Department of Regulatory Agencies

Annual Report of the Commissioner of Insurance

to

The Colorado General Assembly

on

2011 Health Insurance Costs

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

February 16, 2012

Division of Insurance
Jim Riesberg
Commissioner of Insurance

February 16, 2012

To the Members of the House and Senate,

I am pleased to submit the 2011 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,

Jim Riesberg

Jim Riesberg
Commissioner of Insurance

1560 Broadway, Suite 850 Denver, Colorado 80202 Phone 303.894.7499
Fax 303.894.7455 Toll Free 800.930.3745 www.dora.state.co.us V/TDD 711

2011 COLORADO HEALTH INSURANCE REPORT

ACKNOWLEDGEMENTS

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

The report was written and researched by:
Kelly Schultz (Senior Market Analyst)
Susan Buth (Administrative Assistant)
Tom Abel (Supervisor, Rates and Forms Section)

Data compilation and analysis assistance was provided by:
Erin Colbrese (Rate Financial Analyst)
Sean Brady (Actuary)
John Barela (Actuary)

Editorial assistance was provided by:
Jo Donlin (Director of External Affairs)
Joan Tanenbaum (Assistant to the Commissioner)
Craig Chupp (Chief Actuary)

For further information, please contact the Division of Insurance, Rates and Forms Section,
303-894-7499 or visit our website at www.dora.state.co.us/insurance.

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 only a small portion of the total 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 HMOs) in Colorado. This report fulfills this 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 2010. This is the most recent, complete and reliable data available due to the timing of this report and the timing of its primary source. A significant portion of the data for this report was gathered from the carriers' 2010 Annual Financial Statements, which were filed in March 2011; and the information gathered from the 2011 Colorado Health Cost Survey, completed in June of 2011.

2010 Highlights

- The Colorado Division of Insurance has responsibility to oversee health insurance coverage for over 10.4 million different coverage plans for Coloradans. There are 27.8% of Coloradans with health insurance coverage through government programs, including but not limited to Medicare, Medicaid, the Federal Employees' Health Benefit Plan and the Veteran's Administration. Moreover 13% of Coloradans were uninsured.

- During 2010, 58.4% of Coloradans were covered by employment-based insurance, compared to 55.3% of citizens in other states nationwide.

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

- During 2010, approximately 81% of premiums collected in 2010 by carriers in Colorado went directly to the cost of providing healthcare services. Approximately 19% of premiums were used for administrative expenses and producer commissions.

- While the percentage of health premiums that employees in Colorado are being asked to pay by their employers has been increasing more quickly than the national average in the last several years, the percentages are the same or lower than the national average in 2010.

- 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 35.5% in 2010. This 9.5% increase is more dramatic than the rate nationwide, which increased from 26.9% in 1998 to 35.8% in 2010. 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 68% of the market share in Colorado. There are approximately 450 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 2010 and 2011 were used. 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.

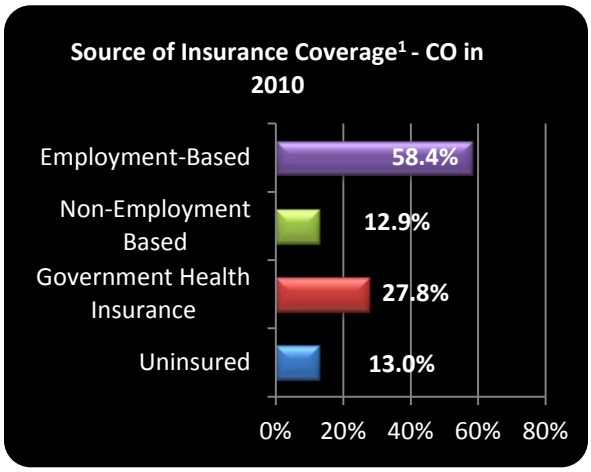


Figure 1:Source of Insurance Coverage - CO in 2010

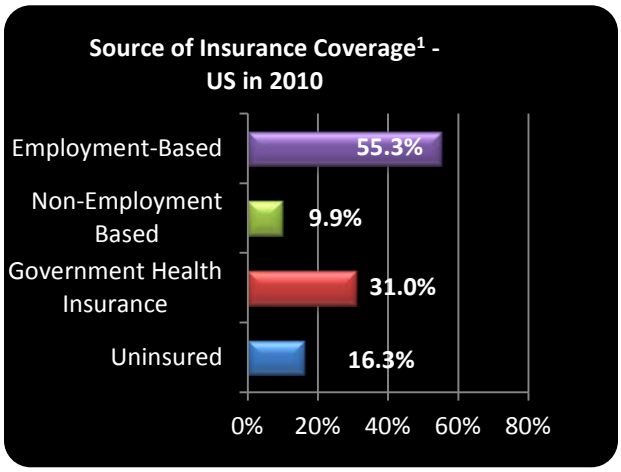


Figure 2:Sources of Insurance Coverage - US in 2010

As shown in Figures 1and 2, 58.4% of Coloradans secure health coverage through their employer, compared with 55.3% nationwide. The Colorado non-employment-based insurance market is also larger than the national figures with 12.9% of Coloradans having non-employment-based health insurance policies, compared with 9.9% nationwide. **Therefore,71.3% of Coloradans are covered by either employment-based or non-employment-based health plans, which is more than the 65.2% of citizens nationwide.**

According to the US Census Bureau, 27.8% 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 governments, and are paid for by a combination of participant premiums and tax dollars.

An estimated 13% of Coloradans have no health insurance, less than the estimated 16.3% nationwide.

[1] The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Table 1 below provides further detail on the number of covered lives for health coverage in Colorado. NOTE: The covered lives under the jurisdiction of the Division may be covered by more than one type of health insurance during the year, and are not mutually exclusive.

Colorado Health Insurance Covered Lives in 2010	
Colorado population	5,049,527
Insured	4,393,106
Uninsured	656,421
Jurisdiction of the Division of Insurance	
Individual	1,402,770
Small Group	1,413,145
Large Group	7,588,611
Total Under State Regulation	10,404,526
Insured, Not Regulated by the Division of Insurance	
Medicare	607,365
Medicaid	611,160
Other Public	342,089
Self-funded	3,080,211
Total Not Regulated by the Division of Insurance	4,640,825

Table 1: Colorado Health Insurance Covered Lives in 2010

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 12.9% of the population purchases their own private individual insurance (non-employment-based 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 policy.
- **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)-**HMOs represent "prepaid" 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 fee remains the same, regardless of types

or levels of service 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 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 (LTC)-**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.
    - 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).
    - 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.
    - 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 and Tissue Transplant)
    - Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as the expense is incurred, per diem, or a principle sum.
    - 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 are not to exceed a stated dollar amount per day.
    - 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 are not to exceed a stated dollar amount per day.
- **Medicare Supplement-**Insurance coverage sold on an individual or group basis to help fill the "gaps" in the protections granted by the federal Medicare program. This is strictly supplemental coverage and may not 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. Medicare Supplement Insurance is 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 have 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 Covered Lives by Health Insurance Types in 2010[2]				
	Individual	**Large Group**	**Small Group**	**Grand Total**
Accidental Death & Dismemberment	254,904	2,847,740	793,751	3,896,395
Comprehensive Major Medical	279,924	523,881	190,208	994,013
Credit Accident and Health	11,349	51,595	7,773	70,717
Dental	51,376	846,711	172,055	1,070,142
Disability Income	100,712	1,101,385	40,260	1,242,357
Managed Care (HMO)	162,223	446,801	85,538	694,562
Limited Benefit Plan	214,954	51,658	3,944	270,556
Long-term Care	98,589	39,384	278	138,251
Medicare Supplement	66,148	39,027	29	105,204
Vision	7,296	939,342	106816	1,053,454
All Other Health Insurance	155,295	701,087	12493	868,875
Grand Total	**1,402,770**	**7,588,611**	**1,413,145**	**10,404,526**

Table 2: Colorado Covered Lives by Health Insurance Types in 2010

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, and 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

[2]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 policies 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 account for movement in and out of Colorado: Some carriers may include all policies originally written in Colorado while others include only the current membership active in Colorado. Similarly, it is possible that some companies may include group lives purchased by a Colorado company but living in another state in this report.

