COLORADO

Department of Regulatory Agencies

Division of Insurance

Health Insurance Cost Report

to

The Colorado General Assembly

for

Calendar year 2013

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

Published December 8, 2014

Marguerite Salazar

Commissioner

December 8, 2014

To the Members of the House and Senate,

I am pleased to submit the Annual Health Insurance Report of the Commissioner of Insurance covering calendar year 2013, 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.

This year's report comes amid changes in health insurance regulation. Now that the initial new consumer protections and benefits under the federal Affordable Care Act have been implemented, the Division of Insurance continues to monitor the reforms that went live in January 2014.

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,

Marguerite Salazar

Commissioner of Insurance

2014 COLORADO HEALTH INSURANCE REPORT

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Executive Summary

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 health maintenance organizations (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, focusing primarily on the health insurance market for individual, small and large group health plans.

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 be a reduction in the cost of providing health care services.

March 2013 marked the third anniversary of the federal Affordable Care Act (ACA), which ushered in new consumer protections and benefits in health insurance, starting in 2010. Major changes, including a requirement for most people to have health insurance and government subsidies to help many afford the costs, were slated for 2014. The focus of reforms in 2012, meanwhile, shifted to state development of a health insurance exchange where small employers and individuals can more easily shop for insurance, and on ways to control costs while improving health care in public programs.

The information in this report is based on data from 2013 covering the top 95% of carriers in the Colorado market. 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' 2013 Annual Financial Statements, which were filed in March 2014; and the information gathered from the 2014 Colorado Health Cost Survey, completed in June of 2014.

2013 Highlights

- The Colorado Division of Insurance ("Division") has responsibility for overseeing health insurance coverage for over 8.2 million different coverage plans for Coloradans. 28.4% of Coloradans have health insurance coverage through government programs, including but not limited to Medicare, Medicaid, the Federal Employees' Health Benefit Plan and the Veteran's Administration. Pg10
- During 2013, 56.3% of Coloradans were covered by employment-based insurance, compared to 53.9% of citizens in other states nationwide. Pg9
- An estimated 12.6% of Coloradans had no health insurance in 2013, versus an estimated 13.4% Nationwide. Pg10

- During 2013, approximately 81.9% of premiums collected in Colorado went directly to the cost of providing healthcare services. Approximately 15.6% of premiums were used for administrative expenses and producer commissions. Pg32

- Colorado employees paid 21% of the total premium for single coverage and 26% for family coverage, compared to 21% for single coverage and 28% for family coverage, nationally. Pg26

- The percentage of private employers in Colorado that offer health plans and self-insure at least one of their plans in Colorado has spikes at 40.6% in 2008 and 41.2% in 2012 falling to 34.7% in 2013. These spikes are significant compared to the percentage nationwide, which has seen a steady increase from 34.2% in 2008 to 37.6% in 2013. 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). Pg20

- The top 10 largest health insurers make up 74% of the market share in Colorado. There are approximately 450 health insurers doing business in Colorado. Pg36

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 2013 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 which the Division of Insurance provide, 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.

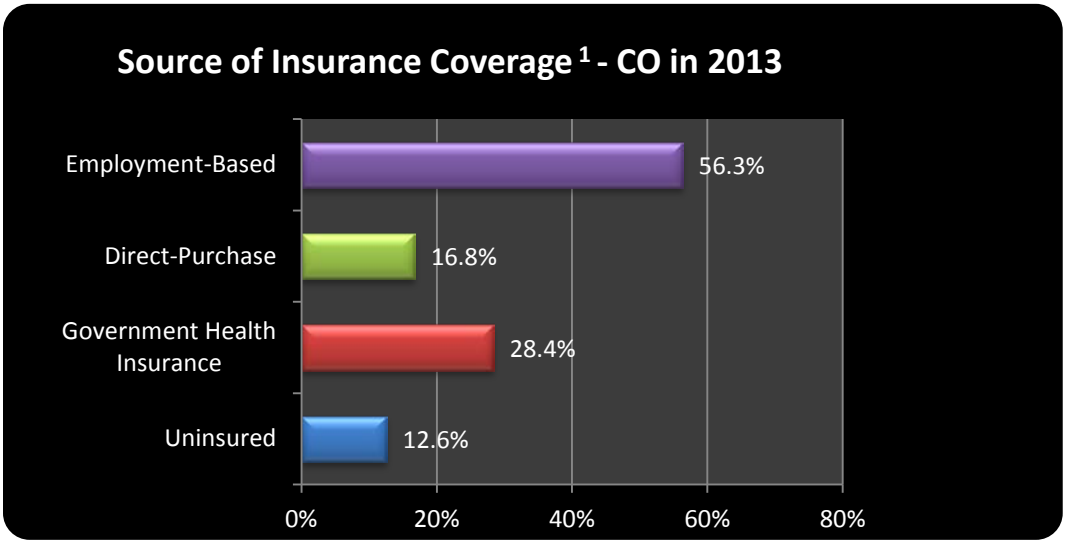


Figure 1 - Source of Insurance Coverage - CO 2013

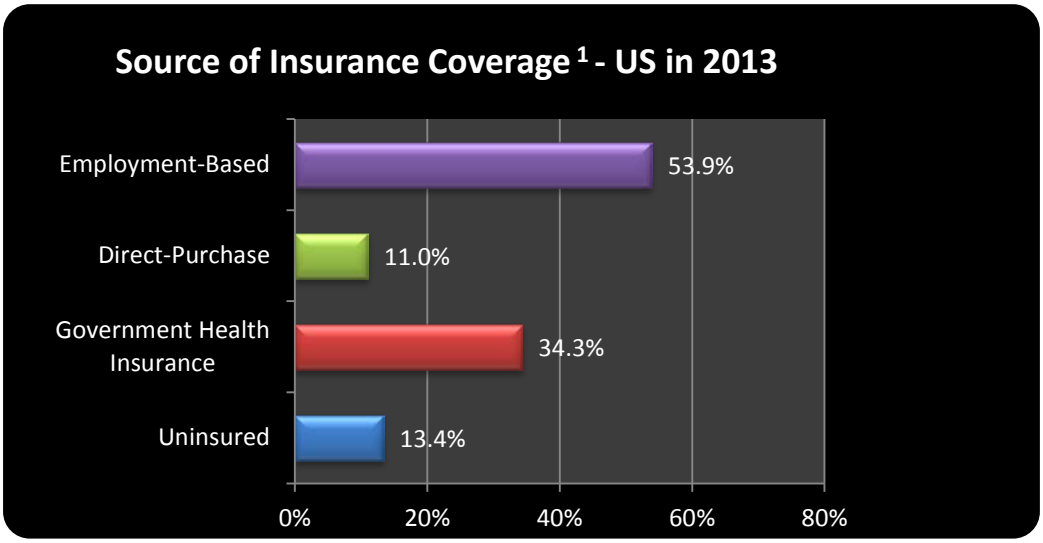


Figure 2 - Source of Insurance Coverage – US 2013

As shown in Figures 1 and 2, 56.3% of Coloradans secured health coverage through their employer, compared with 53.9% nationwide; a slight decrease from 2012 for both Colorado and the US. The Colorado non-employment-based insurance market was also larger than the national figures, with 16.8% of Coloradans having non-employment-based health insurance policies in 2013, compared with 11.0% nationwide. The Colorado employment based insurance decreased with national employment based insurance mirroring the drop. In total, 73.1% of Coloradans are covered by either employment-based or non-employment-based health plans, which is more than the 64.9% of citizens nationwide.

According to the US Census Bureau, 28.4% of Coloradans got their health care coverage through government programs such as Medicare, Medicaid, the Federal Employees' Health Benefit Plan and the Veteran's Administration in 2013. These programs are administered by the state and federal governments, and are paid for by a combination of participant premiums and tax dollars. The percentage of Coloradans who got their health care coverage through government programs went up .3% in 2013, while the percentage nationwide increased by 1.7% in 2013.

An estimated 12.6% of Coloradans had no health insurance in 2013. This number has decreased from the estimated 13.7% in 2012 in a continuing trend. Nationwide there was an estimated 13.4% with no health insurance in 2013, which is lower less than the 15.4 % in 2012.

Tables 1 above and 2 below provide further detail on the number of covered lives for health coverage in Colorado. NOTE: The number of covered lives on both tables appears inflated as individuals may have more than one type of health insurance during the year.

Colorado Health Insurance Covered Lives in 2013[1]	
Colorado population	5,294,228
Insured	4,627,308
Uninsured	666,921
Jurisdiction of the Division of Insurance	
Individual	921,631
Small Group	604,754
Large Group	6,730,576
Total Under State Regulation	8,256,962
Insured, Not Regulated by the Division of Insurance	
Medicare	660,882
Medicaid	706,437
Other Public	276,343
Self-funded	3,007,122
Total Not Regulated by the Division of Insurance	4,650,784

Table 1 - Colorado Health Insurance Covered Lives

Colorado Covered Lives by Health Insurance Types in 2013				
	Individual	Large Group	Small Group	Total
Accidental Death & Dismemberment	166,492	1,915,647	19,427	2,101,566
Association Business	0	2,237	2,956	5,193
Comprehensive Major Medical	237,261	492,353	186,597	916,211
Credit Accident and Health	498	0	381	879
Dental	73,838	859,672	153,089	1,086,599
Disability Income	74,871	970,953	40,111	1,085,934
Managed Care (HMO)	33,586	380,322	96,743	510,651

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

Limited Benefit Plan	158,535	58,134	1,205	217,874
Long-term Care	84,808	28,401	3,250	116,459
Medicare Supplement	44,361	54,755	851	99,967
Vision	9,265	912,387	73,575	995,227
Stop Loss	0	943,288	26,535	969,823
All Other Health Insurance	38,116	112,427	35	150,578
Grand Total	921,631	6,730,576	604,754	8,256,962

Table 2 - Colorado Covered Lives by Health Insurance Types

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 16.8% of the population purchased their own private individual insurance (non-employment-based insurance) up from 12.1% in 2012. There are a variety of types of health insurance and a variety of ways health insurance policies can be issued.

