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2008 Health Insurance Market Report

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Executive Summary

Health insurance is an important issue for the people of Utah. Utah's residents receive their health insurance coverage through health plans sponsored by the government, employers, and commercial health insurers. The commercial health insurance market is the only source of health insurance directly regulated by the Insurance Department.

Approximately 61 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves approximately 32 percent of Utah residents. The typical policy in this industry is an employer group policy with a managed care plan administered by a domestic commercial health insurer.

A key function of the Insurance Department is to assist consumers with questions and concerns they have about insurance coverage. The Office of Consumer Health Assistance (OCHA) is the agency within the Insurance Department that handles consumer concerns about their health insurance. Based on the number of complaints received by OCHA, most Utah consumers are receiving good consumer service from Utah's commercial health insurers. For example, the numbers of consumer complaints received by the Insurance Department declined from 1999 to 2003, remained fairly constant during 2004 and 2005, and then declined again during 2006 and 2007. This is primarily due to efforts by OCHA's staff and the Utah health insurance industry to resolve consumer concerns before they rise to the level of a formal complaint. This is a positive trend for Utah consumers and the Utah health insurance industry.

Over the last nine years, there have been four significant trends in the comprehensive health insurance market that the Insurance Department continues to monitor: changes in the number of insurers, the cost of comprehensive health insurance, the number of Utah residents with comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers declined steadily from 1999 to 2003, and then remained fairly constant during 2004, with a slight increase during 2005 and 2006, followed by another slight decline during 2007. Most of this change was due to a decrease in the number of small foreign comprehensive health insurers participating in the comprehensive health insurance market during 1999 to 2003. In contrast, there has been little or no change in the number of medium to large comprehensive health insurers. Large domestic comprehensive health insurers account for more than 90 percent of the market and provide a solid pool of commercial health insurers. These insurers are financially solvent and provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market. The decline has affected a small portion of the marketplace and the number of large commercial health insurers offering comprehensive health insurance has remained stable since 1999.

Like the rest of the United States, Utah's comprehensive health insurance market is experiencing significant increases in the costs of health insurance. For example, the average premium per member per month increased from \$192 during 2006 to \$204 during 2007, an increase of 6.3 percent. This growth in premiums is being driven primarily by increases in the underlying cost of health care that commercial health insurers contract to pay for. For example,

the average losses per member per month increased from \$157 during 2006 to \$166 during 2007, an increase of 5.7 percent. Over the last nine years, increases in premium per member per month have averaged 9.2 percent per year, while increases in losses per member per month have averaged 7.8 percent per year. Overall, the data suggests that while premiums have fluctuated year to year, there is consistent pricing pressure on health care costs that has remained constant over the last nine years. These pricing pressures are not unique to Utah and are being driven by national health care trends that are affecting most states in a similar way. Although these increases are difficult, Utah's health insurance premiums appear to be lower than the national average. Based on data from the NAIC financial database, the average cost for comprehensive health insurance coverage was \$259 per member per month during 2007. Although this comparison does not control for differences in benefits, health status, or demographics, this national estimate is higher than the average in Utah's commercial market. However, the premium that consumers actually pay will differ from the market average depending on their individual circumstances.

During 1999 to 2007, the number of Utah residents covered by comprehensive health insurance has seen period of decline followed by periods of increase. Comprehensive health insurance membership declined the most from 1999 to 2003, and then remained fairly consistent during 2004, and then increased from 2005 to 2007. Based on the available information, the decline during 1999 to 2003 appears to be primarily due to a shift by large employers and other large group plans from commercial insurance to self-funding arrangements. However, recent increases in the uninsured and the number of residents covered by government sponsored health benefit plans may also be contributing factors.

During 2005 to 2007, comprehensive health insurers reported an increase in membership with most of this increase occurred during 2006. However, another significant increase occurred during 2007, with comprehensive health insurers reporting an increase of over 33,000 members, an increase of 3.9 percent. Most of the increase occurred among large group plans, with the remainder occurring among small group plans. Individual plans reported a slight decrease. As for plan types, increases were reported among every plan type except Health Maintenance Organization plans, which experienced a significant decline. This was due in part to a one-time restructuring of the market place. This restructuring has two components. First, nearly half of the increase was due to two new foreign insurers entering Utah's comprehensive health insurance market and acquiring new members, with most of the remaining increase occurring among the top three domestic insurers. Second, one of Utah's large domestic insurers, in response to market demands for products with more open provider networks, shifted a large block of business from Health Maintenance Organization plans (which have a more limited provider network) to Health Maintenance Organization with Point of Service features plans (which provide the option to use non-network providers but at a higher cost). This shift from Health Maintenance Organization plans to Health Maintenance Organization with Point of Service features plans appears to a response to market forces that were demanding insurance products with more open provider networks and the insurer responded to meet market demand. These are positive signs for the industry, particularly given the stress caused by the rising cost of health care. These changes suggest that Utah's comprehensive health insurance market is attractive and new insurers want to do business here and Utah's insurers are responsive to market forces and will change how they do business if the demand is there.

Over the last thirteen years the top insurers in the comprehensive health insurance industry have experienced an average financial gain of 1.59 percent. Commercial health insurers experienced significant losses from 1996 to 1998. However, company financials have improved since 1998, with the core of the industry experiencing an average financial gain of 2.58 percent over the last nine years, with financial gains of 4.34 percent during 2007. Overall, Utah's core commercial health insurers are financially solvent and have adequate reserves to cover health insurance claims. Utah's commercial health insurers are financially stable and are able to meet their financial obligations to consumers.

As requested by the Utah Legislature, the Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market. These recommendations are reported in the Appendix (see page 43). This year's report also includes new data on long-term care insurance and Medicare products.

Introduction

For most people, health insurance is essential for managing the costs of personal health care. Health insurance protects against the risk of financial loss that can occur from unexpected accidents and illnesses. It also provides a way for chronic health problems to be treated and managed in ways that many people could not otherwise afford. Because health insurance is so important to the citizens of Utah, it is in the interest of the State to monitor and maintain a stable health insurance industry.

An important purpose of the Insurance Department is to ensure that Utah has an adequate and healthy insurance market. The purpose of this report is to provide an annual evaluation of Utah's commercial health insurance market as required by Utah Code Annotated (U.C.A.) § 31A-2-201(7).

What is Health Insurance?

In general, health insurance transfers the risk of paying for personal health care from an individual to an entity that pools the risk. The individual shares in the management of his or her personal health care risk through the use of deductibles, coinsurance, and the health benefits provided by insurance. Individuals obtain their health benefits from one or more of three health insurance sources: government sponsored health benefit plans, employer sponsored self-funded health benefit plans, and commercial insurance health benefit plans. The health benefits provided by these plans will range from comprehensive major medical benefits to single disease or accident only benefits.

Government sponsored health benefit plans are government programs that provide health insurance benefits. These programs may be funded entirely by government funds or by a combination of government funds and premiums paid by the covered individuals enrolled in the program. The risk of financial loss is borne by the government. These programs may provide comprehensive major medical health insurance benefits (such as Medicaid and Medicare), limited primary health insurance benefits (such as county health clinics), or limited specialized health insurance benefits (such as Wee Care).

Employer sponsored self-funded health benefit plans are plans sponsored by an employer to provide health insurance benefits to the employer's employees. These plans may be funded entirely by the employer or by a combination of employer funds and amounts withheld from covered employees' wages. The risk of financial loss is borne by the employer. However, most self-funded plans purchase commercial stop loss coverage for added protection. These plans usually provide comprehensive major medical health insurance benefits, and may provide benefits only to the employee or to the employee and the employee's dependents.

Commercial insurance health benefit plans are plans marketed by an insurance company to provide health insurance benefits to insured persons. These plans are funded by the premiums collected from insured employers and individuals. The risk of financial loss is borne by the insurance company. Commercial insurance benefit plans can be issued as fee for service plans (such as Western Mutual Insurance Company), nonprofit health service plans (such as Regence

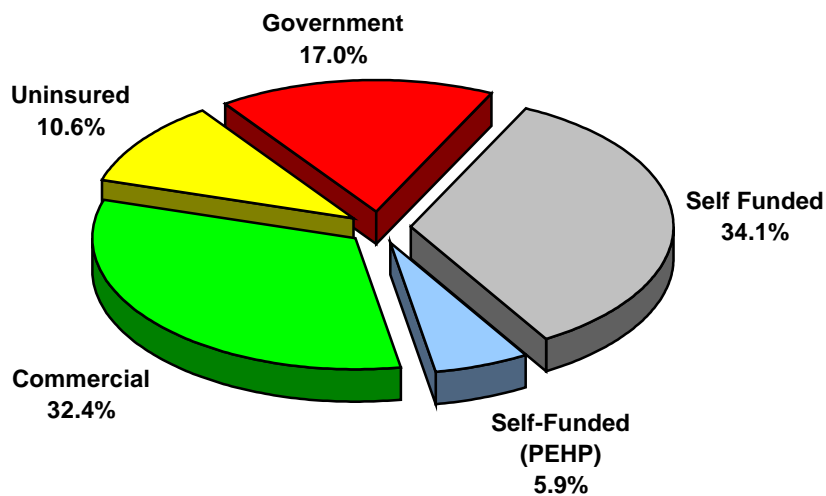
Blue Cross Blue Shield of Utah), health maintenance organizations (such as SelectHealth, Inc.), and limited health plans (such as Delta Dental Care of Utah). The health insurance benefits provided will vary from comprehensive major medical health insurance to specified limited health insurance benefits such as dental, vision, or specified disease.

Each of these three sources of health insurance is regulated by a different set of laws and government programs. Government sponsored health benefit plans are regulated by Federal regulatory agencies like the Centers for Medicare and Medicaid Services (CMS). Employer sponsored self-funded health benefit plans are regulated for the most part under the Federal ERISA statute through the Department of Labor (DOL), the Centers for Medicare and Medicaid Services (CMS), and the Internal Revenue Service (IRS). Commercial health insurance is governed by state and federal law and is regulated by state insurance departments. This report focuses on the commercial health insurance market regulated by the Insurance Department.

Estimate of Health Insurance Coverage in Utah

As mentioned previously, health insurance comes from three sources: government, employers, and commercial insurers. The Insurance Department has attempted to estimate how much of the state is insured by each source of health insurance. The estimate is for comprehensive health insurance coverage only (also known as major medical). A general overview of the department’s estimate is shown below in Figure 1 (see Table 1 for details).

Figure 1. Estimate of Health Insurance Coverage for 2007



Data Sources: Centers for Medicare & Medicaid Services, Deseret Mutual Benefit Administrators, Utah Comprehensive Health Insurance Pool, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the Utah Population Estimates Committee.

Note: The estimate of the 2007 employer sponsored self-funded membership is based on limited data from commercial insurers and employers. It is not a complete count of the self-funded membership in Utah and should be used with caution. Estimates may not total exactly due to rounding and differences in methodology.

Caution should be used interpreting these results, however, as multiple data sources with differing methods were required to create this estimate. For example, membership data for government sponsored health benefit plans was obtained from the Utah Department of Health and the Centers for Medicare and Medicaid Services (CMS). Membership data for commercial health insurance was obtained from the Utah Accident & Health Survey, a survey conducted annually by the Insurance Department.

The estimate for the uninsured was obtained from the Utah Health Status Survey. This survey is believed to be a more accurate estimate of the uninsured in Utah than the Census Bureau estimates developed from the Current Population Survey. The Current Population Survey tends to overestimate the number of uninsured in small states like Utah. The Utah Health Status Survey has a larger sample size and is a better measure of the uninsured for Utah.

Finally, membership for employer sponsored self-funded benefit plans was estimated using the best information available to the Insurance Department. Currently, there is no single source of self-funded membership data for Utah. As a result, a “best guess” estimate was created using a combination of membership data obtained from government sponsored plans, large self-funded employers, commercial health insurers who administer self-funded health benefit plans, and data from the Utah Health Status Survey. The result is imperfect, but it does provide an estimate of the self-funded population.

Given these limitations, the Insurance Department estimates that seventeen percent of Utah residents were covered by government plans, forty percent were covered by self-funded plans, thirty-two percent were covered by commercial health insurance, and ten point six percent were uninsured (see Table 1).

Table 1. Estimate of Health Insurance Coverage for 2007

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans	458,468	17.0%
Medicare	252,572	9.4%
Medicaid	159,849	5.9%
Children’s Health Insurance Program (CHIP)	24,747	0.9%
Primary Care Network (PCN)	17,795	0.7%
Utah Comprehensive Health Insurance Pool (HIPUtah)	3,505	0.1%
Employer Sponsored Self-Funded Plans	1,078,031	40.0%
Plans Administered by Commercial Insurers	502,657	18.6%
Public Employee Health Program (PEHP)	159,460	5.9%
Federal Employee Health Benefit Plan (FEHBP)	91,547	3.4%
Other Known Self-Funded Plans	60,878	2.3%
Other Self-Funded Plans (Estimated)	263,489	9.9%
Commercial Health Insurance Plans	875,855	32.4%
Group	731,611	27.1%
Individual	144,244	5.3%
Uninsured	287,200	10.6%
Total	2,699,554	100.0%

Data Sources: Centers for Medicare & Medicaid Services, Deseret Mutual Benefit Administrators, Utah Comprehensive Health Insurance Pool, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the Utah Population Estimates Committee.

Note: The estimate of the 2007 employer sponsored self-funded membership is based on limited data from commercial insurers and employers. It is not a complete count of the self-funded membership in Utah and should be used with caution. Estimates may not total exactly due to rounding and differences in methodology.

Utah's Commercial Health Insurance Market

Commercial insurers are companies in the business of managing risk. They accept the risk of loss to individuals or organizations in exchange for a premium. In doing so, the risk of loss is shared (or pooled) so that any one individual does not bear all the risk of loss.

Insurance companies report financial data to the Insurance Department and the National Association of Insurance Commissioners (NAIC) on the health insurance business written in Utah. Health insurance premium data includes premiums from individual and group policyholders and from government sponsored programs such as Medicare and Medicaid. The premium reported does not include fees paid to insurers for administration of self-funded health benefit plans.

One measure of a commercial insurer's financial health is the ratio of incurred losses to premiums earned. This ratio is called a loss ratio. A ratio of less than 100 indicates that an insurance company received more premium income than it paid out in claims. A ratio of more than 100 indicates that a company paid more in claims than it received in premium income. While the benchmarks vary depending on the type of insurance, commercial health insurers generally try to maintain a loss ratio of less than 85 (85 cents of losses for every dollar of premium). If the loss ratio increases much beyond 85, an insurer may have more expenses than income and suffer a financial loss.

Commercial Health Insurance Market Overview

Among commercial health insurers there is a broad universe of "health insurance" products. Commercial health insurance may include comprehensive health insurance, as well as insurance products that cover a specialized category such as long-term care, dental, vision, disability, accident, specified disease, or as a supplement to other kinds of health benefit plans.

