COLORADO

Department of Regulatory Agencies

Division of Insurance

Health Insurance Cost Report

to

The Colorado General Assembly

for

Calendar year 2015

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

Published January 3, 2016

Marguerite Salazar

Commissioner

January 3, 2016

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 2015, pursuant to §10-16-111(4)(c) and (d), C.R.S.

This report analyzes the health insurance marketplace in Colorado - availability, premiums, the factors that drive premiums, and the trends impacting the marketplace - both in the individual and group markets. It also reports on the financial status of health insurance carriers, as well as the regulatory oversight of these carriers.

The report this year covers year two of the full implementation of the Affordable Care Act (ACA), including the benefits and consumer protections provided in that law. It is challenging to draw conclusions in such a limited time for a law that changed the health insurance landscape, and to that end, the Division of Insurance is committed to monitoring the reforms brought about by the ACA.

In FY 2015-16, the Division upgraded its mission to fully-encompass its roles: To promote compliance and enforce laws to help protect consumers. Concerns about health insurance are a priority for our leaders and our citizens, so we value the opportunity to provide detailed analysis of health insurance in Colorado and the myriad factors driving its cost and availability.

If you have any questions, please contact me at the Division of Insurance.

Sincerely,

Marguerite Salazar

Commissioner of Insurance

2015 COLORADO HEALTH COST REPORT

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Introduction

This report provides an overview of health insurance in Colorado, the sources of coverage and the types of coverage available. It also contains an overview of health insurance regulation in Colorado and the role which the Division of Insurance plays, including the steps taken to ensure consumer protection. This report examines the increases in premiums in Colorado, compares them to nationwide data and provides a breakdown of how premiums collected in Colorado during 2015 were used. Many factors drive the increase in health premiums: inflation, cost shifting, utilization, introduction of new technology, and many others. Finally, this report examines the ten largest health insurers in Colorado and provides financial information for each. Additional data, definitions and an explanation of insurance terms are located in Appendices 1 & 2.

2015 Highlights

- The Colorado Division of Insurance ("Division") has responsibility for overseeing health insurance coverage for over 1.3 million major medical health coverage plans for Coloradans.
- 37% 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. Note that these programs are not regulated by the Division.
- During 2015, 59% of Coloradans were covered by employment-based insurance, compared to 56% of citizens nationwide.
- An estimated 9% of Coloradans had no health insurance in 2015, versus an estimated 11% in 2014.
- During 2015, approximately 88% of premiums collected in Colorado went directly to the cost of providing healthcare services. This exceeds the 80% required for individual and small group plans, as well as the 85% required for large group plans. Approximately 20% of premiums were used for administrative expenses and producer commissions. Combined this means that insurance companies operated at a loss as they spent 108% of the premium they took in during 2015.
- For employer-based coverage in our state, Colorado employees paid 21% of the total premium for single coverage and 28% for family coverage, compared to 21% for single coverage and 27% for family coverage, nationally. With employer-based coverage, the employers paid the remaining portion of premiums.
- The percentage of Colorado's private employers offering health insurance that self-insure at least one of their plans has risen to 43% in 2015 from 32% in 2005. This increase is significant compared to the percentage nationwide, which while it has seen lower volatility, has only increased from 33% in 2005 to 39% in 2015. Employer-funded or self-insured plans are often called "ERISA" plans as they are regulated by the federal government under the Employees' Retirement Income Security Act (ERISA).
- The top 10 largest health insurers make up 74% of the Health Coverage market in Colorado which includes Major Medical as well as additional types of health insurance such as dental, vision, accident only and others. There are approximately 425 health insurers doing business in Colorado.

SECTION 1: THE HEALTH INSURANCE MARKETPLACE IN COLORADO

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. Some of the population purchased their own private individual insurance (non-employment-based insurance).

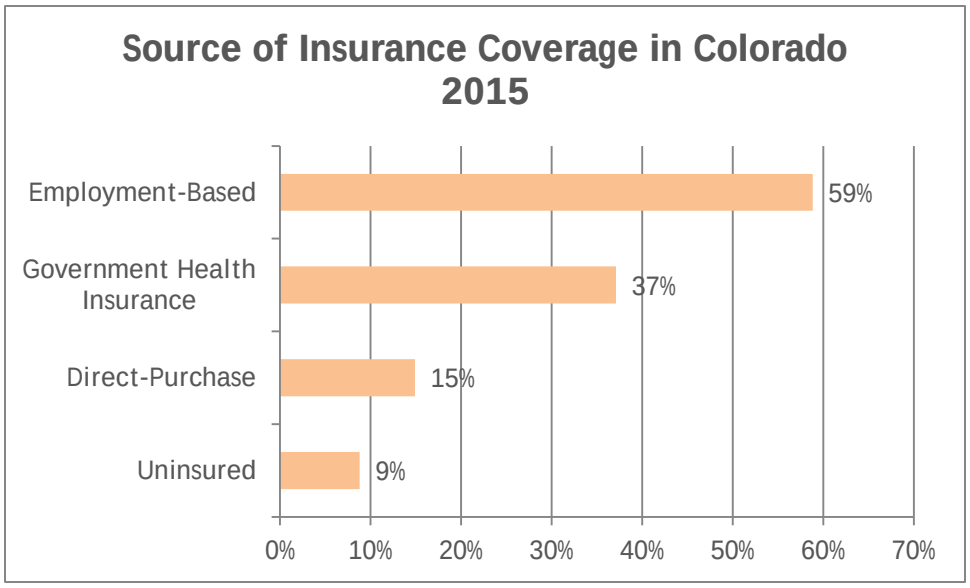


Figure 1 - Source of Insurance Coverage CO

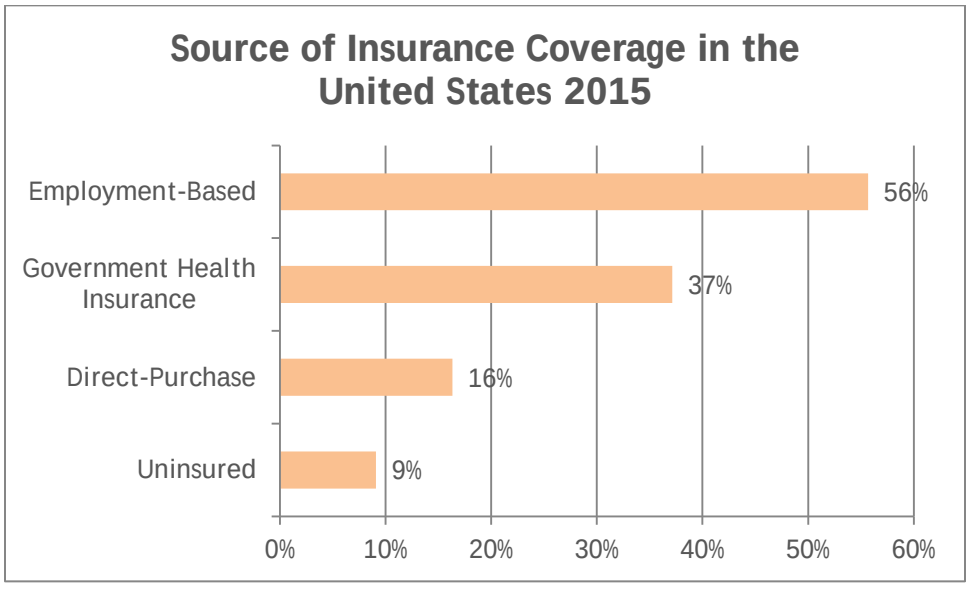


Figure 2 - Source of Insurance Coverage US

As shown in Figures 1 and 2, 59% of Coloradans secured health coverage through their employer, compared with 56% nationwide. The Colorado direct purchase market is slightly smaller than the national figure at 15%. Only 9% of Coloradans remained uninsured in 2015, equal to the national

uninsured figure. This represents a drop of 2% since 2014 continuing a steady decrease in the number of uninsured Coloradans over the last two years. Many people have more than one source of insurance or move from one type of insurance to another throughout the year and may therefore be counted in multiple categories above.

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. There are four primary markets for health insurance that are subject to state regulation: the individual, the small group, and the large group markets, as well as Connect 4 Health Colorado which is also referred to as the exchange. The average costs for coverage are shown in Table 2 in Section 2 of this report.

Government Health Insurance

According to the US Census Bureau, 37% of Coloradans got their health care coverage through government programs such as Medicare, Medicaid, the Federal Employees' Health Benefit Plan, the Veteran's Administration, and other government programs in 2015. 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 less than 1% in 2015.

