

Leanne Gassaway
SVP, State Affairs and Policy