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2013 Health Insurance Market Report

The *2013 Health Insurance Market Report* was prepared by Jeffrey E. Hawley, Ph.D. of the Health & Life Insurance Division for the Utah Insurance Commissioner pursuant to Utah Code Annotated (U.C.A.) § 31A-2-201.2. Publication date: December 2, 2014.

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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 51 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves approximately 28 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 remained relatively constant from 2003 to 2005, declined during 2006 to 2008, and increased from 2009 to 2012. The increase in complaints from 2009 to 2012 appears to be due to the combined impact of the economic recession and the changes in government regulations. During 2009 to 2012, consumers contacted the Insurance Department in greater numbers, and many of those calls were questions and concerns regarding the new options under COBRA, questions and concerns related to changes to their health insurance coverage and how their claims were paid, some of which were connected to changes in state and federal health regulations, and the state health insurance exchange for small employers.

Over the last ten 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 has declined from 2003 to 2012. For example, the number of comprehensive health insurers remained fairly constant from 2003 to 2007, and then declined from 2008 to 2012. Most of this change was due to a decrease in the number of very small foreign comprehensive health insurers with less than $1 million in premium. In contrast, the total number of large and medium insurers has remained fairly stable. Large domestic comprehensive health insurers account for more than 80 percent of the market and provide a solid pool of commercial health insurers. However, while the number of medium insurers has remained relatively stable, there has been a shift from domestic to foreign insurers during this period. For example, in 2003, medium insurers were primarily domestic, while by 2012 medium size insurers are primarily foreign. Large and medium health insurers provide the majority of Utah's comprehensive health insurance coverage, are financially solvent, and provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market.

Like the rest of the United States, Utah's comprehensive health insurance market continues to experience increases in the costs of health insurance. For example, the average premium per member per month increased from $240 during 2011 to $247 during 2012, an increase of 2.9 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, over the last ten years, increases in premium per member per month have averaged 5.8 percent per year, while increases in losses per member per month have averaged 5.7 percent per year. Overall, the data suggests that while premiums have fluctuated year to year, there is consistent pricing pressure on health care costs which has remained constant over the last ten years; however, the rate of increase in health care costs has slowed over the last five years. These pricing pressures are not unique to Utah and are being driven by trends in national health care costs 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 premium for comprehensive health insurance coverage was $320 per member per month during 2012. 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.

From 2003 to 2012, the number of Utah residents covered by comprehensive health insurance has seen periods of decline followed by periods of increase. However, the membership fluctuations have hovered close to an average of 829,000 over the last 10 years. Comprehensive health insurance membership declined from 2003 to 2005, increased from 2006 to 2008, declined during 2009, remained relatively stable during 2010, followed by a period of decline during 2011 and 2012. The changes during 2009, 2010, and 2011 appear to be connected to the economic recession with the number of commercially insured members declining as unemployment started to increase during 2009. During 2012, the decline in membership appears to be a shift from fully insured to self-funded health benefit plans rather than an increase in the uninsured. This is consistent with the current trends in the uninsured and the number of residents covered by government sponsored health benefit plans which may also be factors in this change.

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 top insurers in the comprehensive health insurance industry have experienced an average financial gain of 2.6 percent in net income after expenses over the last ten years, with comprehensive health insurers reporting an average of 4.8 percent in net income after expenses during 2012. 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).

Introduction

For most people, health insurance is the financing mechanism to manage personal health care costs. 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-2-201.2.

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 health insurance 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 United Healthcare Insurance Company), nonprofit health service plans (such as Regence

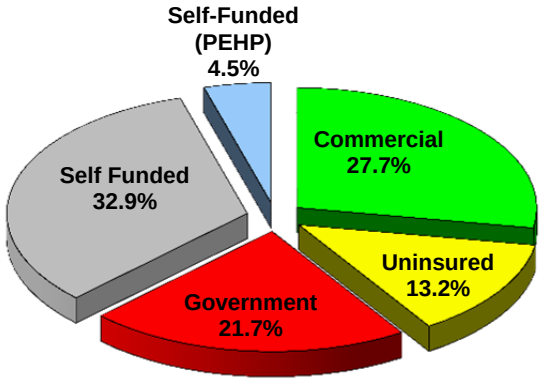
Blue Cross Blue Shield of Utah), health maintenance organizations (such as SelectHealth, Inc.), and limited health plans (such as Delta Dental Care of Utah). The health insurance benefits provided will vary from comprehensive major medical health insurance to specified limited health insurance benefits 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 U.S. 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 2012



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 2012 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 Behavioral Risk Factor Surveillance System Survey (BRFSS) conducted by the Utah Department of Health.

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 Behavioral Risk Factor Surveillance System Survey. The result is imperfect, but it does provide an estimate of the self-funded population.

Given these limitations, the Insurance Department estimates that nearly twenty-two percent of Utah residents were covered by government plans, over thirty-seven percent were covered by self-funded plans, nearly twenty-eight percent were covered by commercial health insurance, and more than thirteen percent were uninsured (see Table 1).