There were 1,441 commercial insurers licensed with the Insurance Department at the end of 2007. Of these, three hundred and fifty-one commercial insurers reported commercial health insurance business in Utah on their 2007 annual financial statements. These insurers represent all of the commercial health insurance sold in Utah. Each commercial insurer reported direct premium and losses in Utah, as well as total revenue and net income for their company.

Table 2 summarizes some of the characteristics of Utah's commercial health insurance market that can be obtained from annual financial statements. Utah's commercial health insurance market is highly concentrated among nine commercial health insurers, which represent nearly 69 percent of the market. As a group, Utah's commercial health insurers had a loss ratio of 80 and net income of 6.52 percent (see Table 2). While looking at the loss ratio does give an accurate view of Utah's commercial health insurance market, net income (at this level) does not. In this case, net income is not a good measure of the financial health of Utah's market as less than one percent of total revenues reported were in Utah. A more accurate view is obtained by looking at state of domicile.

Domestic insurers have a home office in Utah. Foreign insurers have a home office in another state. Approximately 71 percent of Utah’s commercial health insurance market is domestic. These 23 domestic insurers are much more representative of the Utah market as more than 70 percent of their total revenue comes from Utah business. Thus, their loss ratios and net income are a much more accurate measure of the Utah market. As a group, domestic insurers had a loss ratio of 83 and net income of –1.77 percent. Nine commercial health insurers represent approximately 97 percent of Utah’s domestic market. The remaining three percent of the domestic market consists of life insurers and limited health plans.

There are 328 foreign insurers in Utah’s commercial health insurance market, most of which are life insurers. These foreign insurers account for approximately 29 percent of Utah’s market. Foreign insurers had a loss ratio of 73 for Utah business. Net income was 6.55 percent, but a negligible amount of total revenue (just over 0.01 percent) was from Utah business and is, therefore, not representative of Utah (see Table 2). Overall, foreign insurers have a small presence in Utah’s health insurance market.

Table 2. Total Commercial Health Insurance Market by Insurer Type for 2007

Insurer Type	Company Count	Utah Operations			National Operations	
		Direct Earned Premium	Market Share	Loss Ratio	Total Revenue	Net Income (% Rev)
Domestic Insurers						
Health	9	\$2,356,796,900	68.75%	83.17	\$2,416,990,175	4.07%
Life	11	\$60,878,439	1.78%	75.96	\$999,308,829	-15.93%
Limited Health Plan	3	\$4,812,398	0.14%	56.80	\$4,872,645	5.80%
Total Domestic	23	\$2,422,487,737	70.67%	82.94	\$3,421,171,649	-1.77%
Foreign Insurers						
Fraternal	13	\$624,397	0.02%	42.22	\$10,098,174,966	13.62%
Life	276	\$952,368,473	27.78%	72.18	\$609,712,034,607	5.35%
Property & Casualty	39	\$52,407,236	1.53%	91.47	\$107,759,944,388	12.70%
Total Foreign	328	\$1,005,400,106	29.33%	73.16	\$727,570,153,961	6.55%
Utah Insurers						
Fraternal	13	\$624,397	0.02%	42.22	\$10,098,174,966	13.62%
Health	9	\$2,356,796,900	68.75%	83.17	\$2,416,990,175	4.07%
Life	287	\$1,013,246,912	29.56%	72.40	\$610,711,343,436	5.32%
Limited Health Plan	3	\$4,812,398	0.14%	56.80	\$4,872,645	5.80%
Property & Casualty	39	\$52,407,236	1.53%	91.47	\$107,759,944,388	12.70%
Total Utah	351	\$3,427,887,843	100.00%	80.07	\$730,991,325,610	6.52%

Data Source: NAIC Financial Database

Note: The total direct earned premium and total revenue reported here is based the annual financial statement data submitted by commercial insurers to the National Association of Insurance Commissioners (NAIC).

Commercial Health Insurance Market by Policy Type

Financial statement data is designed to measure the financial solvency of commercial insurers. As such, it is not designed to provide detailed information on a particular type of insurance. To compensate for this, Utah’s commercial health insurers are required to participate in the Utah Accident & Health Survey. This survey collects data about the various types of health insurance in greater detail than the annual statement. Data was collected from 351 commercial health insurers who reported accident & health premium in Utah for 2007.

The top three policy types by market share were comprehensive health insurance (61 percent), Medicare Advantage products (10 percent), and the Federal Employee Health Benefit Plan (FEHBP) (8 percent)(see Table 3). The results of the survey differ slightly from the total accident & health reported on the 2007 annual statement. However, the difference is small. The net difference in total reported direct earned premium is less than 0.01 percent.

Table 3. Total Commercial Health Insurance Market by Policy Type for 2007

Policy Type	Company Count^a	Member Count^b	Direct Earned Premium	Market Share	Loss Ratio
Comprehensive	74	875,855	\$2,100,879,121	61.28%	81.10
Medical Only	41	10,690	\$2,717,430	0.08%	75.25
Medicare Supplement	82	53,783	\$98,979,536	2.89%	74.42
Medicare Advantage	11	47,509	\$357,897,591	10.44%	79.66
Medicare Part D (Pharmacy)	17	77,279	\$93,857,760	2.74%	86.10
Dental	80	729,631	\$142,981,351	4.17%	89.22
Vision	32	233,438	\$9,205,610	0.27%	57.62
FEHBP	5	64,142	\$285,179,641	8.32%	93.87
Medicare	4	1,452	\$6,034,916	0.18%	92.08
Medicaid	4	23	\$1,525	< 0.01%	NA
Stop Loss	38	240,536	\$74,570,845	2.18%	58.14
Disability Income	161	530,450	\$103,384,426	3.02%	71.63
Long-Term Care	82	37,675	\$42,456,985	1.24%	32.27
Credit A&H	36	138,094	\$13,667,982	0.40%	21.65
Other	217	-	\$96,479,700	2.81%	58.20
Total	351	-	\$3,428,294,419	100.00%	79.98

Data Source: Utah Accident & Health Survey

Note: The Federal Employee Health Benefit Plans (FEHBP), Medicare, and Medicaid business reported here includes some health benefit plans that are not fully insured as NAIC accounting rules allow certain types of administrative business to be reported on the state page of the annual statement. These categories are included here to ensure that the accident & health business being reported in the Utah Accident & Health Survey is consistent with the accident & health business being reported on the Utah state page of the NAIC annual statement.

^a Company count column does not add up to total because an insurer may have more than one policy type.

^b A total is not reported for the column “Member Count” and for “Other.” A sum total of the membership counts of all types of health insurance would overestimate the actual number of persons covered by commercial health insurance due to uncontrolled double counting of members.

Consumer Complaints Against Commercial Health Insurance Companies

A key function of the Insurance Department is to assist consumers with questions and concerns that they have about commercial health insurance coverage. The primary agency within the Insurance Department that assists consumers with health insurance issues is the Office of Consumer Health Assistance (OCHA).

OCHA seeks to provide a variety of needed services to health care consumers and policymakers, including (but not limited to):

- Assisting consumers in understanding their contractual rights and responsibilities, statutory protections and available remedies under their health plan
- Providing health care consumer education (producing, collecting, disseminating educational materials; conducting outreach programs and other educational activities)
- Investigating and resolving complaints
- Assistance to those having difficulty accessing their health care plan because of language, disability, age, or ethnicity
- Providing information and referral to these persons as well as help with initiating a grievance process
- Analyzing and monitoring federal and state regulations that apply to health care consumers

OCHA processes more than 6,000 consumer inquiries each year (see Table 4). These inquiries range from simple questions about how to obtain health insurance coverage to complaints against a particular health insurance company.

Table 4. Estimated Number of Consumer Inquiries Handled by OCHA Staff: 1999 - 2007

Consumer Inquiries^a	1999	2000	2001	2002	2003	2004	2005	2006	2007
Telephone (in/out)	6,234	14,108	14,886	11,535	10,054	9,213	8,633	7,125	5,180
Walk-in	38	67	27	36	75	83	43	33	16
Other (in/out)	172	63	516	682	999	1,217	736	616	825
Total Inquires	6,444	14,238	15,429	12,253	11,128	10,513	9,412	7,774	6,021

Data Source: Utah Insurance Department

^a The Office of Consumer Health Assistance (OCHA) was created July 1, 1999. Data reported here is only for consumer inquiries received after the creation of OCHA.

When a consumer inquiry involves a possible violation of the Utah Insurance Code by a commercial health insurance company, OCHA encourages consumers to file a written complaint. Once a written complaint is received, OCHA conducts an investigation and seeks to resolve the consumer complaint. OCHA tracks all written complaints made against commercial health insurers. These complaints are classified into three types: justified, question of fact, and unjustified (see Table 5).

Justified complaints. Justified complaints are those where the Insurance Department rules in favor of the consumer making the complaint. The Insurance Department determines that the complaint is warranted under the law and resolves the complaint by requiring the commercial health insurer to act to correct the problem.

Question of fact complaints. Question of Fact complaints are those where the complaint appears to be legitimate, but the Insurance Department was unable to make a ruling, either because there are unresolved questions about the facts of the case or because the department does not have the legal authority to do so. These complaints usually must be resolved by arbitration, mediation, or litigation.

Unjustified complaints. Unjustified complaints are those where the Insurance Department rules in favor of the commercial insurer as the insurer was judged to be acting within the bounds of the law. The Insurance Department educates consumers as to their rights under the law and how health insurance contracts work.

As shown in Table 5, the total number of complaints declined steadily from 1999 to 2003, remained relatively constant during 2004 and 2005, and declined again in 2006 and 2007. The number of justified complaints has remained relatively stable from 1999 to 2006, except for 2001, where the number of justified complaints was much higher than the trend, and 2007, where the number of justified complaints declined significantly compared to previous years. The number of unjustified complaints has also remained fairly constant over time, but also declined slightly during 2007. The most significant change over time has been in the number of question of fact complaints, which have declined significantly since 1999. This trend towards fewer complaints is primarily due to an active effort by OCHA staff and the Utah health insurance industry to resolve consumer concerns before they rise to the level of a formal written complaint. This is a positive trend for the industry.

Table 5. Complaints Filed with OCHA by Type: 1999 - 2007

Year	Total		Justified		Question of Fact		Unjustified	
	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
1999	326	100.0%	70	21.5%	179	54.9%	77	23.6%
2000	244	100.0%	70	28.7%	123	50.4%	51	20.9%
2001	258	100.0%	127	49.2%	36	14.0%	95	36.8%
2002	174	100.0%	73	42.0%	27	15.5%	74	42.5%
2003	120	100.0%	54	45.0%	7	5.8%	59	49.2%
2004	135	100.0%	45	33.3%	20	14.8%	70	51.9%
2005	122	100.0%	39	32.0%	25	20.5%	58	47.5%
2006	107	100.0%	39	36.4%	10	9.3%	58	54.2%
2007	72	100.0%	18	25.0%	9	12.5%	45	62.5%
Average	173	100.0%	59	34.3%	53	27.9%	65	37.8%

Data Source: Utah Insurance Department

Note: Percentages may not total exactly due to rounding

In addition to tracking the number of written complaints and how they are resolved, the Insurance Department also tracks the reason for the complaint. As shown in Table 6, on average, more than sixty percent of all consumer complaints are due to claim handling issues, while policyholder services and marketing & sales issues account for the remainder (see Table 6).

Table 6. Complaints Filed with OCHA by Reason: 1999 – 2007

Year	Total ^a		Claim Handling		Policyholder Services		Marketing & Sales	
	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
1999	326	100.0%	218	66.9%	80	24.5%	28	8.6%
2000	244	100.0%	163	66.8%	31	12.7%	50	20.5%
2001	265	100.0%	174	65.7%	74	27.9%	17	6.4%
2002	175	100.0%	125	71.4%	44	25.1%	6	3.4%
2003	120	100.0%	77	64.2%	39	32.5%	4	3.3%
2004	136	100.0%	65	47.8%	57	41.9%	14	10.3%
2005	124	100.0%	71	57.3%	44	35.5%	9	7.3%
2006	107	100.0%	56	52.3%	35	32.7%	16	15.0%
2007	72	100.0%	18	25.0%	9	12.5%	45	62.5%
Average	174	100.0%	107	61.5%	46	26.4%	21	12.1%

Data Source: Utah Insurance Department

^a A complaint may have more than one reason code, so totals may be slightly higher than the actual number of complaints.

Note: Policyholder Services includes complaints regarding policyholder services and underwriting practices. Percentages may not total exactly due to rounding.

Complaint ratios. Another measure of complaint activity is the complaint ratio. A complaint ratio is a measure of how many consumer complaints were received compared to the amount of business a commercial health insurer did in the state. Table 7 reports the average complaint ratios for the commercial health insurance market from 1999 to 2007 (see Table 7). Each complaint ratio reports the number of complaints per \$1,000,000 in total direct earned premium. For example, a ratio of 1 means the insurer had 1 complaint for every \$1,000,000 in premium.

Table 7. Complaint Ratios for the Commercial Health Insurance Market: 1999 – 2007

Year	Direct Earned Premium	Total		Justified		Question of Fact		Unjustified	
		Count	Ratio	Count	Ratio	Count	Ratio	Count	Ratio
1999	\$1,887,679,133	326	0.17	70	0.04	179	0.09	77	0.04
2000	\$2,053,470,759	244	0.12	70	0.03	123	0.06	51	0.02
2001	\$2,171,040,169	258	0.12	127	0.06	36	0.02	95	0.04
2002	\$2,181,743,936	174	0.08	73	0.03	27	0.01	74	0.03
2003	\$2,180,896,901	120	0.06	54	0.02	7	< 0.01	59	0.03
2004	\$2,210,803,474	135	0.06	45	0.02	20	0.01	70	0.03
2005	\$2,429,487,633	122	0.05	39	0.02	25	0.01	58	0.02
2006	\$3,017,726,661	107	0.04	39	0.01	10	< 0.01	58	0.02
2007	\$3,427,887,843	72	0.02	18	0.01	9	< 0.01	45	0.01
Average	\$2,395,637,390	173	0.07	59	0.02	48	0.02	65	0.03

Data Sources: NAIC Financial Database and Utah Insurance Department

As discussed previously, the Insurance Department has seen a decline in the total number of complaints from 1999 to 2003, remaining fairly constant during 2004 and 2005, and declined again in 2006 and 2007. This is primarily due to a decline in the number of question of fact complaints as part of a concerted effort by OCHA staff and the Utah health insurance industry to reduce the number of these kinds of complaints.

