AIS RISK CONSULTANTS, INC.

Consulting Actuaries • Insurance Advisors

4400 Route 9 South • Suite 1200 • Freehold, NJ 07728 • (732) 780-0330 • Fax (732) 780-2706

July 23, 2014

Ms. Debra Judy
Policy Director
Colorado Consumer Health Initiative
1536 Wynkoop Street, Ste 101
Denver, Colorado 80202

Re: Time Insurance Company
Individual Rate Filing Submitted on June 6, 2014
Proposed Rate Increase of 35.0%
SERFF Tracking No. ASPC-129568044

Dear Ms. Judy:

In accordance with your request, we have reviewed the above captioned individual rate filing by Time Insurance Company (TIC) submitted to the Colorado Department of Regulatory Agencies, Division of Insurance (CODOI) on June 6, 2014. The purpose of this document is to assist the Colorado Consumer Health Initiative (CCHI) in submitting comments on the TIC filing to the CODOI.[1] It should not be used for any other purpose. Our comments are based upon the information contained in the SERFF filing available from the CODOI website, as well as other publicly available documents.[2]

The TIC filing proposed an average rate increase of 35.0% with an implementation date requested of January 1, 2015.[3,4] The majority of the proposed increase comes from two factors – "Trend" with an impact of +9.5% and "Morbidity" with an impact of +19.0%.[5] These two items alone result in a 30.3% rate increase.[6] All the other factors combined account for a 3.6% rate increase.[7] Interestingly, the "Change in Baseline Experience" results in a rate decrease of -

[1] This would include CCHI submitting this letter to CODOI.

[2] These types of documents are commonly relied upon by actuaries and are generally considered reliable. However, we have not verified that the information contained in the filing or documents are accurate.

[3] TIC filing, Filing at a Glance and General Information Page

[4] The filing also proposes changing: (i) plan rating factors and (ii) geographical rating area factors. Reflecting these other changes, the range of rate changes by policyholder is from a minimum of +21.0% to a maximum of 60.0%.

[5] Actuarial Memorandum - A. Summary - 2. Requested Rate Action - Contributing Factors

[6] 1.095 X 1.190 = 1.303

[7] 1.350 / 1.303 = 1.036

1.5%.[8] That is, even though the actual historical experience has improved, TIC has added on other factors that result in the massive proposed rate increase of 35.0%

The total annual premium increase being requested is about $9.579 million.[9] The average annual premium increase per policyholder is about $2,743.[10] To put this is some perspective relative to other insurance costs, this proposed *increase* in premiums by TIC is about 50% more than the *total* premium paid by the average Colorado policyholder for private passenger and homeowners insurance combined on an annual basis.[11]

Our overall opinion is that the TIC filing was not adequately documented and can be expected to result in excessive rates being charged to Colorado policyholders.

Various concerns we have with the rate filing are:[12,13]

- Lack of Documentation of Ratemaking Factors
- Unsupported Risk Adjustment Factor
- Unsupported Morbidity Factor
- Excessive Loss Trends
- Cost Containment Issues
- Excessive Profit Provision
- Failure to Account for Reduction in Uncompensated / Charity Care

These items are discussed in more detail in the remainder of this letter.

---

[8] *Ibid*.

[9] TIC filing; Rate Information Page

[10] $9,579,304 / 3,492 (number of policyholders), TIC filing; Rate Information Page

[11] According to the NAIC, the Colorado average premium in 2011 for private passenger automobile insurance and homeowners insurance was $724 and $989, respectively. The combined value is $1,713. ($2,743 / $1,713 = 1.60) See NAIC publications "Auto Insurance Database Report 2010/2011" and "Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners Insurance: Data for 2011"

[12] If an issue in the rate filing is not discussed, that should not be taken to mean that we agree with the procedures used in the rate filing.

[13] Our analysis is based upon the information available to us. If additional information becomes available, that could impact our analysis.

