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."