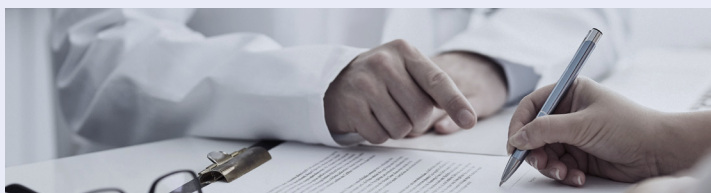


To make meaningful changes in health care policy, it is essential to understand the basics of health insurance in Colorado – especially when it comes to lowering premiums. CAHP supports efforts to lower health insurance premiums but believes it is crucial to understand the highly regulated marketplace that drives premium construction.



Premiums rates are reviewed annually by the Division of Insurance

Health insurance companies submit their rates for their products annually to the Division of Insurance (DOI) for intensive rate review process. Whether rates go up or down in a given year is dependent on the costs associated with offering a plan in Colorado and the determination of the DOI. The DOI reviews submissions to make sure rates are actuarially sound and justified, verifying that the rates allow a health insurer to be solvent and pay out the claims on behalf of its members.

Premiums rates are tied to geographic areas

The state is divided into nine geographic rating areas for individual and small group insurance. Each area is comprised of counties with similar health care costs so that areas with higher costs (more expensive hospitals and doctors) aren't subsidized by lower-cost areas.

Every health plan must meet network adequacy laws

In Colorado, all insurers are required to have enough physicians of all specialties, hospitals and pharmacies to provide care for health care services covered by their insurance. These laws require insurers to have a sufficient number, specialty type, and geographic distribution of providers to ensure all covered individuals have access to care without an "unreasonable delay."

Every health insurer must meet medical loss ratio requirements

For individual and small group plans, health insurers MUST spend at least 80% of every dollar on patient care or provide refunds to their members. For large group plans, health insurers must spend at least 85% of every premium dollar medical care or refund money to their members.

The costs of medical care depend on the contract between the insurer and provider

Insurers negotiate contractual rates with providers across the state. These negotiations must strike a balance between ensuring access for their consumers and contending with market pressures for higher reimbursement rates for health care services. In Colorado, there has been considerable market consolidation on the hospital/provider side, driving up health care costs since insurers have to meet network adequacy laws to offer a plan.

There are different types of health insurance markets

Everything in health insurance depends on the market, including the laws that govern it. Depending on the market, the Division of Insurance and/or the Colorado Legislature may or may not have authority to regulate it.

- 1. Individual** – covers one person including family members if applicable. They are paid for exclusively by the person covered by the plan. They are always regulated under Colorado law in Colorado.
- 2. Small Group** - cover businesses with up to 100 employees. Companies with more than 50 full-time employees MUST offer coverage to all of those full-time employees. Small group plans are regulated under Colorado law except if they opt to self-insure.
- 3. Large Group** - cover businesses with more than 100 employees. All full-time employees of companies with fully-insured plans MUST be offered coverage and can only be excluded if they have another plan (either an individual plan or if they are on a spouse's insurance plan). Some of these plans are regulated by Colorado law, but a large majority are self-insured.
- 4. Self-insured (ERISA)** - are usually managed by a large business that decides to take on the financial risk of covering its employees. The business sets up its own benefits design and pharmacy coverage. In these situations, an insurer is only the administrator of the plan. The business sets the rules and pays the medical bills directly rather than paying a premium to an insurer. These insurance plans are often known as ERISA plans because the plans are regulated under federal laws (including ERISA) rather than being regulated by the state. This means that many consumer protections provided for in Colorado law do not cover employees of self-insured plans.

There are certain essential health benefits required

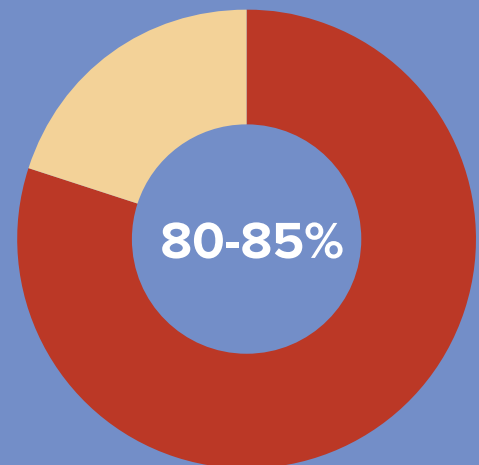
When the ACA passed, it included a list of benefit categories that were required coverage in every non-grandfathered health insurance plan. Those categories are:

1. Ambulatory Patient Services
2. Emergency Services Hospitalization
3. Maternity and Newborn Care
4. Mental Health and Substance Use Disorder Services
Including Behavioral Health Treatment
5. Prescription Drugs
6. Rehabilitative and Habilitative Services and Devices
7. Laboratory Services
8. Preventative and Wellness Services and Chronic Disease Management
9. Pediatric Services, Including Oral and Vision Care



To address high health insurance premiums, policymakers must recognize the following

1. Premiums reflect the cost of care and must be approved by the Division of Insurance.
2. Health plans are required to spend 80-85% of all premium dollars on medical care.
3. Because of laws that govern health insurance, premiums can only be significantly reduced in one of two ways: lowering unit costs for health care services or restructuring benefits.
4. About 75% of Coloradans are covered under self-insured plans or government plans (Medicaid, etc.) – neither of which are regulated by Colorado. That means any Colorado legislation or law ONLY affects about 25 percent of health plans in the state.



The percent of premium dollars health plans are required to spend on medical care