1. Lack of Documentation of Ratemaking Factors

The rate filing by TIC that was made publicly available did not contain support for many of the factors used to calculate the rate change. In deriving the proposed rate change, TIC's projected rate period loss cost PMPM was increased by a huge amount relative to the historical value. TIC projected a "2015 PMPM Allowed Claims" that was 123% higher than the historical 2013 experience period value.[14] The various factors used by TIC to obtain this enormous increase were:

Trend:	Increase of 19.9%
Adjust Experience to 2013 Market Risk:	Increase of 13.6%
Adjust Experience to 2015 Market Risk:	Increase of 55.0%
Cost of Essential Benefits Not covered within Experience Data:	Increase of 3.5%
Adjust to Account for Additional USPSTF Preventative Items:	Increase of 1.0%
Adjust to Account for the Pent Up Demand of Uninsured:	Increase of 0.5%
Adjust Experience for Expected Change in Network Discounts:	Increase of 0.5%
Combined Value:	Increase of 123.1%

The combined value of a 123.1% increase used in the current filing is a significant change from the 75.9% value used in the prior filing to adjust the historical experience to a prospective basis.[15] This combined change in the assumed values from the prior filing to the current filing results in an increase of 26.8%.[16] Without these changes in assumptions, the indicated rate change from the current filing would be 6.5%.[17,18]

---

[14] $583.00 / $261.36 = 2.231; Appendix A: Market Adjusted Index Rate Development – Lines M and D

[15] $467.49 / $265.77 = 1.759; Appendix A: Base Rate Development – Lines M and D, prior TIC filing, SERFF Tracking #: ASWX-G129048379, State Tracking #: 278708

[16] 2.231 / 1.759 = 1.268

[17] 1.350 / 1.268 = 1.065

[18] This should not be taken to mean we agree with the assumptions used by TIC in either the current or prior filing. For example, both of those TIC filings included excessive values for the loss trend.

While an actuarial memorandum was included in the TIC filing, it provided only vague statements about the methods and some of the factors used in the analysis. TIC did not request that the underlying data, analysis, calculations and support for these various factors be kept confidential.[19] Instead, the TIC filing simply did not provide the details and adequate justification for the various factors used.

The lack of information in the filing appears to be contrary to the intent of CODOI Regulation 4-2-11 which states in part:

> Section 6 Actuarial Memorandum
>
> K. Complete Explanation as to How the Proposed Rates were Determined: The memorandum must contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption.

Given the huge number of pricing assumptions for which information was not provided in the filing, it is quite clear that the ability of Colorado policyholders to evaluate how the proposed rates were determined is seriously obstructed.

Actuarial Standards of Practice also address the issue of disclosure as follows[20]:

> 3.2 Actuarial Report
> …
> In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report.

The lack of information contained in the rate filing impedes the ability of another actuary to evaluate the TIC filing.

In summary, we believe that adequate documentation and support for many of the specific numerical ratemaking values and calculations used in the filing were not provided. We believe the CODOI should carefully consider whether this information should be disclosed to Colorado policyholders.

---

[19] A Vaughn Index was not included with the filing

[20] Actuarial Standard Of Practice No. 41, "Actuarial Communications", http://www.actuarialstandardsboard.org/asops.asp

2. Unsupported Risk Adjustment Factor

TIC applies a risk adjustment factor to increase its historical experience by 13.6%, stating "Our pricing was adjusted by a factor of 1.0/0.88 to represent the average actuarial risk, as shown in Appendix A."[21] This factor is related to the ACA Risk Adjustment Program. Instead of performing a rate analysis where TIC is a net payer into the program and that amount is included in the calculations, TIC increases its historical losses, allegedly to adjust its experience to a market average basis so that it will not be a net payer. Both methods, however, give the same result of a significant increase in rates.