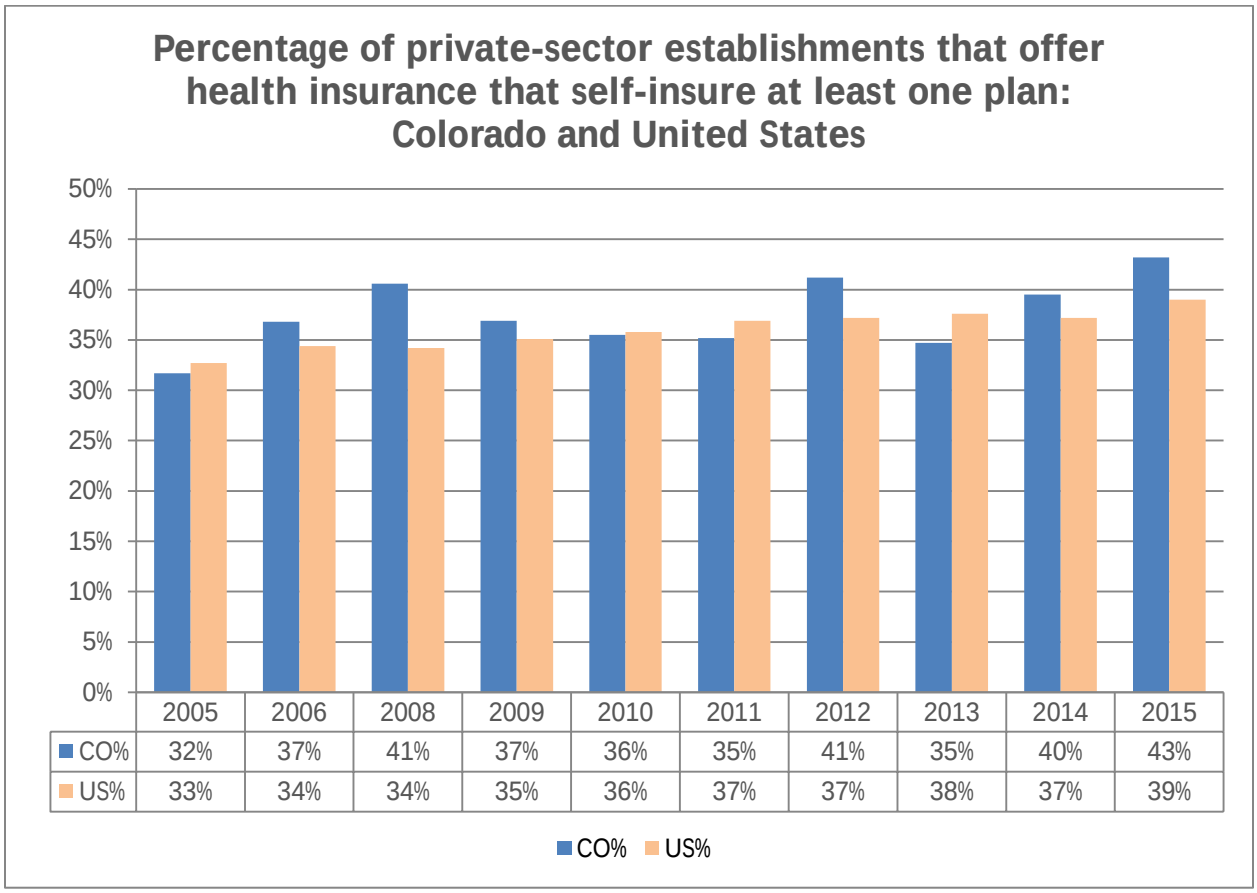
Colorado Health Insurance Covered Lives in 2015[1]	
Colorado population	5,421,000
Insured	4,946,000
Uninsured	476,000
Jurisdiction of the Division of Insurance	
Individual	347,974
Small Group	214,652
Large Group	776,979
Total Under State Regulation	1,339,605
Not Regulated by the Division of Insurance	
Medicare	825,000
Medicaid	1,037,000
Military	341,000
Self-Insured (Employer-based)	3,279,705
Total Not Regulated by the Division of Insurance	5,482,705

Table 1 - Colorado Health Insurance Covered Lives

[1] Enrollment numbers in Table 1 include multiple policies per person. Individuals may be covered by both Medicare and Medicaid, or start the year with coverage from one plan and end the year with a different plan.

SELF-INSURED MARKET

Even though the Division does not regulate employer self-insured health plans (also called ERISA plans), it is interesting to note the changes in the number of such plans in Colorado over the last 10years. Figure 3 below 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 41% in 2008 and again at 41% in 2012 with lows of 32% in 2005 and 35% in 2013. These spikes are significant compared to the percentage nationwide, which has seen a mostly steady increase from 34% in 2008 to 39% in 2015.



	2005	2006	2008	2009	2010	2011	2012	2013	2014	2015
CO%	32%	37%	41%	37%	36%	35%	41%	35%	40%	43%
US%	33%	34%	34%	35%	36%	37%	37%	38%	37%	39%

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

EXCESS LOSS COVERAGE

Excess Loss or Stop Loss coverage protects the Self-Insured Market from catastrophic losses by insuring them against severe losses. Typically it insures the companies against a very costly single (per person), or aggregate (per company) event. This allows even smaller companies to self-insure.

- 64,215 lives were insured by companies with 100 or fewer employees covered by Excess Loss in 2015.
- This represents a decrease of 25% from 2014.
- There were an average of 43 covered lives per employer.
- 53% of covered lives fell under employers in the 51-100 employee range with an average of 71 employees and 84 covered lives.
- The smallest category (10 or fewer employees), covered only 5% of covered lives, with on average, 5 employees per group and 9 covered lives.

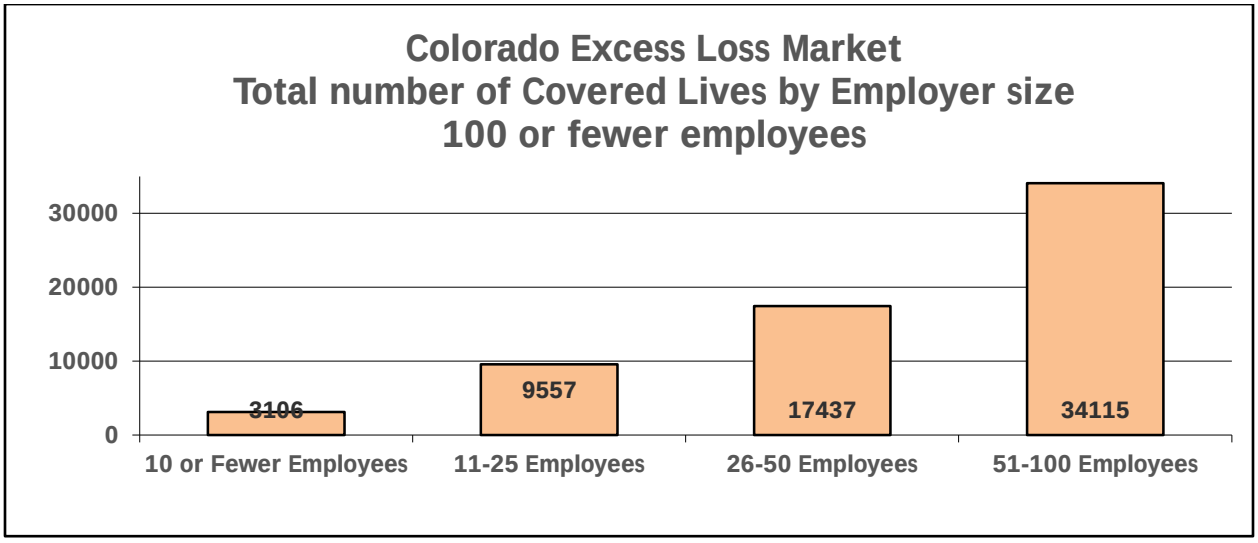


Figure 4 - Colorado Excess Loss Market

SECTION 2: HEALTH INSURANCE PREMIUMS

This section examines health premiums and presents factual data on how premiums collected in Colorado are used.

Increases in health premiums are driven by a wide range of factors. Some of these 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.

When looking at the table below, keep in mind that carriers who offer on-exchange plans must also offer those plan's off the exchange. However Large Group plans are not available on the exchange. These numbers do not reflect the impact tax credits under the ACA has on the cost to consumers for exchange based plans

OVERVIEW OF COLORADO HEALTH PLAN PREMIUMS

Major Medical Coverage	Individual On Exchange	Individual Off Exchange	Small Group On Exchange	Small Group Off Exchange	Large Group
Average Premium per life per month	$331	$247	$334	$380	$343
Average Premium per life per year	$3,974	$2,968	$4,009	$4,561	$4,114
Number of companies providing coverage	8	20	6	14	15

Table 2 - Average Earned Premiums 2015

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 26% of small companies with less than fifty employees offer insurance compared to the 98% of larger firms that offer insurance. The number of small companies offering health insurance has dropped slowly since 2011 but had a spike in 2014 before falling again. The percentage of large companies offering health insurance has risen and fallen within a range of 90%-98% for the last 5 years.

