Department of Regulatory Agencies

Annual Report of the Commissioner of Insurance

to

The Colorado General Assembly

on

2010 Health Insurance Costs

in accordance with §10-16-111(4)(c) & (d), C.R.S.

February 16, 2011

Department of Regulatory Agencies

Division of Insurance
John J. Postolowski
Interim Commissioner of Insurance

February 16, 2011

To the Members of the House and Senate,

I am pleased to submit the 2010 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,

John J. Postolowski
Interim Commissioner of Insurance

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Consumer Protection

2010 COLORADO HEALTH INSURANCE REPORT

Acknowledgements

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Executive Summary

As health insurance premiums continue to increase, the need 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 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 fulfills the requirement and examines increases in health insurance premiums in the state of Colorado. The report also provides an overview of the companies' expenses and financial statements of companies, 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 2009. 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' 2009 Annual Financial Statements, which were filed in March 2010; and the information gathered from the 2010 Colorado Health Cost Survey, completed in June of 2010.

2009 Highlights

- In Colorado, 40.3% of Coloradans have health coverage that is regulated by the Division of Insurance. There are 21% covered by federally regulated self-insured plans offered through their employer. Another 23% received coverage through government programs, including but not limited to Medicare, Medicaid, the Federal Employees' Health Benefit Plan and the Veteran's Administration. Moreover 15.7% of Coloradans were uninsured.

- During 2009, 61.3% of Coloradans were covered by either the commercial health insurance market or a self-insured employer health plan, compared to the 54% of citizens in other states nationwide.

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

- During 2009, approximately 84% of premiums collected in 2009 by carriers in Colorado went directly to the cost of providing health care services. Approximately 13.87% 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 employees' contribution to those premiums has increased more than the national average.

- The number of private employers offering self-insured health plans to their employees increased in Colorado at twice the national rate. Employer-funded or self-insured plans are often called "ERISA" plans as they are regulated by the federal government under the Employees' Retirement Income Security Act (ERISA).

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

Introduction

Many factors drive 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 2009 and 2010 were used. Also, this report provides an overview of health insurance in Colorado, the sources of coverage and the types of coverage available. 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 health insurers in Colorado and provides financial information for each.

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.

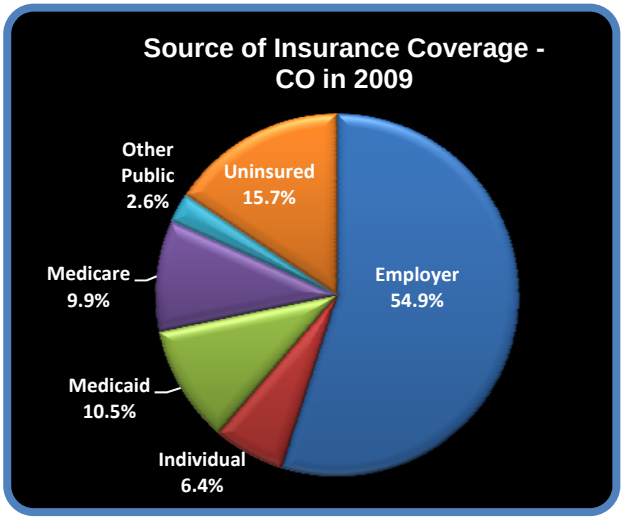


Figure 1: Sources of Insurance Coverage- CO in 2009

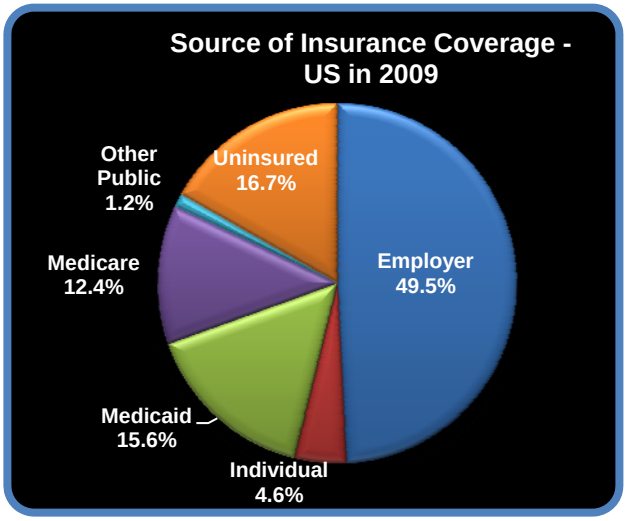


Figure 2: Sources of Insurance Coverage - US in 2009

As shown in Figures 1 & 2, 54.9% of Coloradans secure health coverage through their employer, compared with 49.5% nationwide. The Colorado individual insurance market is also slightly larger than the national figures with 6.4% of Coloradans having individual health insurance policies, compared with 4.6% nationwide. **Therefore, 61.3% of Coloradans are covered by either the commercial health insurance market or a self-insured employer health plan, which is significantly more than the 54.1% of citizens nationwide.**

Another 23% of Coloradans get their health care coverage through government programs such as Medicare, Medicaid, the Federal Employees' Health Benefit Plan and the Veteran's Administration. These programs are administered by the state and federal government, and are paid for by a combination of participant premiums and tax dollars.

An estimated 15.7% of Coloradans have no health insurance.

Table 1 below provides further detail on the enrollment of health coverage in Colorado.

Colorado Health Insurance Enrollment in 2009	
Colorado population	4,917,600
•Insured	4,146,400
•Uninsured	771,200
Jurisdiction of the Division of Insurance	
•Individual	314,000
•Small Group	287,239
•Large Group	1,381,076
•**Total Under State Regulation**	**1,982,315**
Insured, Not Regulated by the Division of Insurance	
•Medicare	489,000
•Medicaid	513,900
•Other Public	128,800
•Self-funded	1,032,385
•**Total Not Regulated by the Division of Insurance**	**2,164,085**

Table 1: Colorado Health Insurance Enrollment in 2009

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, approximately 6% 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:

- **Accident Only -** An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident.
- **Accidental Death & Dismemberment -** An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.
- **Comprehensive Major Medical (group or individual) -** Provides benefits for most types of medical expenses that may be incurred. Offering more complete coverage with fewer gaps, major medical insurance covers a much broader range of medical expenses - including those incurred both in and out of the hospital - with generally higher individual benefits and policy maximum limits.
- **Conversion -** Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability.
- **Credit Accident and Health -** Designed to cover a borrower's indebtedness, with the creditor receiving the policy benefits to pay off the debt if the borrower becomes disabled or dies accidentally or loses a job. Credit insurance can be written as an individual policy for a single borrower or group coverage for a number of debtors with the creditor as master policyowner.
- **Managed Care (group or individual) -** A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMOs and PPOs that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality, by emphasizing prevention of disease.
- **Health Maintenance Organizations (HMOs)** - Health Maintenance Organizations represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed

monthly fee for services, instead of a separate charge for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided, Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design. Depending on the type of the HMO, services may be provided in a central facility or in a physician's own office.

- **Hospital/Surgical/Medical Expense -** An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.
- **Dental -** Insurance that provides benefits for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.
- **Disability Income -** (includes Business Overhead Expense; Short Term; Long Term; and Combined Short Term and Long Term) - A policy designed to compensate insureds for a portion of the income they lose because of a disabling injury or illness.
- **Vision -** Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.
- **Long-term Care** - Long Term Care Insurance is a special type of health insurance that is designed to cover expenses of nursing home care, home health care or other types of defined care that persons may need at various stages of their lives, and not necessarily just at advanced ages.
    a) LTC products must have a minimum 12-month benefit period, but can have longer benefit periods. LTC benefits are frequently described as a specific dollar amount per day (e.g. $100 per day).
    b) LTC products have elimination periods, expressed in days, before which LTC covered benefits become payable after disablement. Elimination periods basically work like deductibles and represent a form of cost sharing where the policyholder agrees that LTC benefits won't be paid for the first few days after a person qualifies for benefits under the LTC coverage. These elimination periods reduce the premium for LTC.
    c) Generally, eligibility for benefits under LTC is conditioned on a covered person not being able to perform two or more activities of daily living (such as eating, bathing, dressing, transferring from bed, continence, etc.) and cognitive challenges such as Alzheimer's can also qualify a person for benefits. LTC can be sold on an individual or on a group basis.
- **Limited Benefit Plans -** (includes Specified Disease; Critical Illness; Dread Disease; Dread Disease - Cancer Only; HIV Indemnity; Intensive Care; and Organ & Tissue Transplant)
    a) Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.
    b) Provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits not to exceed a stated dollar amount per day.
    c) Provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day.
- **Medicare Supplement -** Insurance coverage sold on a individual or group basis to help fill the "gaps" in the protections granted by the federal Medicare program. This is strictly supplemental coverage and cannot duplicate any benefits provided by Medicare. It is structured to pay part or all of Medicare's deductibles and copayments. It may also cover some services and expenses not covered by Medicare. Also known as "Medigap" insurance.
- **Medicare Part D Prescription Drug Coverage -** Medicare prescription drug coverage is insurance that covers both brand-name and generic prescription drugs at participating pharmacies. Medicare prescription drug coverage provides protection for people who have very high drug costs or from unexpected prescription drug bills in the future.

- **Champus/Tricare Supplement-** Civilian Health and Medical Program of the Uniformed Services (Champus). A private health plan that provides beneficiaries eligible for Champus with supplemental health care coverage.

Colorado Enrollment by Health Insurance Types in 2009[1]				
	Individual	Large Group	Small Group	Grand Total
Accidental Death & Dismemberment	243,919	6,934,504	639,364	7,817,787
Comprehensive Major Medical	262,149	576,098	203,759	1,042,006
Credit Accident and Health	126,259	92,662	8,856	227,777
Dental	43,324	772,100	188,356	1,003,780
Disability Income	99,835	1,034,233	68,508	1,202,576
Managed Care (HMO)	34,408	472,592	113,543	620,543
Limited Benefit Plan	231,251	108,744	3,566	343,561
Long-term Care	99,279	37,409	418	137,106
Vision	53,872	855,289	105,880	1,015,041
Medicare Supplement	26,545	77,144		103,689
Grand Total	**1,220,841**	**10,960,775**	**1,332,250**	**13,513,866**

Table 2: Colorado Enrollment by Health Insurance Types in 2009

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.

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

[1] The number of covered lives in Table 2 may appear inflated for a variety of reasons. Individuals typically have multiple types of policies such as single individual having both an AD & D and major medical policy. In addition for some types of policy it is not uncommon for an individual to be covered by both a group and individual policy or multiple individual policies. Finally since the data is self-reported by carriers and several of these policy types have long lives there may be inconsistencies between how carriers are accounting for movement in and out of Colorado. Some carriers may be including all policies originally written in Colorado while others are included only the current membership active in Colorado. Similarly it is possible that some companies may be including group lives purchased by a Colorado company but living in another state in this report.

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 or medical facility which 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 which to choose.

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. **The Division has responsibility to oversee coverage for 40.31% of Coloradans through the small group, large group and individual markets.** Section 4 of this report focuses on the regulatory role that the Division plays in the marketplace and the tools used to protect consumers.

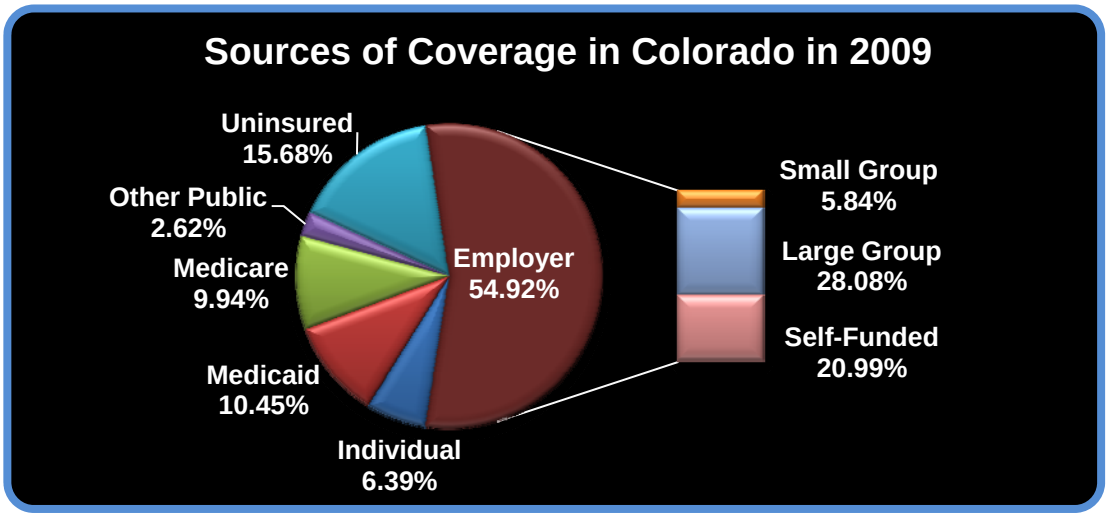


Figure 3: Sources of Coverage in Colorado in 2009

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 that must be covered in a policy. 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 with individual plans for their insurance is small, there are a number of carriers in the state that offer such plans. There were 65 carriers who reported offering individual major medical comprehensive policies in Colorado during 2009. Table 3 below reflects the number of carriers that offer Individual health coverage and the average premiums per member per month reported from the 2010 Colorado Health Cost Survey.