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, pre-tax 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 FSA. Typically, benefits or cash must be used within a given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover child care 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 pre-tax 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 a calendar year, and is portable if the person changes employment. HSAs are medical savings accounts that earn interest and can be used to pay for current medical expenses or saved for future medical expenses.

- **Flexible benefits plan (Cafeteria plan or 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 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 Table 1, 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 over 10.4 million different coverage plans for Coloradans.** Section 4 of this report focuses on the regulatory role that the Division plays in the marketplace and the tools used to protect consumers. 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 health insurance plans is small, there are a number of carriers in the state that offer such plans. There were 64 carriers who reported offering individual major medical comprehensive policies in Colorado during 2010, in the 2011 Colorado Health Cost Survey. Table 3below reflects the number of carriers that offer individual health coverage and the average premiums per covered life per month.

Individual	Number of Companies offering Individual Coverage	Average Premium Earned per Covered Life per Month	Average Premium Earned per Covered Life Annually
Accidental Death & Dismemberment	103	$12.90	$154.79
Comprehensive Major Medical	64	$182.22	$2,186.60
Credit Accident and Health	15	$12.81	$153.69
Dental	39	$20.59	$247.08
Disability Income	148	$86.14	$1,033.64
Managed Care (HMO)	8	$109.48	$1,313.76
Limited Benefit Plans	109	$23.97	$287.65
Long-Term Care	81	$152.35	$1,828.19
Medicare Supplement	87	$179.24	$2,150.92
Vision	8	$6.45	$77.35
All Other	50	$195.54	$2,346.42

Table 3: Individual Average Earned Premiums in 2010

CoverColorado[3]

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[3]. 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. Enrollment in CoverColorado was 12,732 on December 31, 2010. Colorado is one of 35 states that have a high-risk pool insurance plan.

GettingUSCovered[4]

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.

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

After that date, 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 and medical treatment can begin upon the effective date.

GettingUSCovered expects to expand coverage to up to 4,000 currently uninsured individuals and 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.

Employer-Provided Insurance

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

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.

Small Group Market

A small group health plan is a health plan offered to employer groups of no more than 50 and includes employer groups of one. Small group insurance is the most heavily regulated market in the state. Small group plans have mandated benefits: they must be guaranteed renewable and premium rating can only be based on smoking status, industrial classification, age, family size and geographic region. Table 4 below shows the number of companies, the average premiums earned per covered life by month and annually reported from the 2011 Colorado Health Cost Survey.

Small Group	Number of Companies offering Small Group Coverage	Average Premium Earned per Covered Life per Month	Average Premium Earned per Covered Life Annually
Accidental Death & Dismemberment	34	$0.34	$4.05
Comprehensive Major Medical	20	$252.59	$3,031.08
Credit Accident and Health	2	$5.70	$68.35
Dental	39	$24.65	$295.82
Disability Income	33	$35.05	$420.65
Managed Care (HMO)	6	$356.54	$4,278.47
Limited Benefit Plans	22	$22.35	$268.24
Long-Term Care	10	$36.11	$433.31
Medicare Supplement	3	$137.84	$1,654.06
Vision	15	$4.58	$54.97
All Other	14	$159.14	$1,909.69

Table 4: Small Group Market Average Premiums Earned in 2010

The major small market changes in health benefit plans from 2009 to 2010 include the following[5]:

- A decline in both the number of small group plans, by 10%, and covered lives, by 7%.
- Business Groups of One (BG-1s), a subset of small employers, decreased by 15%.
- Ten companies increased their market share to include 99.7% of all covered lives in 2010, compared to 99.0% in 2009.
- Of 16 companies in the small group market, 10 sell new policies and six are in the process of leaving the market.
- Health Savings Account (HSA) qualified plans increased in proportion to other plans by 2%, down from a 4% increase in 2009.
- Health Maintenance Organization (HMO) coverage increased in proportion to other types by 3%, which is lower than the 12% increase in 2009.
- The number of covered lives that left the small group market in 2010 is less than half the number of covered lives that left in 2009.

According to the Division's 2010 Small Group Market Activity and Rating Flexibility Report,**16 carriers offered small group health benefit plans in Colorado during 2010. They covered 33,734 groups, or 267,411 lives.**

"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.

Large Group Market

A large group health plan is a fully insured health plan offered to employer groups of more than 50 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. Table 5 below reflects the number of carriers that offer large group health coverage and the average premiums earned per covered life per month and annually reported from the 2011 Colorado Health Cost Survey.

[5]These notes are based on the 2010 Colorado Small Group Market Activity and Rating Flexibility Report, which is available on the Division's website at: www.dora.state.co.us/insurance/rtfo/2011/rtfoSmallGroupMarket2010Report050211.pdf. This is an annual data request by the Division of Insurance.

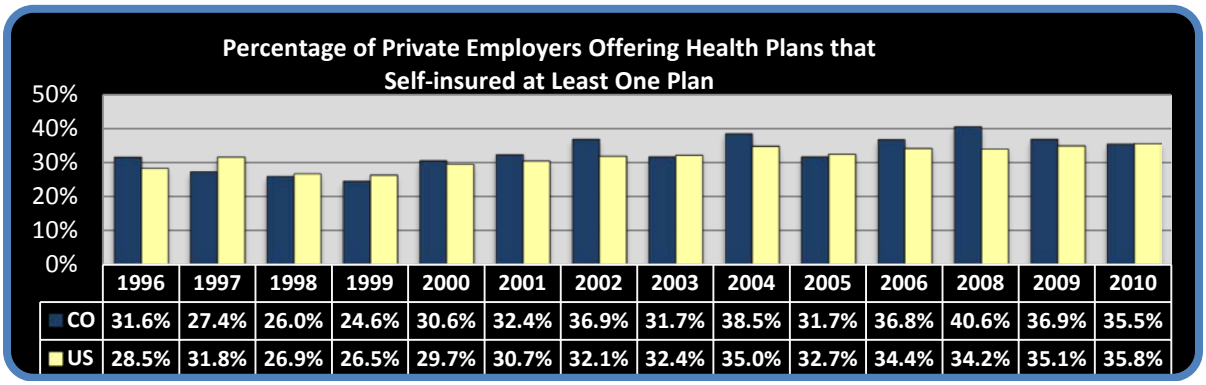
Large Group	Number of Companies offering Large Group Coverage	Average Monthly Premium Earned per Member	Annual Average Premium Earned per Member
Accidental Death & Dismemberment	73	$1.98	$23.74
Comprehensive Major Medical	24	$217.65	$2,611.76
Credit Accident and Health	17	$6.32	$75.89
Dental	43	$23.86	$286.31
Disability Income	53	$14.69	$176.33
Managed Care (HMO)	10	$316.45	$3,797.38
Limited Benefit Plans	40	$34.19	$410.33
Long-Term Care	19	$60.72	$728.65
Medicare Supplement	12	$179.58	$2,154.90
Vision	21	$5.02	$60.22
All Other	33	$72.01	$864.08

Table 5: Large Group Market Average Premiums Earned in 2010

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 3 shows that the number of private employers in Colorado offering health plans and that self-insure at least one of their plans has increased from 26% in 1998 to 35.5% in 2010. The 9.5% increase is more dramatic than the rate nationwide, which increased from 26.9% in 1998 to 35.8% in 2010.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2008	2009	2010
CO	31.6%	27.4%	26.0%	24.6%	30.6%	32.4%	36.9%	31.7%	38.5%	31.7%	36.8%	40.6%	36.9%	35.5%
US	28.5%	31.8%	26.9%	26.5%	29.7%	30.7%	32.1%	32.4%	35.0%	32.7%	34.4%	34.2%	35.1%	35.8%

Figure 3: 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 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 27.8% of Coloradans have some sort of government-funded or government-subsidized health plans. These include the following:

Medicaid

Medicaid is a federal/state program that is administered by the state and 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. In addition, Colorado must accept certain tribal documents to establish citizenship. **More than 611,100Coloradans were receiving health coverage through Medicaid in 2010, representing 12.1% of the state's population**.[6]

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 4.1% from fiscal year 2009 to the fiscal year of 2010. The annual **CHP+ enrollment was 106,600 in Colorado in fiscal year 2010**[7].

