Department of Regulatory Agencies

Annual Report of the Commissioner of Insurance

to

The Colorado General Assembly

on

2009 Health Insurance Report

January 1, 2008 to December 31, 2008
in accordance with §10-16-111(4)(c) & (d), C.R.S.

April 1, 2010

Department of Regulatory Agencies

Division of Insurance
Marcy Morrison
Commissioner of Insurance

Bill Ritter Jr.
Governor

Barbara J. Kelley
Executive
Director

April 1, 2010

To the Members of the House and Senate,

I am pleased to submit the 2009 Annual Health Insurance Report of the Commissioner of Insurance, pursuant to §10-16-111(4)(c) and (d), C.R.S.

This report analyzes the cost of health insurance and the factors that drive the cost of health insurance premiums on an individual and group basis in this state. Additionally, it reports on financial information of health carriers, such as: benefit ratios, rate increases, and the reasons for health insurance rate increases.

Our mission is consumer protection, and we appreciate the opportunity to provide information related to the costs driving health insurance rate increases. If you have any questions, please contact me at the Division of Insurance.

Sincerely,

Marcy Morrison
Commissioner of Insurance

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Consumer Protection

2009 Colorado Health Insurance Report

ACKNOWLEDGEMENTS

The Division of Insurance would like to acknowledge and thank all of the staff that contributed to producing this report.

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Executive Summary

As health insurance premiums continue to increase, the need to find ways to make health care affordable becomes more pressing. Identifying the factors that are driving up health insurance premiums is vital to that effort. Rising health care costs translate directly into rising health insurance premiums, as premiums pass on the underlying cost of the services they cover. A main reason for increasing insurance premiums is the increase in the cost of providing health care services. The vast majority of insurance premiums are used to pay for these costs. Premiums also cover administrative expenses incurred by carriers. However, since insurance administrative expenses are a smaller portion of premium, a reduction in these expenses would provide a far less dramatic reduction in premium than would a reduction in the cost of providing health care services.

In 2008, the Colorado General Assembly enacted House Bill 08-1389 requiring the Commissioner of Insurance to report annually on the cost of health care, the factors that drive the cost of health care and the financial status of health carriers (including HMO's) in Colorado. This report is the first annual installment of the requirement and examines increases in health insurance premiums in the state of Colorado. The report also provides an overview of the expenses and financial statements of companies doing business in Colorado, focusing primarily on the commercial health insurance market for individual, small group and large group health plans.

The information in this report is based on data from 2008. This is the most recent, complete and reliable data available due to the timing of this report and the timing of its primary sources. A significant portion of the data for this report was gathered from the carriers' 2008 Annual Financial Statements, which were filed in March 2009; and the 2008 Colorado Health Cost Report, completed in November 2009.

2008 Highlights

- In Colorado, 33.3%, or one out of three Coloradans, have health coverage that is regulated by the Division of Insurance. There are 29.9% covered by self-insured plans offered through their employer. Another 20.6% receive coverage through government programs, including but not limited to Medicare, Medicaid, the Federal Employees' Health Benefit Plan and the Veteran's Administration and 16.2% of Coloradans are uninsured.

- During 2008, 63.2% of Coloradans were covered by either the commercial health insurance market or a self-insured employer health plan, which is significantly more than the 56.9% of citizens nationwide.

- Health premiums are growing at a faster pace than either inflation or wages.

- During 2008, approximately 81% of premiums collected in 2008 by carriers in Colorado went directly to the cost of providing health care services. Approximately 12.5% of premiums were used for administrative expenses and producer commissions.

- While the increases in premiums for employer provided health coverage in Colorado have mirrored the increase nationwide, the portion contributed by Colorado employees to those premiums has increased much more quickly than the national average.

- The number of private employers offering self-insured health plans to their employees has increased in Colorado at twice the national rate.

- The ten largest health carriers have 70% of the market share in Colorado. There are approximately 400 health insurance carriers doing business in Colorado.

Introduction

There are many factors driving the increase in health premiums, including inflation, cost shifting, utilization, introduction of new technology, and many others. This report examines the increases in premiums in Colorado, compares them to the experience nationwide and provides a breakdown of how the actual premiums collected in Colorado during 2008 were used. Also, this report provides an overview of health insurance in Colorado, the sources of coverage and the types of coverage available. In addition, an overview of health insurance regulation in Colorado and the roles of the Division of Insurance are provided, including the steps taken to ensure consumer protection. Finally, this report examines the ten largest insurers in Colorado and provides financial information for each of them.

A detailed analysis of the different drivers of health costs, their causes, and recommendations for solutions is being studied by numerous other agencies, organizations and groups around the country with significantly more resources and expertise than the Division of Insurance on this topic. Therefore, this report focuses on providing useful, factual information about health insurance in Colorado.

Section 1: The Health Insurance Marketplace in Colorado

In order to gain perspective on the private insurance market in Colorado and how it impacts the population, it is important to examine the sources of health coverage for the citizens of Colorado. As shown in Figure 1, 56.5% of Coloradans secure health coverage through their employer or through family coverage from a spouse's or parent's employer, compared with 52.2% nationwide. The Colorado individual insurance market is also slightly larger than the national figures with 6.7% of Coloradans having individual health insurance policies, compared with 4.7% nationwide. **Therefore, 63.2% of Coloradans are covered by either the commercial health insurance market or a self-insured employer health plan, which is significantly more than the 56.9% of citizens nationwide.**

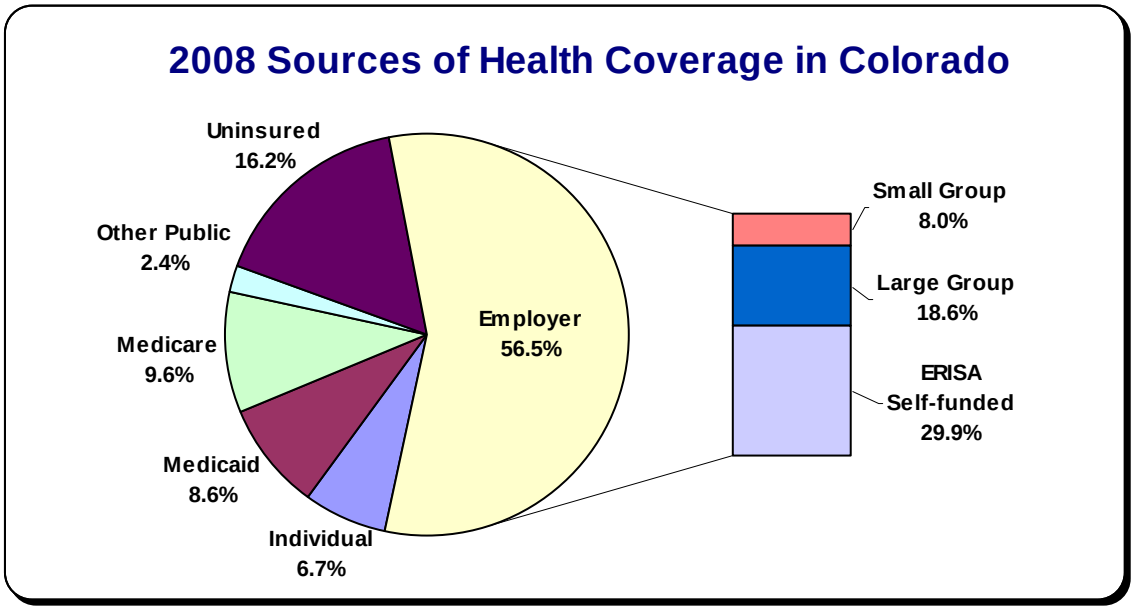

Figure 1 *

Another 20.6% of Coloradans get their health care through government programs such as Medicare, Medicaid, the Federal Employees' Health Benefit Plan and the Veteran's Administration. These

*Figure 1: Kaiser Family Foundation, statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population. Survey (CPS: Annual Social and Economic Supplements), accessed November 7, 2009. Kaiser/HRET 2008 Survey of Employer Sponsored Health Benefits.

programs are administered by the state and federal government, and are paid for by a combination of participant premiums and tax dollars. An estimated 16.2% of Coloradans have no health insurance. Figure 2 provides further detail on how Coloradans receive health care.

Figure 2* **Colorado Health Insurance Enrollment in 2008**	
Colorado population	4,875,000
• Insured	4,085,000
• Uninsured	790,000
Jurisdiction of the Division of Insurance	
• Individual	327,000
• Small Group	390,000
• Large Group	907,000
• Total Under State Regulation	1,624,000
Insured, Not Regulated by the Division of Insurance	
• Medicare	468,000
• Medicaid	419,000
• Other Public	117,000
• Self-funded	1,457,000
• Total Not Regulated by the Division of Insurance	2,461,000

Sources and Availability of Insurance

This section examines the types and sources of health coverage available to the people of Colorado. The majority of Coloradans get their health coverage through group plans offered by their employers (including self-insured plans). Additionally, almost 7% of the population purchases their own private individual insurance. There are a variety of types of health insurance and a variety of ways health insurance policies can be issued.

The types of private health coverage available in Colorado include:

- Comprehensive Major Medical (group or individual)
- Managed Care (group or individual)
- Dental
- Vision
- Long-term Care
- Accidental Death & Dismemberment
- Disability Income
- Limited Benefit
- Credit Accident and Health
- Medicare Supplement
- Medicare Part D Prescription Drug Coverage

The types of health care plans available in the state include:

Indemnity plan - A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

Preferred Provider Organization (PPO) plan - An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

*Figure 2: www.statehealthfacts.org, Colorado, Health Coverage & Uninsured, Total Population; Assumed 53 percent of people covered by employers were covered under a self-insured plan, based on the 2007 figure from America's Health Insurance Plans' report "2007 Health Insurance: Overview and Economic Impact in the States," Colorado summary.

Exclusive Provider Organization (EPO) plan - A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

Health Maintenance Organization (HMO) plan – A health plan where comprehensive health coverage is provided through a specified network of physicians and hospitals for a fixed premium with no deductibles; only visits within the network are covered; a primary care physician within the network handles referrals.

Point-of-service (POS) plan - A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

Flexible spending accounts or arrangements (FSA) - Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Health Savings Accounts (HSA) - Accounts offered by carriers, in coordination with employer provided high deductible health plans and administered by a financial institution, in a similar fashion to a bank account, that provide a way for employees to set aside pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to an HSA. The money deposited into an HSA does not have to be used by any deadline, such as within the calendar year of deposit, and is portable if the person changes employment. HSAs are medical savings accounts, which earn interest, and can be used to pay for current medical expenses or save for future medical expenses.

Flexible benefits plan (Cafeteria plan) (IRS 125 Plan) – A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

Health Care Provider Arrangements

A health care provider is any individual who provides health services to health care consumers (patients). Plans are marketed to individual employees through an employer or at a place of business and may have different options of health care provider arrangements to choose from.

Types of health care provider arrangements include;

- **Exclusive providers** - Enrollees must go to providers associated with the plan for all non-emergency care in order for the costs to be covered.
- **Any providers** - Enrollees may go to providers of their choice with no cost incentives to use a particular subset of providers.
- **Mixture of providers** - Enrollees may go to any provider but there is a cost incentive to use a particular subset of providers.

State Regulated Health Insurance

The Division of Insurance has primary regulatory authority over commercial health carriers in Colorado. As shown in Figure 3, this does not include self-insured employer health plans, Medicare or Medicaid, which are regulated by the federal government. **As you can see, the Division has responsibility to oversee coverage for 33.3% of Coloradans.** Section 4 of this report focuses on the regulatory role that the Division plays in the marketplace and the tools used to protect consumers.

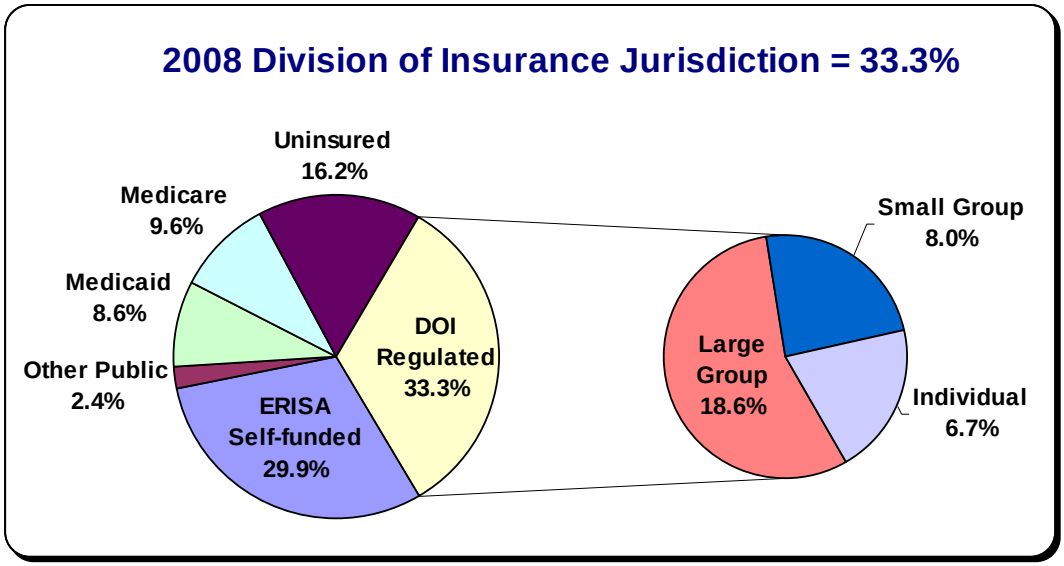

Figure 3*

There are three primary markets for commercial health insurance that are subject to state regulation: the individual, the small group, and the large group markets. Each market operates under different regulations.