Individual	Number of Companies offering Individual Coverage	Average Premium per Member per Month	Average Premium per Member Annually
AD&D	102	$13.15	$145.48
Comprehensive Major Medical	65	$177.73	$2,096.84
Credit	11	$19.28	$219.73
Dental	30	$26.96	$270.35
Disability Income	155	$93.05	$1,057.47
Managed Care - HMO	6	$196.79	$2,211.42
Limited Benefit Plans	126	$47.17	$512.24
Long Term Care	85	$176.71	$1,808.83
Vision	5	$2.44	$31.86

Table 3: Individual Average Premiums

CoverColorado

If a person cannot qualify for 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.[2] 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 8,500 on December 31, 2009. Colorado is one of 35 states that have a high-risk pool insurance plan.

GettingUScovered

GettingUSCovered is the temporary federal high risk pool created in the State of Colorado under the Patient Protection and Affordable Care Act of 2010. GettingUSCovered is wholly funded by Enrollee premiums and federal dollars, with federal funding anticipated to continue through December 31, 2013, at which time other coverage options are to be available under the Act to those with Pre-Existing Conditions. It is a comprehensive health plan for Coloradans who have been uninsured at least six months and have a pre-existing condition. While GettingUSCovered is not a low income plan, it does not cost any more than the price of insurance for healthy individuals. There is no waiting period, once an individual is accepted into the plan, medical treatment can begin upon the effective date.

GettingUSCovered expects to expand coverage to up to 4,000 currently uninsured individuals and to continue through December 31, 2013. Enrollment may need to be limited based on federal funding. The plan is a bridge to 2014, when individuals with pre-existing conditions will be able to purchase health coverage through health insurance exchanges.[3]

Employer Provided Insurance

The group health plan market in Colorado is 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, 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.

Many large and some small employers create "self-funded" health plans for their employees. In these self-funded plans, the employer keeps the risk to pay the claims from the company's budget 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), but the health plan is not subject to state insurance laws and regulations.

[2] www.covercolorado.org
[3] www.gettinguscovered.org

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 and premium rating can only be based on smoking status, industrial classification, age, family size and geographic region. Stated in Table 4 below are the number of companies, the average premiums per member by month and annual average premium reported from the 2010 Colorado Health Cost Survey.

Small Group	Number of Companies offering Small Group Coverage	Average Premium per Member per Month	Average Premium per Member Annually
AD&D	41	$0.43	$5.21
Comprehensive Major Medical	22	$289.85	$3,478.21
Credit	5	$6.98	$83.75
Dental	45	$30.10	$361.19
Disability Income	34	$2.45	$29.44
Managed Care - HMO	7	$276.73	$3,320.72
Limited Benefit Plans	25	$35.58	$426.96
Long Term Care	10	$57.85	$694.23
Vision	18	$4.57	$54.87

Table 4: Small Group Market Average Premiums in 2009

The major small market changes in health benefit plans from 2008 to 2009 include the following[4]:

- The number of small business group plans fell by 10% in 2009, with the exception of Business Groups of One, which fell by 6%.
- The number of small business group plans in Colorado decreased 10% from 41,349 to 37,328.
- The number of covered lives decreased 13% from 330,998 to 287,239.
- The top 10 companies increased their small group market share to include 99% of all lives covered in 2009, as compared to 97.5% in 2008.
- Of 21 companies in the small group market, 16 still sell new policies.
- Health Savings Account (HSA) qualified plans increased in proportion to other plans by 4%.
- HMO-type coverage in proportion to other types increased by 12%.

According to the Division's 2009 Small Group Activity Report, **22 carriers offered small group health benefit plans in Colorado during 2009. They covered 37,328 groups, or 287,239 lives.**[4]

"Health benefit plan" does not include: Accident only; credit; dental; vision; Medicare supplement; benefits for long-term care, home health care, community-based care, or any combination thereof; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage for on-site medical clinics; coverage issued as a supplement to liability insurance, workers' compensation or similar insurance; or automobile medical payment insurance.

The term also excludes specified disease, hospital confinement indemnity, or limited benefit health insurance if such types of coverage do not provide coordination of benefits and are provided under separate policies or certificates. Solely with respect to the provisions of section 10-16-118 (1) (b) concerning creditable coverage for individual policies, the term excludes individual short-term limited duration health insurance policies issued after January 1, 1999. This means such policies do not have to recognize creditable coverage.

[4] These notes are based on the 2009 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.

Large Group Market

A large group health plan is a fully insured health plan offered to employer groups of more than fifty employees. 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 have more ability to negotiate 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.

Large Group	Number of Companies offering Large Group Coverage	Average Monthly Premium per Member	Annual Average Premium per Member
AD&D	77	$0.77	$144.02
Comprehensive Major Medical	39	$141.61	$2,162.23
Credit	19	$6.02	$209.26
Dental	45	$27.80	$270.70
Disability Income	56	$16.53	$1,050.95
Managed Care - HMO	11	$283.81	$2,422.11
Limited Benefit Plans	45	$7.20	$501.61
Long Term Care	22	$61.58	$1,775.53
Vision	18	$5.13	$25.88

Table 5: Large Group Market Average Premiums in 2009

Federally Regulated Health Plans

Self-insured Market

Even though the Division does not regulate employer 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 4 shows that the number of private employers in Colorado that offer health plans and self-insure at least one of their plans has increased from 26% in 1998 to 36.9% in 2009. The 10.9% increase hasn't been nearly as dramatic nationally, with the rate nationwide increasing from 26.9% in 1998 to 35.1% in 2009.

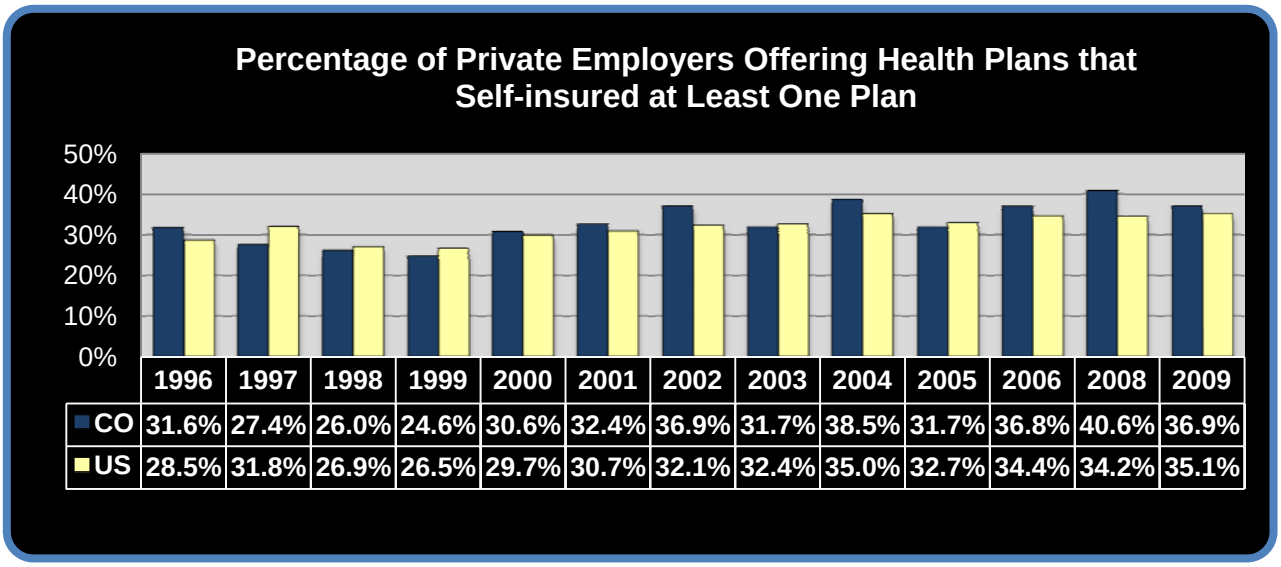


Figure 4: Percentage of Private Employers Offering Health Plans that Self-insured at Least One Plan in Colorado vs. U.S.

Employers who self-insure their health benefit plans retain all of the risk of paying all the claims 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 insures.

Government Health Plans

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

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. Enrollment of children in Medicaid and CHP+ increased overall during 2009. The percent enrollment increase between January and December 2009 was 13.1% for Medicaid.

Colorado adopted rules to comply with several of the Children's Health Insurance Program Reauthorization Act (CHIPRA) provisions in 2009, including a requirement that newborns whose birth was paid for by Medicaid no longer need to prove their citizenship after one year of eligibility ends, and Colorado must accept certain tribal documents to establish citizenship. **More than 513,900 Coloradans were receiving health coverage through Medicaid in 2009, representing 10.5% of the state's population**.[5]

Child Health Plan Plus (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. The enrollment has increased by 6.86% from 2008 to the fiscal year of 2009. The monthly **CHP+ enrollment was 64,598 in Colorado in 2009.**[6]

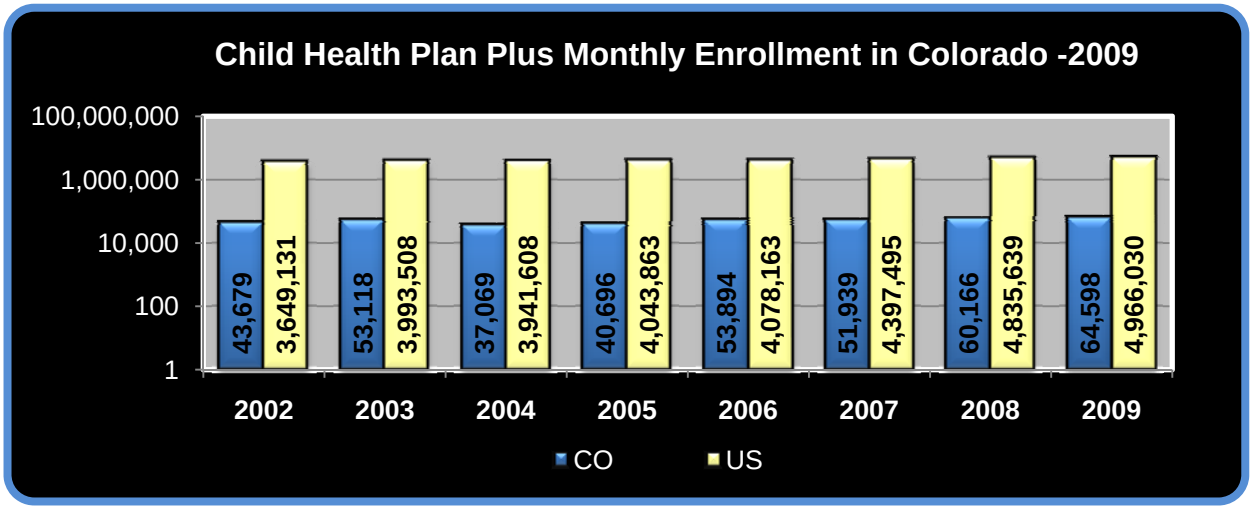


Figure 5: CHIP Monthly Enrollment in Colorado - 2009

[5] The Department of Health Care Policy and Financing. (2010). Premiums, Expenditures, and Caseload Reports. Retrieved August 2, 2010, from http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1209635766663

[6] www.cchp.org

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 489,000 Coloradans in Medicare in 2009, which was 9.9% of the state's population.**[7]

Senior Health Insurance Assistance Program (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 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.

[7] www.statehealthfacts.com

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, factual data about how premiums collected by health carriers in Colorado are used.