LINES OF BUSINESS FOR 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 Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (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 as 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.

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 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 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 8.2 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 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

In Colorado, the Division of Insurance regulates the individual insurance market, however in 2013, that regulation was less restrictive than for group plans. For example, in 2013, carriers in the individual market were still 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. On January 1, 2014, health carriers were no longer allowed to underwrite based on health status. Also, for individual and small group business all carriers must provide the Colorado required essential health benefits.

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 16 carriers who reported offering individual major medical comprehensive policies in Colorado during 2013. Table 3 below 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 per Covered Life per Month	Average Premium per Covered Life Annually
Accidental Death & Dismemberment	16	$15.10	$181.24
Comprehensive Major Medical	16	$217.75	$2,613.01
Credit Accident and Health	1	$9.99	$119.91
Dental	12	$32.77	$393.28
Disability Income	23	$91.26	$1,095.06
Managed Care (HMO)	7	$262.82	$3,153.81
Limited Benefit Plans	17	$26.36	$316.36
Long Term Care	20	$170.00	$2,039.95
Medicare Supplement	16	$190.62	$2,287.38
Vision	5	$12.72	$152.68
All Other	12	$573.90	$6,886.82

Table 3 - Individual Average Earned Premiums in 2013

CoverColorado

In 2013, if a person did not qualify for individual coverage on their own because they were considered "uninsurable" due to a pre-existing medical condition, there was a state-subsidized health plan called CoverColorado[2]. Established by the Colorado legislature in 1991, CoverColorado is a non-profit organization whose mission is to provide a health insurance program that promotes access to health care for Coloradans whose health prohibits or substantially limits access to health insurance. Since this is a high-risk pool, the rates offered are generally higher than commercial insurance carriers. Enrollment in CoverColorado was 13,670 on December 14, 2013. Colorado is one of 35 states that had a high-risk pool insurance plan. CoverColorado stopped providing coverage as of December 31, 2013.

GettingUSCovered

GettingUSCovered was the temporary federal high risk pool created in the State of Colorado under the Patient Protection and Affordable Care Act of 2010. GettingUSCovered was wholly funded by enrollee premiums and federal dollars, with federal funding continued through December 31, 2013. After this date, other coverage options were available under the Act to those with pre-existing conditions. It was a comprehensive health plan for Coloradans who had been uninsured at least six months and have a pre-existing condition. While GettingUSCovered was not a low-income plan, it did not cost any more than the price of insurance for healthy individuals. There was no waiting period once an individual is accepted into the plan and medical treatment began upon the effective date. There were 925 people enrolled in GettingUSCovered as of September 30, 2013. The plan was a bridge to 2014, when individuals with pre-existing conditions were able to purchase health coverage through health insurance exchanges. GettingUSCovered stopped providing coverage as of December 31, 2013.

Connect for Health Colorado

Connect for Health Colorado is a marketplace that opened in October 2013 to help individuals, families and small employers across Colorado purchase health insurance and apply for new federal financial assistance to reduce costs. In addition to the shopping website, Connect for Health Colorado offers a statewide customer support network of Customer Service Center Representatives, Health Coverage Guides and licensed agents/brokers to help Coloradans find the best health plan for their needs. Connect for Health Colorado is the only place where Coloradans can apply for advance premium tax credits and cost-sharing reductions to help pay for commercial insurance coverage.

Connect for Health Colorado is a non-profit entity established by a state law, Senate Bill 11-200, that was passed in 2011. The organization, legally known as the Colorado Health Benefit Exchange, is governed by a Board of Directors with additional direction from a committee of state legislators, known as the Legislative Health Benefit Exchange Implementation Review Committee. Coverage for those enrolled began January 1, 2014.

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 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 business groups of one (BG-1s). 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 2013 Colorado Health Cost Survey.

Due to the significant changes brought to the small group and individual insurance markets beginning in 2014 due to the federal Affordable Care Act and HB13-1266 which brought Colorado's laws into conformance, this report, and the data collected to support it, will be substantially revised in future years.

Small Group	Number of Companies offering Small Group Coverage	Average Premium per Covered Life per Month	Average Premium per Covered Life Annually
Accidental Death & Dismemberment	8	$2.26	$27.17
Association Business	2	$392.59	$4,711.06
Comprehensive Major Medical	9	$399.91	$4,798.96
Credit Accident and Health	1	$18.04	$216.51
Dental	15	$34.74	$416.94
Disability Income	12	$35.97	$431.66
Managed Care (HMO)	6	$358.79	$4,305.48
Limited Benefit Plans	2	$108.33	$1,300.01

Long Term Care	2	$172.50	$2,069.97
Medicare Supplement	1	$184.23	$2,210.76
Stop Loss	4	$141.94	$1,703.28
Vision	8	$5.46	$65.49
All Other	2	$1,533.53	$18,402.40

Table 4 - Small Group Market Average Premiums Earned in 2013

According to the Division's 2013 Small Group Market Activity Report[3], 14 carriers offered small group health benefit plans in Colorado during 2013. They covered 29,179 groups, or 245,024 lives.

The major small market changes from 2012 to 2013 include the following:

- The number of small group plans in Colorado decreased from 31,543 to 29,179.
- The number of covered lives decreased 3% from 252,469 to 245,024.
- The number of BG-1s fell 22% from 5,166 to 4,007.
- While the number of plans for employers of 1 to 10 employees shrank, the number of plans for employers with 11 to 50 employees increased.
- The top 10 companies covered 99.7% of all covered lives in 2013.
- Of 14 companies in the small group market, 11 sell new policies.
- Health Savings Account (HSA) qualified plans decreased in proportion to other plans for the first time in several years.
- There has been a significant shift, approximately 20% from Multi-Option plans to PPO plans.
- The decrease in covered lives in 2013 rose in comparison to the decrease in 2012.

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

[3] 2013 Small Group Market Activity Report, April 2014, available on the Division's website: dora.colorado.gov/doi

premiums earned per covered life per month and annually reported from the 2013 Colorado Health Cost Survey data.

Large Group	Number of Companies offering Large Group Coverage	Average Monthly Premium per Covered Life	Annual Average Premium per Covered Life
Accidental Death & Dismemberment	22	$2.14	$25.70
Association Business	3	$36.31	$435.70
Comprehensive Major Medical	9	$407.05	$4,884.66
Credit Accident and Health	0	$0.00	$0.00
Dental	22	$26.22	$314.68
Disability Income	28	$22.41	$268.94
Managed Care (HMO)	8	$400.38	$4,804.54
Limited Benefit Plans	13	$25.88	$310.58
Long Term Care	12	$59.06	$708.76
Medicare Supplement	2	$178.04	$2,136.50
Stop Loss	17	$24.34	$292.07
Vision	13	$5.15	$61.85
All Other	11	$565.23	$6,782.77

Table 5 - Large Group Market Average Premiums Earned in 2013

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 changes in the number of ERISA self-insured plans in Colorado over the last 16 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 both increased and decreased over the last 10 years. The percentage in Colorado spikes at 40.6% in 2008 and 41.2% in 2012 falling down to 34.7% in 2013. These spikes are significant compared to the percentage nationwide, which has seen a steady increase from 34.2% in 2008 to 37.6% in 2013.

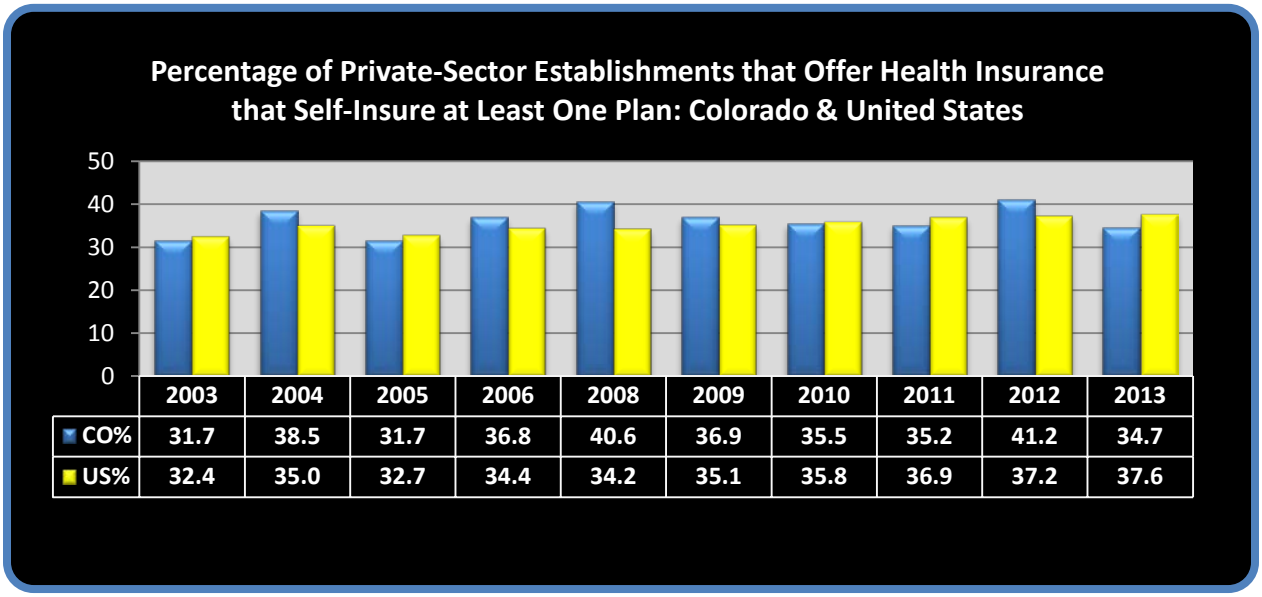


Figure 3 - Percentage of Private-Sector Establishments that Offer Health Insurance that Self-insure at Least One Plan: Colorado and United States

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 regulates stop-loss (excess loss) policies, but does not regulate the self-funded employer health plan that it insures.