The basis given for that 13.6% increase is "Assurant Health business practices (e.g. distribution methods and underwriting) and member selection patterns have created a book of experience with 12% lower costs."[22] That conclusion in turn is based (in part) upon a Wakely analysis "To establish this estimate, Assurant Health participated in the Wakely National Risk Adjustment Simulation Project (WNRASP)". [23]

There are several concerns regarding this. First, the Wakely study was not provided so it is not possible to evaluate whether the results of that study are reliable and whether there are potential concerns and problems involved in that study. Second, even assuming the Wakely study is reliable; there is no way to evaluate whether TIC applied the results of that study appropriately. Third, it appears that TIC did not use the results of that study directly, but made certain adjustments to it.[24] Given all these uncertainties about the Wakely study and how TIC applied it, there are serious concerns about whether it forms a reasonable basis to increase the premiums charged to Colorado policyholders by 13.6%.

Furthermore, it is also worth noting that TIC, in its prior filing[25], relied upon a Wakely study for this issue, and used a value only ½ as much "The final result for use in our pricing methodology was a 0.94 risk score. This indicates that Assurant Health business practices (e.g. distribution methods and underwriting) and member selection patterns have created a book of experience with 6% lower costs."[26] The change in this factor as used by TIC from the prior to current filing increases the rates by 6.8%.[27]

---

[21] Actuarial Memorandum and Certification – Section 5 - Projection Factors - Assurant Health to Market Average; 1.0 / 0.88 = 1.136; see also Appendix A: Market Adjusted Index Rate Development – Line G

[22] *Ibid.*

[23] *Ibid.*

[24] "To calculate an adjustment to account for including grandfathered experience we used the 2013 market to 2012 market risk score." *Ibid*.

[25] SERFF Tracking #: ASWX-G129048379, State Tracking #: 278708

[26] The equivalence between increasing the projected losses or including a factor for payments into the ACA Risk Adjustment Program can be seen from the statement in the prior TIC filing "Risk Adjustment: +6.4% (payments expected to the federal Risk Adjustment Program in 2014)."; 1 / 0.94 = 1.064

TIC has not provided adequate justification for this significant upward swing in its loss projection. No explanation was provided by TIC as to how the impact of this item can change so dramatically from one year to the next. This certainty casts serious doubt upon the reliability of the results provided by Wakely and the manner in which it was used by TIC. Furthermore, the fact the TIC did not provide the calculations underlying the risk adjustment figures also raises concerns about the dependability of the values provided.

In summary, TIC has not provided support for the increase to the incurred losses related to risk adjustment, either on a stand-alone basis, or relative to the much different results presented in the prior year's rate filing.

3. Unsupported Morbidity Factor

TIC applies an upward factor of 55% to reflect morbidity stating "Our final estimate is that the morbidity of the 2015 insured population in Colorado will increase by 55% over the morbidity of the pre-ACA insured population."[28] This is a very large adjustment which TIC has not supported. It also represents a huge increase from the provision for this item that TIC used in its prior filing "We have reviewed various scenarios and have determined a final estimate is that the morbidity of the insured population in Colorado will increase by 30%."[29] The basis given (in part) by TIC for using the 30% factor in the prior filing is "We utilized the data within the 'Cost of the Future Newly Insured under the Affordable Care Act (ACA)' study prepared by Optum Health and commissioned by the Society of Actuaries in order to assess possible scenarios and develop our assumption."[30] That Society of Actuaries study gave values for the "% Change in Non-Group PPMP" costs in Colorado of 35% to 39%.

The change in the numerical value assumed by TIC for the impact of morbidity from the prior to current filing increases the rate indication by 19.2%.[31] TIC has not explained why it is making this enormous change with regard to morbidity.

---

[27] 0.94 / 0.88 = 1.068

[28] Actuarial Memorandum and Certification – Section 5 - Projection Factors - Pre-reform Market to Post Reform Market; see also Appendix A: Market Adjusted Index Rate Development – Line H

[29] Actuarial Memorandum and Certification – Section 5 - Projection Factors - Changes in the Morbidity of the Insured Population; see also Appendix A: Base Rate Development – Line H; prior filing - SERFF Tracking #: ASWX-G129048379, State Tracking #: 278708

[30] *Ibid.*

[31] 1.55 / 1.30 = 1.192

Starting in 2014, insurers can no longer deny coverage due to pre-existing health conditions. It is generally accepted that this will result in an increase in the morbidity of the insured population in 2014 compared to prior years, although there is some uncertainty regarding the precise numerical impact.