Overview of Colorado Employer Provided Health Plan Premiums

Health insurance provided by employers is a key source of coverage for both employees and their families under 65. Job-related health insurance premiums can vary for many reasons, such as the type of health insurance plan offered, the generosity (benefits) of the plan, the size of the company offering the plan, number of persons covered by the plan, where one lives, various workforce characteristics, state health insurance regulations, and the local cost of health care. All of these factors can contribute to differences in the average health insurance premiums.

Figure 6 demonstrates how the size of an employer affects the accessibility of health insurance. Approximately 43% of small companies with less than fifty employees offer insurance compared to the 97% of larger firms that offer insurance.

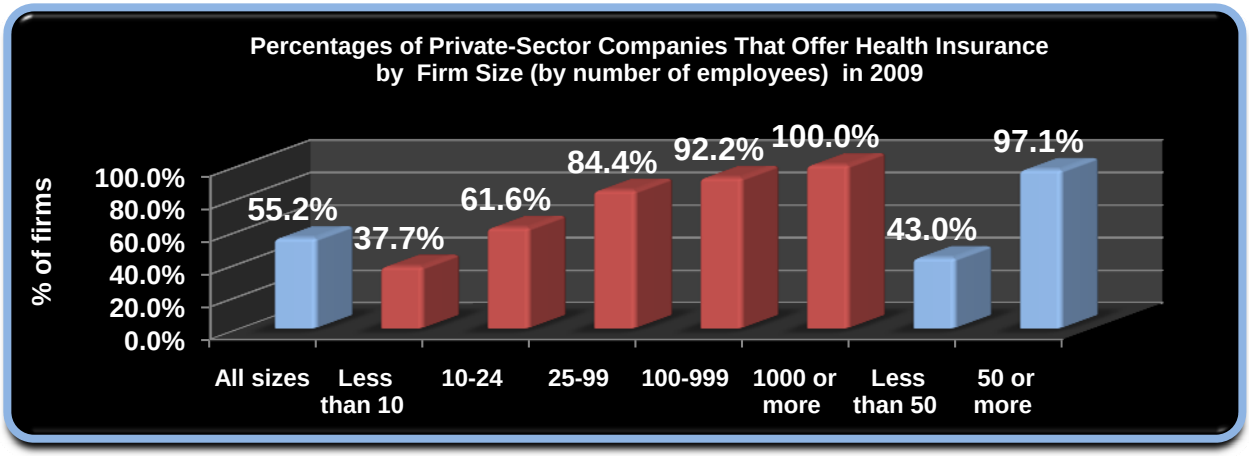


Figure 6: Percentage of Private-Sector Companies That Offer Health Insurance by Firm Size in Colorado - 2009

In 2009, half of private sector employees enrolled in employer-sponsored health insurance took single coverage and half took family coverage (a plan covering the employee and at least one other family member). According to the Insurance Component of the Medical Expenditure Panel Survey, those employees with family coverage contributed both a larger dollar amount and a larger percentage of the total premium for their coverage than did employees with single coverage.

Single Coverage	Average Annual Total Premium	Average Copayment	Average Deductible	Average Annual Employee Contribution	Average Annual Employer Contribution
Exclusive-Provider Plans	$4,321			$901	$3,420
Mixed-Provider Plans	$4,667	$23	$108	$968	$3,699
Any-Provider Plans	$4,414			$1,289	$3,125
Family Coverage	**Average Annual Total Premium**	**Average Copayment**	**Average Deductible**	**Average Annual Employee Contribution**	**Average Annual Employer Contribution**
Exclusive-Provider Plans	$13,178			$2,986	$10,192
Mixed-Provider Plans	$13,466	$23	$1,870	$3,437	$10,029
Any-Provider Plans	$12,123			$3,919	$8,204

Table 6: Premiums, Copayments, Deductibles, and Contributions of Premiums

The average annual Colorado premium in 2009 was $4,570 for single coverage and $13,360 for family coverage. Figure 7, illustrates the increases in private employer-sponsored health premiums since 1996.

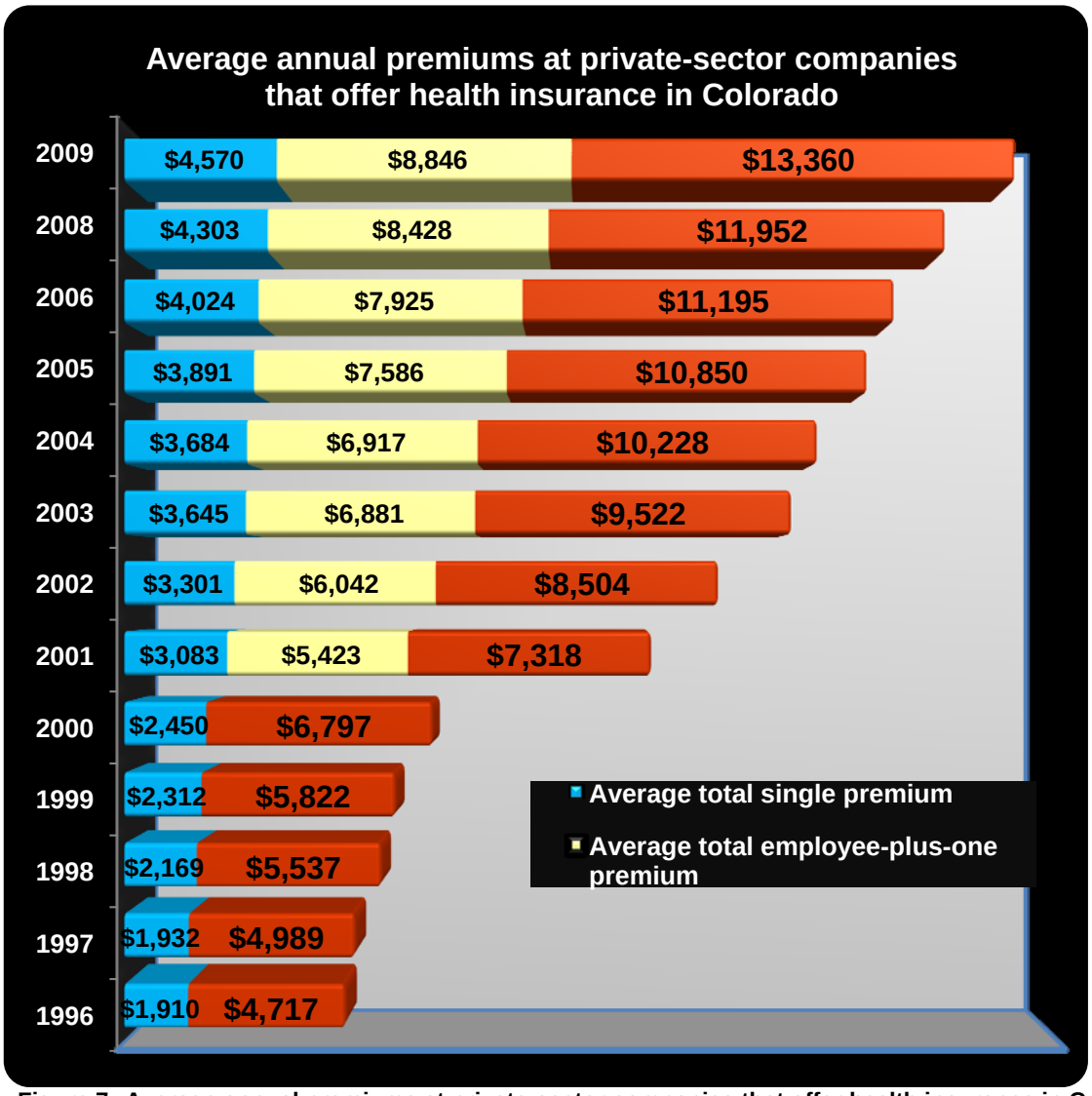
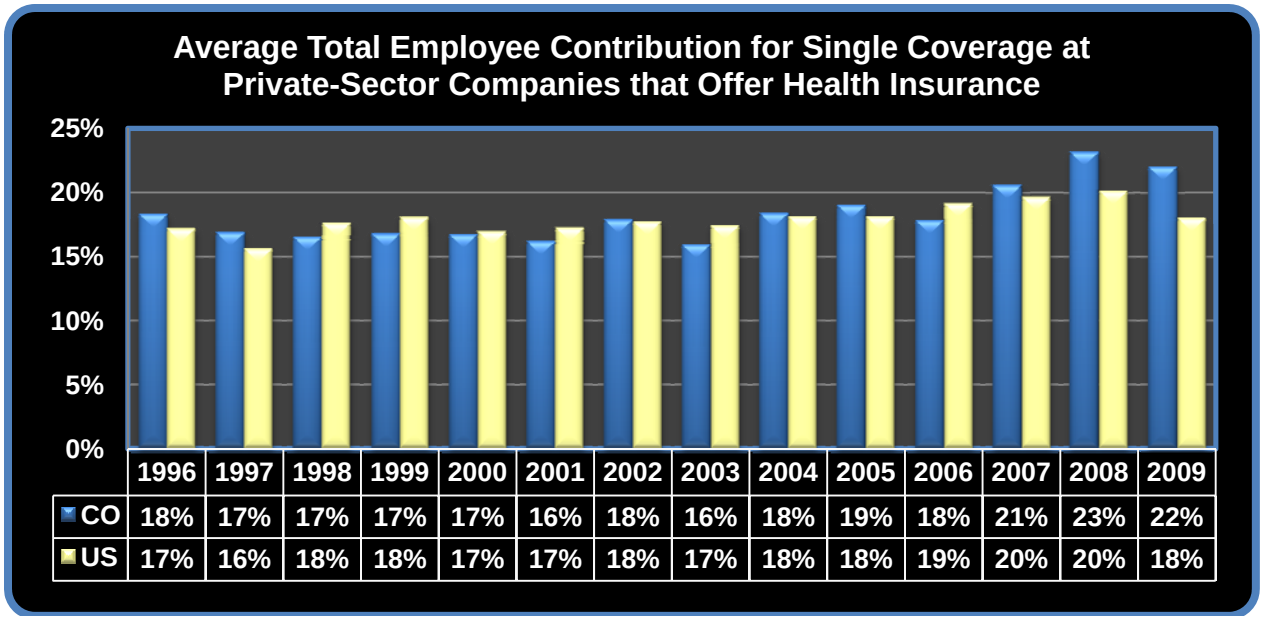


Figure 7: Average annual premiums at private-sector companies that offer health insurance in Colorado

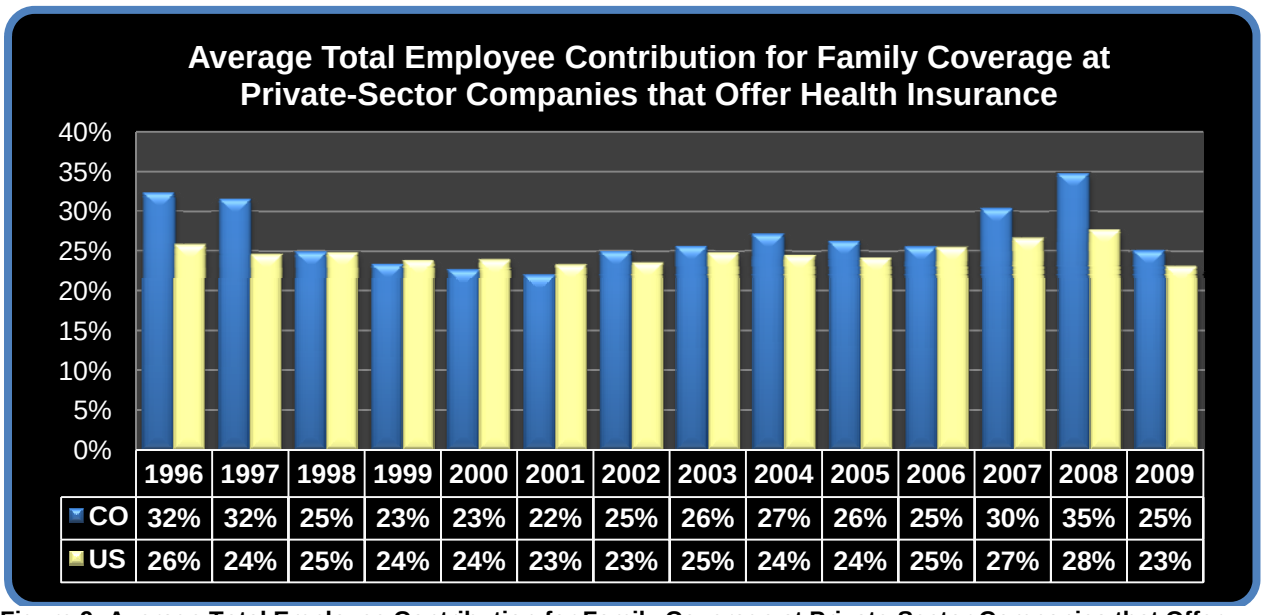
Premium costs for employer-based coverage may be paid completely by the employee, paid in part by the employer and in part by the employee, or paid completely by the employer. The following exhibits indicate that the dollar amount that Colorado employees are contributing is increasing much more quickly 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.**