Individual Market

The individual insurance market in Colorado is regulated by the Division of Insurance; however the rules are less restrictive than those for group plans. For example, carriers are allowed to underwrite based on health status and there are fewer mandated benefits. Colorado does not require health insurers in the individual market to sell standardized policies. However, Colorado does require all health plans to cover certain benefits such as; mammograms, prostate cancer screening, and diabetes treatment.

While the number of Coloradans that rely on individual plans for their insurance in small, there are a large number of carriers in the state that offer such plans. There were 51 carriers that reported offering individual major medical comprehensive policies in Colorado during 2008, and 221 that reported offering a wider range of individual insurance products, including dental, vision, long-term care, etc.[1]

CoverColorado

If a person cannot get individual coverage on their own because they are considered "uninsurable" due to a pre-existing medical condition, there is a state subsidized health plan called CoverColorado. Established by the Colorado legislature in 1991, CoverColorado is a non-profit organization whose mission is to provide a health insurance program that promotes access to health care for Coloradans whose health prohibits or substantially limits access to commercial health insurance. Since this is a high-risk pool, the rates offered are generally higher than commercial insurance carriers. The enrollment in CoverColorado was 8,543 on December 31, 2008.[2] Colorado is one of 35 states that have a high-risk pool insurance plan.

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*Figure 3: Kaiser Family Foundation, *statehealthfacts.org*. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements), accessed November 7, 2009. Kaiser/HRET 2008 Survey of Employer Sponsored Health Benefits.

[1] These figures are based on responses to the 2008 Colorado General Health Information Survey and the 2008 Colorado Health Insurance Cost Report, which are annual data requests by the Division of Insurance.

[2] www.covercolorado.org

Employer Provided Insurance

The group health plan market in Colorado is quite large, with all employer provided health plans and Association provided health plans making up this sector. Employee benefit plans can be either fully insured, or self-funded. (Self-funded plans may also be called self-insured or non-insured). Under a fully-insured employee benefit plan, the employer purchases commercial health coverage from an insurance company and the insurance company assumes the risk for payment of claims. The insurance company is regulated under state law and is subject to rules about mandated benefits, network adequacy, prompt payment of claims, etc.

Other employers create "self-funded" health plans for their employees. In these self-funded plans, the employer keeps the risk to pay the bills and usually hires a plan administrator to process the claims. When an employer self-funds the plan, it is generally not subject to state laws and regulations -- so state mandated benefits, state prompt payment rules or standards of network adequacy do not apply. Self-insured plans are regulated by the federal government under the Employees' Retirement Income Security Act (ERISA).

Sometimes insurance companies act as an administrator to process claims for an employer self-funded plan. In these circumstances, the insurance company is referred to as a "third party administrator" (TPA) and the health plan is not subject to state laws and regulations.

Small Group Market

A small group health plan is a health plan offered to employer groups of no more than fifty, and includes employer groups of one. Small group insurance is the most heavily regulated market in the state. Small group plans have mandated benefits; must be guaranteed renewable; the premium rating cannot be based on health status, gender, claims experience or duration of coverage; premium rating can only be based on smoking status, industrial classification, age, family size and geographic region. According to the Division's 2008 Small Group Activity Report, **21 carriers offered small group health plans in Colorado during 2008. They covered 41,349 groups, or 330,998 lives.**[3]

Large Group Market

A large group health plan is a health plan offered to employer groups of more than fifty. For regulation purposes, Association health plans are treated as large group plans in Colorado. Large group employer plans and Associations are less regulated than small group plans. It is generally assumed that purchasers of large group policies are more sophisticated purchasers of insurance and may have the ability to hire consultants to assist with the process. Large groups can use their size to negotiate, so employer-sponsored plans typically are able to include a wide range of plan options. Surveys conducted by the **Division reported 7,666 large groups covered by health insurers in Colorado during 2008, covering 763,111 lives.**[4]

Federally Regulated Health Insurance

Self-insured Market

Even though the Division does not regulate self-insured health plans, it is interesting to note the growth in the number of ERISA self-insured plans in Colorado over the last 10 years. Figure 3 shows that the number of private employers in Colorado that offer health plans and self-insure at least one of their plans

[3] These figures are based on the 2008 Colorado Small Group Activity Report, which is available on the Division's website at: www.dora.state.co.us/pb/pb.htm. This is an annual data request by the Division of Insurance.

[4] These figures are based on responses to the 2008 Colorado General Health Information Survey and the 2008 Colorado Health Insurance Cost Report, which are annual data requests by the Division of Insurance.

has increased from 26.0% in 1998 to 40.6% in 2008. The increase hasn't been nearly as dramatic nationally, with the rate nationwide increasing from 26.9% in 1998 to 34.2% in 2008. It is difficult to determine exactly why the number of private employers offering self-funded plans has increased so much faster in Colorado than the country as a whole.

Employers who self-insure their health benefit plans retain all of the risk and thus have the ability to design their own plans. Some employers buy stop-loss insurance (also known as excess loss insurance) coverage to limit the risk that they incur by having a self-insured health plan. The coverage is usually available in one of two forms: specific stop loss coverage, which covers claims above a specified limit on an individual employee basis; and aggregate stop loss coverage, which initiates coverage when the employer's total aggregate health claims reach a specified threshold. The Division of Insurance regulates stop-loss (excess loss) policies, but does not regulate the self-funded employer health plan that it is attached to.

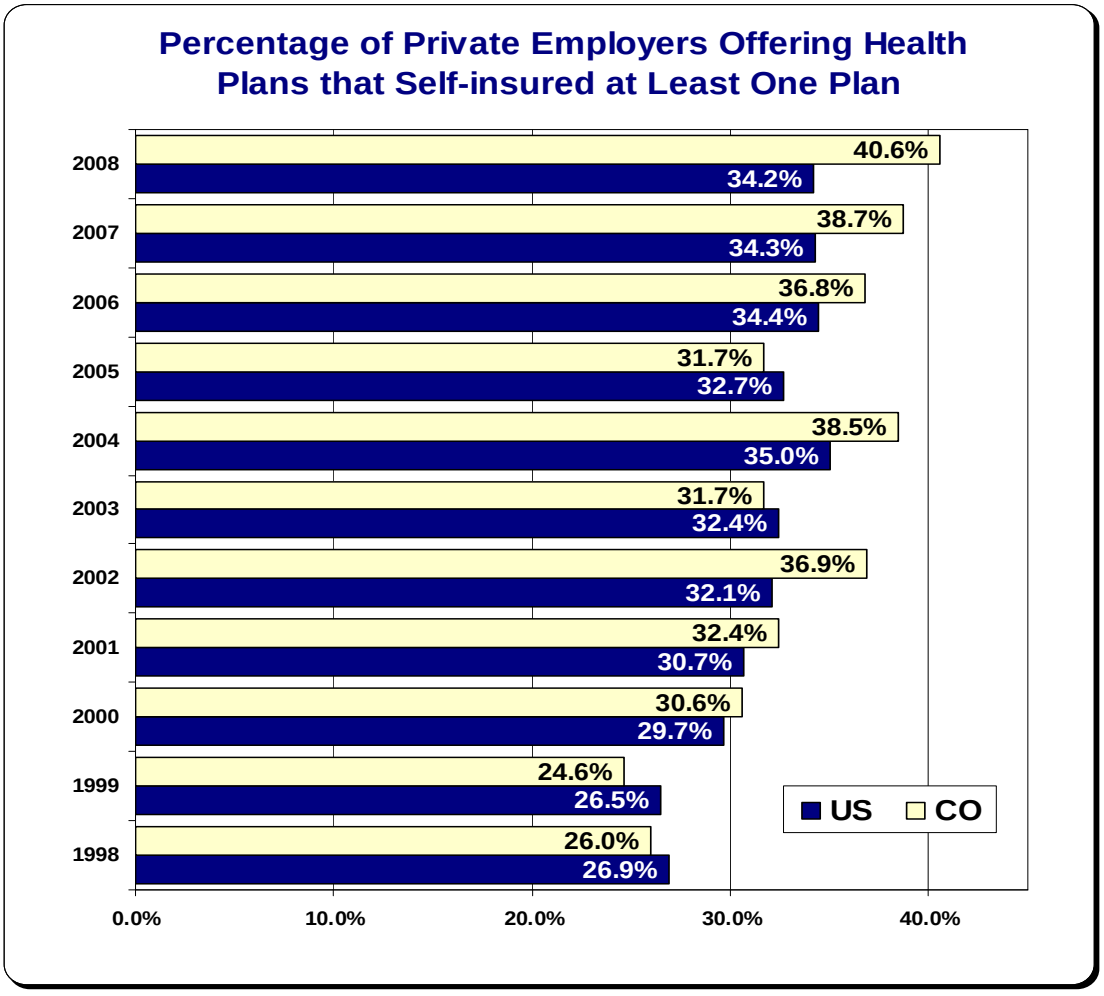


Figure 4[*]

[*] Figure 4: Agency for Healthcare Research and Quality. Percent of private-sector establishments that offer health insurance that self-insure at least one plan by firm size and selected characteristics (Table I.A.2.a), years 1996-2008: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 11, 2009)

Government Health Plans

More than 20% of Coloradans rely on government funded or government subsidized health plans. These include:

Medicaid

Medicaid is a federal/state program, which is state administered, that provides health care for low income families with children and certain individuals with disabilities. Each state has its own eligibility requirements that depend on income, age, disability and medical need. **More than 374,000 Coloradans were receiving health coverage through Medicaid in 2008, representing 8.6% of the state's population**.[5]

CHP+

Child Health Plan Plus is low cost public health insurance for Colorado's uninsured children and pregnant women who earn too much to qualify for Medicaid, but cannot afford private health insurance. For the fiscal year of 2008, the monthly **CHP+ enrollment was 60,166.**[6]

Medicare

Medicare is a federally administered health insurance program for people over age 65, those under 65 with certain disabilities and people of all ages with End-Stage Renal Disease. Medicare is paid for through payroll taxes on working Americans, as well as premiums from its members that are based on the type of coverage they have. It provides comprehensive coverage, including prescription drugs. Many private insurers offer Medicare supplement plans to cover the costs that are not covered under the program, and these plans are heavily regulated in Colorado. **There were 466,900 Coloradans in Medicare in 2008, or 9.6% of the state's population.**[7]

SHIP

The Senior Health Insurance Assistance Program (SHIP) within the Colorado Division of Insurance helps people enrolled in Medicare with questions about health insurance. **SHIP provides free counseling; it is not a health plan**. Topics addressed by the program include Medicare, Medicare supplement insurance (Medigap), Medicare Part D, Medicare HMO's, Medicaid assistance for people on Medicare, and long-term care insurance. The program trains counselors working through regional organizations around the state to provide: individual counseling and assistance; public education presentations about Medicare-related health insurance and Medicare fraud; and distribution of printed materials about these health insurances.

Other

In addition to the health plans mentioned above, there are several other government run plans that subsidize or provide health care to Coloradans. There are health care services are offered to Colorado veterans, our current military personnel and Native American population.

[5 & 7] Kaiser Family Foundation, *statehealthfacts.org*. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements), accessed November 7, 2009.

[6] www.cchp.org

Section 2: Health Insurance Premiums

Increases in health premiums are driven by a wide range of factors. Some of these underlying cost drivers include general inflation, medical inflation in excess of general inflation, increased utilization of health care services, higher priced technologies and new drugs, increases in wages and cost of materials, consumer demand, demographics, benefit mandates and regulations, aging, and cost shifting. This section examines health premiums and presents useful, factual data about how premiums collected by health carriers in Colorado are used.