However, during 2015, it is likely that the mix of customers enrolling in health coverage will be younger and healthier than those who signed up for 2014. This expected difference in the health status between the early enrollees in 2014 compared to later enrollees is a generally recognized actuarial concept, as expressed by the American Academy of Actuaries: "In general, higher-cost individuals are more likely to enroll early during the open enrollment period and in the first year of the program. Lower-cost individuals are more likely to enroll later during the open enrollment period and perhaps in later years as the individual mandate penalty increases."[32] Given this situation, it is unclear why TIC has assumed that there will be a further substantial morbidity increase in 2015 compared to 2014, over and above the increase in morbidity expected from 2013 to 2014 that has already been incorporated into the rates charged to Colorado policyholders.

In summary, TIC has not provided support for the assumed substantial increase in morbidity from 2014 to 2015. We believe the CODOI should evaluate this factor carefully to make sure Colorado policyholders are not being charged excessive premiums related to an unsupported projection of significant morbidity increases above that already reflected in rates.

4. Excessive Loss Trends

TIC used an overall annual loss trend of 9.5%. The filing states "The annual trend assumption is 9.5%."[33] This trend is inconsistent with reasonable expectations based upon broad industry experience.

This industry experience shows much lower trends than those used in the TIC filing as the following demonstrates:

The study *National trends in prescription drug expenditures and projections for 2014* gives a range for "a projected 3–5% increase in total drug expenditures across all settings".[34]

According to CMS "Health spending is projected to grow at an average rate of 5.8 percent from 2012-2022", "In 2014, hospital spending growth is projected to be 4.7 percent", "In

[32] "Drivers of 2015 Health Insurance Premium Changes," http://www.actuary.org/content/actuaries-shed-light-2015-health-insurance-premium-changes

[33] Rate Review Detail

[34] www.ashpmedia.org/AJHP/DrugExpenditures-2014.pdf

2015, hospital spending is projected to increase 5.6 percent", "In 2014, physician and clinical services spending growth is projected to be 7.1 percent", "For 2015 through 2018, average growth in physician and clinical services is expected to be 5.5 percent per year", "Projected prescription drug spending growth for 2014 is 5.2 percent" and "For 2015 through 2022 … 6.5 percent per year".[35]

Express Scripts (a pharmacy benefit manager) publishes a drug trend report[36] which shows annual trends for 2014 and 2015 for traditional drugs of about 2% a year and for specialty drugs of about 17-18% a year. This gives an overall drug trend of about 7% a year.[37]

Altarum Institute has reported "Health care prices in May 2014 were 1.8% higher than in May 2013, compared with 1.6% in April, year-over-year. The May 2014 12-month moving average rose to 1.3% from 1.2% in April. Year over year, hospital prices – a key price index driver – grew 2.1% in May, equal to the April rate. Physician and clinical services prices grew 0.6%, again equal to the April rate, and home health care prices continued a two-month rebound from a yearlong negative growth trend, recording a 0.5% rate in May. Prescription drug prices rose 3.6%, jumping from the April 2.4% rate."[38]

Milliman stated the following regarding the 2014 Milliman Medical Index (MMI) "the 5.4% growth rate from 2013 to 2014 is the lowest annual change since the MMI was first calculated in 2002."[39]

While TIC provided some trend values in its filing, there were several problems what TIC supplied that makes it unreliable to evaluate the proposed rates. First, TIC did not provide Colorado loss trend experience. Instead TIC presented nationwide data "This trend was developed from historical experience of our nationwide block."[40] Second, the trend values provided by TIC were only summary figures without any of the underlying details, data or calculations.[41] This lack of supporting information hinders an analysis of the trends. Third, the

---

[35] National Health Expenditure Projections 2012-2022

[36] "The 2013 Drug Trend Report", April 2014; http://lab.express-scripts.com/drug-trend-report/introduction/year-in-review

[37] It should be noted that PBMs could have incentives to publish inflated drug trend projections. This could be used up-front as a marketing device to sell services to control drug costs, as well as afterwards to show that the actual costs using the PBM services was less than the projected value.