Government Health Plans

More than 28.4% 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. More than 693,361 Coloradans were receiving health coverage through Medicaid in 2012, representing 13.43% of the state's population. Enrollment of children in Medicaid and CHP+ increased overall during fiscal year 2011-2012.

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.

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.

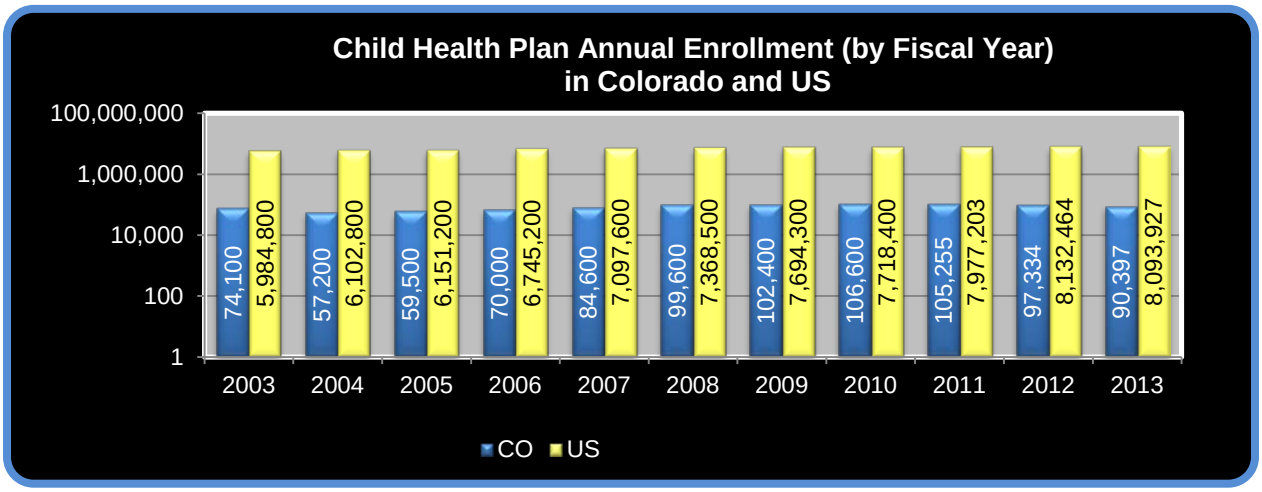


Figure 4 - CHP+ Annual Enrollment (by Fiscal Year) for Colorado and US

The enrollment in CHP+ decreased by 7.7% from fiscal year 2012 to fiscal year of 2013. The annual CHP+ enrollment was 90,397 in Colorado in fiscal year 2013.

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 660,882 Coloradans enrolled in Medicare in 2013, which was 12.5% of the state's population down more than 7% from 2012.

Senior Health Insurance Assistance Program (SHIP)

The Senior Health Insurance Assistance Program (SHIP) within the Division 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 31% of small companies with less than fifty employees offer insurance compared to the 93% of larger firms that offer insurance. The number for small companies offering health insurance has been dropping slowly since 2011. The number for large companies dropped from 97.7% in 2011 to 96.1% in 2012 to 92.5% in 2013.

Figure 5 - Percentage of Private-Sector Establishments That Offer Health Insurance by Firm Size (number of Employees) in Colorado - 2013

In 2013, 49.3% of private sector employees enrolled in employer-sponsored health insurance plans in Colorado chose single coverage, with the balance choosing family coverage (a plan covering the employee and at least one other family member) down from 52.0% in 2012. This remains lower than the U.S. average of 51.3%. 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 Total Premium	Average Copayment	Average Deductible	Average Employee Contribution	Average Employer Contribution
Exclusive-Provider Plans	$5,174	$27	$1,382	$1,326	$3,848
Mixed-Provider Plans	$5,805			$1,157	$4,648
Any-Provider Plans	$5,912			$677	$5,235
Family Coverage	**Average Total Premium**	**Average Copayment**	**Average Deductible**	**Average Employee Contribution**	**Average Employer Contribution**
Exclusive-Provider Plans	$15,160	$27	$2,754	$5,357	$9,803
Mixed-Provider Plans	$16,892			$4,167	$12,725
Any-Provider Plans	$17,852			$3,244	$14,608

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

The average annual Colorado premium in 2013 was $5,668 for single coverage and $16,636 for family coverage. Figure 6 illustrates the increases in private employer-sponsored health premiums since 1996.

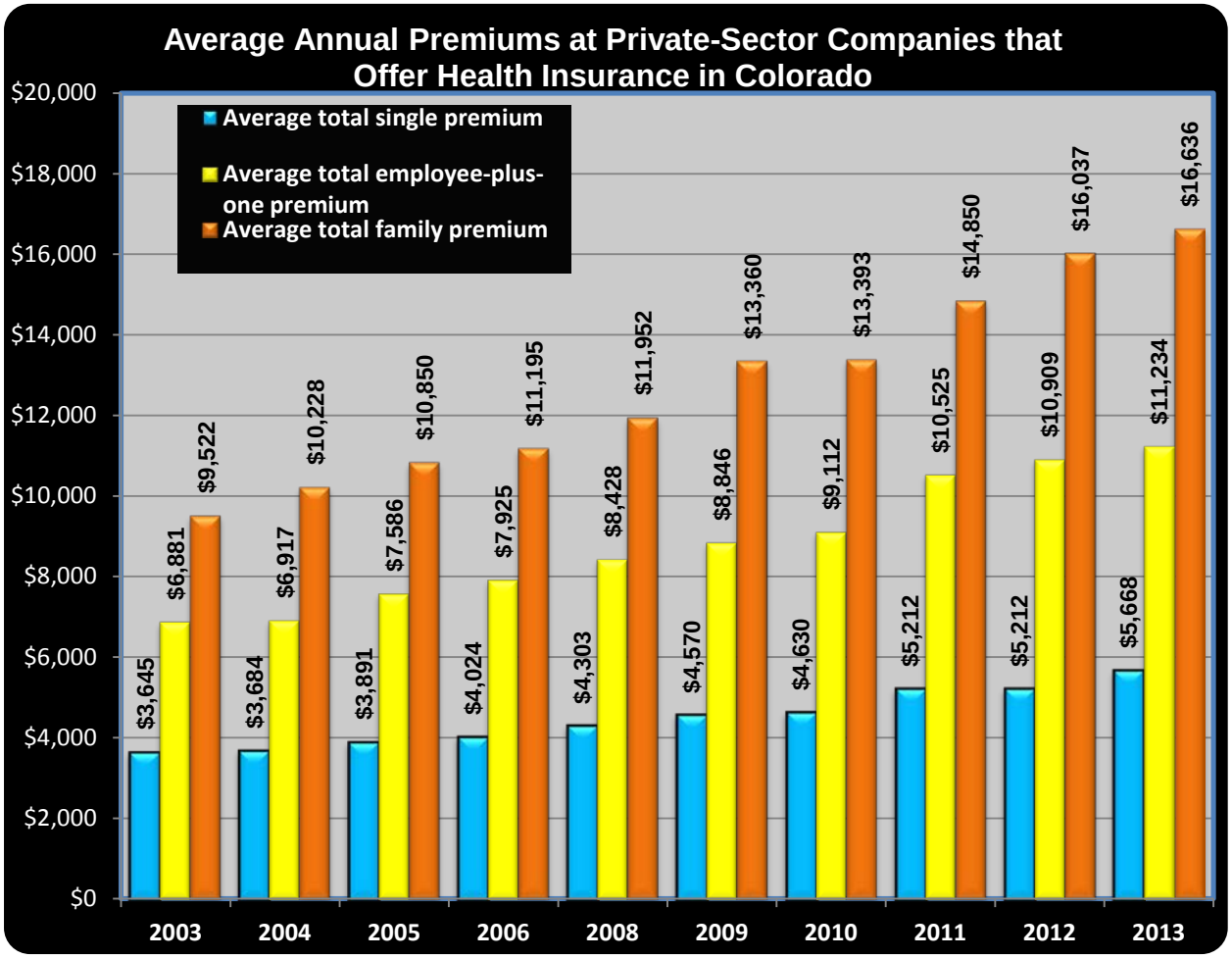
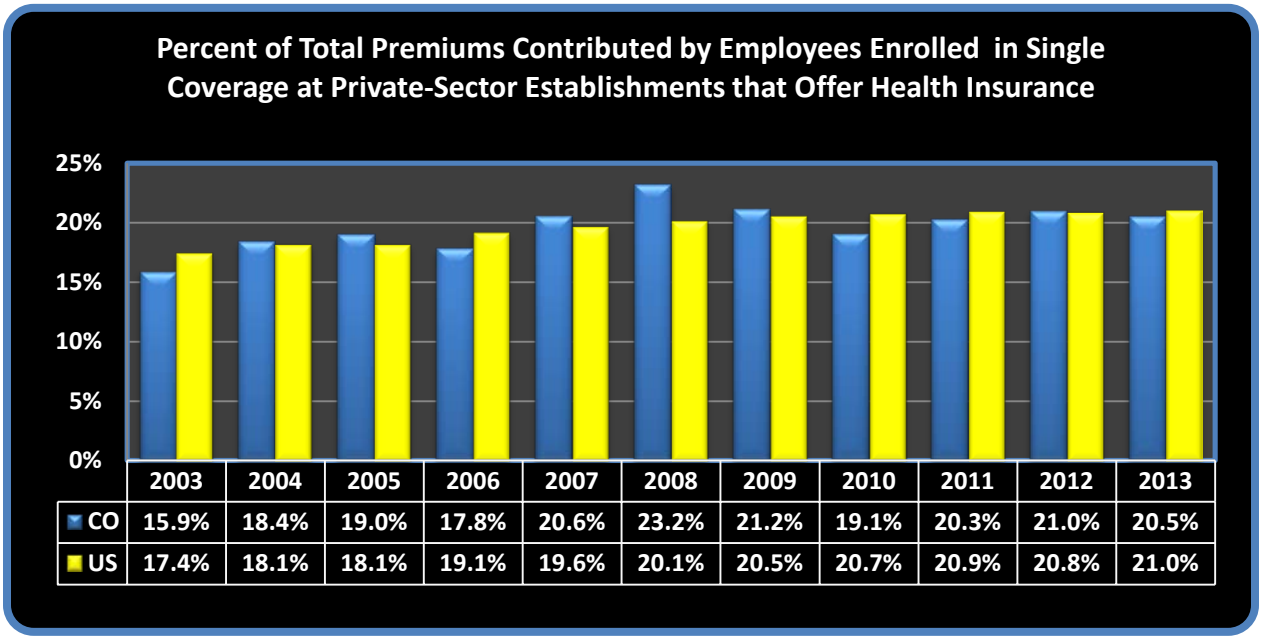