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
CO	18%	17%	17%	17%	17%	16%	18%	16%	18%	19%	18%	21%	23%	22%
US	17%	16%	18%	18%	17%	17%	18%	17%	18%	18%	19%	20%	20%	18%

Figure 8: Average Total Employee Contribution for Single Coverage at Private-Sector Companies that Offer Health Insurance

Colorado employees paid 22% of the total premium for single coverage and 25% for family coverage, compared to 18% for single coverage and 23% for family coverage, nationally. Before 2008, 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 since 2007, 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	2009
CO	32%	32%	25%	23%	23%	22%	25%	26%	27%	26%	25%	30%	35%	25%
US	26%	24%	25%	24%	24%	23%	23%	25%	24%	24%	25%	27%	28%	23%

Figure 9: Average Total Employee Contribution for Family Coverage at Private-Sector Companies that Offer Health Insurance

While 20.6 percent of private sector employees with single coverage were enrolled in a plan that did not require them to contribute toward the premium cost, only 11.4 percent of employees with family coverage and 10.3 percent of those with employee-plus-one coverage were in such a plan. **For both large and small employers, employees with single coverage contributed less toward their plan premium than those with family coverage.**

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 a carrier to submit 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.

Average Percentage Rate Increases by Type of Health Insurance[8]						
	2006	**2007**	**2008**	**2009**	**2010**	**Total 5-Year Average**
Accident Only & Accidental Death and Dismemberment	-0.1	-1.0	-2.0	-4.6	0.0	-1.4
Blanket Accident & Health	1.6	0.0	1.0	1.3	1.5	1.2
Champus (military dependents)	25.0	10.0	17.5	20.2	17.5	18.4
Conversion	13.9	25.9	14.0	7.9	11.4	13.5
Credit	1.0	-1.4	-0.9	-4.6	-1.8	-1.0
Dental	2.6	2.6	2.2	2.3	4.1	2.8
Disability Income	-0.2	-2.7	-3.5	-2.9	-1.4	-1.9
Health-other	0.0	-4.5	2.2	-0.8	4.0	0.3
HMO-Major Medical	4.0	3.0	7.0	7.3	5.0	5.5
HMO- Other	2.1	2.1	5.7	12.6	2.8	4.5
Hospital Indemnity	0.0	4.9	0.2	2.8	-2.3	1.8
Hospital/Surgical/Medical Expense	5.6	8.4	10.6	6.4	7.1	7.4
Limited Benefit Plan	14.6	15.8	10.3	13.3	9.4	12.9
Long Term Care	12.1	12.9	10.1	21.7	9.7	13.0
Major Medical	7.4	8.5	7.9	9.6	8.1	8.1
Medicare Supplement	7.0	6.8	5.6	8.2	3.7	6.4
Prescription Drug	9.0		10.6	8.1	5.9	7.6
Vision	0.2	2.2	-1.2	0.2	-2.9	-0.3
Excess/ Stop Loss	3.4	0.7	7.0	4.4	18.9	5.7
Short Term- Nursing Home	0.0	13.9	0.0	0.0	0.0	2.3
Grand Total	**5.5**	**5.7**	**5.2**	**5.7**	**5.0**	**5.3**

Table 7: Average Annual Percentage Rate Increases by Type of Health Insurance

The table 8 is the Average Percentages for the Comprehensive Major Medical Rate Increases for the top 10 carriers.

Major Medical	2005	2006	2007	2008	2009
Individual	9.80%	13.60%	21.30%	4.00%	11.60%
Small Group	9.20%	17.00%	16.00%	12.80%	11.70%
Large Group	6.00%	9.20%	8.90%	10.%	7.20%

Table 8: Average Comprehensive Major Medical Rate Increases for the top 10 carriers.

[8] Average percentages in Table 7 may appear to be low because these numbers represent all filings submitted during that year. If a company submits quarterly the company's rate increases for the year would be multiplied. The Division does not current have a way of extracting that information.

Individual Market Premium Rate Changes

Average Rate Increase Percentages Summary for Individual Health Plans in Colorado[9]					
Year	Average Increase	Average Minimum Increase	Average Maximum Increase	Lowest Overall Increase	Highest Overall Increase
2005	5.9	5.3	8.3	-100.0	34.0
2006	9.1	8.1	10.4	-40.0	81.8
2007	9.9	7.2	11.5	-33.3	100.0
2008	8.2	6.6	10.2	-56.9	95.5
2009	8.8	6.7	10.0	-53.2	165.5
2010	5.8	4.9	8.4	-52.0	115.0
6 Year Average	**8.0**	**6.5**	**9.8**	**-55.9**	**98.6**

Table 9: Average Annual Percentage Rate Increase Summary for Individual Health Plans in Colorado

Average Rate Increase Percentages By Type of Individual Health Plan in Colorado							
	2005	2006	2007	2008	2009	2010	Grand Total
Accident Only & Accidental Death and Dismemberment	0.0	0.0	0.0	-0.1	-0.1	0.0	0.0
Champus	0.0	25.0	10.0	20.0	15.3	9.9	15.9
Conversion	0.0	13.9	25.9	14.0	7.9	11.4	13.5
Dental	0.0	0.0	0.0	0.0	4.4	1.4	1.7
Disability Income	0.0	2.8	0.0	-8.0	0.0	-0.7	-0.4
Health-other	0.0	0.0	0.0	14.4	1.7	4.0	3.1
HMO- Major Medical	9.3	8.1	5.3	13.9	13.2	6.6	9.4
Hospital Indemnity	0.0	0.0	10.5	2.7	4.9	1.5	5.0
Hospital/Surgical/Medical Expense	0.0	6.5	10.2	11.3	5.9	6.6	8.0
Limited Benefit Plan	8.8	19.2	19.3	13.9	16.3	11.0	16.2
Long Term Care	6.3	12.8	12.9	10.5	23.3	9.5	13.4
Major Medical	7.0	10.5	12.2	10.1	12.4	10.0	11.1
Medicare Supplement	5.9	7.4	7.6	5.8	5.7	4.0	6.1
Prescription Drug	0.0	30.0	0.0	0.0	6.8	0.0	11.4
Grand Total	**2.7**	**9.7**	**8.1**	**7.7**	**8.4**	**5.4**	**8.2**

Table 10: Average Annual Percentage Rate Increase by Type of Individual Health Plan in Colorado

[9] Average Rate Increase Percentages Summary for Individual Health Plans in Colorado includes all lines of business, not all lines are included in Table 10.

Large Group Market Premium Rate Changes

Average Rate Increase Percentage Summary for Large Group Health Plans in Colorado[10]					
Year	Average Increase	Average Minimum Increase	Average Maximum Increase	Lowest Overall Increase	Highest Overall Increase
2005	5.1	2.3	6.9	-35.0	36.5
2006	2.7	0.1	7.2	-77.9	376.8
2007	1.5	-1.2	6.5	-57.0	226.7
2008	3.1	-0.1	6.4	-50.0	70.0
2009	6.0	0.0	17.5	-61.9	902.9
2010	3.0	-2.2	7.4	-50.0	54.5
6 year Average	**3.6**	**-0.2**	**8.7**	**-55.3**	**277.9**

Table 11: Average Annual Rate Increase Summary for Large Group Health Plans in Colorado

Average Rate Increase Percentages By Type of Large Group Health Plan in Colorado							
	2005	2006	2007	2008	2009	2010	Grand Total
Accident Only & Accidental Death and Dismemberment	2.2	-0.1	-1.7	-3.5	-6.5	0.0	-2.3
Blanket Accident & Health		1.6	0.0	1.0	1.3	1.5	1.2
Champus				15.0	30.0	25.0	23.3
Credit		-0.3	-1.5	-1.1	-4.6	-1.8	-1.4
Dental	4.2	2.4	2.2	1.9	2.4	4.7	2.6
Disability Income	0.0	-1.3	-4.2	-1.9	-3.4	-2.2	-2.5
Health-other		0.0	-4.5	0.0	-7.3		-1.9
HMO- Major Medical		2.8	0.6	7.0	7.6	5.6	4.7
HMO-Other	-1.4	2.2	2.0	6.0	13.2	3.0	4.8
Hospital Indemnity		0.0	0.0	-1.8	0.0	-13.1	-1.7
Hospital/Surgical/Medical Expense	15.0	1.9	1.4	18.0	8.1	8.9	4.6
Limited Benefit Plan		0.8	2.3	0.0	2.0	1.2	1.0
Long Term Care		0.0		0.0	2.4	11.5	4.4
Major Medical	1.5	5.1	4.0	6.3	6.0	5.1	5.2
Medicare Supplement	7.9	5.7	4.5	5.0	24.6	0.0	7.8
Prescription Drug	-3.0	-1.5		10.6	13.3	5.9	5.7
Sickness	0.0		0.0	0.0	3.0	6.6	1.6
Vision	0.0	-0.7	2.9	-1.5	0.0	-2.3	-0.5
Excess/ Stop Loss	12.9	4.2	1.4	5.5	4.3	22.3	6.2
Grand Total Average	**3.6**	**1.3**	**0.6**	**3.5**	**5.1**	**4.5**	**3.3**

Table 12: Average Annual Rate Increase By Type of Large Group Health Plan in Colorado

[10] Average Rate Increase Percentage Summary for Large Group Health Plans in Colorado Includes all lines of business, not all lines are included in Table 12.

Small Group Market Premium Rate Changes

Average Rate Increase Percentages Summary for Small Group Health Plans in Colorado[11]					
Year	Average Increase	Average Minimum Increase	Average Maximum Increase	Lowest Overall Increase	Highest Overall Increase
2005	0.9	-0.3	1.6	-7.0	9.1
2006	2.5	-0.2	5.6	-29.5	68.0
2007	3.4	0.2	6.8	-41.3	60.1
2008	4.1	9.0	8.1	-38.6	97.0
2009	3.7	-2.0	29.0	-60.3	902.9[12]
2010	4.5	0.0	6.5	-36.2	29.0
Grand Total	**3.2**	**1.1**	**9.6**	**-35.5**	**194.4**

Table 13: Average Annual Percentage Rate Increase Summary for Small Group Health Plans in Colorado

Average Rate Increase Percentages By Type of Small Group Health Plan in Colorado							
	2005	2006	2007	2008	2009	2010	Grand Total
Dental	4.9	4.1	3.7	4.0	0.6	6.6	3.7
Disability Income		-1.2	0.3	-8.5	-13.0	0.0	-2.2
HMO	2.9	1.9	2.3	5.1	4.5	3.7	3.7
Hospital Indemnity		0.0	0.0	-4.8	-2.5	0.0	-1.5
Major Medical	-0.6	3.2	2.9	4.5	6.2	5.7	4.0
Vision	0.0	1.5	2.4	-0.9	0.8	-4.4	0.2
Excess/ Stop Loss		0.0	-5.0	16.6	4.6	10.1	4.8
Grand Total	**1.8**	**1.3**	**0.9**	**2.3**	**0.1**	**3.1**	**1.8**

Table 14: Average Annual Percentage Rate Increase by Type of Small Group Health Plan in Colorado

Additional Information on Colorado Health Premiums

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

- projected medical expenses from claims;
- administrative expenses;
- commissions:
- taxes; and,
- profit / contingencies factors.

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 is 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. Based on the 2009 data collected from the Colorado Health Insurance Cost Report, the Division has been

[11] Average Rate Increase Percentages Summary for Small Group Health Plans in Colorado includes all lines of business, not all lines are included in Table 14.

[12] While 902.9 % increase seems excessive, in some cases it may represent a unique outlier. For example, if a policy premium was $1 annually and increased to $10 (which would be deemed reasonable), the percentage increase would appear as 900%.

able to breakdown the above components for the year 2009 and illustrate how the health care premiums paid by Coloradans were spent by insurers.