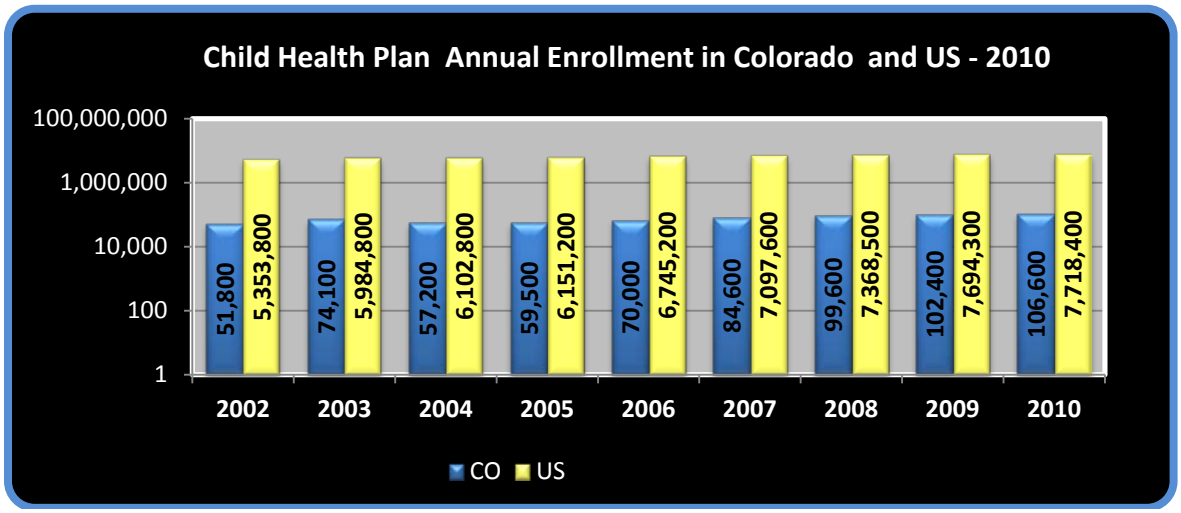


Figure 4: CHP+ Annual Enrollment in Colorado and US - 2010

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 607,367Coloradans enrolled in Medicare in 2010, which was 12% of the state's population.**[8]

[6]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

[7]www.cchp.org

[8]www.statehealthfacts.com

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 HMOs, 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 insurance programs.

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, current military personnel and Native American populations.

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 age 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, the 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 5 demonstrates how the size of an employer affects the accessibility of health insurance. Approximately 39% of small companies with less than fifty employees offer insurance compared to the 97% of larger firms that offer insurance.

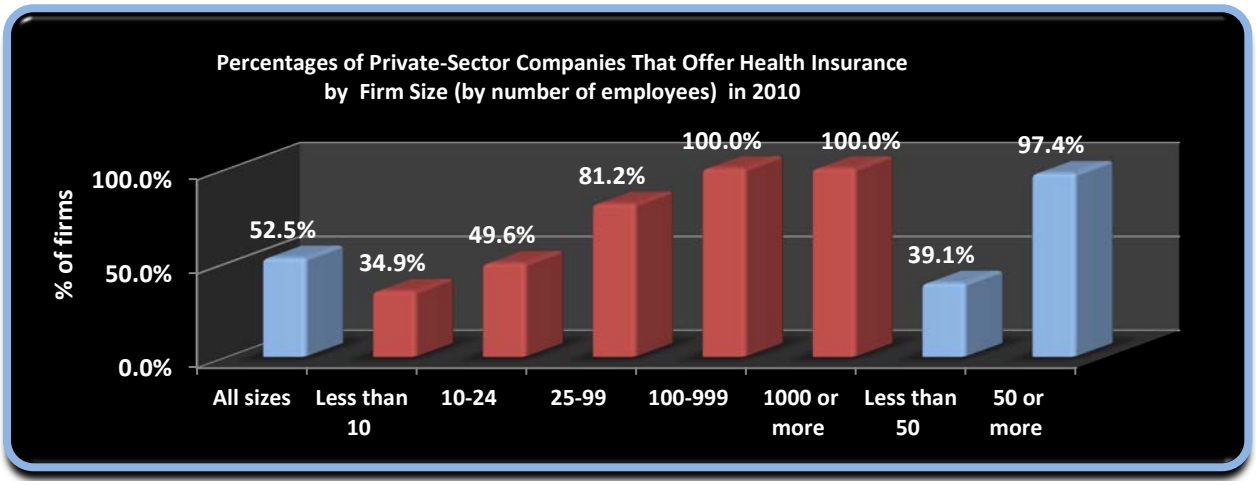


Figure 5: Percentage of Private-Sector Companies That Offer Health Insurance by Firm Size in Colorado – 2010

In 2010, 52% of private sector employees enrolled in employer-sponsored health insurance plans chose single coverage, with the balance choosing 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 (see "Source" for Figures 5 through 8), 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	$4,730			$1,004	$3,726
Mixed-Provider Plans	$4,617	$26	$1,232	$883	$3,734
Any-Provider Plans	$4,555			$611	$3,944

Family Coverage	Average Annual Total Premium	Average Copayment	Average Deductible	Average Annual Employee Contribution	Average Annual Employer Contribution
Exclusive-Provider Plans	$13,234			$3,566	$9,668
Mixed-Provider Plans	$13,370	$26	$2,262	$3,630	$9,740
Any-Provider Plans	$14,179			$3,592	$10,587

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

The average annual Colorado premium in 2010 was $4,630 for single coverage and $13,393 for family coverage. Figure 6 illustrates the increases in private employer-sponsored health premiums since 1996.