However, the number of justified and unjustified complaints has remained fairly constant, and this should be taken into account when looking at the pattern of the complaint ratios. As Table 7 shows, the average complaint ratio for the commercial market is about 0.07 for all complaints, and about 0.02 for each complaint type. Using this average as a benchmark, the complaint ratios for 2007 are lower than their nine-year average.

Table 8 reports individual complaint ratios for commercial health insurance companies during 2007. The averages in Table 7 can be used to give perspective to these individual ratios. For example, a commercial health insurer with a justified complaint ratio of greater than 0.02 has a higher than average number of complaints, while a ratio of less than 0.02 means a lower than average number of complaints. It is also important to remember that a complaint ratio is only one aspect of evaluating a commercial health insurance company (see Table 8).

Table 8. Commercial Health Insurance Companies with Consumer Complaints during 2007

Company Name	Direct Earned Premium	Market Share	Total ^a		Justified		Question Of Fact	
			Count	Ratio	Count	Ratio	Count	Ratio
Aetna Life Ins Co	\$51,747,841	1.51%	1	0.02	-	-	1	0.02
Altius Hlth Plans Inc	\$356,150,178	10.39%	5	0.01	-	-	2	0.01
American Family Life Assur Co of Col	\$26,597,224	0.78%	1	0.04	1	0.04	-	-
American Heritage Life Ins Co	\$1,864,773	0.05%	1	0.54	-	-	-	-
Bankers Fidelity Life Ins Co	\$3,430,565	0.10%	1	0.29	-	-	-	-
Bankers Life & Cas Co	\$5,363,204	0.16%	2	0.37	1	0.19	-	-
Cigna Hlthcare of UT Inc	\$4,194,362	0.12%	1	0.24	-	-	-	-
Conseco Hlth Ins Co	\$4,162,523	0.12%	1	0.24	1	0.24	-	-
Conseco Senior Hlth Ins Co	\$1,318,741	0.04%	1	0.76	-	-	-	-
Cuna Mut Ins Society	\$8,054,407	0.23%	2	0.25	-	-	-	-
Fidelity Security Life Ins Co	\$2,793,739	0.08%	1	0.36	-	-	1	0.36
Great W Life & Ann Ins Co	\$6,277,028	0.18%	1	0.16	-	-	1	0.16
Hartford Life & Accident Ins Co	\$25,602,421	0.75%	1	0.04	-	-	-	-
Humana Ins Co	\$146,263,807	4.27%	1	0.01	1	0.01	-	-
John Hancock Life Ins Co	\$2,491,310	0.07%	1	0.40	-	-	-	-
Mega Life & Hlth Ins Co The	\$9,901,230	0.29%	4	0.40	1	0.10	-	-
Metropolitan Life Ins Co	\$39,707,331	1.16%	3	0.08	-	-	-	-
Mutual Of Omaha Ins Co	\$6,837,041	0.20%	1	0.15	-	-	1	0.15
Pacificare Life & Hlth Ins Co	\$9,959,555	0.29%	1	0.10	-	-	-	-
Penn Treaty Ntwrk Amer Ins Co	\$1,252,774	0.04%	1	0.80	-	-	-	-
Regence BCBS of UT	\$888,649,254	25.92%	11	0.01	3	< 0.01	-	-
SelectHealth Inc	\$912,704,059	26.63%	4	< 0.01	1	< 0.01	-	-
Time Ins Co	\$4,561,979	0.13%	1	0.22	1	0.22	-	-
United American Ins Co	\$13,751,654	0.40%	6	0.44	2	0.15	3	0.22
United Healthcare Ins Co	\$185,888,194	5.42%	12	0.06	3	0.02	-	-
United Teacher Assoc Ins Co	\$2,178,054	0.06%	1	0.46	1	0.46	-	-
Unum Life Ins Co Of Amer	\$9,615,434	0.28%	1	0.10	-	-	-	-
Top 27 companies with complaints ^b	\$2,731,318,682	79.68%	67	0.02	16	0.01	9	< 0.01
Remaining 5 companies with complaints ^c	\$1,603,756	0.05%	5	3.12	2	1.25	-	-
Companies without complaints	\$694,965,405	20.27%	-	-	-	-	-	-
Total Commercial Market	\$3,427,887,843	100.00%	72	0.02	18	0.01	9	< 0.01

Data Sources: NAIC Financial Database and Utah Insurance Department.

^a Total complaints includes Justified, Question of Fact, and Unjustified. Unjustified are not shown separately.

^b Describes all companies with at least \$1,000,000 in total direct earned premium.

^c Separate complaint ratios were not calculated for companies with less than \$1,000,000 in total direct earned premium because it produces distorted ratios that cannot be directly compared to other companies.

Utah's Comprehensive Health Insurance Market

Comprehensive health insurance makes up approximately 63 percent of the commercial health insurance market in the state of Utah (see Table 3) and affects approximately 32 percent of Utah residents (see Table 1). It is the only type of major medical health benefit plan directly regulated by the Insurance Department. The following analysis of the comprehensive market examines various aspects of the market including state of domicile, group size, health benefit plan type, and market trends.

Comprehensive Market by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state. Domestic insurers generally have a larger presence in their state of domicile than foreign insurers. Their local status may assist them in negotiating more favorable provider contracts and creating larger provider networks than foreign insurers.

Approximately 88 percent of the comprehensive health insurance market is served by domestic insurers and is highly concentrated among 12 insurers. Sixty-two foreign insurers represent the remaining market share. Premiums for domestic and foreign insurers were nearly identical with \$204 per member per month for domestics and \$203 per member per month for foreign. Loss ratios were lower for foreign insurers (see Table 9).

Table 9. Total Comprehensive Market by Domicile for 2007

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM ^a
Domestic	12	766,683	\$1,850,891,435	88.10%	82.16	\$204
Foreign	62	109,172	\$249,987,686	11.90%	73.27	\$203
Total	74	875,855	\$2,100,879,121	100.00%	81.10	\$204

Data Source: Utah Accident & Health Survey

^a Direct earned premium per member per month

Comprehensive Market by Group Size

Comprehensive health insurance plans are sold either as an individual, a group, or a conversion policy. Individual policies are sold directly to individual consumers. In contrast, group policies are sold as a single contract to a group of individuals, such as a group of employees. Groups with 2 to 50 employees are classified as small employer groups. Groups with 51 or more employees are classified as large employer groups. Conversion policies are sold to individuals whose eligibility for a group policy ended and who "converted" their group policy membership to an individual policy. Conversion policies are typically classified as individual policies.

Group policies reported higher premium per member per month (\$219) than individual policies (\$133). This is probably due to differences in underwriting practices. In individually underwritten policies, insurers have more ability to set rates based on health criteria. As a result, sicker individuals who would incur higher medical costs would be given policy offers with higher premiums than healthier individuals. However, less expensive policies are more likely to be issued than expensive ones. So the individual market's lower premium may reflect the tendency for healthier individuals to get and accept more affordable health insurance coverage.

In the case of small employer groups, policies are underwritten based on the health status of the group rather than the individual, with each group containing both healthy and sick individuals. However, because the group is small (between 2 to 50 members) the health status of an individual person can have a significant impact on rating. Rates are based on the initial health status of the group, but can change at the annual renewal if the health status of the group declines. Small groups can experience rate increases of up to 15 percent at renewal due to changes in health status. Additional increases are also imposed due to changes in the group's demographics and increasing costs of health care.

In contrast, large group policies are typically underwritten without taking individual health status into account. Each group is a mix of healthy and sick individuals, and the larger the group, the less impact the health status of an individual person can have on costs. However, because less underwriting is used, sicker individuals may freely enter the group, which can increase the overall cost of the group. Thus, medical claims costs tend to be higher and policyholders are charged higher premiums to pay for these additional costs. However, large group premiums tend to be less expensive for sick individuals compared to what they would pay if they were underwritten in the individual or small group markets.

Conversion policies had the highest premium per member per month (\$333). This is due to the fact that conversion policies are often issued to individuals who are ill, who have more expensive medical needs, and who have a critical need to continue coverage even though their group policy is no longer available. Less than one percent of the market was insured by conversion policies (see Table 10).

Table 10. Total Comprehensive Market by Group Size for 2007

Group Size	Company Count^a	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM^b
Total Individual	49	144,244	\$249,128,615	11.86%	79.23	\$136
Individual	44	142,004	\$239,593,834	11.40%	78.39	\$133
Conversion	11	2,240	\$9,534,781	0.46%	100.33	\$333
Total Group	43	731,611	\$1,851,750,506	88.14%	81.36	\$219
Small Group (2-50)	21	237,378	\$568,278,786	27.05%	73.11	\$206
Large Group (50+)	33	494,233	\$1,283,471,720	61.09%	85.01	\$225
Total Comprehensive	74	875,855	\$2,100,879,121	100.00%	81.10	\$204

Data Source: Utah Accident & Health Survey

^a Company count column does not add up to total because an insurer may have more than one plan type.

^b Direct earned premium per member per month

Comprehensive Market by Plan Types

In this report, comprehensive health insurance plans are classified into five major plan types: Fee for Service (FFS), Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), Health Maintenance Organization with Point of Service features (HMO with POS), and HSA eligible High Deductible Health Plan (HDHP). These plan types differ in the amount of managed care used to maintain quality and manage the cost of health care services. The term “managed care” refers to the methods many third-party payers use to ensure quality care (such as disease management programs) and to reduce utilization and cost of health care services (such as pharmacy benefit managers and medical review boards). HMO plans generally have the most management of care; whereas FFS plans generally have the least.

A Fee for Service plan (FFS) refers to a traditional indemnity plan. Under a FFS plan, members can use any health care provider they choose (as long as the services are a covered benefit on the insurance contract). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges).

A Preferred Provider Organization plan (PPO) refers to a health plan that offers a network of “preferred” providers that have contracted to provide health care services for a reduced fee. Members have financial incentives to use this network of preferred providers, as costs for health care services are typically lower. Members are also free to also use providers outside of the network, but services are reimbursed at a lower rate and members must pay a larger portion of the cost for health care services. PPO plans usually include deductibles, co-pays, or coinsurance. This category includes PPO plans where members must obtain preauthorization prior to using non-preferred providers.

A Health Maintenance Organization plan (HMO) refers to a “prepaid” health insurance plan where policyholders pay a fixed monthly fee for comprehensive major medical coverage. A HMO plan usually covers more preventative care services than other kinds of plans, but also manages care more than other kinds of plans. Services are provided through a network of health care providers that have negotiated a fee schedule with the HMO. Members enrolled in the plan generally pay a fixed co-pay for physician visits and drugs. Services are usually not available outside the provider network, except for emergencies.

A Health Maintenance Organization with Point of Service features plan (HMO with POS) is a type of licensed HMO. A HMO with POS refers to an HMO plan that gives members the option to use providers who are outside of the HMO network for certain types of medical services (not emergencies), but at a lower reimbursement rate where members bear a larger portion of the cost for health care services. Except for this out of network option, a HMO with POS functions like a standard HMO.

A HSA eligible High Deductible Health Plan (HDHP) is a new type of insurance product recently authorized by the federal government. High deductible health plans are comprehensive health insurance plans with deductibles and limits that are much higher than traditional insurance options. Comprehensive health insurers have offered insurance products with higher deductibles in the past, however, one of the key features that make these plans different is that the deductible

levels of these plans are set by federal statute and plans that comply with federal guidelines are eligible for use with a savings vehicle called a Health Savings Account (HSA). Payments made into a HSA are tax deductible and can be used to pay for current health care expenses or saved for the future. When the health care expenses reach the level of the deductible, the high deductible health plan pays for covered health care expenses beyond the deductible. High deductible health plans can also be used in conjunction with Health Reimbursement Arrangements (HRA). HRAs are similar to HSAs, except the employer owns the savings account (rather than the employee) and only the employer can deposit funds into the account.

HMO, HMO with POS, and PPO plans are considered managed care plans. FFS plans typically do not involve any form of managed care. Approximately 89 percent of Utah’s comprehensive health insurance market involves some type of managed care; with more than 65 percent of the comprehensive health market in a HMO or HMO with POS. About 1.9 percent of the market had a HDHP plan (see Table 11).

Table 11. Total Comprehensive Market by Plan Type for 2007

Plan Type	Company Count^a	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM^b
Fee for Service	42	88,897	\$227,664,745	10.84%	78.58	\$196
Preferred Provider Organization	40	178,275	\$444,680,945	21.17%	76.32	\$230
Health Maintenance Organization	7	240,462	\$730,513,649	34.77%	83.03	\$212
HMO with Point of Service features ^c	3	331,126	\$643,635,770	30.64%	84.34	\$191
High Deductible Health Plan	11	31,227	\$40,619,149	1.93%	59.48	\$135
Other	10	5,868	\$13,764,863	0.65%	87.67	\$195
Total	74	875,855	\$2,100,879,121	100.00%	81.10	\$204

Data Source: Utah Accident & Health Survey

^a Company count column does not add up to total because an insurer may have more than one plan type.

^b Direct earned premium per member per month

^c SelectHealth, Inc. an HMO, provides Point of Service benefits in conjunction with its affiliated indemnity company SelectHealth Benefit Assurance, Inc.

Premium per member per month was higher for PPO and HMO plans compared to the other plan types, while HMO with POS plans were the lowest among traditional insurance products. The new HDHP plans reported the lowest premium among the various types of plans. Caution should be used in drawing conclusions from this data, however. This comparison does not control for differences in plan structure, covered benefits, health status, or demographics. For example, one reason HDHP plans have lower premiums than other plans may be the higher deductible. When a member accepts a higher deductible, the insurer pays for fewer health care services and the member is responsible for a larger portion of their health care expenses. Thus, the insurer bears less financial risk, which is reflected in a lower premium (see Table 11).

Comprehensive Market Trends

This section reports on four significant trends in Utah’s comprehensive health insurance market: the number of insurers, the cost of insurance, the number of insured members, and the financial status of the market. Each measure represents a different aspect of the market’s “health.”

Trends in the number of insurers. The Insurance Department continues to monitor the number of commercial health insurance companies that are providing comprehensive health insurance. The department has data regarding the number of comprehensive health insurers from 1999 to 2007.

As shown in Table 12, from 1999 to 2007, there was a decline in the number of comprehensive health insurers from 1999 to 2003, followed by a period of relative stability from 2004 to 2006, and ending with a slight decline during 2007. For example, in 1999, there were 123 commercial health insurance companies who reported comprehensive health insurance business during the year. By 2003, this number had declined to 76. There were 76 comprehensive health insurers during 2003 and 2004, followed by an increase of 2 insurers during 2005 and 1 insurer during 2006. As of 2007, there were 74 insurers who reported currently having comprehensive health insurance business in Utah. Although these changes may appear significant, this decline has not affected the competitiveness of the health insurance market (see Table 12).