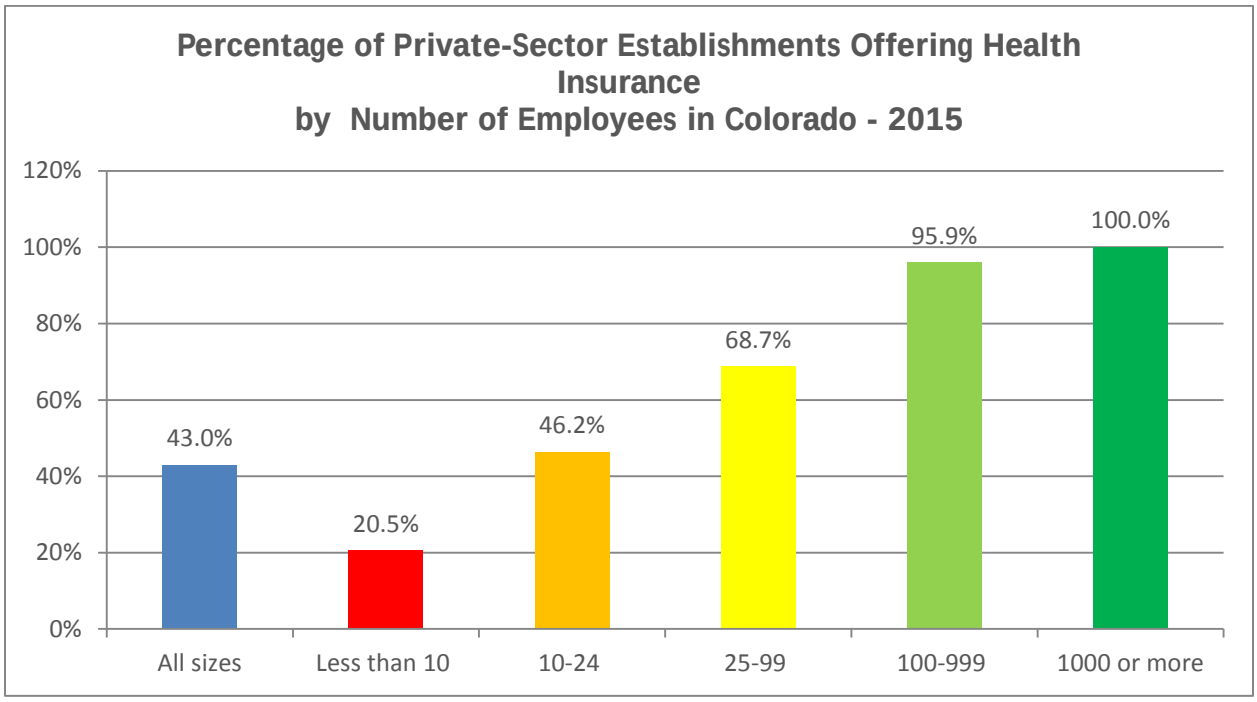


Figure 5 - Percentage of Private-Sector Establishments Offering Health Insurance by Number of Employees in Colorado. Less than 100 Employees is considered Small Group for coverage purposes.

In 2014, 54% of private sector employees enrolled in employer-sponsored health insurance plans in Colorado chose single coverage. The remaining 46% are split between single+1 coverage (18%), and family coverage (28%). Colorado remains within 1% of U.S. averages in all three groupings. According to the Insurance Component of the Medical Expenditure Panel Survey, conducted by the U.S. Department of Health & Human Services, 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	$5,328	$28	$1,680	$1,117	$4,211
Mixed-Provider Plans	$5,920			$1,275	$4,645
Any-Provider Plans	$6,268			$1,256	$5,012
Family Coverage	**Average Total Premium**	**Average Copayment**	**Average Deductible**	**Average Employee Contribution**	**Average Employer Contribution**
Exclusive-Provider Plans	$15,868	$28	$3,062	$5,336	$10,532
Mixed-Provider Plans	$17,056			$4,702	$12,354
Any-Provider Plans	Unavailable			Unavailable	Unavailable

Table 6 – Average Premiums, Copayments, Deductibles and Contributions of Premium by available provider options. Some values are unavailable due to small sample sizes

The following exhibits indicate the total premiums and percentages of total premium that Colorado employees are contributing towards health insurance. 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 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.

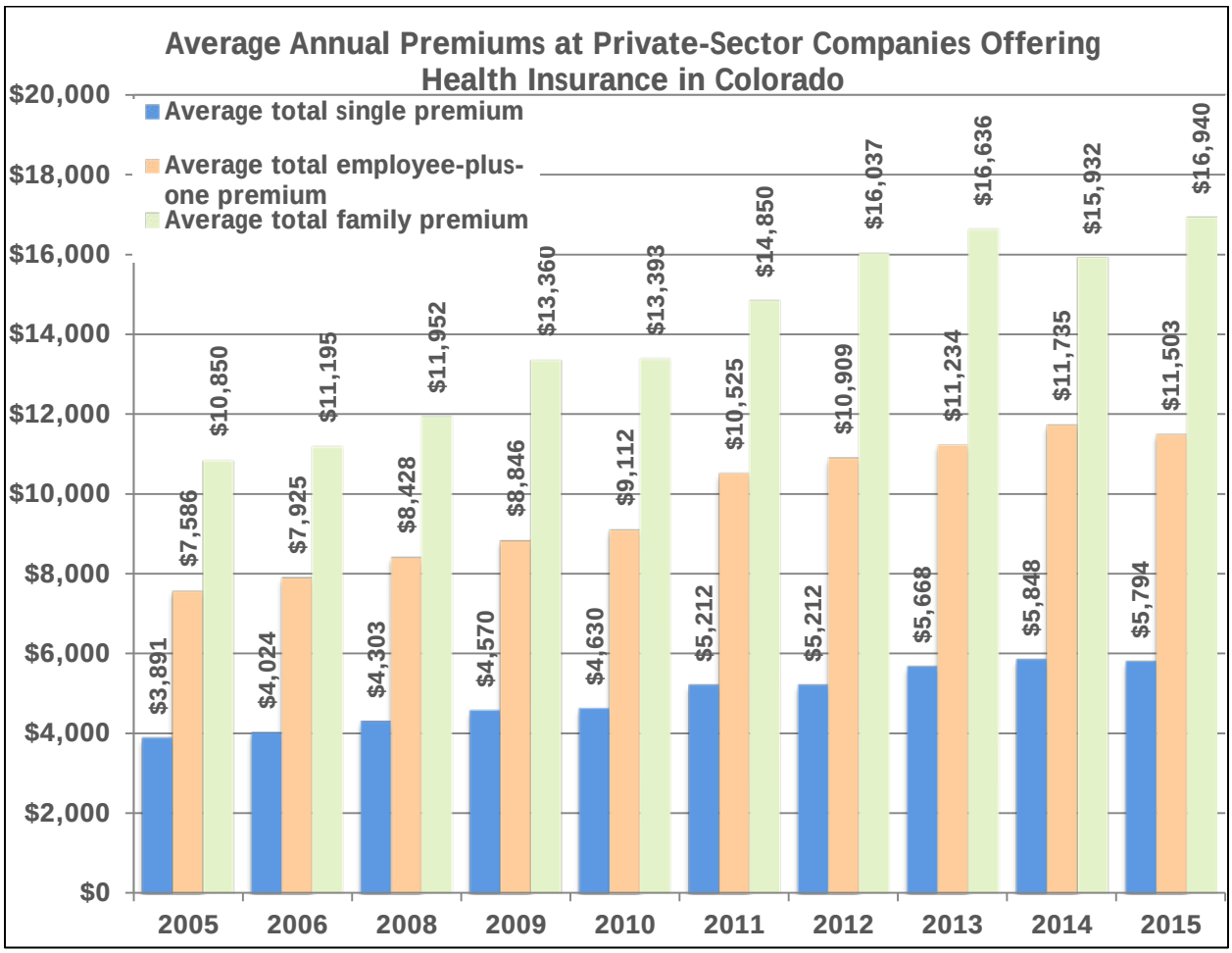
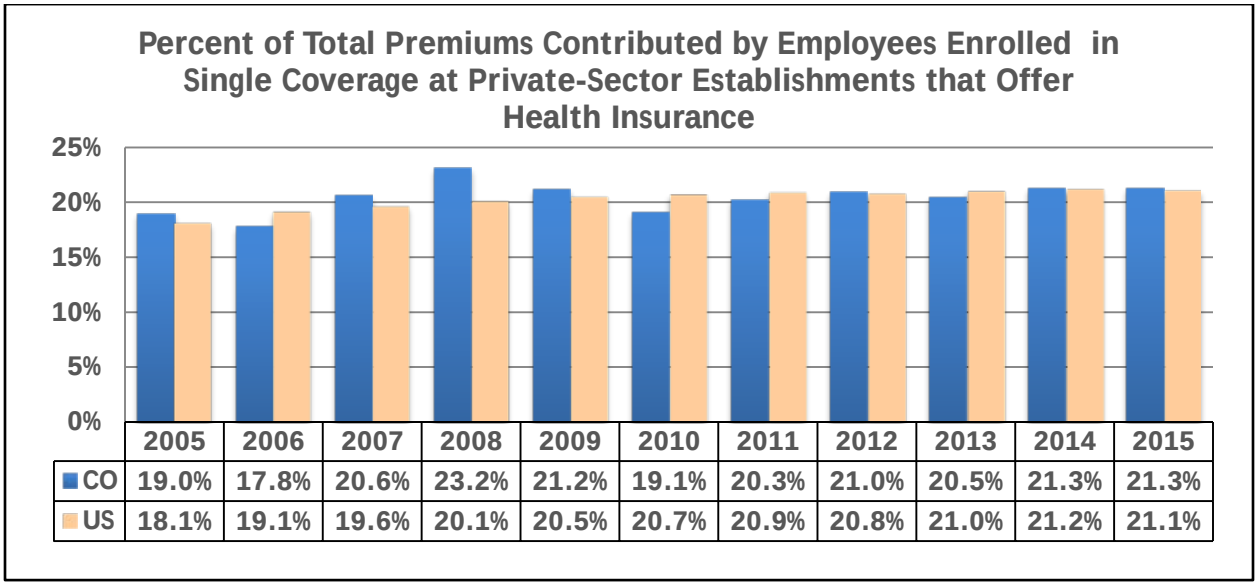