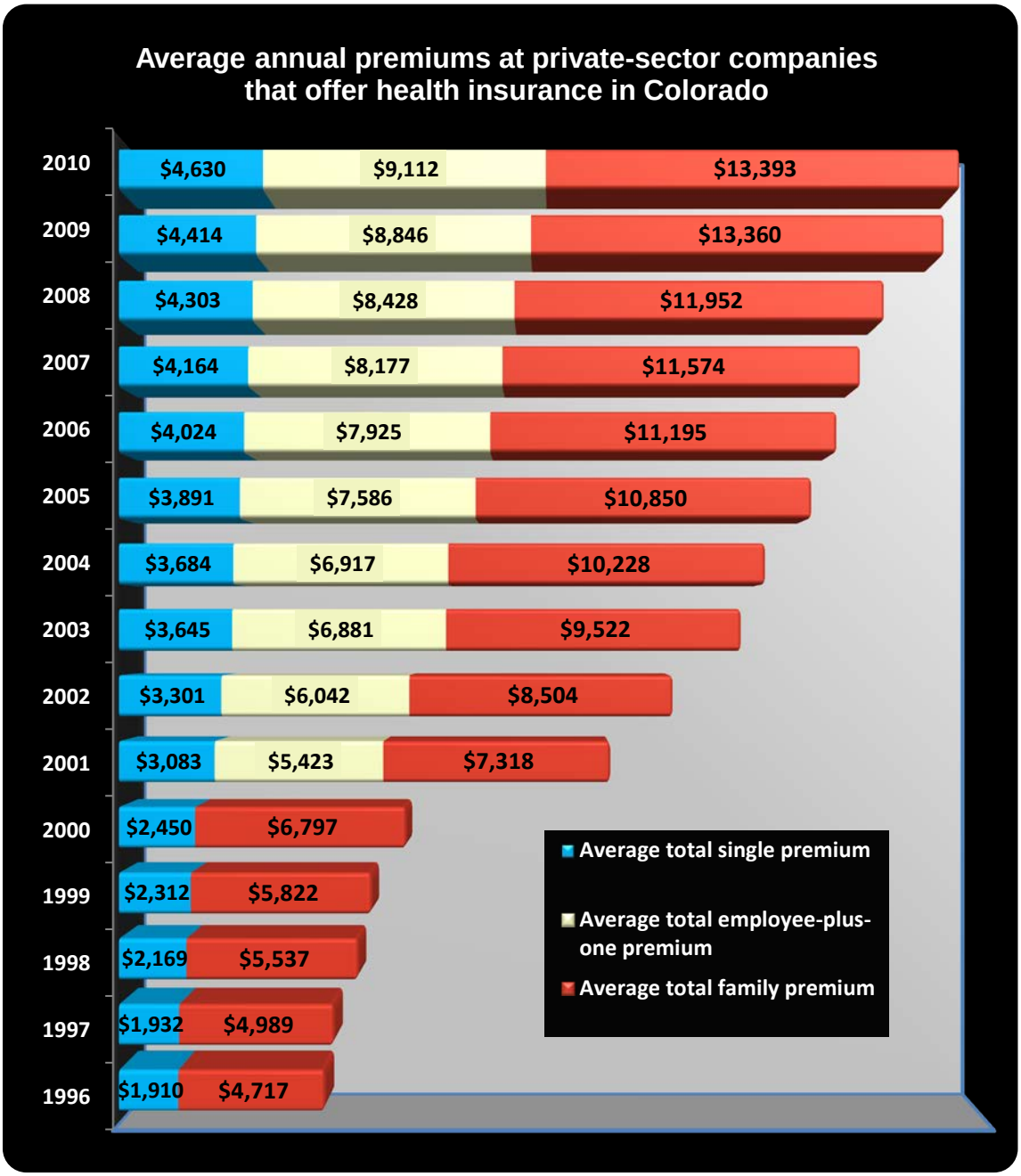
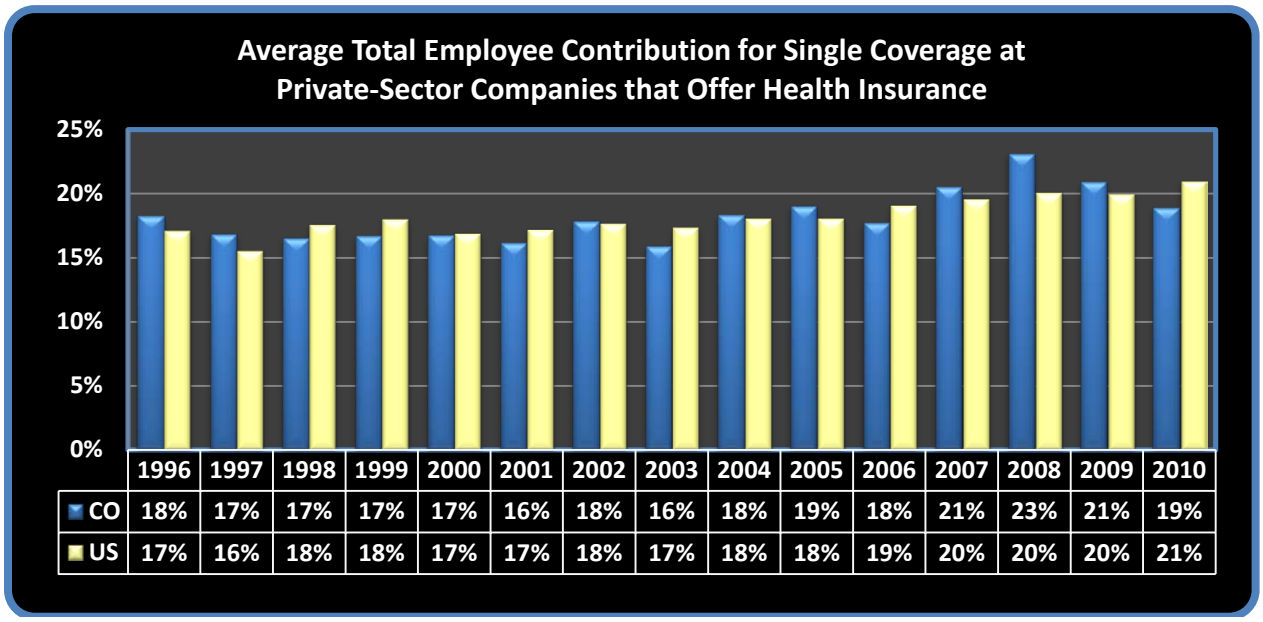


Figure 6: Average annual premiums at private-sector companies that offer health insurance in Colorado

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

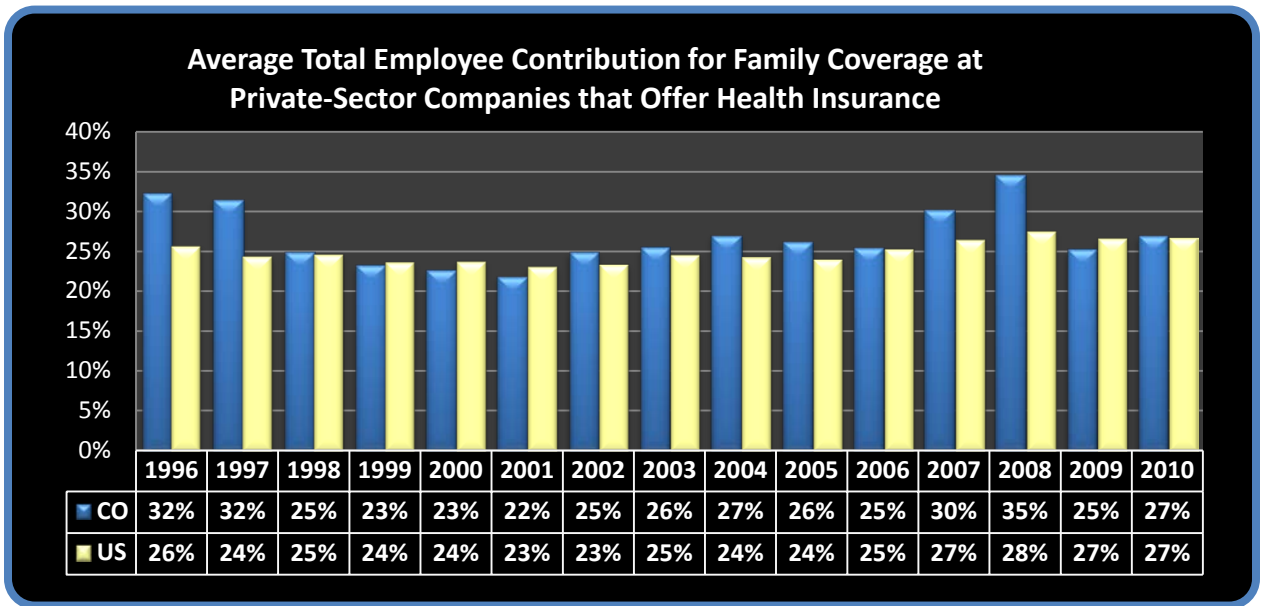
indicate that the dollar amount that Colorado employees are contributing compared to the national average. While the percentage of health premiums that employees in Colorado are being asked to pay by their employers has been increasing more quickly than the national average in the last several years, the percentages are the same or lower than the national average in 2010.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CO	18%	17%	17%	17%	17%	16%	18%	16%	18%	19%	18%	21%	23%	21%	19%
US	17%	16%	18%	18%	17%	17%	18%	17%	18%	18%	19%	20%	20%	20%	21%

Figure 7: Average Total Employee Contribution for Single Coverage at Private-Sector Companies that Offer Health Insurance