Table 12. Changes in the Number of Comprehensive Health Insurers: 1999 - 2007

Insurer Category	1999	2000	2001	2002	2003	2004	2005	2006	2007	<i>Net Change</i>
Domestic Insurers										
Greater than 100 Million	4	4	4	4	3	3	3	3	3	-1
Between 10 and 100 Million	5	4	5	3	4	4	3	4	3	-2
Between 1 and 10 Million	6	6	4	3	2	3	4	3	5	-1
Less than 1 Million	3	3	1	2	1	1	1	2	1	-2
Total Domestic	18	17	14	12	10	11	11	12	12	-6
Foreign Insurers										
Greater than 100 Million	0	0	0	0	0	0	1	1	1	1
Between 10 and 100 Million	1	2	2	1	1	1	1	2	3	2
Between 1 and 10 Million	16	15	12	12	11	11	10	9	12	-4
Less than 1 Million	88	83	75	64	54	53	55	58	46	-42
Total Foreign	105	100	89	77	66	65	67	67	62	-43
All Insurers										
Greater than 100 Million	4	4	4	4	3	3	4	4	4	0
Between 10 and 100 Million	6	6	7	4	5	5	4	6	6	0
Between 1 and 10 Million	22	21	16	15	13	14	14	12	17	-5
Less than 1 Million	91	86	76	66	55	54	56	57	47	-44
Total Utah	123	117	103	89	76	76	78	79	74	-49

Data Source: Utah Accident & Health Survey

Note: Comprehensive health insurers are counted by relative size, broken into four categories of direct earned premium measured in millions of US dollars.

Under current market conditions, the typical comprehensive health insurer needs to be large enough to be able to drive membership volume to providers in order to remain competitive. While there is no absolute rule for how large an insurer needs to be, an insurer with a large number of members has more leverage in contract negotiations with providers. This arrangement can benefit both consumers and providers. Consumers may benefit from lower prices and providers may benefit from a higher volume of clients. Many small comprehensive health insurers cannot “drive volume” as effectively as a large insurer.

Most of the decline in the number of comprehensive health insurers has occurred primarily among smaller comprehensive health insurers, particularly foreign insurers with less than 1 million dollars in comprehensive health insurance premium (see Table 12). In many cases, these small foreign comprehensive health insurers are providing coverage for “non-situated” policies, that is, commercial health insurance policies that are not filed in the state of residence of the employee. These are often policies issued in another state to an employer with less than 25 percent of their employees living in the state of Utah. The premium is reported as covering a Utah resident, but the policy itself was not sold in Utah or filed with the Insurance Department. Many of these companies are not actively selling health insurance in the Utah health insurance market and are only here because an employee of the company they sold health insurance to is currently a resident in the state. As a result, many of these insurers leave the market when the employees leave the company or the company leaves Utah. Thus, many of these smaller foreign comprehensive health insurers are covering a special class of Utah residents and may not be competing directly in the mainstream health insurance market in Utah. As a result, the decline appears to be due to factors external to Utah’s health insurance market and probably has little or no effect on the core of Utah’s health insurance industry (see also Table 27 for a list of the relative market shares of Utah’s comprehensive health insurers).

In contrast, there has been little change in the number of large domestic comprehensive health insurers that represent the core of the comprehensive health insurance market (see Table 12). These large comprehensive health insurers account for more than 90 percent of the market and provide a solid pool of comprehensive health insurers. These insurers are financially solvent and provide an important level of strength, stability, and choice for Utah’s comprehensive health insurance market.

Trends in the cost of insurance. Utah’s comprehensive health insurance premium premiums are increasing at a significant rate. For example, from 1999 to 2007, the average premium per member per month for comprehensive health insurance has increased on average about 9.2 percent per year. In 2007, the average premium per member per month for comprehensive health insurance was 6.3 percent higher than in 2006. Utah’s rate of increase, in comparison with national employer data, appears to be following a national trend (see Table 13). This suggests that Utah’s health insurance market is experiencing similar cost pressures as other parts of the country.

Table 13. Comprehensive Premium Compared to National Economic Trends: 1999 – 2007

Year	Comprehensive Premium in Utah				National Economic Trends (Annual Percent Change)		
	Total Premium ^a	Premium PMPM ^b	Premium PMPY ^c	Annual Percent Change	Health Insurance Premium ^d	Overall Inflation	Workers' Earnings
1999	\$1,161,373,601	\$101	\$1,212	N/A	5.3%	2.3%	3.6%
2000	\$1,239,046,717	\$111	\$1,332	9.9%	8.2%	3.1%	3.9%
2001	\$1,308,837,635	\$123	\$1,476	10.8%	10.9%	3.3%	4.0%
2002	\$1,328,724,448	\$133	\$1,596	8.1%	12.9%	1.6%	2.6%
2003	\$1,405,078,420	\$149	\$1,788	12.0%	13.9%	2.2%	3.0%
2004	\$1,515,423,760	\$162	\$1,944	8.7%	11.2%	2.3%	2.1%
2005	\$1,617,045,445	\$171	\$2,052	5.6%	9.2%	3.5%	2.7%
2006	\$1,890,464,682	\$192	\$2,304	12.3%	7.7%	3.5%	3.8%
2007	\$2,100,879,121	\$204	\$2,448	6.3%	6.1%	2.6%	3.7%

Data Sources: Utah premium data are from the Utah Accident & Health Survey from 1999 to 2007. The national trend data used as a comparison comes from the Kaiser/HRET Employer Health Benefits Survey report for 2007.

^a Total direct earned premium

^b Direct earned premium per member per month

^c Direct earned premium per member per year

^d "Health Insurance Premium" trends are based on premium changes for a family of four in an employer based plan.

One of the main causes of the trend towards higher premiums is a steady increase in the underlying cost of health care. Utah's health care costs, like the United States as a whole, have increased at a significant rate. For example, from 1999 to 2007, the average losses per member per month for comprehensive health insurance has increased about 7.8 percent per year. In 2007, the average losses per member per month for comprehensive health insurance was 5.7 percent higher than in 2006 (see Table 14). Nationally, these costs are being driven by a number of factors, particularly increases in pharmacy and hospital costs (Strunk, Ginsburg, & Gabel, 2002; Strunk and Ginsburg, 2003; Strunk and Ginsburg, 2004; Strunk, Ginsburg, & Cookson, 2005; Ginsburg, Strunk, Banker, & Cookson, 2006). Government mandates, increased consumer demand, litigation, and new technologies also appear to be important factors (PriceWaterhouseCoopers, 2002; PriceWaterhouseCoopers, 2006).

The rising cost of health care creates significant economic pressure on comprehensive insurers. For example, if Utah's comprehensive insurers had kept premiums at 1999 levels and costs had continued to increase, by 2007, the industry's loss ratio would be approximately 164. In other words, the industry would be paying out nearly \$1.64 in claims for every \$1.00 in premium. No business can afford to lose money at such rates for long, so comprehensive insurers responded by raising premiums to levels that would cover their costs.

In addition to claim costs, comprehensive insurers also have to pay general administrative costs such as general business expenses and the cost of processing claims. Furthermore, commercial health insurers are also required by state law to maintain adequate financial reserves and to remain financially solvent. This is because commercial health insurers are selling "a promise to pay in the future." When a consumer purchases a health insurance contract, they are buying a promise to pay for future health care costs under certain conditions. Insurers cannot pay claims on behalf of consumers without adequate funds to do so.

Table 14. Comprehensive Losses Compared to National Health Care Spending: 1999 - 2007

Year	Comprehensive Losses in Utah				National Health Care Expenditures (in Millions of Dollars)			
	Loss Ratio ^a	Losses PMPM ^b	Losses PMPY ^c	Annual Percent Change	Total NHE (All Sources)	Annual Percent Change	NHE for Private Health Insurance Only	Annual Percent Change
1999	89.49	\$91	\$1,092	-	\$1,265,567	-	\$417,103	-
2000	84.59	\$94	\$1,128	3.3%	\$1,353,593	7.0%	\$455,051	9.1%
2001	85.06	\$104	\$1,248	10.6%	\$1,469,591	8.6%	\$497,990	9.4%
2002	82.91	\$110	\$1,320	5.8%	\$1,603,416	9.1%	\$552,478	10.9%
2003	84.06	\$125	\$1,500	13.6%	\$1,732,442	8.0%	\$602,836	9.1%
2004	86.12	\$134	\$1,608	7.2%	\$1,852,284	6.9%	\$645,819	7.1%
2005	81.61	\$139	\$1,668	3.7%	\$1,973,340	6.5%	\$685,575	6.2%
2006	81.69	\$157	\$1,884	12.9%	\$2,105,541	6.7%	\$723,412	5.5%
2007 ^d	81.10	\$166	\$1,992	5.7%	\$2,245,573	6.7%	\$769,413	6.4%

Data Sources: Utah loss data are from the Utah Accident & Health Survey from 1999 to 2007. The National Health Care Expenditure data are from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (January 2008).

^a Ratio of direct incurred losses to direct earned premium

^b Direct incurred losses per member per month

^c Direct incurred losses per member per year

^d National Health Care Expenditure data for 2007 are projections created by CMS.

For Utah employers and consumers, this trend towards higher premiums means that health care is getting more expensive. For a single individual, the average premium per member per year increased from \$1,212 in 1999 to \$2,448 in 2007. This is an increase of over 100 percent over the last nine years. Both consumers and employers are being impacted by this increase. In most cases, employers pay a significant portion of this premium. Nationally, employers pay more than two-thirds of the premium cost (Kaiser/HRET, 2008). However, many employers are responding to the rising cost of health care by increasing the employee's portion of the premium, reducing benefits, or looking at new plan designs such as defined benefit plans. These changes may be difficult for many consumers to accept because the rate of increase in consumer income has not kept pace with the rate of increase in premiums (see Table 15).

Table 15. Changes in Comprehensive Premium and Per Capita Income: 1999 - 2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Premium PMPY ^a	\$1,212	\$1,332	\$1,476	\$1,596	\$1,788	\$1,944	\$2,052	\$2,304	\$2,448
Percent change in Premium	-	9.9%	10.8%	8.1%	12.0%	8.7%	5.6%	12.3%	6.3%
Per Capita Income in Utah	\$22,393	\$23,874	\$24,731	\$25,010	\$25,220(r)	\$26,270(r)	\$28,176(p)	\$29,769(p)	31,433(e)
Percent change in Income	-	6.6%	3.6%	1.1%	0.8%	4.2%	7.3%	5.7%	5.6%

Data Sources: Utah premium data are from the Utah Accident & Health Survey. Per capita income data are from the Economic Report to the Governor (2008).

^a Direct earned premium per member per year

r = revised

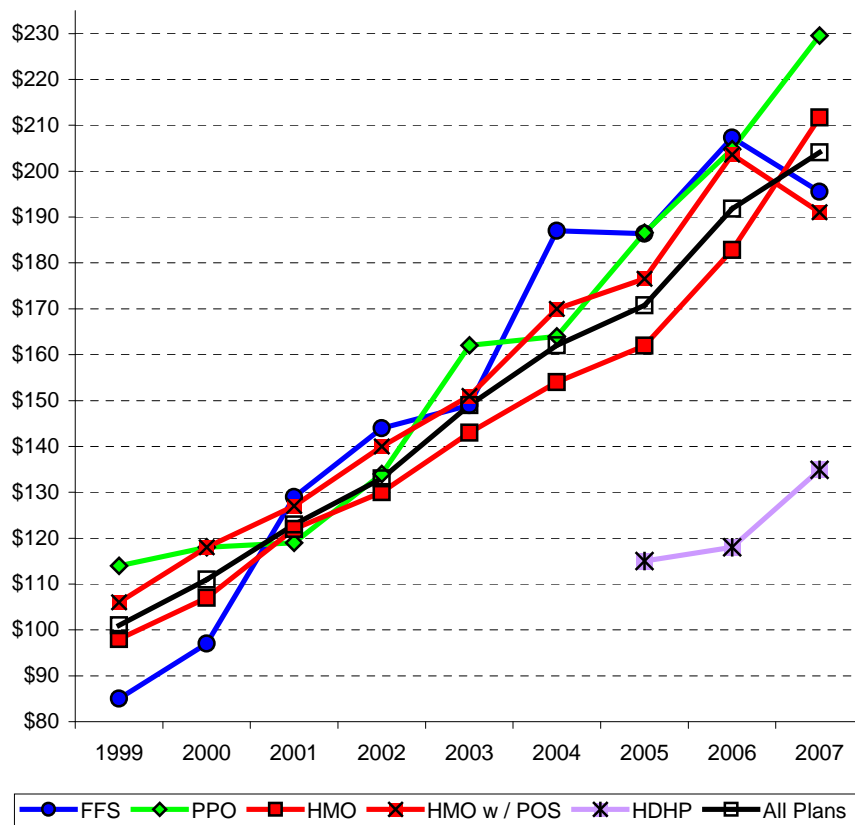
p = preliminary

e = estimated

The recent premium increases have affected all of the different comprehensive health insurance plan types. Over the last nine years, managed care products such as HMO plans increased less than plans with fewer cost controls. The largest increases have been among FFS and PPO plans. However, given their large market share in Utah, HMO and HMO with POS plans have had the most impact on premium trends in the market (see Figure 2).

The difference in premium increases between plans appears to be smaller than the general trend in premium increases. HDHP may be an exception, but these represent only 1.9 percent of the comprehensive health insurance market and we have only limited data on these new plans.

Figure 2. Comprehensive Premium PMPM by Plan Type: 1999 – 2007



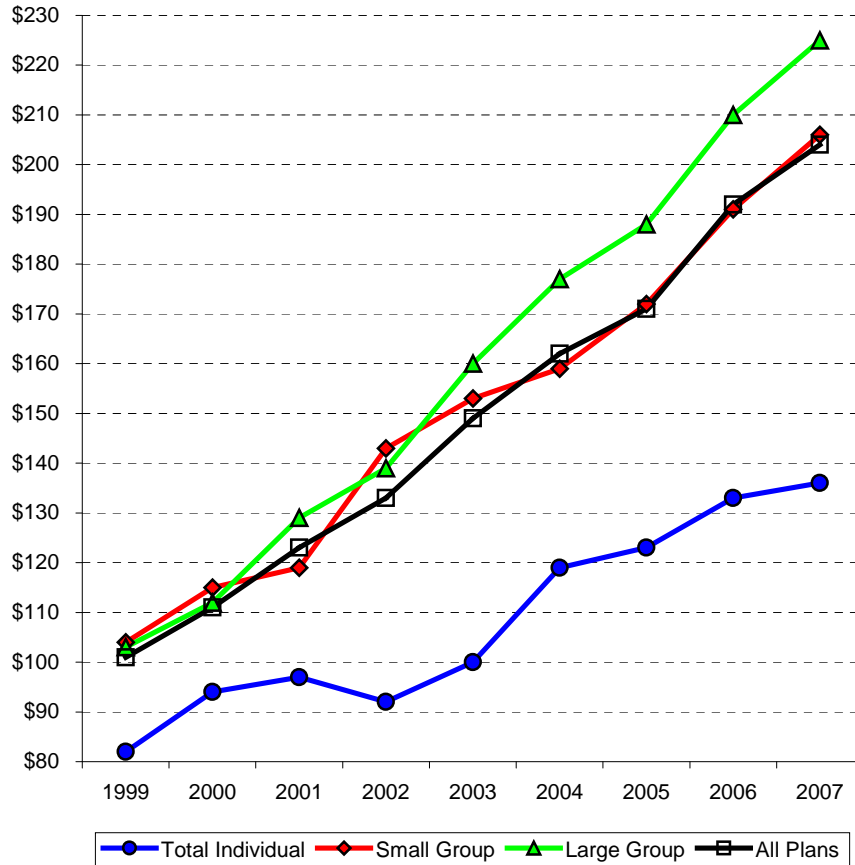
Data Source: Utah Accident & Health Survey

Note: Results may differ slightly from previous reports due to changes in product type categories.