2.1 Overview of Colorado Employer Provided Health Plan Premiums

Employers offering health coverage to their employees are coping with **health premiums that are growing at a much faster pace than either inflation or wages**. Figure 4 illustrates the effect of health care spending on employer-provided health premiums compared to inflation and workers' earnings. While there are some periods of moderate increases in premiums, the trend is clear. For 2008, the Kaiser Family Foundation Annual Employer Health Benefits Survey found that **the cost of health coverage rose 5.0%, which is lower than the 6.1% increase in 2007, but is still higher than the 3.8% overall rate of inflation or the 3.8% increase in workers' earnings.**

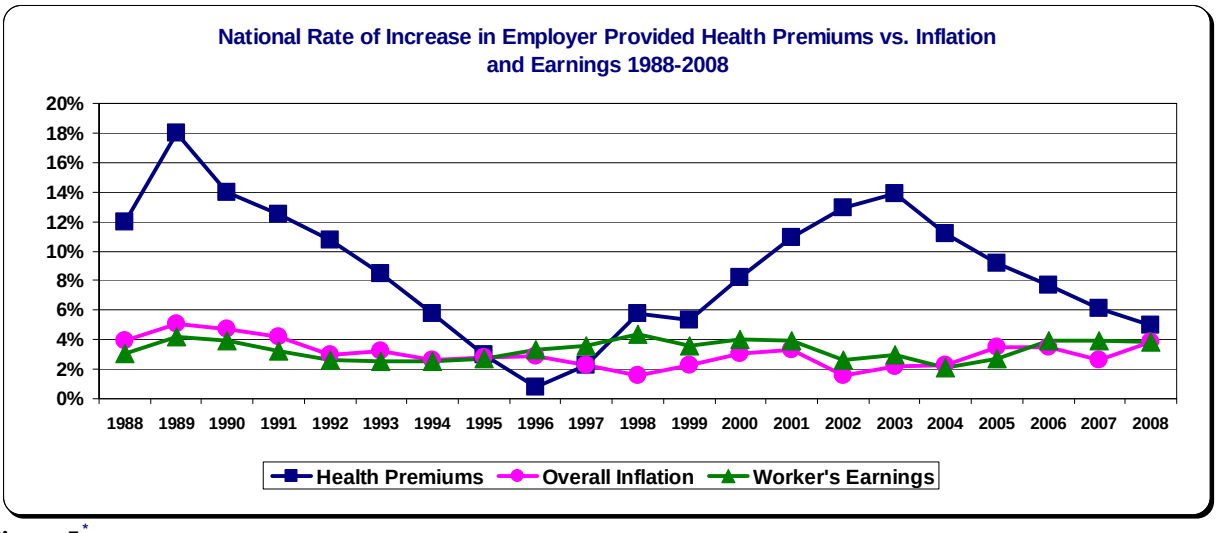


Figure 5[*]

[*] Figure 5: Health Premiums: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1998-2008; KPMG Survey of Employer Sponsored Health Benefits, 1993-1996; The Health Insurance Institute of America (HIAA), 1988-1992. Overall Inflation: Bureau of Labor Statistics, Consumer Price Index, US City Average of Annual Inflation. Worker's Earnings: Bureau of Labor Statistics, Current Employment Statistics Survey, and Average Hourly Earnings of Production Workers.

Nationally, private employer-sponsored health premiums averaged $4,386 annually for single coverage and $12,298 for family coverage in 2008. **The average annual Colorado premium in 2008 was $4,303 for single coverage and $11,952 for family coverage.** Figures 6 and 7 illustrate the increases in private employer-sponsored health premiums in since 1996.

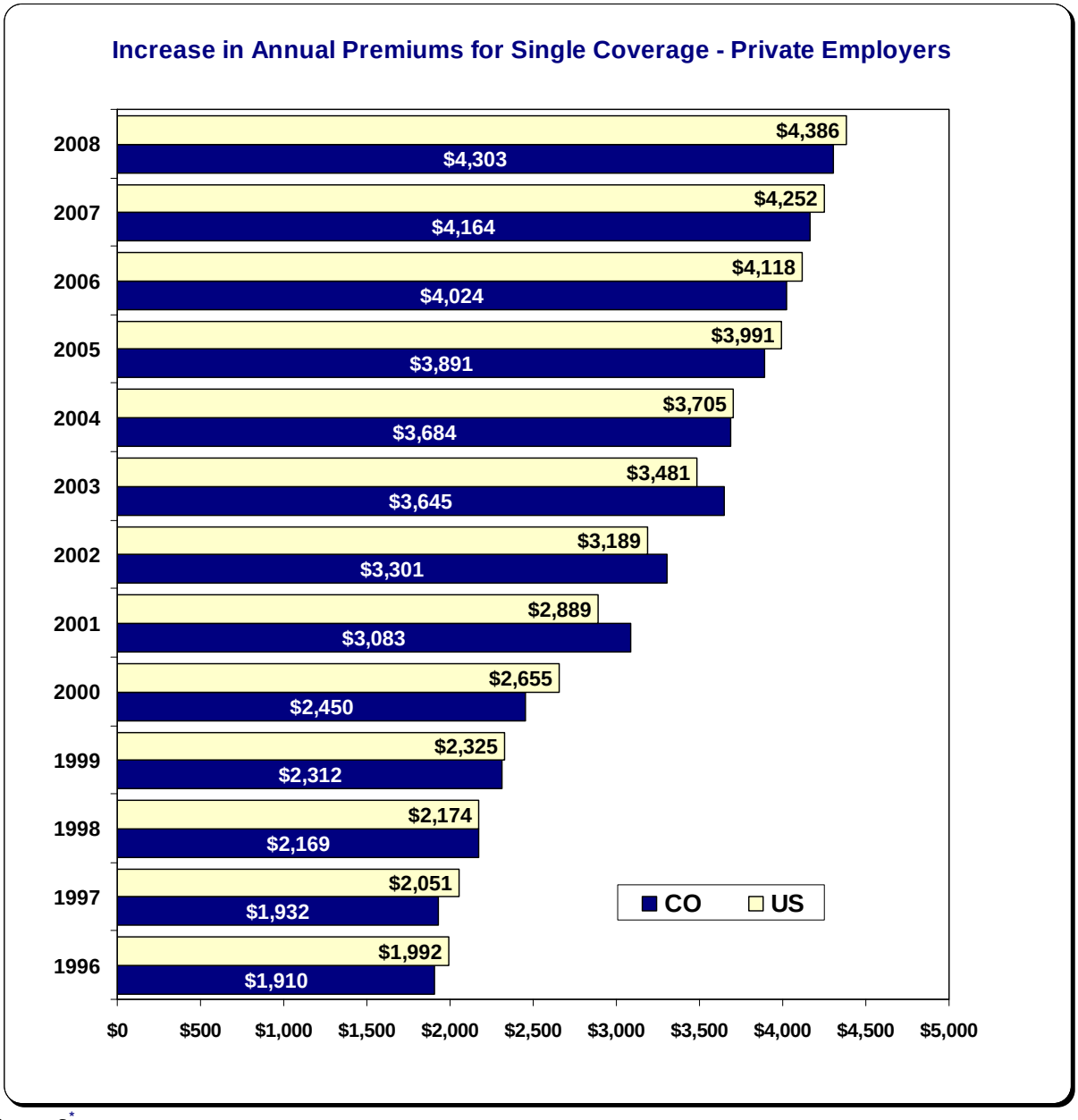


Figure 6 *

*Figure 6: Agency for Healthcare Research and Quality. Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State (Table II.C.1), years 1996-2008: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 08, 2009)

Nationally, annual employee contributions to private employer-sponsored health premiums averaged $882 for single coverage and $3,394 for family coverage in 2008. **The average annual employee contribution to premiums in Colorado in 2008 was $998 for single coverage and $4,151 for family coverage.** Figures 7 and 8 illustrate the increases in employee contributions to private employer-sponsored health premiums in since 1996.

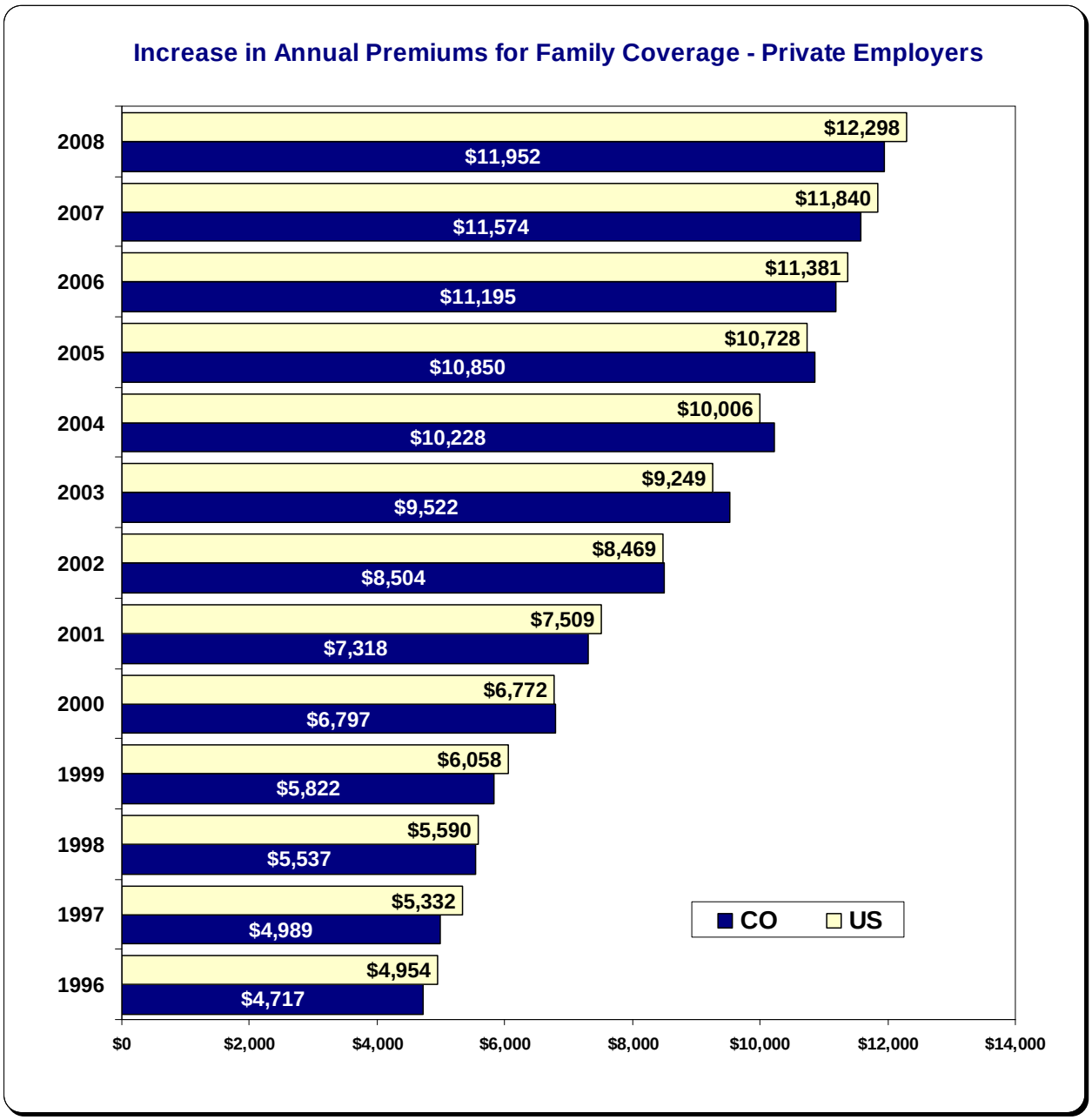


Figure 7[*]

[*] Figure 7: Agency for Healthcare Research and Quality. Average total family premium in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State (Table II.D.1), years 1996-2008: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 08, 2009)

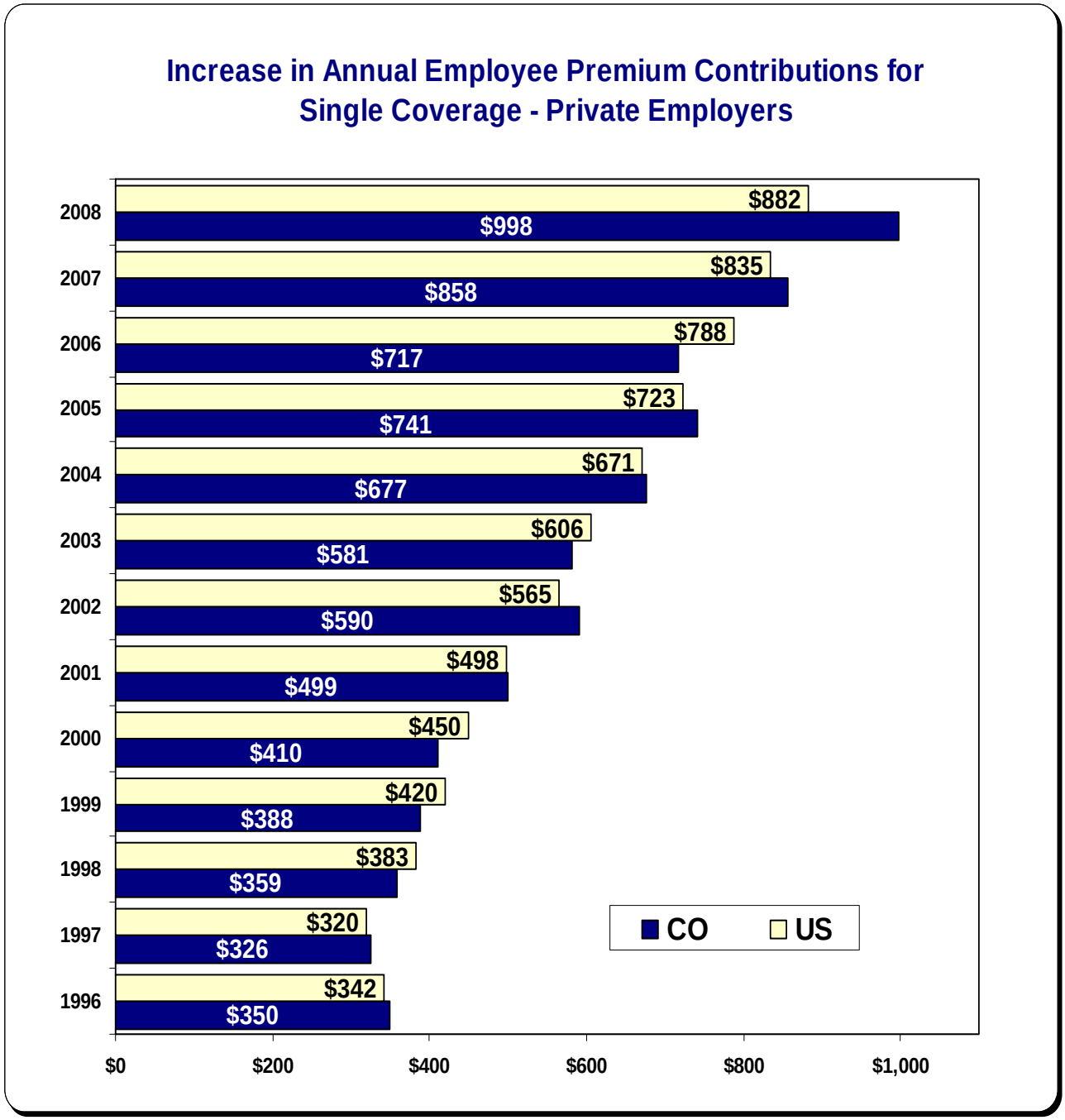


Figure 8[*]