Figure 6 - Average Annual Premiums at Private-Sector Companies That Offer Health Insurance in Colorado

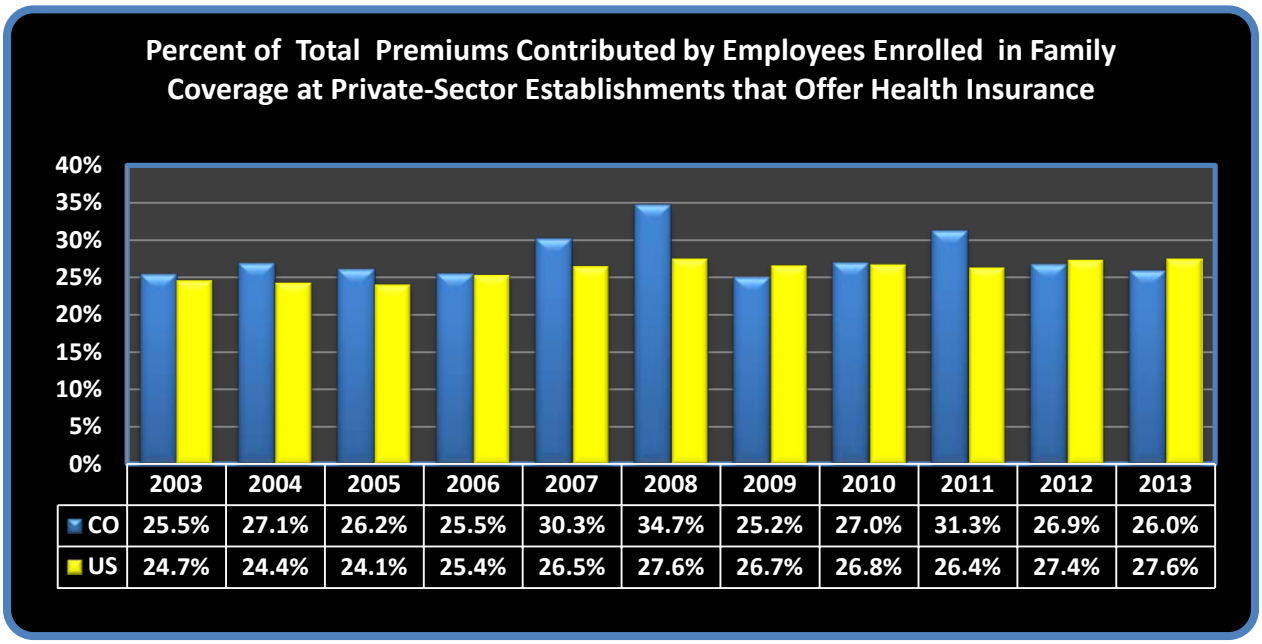
Premium costs for employer-based coverage may be paid completely by the employee, paid in part by the employer and in part by the employee, or paid completely by the employer. The following exhibits indicate the percentages of total premium that Colorado employees are contributing compared to the national average. The percentage of health premiums that employees in Colorado are being asked to pay by their employers has fluctuated up and down and around the national average.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
CO	15.9%	18.4%	19.0%	17.8%	20.6%	23.2%	21.2%	19.1%	20.3%	21.0%	20.5%
US	17.4%	18.1%	18.1%	19.1%	19.6%	20.1%	20.5%	20.7%	20.9%	20.8%	21.0%

Figure 7 – Percent of Total Premium Contributed by Employees Enrolled in Single Coverage at Private-Sector Establishments that Offer Health Insurance

Colorado employees paid 21% of the total premium for single coverage and 26% for family coverage, which is the similar for single but less for family coverage than the national average. Figure 7 indicates that from 2004 through 2010 with the exception in 2006 Colorado individual employees carried a higher burden for health insurance than the national average. However since 2010 this trend has reversed with Coloradans paying similar or less than the national average for health insurance. Colorado employees enrolled in family coverage carried more of the burden of premium increases than was occurring nationally until 2012. In 2012 the share was similar and as of 2013 Colorado employees were paying less than the national average.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
CO	25.5%	27.1%	26.2%	25.5%	30.3%	34.7%	25.2%	27.0%	31.3%	26.9%	26.0%
US	24.7%	24.4%	24.1%	25.4%	26.5%	27.6%	26.7%	26.8%	26.4%	27.4%	27.6%

Figure 8 – Percent of Total Premiums Contributed by Employees Enrolled in Family Coverage at Private-Sector Establishments that Offer Health Insurance

COLORADO MEDICAL TREND IN DETAIL[4]

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 the insured, stated in terms of the average number of claims per insured. 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.

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

[4] Beginning with this report the Division of Insurance is relying solely upon the Health Cost Survey results to populate tables 7-14. Historically this information can be found in the Colorado Health Insurance Cost Information Summary-Aggregated Company Data reports. Insurance Trend information is not universally reported. Those companies reporting trend information must use the best assessment and allocation methods they can to assign portions of total medical trend to those categories of interest to the Division and the public. Therefore information in this section represents an estimation of what portion of total trend each cost category that follows is responsible for.

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.

In 2014 Large Groups are no longer allowed to reject groups due to claims experience.

The Division has summarized the health cost survey responses over the last several years and has provided a more detailed summary of medical and pharmaceutical trend below.

Total Medical Trend						
	2008	2009	2010	2011	2012	2013
Individual	11.39%	1.10%	7.06%	12.84%	5.02%	4.56%
Large Group	10.79%	2.20%	7.66%	4.43%	2.56%	21.27%
Small Group	8.45%	1.90%	7.96%	3.53%	3.32%	1.00%

Table 7 – Total Medical Trend by Year by Type of Health Insurance

Total Pharmaceutical Trend						
	2008	2009	2010	2011	2012	2013
Individual	15.67%	3.78%	11.15%	7.67%	1.68%	9.50%
Large Group	12.29%	4.77%	7.84%	6.69%	0.90%	21.69%
Small Group	11.43%	4.05%	12.12%	3.62%	2.46%	2.06%

Table 8 – Total Pharmaceutical Trend by Year by Type of Health Insurance

Individual Market Trend Changes

Table 9 shows the average Medical Trend for Individual business broken out by product line and some but not all of the components that go into total medical trend.