Premium increases have been fairly uniform among different group sizes. Significant premium increases occurred in both large and small group plans. Individual plans, in comparison, have experienced relatively lower increases over time; however, this pattern changed during 2004 with individual plans reporting a much larger increase than in the past (see Figure 3). As mentioned previously, the cost differences between individual and group products are probably due to differences in underwriting practices (see “Comprehensive Market by Group Size” for further discussion).

Increases in large group plan premiums have had the most impact on the premium trends in the market over the last nine years. This is primarily because, at least in the comprehensive health insurance market, more Utah residents are covered by large group plans than by any other type. As a result, changes in this category have a larger impact on market averages than changes in the individual or small group markets.

Figure 3. Comprehensive Premium PMPM by Group Size: 1999 - 2007



Data Source: Utah Accident & Health Survey

Although Utah has continued to experience significant increases in the cost of comprehensive health insurance coverage, when one compares Utah premiums on a per member per month basis to national data from the National Association of Insurance Commissioners (NAIC), Utah's premium appears to be lower than the national average (see Table 16). For example, during 2007, the average premium for Utah's comprehensive health insurers was approximately \$204 per member per month. In contrast, the average premium for commercial health insurers reporting comprehensive health insurance to the NAIC financial database was approximately \$259 per member per month. Although this comparison does not control for differences in benefits, health status, or demographics, this data suggests that Utah's average premium is lower than the average premium reported to the NAIC.

Table 16. Comparison of Utah Premium to National Premium: 1999 - 2007

Year	Utah Estimate		National Estimate ^b	
	Premium PMPM for Comprehensive Health Insurance ^a	Annual Percent Change	Premium PMPM for Comprehensive Health Insurance	Annual Percent Change
1999	\$101	-	\$129	-
2000	\$111	9.9%	\$143	10.9%
2001	\$123	10.8%	\$149	4.2%
2002	\$133	8.1%	\$177	18.8%
2003	\$149	12.0%	\$199	12.4%
2004	\$162	8.7%	\$219	10.1%
2005	\$171	5.6%	\$235	7.3%
2006	\$192	12.3%	\$245	4.3%
2007	\$204	6.3%	\$259	5.7%

Data Sources: Utah Accident & Health Survey and the NAIC Financial Database

Note: The Utah estimate is based on data obtained from the Utah Accident & Health Survey for comprehensive health insurance. The national estimate is based on data obtained from the NAIC Financial Database. The data represents the average premium per member per month for comprehensive health insurance business as reported by commercial health insurers who filed on the annual financial statement for health related insurance business. Both data sources include only information on commercial health insurers.

^a Premium per member per month is the average premium per person per month for comprehensive health insurance. This is the estimated cost of health insurance for all types of hospital and medical coverage on a per person basis. A division into single and family rates is not possible using data from the Utah Accident & Health Survey or the NAIC Financial Database.

^b Only data for Health Maintenance Organizations was available for 1999 and 2000.

However, the premiums that consumers actually pay may differ significantly from the market average depending on their individual circumstances. Furthermore, although Utah's premiums may be lower by this measure, Utah's premiums are increasing at rates that are very similar to comprehensive insurers nationally (9.2 percent for Utah, 9.1 percent for comprehensive insurers reporting to the NAIC).

Trends in the number of members. Since 1999, the number of residents insured by comprehensive health insurance as a relative percentage of Utah's total population has declined by more than 12 percent. During this same time period Utah's population has increased by more than 26 percent.

As shown in Table 17, from 1999 to 2007, the individual and small group markets have increased overall, generally maintaining their relative distribution in Utah's population, while the conversion and large group markets have declined. The largest change occurred in the large group market, which declined by nearly 13 percent. Most of these changes occurred between 1999 and 2002. During 2003, the decline in membership stopped and increased slightly from 2002, however, another decline in membership occurred in 2004, followed by increases from 2005 to 2007 (see Table 17).

Most of the increase occurred during 2006, with comprehensive health insurers reporting an increase of over 38,000 members in the comprehensive market. The majority of this increase was among large group plans, with individual and small group plans growing only slightly or keeping steady with population growth. This membership increase was primarily in three plan types, specifically, HMO with POS, PPO, and HDHP plans. This was a positive sign for the industry, particularly given the rising cost of health care. This was the largest single year increase in members since 1999 (see Tables 17 and 18).

However, Utah comprehensive health insurers also reported a significant increase during 2007. Insurers reported an increase of over 33,000 members, an increase of 3.9 percent. Nearly 75 percent of the increase occurred among large group plans, with the remainder occurring among small group plans. Individual plans reported a slight decrease. As for plan types, increases were reported among every plan type except HMO, which experienced a significant decline. This was due in part to a one-time restructuring of the market place. This restructuring has two components. First, nearly half of the increase was due to two new foreign insurers entering Utah's comprehensive health insurance market and acquiring new members, with most of the remaining increase occurring among the top three domestic insurers. Second, one of Utah's large domestic insurers, in response to market demands for products with more open provider networks, shifted a large block of business from HMO plans (which have a more limited provider network) to HMO with POS plans (which provide the option to use non-network providers but at a higher cost). These are positive changes Utah's health insurance market and suggest that Utah's commercial health insurance market is attractive to new insurers and that Utah's insurers are responsive to market forces and will change how they do business if the demand is there.

Table 17. Changes in Comprehensive Membership by Group Size: 1999 – 2007

Group Size	1999	2000	2001	2002	2003	2004	2005	2006	2007	Net Change^a
Individual	96,455	99,034	110,295	126,662	129,522	132,765	135,543	142,599	142,004	+45,549
Percent of population ^b	4.5%	4.4%	4.8%	5.4%	5.4%	5.4%	5.3%	5.5%	5.3%	+0.8%
Conversion	3,272	2,949	2,139	2,059	2,029	2,088	2,418	2,466	2,240	-1,032
Percent of population	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	-0.1%
Total Individual	99,727	101,983	112,434	128,721	131,551	134,853	137,961	145,065	144,244	+44,517
Percent of population	4.7%	4.5%	4.9%	5.5%	5.5%	5.5%	5.4%	5.5%	5.3%	+0.6%
Small Group	200,377	208,561	208,100	237,050	224,872	233,098	223,556	228,905	237,378	+37,001
Percent of population	9.4%	9.3%	9.1%	10.1%	9.4%	9.4%	8.8%	8.8%	8.8%	-0.6%
Large Group	655,112	624,524	534,484	447,623	465,842	428,129	442,495	468,877	494,233	-160,879
Percent of population	30.6%	27.8%	23.3%	19.1%	19.5%	17.3%	17.4%	17.9%	18.3%	-12.3%
Total Group	855,489	833,085	742,584	684,673	690,714	661,227	666,051	697,782	731,611	-123,878
Percent of population	40.0%	37.1%	32.3%	29.3%	29.0%	26.8%	26.1%	26.7%	27.1%	-12.9%
Total Comprehensive	955,216	935,068	855,018	813,394	822,265	796,080	804,012	842,847	875,855	-79,361
Percent of population	44.7%	41.6%	37.2%	34.8%	34.5%	32.2%	31.6%	32.2%	32.4%	-12.3%
Utah Population	2,139,014	2,246,544	2,295,971	2,338,761	2,385,358	2,469,230	2,547,389	2,615,129	2,699,554	+560,540
Percent of population	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%

Data Sources: Utah Accident & Health Survey and Utah Population Estimates Committee

Note: Numbers may not add up exactly to totals due to rounding.

^a "Net Change" measures the difference in the absolute number of members from 1999 to 2007 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 26 percent during this period.

^b "Percent of population" estimates the membership as a relative percentage of Utah's total population in each particular year.

Table 18. Changes in Comprehensive Membership by Plan Type: 1999 – 2007

Plan Type^a	1999	2000	2001	2002	2003	2004	2005	2006	2007	Net Change^b
FFS	84,600	89,756	58,075	55,465	93,385	90,840	70,741	74,487	88,897	+4,297
Percent of Population ^c	4.0%	4.0%	2.5%	2.4%	3.9%	3.7%	2.8%	2.8%	3.3%	-0.7%
PPO	149,026	158,804	185,184	208,362	167,239	165,030	168,075	176,097	178,275	+29,249
Percent of Population	7.0%	7.1%	8.1%	8.9%	7.0%	6.7%	6.6%	6.7%	6.6%	-0.4%
HMO	517,583	481,995	431,560	404,460	416,952	403,965	401,769	399,177	240,462	-277,121
Percent of Population	24.2%	21.5%	18.8%	17.3%	17.5%	16.4%	15.8%	15.3%	8.9%	-15.3%
HMO with POS	182,798	183,574	177,408	141,198	143,994	136,244	150,206	163,906	331,126	+148,328
Percent of Population	8.5%	8.2%	7.7%	6.0%	6.0%	5.5%	5.9%	6.3%	12.3%	3.7%
HDHP	-	-	-	-	-	^d	6,740	22,024	31,227	+31,227
Percent of Population	-	-	-	-	-	^d	0.3%	0.8%	1.2%	+1.2%
Other	21,209	20,939	2,791	3,909	695	1	6,481 ^e	7,156 ^e	5,868	-15,341
Percent of Population	1.0%	0.9%	0.1%	0.2%	< 0.1%	< 0.1%	0.3%	0.3%	0.2%	-0.8%
Total Comprehensive	955,216	935,068	855,018	813,394	822,265	796,080	804,012	842,847	875,855	-79,361
Percent of Population	44.7%	41.6%	37.2%	34.8%	34.5%	32.2%	31.6%	32.2%	32.4%	-12.2%
Utah Population	2,139,014	2,246,544	2,295,971	2,338,761	2,385,358	2,469,230	2,547,389	2,615,129	2,699,554	+560,540
Percent of Pop.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%

Data Sources: Utah Accident & Survey and Utah Population Estimates Committee

Note: Numbers may not add up exactly to totals due to rounding.

^a Plan Types Key: FFS = Fee For Service / Indemnity, PPO = Preferred Provider Organization, HMO = Health Maintenance Organization, HMO with POS = Health Maintenance Organization with Point of Service features, HDHP = High Deductible Health Plan (HSA Eligible)

^b "Net Change" measures the difference in the absolute number of members from 1999 to 2007 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 26 percent during this period.

^c "Percent of population" measures the plan membership as a relative percentage of Utah's total population in each particular year.

^d Two companies reported HDHP plans during 2004. These companies had less than 2,000 members. Given the small numbers and because coverage was offered late in the year, these members were not broken out from the other categories in 2004.

^e Includes a company with PPO and FFS plans that could not break out the data into the correct categories due to limitations in their data systems.

The reasons for the general decline in membership from 1999 to 2003 are complex. Various market forces are in operation. To begin with, the decline in the number of comprehensive health insurers could have contributed to the decline (see Table 12), but this is unlikely. It more likely that the recent increases in the cost of health care and insurance premiums may have led some policyholders to seek less expensive kinds of coverage and this may show up as restructuring in the market place (i.e., shifting membership). Some of this restructuring is evident among the different plan types in the market (see Table 18) and can be observed somewhat in the available data.

First, there has been a steady increase in the number of residents with individual plans. Premiums for individual policies have remained low compared to other options in the market. This may be a significant incentive to switch from more costly types of coverage. However, these lower rates are really only available to those with good health, because individual policies have stricter underwriting requirements than group plans.

Second, there has been a decline in the number of residents with individual conversion policies. This is primarily due to changes in the number of conversion policies in two large managed care insurers. Conversion policies are the result of a person in a group policy who “converts” their group plan into an individual conversion policy. They are intended to act as a temporary bridge between employer group coverage and some other kind of coverage. As a result, one would not expect the number of conversion policies to become very large in the market.

Third, there has also been a steady increase in the number of residents covered by policies in the small group market. This suggests that small employers are maintaining insurance coverage despite the rising premiums in Utah’s comprehensive market, which is a positive sign for Utah’s small group market.

Fourth, the largest change in the market over this period has been a significant decrease in the number of residents within large group policies. This is largely explained by declines in HMO membership (see Table 18) within four managed care insurers and changes to a large group student plan. Large group plans are typically sold to large employers. Large employers are the most likely to provide health insurance benefits to their employees and the most likely to provide these benefits through a self-funded health benefit plan. So a decline in this sector could be due to a shift from commercial health insurance to self-funded health benefit plans, rather than an increase in the uninsured or in government sponsored-health benefit plans. This is difficult to confirm with the available data, but when the five insurers most effected were asked, some were able to confirm that a shift from commercial to self-funded had occurred, while others did not provide a specific reason for the change other than their clients had non-renewed their contracts and that this was simply restructuring in the market.

Additional support for a shift by large employers from the commercial health insurance market to self-funded health benefit plans can be found in the available data on the uninsured and government sponsored health benefit plans. A review of the available data suggests that there has been a relatively small increase in the uninsured and government sponsored health benefit plans from 1999 and 2003.

For example, recent surveys of the uninsured by the U.S. Census Bureau (Mills, 2002; Mills, 2003; DeNavas-Walt, Proctor, & Mills, 2004), the Utah Department of Health (Office of Public Health Assessment, 2004; Office of Public Health Assessment, 2002; Office of Public Health Assessment, 2001), and Utah's commercial health insurance industry (Utah Health Insurance Association/Utah Association of Health Underwriters, 2001) suggest that Utah's uninsured rate remained fairly constant between 1999 and 2003. Most of the surveys reported an uninsured rate of about 9 percent. Federal surveys reported a higher rate (between 13 and 14 percent), but report minimal changes in the uninsured during this period. Thus, changes in uninsured are unlikely to be a significant factor in the decline in membership from 1999 to 2003.