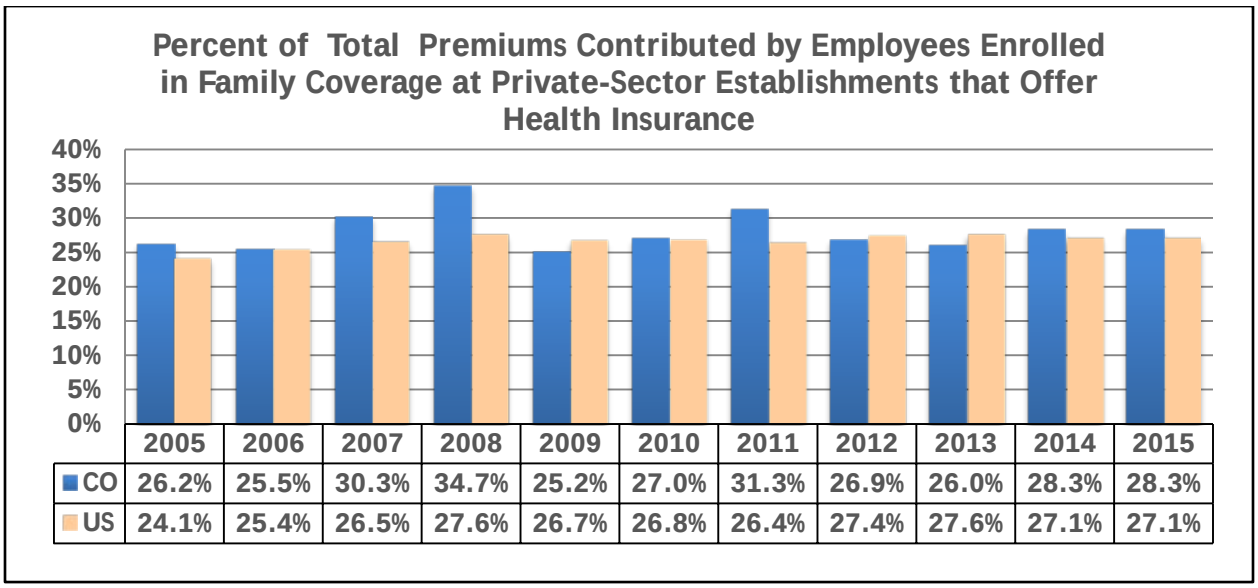
Figure 6 - Average Annual Premiums at Private-Sector Companies Offering Health Insurance in Colorado

Colorado employees paid 21% of the total premium for single coverage and 28% for family coverage. While the single coverage number is similar to the national average, the family coverage number is greater. Figure 7 shows that since 2012 the premium contribution rate for single coverage has remained relatively steady and Colorado has been consistently close to the national average. Looking at Figure 8 shows that, except for 2012 and 2013, Colorado employees enrolled in family coverage typically have carried much more of the burden of premium when compared to national numbers.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CO	19.0%	17.8%	20.6%	23.2%	21.2%	19.1%	20.3%	21.0%	20.5%	21.3%	21.3%
US	18.1%	19.1%	19.6%	20.1%	20.5%	20.7%	20.9%	20.8%	21.0%	21.2%	21.1%

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



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CO	26.2%	25.5%	30.3%	34.7%	25.2%	27.0%	31.3%	26.9%	26.0%	28.3%	28.3%
US	24.1%	25.4%	26.5%	27.6%	26.7%	26.8%	26.4%	27.4%	27.6%	27.1%	27.1%

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

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

Components of Colorado Health Care Premiums in 2015		
	Insurer Expense	**Percent of Premium**
Medical Expenses	$4,704,232,629	87.5%
Administrative Expenses	$1,055,997,772	19.6%
Profit and Contingencies	-$382,750,687	-7.1%
Total Premium	**$5,377,479,714**	**100.00%**

Table 4 - Components of Colorado Health Care Premiums in 2015

It is important to note that the information above is from an aggregation of the data received from companies that reported representing the top 95% of premium. The information in the Colorado Health Insurance Cost Report may not match specific company data based on allocating national data, rounding procedures and non-premium revenue.

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 2015	
Comprehensive Major Medical (Individual)	80%
Comprehensive Major Medical (Small Group)	80%
Comprehensive Major Medical (Large Group)	85%

Table 5 - Minimum Loss Ratio Guidelines in Colorado in 2015

The average medical expense (AKA minimum loss ratio) reported of 87.5% is higher than all of the minimum loss ratio guidelines provided in regulation. This indicates that any focus on controlling premium increases would need to include trying to control the costs of providing health care services.

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.

COLORADO MEDICAL TREND IN DETAIL[1]

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.

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 trends below.

Medical Trend	Average Medical Trend due solely to Provider Price Changes	Average Medical Trend due solely to Utilization Changes	Average Medical Trend due solely to Cost-shifting	Average Medical Trend due solely to New Medical Procedures and Technology	Average Total Medical Trend
Individual on Exchange	10.51%	0.51%	0.79%	0.16%	11.59%
Individual off Exchange	5.86%	4.60%	1.53%	0.39%	12.39%
Small Group on Exchange	20.99%	8.29%	3.41%	0.00%	32.61%
Small Group off Exchange	5.81%	-2.53%	-0.51%	0.21%	3.00%
Large Group	5.21%	-3.13%	-1.67%	0.39%	3.85%

Table 6 – Total Medical Trend by Year by Type of Health Insurance

Pharmaceutical Trend	Average Rx Trend due solely to Pharmaceuti-cal Price Changes	Average Rx Trend due solely to Utilization Changes	Average Rx Trend due solely to Cost-shifting	Average Rx Trend due solely to New Drugs	Average Total Rx Trend
Individual on Exchange	18.49%	2.13%	-0.97%	5.55%	23.84%
Individual off Exchange	14.42%	0.45%	1.31%	5.45%	18.63%
Small Group on Exchange	57.76%	-4.81%	1.07%	2.10%	46.47%
Small Group off Exchange	8.73%	-5.00%	1.87%	3.86%	6.88%
Large Group	10.70%	0.67%	2.16%	4.49%	11.61%

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

[1] The Division of Insurance relies solely upon the Health Cost Survey results to populate tables 6 & 7. 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 estimates for what portion of total trend each cost category is responsible for.

EXPENSES

The administrative expenses of an insurer represent the cost of operating the business. This includes 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 each year. 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 8.

Administrative Expenses 2015		
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	$122,571,337	2.3%
Commissions	$110,983,627	2.1%
Staff Salaries/Benefits	$206,560,472	3.8%
Dividends to Policyholders	$812,567	0.0%
Legal Expenses	$3,885,910	0.1%
Advertising or Marketing	$31,993,097	0.6%
Lobbying Expenses	$1,365,175	0.0%
Charitable Contributions	$126,761,707	2.4%
Federal Income Taxes	$182,318,772	3.4%
State Taxes, Licenses and Fees	$95,590,251	1.8%
All Other	$173,154,859	3.2%
Total	**$1,055,997,772**	**19.6%**

Table 8 - Administrative Expenses reported by carriers covering the top 95% of written premium in the Colorado Health Cost Report

COLORADO HEALTH PREMIUMS, INCURRED LOSSES AND MEDICAL LOSS RATIOS

Major Medical Health Coverage[1]	Earned Premium	Incurred Losses	Loss Ratio
Individual Coverage	$1,161,048,536	$1,329,664,949	114.52%
Small Group Coverage	$1,013,141,181	$767,688,370	75.77%
Large Group Coverage	$3,740,793,554	$3,141,910,275	83.99%
Colorado Totals	**$5,914,983,271**	**$5,239,263,593**	**88.58%**

Table 9 – Colorado Major Medical Health Benefit Plan Coverage Summary

Other Health Coverages[2]	Written Premium	Earned Premium	Incurred Losses	Loss Ratio
Medicare Supplement	$67,073,740	$67,477,279	$47,456,694	70.33%
Title XVIII Medicare Advantage	$2,848,905,550	$2,820,605,122	$2,493,608,602	88.41%
Title XIX Medicaid	$374,089,347	$374,089,347	$340,407,126	91.00%
Other	$459,270,335	$290,224,909	$536,204,935	184.75%
Health Companies Total	**$3,749,338,972**	**$3,552,396,657**	**$3,417,677,357**	**96.21%**

Table 10 – Colorado other Health Plan Coverage Summary

[1]Data taken from all supplemental health exhibits submitted to the NAIC.