Colorado employees paid 19% of the total premium for single coverage and 27% for family coverage, compared to 21% for single coverage and 27% for family coverage, nationally. Before 2008, the data showed that the overall premium increases in Colorado were similar to those being experienced in the rest of the country. This indicates that in 2007 through 2009, Colorado employees were carrying more of the burden of premium increases than was occurring nationally. That was not the case in 2010.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CO	32%	32%	25%	23%	23%	22%	25%	26%	27%	26%	25%	30%	35%	25%	27%
US	26%	24%	25%	24%	24%	23%	23%	25%	24%	24%	25%	27%	28%	27%	27%

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

While 20.4% of Colorado private sector employees with single coverage were enrolled in a plan that did not require them to contribute toward the premium cost, only 12.6% of employees with family coverage and 9.3% 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						
	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	-1.5
Blanket Accident & Health	1.6	0.0	1.0	1.3	1.6	1.1
Champus (military dependents)	25.0	10.0	17.5	20.2	17.5	18.0
Conversion	13.9	25.9	14.0	7.9	11.4	14.6
Dental	2.6	2.6	2.2	2.3	3.1	2.6
Disability Income	-0.2	-2.7	-3.5	-2.9	-1.4	-2.1
Excess/ Stop Loss	3.4	0.7	7.0	4.4	19.6	7.0
Health-other	0.0	-4.5	2.2	-0.8	4.0	0.2
HMO- Other	40	2.1	5.7	12.6	3.7	5.6
HMO-Major Medical	2.1	3.0	7.0	7.3	4.8	4.8
Hospital Indemnity	0.0	4.9	0.2	2.8	-2.3	1.1
Hospital/Surgical/Medical Expense	5.6	8.4	10.6	6.4	7.6	7.7
Limited Benefit Plan	14.6	15.8	10.3	13.3	9.4	12.7
Long-Term Care	12.1	12.9	10.1	21.7	9.9	13.3
Major Medical	7.4	8.5	7.9	9.6	8.1	8.3
Medicare Supplement	7.0	6.8	5.6	8.2	3.7	6.3
Prescription Drug	9.0	0.0	10.6	8.1	5.9	6.7
Short-Term Nursing Home	0.0	13.9	0.0	0.0	0.0	2.8
Sickness	0.0	0.0	0.0	0.0	6.6	1.3
Travel	6.7	0.0	0.0	0.0	0.0	1.3
Vision	0.2	2.2	-1.2	0.2	-2.9	-0.3
Grand Total	**5.5**	**5.2**	**5.0**	**5.6**	**5.3**	**5.3**

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

Table 8 is the Average Percentages for the Comprehensive Major Medical Rate Increases from a sample of large carriers.

Major Medical	2006	2007	2008	2009	20010
Individual	14.0%	11.7%	12.9%	11.9%	11.6%
Small Group	14.7%	13.3%	9.3%	15.1%	12.7%
Large Group	9.0%	8.9%	10.5%	7.2%	7.9%

Table 8:Average Comprehensive Major Medical Rate Increases from a sample of large carriers

Individual Market Premium Rate Changes

Average Rate Increase Percentages - Summary for Individual Health Plans in Colorado					
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	5.9	7.8	13.5	-52.0	115.0
6 Year Average	**8.0**	**6.9**	**10.7**	**-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	Average By Line
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	13.4
Conversion	0.0	13.9	25.9	14.0	7.9	11.4	12.2
Dental	0. 0	0.0	0.0	0.0	4.4	1.6	1.0
Disability Income	0.0	2.8	0.0	-8.0	0.0	-0.7	-1.0
Health-other	0.0	0.0	0.0	14.4	1.7	4.0	3.4
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	3.3
Hospital/Surgical/Medical Expense	0.0	6.5	10.2	11.3	5.9	6.6	6.7
Limited Benefit Plan	8.8	19.2	19.3	13.9	16.3	11.0	14.8
Long-Term Care	6.3	12.8	12.9	10.5	23.3	9.7	12.6
Major Medical	7.0	10.5	12.2	10.1	12.4	10.0	10.4
Medicare Supplement	5.9	7.4	7.6	5.8	5.7	4.2	6.1
Prescription Drug	0.0	30.0	0.0	0.0	6.8	0.0	6.1
Vision	0.0	0.0	0.0	0.0	0.0	-3.3	-0.6
Average by Year	**2.5**	**9.1**	**7.6**	**7.2**	**7.8**	**4.8**	**6.5**

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

Large Group Market Premium Rate Changes

Average Rate Increase Percentage Summary for Large Group Health Plans in Colorado9F[9]					
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

[9]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.

2010	3.2	-2.8	11.0	-46.7	54.5
6 year Average	**3.6**	**-0.3**	**9. 2**	**-54.8**	**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**	**6 Year Average**
Accident Only & Accidental Death and Dismemberment	2.2	-0.1	-1.7	-3.5	-6.5	0.0	-1.6
Blanket Accident & Health	0.0	1.6	0.0	1.0	1.3	1.6	0.9
Champus	0.0	0.0	0.0	15.0	30.0	25.0	11.7
Dental	4.2	2.4	2.2	1.9	2.4	2.6	2.6
Disability Income	0.0	-1.3	-4.2	-1.9	-3.4	-2.0	-2.1
Excess/ Stop Loss	12.9	4.2	1.4	5.5	4.3	19.4	8.0
HMO- Major Medical	0.0	2.8	0.6	7.0	7.6	3.7	3.6
HMO-Other	-1.4	2.2	2.0	6.0	13.2	13.1	1.5
Hospital Indemnity	0.0	0.0	0.0	-1.8	0.0	11.6	1.6
Hospital/Surgical/Medical Expense	15.0	1.9	1.4	18.0	8.1	1.2	7.6
Limited Benefit Plan	0.0	0.8	2.3	0.0	2.0	11.5	2.8
Long-Term Care	0.0	0.0	0.0	0.0	2.4	5.1	1.2
Major Medical	1.5	5.1	4.0	6.3	6.0	-0.8	3.7
Medicare Supplement	7.9	5.7	4.5	5.0	24.6	5.9	8.9
Prescription Drug	-3.0	-1.5	0.0	10.6	13.3	6.6	4.3
Sickness	0.0	0.0	0.0	0.0	3.0	0.0	0.5
Travel	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Vision	0.0	-0.7	2.9	-1.5	0.0	-1.9	-0.2
Average by Year	**2.2**	**1.3**	**0.9**	**3. 8**	**6.0**	**4.2**	**3.1**

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

Small Group Market Premium Rate Changes

Average Rate Increase Percentages Summary for Small Group Health Plans in Colorado10F[10]					
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	902.91[11]
2010	4.3	0.0	7.6	-36.2	29.0
6 Year Average	**3.2**	**1.0**	**9.8**	**-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**	**6 Year Average**
Accident Only	-1.0	0.0	0.0	0.0	0.0	0.0	-0.2
Dental	4.9	4.1	3.7	4.0	0.6	6.6	4.0

[10] 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.

[11] While a 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%.

Disability Income	0.0	-1.2	0.3	-8.5	-13.0	0.0	-3.7
Excess/ Stop Loss	0.0	0.0	-5.0	16.6	4.6	20.3	6.1
HMO	2.9	1.9	2.3	5.1	4.5	3.3	3.3
Hospital Indemnity	0.0	0.0	0.0	-4.8	-2.5	0.0	-1.2
Major Medical	-0.6	3.2	2.9	4.5	6.2	5.3	3.6
Medicare Supplement	0.0	0.0	-18.0	0.0	0.0	0.0	-3.0
Vision	0.0	1.5	2.4	-0.9	0.8	-4.4	-0.1
Average by Year	**0.7**	**1.1**	**-1.3**	**1.8**	**0.1**	**3.4**	**1.0**

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 2010data collected from the Colorado Health Insurance Cost Report, the Division has been able to breakdown the above components for the year 2010 and illustrate how the health care premiums paid by Coloradans were spent by insurers.

For the 375 companies that reported, the total premium collected was over$7 billion. This premium was for all types of health insurance coverage offered by private insurers in our state, including comprehensive major medical, dental, vision, disability income, long-term care, accident only and accidental death and dismemberment and credit health.