For the 353 companies that reported, the total premium collected was approaching 6 billion dollars. 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 only and accidental death and dismemberment, and credit health.

Components of Colorado Health Care Premiums in 2009		
	Insurer Expense	**Percent of Premium**
Medical Expenses	$4,455,152,122	76.84%
Administrative Expenses	$578,062,902	9.97%
Commissions	$225,965,884	3.90%
Taxes (Federal and State)	$38,110,523	0.66%
Profit and Contingencies	$500,915,034	8.64%
Total	**$5,798,206,466**	**100.00%**

Table 15: Components of Colorado Health Care Premiums in 2009

It is important to note that the information above is from an aggregation of the data received from all 353 companies that reported. The information in Colorado Health Insurance Cost Report may not match specific company data based on allocating national data, rounding procedures and non-premium revenue. In addition, the data presented is only one year of data, 2009.

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 Colorado Insurance Regulation 4-2-11 include:

Minimum Loss Ratio Guidelines in Colorado in 2009	
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%

The average loss ratio reported of 76.84% is higher than any of the minimum loss ratio guidelines provided in regulation. This indicates 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 2009. If an insurer was unable to isolate a particular expense so that it represented the portion attributable to their Colorado health insurance business, the insurers 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 on the next page.

Administrative Expenses		
Administrative Expenses	**Insurer Expense**	**Percent of Premium**
Commissions	$225,965,884	3.90%
Staff Salaries	$146,451,070	2.53%
Dividends to Policyholders	$19,041,653	0.33%
Legal Expenses	$1,821,535	0.02%
Advertising or Marketing	$13,251,163	0.16%
Lobbying Expenses	$299,121	0.004%
Charitable Contributions	$43,086,842	0.51%
Federal Income Taxes	$25,602,447	0.31%
State Taxes, Licenses and Fees	$12,508,077	0.15%
All Other	$353,871,787.48	6.62%
Total	**$841,899,579**	**14.52%**

Table 16: Administrative Expenses reported from 353 carriers in the Colorado Health Cost Report

Medical Trend

Medical cost trend is the projected increase in the costs of medical services assumed in setting premiums for health insurance plans. Insurance companies use medical cost trends to estimate what the same plan would cost in the next year. Medical cost trend is influenced primarily by:

- Unit cost inflation, or changes in the intensity, and changes in the unit price of medical products and services.
- Utilization increases, or changes in the volume of services used, which may be affected by demographic changes, advertising, and the use of new technology.

Medical expenses are subject to inflation, in the same way as most products and services. Medical trend is higher than normal inflation primarily because of increases in utilization. Utilization is the measurement of the use of health insurance by employees of an insured employer, stated in terms of the average number of claims per employee. In general the cost of each service tends to rise with the overall inflation level but each additional service a policyholder receives adds directly to the cost of health insurance. Additionally as the intensity of the service increases the cost increases.

For example, as more and more diagnostic imaging shifts from older technologies such as x-rays towards more advanced imaging such as MRI the overall costs rise much faster than inflation because of the cost differential between an x-ray and an MRI even though there may not have been a large increase in per unit cost of x-rays or MRIs or the overall number of services has increased since only one image may be taken.

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. In addition, these numbers will vary with benefit plan design. An example of this is demonstrated in Table 17 below. It represents the medical trend for comprehensive major medical plans by individual and group size for the past five years, submitted by carriers through rate filings to the Division.

Comprehensive Major Medical Trend

	2005	2006	2007	2008	2009
Individual	14.10%	17.10%	13.30%	11.80%	13.30%
Small Group	12.40%	13.40%	10.80%	10.90%	11.10%
Large Group	7.40%	11.20%	11.90%	9.00%	8.40%

Table 17: Comprehensive Major Medical Trend Percentage attributable to premium rate increase from Top 10 Largest Carriers

Cost trends may vary from market to market, depending on the level of provider and health plan competition and the regional economy. The individual market tends to be the most volatile so the actual population projected varies the most from year to year. In addition, individuals will tend to have plans with more policyholder cost sharing. These plans initially cost less but have higher cost increases as medical inflation erodes the effectiveness of the policy holder costs sharing. Finally applicants in the individual market tend to have a reason for applying to the individual market and therefore may be more likely to develop medical conditions after purchasing the policy.

The opposite effects are seen in the large group market. Populations tend to be fairly stable and have lower cost sharing. Employers also seek to enroll most employees spreading the risk of employees with medical conditions across a broader population.

Cost Shifting

Private health insurance premiums are higher, to some degree, because different populations pay different amounts for the same care. Uninsured people and members of government programs, Medicaid and Medicare, typically pay less than commercially insured populations. Doctors and hospitals charge commercial insurers more for the services provided to provide an adequate overall margin. 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. **Figure10 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.**

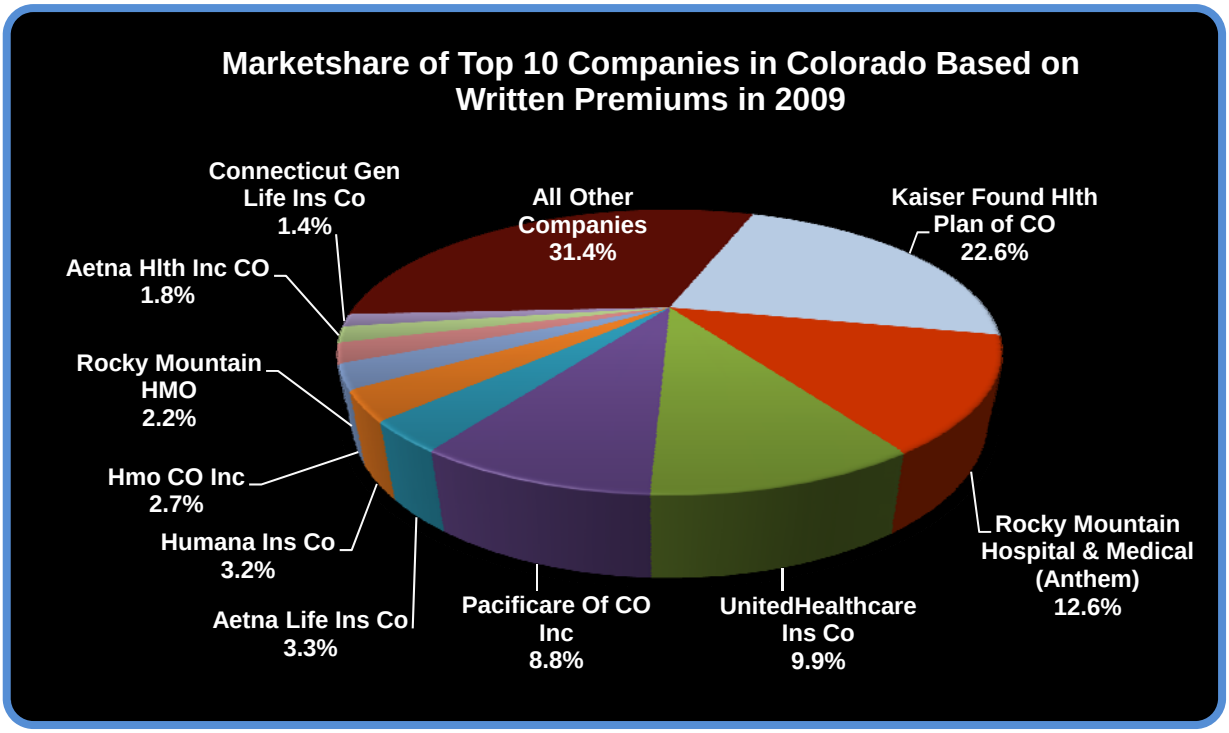


Figure 10: Marketshare of Top 10 Companies in Colorado Based on Written Premiums in 2009

Market Share of the Top 10 Health Carriers in Colorado		
Company	**2009 Written Premiums**	**2009 % of Market Share**
Kaiser Found Health Plan of CO	$2,183,129	22.6%
Anthem Blue Cross and Blue Shield[13]	$1,211,611	12.6%
UnitedHealthcare Insurance Company	$957,748	9.9%
Pacificare Of CO Inc	$849,260	8.8%
Aetna Life Insurance Company	$315,918	3.3%
Humana Insurance Company	$312,846	3.2%
HMO CO Inc	$261,066	2.7%
Rocky Mountain HMO Inc	$215,623	2.2%
Aetna Health Inc CO Corp	$173,428	1.8%
Connecticut General Life Insurance Company	$139,599	1.4%
All Other Companies	$3,025,648	31.4%
Total	$9,645,876	100.00%

Table 18: Market Share of the Top 10 Health Carriers in Colorado

[13] Anthem Blue Cross and Blue Shield does business as Rocky Mountain Medical and Hospital Services 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 monitor and ensure the insurers' financial solvency. At least once every five 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 unable to pay claims.

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.

Risk-based Capital Percentage (RBC %)							
Company	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**5-Year Average**
Aetna Health Inc CO Corporation	205%	443%	362%	336%	341%	440%	355%
Aetna Life Insurance Company	860%	867%	808%	706%	714%	772%	788%
Anthem Blue Cross and Blue Shield*	613%	541%	512%	388%	488%	449%	499%
Connecticut General Life Insurance Company	903%	1142%	648%	560%	575%	799%	771%
HMO Colorado, Inc.	744%	715%	807%	424%	368%	578%	606%
Humana Insurance Company	289%	319%	310%	448%	438%	446%	375%
Kaiser Found Health Plan of CO	519%	712%	594%	395%	1244%	1319%	797%
PacifiCare Of Colorado, Inc.	370%	447%	512%	675%	825%	507%	556%
Rocky Mountain HMO, Inc.	916%	1090%	1105%	1161%	1270%	1657%	1200%
UnitedHealthcare Insurance Company	590%	566%	524%	559%	396%	413%	508%

Table 19: Risk-based Capital Percentage (RBC %)

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Medical and Hospital Services in Colorado

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.

Colorado Medical Loss Ratios						
Company	**2005**	**2006**	**2007**	**2008**	**2009**	**5-Year Average**
Aetna Health Inc CO Corporation	79.35%	85.04%	85.14%	89.40%	83.38%	**84.46%**
Aetna Life Insurance Company	77.07%	79.32%	84.60%	81.89%	88.22%	**82.22%**
Connecticut General Insurance Company	78.27%	83.67%	80.56%	83.32%	85.83%	**82.33%**
HMO Colorado Inc	80.53%	78.27%	88.22%	83.66%	91.70%	**84.48%**
Humana Insurance Company	78.99%	81.53%	81.47%	82.42%	81.20%	**81.12%**
Kaiser Foundation Health Plan of CO	93.34%	89.47%	88.17%	88.24%	91.42%	**90.13%**
Pacificare of CO Inc	83.91%	79.21%	79.63%	76.50%	82.86%	**80.42%**
Rocky Mountain HMO Inc	89.07%	86.41%	87.46%	84.16%	80.25%	**85.47%**
Anthem Blue Cross and Blue Shield*	80.66%	75.94%	86.40%	78.58%	83.14%	**80.94%**
United Healthcare Insurance Company	78.36%	79.64%	75.88%	79.98%	84.05%	**79.58%**
Grand Total	**81.95%**	**81.85%**	**83.75%**	**82.82%**	**85.20%**	**83.12%**

Table 20: Colorado Medical Loss Ratios

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Medical and Hospital Services in Colorado

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.

Table 21 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 9.37% for all ten insurers.

Administrative Expenses as a Percent of Colorado Earned Health Premiums						
Company	**2005**	**2006**	**2007**	**2008**	**2009**	**5-Year Average**
Aetna Health Inc CO Corporation	11.71%	12.77%	9.62%	10.27%	10.41%	**10.96%**
Aetna Life Insurance Company	6.67%	3.30%	3.70%	4.99%	6.02%	**4.94%**
Connecticut General Insurance Company	14.58%	16.69%	10.46%	12.04%	12.12%	**13.18%**
HMO Colorado Inc	9.35%	8.44%	5.29%	5.88%	5.71%	**6.93%**
Humana Insurance Company	22.80%	16.85%	14.64%	14.19%	15.61%	**16.82%**
Kaiser Foundation Health Plan of CO	8.05%	7.94%	5.94%	6.31%	6.55%	**6.96%**
Pacificare of CO Inc	9.40%	9.55%	7.42%	8.00%	7.37%	**8.35%**
Rocky Mountain HMO Inc	9.73%	6.77%	7.51%	6.30%	6.80%	**7.42%**
Anthem Blue Cross and Blue Shield*	9.45%	10.08%	5.11%	7.45%	9.02%	**8.22%**
United Healthcare Insurance Company	9.16%	8.90%	10.39%	10.78%	10.52%	**9.95%**
Grand Total	**11.09%**	**10.13%**	**8.01%**	**8.62%**	**9.01%**	**9.37%**

Table 21: Administrative Expenses as a Percent of Colorado Earned Health Premiums

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Medical and Hospital Services in Colorado

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.