Line of Business	Average of Medical trend due solely to medical cost-shifting	Average of Medical trend due solely to new medical procedures and technology	Average of Medical trend due solely to provider price changes	Average of Medical trend due solely to utilization changes	Average of Total Medical Trend
Individual					
Accident Only & AD&D	0.00%	0.00%	0.00%	0.00%	18.00%
All Other Premiums	0.00%	0.00%	3.87%	2.11%	-8.76%
Comprehensive MM	0.03%	0.39%	4.23%	1.33%	6.00%
Credit Health	0.00%	0.00%	0.00%	0.00%	0.00%
Dental	0.00%	0.00%	0.11%	4.58%	3.60%
Disability Income	0.00%	0.00%	0.00%	0.00%	0.00%
HMO	2.10%	0.37%	-2.47%	4.68%	4.94%

Limited Benefit Plans	0.49%	0.49%	0.49%	7.40%	15.92%
Long-Term Care	0.00%	0.00%	0.00%	0.00%	0.00%
Medicare Supplement	3.08%	0.57%	1.35%	1.38%	6.01%
Vision	0.00%	0.00%	0.00%	1.30%	4.40%
Individual Total	**0.52%**	**0.17%**	**0.69%**	**2.07%**	**4.56%**

Table 9 – Individual Average Medical Trend Changes by Category and Line of Business

Table 10 shows the average Pharmaceutical Trend for Individual business broken out by product line and some but not all of the components that go into total medical trend.

Line of Business	Prescription drug trend due solely to introductions of new brand name and generic drugs	Rx trend due solely to cost-shifting	Rx trend due solely to pharmaceutical price changes	Rx trend due solely to utilization changes	Average of Total Rx Trend
Individual					
Accident Only & AD&D	0.00%	0.00%	12.65%	0.00%	0.00%
All Other Premiums	0.00%	-10.06%	31.74%	-6.55%	17.94%
Comprehensive MM	0.40%	7.39%	3.97%	7.99%	18.57%
Credit Health	0.00%	0.00%	0.00%	0.00%	0.00%
Dental	0.00%	0.00%	1.52%	0.00%	0.00%
Disability Income	0.00%	0.00%	0.00%	0.00%	0.00%
HMO	6.40%	29.64%	1.74%	8.03%	53.21%
Limited Benefit Plans	0.49%	0.49%	15.45%	7.40%	8.88%
Long-Term Care	0.00%	0.00%	0.00%	0.00%	0.00%
Medicare Supplement	0.00%	0.00%	2.95%	2.95%	5.90%
Vision	0.00%	0.00%	0.00%	0.00%	0.00%
Individual Total	**0.66%**	**2.50%**	**6.37%**	**1.80%**	**9.50%**

Table 10 – Individual Average Pharmaceutical Trend Changes by Category and Line of Business

Large Group Market Trend Changes

Table 11 shows the average Medical Trend for Large Group business broken out by product line and some but not all of the components that go into total medical trend.

Line of Business	Average of Medical trend due solely to medical cost-shifting	Average of Medical trend due solely to new medical procedures and technology	Average of Medical trend due solely to provider price changes	Average of Medical trend due solely to utilization changes	Average of Total Medical Trend
Large Group					
Accident Only & AD&D	0.00%	0.00%	0.00%	0.00%	0.00%
All Other Premiums	-0.12%	1.00%	3.31%	1.56%	5.83%

Association Business	0.00%	0.00%	0.00%	0.00%	0.00%
Comprehensive MM	19.10%	18.34%	184.76%	46.01%	256.18%
Credit Health	0.00%	0.00%	0.00%	0.00%	0.00%
Dental	0.40%	0.00%	2.46%	2.57%	5.00%
Disability Income	0.00%	0.00%	0.00%	0.00%	0.00%
HMO	-0.28%	0.69%	3.88%	0.01%	3.71%
Limited Benefit Plans	0.00%	0.00%	1.15%	-3.06%	-1.77%
Long-Term Care	0.00%	0.00%	0.00%	0.00%	0.00%
Medicare Supplement	0.00%	0.00%	0.74%	2.39%	3.16%
Stop Loss	-0.59%	-2.16%	2.88%	-1.80%	1.17%
Vision	0.00%	0.00%	1.07%	2.57%	3.23%
Large Group Total	**1.42%**	**1.37%**	**15.40%**	**3.87%**	**21.27%**

Table 11 – Large Group Average Medical Trend Changes by Category and Line of Business

Table 12 shows the average **Pharmaceutical** Trend for Large Group business broken out by product line and some but not all of the components that go into total medical trend.

Line of Business	Prescription drug trend due solely to introductions of new brand name and generic drugs	Rx trend due solely to cost-shifting	Rx trend due solely to pharmaceutical price changes	Rx trend due solely to utilization changes	Average of Total Rx Trend
Large Group					
Accident Only & AD&D	0.00%	0.00%	0.00%	0.00%	0.00%
All Other Premiums	2.36%	5.63%	2.00%	3.32%	13.53%
Association Business	0.00%	0.00%	0.00%	0.00%	0.00%
Comprehensive MM	78.40%	21.37%	200.22%	-10.84%	253.49%
Credit Health	0.00%	0.00%	0.00%	0.00%	0.00%
Dental	0.00%	0.00%	0.63%	2.56%	3.18%
Disability Income	0.00%	0.00%	0.00%	0.00%	0.00%
HMO	1.79%	1.75%	-0.44%	0.08%	3.62%
Limited Benefit Plans	0.00%	0.00%	4.72%	0.00%	4.72%
Long-Term Care	0.00%	0.00%	0.00%	0.00%	0.00%
Medicare Supplement	0.00%	0.00%	0.00%	-6.71%	-6.71%
Stop Loss	1.92%	4.27%	1.54%	2.52%	10.11%
Vision	0.00%	0.00%	0.00%	0.00%	0.00%
Large Group Total	**6.50%**	**2.54%**	**16.05%**	**-0.70%**	**21.69%**

Table 12 – Large Group Average Pharmaceutical Trend Changes by Category and Line of Business

Small Group Market Trend Changes

Table 13 shows the average Medical Trend for Small Group business broken out by product line and some but not all of the components that go into total medical trend.

Line of Business	Average of Medical trend due solely to medical cost-shifting	Average of Medical trend due solely to new medical procedures and technology	Average of Medical trend due solely to provider price changes	Average of Medical trend due solely to utilization changes	Average of Total Medical Trend
Small Group					
Accident Only & AD&D	0.00%	0.00%	0.00%	0.00%	0.00%
All Other Premiums	0.00%	0.00%	0.00%	0.00%	0.00%
Association Business	-1.27%	-1.82%	3.85%	-3.86%	-3.10%
Comprehensive MM	0.23%	-0.34%	4.70%	0.37%	5.01%
Credit Health	0.00%	0.00%	0.00%	0.00%	0.00%
Dental	0.00%	0.00%	-0.01%	4.48%	3.77%
Disability Income	0.00%	0.00%	0.00%	0.00%	0.00%
HMO	0.67%	-0.52%	2.69%	-0.40%	2.78%
Limited Benefit Plans	0.00%	0.00%	0.00%	0.00%	0.00%
Long-Term Care	0.00%	0.00%	0.00%	0.00%	0.00%
Medicare Supplement	0.00%	0.00%	0.00%	0.00%	0.00%
Stop Loss	0.00%	0.00%	0.00%	0.00%	0.00%
Vision	0.00%	0.00%	0.00%	4.47%	4.47%
Small Group Total	**-0.03%**	**-0.21%**	**0.86%**	**0.39%**	**0.99%**

Table 13 – Small Group Average Medical Trend Changes by Category and Line of Business

Table 14 shows the average **Pharmaceutical** Trend for Small Group business broken out by product line and some but not all of the components that go into total medical trend.

Line of Business	Prescription drug trend due solely to introductions of new brand name and generic drugs	Rx trend due solely to cost-shifting	Rx trend due solely to pharmaceutical price changes	Rx trend due solely to utilization changes	Average of Total Rx Trend
Small Group					
Accident Only & AD&D	0.00%	0.00%	0.00%	0.00%	0.00%
All Other Premiums	0.00%	0.00%	0.00%	0.00%	0.00%
Association Business	-1.55%	6.49%	2.19%	6.14%	13.28%
Comprehensive MM	2.03%	2.24%	4.17%	0.76%	8.77%
Credit Health	0.00%	0.00%	0.00%	0.00%	0.00%
Dental	0.00%	0.00%	0.00%	0.00%	0.00%
Disability Income	0.00%	0.00%	0.00%	0.00%	0.00%
HMO	3.04%	4.17%	-0.41%	-0.25%	4.69%
Limited Benefit Plans	0.00%	0.00%	0.00%	0.00%	0.00%
Long-Term Care	0.00%	0.00%	0.00%	0.00%	0.00%
Medicare Supplement	0.00%	0.00%	0.00%	0.00%	0.00%
Stop Loss	0.00%	0.00%	0.00%	0.00%	0.00%

Vision	0.00%	0.00%	0.00%	0.00%	0.00%
Small Group Total	**0.27%**	**0.99%**	**0.46%**	**0.51%**	**2.06%**

Table 14 – Small Group Average Pharmaceutical Trend Changes by Category and Line of Business

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 2013 data collected from the Colorado Health Insurance Cost Report, the Division has been able to breakdown the above components for the year 2013 and illustrate how the health care premiums paid by Coloradans were spent by insurers.

For the 58 companies that reported, the total premium collected was over $6.9 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 2013		
	Insurer Expense	**Percent of Premium**
Medical Expenses	$6,019,946,926	81.91%
Administrative Expenses	$1,151,771,451	15.67%
Profit and Contingencies	$177,349,801	2.41%
Total	**$7,349,068,179**	**100.00%**

Table 15 - Components of Colorado Health Care Premiums in 2013

It is important to note that the information above is from an aggregation of the data received from all 58 companies that reported representing the top 95% of insurers. 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 for only one year of data, 2013.