However, the most recent data from the Utah Health Status Survey suggests that Utah's uninsured rate increased from 9.1 percent to 10.6 percent from 2003 to 2007 (Office of Public Health Assessment, 2006a; Office of Public Health Assessment, 2006b; Office of Public Health Assessment, 2007; Office of Public Health Assessment, 2008). While the available data cannot confirm this, the change in the uninsured from 2003 to 2007 may be a contributing factor in the more recent changes in comprehensive membership.

The available data on Utah's government sponsored health benefit plans shows a moderate increase in membership (see Table 19), but this increase can only account for a small portion of the decline in the commercial market and could be connected to other factors such as changes in the economy and population increases. Most of the increases are in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Table 19. Changes in Government Sponsored Health Benefit Plans: 1999 - 2007

Plan Type	1999	2000	2001	2002	2003	2004	2005	2006	2007	Net Change ^a
Medicare	201,217	206,056	210,169	214,507	220,221	226,749	231,263	238,286	252,572	+51,355
Medicaid	132,397	132,569	139,426	154,784	156,031	171,302	179,299	174,800	159,849	+27,452
Children's Health Insurance Program (CHIP)	10,500	17,391	24,448	24,505	23,761	31,010	28,311	35,248	24,747	+14,247
Utah Health Assistance Program (UMAP)	3,623	3,615	3,346	4,447	-	-	-	-	-	-3,623
Primary Care Network (PCN)	-	-	-	-	17,228	16,499	18,311	16,043	17,795	+17,795
Utah Comprehensive Health Insurance Pool (HIPUtah)	994	1,265	1,767	2,347	2,854	2,999	3,143	3,346	3,505	+2,511
Government Sponsored Health Benefit Plans	348,731	360,896	379,156	400,590	420,095	448,559	460,327	467,723	458,468	+109,737
As percent of population ^b	16.3%	16.1%	16.5%	17.1%	17.6%	18.2%	18.1%	17.9%	17.0%	+0.7%

Data Sources: Centers for Medicare & Medicaid Services and Utah Department of Health

^a "Net Change" measures the difference in the absolute number of members from 1999 to 2007 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 22 percent over this period.

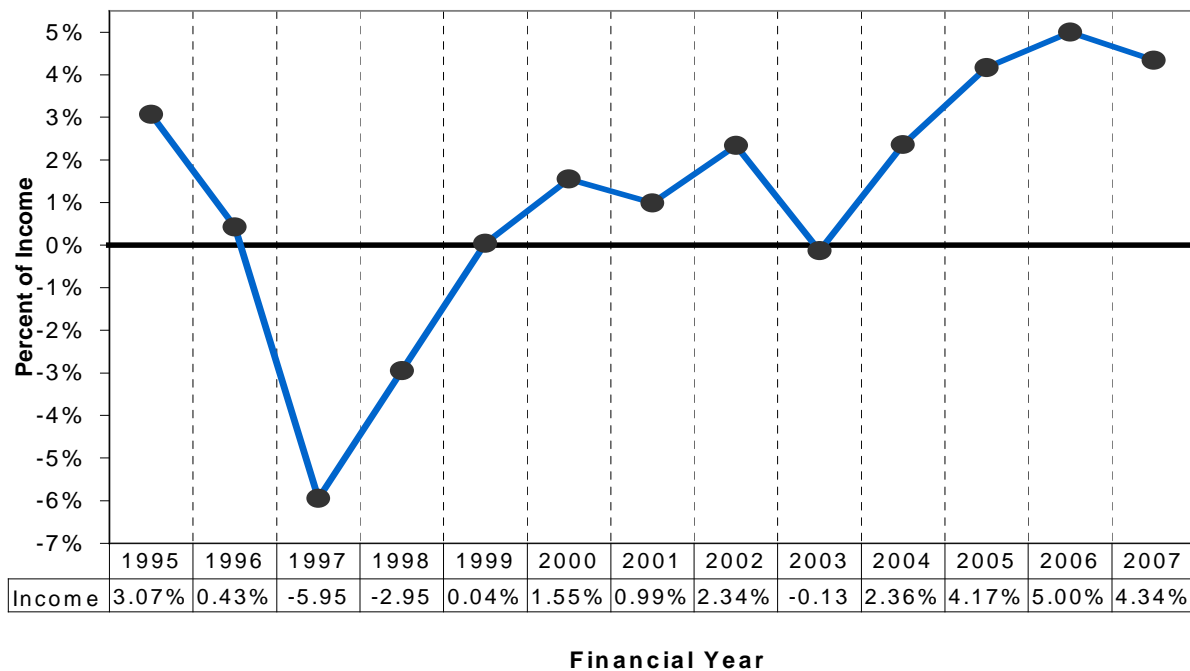
^b "As percent of population" measures the relative percentage of Utah's total population in each particular year.

In summary, changes in the individual and small group market do not seem to account for the significant declines in the large group market from 1999 to 2003. The available data are consistent with a shift by large employers from the commercial health insurance market to self-funded health benefit plans. This would be a reasonable response from large employers seeking to control the rate of health care costs. Self-funding can be attractive to large employers due to fewer state mandates and greater control over costs due to greater flexibility in health benefit plan design. However, recent increases in the uninsured and the number of residents covered by government sponsored health benefit plans may also be contributing factors.

Following the declines in membership from 1999 to 2003, comprehensive membership remained steady during 2003 and 2004, followed by an increase in membership from 2005 to 2007. Most of this increase was during 2006 and 2007 and occurred primarily among large group plans, with individual and small group plans growing only slightly or keeping steady with population growth.

Financial trends. To measure the current financial condition of the market, the financial results of the top seven comprehensive health insurers in Utah were used as an index of Utah's comprehensive health insurance market. These companies were selected because: 1) they represent 90 percent of the 2007 comprehensive health insurance market, 2) they receive more than 70 percent of their revenues from comprehensive health insurance, 3) nearly all of their revenues come from Utah business, and 4) their primary business model is that of a comprehensive health insurer. Thus, these companies are Utah's best examples of pure comprehensive health insurers and they can provide an index of how well comprehensive health insurers are doing in the Utah market over time (see Figure 4).

Figure 4. Income After Expenses For Comprehensive Health Insurers: 1995 – 2007



Data Source: NAIC Financial Database

Note: This figure represents the ratio of net income to total revenue as reported on the NAIC annual statement for the seven largest managed care health insurers that have been operating in Utah since 1995.

Comprehensive health insurers, whether for-profit or non-profit, need enough income after expenses to fund state-mandated reserve requirements, to reinvest in new equipment and new markets, and to acquire and maintain needed capital. The results of this index indicate that Utah’s comprehensive health insurance market has experienced an average gain of 1.59 percent in net income per year since 1995 (see Figure 4). However, this trend has improved since 1998, with an average of 2.58 percent in net income per year over the last nine years, although the market reported a slight loss of 0.13 percent for 2003. During 2007, the financials of these companies declined slightly, with an average net income per year of 4.34 percent. Net income for 2007 appears to be following a similar pattern in investment income, income from underwriting practices, and taxes paid during 2005 and 2006. According to the NAIC, the industry average for net income after expenses for Health Maintenance Organizations for 2007 was 3.7 percent, which suggests that Utah’s comprehensive health insurers performed at or above the industry average for 2007. Overall, Utah’s core comprehensive health insurers are financially solvent and have adequate reserves to cover health insurance claims. Utah’s comprehensive health insurers are financially stable and are able to meet their financial obligations to consumers.

Utah's Long-Term Care Insurance Market

Long-term care insurance is designed to provide specialized insurance coverage for skilled nursing care and custodial care in a nursing home, assisted living facility, or home health care situation following a serious illness or injury. Long-term care insurance typically covers specialized services that are not usually covered by comprehensive or major medical health insurance.

Long-term care insurance accounts for approximately 1.2 percent of the commercial health insurance market in Utah (see Table 3) and provides coverage for over 37,000 members, or approximately 1.4 percent of Utah residents. These estimates only refer to commercial long-term care insurance regulated by the Insurance Department. They do not include other types of long-term care coverage offered by self-funded employers or government programs. This section summarizes various aspects of the market including state of domicile, group size, and age and gender demographics.

Long-Term Care Market by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state. Foreign insurers provide nearly all of Utah's long-term care insurance. The eighty-one foreign insurers account for over 95 percent of the market, with only one domestic insurer providing long-term care coverage (see Table 20). Loss ratios were slightly lower for the domestic insurer.

Table 20. Total Long-Term Care Market by Domicile for 2007

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	1	1,627	\$1,818,212	4.28%	27.76
Foreign	81	36,048	\$40,638,773	95.72%	32.47
Total	82	37,675	\$42,456,985	100.00%	32.27

Data Source: Utah Accident & Health Survey

Long-Term Care Market by Group Size

Long-term care insurance plans are sold either as an individual or a group policy. Individual policies are sold directly to individual consumers. In contrast, group policies are sold as a single contract to a group of individuals, such as a group of employees, or an association plan.

Nearly all long-term care insurers reported individual business, while only 24 companies reported group business. Group business includes small group and large group business and refers to groups of 2 or more members. Most of the premium and membership reported was for individual business. Loss ratios were higher for individual policies than for group policies (see Table 21).

Table 21. Total Long-Term Care Market by Group Size for 2007

Group Size	Company Count^a	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Individual	79	20,624	\$29,230,120	68.85%	38.74
Group	24	17,051	\$13,226,865	31.15%	17.97
Total	82	37,675	\$42,456,985	100.00%	32.27

Data Source: Utah Accident & Health Survey

^a Company count column does not add up to total because an insurer may have more than one group size.

Long-Term Care Market by Age and Gender

As Utah's population has grown, the number of individuals over the age of 65 has increased. As a result, the role of long-term care insurance coverage has grown, because the cost of health care increases as we age.

Long-Term Care membership by age and gender. Commercial health insurers reported 37,676 members with long-term care insurance in Utah during 2007. Nearly forty-six percent of the membership was under age 60, with the majority (54 percent) being sixty or older. Overall, there were slightly more women than men with long-term care coverage at every age group, except for those under 60, where more men had coverage (see Table 22).

Table 22. Long-Term Care Membership by Age and Gender for 2007

Age	Men	Percent	Women	Percent	Total	Percent
Age 0-59	9,143	24.3%	8,083	21.5%	17,226	45.8%
Age 60-64	2,405	6.4%	2,610	6.9%	5,015	13.3%
Age 65-69	2,186	5.8%	2,353	6.2%	4,539	12.0%
Age 70-74	1,779	4.7%	2,136	5.7%	3,915	10.4%
Age 75-79	1,578	4.2%	1,831	4.9%	3,409	9.0%
Age 80-84	957	2.5%	1,292	3.4%	2,249	6.0%
Age 85+	526	1.4%	796	2.1%	1,322	3.5%
Total Members	18,574	49.3%	19,101	50.7%	37,675	100.0%

Data Source: Utah Accident & Health Survey

Utah's Medicare Product Market

Medicare Supplement and Medicare Advantage policies are specialized health insurance products designed to complement the federal Medicare program. Medicare Supplement policies are sold as a “supplement” to the basic Medicare Part A (Hospital) and Part B (Medical) programs and provide additional coverage beyond the basic Medicare benefits. Medicare Advantage (also known as Medicare Part C) policies, however, are sold as full replacement products. In other words, instead of providing specialized coverage for the “gaps” in Medicare like a supplementary product (with Medicare still bearing most of the insurance risk), Medicare Advantage products replace Medicare completely and the health insurance company bears the full risk of financial loss (with Medicare bearing no financial risk, other than paying the member's portion of the premium to the health insurer).

Another important Medicare product is Medicare Part D. Medicare Part D is a new product that became available during 2006 as a result of changes to the federal Medicare program. Medicare allows commercial health insurers to offer stand-alone pharmacy coverage via specialized insurance products called Medicare Part D drug plans. These plans provide coverage for prescription drugs, a medical benefit that Medicare Part A and B do not normally pay for.

Medicare Supplement and Medicare Advantage products account for over 13 percent of Utah's accident & health insurance market, with approximately 2.9 percent of the market share in Medicare Supplement coverage and over 10 percent of the market share in Medicare Advantage coverage. Approximately 3.8 percent of Utah residents had coverage under a Medicare Supplement or Medicare Advantage product, with about 2.0 percent in Medicare Supplement product and about 1.8 percent in a Medicare Advantage product. Medicare Part D products account for nearly 3 percent of Utah's accident & health insurance market and provide coverage for over 77,000 members, or approximately 2.9 percent of Utah residents.

These estimates only refer to commercial Medicare products offered in the Utah's commercial health insurance market. They do not include other types of Medicare products offered by self-funded employers or government programs. This section summarizes various aspects of the market including state of domicile, age and gender demographics, and plan type.

Medicare Products by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state.

Medicare Supplement by domicile. In Utah, Medicare Supplement coverage is divided relatively equally between domestic and foreign insurers. However, there are more foreign than domestic insurers. Seventy-seven foreign insurers account for nearly 50 percent of the market, with five domestic insurers covering the remaining 50 percent (see Table 23).

Table 23. Total Medicare Supplement Market by Domicile for 2007

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	5	26,471	\$49,607,334	50.12%	74.13
Foreign	77	27,312	\$49,372,202	49.88%	74.13
Total	82	53,783	\$98,979,536	100.00%	74.42

Data Source: Utah Accident & Health Survey

Medicare Advantage by domicile. Foreign insurers provide the majority of Medicare Advantage coverage in Utah. Eight foreign insurers account for more than 58 percent of the market, with three domestic insurers covering the remaining 41 percent (see Table 24).

Table 24. Total Medicare Advantage Market by Domicile for 2007

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	3	17,988	\$209,825,606	41.37%	81.94
Foreign	8	29,521	\$148,071,985	58.63%	78.06
Total	11	47,509	\$357,897,591	100.00%	79.66

Data Source: Utah Accident & Health Survey

Medicare Part D by domicile. Seventeen commercial health insurers reported Medicare Part D business during 2007. Most of the coverage was provided by foreign insurers, which accounted for over 90 percent of the market. Only one domestic company reported Medicare Part D business for 2007 (see Table 25).

Table 25. Total Medicare Part D Market by Domicile for 2007

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	2	3,371	\$9,145,752	9.74%	98.84
Foreign	15	73,908	\$84,712,008	90.26%	84.72
Total	17	77,279	\$93,857,760	100.00%	86.10

Data Source: Utah Accident & Health Survey

Medicare Products by Age and Gender

The number of individuals in Utah over the age of 65 continues to grow. Medicare products, such as Medicare Supplement policies, Medicare Advantage products, and Medicare Part D drug plans are specifically designed for this population, and provide an important type of health care coverage for older Utah residents.