Claims Adjustment Expenses as a Percent of Colorado Earned Health Premium						
Company	**2005**	**2006**	**2007**	**2008**	**2009**	**5-Year Average**
Aetna Health Inc CO Corporation	1.83%	1.88%	1.79%	1.79%	1.67%	**1.79%**
Aetna Life Insurance Company	5.56%	4.32%	4.42%	4.08%	3.89%	**4.45%**
Connecticut General Insurance Company[14]	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
HMO Colorado Inc	4.05%	2.96%	5.21%	3.72%	2.91%	**3.77%**
Humana Insurance Company	2.39%	2.43%	3.06%	2.29%	1.63%	**2.36%**
Kaiser Foundation Health Plan of CO	1.22%	1.36%	1.12%	1.34%	1.39%	**1.29%**
Pacificare of CO Inc	1.71%	1.53%	2.13%	1.55%	1.95%	**1.77%**
Rocky Mountain HMO Inc	9.86%	5.79%	6.14%	5.49%	6.84%	**6.82%**
Anthem Blue Cross and Blue Shield*	3.30%	1.94%	5.38%	2.70%	3.15%	**3.29%**
United Healthcare Insurance Company	1.80%	1.55%	1.11%	1.02%	1.30%	**1.36%**
Grand Total	**3.17%**	**2.38%**	**3.04%**	**2.40%**	**2.47%**	**2.69%**

Table 22: Claims Adjustment Expenses as a Percent of Colorado Earned Health Premiums

[14] Connecticut General Insurance Company reported zeros in their annual financial statements.

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Medical and Hospital Services in Colorado

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.

Underwriting Gain or Loss as a Percent of Colorado Earned Health Premiums						
Company	**2005**	**2006**	**2007**	**2008**	**2009**	**5-Year Average**
Aetna Health Inc CO Corporation	9.41%	-1.74%	3.96%	-1.49%	3.98%	**2.82%**
Aetna Life Insurance Company	11.66%	13.61%	7.99%	9.64%	2.39%	**9.06%**
Connecticut General Insurance Company	9.06%	1.76%	10.49%	6.11%	3.22%	**6.13%**
HMO Colorado Inc	6.60%	9.75%	-1.17%	8.78%	-0.03%	**4.79%**
Humana Insurance Company	-4.18%	-0.82%	0.83%	1.10%	1.56%	**-0.30%**
Kaiser Foundation Health Plan of CO	-1.01%	2.75%	6.19%	5.67%	2.99%	**3.32%**
Pacificare of CO Inc	4.94%	7.81%	10.23%	14.28%	7.57%	**8.97%**
Rocky Mountain HMO Inc	0.23%	2.12%	0.23%	5.09%	6.24%	**2.78%**
Anthem Blue Cross and Blue Shield*	7.08%	10.06%	4.92%	8.60%	3.88%	**6.91%**
United Healthcare Insurance Company	10.61%	9.91%	12.61%	8.22%	4.10%	**9.09%**
Grand Total	**5.44%**	**5.52%**	**5.63%**	**6.60%**	**3.59%**	**5.36%**

Table 23: Underwriting Gain or Loss as a Percent of Colorado Earned Health Premiums

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Medical and Hospital Services in Colorado

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.

Net Investment Gain (or loss) as a Percent of Colorado Earned Health Premium						
Company	**2005**	**2006**	**2007**	**2008**	**2009**	**5-Year Average**
Aetna Health Inc CO Corporation	0.81%	0.89%	0.81%	0.79%	0.94%	**0.85%**
Aetna Life Insurance Company	1.86%	1.72%	1.45%	1.05%	0.92%	**1.40%**
Connecticut General Insurance Company	5.61%	6.48%	4.14%	3.79%	4.07%	**4.82%**
HMO Colorado Inc	2.01%	1.49%	0.81%	0.74%	0.96%	**1.20%**
Humana Insurance Company	1.26%	1.06%	2.20%	1.56%	1.01%	**1.42%**
Kaiser Foundation Health Plan of CO	0.40%	0.77%	1.01%	0.44%	1.36%	**0.80%**
Pacificare of CO Inc	0.93%	0.99%	1.52%	1.01%	0.72%	**1.03%**
Rocky Mountain HMO Inc	1.31%	1.30%	2.43%	2.05%	1.01%	**1.62%**
Anthem Blue Cross and Blue Shield*	3.51%	2.70%	2.48%	2.71%	3.15%	**2.91%**
United Healthcare Insurance Company	3.03%	2.71%	2.43%	1.69%	1.24%	**2.22%**
Grand Total	**2.08%**	**2.01%**	**1.93%**	**1.58%**	**1.54%**	**1.83%**

Table 24: Net Investment Gain (or loss) as a Percent of Colorado Earned Health Premium

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Medical and Hospital Services in Colorado

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 (including claims), 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 2009, with average profit margins varying from .44% to 7.72%, with an average profit of 3.42%.

Net Income as a Percent of Colorado Earned Health Premiums						
Company	**2005**	**2006**	**2007**	**2008**	**2009**	**5-Year Average**
Aetna Health Inc CO Corporation	7.47%	-1.36%	2.85%	1.89%	3.59%	2.89%
Aetna Life Insurance Company	8.02%	10.63%	5.19%	6.83%	0.60%	6.25%
Connecticut General Insurance Company	14.77%	2.43%	11.07%	7.33%	4.56%	8.03%
HMO Colorado Inc	6.65%	8.75%	1.23%	9.75%	0.44%	5.36%
Humana Insurance Company	-2.51%	0.63%	1.36%	2.10%	1.38%	0.59%
Kaiser Foundation Health Plan of CO	0.32%	4.17%	5.99%	4.74%	2.03%	3.45%
Pacificare of CO Inc	4.00%	5.52%	7.86%	10.17%	5.55%	6.62%
Rocky Mountain HMO Inc	5.09%	3.85%	3.23%	7.56%	7.72%	5.49%
Anthem Blue Cross and Blue Shield*	7.45%	9.37%	5.50%	8.16%	5.58%	7.21%
United Healthcare Insurance Company	12.34%	8.34%	11.16%	7.25%	2.76%	8.37%
Grand Total	**6.36%**	**5.23%**	**5.54%**	**6.58%**	**3.42%**	**5.43%**

Table 25: Net Income as a Percent of Colorado Earned Health Premiums

* Anthem Blue Cross and Blue Shield does business as Rocky Mountain Medical and Hospital Services in Colorado

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 provides an overview of the regulatory authority of the Division, as well information about the Division's progress towards DORA's primary mission, consumer protection. It also embodies 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. 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 insures carriers can pay claims. The state enforces financial solvency and consumer protection requirements for all health insurers. Financial regulation provides crucial safeguards for consumers. Financial regulation is maintained by states 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 certificate suspension or revocation.

Rate Regulation

Rates are reviewed by the Colorado Division of Insurance to determine if rates are "excessive, inadequate or unfairly discriminatory." "Excessive Rates" occur when 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 occur when 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.

Colorado Division of Insurance - Rates and Forms Consumer Savings From Review and Intervention 2005-2009	
2005	**$6,996,602**
2006	**$3,155,712**
2007	**$3,725,174**
2008	**$11,833,682**
2009	**$32,094,080**

Table 26: Colorado Consumer Savings Realized through Reviews and Intervention

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 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.

The following are the two types of health rate procedures in Colorado:

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.

In 2008, Colorado passed HB 08-1389, which requires the carrier to submit for prior approval its expected health rate increases to the Colorado Division of Insurance (Division) at least 60 days prior to the proposed implementation of the rates.

The Division reviews the proposed rate change and supporting documentation to determine whether the company has provided all the information required by law and whether or not the requested rate is justified. If a requested rate increase is not justified, HB08-1389 gives the Division the authority to disapprove the rate or to request additional supporting documentation from the carrier. Also, if a filing requesting a rate increase is incomplete (i.e., carrier did not provide all the required justification) the filing may be disapproved. However, if the rate increase is justified and meets all applicable laws and regulations, the Division will approve the filing.

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.

This chart summarizes the differences in regulatory requirements in Colorado for the individual, small group and large group markets.

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)	Applies	Applies	May Apply: Carriers use age in developing rates but supply an ageless rate to employers.
Age (no bands)	Applies	Does Not Apply	Does Not Apply
Family Composition: 4 Tiers	Applies	Applies	As specified by the group.
Gender	Unisex Rating	Unisex Rating	Applies
Area Factors:	Usually based on zip code, grouped by county.	Based on county where small group is located and as required by Colorado Insurance 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 or formula 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 or formula filed for use by the carrier.
Standard Industrial Classification:	Does Not Apply	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**	Applies	Applies	Applies

Table 27: Summary of Rating Factors for Private Health Plans in Colorado

2009 & 2010 Recent Legislation and Health Care Reform

Colorado Legislation

Governor Ritter and state policymakers introduced a series of bills and that focused on cost-savings and efficiencies, changes to private insurance, and care for women.

2009

H.B. 09-1012 Health insurance - individual and small group plans - wellness and prevention programs - incentives or rewards - information collected by division of insurance - reporting to health care task force.

For individual and small group health coverage plans issued or renewed or on after July 1, 2009, authorizes carriers to offer incentives or rewards for covered persons and small groups to participate in wellness and prevention programs (programs).

Allows the board of directors of the CoverColorado program or carriers providing health benefit plans to CoverColorado participants to also offer the incentives.

Permits incentives or rewards to include premium discounts or rebates; modifications to copayment, deductible, or coinsurance amounts; or a combination of those incentives. Requires incentives or rewards to be reasonably related to the program and tied to participation in the program rather than to particular outcomes.

Requires programs and incentives or rewards offered by carriers to comply with:

- The federal "Health Insurance Portability and Accountability Act of 1996" and related federal regulations; and
- The federal "Americans with Disabilities Act of 1990" and state antidiscrimination laws.

Allows carriers to determine the types of programs and incentives to offer as long as:

- Participation in the programs is voluntary and is not a condition of coverage;
- Incentives or rewards are uniformly applied based on the program, not the size or composition of the small group;
- Nonparticipation cannot be penalized;
- The participant is not required to achieve a certain outcome in order to receive the incentive; and
- The carrier does not market the program so as to induce individuals or small groups to purchase health coverage from the carrier.

Requires the Division of Insurance to collect and report to the health care task force information regarding wellness and prevention programs offered in the state, including the types of programs offered; the types and nature of incentives or rewards provided; the total number of small groups and individuals participating in programs; and the percentage of carriers offering individual or small group health coverage plans in the state that also offer wellness and prevention programs.

Prohibits a small employer that makes a program available to its employees as part of its small group plan from making participation or disclosure of participation in the program a condition of employment with the small employer.

APPROVED by Governor April 25, 2009
EFFECTIVE July 1, 2009

H.B. 09-1059 Mandatory health insurance coverage - routine patient care during clinical trial or study.

Requires all individual and group health benefit plans to provide coverage for routine patient care costs while the covered person participates in a clinical trial or study if the coverage is a benefit that the covered person would receive outside of the clinical trial or study. Requires the clinical trial or study to meet specific standards of approval.

APPROVED by Governor May 2, 2009
EFFECTIVE August 5, 2009

H.B. 09-1252 Local access to health care pilot program - expansion to San Luis valley - prioritization of vendors for performing pilot program functions - report - repeal.

Expands the "Local Access to Health Care Pilot Program Act" to allow the creation of a pilot program in the San Luis valley. Authorizes the San Luis valley county commissioners association (association) to create a pilot program to provide access to health care services to individuals employed by San Luis valley employers who are uninsured and ineligible for participation in programs available under the "Colorado Medical Assistance Act", the "Children's Basic Health Plan Act", or Medicare pursuant to Title XVIII of the federal "Social Security Act".