Components of Colorado Health Care Premiums in 2010		
	Insurer Expense	**Percent of Premium**
Medical Expenses	$5,764,658,073	81.03%
Administrative Expenses	$1,233,059,942	17.33%
Profit and Contingencies	$116,656,153	1.64%
Total	**$7,114,374,168**	**100.00%**

Table 15: Components of Colorado Health Care Premiums in 2010

It is important to note that the information above is from an aggregation of the data received from all 375 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, 2010.

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 2010	
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 80.13% 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 2010. 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 in Table 16. Executive salaries are reported with the Health Insurance Cost Report, but are not part of Staff Salaries, and are not reported on the table below.

Administrative Expenses 2010		
Administrative Expenses	**Insurer Expense**	**Percent of Premium**
Commissions	$159,423,218	2.24%
Staff Salaries	$312,428,159	4.39%
Dividends to Policyholders	$7,251,092	0.10%
Legal Expenses	$5,886,436	0.08%
Advertising or Marketing	$46,846,811	0.66%
Lobbying Expenses	$885,472	0.01%
Charitable Contributions	$69,986,055	0.98%
Federal Income Taxes	$116,983,864	1.64%
State Taxes, Licenses and Fees	$88,904,467	1.25%
All Other	$424,464,369	5.97%
Total	**$1,233,059,942**	17.33%

Table 16: Administrative Expenses reported from 375 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 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, 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 Premium Trend					
	2006	**2007**	**2008**	**2009**	**2010**
Individual	17.10%	13.30%	11.80%	13.30%	6.60%
Small Group	13.40%	10.80%	10.90%	11.10%	11.00%
Large Group	11.20%	11.90%	9.00%	8.40%	8.00%

Table 17:Comprehensive Major Medical Premium Trend from a sample of Large 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 policyholder cost 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 healthy employees, thereby 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 individuals and members of government programs such as 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 highest earned premiums from health insurance in Colorado. All figures in this section are derived or directly from each company's annual financial statement. **Figure 8 shows that the top 10 largest health insurers make up 68% of the market in Colorado. There are approximately 450 health insurers doing business in Colorado.**

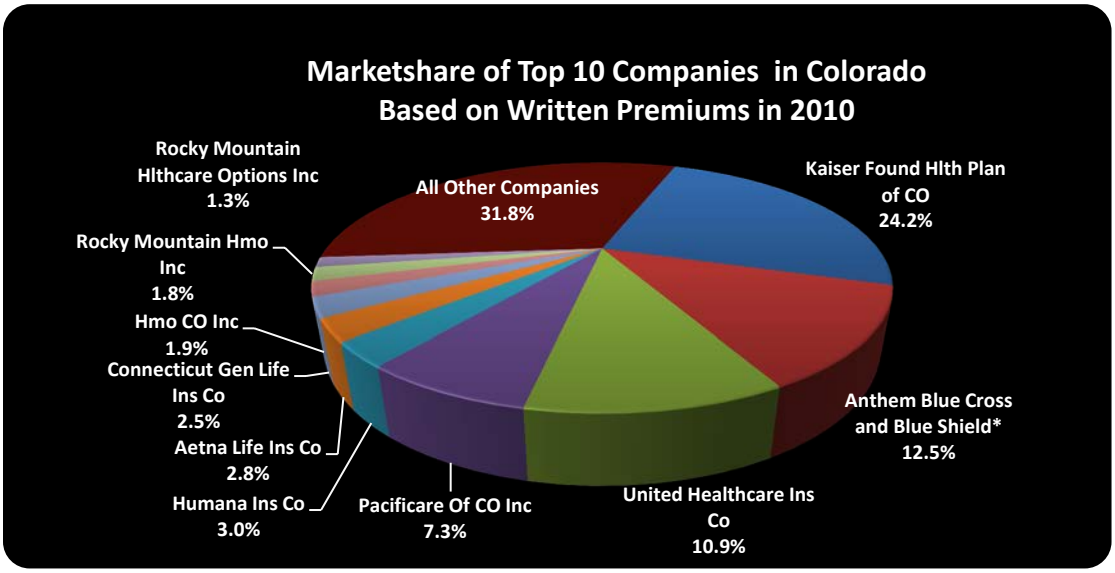


Figure 9: Marketshare of Top 10 Companies in Colorado Based on Written Premiums in 2010

Company	2010 Written Premiums	2010 % of Market Share
Kaiser Found Health Plan of CO	2,404,286	24.2%
Anthem Blue Cross and Blue Shield*	1,240,068	12.5%
UnitedHealthcare Ins Co	1,084,157	10.9%
Pacificare Of CO Inc.	727,762	7.3%
Humana Ins Co	299,981	3.0%
Aetna Life Ins Co	274,023	2.8%
Connecticut Gen Life Ins Co	249,833	2.5%
HMO CO Inc.	187,936	1.9%
Rocky Mountain HMO Inc	177,882	1.8%
Rocky Mountain Healthcare Options Inc.	130,364	1.3%
All Other Companies	3,148,830	31.8%
Total	9,925,122	100.0%

Table 18: Market Share of the Top 10 Health Carriers in Colorado[12]

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. Each domestic insurer is audited by the Division at least once every five years, and representatives from other states in which the insurer does business that may join the audit.

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

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

By law, insurers 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. These values protect the interests of the company's policyholders in the event the company develops financial problems. The policyholder's 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	**2006**	**2007**	**2008**	**2009**	**2010**	**5-Year Average**
Aetna Life Ins Co	808%	706%	714%	772%	765%	753%
Anthem Blue Cross and Blue Shield*	512%	388%	488%	449%	466%	461%
Connecticut General Life Ins Company	648%	560%	575%	799%	703%	657%
HMO Colorado, Inc.	807%	424%	368%	578%	787%	593%
Humana Insurance Company	310%	448%	438%	446%	534%	435%
Kaiser Found Health Plan of CO	594%	395%	1244%	1319%	1287%	968%
PacifiCare Of Colorado, Inc.	512%	675%	825%	507%	507%	605%
Rocky Mountain Healthcare Options Inc.	181%	245%	229%	306%	187%	230%
Rocky Mountain HMO, Inc.	1105%	1161%	1270%	1657%	1743%	1387%
UnitedHealthcare Ins Co	524%	559%	396%	413%	467%	472%

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

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 the 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 carrier's goal is to keep this ratio well below 100% since the carrier's profit is generated from the premiums that remain after they

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have paid both the cost of providing health care and 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	**2006**	**2007**	**2008**	**2009**	**2010**	**5 year Average**
Aetna Life Ins Co	79.32%	84.60%	81.89%	88.22%	84.25%	**83.66%**
Anthem Blue Cross and Blue Shield*	75.94%	86.40%	78.58%	83.14%	84.55%	**81.72%**
Connecticut General	83.67%	80.56%	83.32%	85.83%	72.97%	**81.27%**
HMO Colorado Inc	78.27%	88.22%	83.66%	91.70%	86.47%	**85.66%**
Humana Ins Co	81.53%	81.47%	82.42%	81.20%	71.49%	**79.62%**
Kaiser Foundation Health Plan of CO	89.47%	88.17%	88.24%	91.42%	93.34%	**90.13%**
Pacificare of CO Inc.	79.21%	79.63%	76.50%	82.86%	75.98%	**78.84%**
Rocky Mountain Healthcare Options Inc.	86.09%	87.08%	85.69%	83.24%	86.41%	**85.70%**
Rocky Mountain HMO Inc	86.41%	87.46%	84.16%	80.25%	79.11%	**83.48%**
UnitedHealthcare Ins Co	79.64%	75.88%	79.98%	84.05%	78.67%	**79.64%**
Grand Total	**81.96%**	**83.95%**	**82. 45%**	**85.19%**	**81.32%**	**82.97%**

Table 20: Colorado Medical Loss Ratios

Administrative Expenses

Administrative expenses are the expenses incurred by an insurer to operate its business. This includes expenses not directly related to paying claims, including, but not limited to, commissions, telephone charges, marketing and advertising expenses, office supplies, rent, taxes, depreciation, legal fees, postage, real estate expenses, salaries and benefits.