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 (MLR), 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 Regulations 4-2-11 and 4-3-1 include:

Minimum Loss Ratio Guidelines in Colorado in 2013	
Comprehensive Major Medical (Individual)	80%
Comprehensive Major Medical (Small Group)	80%
Comprehensive Major Medical (Large Group)	85%
Specified or Dread Disease	60%
Limited Benefit Plans	60%
Disability Income	60%
Dental/Vision	60%
Stop Loss	60%
Medicare Supplement (Individual)	65%
Medicare Supplement (Group)	75%

Table 16 - Minimum Loss Ratio Guidelines in Colorado in 2013

The average medical expense (AKA minimum loss ratio) reported of 81.91% is higher than most 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.

Under the Affordable Care Act, an insurance company is required to rebate premiums when it fails to spend at least 80 percent of premiums collected in a state's small group and individual markets on medical care and quality improvement. It must spend at least 85 percent of premiums on these activities in a state's large group market or pay a rebate. Under federal regulations issued in late November 2010, insurance companies that issue individual, small group, or large group coverage have to report the following for each market in each state in which they do business:

- Total earned premiums
- Total reimbursement for clinical services
- Total spending on quality improvement activities
- Total spending on all other non-claims costs, excluding federal and state taxes and fees

The report is due June 1 of every year, and the information received from the report is public and posted on the Center for Medicare & Medicaid Services website.

In 2013, insurers that fail to meet these standards must rebate to enrollees an amount proportional to the amount of premiums paid the previous calendar year. For example, if an insurer had a 75 percent medical loss ratio in the small group market, the insurer would have to rebate 5 percent of the amount of premiums paid by each enrollee in a small group plan. In other words, a $1,000 premium payment would result in a $50 rebate. Rebates in the group market will be paid to the employer. Under federal regulations issued in December 2011, employers must use the rebates they receive for the benefit of

enrollees. For example, an employer might reduce employees' future premium contributions. Rebates must be paid by August 1 each year.

NOTE: The federal medical loss ratio is not the same as Colorado's benefit ratio, in that the federal MLR makes modifications to its calculation, i.e. subtracting out federal and state taxes and licensing and regulatory fees, as well expenses to improve the quality of care.

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 2013. 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 17. 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 2013		
Administrative Expenses	**Insurer Expense**	**Percent of Premium**
Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses	$162,620,167	2.21%
Commissions	$212,213,953	2.89%
Staff Salaries	$297,343,661	4.05%
Dividends to Policyholders	$17,391,693	0.24%
Legal Expenses	$4,877,005	0.07%
Advertising or Marketing	$49,232,412	0.67%
Lobbying Expenses	$1,817,335	0.02%
Charitable Contributions	$75,918,514	1.03%
Federal Income Taxes	$114,420,748	1.56%
State Taxes, Licenses and Fees	$66,958,014	0.91%
All Other	$148,977,949	2.03%
Total	**$1,151,771,451**	15.67%

Table 17 - Administrative Expenses reported from carriers covering the top 95% written premium in the Colorado Health Cost Report

Rate Changes

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
- Mandated benefits

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 medical trend, 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 9 shows that the top 10 largest health insurers make up 74% of the market in Colorado. There are approximately 440 health insurers in Colorado.

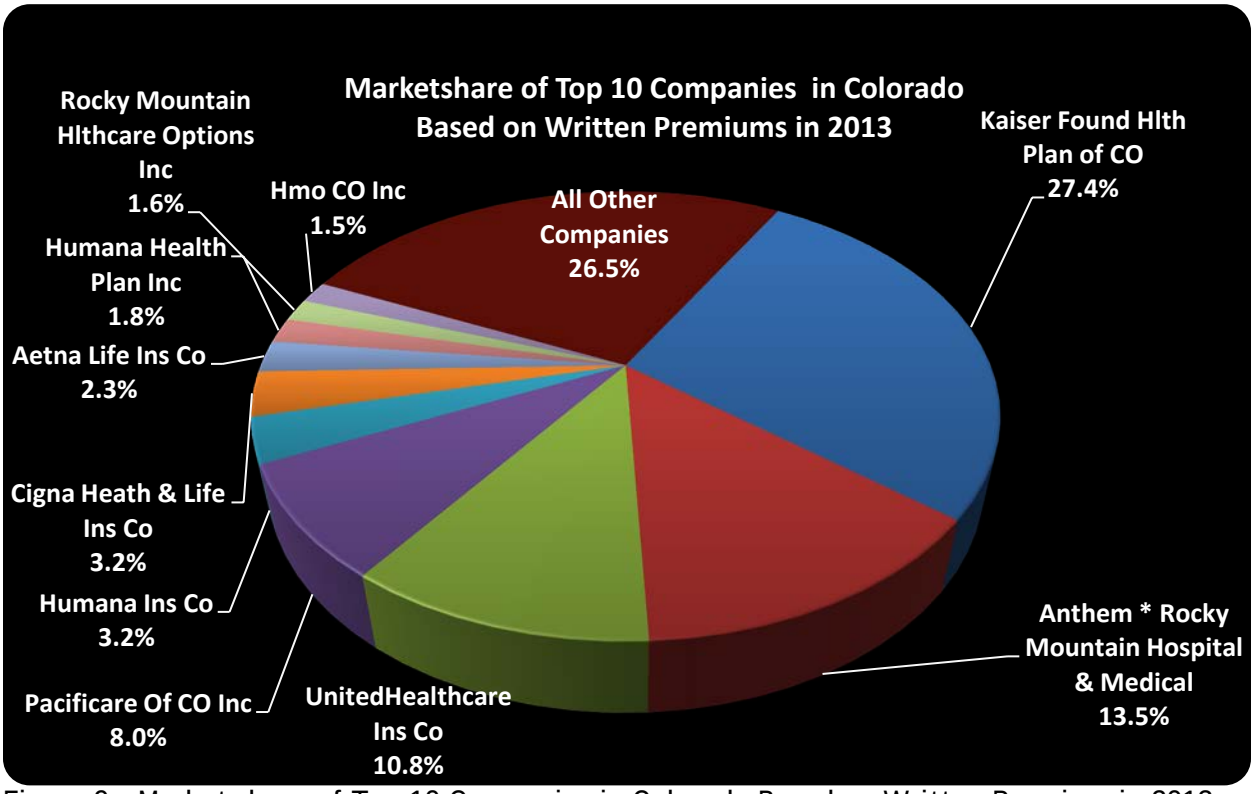


Figure 9 – Market share of Top 10 Companies in Colorado Based on Written Premium in 2013

Company	2013 Written Premiums ($1,000s)	2013 Market Share Percentage
Kaiser Found Hlth Plan of CO	2,882,199	27.4%
Anthem * Rocky Mountain Hospital & Medical	1,418,052	13.5%
UnitedHealthcare Ins Co	1,140,195	10.8%
Pacificare Of CO Inc	846,732	8.0%
Humana Ins Co	340,398	3.2%
Cigna Heath & Life Ins Co	339,021	3.2%
Aetna Life Ins Co	238,977	2.3%
Humana Health Plan Inc	190,272	1.8%
Rocky Mountain Hlthcare Options Inc	170,594	1.6%
Rocky Mountain Hmo Inc	168,231	1.6%
All Other Companies	2,786,421	26.5%
Total	10,521,092	100.0%

Table 18 - Marketshare of the Top 10 Health Carriers in Colorado

All domestic insurance companies doing business in Colorado must submit quarterly and annual financial statements with the Colorado 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 may join the audit.

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

Capital and Surplus

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	**2009**	**2010**	**2011**	**2012**	**2013**	**5-Year Average**
Kaiser Found Hlth Plan of CO	1319%	1287%	592%	614%	528%	868%
Anthem * Rocky Mountain Hospital & Medical	449%	466%	433%	503%	589%	488%
UnitedHealthcare Ins Co	413%	467%	528%	532%	555%	499%
Pacificare Of CO Inc	507%	507%	405%	396%	625%	488%
Humana Ins Co	446%	534%	565%	388%	445%	476%
Cigna Health & Life Ins Co	1133%	1525%	1257%	605%	508%	1005%
Aetna Life Ins Co	772%	765%	694%	701%	670%	720%
Humana Health Plan Inc	325%	530%	411%	365%	385%	403%

Rocky Mountain HIthcare Options Inc	306%	187%	287%	200%	200%	236%
Rocky Mountain Hmo Inc	1657%	1743%	1655%	1831%	1553%	1688%

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 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	**2009**	**2010**	**2011**	**2012**	**2013**	**5 year Average**
Kaiser Foundation HIth Plan of CO	91.42%	93.34%	93.86%	94.39%	94.54%	**93.51%**
Rocky Mountain Hospital & Medical	83.14%	84.55%	83.05%	84.53%	85.22%	**84.10%**
United Healthcare Ins Co	84.05%	78.67%	78.05%	79.48%	83.30%	**80.71%**
Pacificare of CO Inc	82.86%	75.98%	77.95%	78.00%	81.21%	**79.20%**
Humana Ins Co	81.20%	71.49%	98.61%	77.80%	77.37%	**81.30%**
HMO Colorado Inc	70.12%	106.36%	78.83%	80.85%	80.34%	**83.30%**
Aetna Life Ins Co	88.22%	84.25%	79.85%	81.98%	81.63%	**83.18%**
Connecticut General	53.22%	98.22%	86.57%	81.11%	83.69%	**80.56%**
Rocky Mountain HIthcare Options Inc	83.24%	86.41%	86.89%	91.67%	89.03%	**87.45%**
Rocky Mountain HMO Inc	80.25%	79.11%	79.54%	77.45%	78.78%	**79.03%**
Grand Total	**79.77%**	**85.84%**	**84.32%**	**82.73%**	**83.51%**	**83.23%**

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.

