9. Benefit Utilization and Review

Description: Perform a variety of analyses to understand the utilization patterns and costs of specific services to assess the impacts of potential new benefits and to validate and add context to carrier submitted data, including transparency data submitted pursuant to SB24-080.
Business Significance and Triple Aim Impact: The Division must often assess the impact of new or shifting benefits to DOI-regulated plans. This can come in the form of legislative requests, public health mandates, or in review of current coverage issues. Reviewing utilization and cost coverage also assists the division in validating and enabling better analysis of carrier submitted data. By reviewing utilization and cost patterns, the Division can assess whether enrollees are receiving high quality care at low cost and how potential changes would impact the triple aim.
Analytic Steps

- Review utilization patterns regionally and across networks for different services to understand impacted populations, costs, providers, and networks.
- Review cost and utilization patterns across different services to understand and evaluate service mix across different populations, networks, and providers. For example, to assess the validity of carrier submitted service mix in one network across a system of hospitals.
- Use the service mix to add context to insurer submitted transparency files.
- Assess potential costs of new mandated benefits or potential implications of shifting utilization from one benefit to another.
- Combine utilization and cost data with premiums to understand if and how changes might impact consumers in different geographies with different levels of coverage.

PHI Requested:

- Member 5 digit Zip Code: necessary to understand differences in utilization across different geographic areas and the implications of any changes, particularly in rural areas.
- Date of Service: necessary to review when specific cost changes were applied and how they have changed over time as well as any seasonality of utilization patterns. Having date of service ensures that geographic comparisons of enrollees in the same plan are comparing appropriate rates. It will also ensure that the correct service mix is being applied, as different populations enroll in DOI-regulated plans, specifically the CO Option plans, the service mix may change more than in a more established population, so knowing when the service happened is key
- Member enrollment dates: Having enrollment data will allow DOI to ensure that similar populations are being compared and enables review of any pent-up demand utilization factors.
- Paid Dates: necessary to assess if some carriers take a significantly longer time to pay specific benefits

10. PBM Utilization and costs

Description: In the passage of HB 23-1227, the Division gained some regulatory authority over pharmacy benefit managers (PBMs). This use case will allow the Division to segment analyses by PBM payer submitted data and networks to better understand PBM operations and consumer experience.
Business Significance and Triple Aim Impact: Analyzing the differences and cost and utilization across different networks based on the PBMs will allow the Division to assess

enrollees' access to affordable medicines regardless of where they live or which PBM their plan uses. It will also allow the Division to assess if particular plans, especially those available to rural enrollees, have more narrow pharmacy networks than other plans.

Analytic Steps:

- Identify which payer codes apply to PBMs and review enrollment data to establish which DOI-regulated plans are associated with which PBMs and pharmacy networks.
- Using plan and PBM data submitted to the DOI, assess which enrollees have pharmacy networks where the only in-network pharmacies are associated with the PBM.
- Review utilization of these enrollees' pharmacy claims to assess if they have a different pattern of utilization in which pharmacies they use, whether these enrollees in rural areas have to drive further for prescriptions or use mail, and whether high-cost specialty drugs are harder for these enrollees to get or more expensive based on the closest pharmacy.

PHI Requested:

- Member enrollment spans and plan attributes: necessary to determine which plan and pharmacy network enrollees are enrolled in
- Member 5 digit zip code: necessary to compare geographic differences in access to narrow networks and to review utilization differences across networks in the same regions
- Date of service: necessary to ensure the correct pharmacy/ PBM network is being applied based on when the prescription was filled and to apply the correct plan information to the consumer's experience

11. Network Adequacy

Description: The Division is required to assess carrier's networks and ensure they are adequate per our regulations to ensure access to care. Assessing utilization of those networks will allow the Division to assess the existence of 'ghost networks', where providers on carrier's provider directories are not actually providing services to enrollees in the network.

Business Significance and Triple Aim Impact: Ensuring that DOI-regulated plans have adequate networks is a necessary component of health insurance regulation that ensures carriers are providing adequate networks for enrollees access to care. Additionally, the Colorado Option requires carriers to have culturally responsive networks where enrollees can find representative providers in their networks.

Analytic Steps:

- Review utilization patterns across networks of DOI regulated plans and compare to provider directories to identify providers who are not actively submitting claims for that network and assess what portion of providers on the directory are providing services to enrollees in that network.
- Compare these results across carriers, networks, regions, and specific services
- Review member enrollment data in Colorado Options plans by census tract to pull available social determinant and demographic information to assess proxies of culturally responsive networks

PHI Requested

- Member 5 digit zip code: necessary to assess geographic distances traveled to receive care and whether these meet minimum standards per our regulations
- Month and Year of date of service: necessary to ensure claims are referencing the correct plan year

- Census tract data: necessary to pull in additional demographic and health equity data pertinent to where enrollees live and to compare against culturally responsive network requirements in Colorado Option plans.