Administrative expenses for HMOs are consistently lower than for non-HMOs. One reason for this is that expenses which 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 and from year to year. The five-year average administrative expense as a percent of premium was 9.30% for all ten insurers.

Administrative Expenses as a Percent of Colorado Earned Health Premiums						
Company	**2006**	**2007**	**2008**	**2009**	**2010**	**5 year Average**
Aetna Life Ins Co	7.35%	7.67%	8.52%	9.46%	12.32%	**9.06%**
Anthem Blue Cross and Blue Shield*	10.08%	5.11%	7.45%	9.02%	7.91%	**7.91%**
Connecticut General	16.69%	10.46%	12.04%	12.12%	11.25%	**12.51%**

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HMO Colorado Inc	8.44%	5.29%	5. 88%	5.71%	5.75%	**6.21%**
Humana Ins Co	16.85%	14.64%	14.19%	15.61%	14.51%	**15.16%**
Kaiser Foundation Health Plan of CO	7.94%	5.94%	6.31%	6.55%	5.99%	**6.54%**
Pacificare of CO Inc.	9.55%	7.42%	8.00%	7.37%	8.16%	**8.10%**
Rocky Mountain Healthcare Options Inc.	8.74%	9.69%	9.87%	10.54%	10.45%	**9.86%**
Rocky Mountain HMO Inc	6.77%	7.51%	6.30%	6.80%	7.46%	**6.97%**
UnitedHealthcare Ins Co	8.90%	10.39%	10.78%	10.52%	12.63%	**10.64%**
Yearly Average	**10.13%**	**8.41%**	**8.93%**	**9.37%**	**9.64%**	**9.30%**

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

Claims Adjustment Expenses

Claims Adjustment Expenses are 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	**2006**	**2007**	**2008**	**2009**	**2010**	**5 year Average**
Aetna Life Ins Co	4.32%	4.42%	4.08%	3.89%	4.83%	**431%**
Anthem Blue Cross and Blue Shield*	1.94%	5.38%	2.70%	3.15%	3.44%	**3.32%**
Connecticut General[13]	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
HMO Colorado Inc	2.96%	5.21%	3.72%	2.91%	3.35%	**3.63%**
Humana Ins Co	2.43%	3.06%	2.29%	1.76%	0.00%	**1.91%**
Kaiser Foundation Health Plan of CO	1.36%	1.12%	1.34%	1.39%	1.58%	**1.36%**
Pacificare of CO Inc.	1.53%	2.13%	1.55%	1.95%	1.95%	**1.82%**
Rocky Mountain Healthcare Options Inc.	6.02%	6.14%	6.46%	7.79%	7.77%	**6.84%**
Rocky Mountain HMO Inc	5.79%	6.14%	5.49%	6.84%	7.54%	**6.36%**
UnitedHealthcare Ins Co	1.55%	1.11%	1.02%	1.30%	0.01%	**1.00%**
Grand Total	**2.79%**	**3. 47%**	**2.86%**	**3.10%**	**3.05%**	**3.05%**

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

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.

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

Underwriting Gain or Loss as a Percent of Colorado Earned Health Premiums						
Company	**2006**	**2007**	**2008**	**2009**	**2010**	**5 year Average**
Aetna Life Ins Co	9.56%	4.02%	6.12%	-1.05%	0.22%	**3.77%**
Anthem Blue Cross and Blue Shield*	10.06%	4.92%	8.60%	3.88%	3.50%	**6.19%**
Connecticut General	1.76%	10.49%	6.11%	3.22%	17.20%	**7.76%**
HMO Colorado Inc	9.75%	-1.17%	8.78%	-0.03%	4.74%	**4.41%**
Humana Ins Co	-0.82%	0.83%	1.10%	1.43%	14.00%	**3.31%**
Kaiser Foundation Health Plan of CO	2.75%	6.19%	5.67%	2.99%	0.49%	**3.62%**
Pacificare of CO Inc.	7.81%	10.23%	14.28%	7.57%	13.86%	**10.75%**
Rocky Mountain Healthcare Options Inc.	-0.85%	-3.49%	-2.44%	-1.55%	-5.06%	**-2.68%**
Rocky Mountain HMO Inc	2.12%	0.23%	5.09%	6.24%	6.91%	**4.12%**
UnitedHealthcare Ins Co	9.91%	12.61%	8.22%	4.10%	8.69%	**8.70%**
Grand Total	**5.21%**	**4.49%**	**6.15%**	**2.68%**	**6.46%**	**5.00%**

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

Net Investment Income Gain (or loss)

Net Investment Income is the income received from pre-tax investment assets 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	**2006**	**2007**	**2008**	**2009**	**2010**	**5 year Average**
Aetna Life Ins Co	1.72%	1.45%	1.05%	0.92%	0.99%	**1.22%**
Anthem Blue Cross and Blue Shield*	2.70%	2.48%	2.71%	3.15%	2.47%	**2.70%**
Connecticut General	6.48%	4.14%	3.79%	4.07%	4.34%	**4.56%**
HMO Colorado Inc	1.49%	0.81%	0.74%	0.96%	1.14%	**1.03%**
Humana Ins Co	1.06%	2.20%	1.56%	1.01%	1.38%	**1.44%**
Kaiser Foundation Health Plan of CO	0.77%	1.01%	0.44%	1.36%	1.19%	**0.95%**
Pacificare of CO Inc.	0.99%	1.52%	1.01%	0.72%	0.72%	**0.99%**
Rocky Mountain Healthcare Options Inc.	0.88%	1.08%	1.04%	1.44%	0.82%	**1.05%**
Rocky Mountain HMO Inc	1.30%	2.43%	2.05%	1.01%	1.72%	**1.70%**
UnitedHealthcare Ins Co	2.71%	2.43%	1.69%	1.24%	0.95%	**1.80%**
Grand Total	**2.01%**	**1.96%**	**1.61%**	**1.59%**	**1.57%**	**1.75%**

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

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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 five-year summary of Colorado's largest health insurers' profitability expressed as a percentage of earned premiums. These ten companies had profit margins ranging from -2.96% to 17.59% in 2010, with an average profit of 6.29%.

Net Income as a Percent of Colorado Earned Health Premiums						
Company	**2006**	**2007**	**2008**	**2009**	**2010**	**5 year Average**
Aetna Life Ins Co	6.58%	1.22%	3.30%	-2.84%	-2.05%	**1.24%**
Anthem Blue Cross and Blue Shield*	9.37%	5.50%	8.16%	5.58%	4.25%	**6.57%**
Connecticut General	2.43%	11.07%	7.33%	4.56%	17.59%	**8.60%**
HMO Colorado Inc.	8.75%	1.23%	9.75%	0.44%	4.59%	**4.95%**
Humana Ins Co	0.63%	1.36%	2.10%	1.25%	13.06%	**3.68%**
Kaiser Foundation Health Plan of CO	4.17%	5.99%	4.74%	2.03%	2.75%	**3.94%**
Pacificare of CO Inc.	5.52%	7.86%	10.17%	5.55%	9.67%	**7.76%**
Rocky Mountain Healthcare Options Inc.	0.25%	-1.88%	-1.07%	0.08%	-2.96%	**-1.12%**
Rocky Mountain HMO Inc	3.85%	3.23%	7.56%	7.72%	9.18%	**6.31%**
UnitedHealthcare Ins Co	8.34%	11.16%	7.25%	2.76%	6.78%	**7.26%**
Grand Total	**4.99%**	**4.67%**	**5.93%**	**2.71%**	**6.29%**	**4.92%**

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

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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 Division's regulatory authority as well as information about the Division's progress towards DORA's primary mission, consumer protection.

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 forover5,000 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 a 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 five years.