Medicare Supplement membership by age and gender. Eighty-two commercial health insurers reported 53,783 members with Medicare Supplement coverage in Utah during 2007. Nearly all (98.6 percent) of the residents with coverage were over age 65. This probably due to Medicare's eligibility requirements, which requires most people to be age 65 or older in order to

receive coverage. More women had Medicare Supplement coverage than men at every age bracket. This may simply be due to women's greater longevity (i.e., women tend to live longer than men) (see Table 26).

Table 26. Medicare Supplement Membership by Age and Gender for 2007

Age	Men	Percent	Women	Percent	Total	Percent
Age 0-59	91	0.2%	117	0.2%	208	0.4%
Age 60-64	199	0.4%	365	0.7%	564	1.0%
Age 65-69	5,768	10.7%	6,631	12.3%	12,399	23.1%
Age 70-74	5,585	10.4%	6,698	12.5%	12,283	22.8%
Age 75-79	4,844	9.0%	5,804	10.8%	10,648	19.8%
Age 80-84	3,975	7.4%	4,907	9.1%	8,882	16.5%
Age 85+	3,719	6.9%	5,080	9.4%	8,799	16.4%
Total Members	24,181	45.0%	29,602	55.0%	53,783	100.0%

Data Source: Utah Accident & Health Survey

Medicare Advantage membership by age and gender. Eleven commercial health insurers reported 47,509 members with Medicare Advantage coverage in Utah during 2007. Most (89.6 percent) of the residents with coverage were over age 65. This probably due to Medicare's eligibility requirements, which requires most people to be age 65 or older in order to receive coverage. More women had Medicare Advantage coverage than men at every age bracket. This may simply be due to women's greater longevity (i.e., women tend to live longer than men) (see Table 27).

Table 27. Medicare Advantage Membership by Age and Gender for 2007

Age	Men	Percent	Women	Percent	Total	Percent
Age 0-59	1,633	3.4%	1,675	3.5%	3,308	7.0%
Age 60-64	759	1.6%	877	1.8%	1,636	3.4%
Age 65-69	6,214	13.1%	7,680	16.2%	13,894	29.2%
Age 70-74	5,265	11.1%	5,961	12.5%	11,226	23.6%
Age 75-79	3,990	8.4%	4,437	9.3%	8,427	17.7%
Age 80-84	2,516	5.3%	2,954	6.2%	5,470	11.5%
Age 85+	1,382	2.9%	2,166	4.6%	3,548	7.5%
Total Members	21,759	45.8%	25,750	54.2%	47,509	100.0%

Data Source: Utah Accident & Health Survey

Medicare Part D membership by age and gender. Seventeen commercial health insurers reported 77,279 members with Medicare Part D Drug Plan coverage in Utah during 2007. Most (82.2 percent) of the residents with coverage were over age 65. This probably due to Medicare's eligibility requirements, which requires most people to be age 65 or older in order to receive coverage. More women had Medicare Supplement coverage than men at every age bracket, except for those under age 60. This may simply be due to women's greater longevity (i.e., women tend to live longer than men) (see Table 28).

Table 28. Medicare Part D Membership by Age and Gender for 2007

Age	Men	Percent	Women	Percent	Total	Percent
Age 0-59	5,860	7.6%	5,724	7.4%	11,584	15.0%
Age 60-64	965	1.2%	1,192	1.5%	2,157	2.8%
Age 65-69	7,729	10.0%	8,900	11.5%	16,629	21.5%
Age 70-74	7,683	9.9%	8,304	10.7%	15,987	20.7%
Age 75-79	5,958	7.7%	6,571	8.5%	12,529	16.2%
Age 80-84	4,547	5.9%	4,930	6.4%	9,477	12.3%
Age 85+	4,087	5.3%	4,829	6.2%	8,916	11.5%
Total Members	36,829	47.7%	40,450	52.3%	77,279	100.0%

Data Source: Utah Accident & Health Survey

Medicare Products by Plan Type

Medicare Supplement membership by plan type. Commercial health insurers reported 53,783 members with Medicare Supplement in Utah during 2007. Commercial health insurers reported members in one of 14 Standardized Medicare Supplement plans, or in Pre-Standardized plans (plans in force prior to the Federal government standardizing the plans that can be offered) (see Table 29).

The most commonly reported Medicare Supplement plan was Plan F with 42.7 percent of the membership. The next closest plans were Medicare Supplement Plan C, with 13.4 percent; Pre-Standardized Plans, with 10.7 percent; Medicare Supplement Plan J, with 8.3 percent; Medicare Supplement Plan D, with 8.1 percent; and Medicare Supplement Plan G, with 6.3 percent. All other plans had 2.5 percent of the membership or less, with three plans having less than 45 members (see Table 29).

Table 29. Medicare Supplement Membership by Plan Type for 2007

Plan Type	Members	Percent
Plan A	1,224	2.3%
Plan B	1,268	2.4%
Plan C	7,209	13.4%
Plan D	4,335	8.1%
Plan E	1,358	2.5%
Plan F	22,976	42.7%
Plan F (High Deductible Plan)	256	< 0.1%
Plan G	3,376	6.3%
Plan H	869	1.6%
Plan I	615	1.1%
Plan J	4,451	8.3%
Plan J (High Deductible Plan)	4	< 0.1%
Plan K	45	< 0.1%
Plan L	17	< 0.1%
Pre-Standardized Plans	5,780	10.7%
Total Members	53,783	100.00%

Data Source: Utah Accident & Health Survey

Medicare Advantage membership by plan type. Commercial health insurers reported 47,509 members with Medicare Advantage (full Medicare replacement policies) in Utah during 2007. Medicare Advantage plans (which completely replace Medicare and bear the full risk of loss) come in one of five major plan types.

During 2007, most of the membership was covered under a Private Fee-for-Service plan, with 57.3 percent of the membership. Second most common was a Preferred Provider Organization plan, with 31.5 percent of the membership. Third most common was a Health Maintenance Organization plan, with 10.3 percent of the membership. None of the companies reported membership in plans with Medical Savings Accounts and there were only 417 members in Special Needs Plans (less than 1 percent) (see Table 30).

Table 30. Medicare Advantage Membership by Plan Type for 2007

Plan Type	Members	Percent
Private Fee-for-Service	27,217	57.3%
Preferred Provider Organization	14,959	31.5%
Health Maintenance Organization	4,916	10.3%
Medical Savings Account	0	0.0%
Special Needs Plan	417	0.9%
Total Members^a	47,509	100.0%

Data Source: Utah Accident & Health Survey

Summary

Health insurance is an important issue for the people of Utah. Utah's residents receive their health insurance coverage through health plans sponsored by the government, employers, and commercial health insurers. The commercial health insurance market is the only source of health insurance directly regulated by the Insurance Department.

Approximately 61 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves approximately 32 percent of Utah residents. The typical policy in this industry is an employer group policy with a managed care plan administered by a domestic comprehensive health insurer.

A key function of the Insurance Department is to assist consumers with questions and concerns they have about insurance coverage. The Office of Consumer Health Assistance (OCHA) is the agency within the Insurance Department that handles consumer concerns about their health insurance. Based on the number of complaints received by OCHA, most Utah consumers are receiving good consumer service from Utah's commercial health insurers. For example, the numbers of consumer complaints received by the Insurance Department declined from 1999 to 2003, remained fairly constant during 2004 and 2005, and then declined again during 2006 and 2007. This is primarily due to efforts by OCHA's staff and the Utah health insurance industry to resolve consumer concerns before they rise to the level of a formal complaint. This is a positive trend for Utah consumers and the Utah health insurance industry.

Over the last nine years, there have been four significant trends in the comprehensive health insurance market that the Insurance Department continues to monitor: changes in the number of insurers, the cost of comprehensive health insurance, the number of Utah residents with comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers declined steadily from 1999 to 2003, and then remained fairly constant during 2004, with a slight increase during 2005 and 2006, followed by another slight decline during 2007. Most of this change was due to a decrease in the number of small foreign comprehensive health insurers participating in the comprehensive health insurance market during 1999 to 2003. In contrast, there has been little or no change in the number of medium to large comprehensive health insurers. Large domestic comprehensive health insurers account for more than 90 percent of the market and provide a solid pool of comprehensive health insurers. These insurers are financially solvent and provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market. The decline has affected a small portion of the marketplace and the number of large comprehensive health insurers offering comprehensive health insurance has remained stable since 1999.

Like the rest of the United States, Utah's comprehensive health insurance market is experiencing significant increases in the costs of health insurance. For example, the average premium per member per month increased from \$192 during 2006 to \$204 during 2007, an increase of 6.3 percent. This growth in premiums is being driven primarily by increases in the underlying cost of health care that comprehensive health insurers contract to pay for. For

example, the average losses per member per month increased from \$157 during 2006 to \$166 during 2007, an increase of 5.7 percent. Over the last nine years, increases in premium per member per month have averaged 9.2 percent per year, while increases in losses per member per month have averaged 7.8 percent per year. Overall, the data suggests that while premiums have fluctuated year to year, there is consistent pricing pressure on health care costs that has remained constant over the last nine years. These pricing pressures are not unique to Utah and are being driven by national health care trends that are affecting most states in a similar way. Although these increases are difficult, Utah's health insurance premiums appear to be lower than the national average. Based on data from the NAIC financial database, the average cost for comprehensive health insurance coverage was \$259 per member per month during 2007. Although this comparison does not control for differences in benefits, health status, or demographics, this national estimate is higher than the average in Utah's commercial market. However, the premium that consumers actually pay will differ from the market average depending on their individual circumstances.

During 1999 to 2007, the number of Utah residents covered by comprehensive health insurance has seen period of decline followed by periods of increase. Comprehensive health insurance membership declined the most from 1999 to 2003, and then remained fairly consistent during 2004, and then increased from 2005 to 2007. Based on the available information, the decline during 1999 to 2003 appears to be primarily due to a shift by large employers and other large group plans from commercial insurance to self-funding arrangements. However, recent increases in the uninsured and the number of residents covered by government sponsored health benefit plans may also be contributing factors.

During 2005 to 2007, comprehensive health insurers reported an increase in membership with most of this increase occurred during 2006. However, another significant increase occurred during 2007, with comprehensive health insurers reporting an increase of over 33,000 members, an increase of 3.9 percent. Most of the increase occurred among large group plans, with the remainder occurring among small group plans. Individual plans reported a slight decrease. As for plan types, increases were reported among every plan type except Health Maintenance Organization plans, which experienced a significant decline. This was due in part to a one-time restructuring of the market place. This restructuring has two components. First, nearly half of the increase was due to two new foreign insurers entering Utah's comprehensive health insurance market and acquiring new members, with most of the remaining increase occurring among the top three domestic insurers. Second, one of Utah's large domestic insurers, in response to market demands for products with more open provider networks, shifted a large block of business from Health Maintenance Organization plans (which have a more limited provider network) to Health Maintenance Organization with Point of Service features plans (which provide the option to use non-network providers but at a higher cost). This shift from Health Maintenance Organization plans to Health Maintenance Organization with Point of Service features plans appears to a response to market forces that were demanding insurance products with more open provider networks and the insurer responded to meet market demand. These are positive signs for the industry, particularly given the stress caused by the rising cost of health care. These changes suggest that Utah's comprehensive health insurance market is attractive and new insurers want to do business here and Utah's insurers are responsive to market forces and will change how they do business if the demand is there.

Over the last thirteen years the top insurers in the comprehensive health insurance industry have experienced an average financial gain of 1.59 percent. Comprehensive health insurers experienced significant losses from 1996 to 1998. However, company financials have improved since 1998, with the core of the industry experiencing an average financial gain of 2.58 percent over the last nine years, with financial gains of 4.34 percent during 2007. Overall, Utah's core comprehensive health insurers are financially solvent and have adequate reserves to cover health insurance claims. Utah's comprehensive health insurers are financially stable and are able to meet their financial obligations to consumers.

As requested by the Utah Legislature, the Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market. These recommendations are reported in the Appendix (see page 43). This year's report also includes new data on long-term care insurance and Medicare products.

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Appendix

Recommendations

As requested by the Utah Legislature, the Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market. These recommendations are listed by order of importance:

- 1) Implement in the state of Utah, a health insurance portal for the convenient and cost effective purchase of health insurance for the benefit of health care consumers residing in the state.
- 2) Encourage the development of, and the requirement to use, electronic data interchange standards for clinical health information exchange (cHIE) and electronic health records.
- 3) HIPUtah funding be actuarially sound.
- 4) Encourage transparency in the marketing, purchasing, and consumption of health care products and services, as well as in the marketing and purchase of health insurance.
- 5) Create a prescription drug purchasing plan to reduce costs to both individuals and payers.
- 6) Reform the current medical malpractice system with a no-fault dispute resolution system modeled after workers' compensation insurance.
- 7) Remove state mandates and allow the option to adopt any state mandate at its appropriate cost.
- 8) Institute long term cultural training and education to educate health care and health insurance consumers on the value of "Wellness" as a means of extending life and reducing health care costs over time. This may include the initiation of appropriate economic incentives to promote wellness in the population.
- 9) Institute a training program for health care professionals (doctors, physician assistants, physical therapists, nurses and nurse practitioners) designed to fundamentally change the way lower level medical procedures are delivered to consumers in an effort to increase efficiency and lower costs.
- 10) Be prepared to react swiftly and reasonably to Federal health initiatives as they come forth over the next 24 months.
- 11) Include education and training on the nature of health care and health insurance costs to State consumer and financial education curriculum standards, with an emphasis on teaching consumers how to spend less and get more value out of their health care purchases.