[*] Figure 8: Agency for Healthcare Research and Quality. Average total employee contribution (in dollars) per enrolled employee for single coverage at private-sector establishments that offer health insurance by firm size and State (Table II.C.2), years 1996-2008: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 08, 2009)

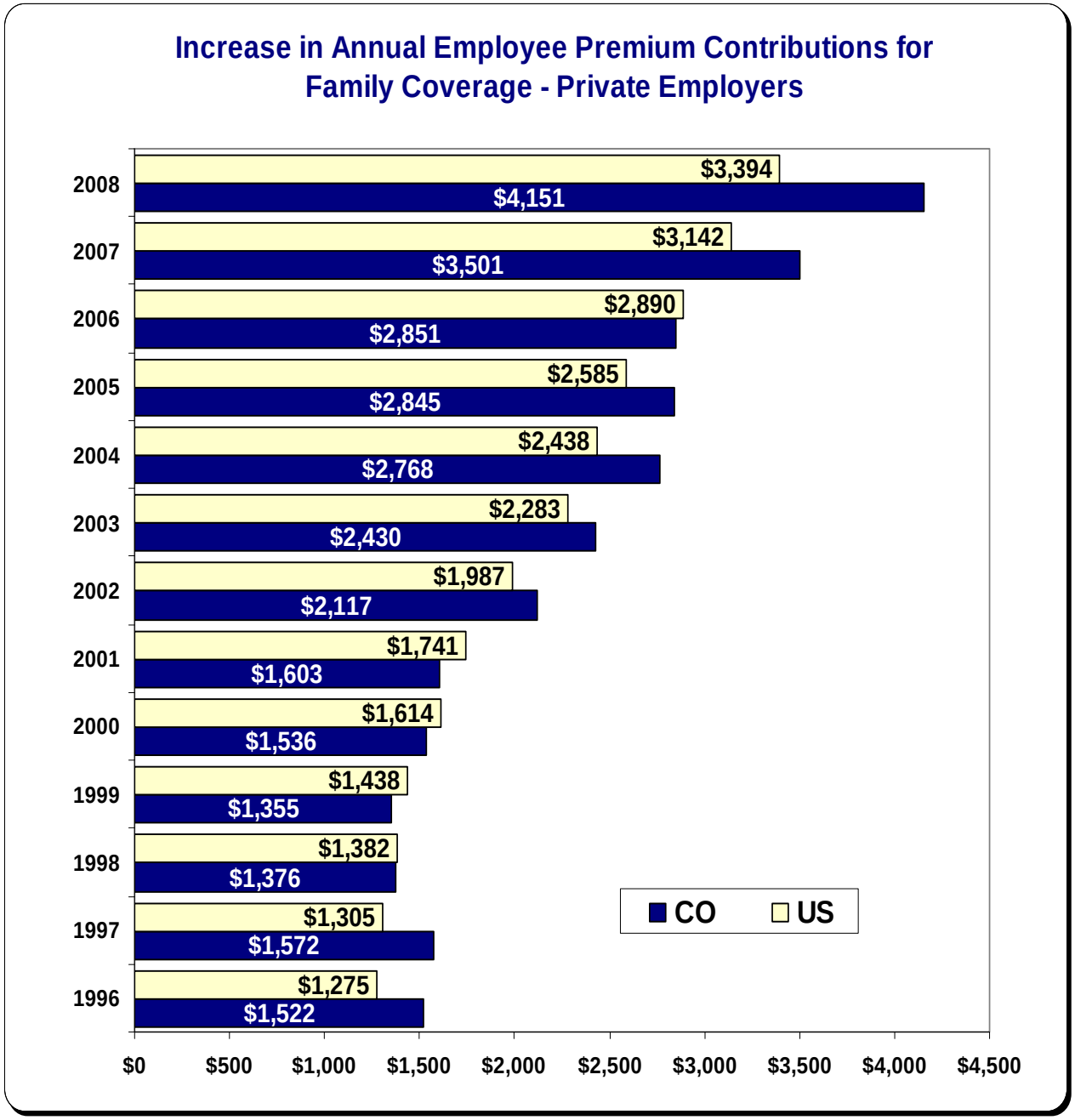
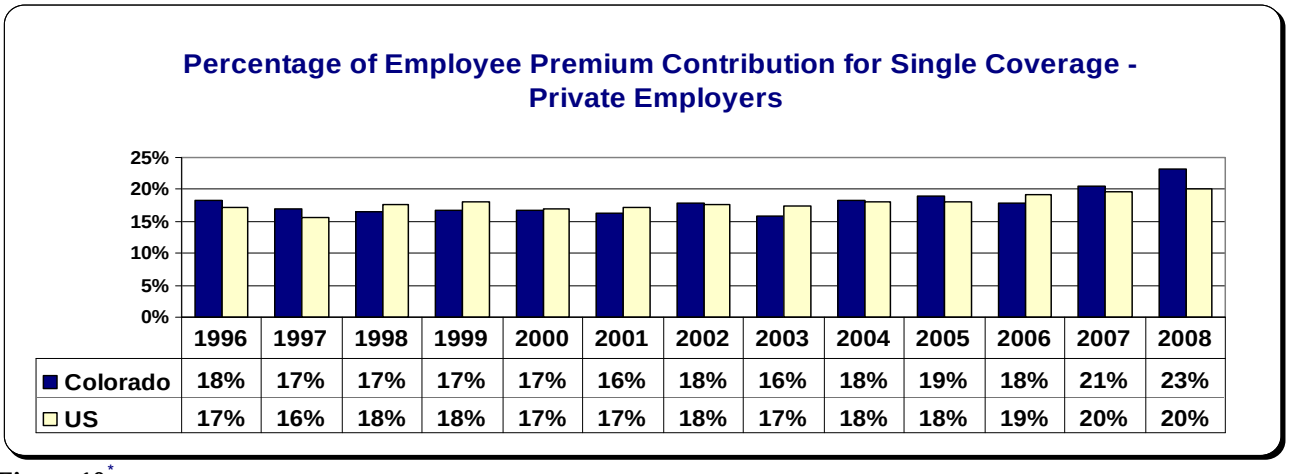


Figure 9[*]

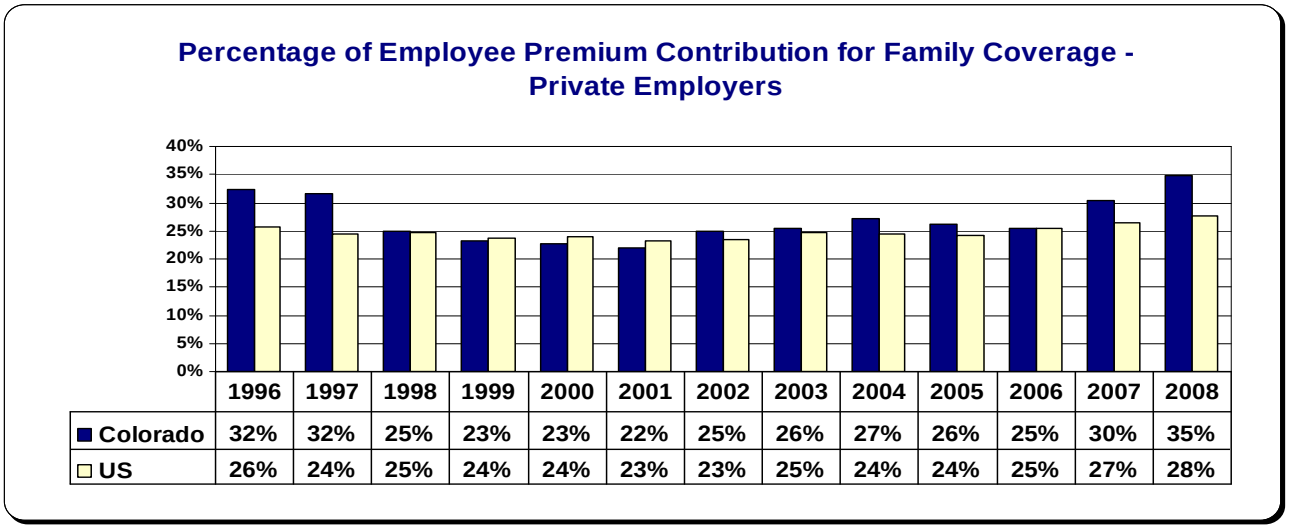
[*]Figure 9: Agency for Healthcare Research and Quality. Average total employee contribution (in dollars) per enrolled employee for family coverage at private-sector establishments that offer health insurance by firm size and State (Table II.D.2), years 1996-2008: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 08, 2009)

These exhibits indicate that the dollar amount that Colorado employees are contributing is increasing much more quickly than the national average. **In fact, the percentage of health premiums that employees in Colorado are being asked to pay by their employers is also increasing more quickly than the national average.** Figures 10 and 11 show that in 2008, Colorado employees paid 23% of the total premium for single coverage and 35% for family coverage, compared to 20% for single coverage and 28% for family coverage, nationally. Earlier, the data showed that the overall premium increases in Colorado were similar to what was being experienced in the rest of the country. This indicates that Colorado employees are carrying more of the burden of premium increases than is occurring nationally.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Colorado	18%	17%	17%	17%	17%	16%	18%	16%	18%	19%	18%	21%	23%
US	17%	16%	18%	18%	17%	17%	18%	17%	18%	18%	19%	20%	20%

Figure 10[*]



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Colorado	32%	32%	25%	23%	23%	22%	25%	26%	27%	26%	25%	30%	35%
US	26%	24%	25%	24%	24%	23%	23%	25%	24%	24%	25%	27%	28%

Figure 11[*]

[*]Figures 10 & 11: Agency for Healthcare Research and Quality. Average total employee contribution (in dollars) per enrolled employee for single coverage at private-sector establishments that offer health insurance by firm size and State (Table II.C.2), years 1996-2008: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 08, 2009)

2.2: Colorado Health Premium Rate Changes in Detail

Colorado law requires carriers to file any health premium rate changes with the Division of Insurance. These rate filings are reviewed by analysts and actuaries at the Division to determine whether they are in compliance with state insurance regulations. The minimum standard for the approval of a premium rate change is that the new rates must not be excessive, inadequate or unfairly discriminatory.

The most common reasons for rate filings include but are not limited to;

- Increase in benefits
- Reduction in benefits
- Change needed to meet projected losses
- Trend only
- Change in rating methodology
- New product (initial offering as opposed to rate revision)
- New options/methodology

The Division summarized the health rate filings received over the last several years and has provided a more detailed summary of the premium rate changes that have occurred below.