[38] Price Brief, July 10, 2014; http://altarum.org/our-work/cshs-health-sector-economic-indicators-briefs

[39] 2014 Milliman Medical Index report, http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/2014-mmi.pdf; Milliman is an actuarial firm often relied upon by health insurance companies

[40] Actuarial Memorandum and Certification – Section 5 - Projection Factors - Trend Factors (cost/utilization)

[41] Appendix B: Trend Exhibit

9.5% trend used by TIC includes an annual increase for utilization of 7.7%.[42] This very high projected increase in utilization of 16.0% from trend[43] during the two year period from 2013 to 2015 is unusual and suspect. For all these reasons, the trend information included in the TIC filing does not provide a suitable basis from which to determine an appropriate trend factor.

The trend used by TIC is excessive and will result in inflated rates being charged to Colorado policyholders.

5. Cost Containment Issues

Given the 35% rate increase proposed by TIC, along with the multitude of various factors TIC has included which increase the projected claims, a possible issue is whether TIC is taking reasonable steps to control health care costs.

This is a critical issue for not just TIC, but also other insurance companies, as well as health care providers. It has been estimated that about 30% of health care expenditures are wasted.[44] With rising costs making health care a significant financial burden for many people, CODOI can encourage all insurance companies to strengthen efforts to contain costs by cutting waste and focusing on prevention and other proven strategies that keep patients healthier. Various programs can be expected to control, and have reduced, health care costs.

Subjects such as the manner in which health care providers are compensated, along with the use of electronic health records / "big data" in improving outcomes and lowering costs are reasonable issues to consider. The July 2014 edition of Health Affairs has several articles dealing with the later issue as the following excerpts show. "Big data has the potential to improve clinical decision making at the point of care. Tapping into vast databases, a physician can access knowledge relevant to the individual patient, yielding better decisions and outcomes."[45] "Simultaneously, rapid progress has been made in clinical analytics—techniques

[42] Appendix B: Trend Exhibit and Actuarial Memorandum – J. Trend

[43] In addition to utilization increases from trend, the TIC filing includes other items which include even further increases in utilization – such as the factors to "Adjust Experience to 2013 Market Risk" and "Adjust Experience to 2015 Market Risk"

[44] Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (2012), available at http://iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx -- "Current waste diverts resources; the committee estimates $750 billion in unnecessary health spending in 2009 alone." Compared to the 2009 Health Care Expenditures of $2.5 trillion, this is 30%.

[45] Alan R. Weil; Big Data In Health: A New Era For Research And Patient Care; *Health Affairs*, 33, no.7 (2014):1110

for analyzing large quantities of data and gleaning new insights from that analysis—which is part of what is known as *big data*. As a result, there are unprecedented opportunities to use big data to reduce the costs of health care in the United States. We present six use cases—that is, key examples—where some of the clearest opportunities exist to reduce costs through the use of big data: high-cost patients, readmissions, triage, decompensation (when a patient's condition worsens), adverse events, and treatment optimization for diseases affecting multiple organ systems."[46]

The beneficial outcomes that can result from improvements in how health care is provided are documented by the experience of the Oregon Health Plan in 2013, as seen from the following[47]:

> "Overall, the coordinated care model showed large improvements in the following areas for the state's Oregon Health Plan members:
>
> √ **Decreased emergency department visits.** Emergency department visits by people served by CCOs have decreased 17% since 2011 baseline data. The corresponding cost of providing services in emergency departments decreased by 19% over the same time period.
>
> √ **Decreased hospitalization for chronic conditions.** Hospital admissions for congestive heart failure have been reduced by 27%, chronic obstructive pulmonary disease by 32%, and adult asthma by 18%.
>
> √ **Developmental screening during the first 36 months of life.** The percentage of children who were screened for the risk of developmental, behavioral, and social delays increased from a 2011 baseline of 21% to 33% in 2013, an increase of 58%.
>
> √ **Increased primary care.** Outpatient primary care visits for CCO members' increased by 11% and spending for primary care and preventive services are up over 20%. Enrollment in patient-centered primary care homes has also increased by 52% since 2012, the baseline year for that program."

