

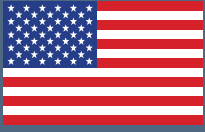


Health Insurance in Colorado

WHAT YOU NEED TO KNOW

The Colorado Association of Health Plans is committed to working with legislators to expand affordable health care coverage to all Coloradans. Policies to achieve that goal must take account of current federal and state laws that govern the industry and consider how proposals to change laws may impact the various insurance markets, and therefore Coloradans, differently.

HEALTH INSURANCE 101



FEDERAL



STATE

KEY TAKEAWAY: Laws passed at the state level will typically only affect about one-third of the commercial Colorado health insurance market (those with “CO DOI” on their health insurance card) because about two-thirds of the commercial Colorado health insurance market are self-insured or self-funded ERISA plans. Additionally, federal government programs and self-funded health plans are typically exempt from state regulation.

The Affordable Care Act (ACA) is the basis for most of the laws governing health insurance in Colorado. Federal laws, including the ACA, created the following insurance markets:

Health insurance is overseen by the Division of Insurance (DOI). The DOI has the authority to ensure compliance with the ACA and other state laws and regulations. Colorado’s health insurance marketplace is dominated by employer sponsored insurance plans. The DOI’s authority extends to:

INDIVIDUAL MARKET

Purchased on Connect for Health or off exchange



INDIVIDUAL MARKET

Purchased on Connect for Health or off exchange. Overseen by DOI

SMALL GROUP INSURED

1-50 employees or less



SMALL GROUP

Less than 100 employees. Overseen by DOI

LARGE GROUP INSURED

More than 50 employees



LARGE GROUP

More than 100 employees. Overseen by DOI

SELF-INSURED

Self-funded employee health benefits



SELF-INSURED

Subject to ERISA. No DOI Authority

MEDICAID

Also known as Health First Colorado (federal/state program for low income individuals and individuals with disabilities)



MEDICAID

Some aspects overseen by Department of Health Care Policy and Financing

CHILD HEALTH PLAN PLUS

Federal/state program for children in families who earn too much to qualify for Medicaid but not enough to buy private insurance and pregnant women



CHILD HEALTH PLAN PLUS

Some aspects overseen by Department of Health Care Policy and Financing

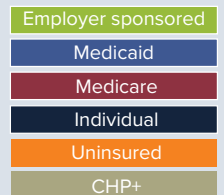
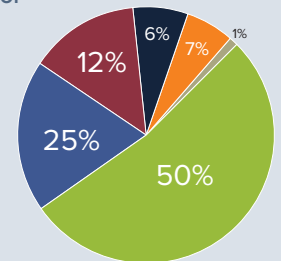
MEDICARE

Federal program for Americans 65 and older



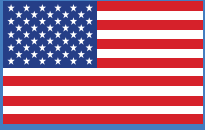
MEDICARE

No DOI Authority



Data from 2021 CHAS survey

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KEY TAKEAWAY: Additional coverage or benefit mandates at the state level impact and increase premium costs across the individual, small group insured and large group insured markets.

The ACA determined the **10 essential health benefits** (EHB) that all individual and small group plans must cover.*

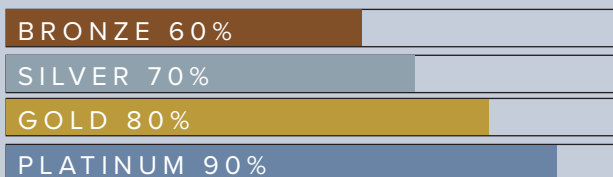
- Prescription Drugs
- Pediatric Services
- Preventive and Wellness Services and Chronic Disease Management
- Emergency Services
- Hospitalization
- Pregnancy, Maternity and Newborn Care
- Ambulatory Patient Services
- Laboratory Services
- Rehabilitative and Habilitative Services and Devices

*Insured large group plans are not required to cover EHBs, but may not impose annual and lifetime dollar limits on any EHBs that are offered.

KEY TAKEAWAY: Cost sharing amounts and actuarial values are set at the federal level and cannot be changed at the state level.

The ACA sets actuarial values (AV) and cost shares for health plans sold on the individual and small group markets. On average, the lower AV, the greater the cost sharing for the consumer. The ACA created four metal tiers:

- Bronze: 60% AV - insurance company pays **60% of medical costs, consumer pays 40%**
- Silver: 70% AV - insurance company pays **70% of medical costs, consumer pays 30%**
- Gold: 80% AV - insurance company pays **80% of medical costs, consumer pays 20%**
- Platinum: 90% AV - insurance company pays **90% of medical costs, consumer pays 10%** (Colorado no longer sells Platinum plans on the Exchange)



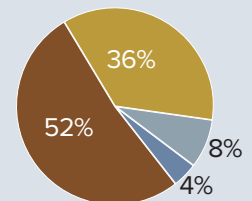
The federal government also sets the out of pocket maximum annually. **In 2025, it is \$9,200 for an individual and \$18,400 for a family.**

In Colorado, carriers must cover the **10 essential benefits** and others that have been added by lawmakers which include:

- Medically Necessary Bariatric Surgery Services
- Infertility Services (including artificial insemination, In-vitro fertilization and egg preservation services)
- Chiropractic Services
- Autism (including social and educational therapies for autism)
- Acupuncture care
- Medically necessary gender affirming care
- Annual mental health wellness exam
- In-vitro fertilization treatment & egg preservation (large group market only)
- Abortion services (large group)
- Sterilization services
- Pediatric coverage of neuropsychiatric syndrome
- Biomarker testing

In 2024, returning customers to Connect for Health Colorado who do NOT receive financial help, chose the following types of plans²:

- **4% chose catastrophic**
- **52% chose Bronze plans**
- **8% chose Silver plans**
- **36% chose Gold plans**



Bronze and Silver plans are often chosen because of lower monthly premiums which come with higher cost shares.