Figure 12
2008 Average Annual Rate Increases by Type of Health Insurance

	2005	2006	2007	2008	Total 4 Year Average
Conversion	15%	28%	22%	23%	22%
Credit	NR*	-2%	NR*	-6%	-3%
HMO	5%	4%	-6%	9%	6%
Long-term Care	34%	25%	23%	24%	25%
Major Medical	10%	11%	12%	9%	11%
Medicare Supplement	7%	10%	9%	7%	8%
Other	8%	11%	12%	6%	9%
Stop Loss	8%	5%	7%	9%	6%
Travel	NR*	10%	NR*	NR*	10%
Total Average	**8%**	**10%**	**11%**	**9%**	**10%**

* NR means none reported

Individual Market Premium Rate Changes

Figure 13
Average Annual Rate Increase Summary for Individual Health Plans in Colorado

Year	Average Increase	Average Minimum Increase	Average Maximum Increase	Lowest Overall Increase	Highest Overall Increase
2005	**10%**	11%	13%	-40%	50%
2006	**16%**	14%	18%	-33%	82%
2007	**16%**	12%	19%	-32%	100%
2008	**12%**	10%	15%	-57%	96%
4 year Average	**14%**		17%		

Figure 14
Average Annual Rate Increase By Type of Individual Health Plan in Colorado

Year	Conversion	HMO	LTC	Major Medical	Medicare Supplement	Other	Travel	Total Average
2005	15%	8%	34%	14%	6%	21%	NR*	**10%**
2006	28%	11%	26%	17%	11%	28%	10%	**16%**
2007	20%	14%	23%	18%	10%	21%	NR*	**16%**
2008	22%	12%	24%	12%	8%	14%	NR*	**12%**
Total Average	17%	12%	26%	16%	9%	20%	10%	**14%**

* NR means none reported

Large Group Market Premium Rate Changes

Figure 15
Average Annual Rate Increase Summary for Large Group Health Plans in Colorado

Year	Average Increase	Average Minimum Increase	Average Maximum Increase	Lowest Overall Increase	Highest Overall Increase
2005	**6%**	1%	10%	-35%	36%
2006	**4%**	0%	14%	-78%	377%
2007	**3%**	-3%	12%	-57%	100%
2008	**5%**	0%	10%	-42%	70%
4 year Average	**4%**	1%	12%		

Figure 16
Average Annual Rate Increase By Type of Large Group Health Plan in Colorado

Year	HMO	Major Medical	Medicare Supplement	Other	Stop Loss	Total Average
2005	4%	6%	8%	4%	8%	**6%**
2006	2%	7%	6%	1%	5%	**4%**
2007	4%	6%	5%	0%	6%	**3%**
2008	7%	7%	5%	1%	7%	**5%**
Total Average	5%	7%	6%	1%	6%	**4%**

Small Group Market Premium Rate Changes

Figure 17
Average Annual Rate Increase Summary for Small Group Health Plans in Colorado

Year	Average Increase	Average Minimum Increase	Average Maximum Increase	Lowest Overall Increase	Highest Overall Increase
2005	**3%**	0%	8%	-14%	21%
2006	**4%**	-1%	8%	-41%	39%
2007	**4%**	0%	7%	-25%	25%
2008	**7%**	20%	15%	-39%	97%
4 year Average	**5%**	6%	10%		

Figure 18 Average Annual Rate Increase By Type of Small Group Health Plan in Colorado			
Year	**HMO**	**Major Medical**	**Total Average**
2005	3%	2%	**3%**
2006	3%	4%	**4%**
2007	4%	4%	**4%**
2008	8%	7%	**7%**
Total Average	5%	5%	**5%**

2.3: Additional Information on Colorado Health Premiums

In general, health care premium rates are determined by the sum of:

- projected medical expenses;
- administrative expenses;
- commissions:
- taxes; and,
- profit / contingencies factor.

When submitting a rate filing with the Division, carriers are required to provide a projection of each of the components above as a percent of premium. The sum of these components as a percent of premium should equal 100% of the projected premium. The Division evaluates whether each of these components are reasonable to determine whether the rate increase or decrease is appropriate.

In accordance with § 10-16-111(4)(a), C.R.S., health insurance carriers doing business in the state of Colorado are required to report a variety of health insurance cost information to the Division of Insurance. In 2008, carriers submitted this information using the Colorado Health Insurance Cost Report (HICR). Based on the data collected from the Colorado Health Insurance Cost Report, we have been able to breakdown the above components for the year 2008 and illustrate how the health care premiums paid by Coloradans were spent by insurers.

For the 325 companies that reported, the total premium collected was $ 8.346 billion. This premium was for all types of health insurance coverage offered by private insurers in our state, including comprehensive major medical, dental, vision, disability income, long-term care, accident, credit health and Medicare Supplement insurance.

Figure 19 Components of Colorado Health Care Premiums in 2008		
	Insurer Expense	**Percent of Premium**
Medical Expenses	$ 6,744,530,000	80.81%
Administrative Expenses	$ 685,381,000	8.20%
Commissions	$ 306,864,000	3.68%
Taxes (Federal and State)	$ 122,676,000	1.47%
Profit and Contingencies	$ 615,920,000	7.38%
Total	$ 8,475,371,000	101.54%

It is important to note that the information above is from an aggregation of the data received from all 325 companies that reported. The sum of the components of the Colorado Health Insurance Cost Report does not equal 100% due to: how companies derived Colorado data based on allocating national data, rounding procedures and non-premium revenue (i.e. administration of self-funded plans). In addition, the data presented is only one year of data, 2008.

Loss Ratios

Medical expenses are the cost of providing health care services to the insured, and include payments to hospitals, doctors and other providers. **The medical loss ratio, which is the ratio of medical expenses incurred divided by premiums earned, is a reflection of the cost of health care delivery and a key measure of whether premium rates are reasonable.**

Some examples of the minimum loss ratio guidelines provided in regulation include:

Comprehensive Major Medical (Individual)	65%
Comprehensive Major Medical (Small Group)	70%
Comprehensive Major Medical (Large Group)	75%
Dental/Vision	60%
Disability Income	60%
Long-term Care	60%
Medicare Supplement (Individual)	65%
Medicare Supplement (Group)	75%

Upon reviewing the Colorado Health Cost Insurance Report results summarized above, the average loss ratio reported of 80.81% is higher than any of the minimum loss ratio guidelines provided in regulation. This would indicate that any focus on controlling premium increases would have to consider trying to control the costs of providing health care services.

Expenses

The administrative expenses of an insurer represent the cost of operating the business, including staff salaries, producer commissions, dividends to policyholders, legal expenses, lobbying expenses, advertising or marketing expenses, charitable contributions and taxes, licenses and fees. The Colorado Health Insurance Cost Report asked insurers to provide the amount they paid for each of these types of expenses in Colorado during 2008. Please note that if an insurer was unable to isolate a particular expense so that it represented the portion attributable to their Colorado health insurance business, they were asked to allocate it using earned premium. A summary of the expenses reported by the insurers submitting a Colorado Health Insurance Cost Report is below.

Figure 20
Administrative Expenses

Administrative Expenses	Insurer Expense	Percent of Premium
Commissions	$ 306,864,000	3.68%
Staff Salaries	$ 424,397,000	5.08%
Dividends to Policyholders	$ 3,130,000	0.04%
Legal Expenses	$ 5,485,000	0.07%
Advertising or Marketing	$ 68,627,000	0.82%
Lobbying Expenses	$ 590,000	0.01%
Charitable Contributions	$ 61,836,000	0.74%
Federal Income Taxes	$ 70,926,000	0.85%
State Taxes, Licenses and Fees	$ 51,750,000	0.62%
All Other	$ 50,389,000	0.60%
Total	$ 1,043,994,000	12.51%

Trend

Medical expenses are subject to inflation, in the same way as most products and services. This inflation is generally built into the premium rate increases that health carriers apply to their products, and it is referred to as medical trend. Medical trend is composed of four components, provider price increases, utilization changes, cost shifting and the introduction of new procedures and technology.

Cost Shifting

Private health insurance premiums are higher, to some degree, because uninsured people who receive health care often cannot afford to pay the full amount themselves. To make up for these uncompensated costs, doctors and hospitals charge insurers more for the services provided to patients who do have health coverage. In turn, the costs that are shifted to insurers are passed on in the form of higher premiums to consumers and businesses that purchase health coverage. A detailed examination of cost shifting and many of the other factors that are driving the increase in health costs are beyond the scope of this report.

Section 3: Financial Status of the Top 10 Largest Health Insurers in Colorado

This section presents an overview of the operating results and financial status of the top ten companies with the most earned premium from health insurance in Colorado. All figures in this section are derived or directly from each company's annual financial statement. **Figure 11 shows that the top 10 largest health insurers make up 70% of the market in Colorado. There are approximately 400 health insurers doing business in Colorado.**

Every insurance company that does business in Colorado must submit quarterly and annual financial statements with the Division of Insurance. These statements are reviewed by financial analysts to ensure that insurers are operating at acceptable levels. At least once every 5 years, each domestic insurer is audited by the Division of Insurance, and there may be representatives from other states in which the insurer does business that may join the audit.

Statutory accounting records are designed for financial reporting to state insurance regulators, whose primary interest is in evaluating insurance companies' solvency and long-term financial stability. The Division of Insurance closely monitors domestic insurers for signs of financial problems. The state has an interest in maintaining insurer solvency, because consumers can encounter financial difficulties if an insurer becomes insolvent and is unable to pay claims.

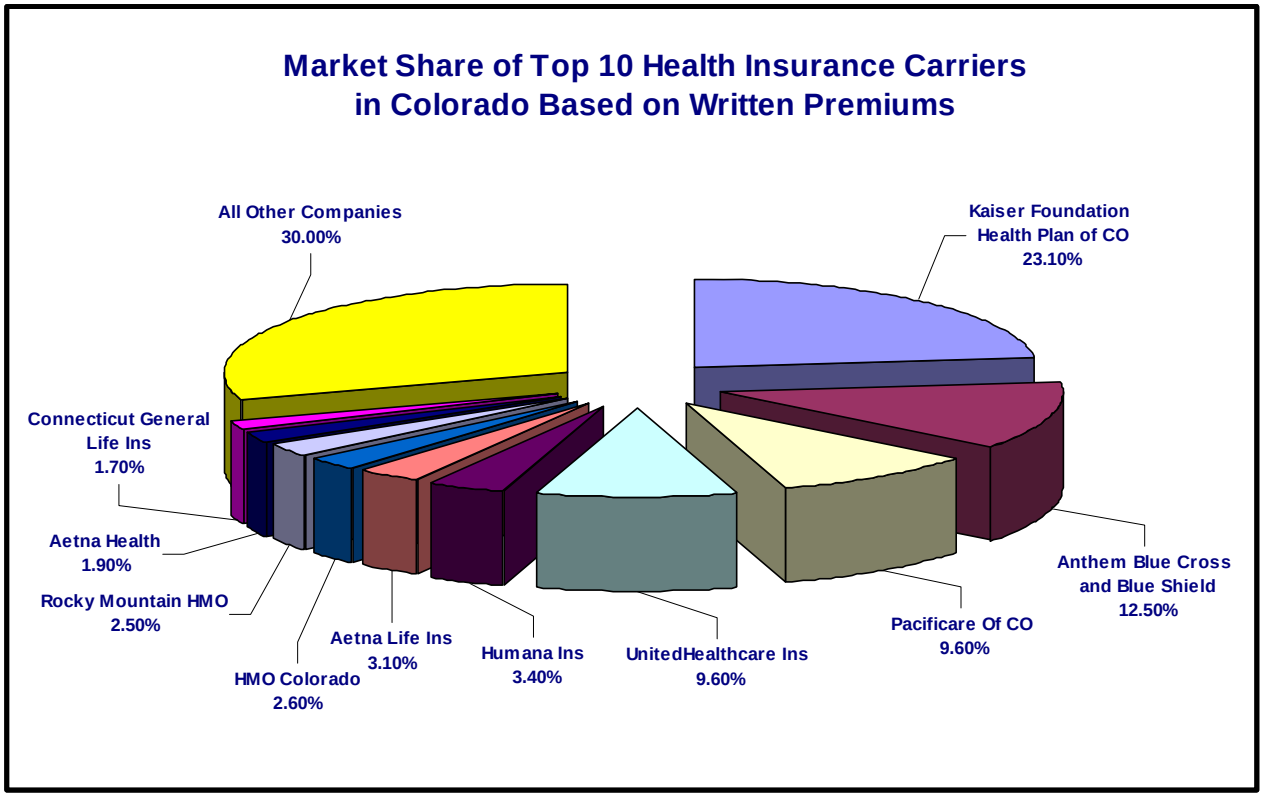


Figure 21

Market Share of the Top 10 Health Carriers in Colorado

Company	2008 Written Premium	% of Market Share
Kaiser Foundation Health Plan of Colorado	$2,121,314,897	23.1%
Anthem Blue Cross and Blue Shield*	$1,144,040,463	12.5%
PacifiCare Of Colorado, Inc.	$878,548,262	9.6%
UnitedHealthcare Insurance Company	$876,480,000	9.6%
Humana Insurance Company	$310,191,776	3.4%
Aetna Life Insurance Company	$282,449,472	3.1%
HMO Colorado, Inc.	$242,070,010	2.6%
Rocky Mountain HMO, Inc.	$228,629,202	2.5%
Aetna Health Inc. (a Colorado corporation)	$170,724,448	1.9%
Connecticut General Life Insurance Company	$160,131,154	1.7%
All Other Companies	$2,754,017,316	30.0%
Total	**$9,168,597,000**	100.00%

Figure 22

Four of the Top 10 Health Insurance Carriers in Colorado are Health Maintenance Organizations

Non-HMO's	HMO's
Anthem Blue Cross and Blue Shield*	Kaiser Foundation Health Plan of Colorado
UnitedHealthcare Insurance Company	PacifiCare Of Colorado, Inc.
Humana Insurance Company	HMO Colorado, Inc.
Aetna Life Insurance Company	Rocky Mountain HMO, Inc.
Aetna Health Inc. (a Colorado corporation)	
Connecticut General Life Insurance Company	

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Hospital & Medical

Capital and Surplus

Insurers, by law, must maintain minimum levels of capital and surplus to ensure they will be able to meet financial obligations to policyholders. Shareholders interest is second to that of the policyholders. Capital and surplus requirements vary by insurer depending on the volume of business, investment portfolio, and other risk factors unique to each insurer's situation. This value protects the interests of the company's policyholders in the event it develops financial problems; the policyholders' benefits are thus protected by the insurance company's capital. All insurers must maintain capital and surplus. For-profit insurers report capital and surplus amounts; not-for-profit insurers report only surplus. The combination of capital and surplus is the amount an insurer's assets exceed its liabilities.