We believe it is reasonable and appropriate for CODOI to encourage insurance companies to contain healthcare costs, and to take into account the changing environment in which insurance companies and health care providers are operating in evaluating reasonable loss projection values to use for 2015 rates.

---

[46] David W. Bates, Suchi Saria, Lucila Ohno-Machado, Anand Shah and Gabriel Escobar, Big Data In Health Care: Using Analytics To Identify And Manage High-Risk And High-Cost Patients, *Health Affairs*, 33, no.7 (2014):1123-1131

[47] Oregon Health Authority, Office of Health Analytics, 2013 Performance Report, June 24, 2014

6. Excessive Profit Provision

The TIC filing states the following regarding the profit provision[48]:

> Target: 6% pre tax, 3% after tax
>
> For 2015, expected profit is 4.4% pre tax and 2% after tax due to expense levels.

With regard to the "target" profit value there are two concerns. First, the 3% after tax return results in an excessive result on surplus. Second, the 50% tax rate assumed is excessive and hence the after tax return is higher than the value stated in the filing.

TIC operates with a premium to surplus ratio in the range of about 5 to 6.[49,50] Given these leverage ratios, a 3% after-tax profit as a percent of premium translates into an after-tax return on surplus of 15% to 18%.[51] This is clearly excessive and much higher than the cost of capital. Under current conditions, a target return on surplus of 10% (or less) is appropriate.

In deriving the after-tax target return, TIC uses a 40% tax rate "40% is an approximation of the federal income tax rate for Assurant Health."[52] The standard corporate income tax rate is 35%, and the average tax rate on investment income and capital gains is even lower. TIC attempts to justify the higher tax rate on the basis of excessive compensation unrelated to health insurance "Please note that our effective federal income tax rate is expected to be greater than the standard 35% due to the non-deductibility of certain internal and external individual compensation. This non-deductible compensation is primarily incurred within non-health insurance lines of business from our parent company, Assurant, Inc."[53] It is inappropriate for Colorado health insurance policyholders to pay inflated premiums to subsidize excessive compensation paid for non-health insurance lines of business.

With regard to the "expected" profit value there are two concerns. First, as with the "target" profit, the tax rate assumed is excessive. Second, it is not clear what is meant by the

---

[48] Actuarial Memorandum – H. Provision for Profit and Contingencies

[49] During 2013, the written premium and average surplus (in millions) for TIC were $1,269 and $209. (TIC Annual Statement – Summary of Operations) $1,269 / $209 = 6.1

[50] The recent higher premium to surplus ratio for TIC can be attributed in part to the dividend to stockholders of $105 million during 2012. (TIC Annual Statement – Summary of Operations)

[51] 3% X 5 = 15%, 3% X 6 = 18%

[52] Actuarial Memorandum – G. Relation of Benefits to Premium – Income Taxes

[53] *Ibid*.

issue of "expense levels". Perhaps TIC is expecting lower profits than the target value because of the excessive compensation previously discussed or other inflated expenses. The TIC filing states "We are working to lower our administrative expenses."[54] It is not appropriate for Colorado policyholders to pay excessive premiums to support inflated expenses for TIC.

We believe the CODOI should carefully examine the profit provision used by TIC to determine if it is reasonable, especially in light of the large rate increase being requested.

7. Failure to Account for Reduction in Uncompensated / Charity Care

TIC does not appear to have adjusted its cost projections to reflect a reduction in uncompensated care and charity care (i.e., "bad debt") from the Affordable Care Act's expansion of coverage. The savings associated with these reductions could be substantial, and should be passed along to consumers in the form of lower rates.

Among the outcomes of this expansion has been a reduction in uncompensated hospital care for uninsured individuals. Since the uninsured often cannot pay for their own care out of pocket, the cost of providing needed care in emergency situations is frequently shifted onto the insured population and is reflected in the reimbursement rates insurers pay hospitals and doctors for various services. This is the so-called "bad debt" factor, and the anticipated reduction in bad debt should exert substantial downward pressure on hospital rates.