[2]Data taken from state page filings submitted to the NAIC.

Rate 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.

Rates are reviewed by the Division of Insurance to determine if rates are "excessive, inadequate or unfairly discriminatory". "Excessive Rates" occur when unreasonably 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. Those filings determined to be too high are either rejected or allowed at a lower increase than requested. The following table shows 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 2011-2015	
2011	$23,722,120
2012	$38,647,924
2013	$62,674,703
2014	$50,936,176
2015	$74,924,033

Table 11 Rates and Forms Consumer Savings from Review & Interventions

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 when the rates are changed on an existing product, even if the rate change only pertains to new business. In addition 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, they must submit a rate filing on at least an annual basis for continued appropriateness. These rate filings must contain detailed support as to why the assumptions continue to be appropriate.

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 12 - Summary of Rating Factors for Private Health Plans in Colorado

SECTION 3: Financial Status of the Top 10 Largest Health Insurers 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 be harmed if an insurer becomes insolvent and is unable to pay claims.

This section presents an overview of the operating results and financial status of the top ten companies with the highest written premiums from health insurance in Colorado. All figures in this section are from each company's annual financial statement and represent their *total* health business, including dental, vision and other health insurance products, not just major medical coverage. Figure 9 shows that the top 10 largest health insurers make up 74% of the total health market in Colorado. There are approximately 425 health insurers in Colorado, many of which provide products other than major medical insurance.

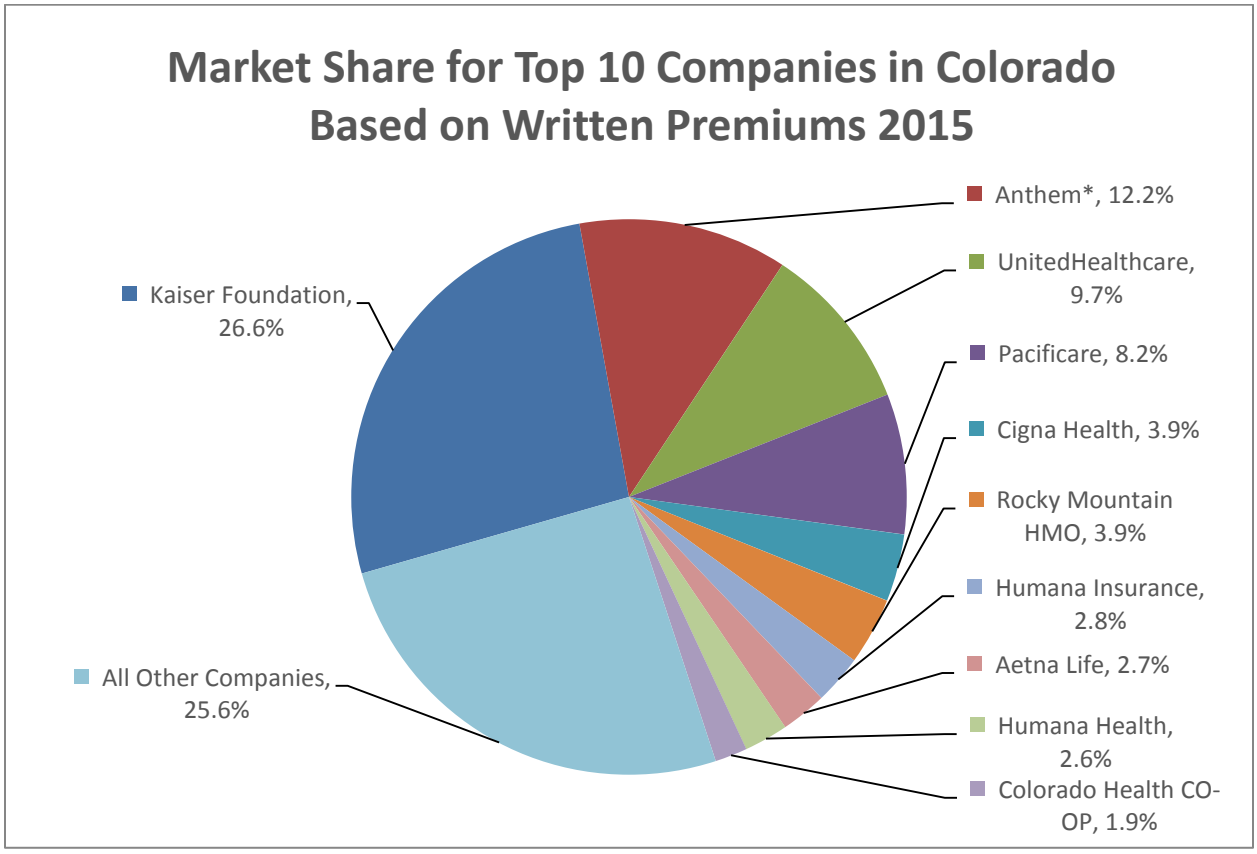


Figure 9 - Market share of Top 10 Companies in Colorado Based on Written Premium in 2015

Market Share of the Top 10 Health Carriers in Colorado		
Company	**2015 Written Premiums ($1,000s)**	**2015 Market Share**
Kaiser Foundation Health Plan Co	3,193,293	26.6%
Anthem* Rocky Mountain Hospital & Medical	1,460,930	12.2%
United Healthcare Insurance Co	1,167,314	9.7%
Pacificare of Colorado Inc	979,594	8.2%
Cigna Heath & Life Ins Co	471,371	3.9%
Rocky Mountain HMO Inc	469,523	3.9%
Humana Ins Co	342,070	2.8%
Aetna Life Insurance Co	320,509	2.7%
Humana Health Plan Inc	307,700	2.6%
Colorado Health Ins CO-OP Inc	226,159	1.9%
All Other Companies	3,076,366	25.6%
Total	12,014,829	100.0%

Table 13 - Market share of the Top 10 Health Carriers in Colorado

Capital and Surplus

Risk-based Capital Percentage (RBC %)						
Company	**2011**	**2012**	**2013**	**2014**	**2015**	**5-Year Average**
Kaiser Foundation Health Plan Co	592%	614%	528%	267%	490%	499%
Anthem* Rocky Mountain Hospital & Medical	433%	503%	589%	610%	640%	555%
United Healthcare Insurance Co	528%	532%	555%	560%	557%	546%
Pacificare of Colorado Inc	405%	396%	625%	542%	471%	488%
Cigna Heath & Life Ins Co	1257%	605%	508%	604%	558%	706%
Rocky Mountain HMO Inc	1655%	1831%	1553%	478%	225%	1148%
Humana Ins Co	565%	388%	445%	412%	414%	445%
Aetna Life Insurance Co	694%	701%	670%	606%	565%	647%
Humana Health Plan Inc	411%	365%	385%	433%	366%	392%
Colorado Health Ins CO-OP Inc				478%	225%	351%

Table 14 - Risk-based Capital Percentage (RBC %)

Medical and Hospital Expenses

Colorado Medical Loss Ratios						
Company	2011	2012	2013	2014	2015	5 year Average
Kaiser Foundation Health Plan Co	93.9%	94.4%	94.5%	91.9%	95.9%	**94.1%**
Anthem* Rocky Mountain Hospital & Medical	83.1%	84.5%	85.2%	85.7%	83.0%	**84.3%**
United Healthcare Insurance Co	78.0%	79.5%	83.3%	77.7%	77.7%	**79.2%**
Pacificare of Colorado Inc	77.9%	78.0%	81.2%	79.0%	77.8%	**78.8%**
Cigna Heath & Life Ins Co	78.8%	80.9%	80.3%	79.3%	79.3%	**79.7%**
Rocky Mountain HMO Inc	79.5%	77.4%	78.8%	100.3%	104.2%	**88.1%**
Humana Ins Co	98.6%	77.8%	77.4%	81.1%	84.7%	**83.9%**
Aetna Life Insurance Co	79.8%	82.0%	81.6%	81.6%	80.1%	**81.0%**
Humana Health Plan Inc	86.6%	81.1%	83.7%	87.0%	91.7%	**86.0%**
Colorado Health Ins CO-OP Inc				157.9%	139.6%	**148.8%**
Grand Total	**84.0%**	**81.7%**	**82.9%**	**92.2%**	**91.4%**	**90.4%**

Table 15 - Colorado Medical Loss Ratios

Administrative Expenses

Administrative Expenses as a Percent of Colorado Earned Health Premiums						
Company	2011	2012	2013	2014	2015	5 year Average
Kaiser Foundation Health Plan Co	5.5%	5.0%	5.2%	7.9%	8.0%	**6.3%**
Anthem* Rocky Mountain Hospital & Medical	7.0%	7.2%	8.0%	9.9%	9.8%	**8.4%**
United Healthcare Insurance Co	13.8%	13.7%	13.4%	15.3%	15.9%	**14.4%**
Pacificare of Colorado Inc	7.9%	7.8%	6.9%	9.0%	9.3%	**8.2%**
Cigna Heath & Life Ins Co	-7.0%	-0.5%	9.4%	4.2%	4.5%	**2.1%**
Rocky Mountain HMO Inc	8.9%	10.0%	7.3%	6.7%	9.3%	**8.4%**
Humana Ins Co	14.0%	13.5%	14.1%	9.9%	9.5%	**12.2%**
Aetna Life Insurance Co	16.1%	15.0%	17.1%	14.4%	15.0%	**15.5%**
Humana Health Plan Inc	11.9%	10.1%	11.4%	10.2%	9.1%	**10.5%**
Colorado Health Ins CO-OP Inc				35.2%	16.2%	**25.7%**
Grand Total	**8.7%**	**9.1%**	**10.3%**	**12.3%**	**10.7%**	**11.2%**