Capital is the amount of equity of the shareholders for a stock insurance company.

Surplus is the amount that represents the assets a company has over and above its reserves and other financial obligations.

Risk-based capital (RBC) is a method for evaluating an insurer's surplus in relation to its overall business operations according to its size and lines of business written. An insurer's RBC is calculated by applying factors to various assets, premium, and reserve items. The calculation produces the "authorized control level." The RBC ratio is the insurer's surplus divided by the authorized control level. The state is authorized to take regulatory action against an insurer that fails to maintain a RBC equal to or greater than 200 percent.

Figure 23

Risk-based Capital Percentage (RBC %)

Company	2004	2005	2006	2007	2008	5 year Average
Aetna Health Inc. (a Colorado corporation)	205%	443%	362%	336%	341%	337%
Aetna Life Insurance Company	860%	867%	808%	706%	714%	791%
Anthem Blue Cross and Blue Shield*	613%	541%	512%	388%	488%	508%
Connecticut General Life Insurance Company	903%	1142%	648%	560%	575%	766%
HMO Colorado, Inc.	744%	715%	807%	424%	368%	612%
Humana Insurance Company	289%	319%	310%	448%	438%	361%
Kaiser Foundation Health Plan of Colorado	519%	712%	594%	395%	1244%	693%
PacifiCare Of Colorado, Inc.	370%	447%	512%	675%	825%	566%
Rocky Mountain HMO, Inc.	916%	1090%	1105%	1161%	1270%	1108%
UnitedHealthcare Insurance Company	590%	566%	524%	559%	396%	527%

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Hospital & Medical.

Medical and Hospital Expenses

Medical Loss Ratio is the percentage of health insurance premiums used to cover the cost of providing health care services. This is calculated by taking the ratio of the cost of providing health care divided by earned premium, and is represented as a percentage. If the medical loss ratio is 85%, this means that 85% of premiums were spent on providing health care to policyholders. The carriers' goal is to keep this ratio well below 100%—since the carriers' profit is generated from the premiums that remain after they have paid for both the cost of providing health care and for the administrative expenses incurred from operating the business.

Medical expense is the cost of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

Figure 24

Colorado Medical Loss Ratios

Company	2004	2005	2006	2007	2008	5 year Average
Aetna Health Inc. (a Colorado corporation)	88%	79%	85%	85%	89%	85%
Aetna Life Insurance Company	75%	77%	79%	85%	82%	80%
Anthem Blue Cross and Blue Shield*	76%	80%	76%	84%	80%	79%
Connecticut General Life Insurance Company	94%	78%	84%	81%	83%	84%
HMO Colorado, Inc.	76%	81%	78%	88%	83%	81%
Humana Insurance Company	79%	79%	82%	81%	82%	81%
Kaiser Foundation Health Plan of Colorado	91%	93%	89%	88%	88%	90%
PacifiCare Of Colorado, Inc.	88%	84%	81%	80%	76%	82%
Rocky Mountain HMO, Inc.	84%	89%	86%	87%	84%	86%
UnitedHealthcare Insurance Company	76%	78%	80%	76%	80%	78%
Average of these 10 companies	83%	82%	82%	84%	83%	83%

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Hospital & Medical.

Claims Adjustment Expenses

Claims Adjustment Expenses are the expenses attributable to claims settlement, including cost-containment expenses. Included in claims adjustment expenses are all expenses directly attributed to settling and paying claims from the insured.

Figure 25
Claims Adjustment Expenses as a Percent of Colorado Earned Health Premium

Company	2004	2005	2006	2007	2008	5 year Average
Aetna Health Inc. (a Colorado corporation)	2.40%	1.80%	1.90%	1.80%	1.80%	1.90%
Aetna Life Insurance Company	8.20%	5.60%	3.70%	3.80%	3.10%	4.90%
Anthem Blue Cross and Blue Shield*	3.90%	3.30%	1.90%	5.30%	2.80%	3.40%
Connecticut General Life Insurance Company	2.30%	1.80%	2.10%	1.70%	1.80%	1.90%
HMO Colorado, Inc.	3.20%	4.00%	3.00%	5.20%	3.70%	3.80%
Humana Insurance Company	0.80%	0.90%	0.50%	0.50%	0.30%	0.60%
Kaiser Foundation Health Plan of Colorado	1.30%	1.20%	1.40%	1.10%	1.30%	1.30%
PacifiCare Of Colorado, Inc.	1.50%	1.70%	1.50%	2.10%	1.50%	1.70%
Rocky Mountain HMO, Inc.	9.20%	9.90%	5.80%	6.10%	5.50%	7.30%
UnitedHealthcare Insurance Company	0.80%	0.70%	0.60%	0.30%	1.80%	0.80%
Average of these 10 companies	3.40%	3.10%	2.20%	2.80%	2.40%	2.80%

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Hospital & Medical.

Administrative Expenses

Administrative expenses are the expenses an insurer incurs to operate its business and includes all expenses not directly related to paying claims. Included, but not limited to, in this category are; commissions, telephone charges, marketing and advertising expenses, office supplies, rent, taxes, depreciation, legal fees, postage, real estate expenses, salaries and benefits.

Administrative expenses for HMO's are consistently lower than for non-HMO's. One reason for this is expenses that other insurers record as administrative costs are bundled into claims costs in the HMO integrated system.

Figure 28 illustrates that administrative expenses, as a percent of earned premium, can vary from insurer to insurer, but are generally consistent from year to year. The five-year average administrative expense as a percent of premium was 9.5% for all ten insurers.

Figure 26
Administrative Expenses as a Percent of Colorado Earned Health Premiums

Company	2004	2005	2006	2007	2008	5 year Average
Aetna Health Inc. (a Colorado corporation)	13.80%	13.50%	14.60%	11.40%	12.10%	13.10%
Aetna Life Insurance Company	3.40%	-1.90%	-0.40%	0.30%	2.10%	0.70%
Anthem Blue Cross and Blue Shield*	14.80%	12.60%	12.00%	10.30%	10.40%	12.00%
Connecticut General Life Insurance Company	3.70%	10.70%	9.40%	4.10%	4.60%	6.50%
HMO Colorado, Inc.	15.20%	13.30%	11.50%	10.50%	9.60%	12.00%
Humana Insurance Company	11.10%	15.40%	11.80%	10.60%	10.90%	12.00%
Kaiser Foundation Health Plan of Colorado	8.00%	9.30%	9.30%	7.10%	7.60%	8.30%
PacifiCare Of Colorado, Inc.	10.90%	11.10%	11.20%	9.60%	9.50%	10.40%
Rocky Mountain HMO, Inc.	18.10%	19.60%	12.50%	13.60%	11.80%	15.10%
UnitedHealthcare Insurance Company	3.90%	4.00%	4.80%	6.50%	7.10%	5.30%
Average of these 10 companies	10.30%	10.80%	9.70%	8.40%	8.60%	9.50%

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Hospital & Medical.

Net Underwriting Gain (or loss)

Net underwriting gain/ (loss) is the difference between earned premiums and the sum of incurred loss and loss adjustment expenses; other incurred underwriting expenses and policyholder dividends. Net underwriting gain/ (loss) is also known as underwriting income.

Figure 27
Net Underwriting Gain (or loss) as a Percent of Colorado Earned Health Premium

Company	2004	2005	2006	2007	2008	5 year Average
Aetna Health Inc. (a Colorado corporation)	-2.90%	9.30%	-0.80%	4.00%	-0.90%	1.70%
Aetna Life Insurance Company	0.00%	0.00%	14.30%	12.50%	10.90%	7.50%
Anthem Blue Cross and Blue Shield*	7.50%	7.20%	10.10%	4.10%	8.10%	7.40%
Connecticut General Life Insurance Company	0.00%	0.00%	8.50%	10.10%	7.10%	5.10%
HMO Colorado, Inc.	8.90%	6.90%	8.50%	-6.20%	1.60%	3.90%
Humana Insurance Company	0.00%	0.00%	-0.80%	3.50%	1.50%	0.90%
Kaiser Foundation Health Plan of Colorado	2.80%	-1.00%	2.80%	6.20%	5.70%	3.30%
PacifiCare Of Colorado, Inc.	1.60%	4.90%	8.60%	10.20%	14.20%	7.90%
Rocky Mountain HMO, Inc.	6.00%	0.50%	2.30%	0.00%	4.60%	2.70%
UnitedHealthcare Insurance Company	0.00%	0.00%	11.80%	10.60%	7.90%	6.10%
Average of these 10 companies	2.40%	2.80%	6.50%	5.50%	6.10%	4.70%

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Hospital & Medical.

Net Investment Income Gain (or loss)

Net Investment Income is the income received from investment assets (before taxes) such as bonds, stocks, mutual funds, loans and other investments (less related expenses). The individual tax rate on net investment income depends on whether it is interest income, dividend income or capital gains.

Net investment income gain (or loss**)** includes all income earned from invested assets minus expenses associated with investments, plus the profit (or loss) realized from the sale of assets.

Figure 28
Net Investment Gain (or loss) as a Percent of Colorado Earned Health Premium

Company	2004	2005	2006	2007	2008	5 year Average
Aetna Health Inc. (a Colorado corporation)	1.20%	0.80%	0.90%	0.80%	0.80%	0.90%
Aetna Life Insurance Company	0.00%	0.00%	1.80%	1.50%	1.20%	0.90%
Anthem Blue Cross and Blue Shield*	4.30%	3.50%	2.70%	2.40%	2.80%	3.10%
Connecticut General Life Insurance Company	0.00%	0.00%	7.50%	3.70%	2.30%	2.70%
HMO Colorado, Inc.	2.10%	2.00%	1.50%	0.80%	0.70%	1.40%
Humana Insurance Company	0.00%	0.00%	1.10%	2.30%	1.50%	1.00%
Kaiser Foundation Health Plan of Colorado	0.50%	0.40%	0.80%	1.00%	0.40%	0.60%
PacifiCare Of Colorado, Inc.	0.70%	0.90%	1.00%	1.50%	1.00%	1.00%
Rocky Mountain HMO, Inc.	0.40%	1.30%	1.30%	2.40%	2.00%	1.50%
UnitedHealthcare Insurance Company	0.00%	0.00%	3.10%	2.80%	1.80%	1.60%
Average of these 10 companies	0.90%	0.90%	2.20%	1.90%	1.50%	1.50%

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Hospital & Medical.

Net Income (or loss)

Net Income is any money that remains from the company's revenues after deductions have been made for sales costs, operating expenses, and taxes.

Below provides a 5-year summary of Colorado's largest health insurers' profitability expressed as a percentage of earned premiums. All ten companies were profitable in 2008, with average profit margins varying from 2.3% to 10.1%, with an average profit of 5.7%.

Figure 29
Net Income as a Percent of Colorado Earned Health Premium

Company	2004	2005	2006	2007	2008	5 year Average
Aetna Health Inc. (a Colorado corporation)	-1.90%	7.40%	-0.40%	2.90%	2.50%	2.10%
Aetna Life Insurance Company	0.00%	0.00%	10.40%	8.80%	7.60%	5.40%
Anthem Blue Cross and Blue Shield*	8.70%	7.60%	9.40%	4.70%	7.60%	7.60%
Connecticut General Life Insurance Company	8.20%	6.90%	7.40%	-4.00%	2.50%	4.20%
HMO Colorado, Inc.	0.00%	0.00%	0.70%	4.00%	2.30%	1.40%
Humana Insurance Company	3.40%	0.40%	4.20%	6.00%	4.70%	3.70%
Kaiser Foundation Health Plan of Colorado	1.90%	3.90%	6.30%	7.80%	10.10%	6.00%
PacifiCare Of Colorado, Inc.	6.30%	5.40%	4.00%	3.00%	7.10%	5.20%
Rocky Mountain HMO, Inc.	0.00%	0.00%	8.30%	10.10%	6.40%	5.00%
UnitedHealthcare Insurance Company	0.00%	0.00%	10.00%	9.00%	6.60%	5.10%
Average of these 10 companies	2.70%	3.20%	6.00%	5.20%	5.70%	4.60%

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Hospital & Medical.