Colorado Division of Insurance - Rates and Forms Consumer Savings From Review and Intervention 2006-2010	
2006	**$3,155,712**
2007	**$3,725,174**
2008	**$11,833,682**
2009	**$32,094,080**
2010	**$32,295,133**

Table 26: Colorado Consumer Savings Realized through Reviews and Intervention

Rate standards are included in state laws and are the foundation for the acceptance, denial or adjustment to rate filings. Typical rate standards included in 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 to the Colorado Division of Insurance for prior approval its expected health rate increases 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, and 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 renewing 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.

Summary of Rating Factors for Private Health Plans in Colorado			
Rating Factor	**Individual Plans**	**Small Group Plans**	**Large Group Plans**
Smoking Status or Tobacco Use:	Rate-up or discount	Rate-up or discount up to 15% for tobacco use; or 10% discount for smoking cessation. Must be applied at the individual level and cannot be aggregated over the entire group.	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

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

2010 Colorado Health Benefit Plan Coverage Summary by Company Type			
Colorado 2010	**Direct Earned Premium**	**Direct Losses Incurred**	**Pure Direct Loss Ratio**
Health Companies			
Individual Coverage	$321,646,795	$266,758,120	82.94%
Small Group Coverage	$720,642,282	$599,206,410	83.15%
Large Group Coverage	$2,477,300,292	$2,177,959,724	87.92%
Government Coverage	$1,675,914,627	$1,423,155,835	84.92%
Other Excluded Business	$36,219,667	$26,339,009	72.72%
Other Health Coverage	$42,006,951	$38,240,217	91.03%
Health Company Totals	**$5,273,730,614**	**$4,531,659,315**	**85.93%**
Property Companies			
Individual Coverage	$7,914,379	$5,900,273	74.55%
Small Group Coverage	$0	-$10,179	N/A
Large Group Coverage	$808,898	$795,013	98.28%
Government Coverage	$0	$0	N/A
Other Excluded Business	$7,480,472	$5,258,642	70.30%
Other Health Coverage	$9,729,090	$17,632,596	181.24%
Property Company Totals	**$25,932,839**	**$29,576,345**	**114.05%**
Life Companies			
Individual Coverage	$338,989,931	$231,158,046	68.19%
Small Group Coverage	$504,817,634	$389,337,219	77.12%
Large Group Coverage	$566,514,893	$450,707,797	79.56%
Government Coverage	$406,673,564	$316,091,575	77.73%
Other Excluded Business	$243,069,116	$182,744,437	75.18%
Other Health Coverage	$226,232,061	$180,678,690	79.86%
Life Company Totals	**$2,286,297,200**	**$1,750,717,766**	**76.57%**
Fraternal Companies			
Individual Coverage	$330,377	$86,851	26.29%
Small Group Coverage	$0	$0	N/A
Large Group Coverage	$0	$0	N/A
Government Coverage	$0	$0	N/A
Other Excluded Business	$0	$0	N/A
Other Health Coverage	$86,851	$50,211	57.81%
Fraternal Company Totals	**$417,228**	**$137,062**	**32.85%**
All Health Benefit Plans			
Colorado Totals	**$7,586,377,881**	**$6,312,090,487**	**83.20%**

Table 28: 2010 Colorado Health Coverage Summary by Company Type

2010 Total Colorado Health Coverage Summary by Company Type				
Health Companies	**Written Premium**	**Earned Premium**	**Incurred Losses**	**Pure Direct Loss Ratio**
Health Companies				
Individual Comprehensive	$393,382,165	$392,789,790	$325,974,426	82.99%
Group Comprehensive	$2,660,040,599	$2,660,136,034	$2,352,870,824	88.45%
Medicare Supplement	$31,392,095	$31,254,621	$21,559,874	68.98%
Vision Only	$41,857,276	$41,858,731	$31,647,374	75.61%
Dental Only	$944,071,020	$822,901,099	$779,491,027	94.72%
Federal Employees Health Benefit Plan	$564,771,627	$560,861,538	$525,628,413	93.72%
Title XVIII Medicare	$1,662,938,570	$1,662,468,067	$1,419,582,641	85.39%
Title XIX Medicaid	$43,347,697	$43,348,524	$36,232,911	83.59%
Other	$73,615,924	$75,596,074	$70,166,612	92.82%
Health Companies Total	$6,415,416,973	$6,291,214,478	$5,563,154,102	88.43%
Property Companies				
Group accident and health	$38,312,770	$35,807,889	$25,957,292	72.49%
Credit A&H (group and individual)	$1,520,504	$1,508,595	$337,463	22.37%
Collectively renewable A&H	$656	$593	$5,145	867.62%
Non-cancelable A&H	$268	$18,444	$2	0.01%
Guaranteed renewable A&H	$23,366,626	$12,146,008	$16,963,992	139.67%
Non-renewable for stated reasons only	$2,103,684	$2,217,898	$1,041,352	46.95%
Other accident only	$362,439	$395,164	$62,259	15.76%
Medicare Title XVIII exempt from state taxes or fees	$0	$0	$0	N/A
All other A&H	$1,407,573	$1,419,032	$2,797,354	197.13%
Federal employees health benefits program premium	$0	$0	$0	N/A
Property Companies Total	$67,074,520	$53,513,623	$47,164,859	88.14%
Life Companies				
Group Policies	$2,015,286,496	$2,009,769,080	$1,550,385,324	77.14%
Federal employees health benefits program premium	$19,609,191	$19,408,910	$17,111,678	88.16%
Credit (group and individual)	$4,898,624	$7,010,167	$2,725,042	38.87%
Collectively renewable policies	$401,564	$400,835	$217,526	54.27%
Medicare Title XVIII exempt from state taxes or fees	$480,753,682	$478,471,788	$388,120,729	81.12%
Non-cancelable (other individual certificates)	$80,946,194	$80,943,620	$84,047,562	103.83%
Guaranteed renewable (other individual certificates)	$381,634,091	$380,483,708	$219,670,278	57.73%
Non-renewable for stated reasons only (other individual certificates)	$232,485,184	$231,233,840	$140,134,950	60.60%
Other accident only (other individual certificates)	$894,676	$909,489	$470,699	51.75%
All other (other individual policies)	$29,678,040	$28,535,674	$16,487,157	57.78%
Totals (other individual certificates)	$725,638,190	$722,106,334	$460,810,643	63.81%
Totals (collectively renewable and other individual policies)	$3,246,587,741	$3,237,167,116	$2,419,370,952	74.74%
Life Companies total	$7,218,813,673	$7,196,440,561	$5,299,552,540	73.64%
Fraternal Companies				
Collectively renewable certificates	$10	$0	$0	N/A
Non-cancelable (other individual certificates)	$1,023,113	$1,012,419	$635,691	62.79%
Guaranteed renewable (other individual certificates)	$11,281,368	$11,255,933	$11,233,966	99.80%
Non-renewable for stated reasons only (other individual certificates)	$44,067	$44,318	$57,884	130.61%
Other accident only (other individual certificates)	$13,586	$13,885	$12,121	87.30%
Medicare Title XVIII exempt from state taxes or fees	$0	$0	$0	N/A
All other (other individual certificates)	$49,091	$48,163	$62,042	128.82%
Fraternal Companies Total	$12,411,235	$12,374,718	$12,001,704	96.99%
All Health Coverage Plans				
Colorado Totals	**$13,713,716,401**	**$13,553,543,380**	**$10,921,873,205**	**80.58%**

Table 29: 2010 Total Colorado Health CoverageSummary by Company Type

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 paying the balance of the charge to the medical service provider.

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; you incur an office visit that costs $80. In year one, the office visit co-pay paid by you, the policyholder, is $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-The Colorado 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, but 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 insurance.

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-The cost involved in an insurance company’s adjustment of losses under a policy.

Loss Ratio-The 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 one member being enrolled for one month. For example, an individual who is a member of a plan for a full year generates 12 member months and a

family of five enrolled for six 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-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.

Non-cancelable-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 its company operations and investments. This ratio identifies the companies that are inadequately capitalized by dividing the company's surplus 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 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 is 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 the insurer's 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.

Detailed financial statements of 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. 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 website, 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 website, select "Consumer Information Source" and follow the directions for accessing information.

Figures

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