Table 16 - Administrative Expenses as a Percent of Colorado Earned Health Premiums

Claims Adjustment Expenses

Claims Adjustment Expenses as a Percent of Colorado Earned Health Premiums						
Company	2011	2012	2013	2014	2015	5 year Average
Kaiser Foundation Health Plan Co	2.0%	2.9%	2.8%	3.6%	2.6%	**2.8%**
Anthem* Rocky Mountain Hospital & Medical	2.8%	2.6%	2.6%	2.5%	1.8%	**2.5%**
United Healthcare Insurance Co	0.0%	0.1%	0.0%	0.0%	0.0%	**0.0%**
Pacificare of Colorado Inc	2.8%	2.7%	3.6%	4.2%	5.0%	**3.7%**
Cigna Heath & Life Ins Co	0.1%	0.3%	0.0%	0.0%	0.0%	**0.1%**
Rocky Mountain HMO Inc	7.9%	8.4%	9.6%	6.7%	5.0%	**7.5%**
Humana Ins Co	0.0%	0.0%	0.0%	4.4%	4.2%	**1.7%**
Aetna Life Insurance Co	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Humana Health Plan Inc	4.8%	5.6%	4.7%	4.9%	4.8%	**5.0%**
Colorado Health Ins CO-OP Inc				12.0%	13.4%	**12.7%**
Grand Total	**2.3%**	**2.5%**	**2.6%**	**3.8%**	**3.7%**	**3.6%**

Table 17 - Claims Adjustment Expenses as a Percent of Colorado Earned Health Premium

Net Underwriting Gain (or Loss)

Underwriting Gain or Loss as a Percent of Colorado Earned Health Premiums						
Company	2011	2012	2013	2014	2015	5 year Average
Kaiser Foundation Health Plan Co	0.5%	0.2%	0.1%	-1.5%	-4.3%	**-1.0%**
Anthem* Rocky Mountain Hospital & Medical	16.2%	13.6%	3.7%	5.0%	3.6%	**8.4%**
United Healthcare Insurance Co	12.5%	9.2%	3.3%	7.0%	6.3%	**7.7%**
Pacificare of Colorado Inc	11.2%	11.3%	8.8%	7.8%	7.3%	**9.3%**
Cigna Heath & Life Ins Co	-50.9%	-47.8%	12.1%	18.0%	17.5%	**-10.2%**
Rocky Mountain HMO Inc	0.7%	4.3%	-0.2%	-30.8%	-19.1%	**-9.0%**
Humana Ins Co	-12.7%	8.6%	8.6%	4.1%	1.3%	**2.0%**
Aetna Life Insurance Co	7.8%	7.2%	6.5%	7.7%	8.9%	**7.6%**
Humana Health Plan Inc	-3.5%	2.5%	-1.7%	-11.1%	-16.7%	**-6.1%**
Colorado Health Ins CO-OP Inc				-274.8%	-67.8%	**-171.3%**
Grand Total	**-2.0%**	**1.0%**	**4.6%**	**-26.9%**	**-6.3%**	**-16.3%**

Table 18 - Underwriting Gain (or Loss) as a Percent of Colorado Earned Health Premiums

Net Investment Income Gain (or Loss)

Net Investment Gain (or loss) as a Percent of Colorado Earned Health Premiums						
Company	2011	2012	2013	2014	2015	5 year Average
Kaiser Foundation Health Plan Co	0.9%	1.2%	1.9%	1.4%	1.2%	**1.3%**
Anthem* Rocky Mountain Hospital & Medical	1.3%	1.7%	2.8%	4.6%	2.7%	**2.6%**
United Healthcare Insurance Co	0.8%	1.1%	0.8%	1.4%	1.5%	**1.1%**
Pacificare of Colorado Inc	0.7%	0.4%	0.4%	0.4%	0.4%	**0.5%**
Cigna Heath & Life Ins Co	1.1%	0.8%	2.9%	3.1%	3.0%	**2.2%**
Rocky Mountain HMO Inc	2.4%	3.4%	1.9%	0.6%	0.4%	**1.8%**
Humana Ins Co	1.4%	1.4%	1.2%	1.0%	1.0%	**1.2%**
Aetna Life Insurance Co	1.4%	1.3%	1.2%	1.0%	0.9%	**1.2%**
Humana Health Plan Inc	0.5%	0.5%	0.5%	0.4%	0.5%	**0.5%**
Colorado Health Ins CO-OP Inc				0.4%	0.0%	**0.2%**
Grand Total	**1.2%**	**1.3%**	**1.5%**	**1.4%**	**1.2%**	**1.3%**

Table 19 - Net Investment Gain (or Loss) as a Percent of Colorado Earned Premium

Net Income (or Loss)

Net Income as a Percent of Colorado Earned Health Premiums						
Company	2011	2012	2013	2014	2015	5 year Average
Kaiser Foundation Health Plan Co	2.2%	2.3%	2.9%	0.7%	-2.1%	**1.2%**
Anthem* Rocky Mountain Hospital & Medical	15.5%	13.4%	4.4%	6.0%	3.8%	**8.6%**
United Healthcare Insurance Co	10.3%	7.3%	1.6%	6.2%	5.2%	**6.1%**
Pacificare of Colorado Inc	7.7%	7.8%	6.2%	5.0%	4.5%	**6.2%**
Cigna Heath & Life Ins Co	-54.3%	-49.7%	11.1%	14.9%	15.2%	**-12.6%**
Rocky Mountain HMO Inc	3.7%	8.3%	2.4%	-29.5%	-22.0%	**-7.4%**
Humana Ins Co	-13.5%	8.5%	8.2%	3.6%	0.7%	**1.5%**
Aetna Life Insurance Co	4.7%	4.4%	4.0%	4.9%	4.1%	**4.4%**
Humana Health Plan Inc	-3.1%	3.2%	-0.7%	-11.4%	-16.4%	**-5.7%**
Colorado Health Ins CO-OP Inc				-274.2%	-67.7%	**-171.0%**
Grand Total	**-3.0%**	**0.6%**	**4.4%**	**-27.4%**	**-7.5%**	**-16.8%**

Table 20 - Net Income (or Loss) as a Percent of Colorado Earned Health Premiums

Figures

Tables

COLORADO

Department of Regulatory Agencies

Division of Insurance

Colorado Health Insurance Cost Report
Apendix 1:
Aggregated Company Data

2015

In accordance with § 10-16-111(4)(a)(b)&(c), C.R.S.

COLORADO
Department of Regulatory Agencies
Division of Insurance

Division of Insurance
Marguerite Salazar
Commissioner of Insurance

The Division of Insurance is pleased to present the results of the 2015 Colorado Health Insurance Cost Report pursuant to § 10-16-111(4)(a), C.R.S. This report presents an aggregated summary of the costs of providing healthcare in the state of Colorado, as reported by insurance carriers that provide major medical healthcare services in Colorado. This information will be useful to consumers, the industry and the public in determining the factors that drive insurance premiums in our state.

In 2008, the Colorado General Assembly passed and the Governor signed into law House Bill 08-1389 regarding the insurance rates paid by citizens of the state of Colorado. The bill's intent is to ensure that insurance coverage be accessible to all Coloradans, and that in order to provide accessible, affordable coverage, insurance rates should not be excessive, inadequate or unfairly discriminatory. In accordance with Section 9 of the bill, § 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. The Commissioner of Insurance is required to aggregate this data and publish the information on the Division's website.

To aid in the submission of this data, the Division prepared a Health Insurance Cost Report to be completed by each insurer. A total of 28 insurers representing more than 98% of total written premium submitted this report on their costs for 2015. As required, the report below is an aggregated summary of the data collected.