Section 4: Overview of Health Insurance Regulation

The Division of Insurance, within the Colorado Department of Regulatory Agencies (DORA), is the state's primary regulator of all types of insurance companies, including health insurance carriers operating in the state. This section will provide an overview of the regulatory authority of the Division, as well as provide information about the Division's progress towards DORA's primary mission, consumer protection. There will also be a discussion of the legislative initiatives that are taking place in Colorado to address the availability, adequacy and cost of health care in the state.

State-Regulated Commercial Health Insurance

Insurance regulation is structured around several key functions, including company licensing, producer licensing, product regulation, market conduct, financial regulation and consumer services.

The Division of Insurance serves the public interest through the following areas of responsibilities:

- Provide a prompt, effective, complaint resolution process for Colorado consumers.
- Provide prompt and effective service and education to Colorado consumers, the public and regulated entities.
- Promote and preserve a sound, competitive insurance marketplace through effective state regulation.
- Promote access to affordable insurance that allows for adequate consumer choice.
- Promote and develop more streamlined, uniform, and efficient regulatory processes.
- Ensure that management systems are in place to operate the Division efficiently and effectively.

The Division's role regulating the different insurance market segments varies widely, but there are four major responsibilities that are universal: consumer protection, financial solvency, market regulation and rate regulation.

Consumer Protection

The responsibility of consumer protection is accomplished through addressing consumer complaints, verifying the financial ability of the health insurer to pay claims through financial examinations, checking that an insurer's marketing practices are honest and approving only premium rate changes that are not excessive, inadequate or unfairly discriminatory.

Health insurers are subject to a wide range of consumer protections under the Colorado Insurance Code. Through statutes and regulations, the Division assures that health insurers are providing health insurance in a fair, non-discriminatory way, and according to the law of the State of Colorado.

In determining if the rate is excessive or inadequate, the Commissioner may consider profits, dividends, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice.

Financial Solvency

Financial Regulation is to make certain an insurer can pay claims. The state enforces financial solvency and consumer protection requirements for all health insurers. Financial regulation provides crucial safeguards for America's insurance consumers. The states maintain at the National Association of Insurance Commissioners (NAIC) the world's largest insurance financial database, which provides a 15-year history of annual and quarterly filings on 5,200 insurance companies.

Periodic financial examinations occur on a scheduled basis. State financial examiners investigate a company's accounting methods, procedures and financial statement presentation. These exams verify and validate what is presented in the company's annual statement to ascertain whether the carrier is in good financial standing.

When an examination of financial records shows the company to be financially impaired, the state insurance department takes control of the company. Aggressively working with financially troubled companies is a critical part of the regulator's role. In the event the company must be liquidated or becomes insolvent, the states maintain a system of financial guaranty funds that cover consumers' personal losses.

Market Regulation

Market regulation attempts to ensure fair and reasonable insurance prices, products and trade practices in order to protect consumers. With improved cooperation among states and uniform market conduct examinations, regulators hope to ensure continued consumer protections at the state level.

Market conduct examinations occur on a routine basis, but also can be triggered by complaints against an insurer. These exams review agent- licensing issues, complaints, types of products sold by the company and agents, agent sales practices, proper rating, claims handling and other market-related aspects of an insurer's operation.

When violations are found, the Division of Insurance makes recommendations to improve the company's operations and to bring the company into compliance with state law. In addition, a company may be subject to civil penalties and/or license suspension or revocation.

Rate Regulation

Rates are reviewed to determine if rates are "excessive, inadequate or unfairly discriminatory." "Excessive Rates" are where unreasonable high profits result or expenses are high in relation to the benefits provided. "Inadequate Rates" are where rates are not sufficient to pay losses and expenses, or where the use of the rates will result in a monopoly. "Unfairly Discriminatory" rates are where the product prices do not equitably reflect differences in risks.

The Division reviews several thousand filings a year to determine if the rates are justified and comply with Colorado laws and regulations. Below are the resulting consumer savings, due to the Division's review of health insurance filings and intervention for the past four years.

Figure 30

Colorado Division of Insurance – Rates and Forms Consumer Savings From Review and Intervention 2005-2008

2005	**$ 6,996,602**
2006	**$ 3,155,712**
2007	**$ 3,725,174**
2008	**$ 11,833,682**

Rate standards are included in the state laws and are the foundation for the acceptance, denial, or adjustment to rate filings. Typical rate standards included in the state laws require that "The benefits are reasonable in relation to the premium charged." This is usually accomplished by reference to an expected loss ratio which is the ratio of the expected incurred claims to the expected earned premiums. The loss ratio standards are either specified in law or set by the regulatory authorities. For example, the minimum

loss ratio for Medicare Supplement insurance is 65% for individual business and 75% for group business. The expected loss ratio is calculated by projecting earned premiums and incurred claims, and determining the lifetime loss ratio.

Prior Approval: is a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to agents, collections of premium, advertising or any other use of the rate. Under no circumstances shall the carrier provide insurance coverage under the rates until after the proposed effective date specified in the rate filing. Carriers may bill members but not require the member to remit premium, prior to the effective date of the rate change.

File and Use: is a filing procedure that requires rates and rating data to be filed with the Division of Insurance concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage under the rates until after the proposed effective date. Carriers may bill members, but not require the member remit the premium prior to the effective date of the rate change.

Submissions of Rate Filings in Colorado

All companies must submit rate filings whenever the rates charged to new or renewal policyholders or certificate-holders differ from the rates on file with the Division of Insurance. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in the trend or other rating assumptions.

All companies must submit a rate filing on at least an annual basis, when rating factors are used which automatically change rates on a predetermined basis, such as trend, durational factors, or the Index Rate for small group business, for continued appropriateness. These rate filings must contain detailed support as to why the assumptions continue to be appropriate.

All companies must submit a rate filing when the rates are changed on an existing product, even if the rate change only pertains to new business.

On the next page, we have provided a chart that summarizes the differences in regulatory requirements in Colorado for the individual, small group and large group markets.

Figure 31[*]

Summary of Rating Factors for Private Health Plans in Colorado

Rating Factor	Individual Plans	Small Group Plans	Large Group Plans
Attained Age: Age Bands (5-year)		√	Many don't vary rates by the employee's attained age.
Age (no bands)	√		
Family Composition: 4 Tiers		√	As specified by the group.
Gender	√		√
Area Factors:	Usually based on zip code.	Based on county where small group is located and as required by Colorado Regulation 4-6-7	Limited to the area factors filed for use by the carrier.
Smoking Status or Tobacco Use:	Rate-up or discount	Rate-up or discount up to 15% for tobacco use; 10% discount for smoking cessation	No prohibition or requirement specified in CO law.
Health Status:	Tiers by each individual covered.(Preferred, Standard, Non-Standard) – Can be medically underwritten.	Not allowed after 12/31/2008.	Aggregated for group and limited to the range filed for use by the carrier.
Claims Experience:	Not allowed as a separate factor for rate calculation for an individual policyholder.	Not allowed after 12/31/2008.	Aggregated for group and limited to the range filed for use by the carrier.
Standard Industrial Classification:		Can be used to adjust rate within range filed by carrier and limited by increase of 15% and between 0.75 and 1.10% of index rate. In statute: § 10-16-05(8.5)(a)(V), C.R.S.	Aggregated for group and limited to the range filed for use by the carrier.
Plan Design Factors: Deductibles, etc. Managed Care Networks	√	√	√

[*] Exhibit 31: Centennial Care Choices Meeting presentation, August 2008. Additional Sources: Title 10, Article 16, C.R.S.

Recent Legislation

During the 2007 and 2008 legislative session, the Colorado General Assembly considered several health related bills. Below is a summary of some of the legislation that passed and was signed into law by the Governor.

HB 08-1389: Fair Accountable Insurance Rates

The act creates the Fair Accountable Insurance Rates Act for health insurance rates that take effect on or after January 1, 2009. Rate filings that include rate increases, must be filed with the commissioner at least 60 days prior to the proposed use of the rates. If the commissioner does not approve or disapprove the rates filed within a 60-day period, the insurance company may implement and reasonably rely on the rates on the condition that the commissioner may require correction of any deficiencies in the rate filing upon later review if the rate charged is excessive, inadequate, or unfairly discriminatory.

HB 08-1228: Insurance Responsibility Unfair Business Practice

The act authorizes the Commissioner of Insurance to collect restitution from an insurance producer (agent) or insurer for violating insurance laws or rules. Further, insurers are financially responsible for the unfair business practices of a producer authorized to sell its products if the insurer knew or should have known of the unfair business practices.

HB 08-1385: Concerning Increased Transparency to Consumers Regarding Health Care Insurance.

The act creates an apples to apples shopping guide for health insurance on the DOI's website. It also brings greater transparency to the commission fees that insurance producers earn while selling health insurance.

HB 08-1393: Consumer Transparency Health Care Act

The act requires the Insurance Commissioner to work with the Colorado Hospital Association (CHA) to include information about charges for the 25 most common inpatient procedures in the hospital report card. Hospitals must report the data to the CHA annually and the CHA must make the information available on its website by August 1, 2009.

By March 1, 2009, and annually thereafter, health insurance carriers must submit certain information to the Department of Regulatory Agencies, Division of Insurance, with regard to the 25 most common inpatient procedures. The Division of Insurance must post that information on its website.

HB 08-1410: Preventive Coverage Colorectal Cancer

The act mandates that most health insurance plans cover screening tests for colorectal cancer with cost sharing limited to 10 percent of the cost of screening. The act specifies what tests are to be covered by an insurance benefit plan. In order for the act to go into effect July 1, 2009, the commission on mandated health insurance benefits must evaluate the effects of the addition of mandating colorectal cancer screenings on health insurance premiums and provide a report to the Insurance Commissioner with the results of the evaluation no later than December 31, 2008.

SB 08-135: Health Insurance Standardized Benefits Card
The act requires state regulated health insurance carriers to develop and issue to their members, a card or other device containing information about the contents of and procedures to access benefits under the plan, which information that can be electronically scanned.

HB 08-1393: **Consumer Transparency Health Care Act/ Hospital Transparency**
The act requires the Insurance Commissioner to work with the Colorado Hospital Association (CHA) to include information about charges for the 25 most common inpatient procedures in the hospital report card. Hospitals must report the data to the CHA annually and the CHA must make the information available on the Division of Insurance website.

Health Care Reform

There are several committees and commissions that have been set up in Colorado, by the Governor or the legislature, to review and recommend health care reform measures in the state. In addition, there is significant work being done on a national level that could impact health insurance in Colorado. Addressing these efforts is outside the scope of this report.

Appendix A: Medical Loss Ratio Summaries

Exhibit 21

2008 Medical Loss Ratio Summary for Colorado*

	Direct Premiums Written	Direct Premiums Earned	Direct Losses Incurred	Pure Direct Loss Ratio
A&H* Health	$6,041,812,000	$5,924,423,000	$5,046,650,000	85.18%
A&H* Life	$3,032,945,000	$3,035,911,000	$2,307,268,000	76.00%
A&H* Property	$69,484,000	$56,708,000	$39,272,000	69.25%
Credit A&H* Life	$9,847,000	$11,283,000	$2,400,000	21.27%
Credit A&H* Property	$3,758,000	$3,771,000	$1,380,000	36.60%
A&H* Fraternal	$10,751,000	$10,132,000	$6,095,000	60.16%
Colorado totals	**$9,168,597,000**	**$9,042,228,000**	**$7,403,065,000**	**81.87%**