Permits the association to contract with a nonprofit corporation for purposes of operating the pilot program. Allows the contractor to prioritize a selection of vendors that are capable, existing local entities to assist in the performance of the daily functions of the pilot program, which functions include the implementation of health benefit designs, payment of hospital and professional claims for services, provision of employer group billing, provision of actuarial and underwriting experience, and management of enrollment and eligibility for participation in the pilot program.

Requires the association and the contractor to submit a report to the general assembly by March 15, 2014, with distribution to the commissioner of insurance, the local government committee of the house of representatives, and the local government and energy committee of the senate, regarding the activities of the San Luis valley pilot program. Specifies that the report is to detail the following information:

- An assessment of whether the pilot program has benefitted the San Luis valley, employers located in the valley, and individuals and families eligible to participate in the pilot program;
- The number of eligible individuals and employers participating in the pilot program;
- The number of months that participating individuals were uninsured prior to enrolling in the pilot program; and
- Any other pertinent information.

Repeals the authority of the association to create a pilot program or contract for the operation of the pilot program on July 1, 2014.

APPROVED by Governor June 2, 2009
EFFECTIVE June 2, 2009

H.B. 10-1004 Health insurance - plans - standardized format - policy form sections - explanation of benefits forms - commissioner rules.

The commissioner of insurance (commissioner) is required to convene a stakeholder group to develop a standardized format, for use in health benefit plans, limited benefit health insurance, and dental plans, for the following:

- Section names and the placement of those sections in the policy forms used by carriers; and
- The required information for carriers to provide on an explanation of benefits form.

After considering input from carriers, health care providers, consumers, and other stakeholders, the commissioner is to adopt rules to implement the standardized format, applicable to health benefit plans, limited benefit health insurance, and dental plans issued or delivered on or after January 1, 2012.

APPROVED by Governor April 20, 2010
EFFECTIVE August 11, 2010

H.B. 10-1008 Health insurance - individual health coverage plans - prohibition against gender rating.

The act prohibits carriers from using gender as a basis for varying premium rates for individual health insurance policies and declares premium rates based on gender to be unfairly discriminatory. The prohibition will apply to individual health coverage plans issued or renewed on or after January 1, 2011.

APPROVED by Governor March 29, 2010
EFFECTIVE January 1, 2011

H.B. 10-1021 Health insurance - mandatory coverage provisions - maternity coverage - contraceptive coverage.

The act requires entities issuing individual sickness and accident insurance polices in this state to provide the same coverage for maternity care as is currently mandated for all group sickness and accident insurance policies; except that individual sickness and accident insurance policies may exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition. The act also requires both individual and group policies to provide coverage for contraception.

APPROVED by Governor May 26, 2010
EFFECTIVE January 1, 2011

H.B. 10-1166 Insurance policies - plain language required.

The act requires that automobile insurance policies, health benefit plans, limited benefit health insurance, dental plans, and long-term care plans that are issued or renewed on or after July 1, 2011, be written at or below the tenth-grade reading level. The act also requires the text of the policies and plans to be written in 12-point type or larger and to contain an index or table of contents if they are longer than 3 pages or 3,000 words. A violation of this requirement is an unfair or deceptive act or practice in the business of insurance.

APPROVED by Governor April 20, 2010
EFFECTIVE January 1, 2012

H.B. 10-1202 Health insurance - mandatory coverage - oral anticancer medication.

The act requires a health benefit plan that covers cancer chemotherapy treatment to provide coverage for prescribed, orally administered anticancer medication at a cost to the patient at the same coinsurance percentage or copayment amount as is applied to the cost of other cancer medications. The act requires that the medication be prescribed only upon a finding that it is medically necessary by the treating physician for the treatment of cancer in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the patient or the health care provider.

The act is applicable to policies issued or renewed on or after January 1, 2011.

APPROVED by Governor April 15, 2010
EFFECTIVE January 1, 2011

H.B. 10-1242 Health insurance - individual plans - uniform application form.

The act requires the commissioner of insurance (commissioner) to implement an initial uniform application form for individual sickness and accident health benefit plans. The commissioner is required to take recommendations from members of the insurance industry regarding the form and content of the uniform application form and to promulgate rules to require its exclusive use by the industry after January 1, 2012.

APPROVED by Governor May 10, 2010
EFFECTIVE August 11, 2010

H.B. 10-1252 Health insurance - mandatory coverage - preventive health care services - mammography.

In 2009, the general assembly changed the required breast cancer screening coverage provisions to tie them to the recommendations of the U.S. preventive services task force. Notwithstanding those requirements, the act requires that breast cancer screening with mammography be covered for all individuals possessing at least one risk factor, including, but not limited to, a family history of breast cancer, being forty years of age or older, or a genetic disposition to breast cancer.

APPROVED by Governor May 17, 2010
EFFECTIVE January 1, 2011

H.B. 10-1332 Medical claims - standard payment rules and claim edits - use by payers and health care providers.

The act creates the "Medical Clean Claims Transparency and Uniformity Act" (act), which requires the executive director of the department of health care policy and financing (department) to establish a task force by November 30, 2010, to develop a standardized set of payment rules and claim edits to be used by payers and health care providers in Colorado. The task force is to be comprised of members of industry segments directly affected who have expertise in the areas of payment rules and claim edits and their impact on the submission and payment of health insurance claims. Members are to include:

- Health care providers or employees of health care providers, with representation from health care community clinics, ambulatory surgical centers, urgent care centers, and hospitals;

- Persons or entities that pay for health care services (payers);
- Practice management system vendors;
- Billing and revenue cycle management service companies; and
- State and federal government entities and agencies that pay for or are involved in the payment or provision of health care services.

The task force is to track the progress of a national initiative led by the secretary of the United States department of health and human services (national initiative) in the development of a national uniform, standardized set of payment rules and claims edits so as to avoid duplication or conflict with any rules and edits developed through the national initiative.

The task force is to develop a base set of rules and edits using existing national industry sources and work with the national initiative to develop a complete set of uniform, standardized payment rules and claim edits applicable to all types of professional services.

The task force is required to report its recommendations to the executive director of the department and the health and human services committees of the senate and house of representatives by November 30, 2012, which shall include recommendations to:

- Adopt any standardized rules and edits developed by the national initiative if appropriate for Colorado, for implementation by commercial payers according to a schedule outlined under the national initiative or by January 1, 2014, whichever occurs first, and by nonprofit payers by January 1, 2015; or
- Adopt the rules and edits sets established by the task force if the national initiative has not come to consensus.

If the task force is required to develop its own standard rules and edits, the task force is to do so by December 31, 2013, and payers are to implement the standard rules and edits according to a schedule outlined under the national initiative or by January 1, 2015, whichever occurs first, for commercial payers and by January 1, 2016, for nonprofit payers.

The use of any proprietary or other claims edits to modify the payment of the charges for covered services is prohibited once the standard payment rules and claim edits are implemented.

Contractual provisions are preserved between contracting persons or entities and health care providers regarding actual contracted reimbursement rates for procedures and other contractual arrangements negotiated by the parties.

The department is not required to provide administrative or research support or assistance to the task force, and the executive director of the department is required to designate a nonprofit or private organization as the custodian of funds for the task force. The designated organization may seek, accept, and expend monetary and in-kind gifts, grants, and donations to further the task force's duties and responsibilities. The designated organization is to prepare, and submit to the executive director, an operating budget for the task force and must certify to the executive director that the task force has received sufficient funding to cover its expenses as identified in its budget. If the task force does not receive sufficient funding by June 30, 2012, the law is repealed.

The act reorganizes provisions pertaining to health care contracts, without making any

substantive changes to those provisions.

APPROVED by Governor May 26, 2010
EFFECTIVE May 26, 2010

H.B. 10-1355 Health insurance - prescription drug coverage - off-label use of cancer drugs.

The act prohibits a health benefit plan from limiting or excluding coverage for a drug that is approved by the federal food and drug administration for the treatment of one specific type of cancer on the basis that the drug has not been approved for another specific type of cancer, if the drug is recognized for treatment for that cancer in the reference compendia as identified by the secretary of the United States department of health and human services, and the treatment is for a covered condition.

APPROVED by Governor May 17, 2010
EFFECTIVE August 11, 2010

S.B. 10-49 Liability limits - life and health insurance protection association - increase of limits for annuity and structured settlement annuity benefits and long-term care benefits.

Current law establishes the life and health insurance protection association (association) to pay benefits to an eligible person whose insurer, that is a member of the association, becomes insolvent and cannot pay benefits. Under current law, with regard to annuities and structured settlement annuities, the benefits for which the association may become liable are capped at $100,000 in the present value of annuity benefits. The current limit for health insurance benefits, which applies to long-term care benefits, is also $100,000.

The annuity and structured settlement annuity benefits limits are increased to $250,000, and the limit applicable to long-term care benefits is increased to $300,000.

APPROVED by Governor March 5, 2010
EFFECTIVE March 5, 2010

S.B. 10-183 Health insurance - benefits - out-of-network charges - balance billing - prohibition on charging patient for services not covered.

Prior case law interpreting Colorado's health insurance statutes had allowed "balance billing" for increased charges of out-of-network providers working in in-network facilities without the prior knowledge or consent of insured patients. The general assembly legislatively overruled that interpretation, subject to future review and repeal. The act continues indefinitely the requirement that health insurers hold consumers harmless for charges over and above the in-network rates for services rendered in an in-network facility.

APPROVED by Governor May 27, 2010
EFFECTIVE May 27, 2010

Federal Legislation

The Affordable Care Act - Implementation Timeline

In March 2010, Congress passed and the President signed into law the Affordable Care Act, which puts in place comprehensive health insurance reforms that intends to hold insurance companies accountable, lower costs, guarantee choice, and enhance quality health care for all Americans. Starting this year and continuing through 2014, the Affordable Care Act will be implemented, increasing access to affordable health care for individuals, families, seniors and businesses. Many important benefits begin immediately.

2010

New Consumer Protections

- **No Discrimination Against Children With Pre-Existing Conditions**. The new law includes new rules to prevent insurance companies from denying coverage to children with pre-existing conditions. ***Effective for health plan years beginning on or after September 23.***

- **Prohibits Insurance Companies from Dropping Coverage.** In the past, insurance companies could search for an error on a customer's application or other technical mistake and use this error to stop covering the person when he or she got sick. The new law makes this illegal. ***Effective for health plan years beginning on or after September 23.***

- **Eliminating Lifetime Limits on Insurance Coverage.** Under the new law, insurance companies will be prohibited from imposing lifetime dollar limits on essential benefits, such as hospital stays. ***Effective for health plan years beginning on or after September 23.***

- **Regulating Annual Limits on Insurance Coverage.** Under the new law, insurance companies' use of annual dollar limits on the amount of insurance coverage a patient may receive is sharply restricted. In 2014, the use of annual dollar limits on essential benefits such as hospital stays will be banned for new plans in the individual market and all group plans. ***Effective for health plan years beginning on or after September 23.***

- **Appealing Insurance Company Decisions.** The law provides consumers with an easy way to appeal to their insurance company and to an outside board if the company denies coverage or a claim. ***Effective for health plan years beginning on or after September 23.***

- **Information for Consumers Online.** The law creates an easy to use website where consumers can compare health insurance coverage options and pick the plan that works for them. ***Effective July 1, 2010.***

Improving Quality and Lowering Costs

- **Small Business Health Insurance Tax Credit.** Up to 4 million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35 percent of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25 percent credit. ***Effective immediately.***

- **Relief for Four Million Seniors Who Hit the Medicare Prescription Drug "Donut Hole."** An estimated four million seniors who hit the gap in Medicare prescription drug coverage known as the "donut hole" this year will receive a $250 rebate. ***First checks mailed in June, 2010, and continued monthly throughout 2010 as seniors hit the coverage gap.***

- **Free Preventive Care.** All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. ***Effective for health plan years beginning on or after September 23.***

- **Preventing Disease and Illness.** A new $15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy -- from smoking cessation to combating obesity. ***Funding begins in 2010.***

- **Cracking Down on Health Care Fraud.** Current efforts to fight fraud have returned more than $2.5 billion to the Medicare Trust Fund in FY 2009 alone. The new law invests new resources and requires new screening procedures for health care providers to boost these efforts and reduce fraud and waste in Medicare, Medicaid, and CHIP. ***Many provisions effective in 2010.***

Increasing Access to Affordable Care

- **Access to Insurance for Uninsured Americans with Pre-Existing Conditions.** A transitional high risk pool program will provide new coverage options to individuals who are uninsured because of a pre-existing condition for at least six months. States have the option of running their own temporary high risk pool. If a state chooses not to do so, a pool will be established by the Department of Health and Human Services. Colorado's federal high risk pool is GettingUSCovered. National pool e***ffective July 1.***