In 2024:

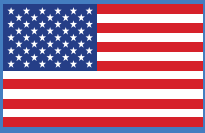
- Average monthly net premium after tax credits for customers receiving financial help: **\$133 per month.**³
- Average monthly net premium for customers not receiving financial help: **\$448 per month**⁴
- **Three out of five C4HCO customers could find a health plan for \$10 or less per month.**
- **77%** of the individuals purchasing insurance on Connect for Health Colorado receive financial help (i.e. federal subsidies or tax credits).

2. Connect for Health Colorado Open Enrollment Report 2024.

3. Ibid

4. Ibid

HEALTH INSURANCE 101



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KEY TAKEAWAY: The health insurance industry is the only part of the health care system with a medical loss ratio. Health plans CANNOT take savings from consumers to increase profits.

The ACA created the medical loss ratio (MLR) which requires insurance carriers to spend a percentage of every premium dollar on medical care or refund money to its customers.

- Individual market MLR: **80%**
- Small/large group markets MLR: **85%**

Rebates from MLRs are paid out to consumers based on a three-year average.

How are the rates of premiums determined?

In the spring, insurance carriers file proposals with the Division of Insurance (DOI) to offer different health plans in different regions of the state in the individual and small group markets for the following calendar year. The DOI reviews and approves the rates. Final rates are published in the fall. Open enrollment for plans sold on Connect for Health Colorado runs from November 1 to January 15 annually. The DOI reviews and approve member cost-sharing amounts and those cannot be later changed without DOI approval.

The projected rates are broken into three factors:

1. Projected medical expenses from claims
2. Administrative expenses including commissions and taxes
3. Profit and contingency factors

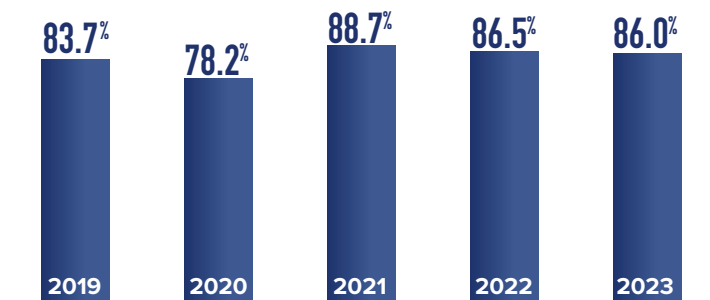
Health plans can only charge more for premiums based on four factors:

- Type of coverage (individual or family)
- Tobacco use
- Age
- Geographic rating area (there are nine geographic rating areas in Colorado)

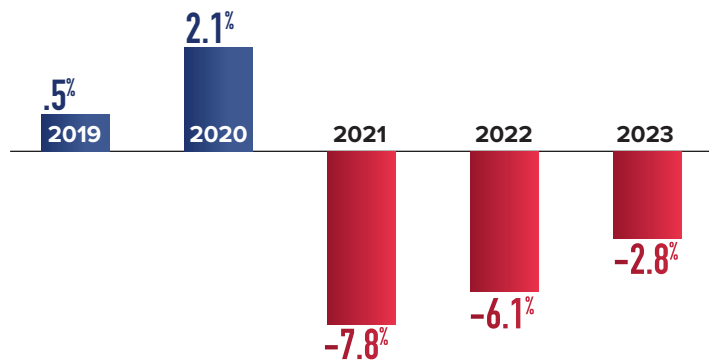
Other considerations for rate filings include:

- Minimum Actuarial Value Requirements
- Medical Loss Ratio
- Network Adequacy Standards
- Network Access Plans
- Limits on Out of Pocket Spending
- Colorado Option standardized plan requirements (beginning 2023)

Medical loss ratios 2019 - 2023



Profit margins 2019 - 2023



KEY TAKEAWAYS:

- Carriers submit hundreds of pages of rate filings to the DOI for approval before they can sell plans to consumers and rates must not be “excessive, inadequate or unfairly discriminatory.”
- Premium rates are a direct reflection of the prices for provider, hospital services and pharmaceuticals. If prices go up, premiums go up.
- There are two main ways to fundamentally reduce premiums:
 - 1) Lower prices for services and drugs;
 - 2) Reduce benefits.
- Self-insured plans subject to ERISA can be more affordable because EMPLOYERS have flexibility to choose benefits and coverage – these types of plans are not governed by state law and coverage is determined by **EMPLOYERS**, not carriers.