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Fax 303.894.7455 Toll Free 800.930.3745 www.dora.state.co.us V/TDD 711

2015 Health Cost Report Aggregated Summary as required by C.R.S. § 10-16-111(4)[1]

Statute Requirement	Average Per Company	Total Sum of All Companies	Percent of Colorado Earned Health Insurance Premium
Direct Written Premium for Colorado Health Insurance Business	$226,868,416	$5,444,841,985	101.25%
Direct Earned Premium for Colorado Health Insurance Business	$224,061,655	$5,377,479,714	100.00%
Authorized Control-level RBC	$10,306,835	$247,364,028	4.60%
Reserves On Hand	$25,160,990	$603,863,752	11.23%
Investment Income	$6,694,675	$160,672,195	2.99%
Net Income	$5,108,729	$122,609,500	2.28%
Surplus	$25,738,151	$617,715,632	11.49%
Capital	$20,896,208	$501,508,985	9.33%
Dividends to Stockholders	$8,983,249	$215,597,978	4.01%
Executive Compensation allocated to Colorado Premiums	$1,884,438	$45,226,506	0.84%
Executive Salaries	$692,051	$16,609,236	0.31%
Executive Stock Options	$680,316	$16,327,582	0.30%
Executive Bonuses	$512,070	$12,289,689	0.23%
Administrative Expenditures	$43,999,907	$1,055,997,774	19.64%
Advertising or Marketing Expenditures	$1,333,046	$31,993,097	0.59%
Charitable Contributions	$5,281,738	$126,761,707	2.36%
Dividends Returned to Colorado Policyholders	$33,857	$812,567	0.02%
Expenditures for Disease or Case Management Programs or Patient Education and Other Cost Containment Expenses	$5,107,139	$122,571,337	2.28%
Insurance Producer Commissions	$4,624,318	$110,983,627	2.06%
Legal Expenses	$161,913	$3,885,910	0.07%
Staff Salaries/Benefits	$8,606,686	$206,560,472	3.84%
Paid Lobbying Expenditures	$56,882	$1,365,175	0.03%
Federal Income Taxes	$7,596,616	$182,318,772	3.39%
State and Local Taxes, Licenses and Fees	$3,982,927	$95,590,251	1.78%
All Other Administrative Expenses	$7,214,786	$173,154,859	3.22%
The Cost of Providing or Arranging Healthcare Services	$196,009,693	$4,704,232,629	87.48%
Administrative Expenses[2]	$43,999,907	$1,055,997,774	19.64%
Medical Expenses[3]	$196,009,693	$4,704,232,629	87.48%
Provision for Profit and Contingencies	($15,947,945)	($382,750,689)	-7.12%

[1]The statistics presented are based on the data reported by the companies that responded to a request for information from the Colorado Division of Insurance as required by C.R.S. § 10-16-111(4). Companies were asked to report information on only major medical types of health insurance written in the state of Colorado. The Executive Salaries were reported by companies on a nationwide basis and were allocated to Colorado major medical health business by the Division of Insurance on a direct earned premium basis. The executives included are those reported on the Supplemental Compensation exhibit that accompanies the Annual Financial Statement.

[2]The total of Advertising or Marketing Expenditures, Charitable Contributions, Dividends Returned to Colorado Policyholders, Expenditures for Disease or Case Management Programs or Patient Education and Other Cost Containment Expenses, Insurance Producer Commissions, Legal Expenses, Staff Salaries, Paid Lobbying Expenditures, Federal Income Taxes, State and Local Taxes, Licenses and Fees and All Other Administrative Expenses is used to calculate the Administrative Ratio.

[3]Medical Expenses, or the Cost of Providing or Arranging Healthcare Services is equal to a companies Direct Losses Incurred and used to determine the Actual Benefits Ratio.

Major Medical Health Benefit Plans

Health Benefit Plans (Table shows numbers in thousands)	Individual On Exchange[1]	Individual Off Exchange[1]	Small Group On Exchange[1]	Small Group Off Exchange[1]	Large Group[1]	Total[1]
Premiums						
Colorado Direct Written Premium	$436,400	$746,453	$9,599	$1,003,462	$3,174,261	$5,370,175
Colorado Direct Earned Premium	$440,965	$748,156	$9,610	$1,003,435	$3,175,313	$5,377,480
Administrative Expenses[2]						
Administrative Expenses	$60,187	$111,849	$3,219	$123,013	$246,266	$544,534
The Cost of Healthcare Services						
Incurred Losses	$576,114	$752,262	$8,066	$756,397	$2,614,496	$4,707,335
Administrative Expenses Ratio	13.65%	14.95%	33.49%	12.26%	7.76%	10.13%
Medical Expenses Ratio	130.65%	100.55%	83.94%	75.38%	82.34%	87.54%
Average Provision for Profit and Contingencies	-44.30%	-15.50%	-17.43%	12.36%	9.91%	2.34%

Health Benefit Plans Covered Lives (Table shows actual numbers)	Individual On Exchange	Individual Off Exchange	Small Group On Exchange	Small Group Off Exchange	Large Group	Total
Number of Colorado covered lives as of 12/31/2014	109,197	241,893	2,414	211,168	687,356	1,252,028
Number of Colorado covered lives as of 12/31/2015	107,070	240,904	2,549	212,103	776,979	1,339,605
Number of Colorado individual subscribers/certificateholders/policy holders as of 12/31/2014	74,664	136,900	1,688	123,546	358,790	695,588
Number of Colorado individual subscribers/certificateholders/policy holders as of 12/31/2015	69,871	140,453	1,781	125,182	406,896	744,183
Number of Member Months in 2015	1,331,574	3,024,394	28,764	2,640,033	9,261,863	16,286,628
Companies with Earned Premiums	8	20	6	14	15	24

[1]values in thousands
[2]The total of Advertising or Marketing Expenditures, Charitable Contributions, Dividends Returned to Colorado Policyholders, Expenditures for Disease or Case Management Programs or Patient Education and Other Cost Containment Expenses, Insurance Producer Commissions, Legal Expenses, Staff Salaries, Paid Lobbying Expenditures, Federal Income Taxes, State and Local Taxes, Licenses and Fees and All Other Administrative Expenses is used to calculate Administrative Expenses.

Trend – Colorado Health Insurance

"Trend" or "trending" means any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing. 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. Information in this section represents an estimate of what portion of total trend each cost category that follows is responsible for. **The tables below demonstrate the number of companies that submitted Medical trend in the Health Cost Survey out of 28 companies.**

Medical Trend	Average Medical Trend due solely to Provider Price Changes	Average Medical Trend due solely to Utilization Changes	Average Medical Trend due solely to Cost-shifting	Average Medical Trend due solely to New Medical Procedures and Technology	Average Total Medical Trend
Individual on Exchange	10.51%	0.51%	0.79%	0.16%	11.59%
Individual off Exchange	5.86%	4.60%	1.53%	0.39%	12.39%
Small Group on Exchange	20.99%	8.29%	3.41%	0.00%	32.61%
Small Group off Exchange	5.81%	-2.53%	-0.51%	0.21%	3.00%
Large Group	5.21%	-3.13%	-1.67%	0.39%	3.85%

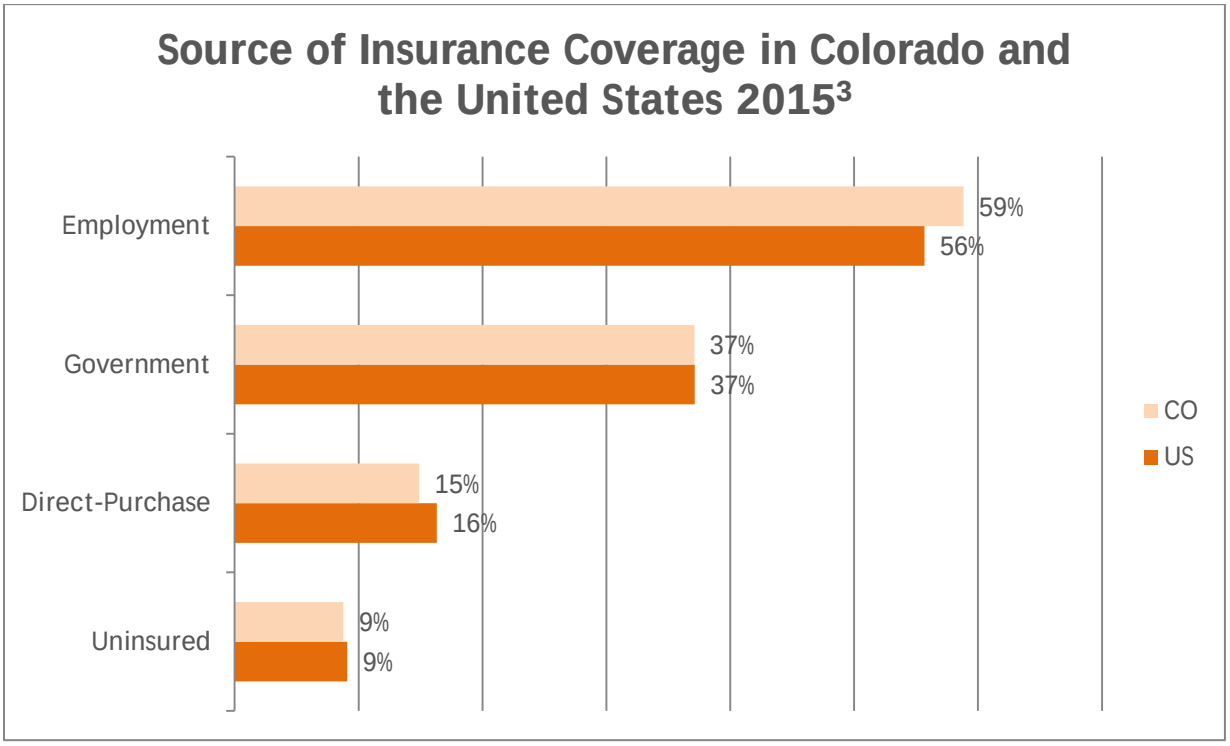
Pharmaceutical Trend	Average Rx Trend due solely to Pharmaceutical Price Changes	Average Rx Trend due solely to Utilization Changes	Average Rx Trend due solely to Cost-shifting	Average Rx Trend due solely to New Drugs	Average Total Rx Trend
Individual on Exchange	18.49%	2.13%	-0.97%	5.55%	23.84%
Individual off Exchange	14.42%	0.45%	1.31%	5.45%	18.63%
Small Group on Exchange	57.76%	-4.81%	1.07%	2.10%	46.47%
Small Group off Exchange	8.73%	-5.00%	1.87%	3.86%	6.88%
Large Group	10.7%	.67%	2.16%	4.49%	11.61%