Appendix B: Colorado Health Premiums, Incurred Losses and Medical Loss Ratios

Exhibit 22

2008 Colorado Health Coverage Summary*

Colorado 2008	Direct Premiums Written	Direct Premiums Earned	Direct Losses Incurred	Pure Direct Loss Ratio
A&H* Health Companies				
Individual Comprehensive	$382,203,000	$375,701,000	$280,816,000	74.74%
Group Comprehensive	$2,805,139,000	$2,792,910,000	$2,365,363,000	84.69%
Vision Only	$39,575,000	$39,547,000	$29,542,000	74.70%
Dental Only	$631,372,000	$537,194,000	$519,314,000	96.67%
Federal Employees Health	$579,817,000	$574,053,000	$528,756,000	92.11%
Medicare Supplement	$30,203,000	$29,254,000	$18,224,000	62.30%
Title XVIII Medicare	$1,463,583,000	$1,464,266,000	$1,199,100,000	81.89%
Title XIX Medicaid	$47,912,000	$47,912,000	$41,046,000	85.67%
Other	$62,008,000	$63,586,000	$64,489,000	101.42%
Total for Lines of Business A&H Health	**$ 6,041,812,000**	**$ 5,924,423**	**$ 5,046,650,000**	**85.18%**
A&H* Life Companies				
Group accident and health	2,022,394,000	2,012,098,000	1,549,211,000	76.99%
Collectively renewable A&H*	365,000	282,000	230,000	81.56%
Non-cancelable A&H*	81,874,000	81,323,000	79,907,000	98.26%
Guaranteed renewable A&H*	338,992,000	340,001,000	174,048,000	51.19%
Non-renewable for stated reasons only	186,894,000	186,140,000	127,868,000	68.69%
Other accident only	1,036,000	978,000	1,049,000	107.26%
Medicare Title XVIII exempt from state taxes or fees	383,606,000	397,213,000	361,046,000	90.89%
All other A&H*	10,082,000	10,208,000	8,072,000	79.08%
Federal Employees' Health Benefit Plan	7,702,000	7,668,000	5,837,000	76.12%
Total for Lines of Business A&H Life	**3,032,945**	**3,035,911,000**	**2,307,268,000**	**76.00%**
A&H* Property & Casualty Companies				
Group accident and health	$37,635,000	$35,957,000	$20,905,000	58.14%
Collectively renewable A&H*	$1,000	$1,000	0	0%
Non-cancelable A&H**	0	$21,000	-$10,000	-47.62%*
Guaranteed renewable A&H*	$25,639,000	$14,145,000	$16,347,000	115.57%
Non-renewable for stated reasons only*	$3,449,000	$3,716,000	$2,084,000	56.08%
Other accident only**	$1,032,000	$1,137,000	-$888,000	-78.10%*
Medicare Title XVIII exempt from state taxes or fees	0	0	0	0%
All other A&H*	$1,728,000	$1,731,000	$834,000	48.18%
Federal employees health benefits program premium	0	0	0	0%
Total for Lines of Business A&H Property	**$69,484,000**	**$56,708,000**	**$39,272,000**	**69.25%**
Credit A&H* Life Companies	**$9,847,000**	**$11,283,000**	**$2,400,000**	**21.27%**
Credit A&H* Property Companies	**$3,758,000**	**$3,771,000**	**$1,380,000**	**36.60%**
A&H* Fraternal Companies	**$10,751,000**	**$10,132,000**	**$6,095,000**	**60.16%**
Colorado Totals	**$9,168,597,000**	**$9,042,228,000**	**$7,403,065,000**	**81.87%**

* A&H means Accident and Health

** Negative losses incurred may be a result of a company holding a loss reserve on pending claims that became unnecessary and resulted in the company releasing the reserve; or may result from a recovery from another party.

Glossary of Terms

Accident and Health Insurance - A type of coverage that pays benefits, sometimes including reimbursement for loss of income, in case of sickness, accidental injury, or accidental death.

Administrative Expenses - Expenses an insurer incurs to run its business. This includes all expenses that are not directly attributed to settling and paying claims of members. Examples are commissions, marketing and advertising expenses, and salaries of non-claims personnel.

ASO (Administrative Services Only) - An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; however, the employer bears the risk for claims. This is common in self-insured health care plans.

Anti-Selection or Adverse Selection – The tendency of individuals who believe they have a greater than average likelihood of loss to seek insurance protection to a greater extent than do those who believe they have an average or less than average likelihood of loss.

For example, those with severe health problems want to buy health insurance, and people going to a dangerous place such as a war zone want to buy more life insurance. Companies employing workers in dangerous occupations want to buy more workers' compensation coverage. In order to combat the problem of adverse selection, insurance companies try to reduce their exposure to large claims by either raising premiums or limiting the availability of coverage to such applicants.

Average Monthly Premium -The approximate monthly cost for insurance coverage. This amount is calculated by dividing the Revenue Amount by Member Months.

Benefits Ratio - The ratio of the value of the actual benefits provided, not including dividends, to the value of the actual premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. "Benefits ratio" is also known as "loss ratio".

Claim - A formal request for payment related to an event or situation that is covered under an in-force insurance policy.

Claim Adjustment Expenses - The cost of settling, recording and paying claims.

Coinsurance - A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

Collectively Renewable - An insurer may not cancel an individual policy under any circumstances. However, the insurer may cancel all policies in similar rating classes.

Copayment - A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement.

Cost Containment Expense - Expenses that an insurer incurs to reduce the number of health services provided or the cost of services. This includes expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses.

Credit Insurance- Insurance on a debtor to provide indemnity for payments or loan balance, or any combination thereof, becoming due on a specific loan or other credit transaction upon contingency for which the insurance is obtained.

Deductible Leveraging – A component of premium increase for plans with a fixed deductible. If the price of services increases from one year to the next, but the deductible stays the same, then an economic adjustment is made to the premium to reflect the increase in the amount of benefits paid in comparison to increases in the total cost of services. The effect of deductible leveraging occurs when one piece of the claim cost is "frozen" while others are not. An example of this is the co-pay.

For example; in year one an office visit co-pay paid by you, the policyholder, is $10. You incur an office visit that costs $80. You pay $10 and the plan pays $70. In the second year there are no plan changes and you have another office visit. With 14% medical care trend that office visit in the second year will now cost $91.20 (1.14 X $80). You still pay $10, but now the plan pays $81.20. In this case, medical care inflation to you, the policyholder, is zero (0 %) while medical care inflation to the plan is not 14% but 16% ($81.20 divided by $70). This effect of deductible leveraging can also occur with fixed deductibles. Fixed deductibles will result in greater inflation in the premium you pay than the underlying trend in medical care costs. The larger the deductible, the greater the impact on premium inflation.

Dividends -The distribution of earnings to the carrier's owners during the year. If an insurer is publicly held, then the dividends would be returned to stockholders. If the insurer is a mutual company, the dividends are returned to the policyholders, who are considered the owners of the company.

Direct Written Premium - The total premiums generated from all policies written by an insurance company within a given period of time.

Division – Means the Division of Insurance.

Domestic- Designates those companies incorporated or formed in this state.

Earned Premiums – The portion of the total premium amount corresponding to the coverage provided during a given period of time.

Experience Rating – A method of calculating group insurance premium rates by which the insurer considers the particular group's prior claims and expense experience.

Fully insured plan - A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

Incurred Claims – The total amount of claims occurring during a given time period.

Guaranteed Renewable - An insurer may not cancel the policy under any circumstances. However, subject to certain conditions (regulatory approval, adverse experience), the premium rates may be increased. It is the most common contract form; especially for individual medical and Long-Term Care.

HMO (Health Maintenance Organization)- Prepaid health insurance plan that entitles members to services of participating physicians, hospitals, and clinics. Members of the HMO pay a flat periodic fee for medical services.

Loss Adjustment Expense – cost involved in an insurance company's adjustment of losses under a policy.

Loss Ratio – relationship of incurred losses plus loss adjustment expense to earned premiums.

Medicare - A federal health insurance program for people 65 years of age and older, and for people of all ages with certain disabilities. Eligibility is not income based.

Medicaid - A federal/state program that provides health coverage for certain categories of people with low incomes.

Medical loss ratio - The percent of health insurance premiums spent on medical claims. A 0.96 loss ratio means that 96 percent of the insurer's health insurance premiums purchased medical services. The more technical definition of medical loss is claims incurred divided by net premium earned.

Member Months - A member month is defined as 1 member being enrolled for 1 month. For example, an individual who is a member of a plan for a full year generates 12 member months and a family of 5 enrolled for 6 months generates (5 X 6) 30 member months. To obtain an approximate number of enrollees in a health plan, divide the member month figure by twelve.

NAIC- Means the National Association of Insurance Commissioners.

Negative Trend – With respect to a life and/or health insurer, negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the RBC instructions

Net Claims Incurred - Cost for hospital and medical benefits, emergency room, and prescription drugs minus recoveries from the reinsurer plus the change in the unpaid claim liability. The unpaid claim liability is the insurer's estimate of the cost for claims already reported but not yet paid and an estimate of claims incurred by a member but not yet submitted for payment.

Net Income - The net result of all revenue, claims incurred, expenses, investment results, taxes, and write-offs. This report uses the term profit margin as synonymous with net income.
Net investment income (or gain) - Includes all income earned from invested assets minus expenses associated with investments plus the profit (or loss) realized from the sale of assets.

Net Income After Taxes - All expenses and losses over the year subtracted from all revenues and gains over the year. This calculation includes investment income, investment gains and other charges.

Net premium Earned - The amount charged by the insurer to the policyholder for the effective period of the contract, reinsurance premiums, plus the change in the unearned premium liability. The unearned premium liability is the portion of the premium that has been received by the insurer for insurance that has not yet been provided. It is the amount that would have to be returned to the policyholder if the policy was canceled before the end of the policy period.

Noncancelable - An insurer may not cancel the policy and may not increase premiums for any reason. Commonly used for Disability Income for most select risks.

Non-renewable for Stated Reasons Only - When the insured reaches a certain age or when all similar policies are not renewed, the policy is said to be nonrenewable for the reasons stated.

Premium-to-Surplus Ratio - This ratio measures an insurer's ability to support its existing business, as well as any growth. Since surplus provides a cushion for claims and expenses that exceed what the insurer expected, this ratio measures the adequacy of the surplus cushion available for unexpected claims and expenses.

Risk-Based Capital (RBC) - A method for evaluating an insurer's surplus in relation to its overall business operations in consideration of its size and lines of business written. An insurer's RBC is calculated by applying factors to various assets, premium, and reserve items. The calculation produces the "authorized control level." The RBC ratio is the insurer's surplus divided by the authorized control level. The state is authorized to take regulatory action against an insurer that fails to maintain surplus equal to 200 percent of its authorized control level.

RBC Ratio – The measurement of the amount of capital (assets minus liabilities) an insurance company has as a basis of support for the degree of risk associated with it s company operations and investments. This ratio identifies the companies that are inadequately capitalized by dividing the company's by the minimum amount of capital that the regulatory authorities feel is necessary to support the insurance operations.

RBC Statistic – A ratio of authorized control level risked based capital of an insurance company to its total adjusted capital. This statistic determines regulatory action taken by the state's insurance commissioner

Reinsurance – A form of insurance that insurance companies buy for their own protection, "a sharing of insurance." An insurer (the reinsured) reduces its possible maximum loss on either an individual risk or a large number of risks by giving (ceding) a portion of liability to another insurance company (reinsurer).

Reinsurer – An insurance company that assumes all or part of an Insurance or Reinsurance policy written by a primary insurance company.

Reserves - Funds created to pay anticipated claims.

Reserves for Unpaid Claims - Expected payments for claims, including reported claims and estimates of potential claims.

Self-insured plan – A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types of plans (Conventional Indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.

Stop-loss coverage – A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Surplus - The amount an insurance company's assets exceed its liabilities. Additional funds are surplus over and above what the insurer expects to pay out for medical claims, expenses, taxes, and other obligations. All insurers must, by law, maintain minimum levels of surplus to ensure they will be able to meet their financial obligations to policyholders. Surplus includes common and preferred stock issued to its shareholders, any funds that are contributed to the insurer, and the accumulation of the insurer's net income or losses since its inception.

Third Party Administrator (TPA) – An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

Total Adjusted Capital - Commonly refers to an insurance company's capital base under Standard & Poor's capital adequacy model. It includes shareholders' funds and adjustments on equity, asset values and reserves.

Total Net Underwriting Gain or Loss - The operating costs that are not allocated to Hospital and Medical Payments, Claim Adjustment Expenses or Investment Expenses.

Trend or Trending- Any procedure used to project claim costs from one period to another. Typically, "trend" is expressed as an annual percentage rate, which represents the rate at which claim costs are expected to change over a period of one year.

Underwriting - The process of identifying and classifying the degree of risk represented by a proposed insured. An insurance company's process to decide whether or not to issue coverage to an applicant and which benefits to offer at which premium rates. Its fundamental purpose is to make sure that the premiums collected reflect the company's estimate of future claim costs. An individual who has been subjected to this process is referred to as being "underwritten."

Underwriting Wear-off - The tendency for the differential in claim costs between groups of individuals who have been "underwritten" and groups of individuals who have not been "underwritten" to narrow over time. As a group of underwritten policies age, the effects of underwriting wear-off will result in higher premium rate increases for this group as compared to a similar group of policies that were not underwritten.

Insurance Company Financial Statements

Detailed financial statements are filed by each insurer covering its financial status and income and expense activity for each calendar quarter and each calendar year. The annual statement (prepared as of December 31 of each year) is due to be filed with the Division of Insurance March 1 of each year. The quarterly statements are prepared as of March 31 due to be filed May 15; as of June 30 due to be filed August 15; and September 30 due to be filed November 15.

The detailed financial statements for Colorado domestic insurers are available at the Division's Denver office. For more information, please visit the Division's Web site at www.dora.state.co.us/insurance, or call (303) 894-7499 in Denver, or from outside of Denver, call toll free (800) 930-3745.

Insurers also file their financial statements electronically with the National Association of Insurance Commissioners (NAIC). State insurance departments also file summarized information with the NAIC about consumer complaints against the insurer. The NAIC makes basic financial and complaint information available on its Web site, www.naic.org. The following information is available without registration or charge: summarized closed complaint reports, licensing by state, and basic financial information (premium, assets, liabilities, financial profile). By setting up an account with the NAIC Consumer Information Source you can access complete financial statement filings. Each year the NAIC allows you to access information on five insurers free of charge. After the first five, there is a charge.

To access the NAIC's insurer information, go to the NAIC Web site, select "Consumer Information Source" and follow the directions for accessing information.