TIC's filing is silent on this issue, and hence it is not possible to know what, if any, consideration TIC gave to this issue in developing the rates it proposed to charge to Colorado policyholders.

The evidence is clear that the ACA has resulted in an increase in Medicaid enrollment and a decrease in charity care. A Colorado Hospital Association study confirms this stating in part[55]:

- The Medicaid proportion of patient volume at hospitals in states that expanded Medicaid increased substantially in the first quarter of 2014. At the same time, the proportion of self-pay and overall charity care declined in expansion-state hospitals.
- Medicaid, self-pay and charity care showed no change outside normal variation for hospitals in non-expansion states in 2014.
- The increase in Medicaid volume, which occurred only in expansion states, is due to Medicaid expansion. The parallel decrease in self-pay and

[54] Part II – Written Explanation of the Rate Increase

[55] Impact of Medicaid Expansion on Hospital Volumes, June 2014, http://www.cha.com/Documents/Press-Releases/CHA-Medicaid-Expansion-Study-June-2014.aspx

> charity care shows that previously uninsured patients are now enrolled in Medicaid.
>
> …
> The changes reported by hospitals in expansion states nationally are also seen locally across Colorado. Urban, rural and critical access hospitals (CAHs) all demonstrate similar increases in Medicaid volume and decreases in self-pay volume and charity care. The magnitude of the changes in Colorado hospitals is greater than the national trend, as seen in Table 1. Furthermore, the values are outside the range of normal variation, indicating an influence beyond the typical month-to-month change. The proportion of Medicaid charges jumped almost five percentage points for urban hospitals and over three percentage points for CAHs and rural hospitals. Across the state, total Medicaid charges for Colorado grew 37 percent, while total self-pay charges dropped by 27 percent from first quarter 2013 to first quarter 2014.

The decrease in the Average Charity Care Per Hospital for Colorado was -36.2%.

A reduction in uninsured patients along with a beneficial financial impact on uncompensated care is also discussed by the rating agency Fitch which has stated "Relative to the early muted influence of insurance expansion on volume growth, expansion of state Medicaid programs had an immediate and dramatic influence on payor mix. In expansion states, hospitals are experiencing strong growth in Medicaid patient volumes and a drop in uninsured patient volumes. Based on only one-quarter of experience under insurance expansion, it is difficult to determine the longer term effect of the payor mix shift, but these early results show the industry could experience a meaningful and durable reduction in the financial headwind created by uncompensated care."[56]

The amount of cost savings from the reduction in bad debt can be expected to become more precise -- and to grow -- over time. However, it is abundantly clear that uncompensated care costs are already going down. Furthermore, it is reasonable to believe that some health care providers will accept lower fees because of the reduction in bad debt. This position is supported by Milliman, an actuarial firm commonly relied upon by health insurance companies, which stated that "some providers may be willing to accept lower rates than in the past, perhaps due to a reduction in uncompensated care for the uninsured."[57]

The pattern of reduced bad debt is already clear, and the impact of that can be expected to be even more important in the coming year. If insurance rates are not adjusted to reflect this reality, consumers will be paying premiums for unjustified costs. We believe the CODOI should carefully consider this issue before making a decision on TIC's rate proposal.

---

[56] https://www.fitchratings.com/gws/en/fitchwire/fitchwirearticle/For-Profit-Hospitals-Potentially?pr_id=837194

[57] 2014 Milliman Medical Index, http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/2014-mmi.pdf

8. Conclusion

The rate increase requested by TIC is based upon a filing that is not adequately documented with respect to a multitude of different items. Furthermore, it appears that many of the assumptions used by TIC are excessive and will result in inflated unreasonable rates being charged to Colorado policyholders.

Please contact me if there is anything you would care to discuss.

Sincerely,

Allan I. Schwartz
FCAS,ASA,MAAA,FCA,ARE,AIC
APA,AU,AIAF,ARM,API,ACS,CRRA
President