2015 Colorado Health Benefit Plan Coverage Summary

Major Medical Health Coverage[1]	Earned Premium	Incurred Losses	Loss Ratio
Individual Coverage	$1,161,048,536	$1,329,664,949	114.52%
Small Group Coverage	$1,013,141,181	$767,688,370	75.77%
Large Group Coverage	$3,740,793,554	$3,141,910,275	83.99%
Colorado Totals	**$5,914,983,271**	**$5,239,263,593**	**88.58%**

2015 Colorado other Health Coverage Plan Summary

Other Health Coverages[2]	Written Premium	Earned Premium	Incurred Losses	Loss Ratio
Medicare Supplement	$67,073,740	$67,477,279	$47,456,694	70.33%
Title XVIII Medicare Advantage	$2,848,905,550	$2,820,605,122	$2,493,608,602	88.41%
Title XIX Medicaid	$374,089,347	$374,089,347	$340,407,126	91.00%
Other	$459,270,335	$290,224,909	$536,204,935	184.75%
Health Companies Total	**$3,749,338,972**	**$3,552,396,657**	**$3,417,677,357**	**96.21%**



[1]Data taken from all supplemental health exhibits submitted to the NAIC.
[2]Data taken from state filing pages submitted to the NAIC.
[3]Data taken from the US Census Current Population Survey. Insurance coverage is not mutually exclusive; people can be covered by more than one type of health insurance or have more than one health plan during a year.

COLORADO

Department of Regulatory Agencies

Division of Insurance

Health Insurance Cost Report

Appendix 2:

Definitions and Legislative History

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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.

March 2014 marked the fourth anniversary of the federal Affordable Care Act (ACA), which ushered in new consumer protections and benefits in health insurance that started in 2010. Major changes, including a requirement for most people to have health insurance and government subsidies to help many afford the costs, went into effect in 2014. Moreover, reforms adopted in Colorado in 2012 became effective at the beginning of 2014 including the establishment 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 2014 covering the top 95% of carriers in the Colorado market filing the Supplemental Health Exhibit with the National Association of Insurance Commissioners (NAIC), of which the Colorado Division of Insurance is a member. This is the most recent, complete and reliable data available given the timing of this report and its primary source. A significant portion of the data for this report was gathered from the carriers' Annual Financial Statements, which are filed in March; and the information gathered from the Colorado Health Cost Survey, completed in June of each year.

AFFORDABLE CARE ACT

Under the Affordable Care Act (ACA), most Americans were required to buy health insurance starting in 2014. Also in 2014, Medicaid expanded to serve more of the lowest-income Americans, and tax credits were granted to reduce the costs of private insurance for millions of lower and middle income families, primarily those lacking employer-sponsored insurance. As most people were required to buy insurance starting in 2014, insurance companies are no longer allowed to deny coverage to anyone based on pre-existing health status or conditions.

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, 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 uses its own exchange or uses the federal exchange, each 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, Coloradans are able to compare their coverage options and enroll in a plan that best fits their needs.

Beginning in October 2013, exchange services were available to Coloradans 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;
- Innovative plan options and central billing and payment for small employers.

Types of Healthcare and Market Division

Types of Healthcare Plans

• 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.

• 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.

• Flexible spending accounts or arrangements (FSAs, for healthcare) - 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 dependent care expenses, but those are different types of accounts and must be established separately from medical FSAs.

- 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.

- Health Savings Accounts (HSA) - Accounts offered by financial institutions, in coordination with high deductible health plans. These are similar to bank accounts, and provide a way for consumers to set aside pre-tax dollars to pay for the insurance premiums or medical expenses not covered by the health plan. If provided by an employer, 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.

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

- 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).

- 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.

Types of 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.

- 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.

Types of Health Insurance Plans Regulated by the State Government Through the Colorado Division of Insurance (DOI)

The Division of Insurance has primary regulatory authority over commercial health carriers in Colorado. This does not include self-insured employer health plans, Medicare or Medicaid, which are regulated by the federal government. There are four primary markets for health insurance that are subject to regulation by the Colorado DOI: the individual, the small group, and the large group markets as well as plans sold through the Connect for Health Colorado Marketplace. Each market operates under different regulations.

Individual Market

In Colorado, the Division of Insurance regulates the individual insurance market. Before 2014 carriers in the individual market were allowed to underwrite based on health status and there were fewer mandated benefits that were to 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.

EMPLOYER-PROVIDED INSURANCE

The group health plan market in Colorado is large, with all employer provided and bona fide association(association) provided health plans making up this sector. Employee benefit plans can be either fully insured or self-funded and either sold through the small group or large group markets. 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 by the DOI, and is subject to rules about mandated benefits, network adequacy, prompt payment of claims, etc.

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. Prior to 2014 they were defined as having no more than 50 employees down to and including business groups of one (BG-1s). Beginning January 1, 2015, this was redefined in Colorado to mean business groups of 2 to 50, as BG-1s were eliminated. After January 1, 2016, it means groups of two to one hundred. 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.

Large Group Market

A large group health plan is a fully insured health plan offered to employer groups of more than 100 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.

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 (the Insurance Commissioner is a non-voting member) with additional direction from a committee of state legislators, known as the Legislative Health Benefit Exchange Implementation Review Committee. The DOI does not regulate Connect for Health Colorado, but rather regulates the plans (individual and small group) sold through the Connect for Health Marketplace. Connect for Health Colorado began by selling plans that were effective January 1, 2014.

Types of Health Insurance Plans Regulated by the Federal Government

Self-Insured Plans

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 collect premiums and then pay the claims, but often hires a plan administrator to process the claims (also known as a third-party administrator or TPA). However, these employers have the ability to design their own plans. 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).

Some employers buy stop-loss insurance (also known as excess loss insurance) to limit the risk that they incur by having a self-insured health plan. This 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 *does* regulate stop-loss (excess loss) policies, but does not regulate the self-funded employer health plan that it insures.

Health First Colorado, Colorado's Medicaid Program

Medicaid is a federal 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.

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.

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 as establishing citizenship.

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 regulated by the Colorado DOI.

Senior Health Insurance Assistance Program (SHIP)

The Senior Health Insurance Assistance Program (SHIP) is not in itself a health plan. Instead it is a program within the Division of Insurance that helps people enrolled in Medicare, about to become eligible for Medicare, or caretakers of Medicare beneficiaries with questions about health insurance. SHIP provides free counseling. Topics addressed by the program include Medicare, Medicare supplement insurance (Medigap), Medicare Part D prescription drug plan coverage, Medicare HMOs also known as Medicare Advantage Plus, 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.

Regulatory Role of the Division of 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 in 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 a 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 & RATE REVIEW

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

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.

SUBMISSION 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 when the rates are changed on an existing product, even if the rate change only pertains to new business. In addition 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, they must submit a rate filing on at least an annual basis for continued appropriateness. These rate filings must contain detailed support as to why the assumptions continue to be appropriate

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, and collection 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. Many types of insurance allow File and Use on any rate filing that does not include a rate increase.

Colorado Medical Trend in Detail

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 trend 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, as more diagnostic imaging shifts from using older technologies such as x-rays to more advanced imaging such as MRIs, the overall costs rise much faster than inflation. This is because of the cost differential between an x-ray and an MRI. Even though there may not have been a large increase in the cost of x-rays or MRIs because the overall number of services has shifted to the more expensive technology overall price rises faster than inflation.

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: 1) provider price increases, 2) utilization changes, 3) cost shifting and 4) the introduction of new procedures and technology. In addition, these numbers will vary with benefit plan design.

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

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

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

Starting 2014, insurers that failed 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.

ADMINISTRATIVE EXPENSES

The administrative expenses of an insurer represent the cost of operating the business, including 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 each year. 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. 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.

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. Commercial insurers pay more for the services provided by doctors and hospitals 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.

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.

Medical and Hospital Expenses

A **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.

A **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.

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.

Net Underwriting Gain (or Loss)

Net underwriting gain (or 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 (or loss) is also known as underwriting income.

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 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.

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 – The process where only those at greater risk seek insurance. This drives prices up or availability down. For example, those with severe health problems want to buy health insurance, or people going to a dangerous place such as a war zone want to buy more life insurance. 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.

Association – see Bona fide association below

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.

Bona fide association – An association that offers health insurance coverage available to all association members without placing any restrictions or requirements around health insurance for membership status and has been actively in existence for at least five years. A Bona fide association may purchase insurance in the large group market.

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 other than non-payment of premium or fraud. 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 designed 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-cancellable - 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."