Administrative Expenses as a Percent of Colorado Earned Health Premiums						
Company	**2009**	**2010**	**2011**	**2012**	**2013**	**5 year Average**
Kaiser Foundation Hlth Plan of CO	6.55%	5.99%	5.49%	4.96%	5.16%	**5.63%**
Rocky Mountain Hospital & Medical	9.02%	7.91%	7.02%	7.25%	8.05%	**7.85%**
United Healthcare Ins Co	10.82%	12.33%	13.83%	13.68%	13.40%	**12.81%**
Pacificare of CO Inc	7.37%	8.16%	7.93%	7.83%	6.88%	**7.63%**
Humana Ins Co	15.61%	14.51%	14.03%	13.52%	14.13%	**14.36%**
HMO Colorado Inc	-25.39%	-15.20%	-7.00%	-0.47%	9.42%	**-7.73%**
Aetna Life Ins Co	9.46%	12.32%	16.07%	14.96%	17.12%	**13.99%**
Connecticut General	12.41%	12.81%	11.87%	10.07%	11.44%	**11.72%**
Rocky Mountain Hlthcare Options Inc	10.54%	10.45%	9.82%	8.91%	8.58%	**9.66%**
Rocky Mountain HMO Inc	6.80%	7.46%	8.89%	9.96%	7.28%	**8.08%**
Yearly Average	**6.32%**	**7.67%**	**8.79%**	**9.07%**	**10.15%**	**8.40%**

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	**2009**	**2010**	**2011**	**2012**	**2013**	**5 year Average**
Kaiser Foundation Hlth Plan of CO	1.39%	1.58%	1.97%	2.88%	2.79%	**2.12%**
Rocky Mountain Hospital & Medical	3.15%	3.44%	2.84%	2.57%	2.59%	**2.92%**
United Healthcare Ins Co	1.37%	0.09%	0.05%	0.05%	0.00%	**0.31%**
Pacificare of CO Inc	1.95%	1.95%	2.81%	2.73%	3.60%	**2.61%**
Humana Ins Co	1.76%	0.03%	0.03%	0.04%	0.00%	**0.37%**
HMO Colorado Inc	0.00%	0.00%	0.08%	0.25%	0.00%	**0.07%**
Aetna Life Ins Co	3.89%	0.03%	0.01%	0.01%	0.00%	**0.79%**
Connecticut General	2.09%	3.19%	4.76%	5.61%	4.70%	**4.07%**
Rocky Mountain Hlthcare Options Inc	7.79%	7.77%	8.94%	7.65%	8.17%	**8.06%**
Rocky Mountain HMO Inc	6.84%	7.54%	7.86%	8.37%	9.58%	**8.04%**

Grand Total	3.02%	2.56%	2.93%	3.02%	3.14%	2.94%

Table 22 - Claims Adjustment Expenses as a Percent of Colorado Earned Health Premium

Net Underwriting Gain (or Loss)

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

Underwriting Gain or Loss as a Percent of Colorado Earned Health Premiums						
Company	2009	2010	2011	2012	2013	5 year Average
Kaiser Foundation Hlth Plan of CO	2.99%	0.49%	0.48%	0.23%	0.14%	**0.87%**
Rocky Mountain Hospital & Medical	3.88%	3.50%	16.24%	13.59%	3.73%	**8.19%**
United Healthcare Ins Co	6.55%	6.58%	12.52%	9.18%	3.33%	**7.63%**
Pacificare of CO Inc	7.57%	13.86%	11.16%	11.29%	8.78%	**10.53%**
Humana Ins Co	1.43%	13.96%	-12.66%	8.65%	8.56%	**3.99%**
HMO Colorado Inc	3.99%	-61.42%	-50.94%	-47.77%	12.05%	**-28.82%**
Aetna Life Ins Co	-1.05%	5.02%	7.84%	7.25%	6.46%	**5.10%**
Connecticut General	27.86%	-17.82%	-3.52%	2.54%	-1.72%	**1.47%**
Rocky Mountain Hlthcare Options Inc	-1.55%	-5.06%	-6.34%	-10.83%	-3.95%	**-5.55%**
Rocky Mountain HMO Inc	6.24%	6.91%	0.73%	4.33%	-0.22%	**3.60%**
Grand Total	**5.79%**	**-3.40%**	**-2.45%**	**-0.15%**	**3.72%**	**0.70%**

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	2009	2010	2011	2012	2013	5 year Average
Kaiser Foundation Hlth Plan of CO	1.36%	1.19%	0.91%	1.17%	1.86%	**1.30%**
Rocky Mountain Hospital & Medical	3.15%	2.47%	1.29%	1.72%	2.75%	**2.28%**
United Healthcare Ins Co	1.27%	0.93%	0.84%	1.05%	0.84%	**0.99%**
Pacificare of CO Inc	0.72%	0.72%	0.74%	0.42%	0.44%	**0.61%**
Humana Ins Co	1.01%	1.38%	1.42%	1.41%	1.21%	**1.29%**
HMO Colorado Inc	0.77%	1.11%	1.13%	0.79%	2.93%	**1.34%**
Aetna Life Ins Co	0.92%	0.99%	1.44%	1.30%	1.24%	**1.18%**
Connecticut General	0.54%	0.52%	0.55%	0.53%	0.50%	**0.53%**

Rocky Mountain HIthcare Options Inc	1.44%	0.82%	1.14%	1.20%	1.23%	**1.17%**
Rocky Mountain HMO Inc	1.01%	1.72%	2.42%	3.42%	1.92%	**2.10%**
Grand Total	**1.22%**	**1.19%**	**1.19%**	**1.30%**	**1.49%**	**1.28%**

Table 24 - Net Investment Gain (or Loss) as a Percent of Colorado Earned Premium

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 -2.43% to 11.07% in 2013, with an average profit of 3.76%.

Net Income as a Percent of Colorado Earned Health Premiums						
Company	**2009**	**2010**	**2011**	**2012**	**2013**	**5 year Average**
Kaiser Foundation HIth Plan of CO	2.03%	2.75%	2.21%	2.32%	2.91%	**2.44%**
Rocky Mountain Hospital & Medical	5.58%	4.25%	15.45%	13.40%	4.37%	**8.61%**
United Healthcare Ins Co	5.17%	4.71%	10.35%	7.29%	1.61%	**5.83%**
Pacificare of CO Inc	5.55%	9.67%	7.73%	7.79%	6.15%	**7.38%**
Humana Ins Co	1.25%	13.03%	-13.47%	8.55%	8.17%	**3.51%**
HMO Colorado Inc	-5.18%	-66.15%	-54.33%	-49.70%	11.07%	**-32.86%**
Aetna Life Ins Co	-2.84%	2.75%	4.75%	4.43%	3.97%	**2.61%**
Connecticut General	27.35%	-18.54%	-3.10%	3.24%	-0.67%	**1.66%**
Rocky Mountain HIthcare Options Inc	0.08%	-2.96%	-5.19%	-9.50%	-2.43%	**-4.00%**
Rocky Mountain HMO Inc	7.72%	9.18%	3.67%	8.34%	2.44%	**6.27%**
Grand Total	**4.67%**	**-4.13%**	**-3.19%**	**-0.38%**	**3.76%**	**0.14%**

Table 25 - Net Income (or Loss) as a Percent of Colorado Earned Health Premiums

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 for over 5,000 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 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 2009-2013	
2009	$3,470,336
2010	$32,268,420
2011	$23,722,120
2012	$38,647,924
2013	$62,674,703

Table 26 Rates and Forms Consumer Savings from Review & Interventions 2009 - 2013

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

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

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)	Single age band from 0 - 20, One year age band from 21 - 63, Single age band from 64+	Single age band from 0 - 20, One year age band from 21 - 63, Single age band from 64+	Does Not Apply
Family Composition:	Per member rating methodology for each family member, no more than 3 oldest children under age 21 can apply	Per member rating methodology for each family member, no more than 3 oldest children under age 21 can apply	As specified by the group.
4 Tiers			
Gender	Unisex Rating	Unisex Rating	Applies
Area Factors:	Based on county where policy holder lives and as required by Colorado Insurance Regulation 4-2-39	Based on county where policy holder lives and as required by Colorado Insurance Regulation 4-2-39	Limited to the area factors filed for use by the carrier.
Smoking Status or Tobacco Use:	Rate-up to 15% for tobacco use	Rate-up to 15% for tobacco use	No prohibition or requirement specified in CO law.
Health Status:	Not allowed after 1/1/14	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 after 1/1/14	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	Not allowed after 1/1/14	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

SECTION 5: FEDERAL HEALTH REFORM

AFFORDABLE CARE ACT

Under the Affordable Care Act (ACA), most Americans must buy health insurance starting in 2014. Also in 2014, Medicaid expanded to serve more of the lowest-income Americans, and tax credits will reduce the costs of private insurance for millions of lower- and middle-income families, primarily those lacking employer-sponsored insurance. Since most people are required to buy insurance starting in 2014, insurance companies will not be allowed to deny coverage to anyone based on health.