- **Extending Coverage for Young Adults.** Under the new law, young adults will be allowed to stay on their parents' plan until they turn 26 years old unless they are offered insurance at work. While the provision took effect in September 2010; most insurance companies have already implemented this new practice. ***Effective for health plan years beginning on or after September 23***

- **Coverage for Early Retirees.** Too often, Americans who retire without employer-sponsored insurance and before they are eligible for Medicare see their life savings disappear because of exorbitant rates in the individual market. To preserve employer coverage for early retirees until affordable coverage is available through the exchanges in 2014, the law creates a $5 billion program to help people who retire before age 65 maintain the affordable care they need. ***Applications for employers to participate in the program were available June 1, 2010.***

- **Rebuilding the Primary Care Workforce.** To strengthen the primary care workforce, new incentives in the law to expand the number of primary care doctors, nurses and physician assistants include funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas. Doctors and nurses with student loans will also receive tax relief if they practice in communities with a shortage of health care providers. ***Effective 2010.***

- **Holding Insurance Companies Accountable for Unreasonable Rate Hikes**. The law allows states that have or plan to implement measures that require insurance companies to justify their premium increases will be eligible for $250 million in new grants. Insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance Exchanges in 2014. ***Grants will be awarded beginning in 2010.***

- **Allowing States to Cover More People on Medicaid.** States will receive increased federal matching funds for covering low-income individuals and families on Medicaid. This will make it easier for states that choose to do so to cover more of their residents. ***Effective April 1, 2010.***

- **Payments for Rural Health Care Providers.** Today, 68 percent of medically underserved communities across the nation are in rural areas, and these communities often have trouble attracting and retaining medical professionals. The law provides rural health care providers the payments they need and ensures they can continue to serve their communities. ***Effective 2010.***

2011

Improving Quality and Lowering Costs

- **Prescription Drug Discounts.** Seniors who fall in the coverage gap will receive a 50 percent discount when buying Medicare Part D covered brand-name prescription drugs. Over the next ten years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is completely closed in 2020. ***Effective January 1, 2011.***

- **Free Preventive Care for Seniors.** The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans for seniors on Medicare. ***Effective January 1, 2011.***

- **Improving Health Care Quality and Efficiency.** The law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients that improve the quality of care, and reduce the rate of growth in health care costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Health and Human Services submitted a national strategy to improve the quality of care provided by these programs. ***Effective January 1, 2011.***

- **Improving Care for Seniors After They Leave the Hospital.** The Community Care Transitions Program will help high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions to the hospital by coordinating care and connecting patients to services in their communities. ***Effective January 1, 2011.***

- **New Innovations to Bring Down Costs.** The Independent Payment Advisory Board will begin operations to develop and submit proposals to Congress and the President aimed at protecting and improving benefits for seniors and extending the life of the Medicare Trust Fund. It will target waste in the system, reduce costs, improve health outcomes for patients, and expand access to high-quality care. ***Administrative funding becomes available October 1, 2011.***

Increasing Access to Affordable Care

- **Increasing Access to Services at Home and in the Community.** The new Community First Choice Option allows States to offer home and community-based services to disabled individuals through Medicaid rather than institutional care in nursing homes. ***Effective October 1, 2011***.

- **Strengthening Community Health Centers.** The law includes new funding to support the construction of and expand services at community health centers, allowing these centers to serve some 20 million new patients across the country. ***Effective 2011.***

Holding Insurance Companies Accountable

- **Bringing Down Health Care Premiums.** To ensure premium dollars are spent on health care, the new law requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. While insurance companies must use some money to administer their plans -- and do things like prevent fraud and improve information technology -- the Affordable Care Act ensures that insurance companies spend more on patients and less on paperwork and overhead. Plans that spend too much on overhead must provide rebates to consumers. ***Rebates begin no later than January 1, 2011.***

- **Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage.** Today, Medicare pays Medicare Advantage insurance companies over $1,000 more per person on average than Original Medicare. These additional payments are paid for in part by increased premiums paid by all Medicare beneficiaries, including 77 percent of seniors not enrolled in a Medicare Advantage plan. The new law levels the playing field by gradually eliminating Medicare Advantage overpayments to insurance companies. Seniors in a Medicare Advantage plan will still receive guaranteed Medicare benefits and the law provides bonus payments to Medicare Advantage plans that provide high quality care. ***Effective January 1, 2011.***

2012

Improving Quality and Lowering Costs

- **Linking Payment to Quality Outcomes.** The law establishes a hospital Value-Based Purchasing program (VBP) in traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures on treating heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care. ***Effective October 1, 2012.***

- **Encouraging Integrated Health Systems.** The new law provides incentives for physicians to join together to form "Accountable Care Organizations," through which doctors can better coordinate

patient care and improve the quality, help prevent disease and illness and reduce unnecessary hospital admissions. If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped to save. ***Effective January 1, 2012.***

- **Reducing Paperwork and Administrative Costs.** Health care remains one of the few industries that relies on paper records. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care. ***First regulation effective October 1, 2012.***

- **Understanding and Fighting Health Disparities.** To help understand and combat persistent health disparities, the law requires any ongoing or new Federal health program to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help identify and fight disparities. ***Effective March, 2012.***

Increasing Access to Affordable Care

- **Providing New, Voluntary Options for Long-Term Care Insurance.** The law creates a voluntary long-term care insurance program -- called CLASS -- to provide cash benefits to adults who become disabled. ***Effective October 1, 2012.***

2013

Improving Quality and Lowering Costs

- **Improving Preventive Health Coverage.** To expand the number of Americans receiving preventive care, the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost. ***Effective January 1, 2013.***

- **Expanded Authority to Bundle Payments.** The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. Under payment "bundling," hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test is billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a "bundled" payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program. ***Effective January 1, 2013.***

Increasing Access to Affordable Care

- **Increasing Medicaid Payments for Primary Care Doctors.** As Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government. ***Effective January 1, 2013.***
- **Additional Funding for the Children's Health Insurance Program.** Under the new law, states will receive two more years of funding to continue coverage for children not eligible for Medicaid. ***Effective October 1, 2013.***

2014

New Consumer Protections

- **No Discrimination Due to Pre-Existing Conditions or Gender.** The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Also limits the ability of insurance companies to charge higher rates due to gender, health status, or other factors. ***Effective January 1, 2014.***

- **Eliminating Annual Limits on Insurance Coverage**. The law prohibits plans from imposing annual dollar limits on the amount of coverage an individual may receive. ***Effective January 1, 2014.***

- **Ensuring Coverage for Individuals Participating in Clinical Trials.** Insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases. ***Effective January 1, 2014.***

Improving Quality and Lowering Costs

- **Makes Care More Affordable.** The act includes tax credits to make it easier for the middle class to afford insurance will become available for people with incomes above 100 percent and below 400 percent of poverty ($43,000 for an individual or $88,000 for a family of four in 2010) who are not eligible for or offered other affordable coverage. These individuals may also qualify for reduced cost-sharing (e.g. copayments, coinsurance, and deductibles). ***Effective January 1, 2014.***

- **Establishing Health Insurance Exchanges.** The law calls for health insurance exchanges to open in each State to enable all Americans to easily shop for more affordable private insurance. Plans offered in the exchange provide at least a basic level of benefits and services. The Exchanges will increase competition and consumer choice, make our health insurance marketplace more transparent and help bring down costs. ***Effective January 1, 2014.***

- **Small Business Tax Credit.** The law implements the second phase of the small business tax credit for qualified small businesses and small non-profit organizations. In this phase, the credit is up to 50 percent of the employer's contribution to provide health insurance for employees. There is also up to a 35 percent credit for small nonprofit organizations. ***Effective January 1, 2014.***

Increasing Access to Affordable Care

- **Increasing Access to Medicaid.** Americans who earn less than 133 percent of poverty (approximately $14,000 for an individual and $29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years. ***Effective January 1, 2014.***

- **Promoting Individual Responsibility.** Under the new law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, they will be eligible for an exemption. ***Effective January 1, 2014***

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- **Ensuring Free Choice.** Workers who cannot afford the coverage provided by their employer may take whatever funds their employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in the new health insurance exchanges. ***Effective January 1, 2014.***

2015

Improving Quality and Lowering Costs

- **Paying Physicians Based on Value Not Volume.** A new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified to reflect the quality of care they provide so that providers who provide higher value care will receive higher payments than those who provide lower quality care. ***Effective January 1, 2015.*** *[15]

[15] http://www.whitehouse.gov/healthreform/timeline

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

2009 Colorado Health Coverage Summary by Company Type[16]				
Colorado 2008	**Direct Premiums Written**	**Direct Premiums Earned**	**Direct Losses Incurred**	**Pure Direct Loss Ratio**
A&H* Health Companies				
Individual Comprehensive	$384,817,049	$386,983,918	$312,653,198	80.79%
Group Comprehensive	$2,783,648,412	$2,783,577,890	$2,437,164,662	87.56%
Vision Only	$42,986,537	$42,974,802	$32,167,787	74.85%
Dental Only	$748,610,111	$744,855,300	$615,310,934	82.61%
Federal Employees Health	$590,625,546	$579,322,868	$544,735,564	94.03%
Medicare Supplement	$29,822,714	$29,824,090	$19,920,226	66.79%
Title XVIII Medicare	$1.596,277,257	$1,591,583,486	$1,339,994,068	84.09%
Title XIX Medicaid	$58,993,064	$58,993,064	$55,464,124	94.02%
Other	$79,445,989	$78,470,537	$78,413,649	99.93%
Total for Lines of Business A&H Health	$6,315,226,679	$6,296,585,954	$5,435,824,212	84.97%
A&H* Life Companies				
Total for Lines of Business A&H Life	3,129,906,030	3,115,091,730	2,451,863,135	78.71%
A&H* Property & Casualty Companies				
Group accident and health	$38,561,280	$38,453,874	$23,570,343	61.30%
Collectively renewable A&H*	$713	$927	$5,051	544.88%
Non-cancelable A&H*	$476	$19,417	$25	0.13%
Guaranteed renewable A&H*	$24,710,346	$14,190,092	$16,630,520	117.20%
Non-renewable A&H* for stated reasons only	$2,682,344	$2,870,695	$2,890,798	100.70%
Other accident only	$417,959	$529,774	$751,668	141.88%
All other A&H*	$1,307,850	$1,338,804	$1,030,547	76.98%
Total for Lines of Business A&H Property	**$69,727,967**	**$59,469,348**	**$45,493,939**	**76.50%**
Credit A&H* Life Companies	**$3,129,906,030**	**$3,115,091,730**	**$2,451,868,135**	**78.71%**
Credit A&H* Property Companies	**$69,727,967**	**$59,469,348**	**$56,493,939**	**76.50%**
A&H* Fraternal Companies	**$11,514**	**$11,535**	**$8,570**	**74.30%**
Colorado Totals	**$9,514,860,675**	**$9,471,147,031**	**$7,933,181,285**	**83.76%**

Table 28: 2009 Colorado Health Coverage Summary by Company Type

2009 Medical Loss Ratio Summary in Colorado by Company Type*				
	Direct Premiums Written	**Direct Premiums Earned**	**Direct Losses Incurred**	**Pure Direct Loss Ratio**
A&H* Health	$6,315,226,678	$6,296,585,953	$5,435,824,211	86.33%
A&H* Life	$3,129,906,030	$3,115,091,730	$2,451,863,135	78.71%
A&H* Property	$69,727,967	$59,469,348	$45,493,939	76.50%
A&H* Fraternal	$11,514	$11,535	$8,570	74.30%
Colorado totals	$9,514,860,675	$9,471,147,031	$7,933,181,285	83.76%

Table 29: 2009 Medical Loss Ratio Summary in Colorado by Company Type

[16] 2009 Colorado Health Coverage Summary by Company Type - Information was reported on the 2009 annual financial statements by company type.

* A&H means Accident and Health

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.

Benefits - The amount of money paid under health insurance plans, to cover the costs of healthcare. "Benefits" is a term also used to describe the services that could be covered in a health policy, such as doctor services, hospital services, laboratory tests, preventive care, prescription medicine and emergency care. Different policies may offer different benefit coverage, all of which will be specified in the policy.

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.

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. Self-insured plans are also called ERISA Plans.

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.

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