List of Comprehensive Health Insurers

Table 31. List of Comprehensive Health Insurers during 2007

Company Name	State of Domicile	Direct Earned Premium	Market Share	Loss Ratio
SelectHealth Inc	UT	\$912,704,059	43.44%	84.63
Regence BCBS of UT	UT	\$438,911,595	20.89%	79.11
Altius Hlth Plans Inc	UT	\$356,146,458	16.95%	82.21
United Healthcare Ins Co	CT	\$143,258,624	6.82%	75.63
Healthwise	UT	\$94,988,319	4.52%	71.00
Aetna Life Ins Co	CT	\$34,876,791	1.66%	75.25
Guarantee Trust Life Ins Co	IL	\$13,344,435	0.64%	82.59
Educators Health Care	UT	\$12,909,962	0.61%	98.28
Connecticut Gen Life Ins Co	CT	\$12,702,887	0.60%	83.89
United Healthcare Of UT Inc	UT	\$10,851,490	0.52%	70.69
Mega Life & Hlth Ins Co The	OK	\$9,046,317	0.43%	41.18
SelectHealth Benefit Assur Co Inc	UT	\$6,741,847	0.32%	80.30
Deseret Mut Ins Co	UT	\$6,253,321	0.30%	80.46
Humana Ins Co	WI	\$5,840,227	0.28%	62.80
Health Care Serv Corp A Mut Legal Re	IL	\$4,335,151	0.21%	83.02
American Medical Security Life Ins C	WI	\$4,281,057	0.20%	34.41
Time Ins Co	WI	\$4,221,688	0.20%	39.98
Cigna Hlthcare of UT Inc	UT	\$4,194,362	0.20%	85.96
Educators Health Plans Health	UT	\$4,061,944	0.19%	89.48
Madison Natl Life Ins Co Inc	WI	\$3,068,899	0.15%	68.14
Western Mut Ins	UT	\$2,785,537	0.13%	89.85
State Farm Mut Auto Ins Co	IL	\$2,719,868	0.13%	94.73
Mid West Natl Life Ins Co Of TN	TX	\$2,412,663	0.11%	32.10
Standard Security Life Ins Co Of NY	NY	\$1,602,428	0.08%	49.09
Unicare Life & Health Ins Co	IN	\$1,270,848	0.06%	50.45
First Hlth Life & Hlth Ins Co	TX	\$1,247,054	0.06%	81.41
National Found Life Ins Co	TX	\$1,047,120	0.05%	97.46
New York Life Ins Co	NY	\$920,897	0.04%	121.08
Regence Life & Health Ins Co	OR	\$682,494	0.03%	60.98
Golden Rule Ins Co	IN	\$382,293	0.02%	93.32
Symetra Life Ins Co	WA	\$354,816	0.02%	44.34
Educators Mut Ins Assoc	UT	\$342,541	0.02%	76.04
John Alden Life Ins Co	WI	\$335,985	0.02%	50.25
American Natl Life Ins Co Of TX	TX	\$314,853	0.01%	100.07
American Underwriters Life Ins Co	AZ	\$209,630	0.01%	65.50
National Hlth Ins Co	TX	\$189,311	0.01%	66.06
Great W Life & Ann Ins Co	CO	\$185,030	0.01%	90.42
World Ins Co	NE	\$132,938	0.01%	176.97
Fidelity Security Life Ins Co	MO	\$127,818	0.01%	4.25
Chesapeake Life Ins Co	OK	\$124,284	0.01%	27.58
Trustmark Life Ins Co	IL	\$101,219	< 0.01%	72.31
Best Life & Hlth Ins Co	TX	\$82,433	< 0.01%	9.08
Trustmark Ins Co	IL	\$80,225	< 0.01%	8.78
United Of Omaha Life Ins Co	NE	\$60,430	< 0.01%	306.06
Prudential Ins Co Of Amer	NJ	\$59,540	< 0.01%	352.02
American Republic Ins Co	IA	\$53,695	< 0.01%	60.43
Celtic Ins Co	IL	\$52,996	< 0.01%	71.20
Union Labor Life Ins Co	MD	\$34,256	< 0.01%	3.28
AXA Equitable Life Ins Co	NY	\$28,227	< 0.01%	1101.57
Pyramid Life Ins Co	KS	\$25,012	< 0.01%	7.81
Freedom Life Ins Co Of Amer	TX	\$23,438	< 0.01%	0.00
Mutual Of Omaha Ins Co	NE	\$23,406	< 0.01%	NA

Continental Gen Ins Co	NE	\$23,185	< 0.01%	212.36
American States Ins Co	IN	\$19,436	< 0.01%	NA
Principal Life Ins Co	IA	\$12,727	< 0.01%	65.23
Metropolitan Life Ins Co	NY	\$11,836	< 0.01%	71.14
LifeSecure Ins Co	MI	\$10,109	< 0.01%	686.98
Central United Life Ins Co	AR	\$7,396	< 0.01%	19.79
American Heritage Life Ins Co	FL	\$6,695	< 0.01%	11.20
Standard Life & Accident Ins Co	OK	\$6,544	< 0.01%	0.00
Republic American Life Ins Co	TX	\$6,116	< 0.01%	37.93
American Natl Ins Co	TX	\$4,812	< 0.01%	10.74
Guardian Life Ins Co Of Amer	NY	\$4,155	< 0.01%	52.18
Union Security Ins Co	IA	\$3,244	< 0.01%	61.31
Transamerica Occidental Life Ins Co	IA	\$2,211	< 0.01%	201.27
Allianz Life Ins Co Of N Amer	MN	\$1,708	< 0.01%	33.20
New England Life Ins Co	MA	\$1,702	< 0.01%	919.51
Reserve Natl Ins Co	OK	\$1,652	< 0.01%	268.95
Lincoln Life & Ann Co of NY	NY	\$775	< 0.01%	56.26
Alta Hlth & Life Ins Co	IN	\$615	< 0.01%	75.77
Conseco Life Ins Co	IN	\$525	< 0.01%	0.00
Assurity Life Ins Co	NE	\$450	< 0.01%	0.00
Central Reserve Life Ins Co	OH	\$334	< 0.01%	90.12
Centre Life Ins Co	MA	\$176	< 0.01%	0.00
All Comprehensive Health Insurers	74	\$2,100,879,121	100.00%	81.10

Data Source: Utah Accident & Health Survey

List of Health Insurance Mandates in Utah

Coverage Mandates

Required by Federal statute:

1. Preexisting conditions (31A-22-605; NAIC Standard)
2. Dependent coverage from the moment of birth or adoption (31A-22-610)
3. Coverage through a noncustodial parent (31A-22-610.5; Social Security Act)
4. Open enrollment for child coverage ordered by a court (31A-22-610.5; Social Security Act)
5. Medicare supplemental insurance, including preexisting conditions provision (31A-22-620; NAIC Standard; Title XVIII of the Social Security Amendment, 1965)
6. Individual and small group guaranteed renewability (31A-30-107; Health Insurance Portability and Accountability Act, 1997)
7. Individual and small group limit on exclusions and preexisting conditions (31A-30-107; Preexisting conditions are required by Federal Statute)
8. Small group portability and individual guaranteed issue (31A-30-108; Health Insurance Portability and Accountability Act, 1997)
9. Maternity coverage on groups of 15 or more employees (Pregnancy Discrimination Act, Public Law 95-555, 1978)
10. COBRA benefits for employees of employer with 20 or more employees (Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, 1985)

Required by State statute:

1. Policy provision standards (31A-22-605)
2. Dependent coverage to age 26 (31A-22-610.5)
3. Extension of policy for a dependent child with a disability (31A-22-611)
4. Conversion privileges for an insured former spouse (31A-22-612)
5. Mini-COBRA benefits for employees of employer with less than 20 employees (31A-22-722; State expansion of Federal COBRA requirements).

Benefit Mandates

Required by Federal statute:

1. Maternity stay minimum limits (31A-22-610.2; Newborn & Mothers Health Protection Act, Public Law 105-35, 1997)
2. Pediatric vaccines – level of benefit (31A-22-610.5, Omnibus Budget Reconciliation Act, 1993)
3. Preauthorization of emergency medical services (31A-22-627; Federal Patient Bill of Rights Plus Act)
4. OB/GYN as primary care physician (31A-22-624)

5. Mastectomy provisions (31A-22-630; Women's Health & Cancer Rights Act, 1996)

Required by State statute:

1. \$4,000 minimum adoption indemnity benefit (31A-22-610.1)
2. Dietary products for inborn metabolic errors (31A-22-623)
3. Catastrophic coverage of mental health conditions (31A-22-625; Required by Federal statute, but State statute is more protective than Federal requirements)
4. Diabetes coverage (31A-22-626)
5. Standing referral to a specialist (31A-22-628)
6. Basic Health Care Plan in individual market (31A-22-613.5 and 31A-30-109)

Provider Mandates

Required by Federal statute:

None

Required by State statute:

1. Preferred provider contract provisions, including 75 percent reimbursement provision for non-preferred providers, quality assurance program, nondiscrimination, and grievance process (31A-22-617)
2. HMO payments to noncontracting providers in rural areas (31A-8-501)

Statutory Requirements and Methods Overview

Statutory Requirements

Utah Code Annotated (U.C.A.) § 31A-2-201(7) requires that the Utah Insurance Department produce an annual evaluation of the health insurance market. The statutory requirements for this evaluation are shown below:

- (7) (a) Each year, the commissioner shall:
- (i) conduct an evaluation of the state's health insurance market;
 - (ii) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1; and
 - (iii) publish the findings of the evaluation of the department website.
- (b) The evaluation shall:
- (i) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of Utahns by assessing such things as the availability and marketing of individual and group products, rate charges, coverage and demographic changes, benefit trends, market share changes, and accessibility;
 - (ii) assess complaint ratios and trends within the health insurance market, which assessment shall integrate complaint data from the Office of Consumer Health Assistance within the department;
 - (iii) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and
 - (iv) include claims loss ratio data for each insurance company doing business in the state.
- (c) When preparing the evaluation required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

Methods Overview

This report primarily uses data from two sources: the NAIC Financial Database and the Utah Accident & Health Survey. It also uses information from national data sources and government agencies. The report will continue to evolve as required to meet the needs of the Utah Legislature.

Qualifications. The accuracy of the information in this publication depends on the quality of the data supplied by commercial health insurers. While the information presented here is believed to be correct and every effort has been made to obtain accurate information, the Insurance Department cannot control for variations in the quality of the data supplied by commercial health insurers or differences in how insurers interpret NAIC and Insurance Department data submission guidelines.

NAIC Financial Database. The NAIC Financial Database is a nationwide database maintained by the National Association of Insurance Commissioners. It contains data obtained from insurance companies' annual financial statements. Data was obtained for companies writing

commercial health insurance in Utah from 1999 to 2007. The data summarizes the total accident & health premium and losses in Utah reported by commercial health insurers to the NAIC. It does not provide information on a particular type of health insurance.

Utah Accident & Health Survey. The Utah Accident & Health Survey is submitted annually to the Insurance Department. All commercial health insurers are required to file this report. This survey provides detailed information on commercial insurance activity in Utah. It includes information that allows the Insurance Department to estimate trends in Utah's commercial health insurance market, including market share, number of covered lives, loss ratios, and cost of insurance. Data is available for year 1999 to 2007. The data includes information on approximately 370 companies each year.

The survey is divided into five parts: accident & health insurance, long term care & Medicare supplement insurance, comprehensive health insurance, administration of self-funded plans, and marketing of accident & health insurance. The accident & health insurance portion of the survey must balance to the total accident & health insurance business reported on the Utah business section of the annual statement. The comprehensive insurance section includes detailed information on plan types, group size, and year-end member months. This additional detail allows the Insurance Department to evaluate changes in the comprehensive health insurance market with much greater accuracy.

During 2005, the Insurance Department conducted a review of the product categories being used in the Utah Accident & Health Survey. As part of this review, additional information was requested from many of Utah's commercial health insurers. Based on the information obtained from the product category review, the product categories were revised as follows.

Fee for Service plans (FFS), Preferred Provider Organization plans (PPO), and Health Maintenance Organization plans (HMO) remained unchanged. The previously used Point of Service plan category was split into two categories: Health Maintenance Organization with Point of Service features (HMO with POS) and Preferred Provider Plan with Point of Service features (PPO with POS).

In order to make the previously collected data comparable with the new categories, licensed HMOs who had reported POS plans were recoded to HMO with POS plans, while licensed commercial health insurers who had reported POS plans were recoded as PPO with POS and merged with PPO plans. This reclassification was made in order to minimize confusion regarding point of service products and, hopefully, increase understanding of the various insurance product options available in Utah's commercial health insurance market.

In the case of HMO with POS plans, offering an option to use out of network providers for some types of non-emergency services is a distinctive feature for a HMO plan. Furthermore, HMO with POS plans play a significant role in Utah's comprehensive health insurance market and cover a large number of Utah residents. Given these issues, this plan type was analyzed separately from other HMO plans.

In contrast, PPO with POS plans have few functional differences from standard PPO plans and the Utah Insurance Code does not distinguish between PPO plans with or without point of service features (such as preauthorization requirements) as both offer a preferred provider network with an out of network option. Also, PPO with POS plans have a limited role in Utah's market place and few residents have this type of coverage. Given the limited differences of PPO with POS plans from standard PPO plans and their minor status in the market place, this plan was analyzed together with the other PPO plans.

The Utah Accident & Health Survey does not specifically measure differences in benefit structure, demographics, or the health status of the commercially insured population. Despite this limitation, this survey (along with the NAIC Financial Database) is a valuable source of data on Utah's commercial health insurance market and as such provides useful information on commercial health insurance.

Glossary

This section includes a brief glossary of some specialized terms used in this report, which may be unclear to readers who are unfamiliar with Utah's health insurance industry.

Domestic insurer: An insurance company licensed to sell insurance in Utah and which also has its home office in Utah. Insurance companies that have a home office in Utah are said to be “domiciled in Utah”. The state of domicile is important because most of the direct regulation of individual insurance companies is done by the state where the company is domiciled (e.g., solvency requirements, etc). See also Foreign insurer.

Commercial health insurance: Any type of accident or health insurance product sold by a commercial health insurer. It refers to any type of accident or health insurance product permitted under the Utah Insurance Code.

Commercial health insurer: A insurance company that is registered with the Utah Insurance Department and is licensed to sell any type of accident or health insurance product in the State of Utah.

Commercial insurance health benefit plan: Another name for comprehensive health insurance. See also Comprehensive health insurance and Comprehensive health insurer.

Comprehensive health insurance: A subset of commercial health insurance. A comprehensive health plan is a general-purpose health insurance product that provides a broad range of insurance coverage for basic medical services typically provided by a physician, including hospital and medical services, and in most cases, durable medical equipment and drugs. Because of the wide variety of basic medical services it covers, these plans are frequently called “major medical”, “comprehensive health”, or “comprehensive hospital and medical” to distinguish them from other types of accident or health insurance products with more limited benefits. It is the insurance product most people think of when they hear the term “health insurance”.

Comprehensive health insurer: A commercial health insurer that offers a comprehensive health insurance product.

Employer sponsored self-funded health benefit plan: The key feature of these plans is the risk of loss is born by the sponsoring organization (e.g., a health benefit plan offered by a large employer or non-profit association group), rather than a commercial health insurer. These plans are exempt from state regulation under the Federal ERISA statute, as they are not considered the “business of insurance”, but an employee benefit plan. Self-funded plans are regulated under the Federal Department of Labor and states have no regulatory authority over these plans.

Foreign insurer: An insurance company licensed to sell insurance in Utah, but it does not have a home office in Utah. It is domiciled in another state. See also Domestic insurer.

Government sponsored health benefit plan: Any health benefit plan offered by a federal or state government agency, where the government bears the risk of loss. These plans include

Medicare, Medicaid, Children's Health Insurance Program (CHIP), Primary Care Network (PCN), and the Utah Comprehensive Health Insurance Pool (HIPUtah). These plans do not include any health benefit plans for government employees, which are considered employer sponsored self-funded health benefit plans. See also Employer sponsored self-funded health benefit plans.