The expectation is that by increasing the number of insured people, hospitals and other providers will shift fewer uncompensated costs to the insured population.

Once reforms are fully implemented, federal officials estimate that 93 percent of the U.S. population will be insured by 2019, an increase of 10 percent. If accurate, an additional 32 million Americans will be covered.

AFFORDABLE CARE ACT REFORMS, EFFECTIVE 2014

- Most taxpayers must have basic coverage or pay an annual tax penalty.
- Federal tax credits will help many more people afford private coverage.
- Some large employers (more than 100 employees) will pay per-employee penalties under certain circumstances if they do not offer certain basic health benefits.
- Medicaid programs will cover many more people.
- Every state will have a state or federal exchange offering one-stop shopping to consumers who will be able to compare prices, benefits, and health plan performance on easy-to-use websites. People who want to take advantage of tax credits must purchase insurance through an exchange.

CONNECT FOR HEALTH COLORADO

The Affordable Care Act requires that all states have exchanges. In 2011, Colorado passed Senate Bill 11-200, known as the "Colorado Health Benefit Exchange Act.

Connect for Health Colorado is a central marketplace where consumers and small employers can shop for health insurance plans and may access federal tax credits to help them pay for coverage. Through the exchange, Coloradoans will be able to easily compare their coverage options and enroll in a plan that best fits their needs.

Beginning in October 2013, exchange services were available to Coloradoans through a Web portal, toll-free phone number, and other formats. Key services include:

- Central place to shop for insurance plans, with easy-to-compare information on quality and price,
- Seamless eligibility and enrollment process for individual and small group plans and Medicaid,

- Access to federal tax credits and other assistance available to help make coverage more affordable,
- Community-based assistance through navigators (a.k.a. health coverage guides) and insurance agents, and
- Innovative plan options and central billing and payment for small employers.

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

2013 Colorado Health Benefit Plan Coverage Summary by Company Type			
	Earned Premium	Incurred Losses	Pure Direct Loss Ratio
Health Companies			
Individual Coverage	$444,056,216	$364,621,422	82.11%
Small Group Coverage	$756,310,303	$612,576,954	81.00%
Large Group Coverage	$2,641,492,374	$2,321,869,055	87.90%
Government Coverage	$1,270,542,087	$1,153,970,117	90.83%
Other Health Coverage	$278,136,859	$285,355,103	102.60%
Expatriate Plan Coverage	$0	$0	N/A
Mini Medical Plan coverage	$0	$0	N/A
Health Company Totals	**$5,390,537,839**	**$4,738,392,651**	**87.90%**
Property Companies			
Individual Coverage	$4,777,775	$5,484,075	114.78%
Small Group Coverage	$54,382	$18,975	34.89%
Large Group Coverage	$686,359	$676,064	98.50%
Government Coverage	$0	$0	N/A
Other Health Coverage	$51,863,871	$54,767,136	105.60%
Expatriate Plan Coverage	$0	-$7,413	N/A
Mini Medical Plan coverage	$82,311	$11,734	14.26%
Property Company Totals	**$57,464,698**	**$60,950,571**	**106.07%**
Life Companies			
Individual Coverage	$332,678,448	$280,651,497	84.36%
Small Group Coverage	$368,417,412	$294,641,901	79.98%
Large Group Coverage	$748,073,846	$593,255,687	79.30%
Government Coverage	$453,555,717	$368,925,197	81.34%
Other Health Coverage	$604,220,505	$484,692,390	80.22%
Expatriate Plan Coverage	$409,086	$251,065	61.37%
Mini Medical Plan coverage	$10,708,775	$6,708,214	62.64%
Life Company Totals	**$2,518,063,790**	**$2,029,125,951**	**80.58%**
Fraternal Companies			
Individual Coverage	$40,570	-$48,660	-119.94%
Small Group Coverage	$0	$0	N/A
Large Group Coverage	$0	$0	N/A
Government Coverage	$0	$0	N/A
Other Health Coverage	$1,032,633	$932,680	90.32%
Expatriate Plan Coverage	$0	$0	N/A
Mini Medical Plan coverage	$0	$0	N/A
Fraternal Company Totals	**$1,073,203**	**$884,020**	**82.37%**
Total All Health Benefit Plans			
Colorado Totals	**$7,967,139,530**	**$6,829,353,192**	**85.72%**

Table 6 - 2013 Colorado Health Benefit Plan Coverage Summary by Company Type

2013 Total Colorado Health Coverage Summary by Company Type				
	Written Premium	**Earned Premium**	**Incurred Losses**	**Direct Loss Ratio**
Health Companies				
Individual Comprehensive	$563,792,005	$563,202,490	$461,647,499	81.97%
Group Comprehensive	$2,738,330,616	$2,732,658,674	$2,373,239,627	86.85%
Medicare Supplement	$52,830,064	$51,676,883	$37,209,499	72.00%
Vision Only	$47,537,240	$47,535,071	$35,925,525	75.58%
Dental Only	$350,668,288	$350,495,146	$274,366,099	78.28%
Federal Employees Health Benefit Plan	$685,187,575	$693,453,769	$657,997,196	94.89%
Title XVIII Medicare	$2,097,024,273	$2,101,319,659	$1,856,385,338	88.34%
Title XIX Medicaid	$56,832,606	$56,659,776	$48,267,476	85.19%
Other	$79,346,503	$78,120,104	$134,128,664	171.70%
Health Companies Total	**$6,671,549,170**	**$6,675,121,572**	**$5,879,166,923**	**88.08%**
Property Companies	Written Premium	Earned Premium	Incurred Losses	**Direct Loss Ratio**
Group accident and health	$68,852,297	$66,350,289	$49,629,703	74.80%
Credit A&H (group and individual)	$858,083	$911,519	$189,964	20.84%
Collectively renewable A&H	$748	$744	$35,407	4759.01%
Non-cancelable A&H	$376	$17,019	($22)	-0.13%
Guaranteed renewable A&H	$24,219,599	$14,496,880	$20,313,284	140.12%
Non-renewable for stated reasons only	$1,385,360	$1,441,928	$2,452,761	170.10%
Other accident only	$388,407	$374,351	$197,307	52.71%
Medicare Title XVIII exempt from state taxes or fees	$0	$0	$0	N/A
All other A&H	$1,491,485	$1,506,608	$477,360	31.68%
Federal employees health benefits program premium	$0	$0	$0	N/A
Property Companies Total	**$97,196,355**	**$85,099,338**	**$73,295,764**	**86.13%**
Life Companies	Written Premium	Earned Premium	Incurred Losses	Direct Loss Ratio
Group Accident and Health Policies	$2,229,824,703	$2,237,359,481	$1,787,710,079	79.90%
Federal Employee Health Benefits program premium	$21,616,148	$22,345,319	$18,302,803	81.91%
Credit (group and individual)	$4,063,290	$4,154,360	$1,344,944	32.37%
Collectively renewable policies	$372,921	$390,163	$150,842	38.66%
Medicare Title XVIII exempt from state taxes or fees	$461,530,290	$471,532,199	$387,568,421	82.19%
Non-cancelable (other individual certificates)	$82,611,242	$81,856,387	$81,705,925	99.82%
Guaranteed renewable (other individual certificates)	$510,518,864	$512,313,834	$328,398,190	64.10%
Non-renewable for stated reasons only (other individual certificates)	$150,763,755	$150,789,053	$116,210,775	77.07%
Other accident only (other individual certificates)	$2,285,106	$2,312,886	$443,307	19.17%
All other (other individual policies)	$60,345,886	$59,783,082	$42,434,562	70.98%
Life Companies total	**$3,523,932,205**	**$3,542,836,764**	**$2,764,269,848**	**78.02%**

Fraternal Companies	Written Premium	Earned Premium	Incurred Losses	Direct Loss Ratio
Collectively renewable certificates	$0	$0	$0	N/A
Non-cancelable (other individual certificates)	$534,576	$540,512	$308,351	57.05%
Guaranteed renewable (other individual certificates)	$12,213,852	$12,182,657	$9,358,835	76.82%
Non-renewable for stated reasons only (other individual certificates)	$40,048	$39,933	$295	0.74%
Other accident only (other individual certificates)	$7,386	$7,597	$39,888	525.05%
Medicare Title XVIII exempt from state taxes or fees	$0	$0	$0	N/A
All other (other individual certificates)	$46,528	$46,923	($19,823)	-42.25%
Fraternal Companies Total	$12,842,390	$12,817,622	$9,687,546	75.58%
All Health Coverage				
Colorado Totals	**$10,305,520,120**	**$10,315,875,296**	**$8,726,420,081**	**84.59%**

Table 7 - 2013 Total Colorado Health Coverage Summary 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.

Adverse Selection - 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.

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.

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.

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.

ERISA (Employees' Retirement Income Security Act) - Self-insured plans are regulated by the federal government under this act.

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.

LTC (Long Term Care) - Long-term Care Insurance is a special type of health insurance that is designed to cover expenses of nursing home care, home health care or other types of defined care that persons may need at various stages of their lives, and not necessarily just at advanced ages.

Managed Care - 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.

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 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.

NAIC - The National Association of Insurance Commissioners.

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 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.

Net Underwriting Gain or Loss - The operating costs that are not allocated to: hospital and medical payments, claim adjustment expenses or investment expenses.

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.

PPO (Preferred Provider Organization) - An indemnity health insurance 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.

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.

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.

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. 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.

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."

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

Tables

Source: 2013 Annual financial statements