Table 1. Estimate of Health Insurance Coverage for 2012

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans	**620,069**	**21.7%**
Medicare	304,202	10.7%
Medicaid	257,691	9.0%
Children's Health Insurance Program (CHIP)	36,893	1.3%
Primary Care Network (PCN)	16,734	0.6%
Utah Comprehensive Health Insurance Pool (HIPUtah)	3,381	0.1%
Federal Pre-Existing Condition Insurance Plan (Federal HIPUtah)	1,168	< 0.1%
Employer Sponsored Self-Funded Plans	**1,066,114**	**37.4%**
Plans Administered by Commercial Insurers	515,645	18.1%
Public Employee Health Program (PEHP)	127,049	4.5%
Federal Employee Health Benefit Plan (FEHBP)	97,749	3.4%
Other Known Self-Funded Plans	63,005	2.2%
Other Self-Funded Plans (Estimated)	262,666	9.2%
Commercial Health Insurance Plans	**789,806**	**27.7%**
Group	633,380	22.2%
Individual	156,426	5.5%
Uninsured	**376,600**	**13.2%**
Total	**2,852,589**	**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 2012 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 1,403 commercial fraternal, life, health, and property & casualty insurers licensed with the Insurance Department at the end of 2012. Of these, three hundred and forty-one commercial insurers reported commercial health insurance business in Utah on their 2012 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. As a group, Utah's commercial health insurers had a loss ratio of 83 and net income of 5.92 percent (see Table 2). Although, company loss ratios for accident & health business in Utah do provide an accurate view of commercial health insurer's Utah operations, net income (at the company 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. About 73 percent of Utah's commercial health insurance market is domestic. These 26 domestic insurers are much more representative of the Utah market as more than 80 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 86 and net income of 4.29 percent. Utah's commercial health insurance market is highly concentrated among ten domestic commercial health insurers, which account for over 70 percent of the commercial health insurance market. These ten commercial health insurers represent about 97 percent of the domestic market. They had a loss ratio of nearly 86 and net income of 4.51%. The remaining three percent of the domestic market consists of life insurers and limited health plans.

There are 315 foreign insurers in Utah's commercial health insurance market, most of which are life insurers. These foreign insurers account for about 27 percent of Utah's market. Foreign insurers had a loss ratio of 77 for Utah business. Net income was 5.93 percent, but a negligible amount of total revenue (less than 1 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 2012

		Utah Operations			National Operations	
Insurer Type	**Company Count**	**Direct Earned Premium**	**Market Share**	**Loss Ratio**	**Total Revenue**	**Net Income (% Rev)**
Domestic Insurers						
Health	10	$3,246,333,303	71.68%	85.66	$3,387,663,344	4.51%
Life	12	$69,459,622	1.53%	91.79	$694,939,863	3.18%
Limited Health Plan	4	$5,971,146	0.13%	55.74	$6,031,187	6.32%
Total Domestic	**26**	**$3,321,764,071**	**73.34%**	**85.74**	**$4,088,634,394**	**4.29%**
Foreign Insurers						
Fraternal	11	$1,342,867	0.03%	34.27	$12,416,664,894	5.14%
Life	262	$1,153,883,190	25.48%	77.49	$686,694,252,577	5.33%
Property & Casualty	42	$52,026,139	1.15%	63.24	$113,641,392,092	9.64%
Total Foreign	**315**	**$1,207,252,196**	**26.66%**	**76.83**	**$812,752,309,563**	**5.93%**
Utah Insurers						
Fraternal	11	$1,342,867	0.03%	34.27	$12,416,664,894	5.14%
Health	10	$3,246,333,303	71.68%	85.66	$3,387,663,344	4.51%
Life	274	$1,223,342,812	27.01%	78.30	$687,389,192,440	5.33%
Limited Health Plan	4	$5,971,146	0.13%	55.86	$6,031,187	6.32%
Property & Casualty	42	$52,026,139	1.15%	63.24	$113,641,392,092	9.64%
Total Utah	**341**	**$4,529,016,267**	**100.00%**	**83.36**	**$816,840,943,957**	**5.92%**

Data Source: NAIC Financial Database

Note: The total direct earned premium and total revenue reported here is based on the annual financial statement data submitted by commercial insurers to the National Association of Insurance Commissioners (NAIC). Estimates may not total exactly due to rounding.

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 341 commercial health insurers who reported accident & health premium in Utah for 2012.

The top three policy types by market share were comprehensive health insurance (51 percent), Medicare Advantage products (18 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 2012 annual statement. However, the difference is small. The net difference in total reported direct earned premium is less than 0.1 percent.

Table 3. Total Commercial Health Insurance Market by Policy Type for 2012

Policy Type	Company Count [a]	Member Count [b]	Direct Earned Premium	Market Share	Loss Ratio
Comprehensive	57	789,806	$2,324,561,535	51.28%	83.61
Hospital-Medical-Surgical	34	4,856	$2,266,339	0.05%	37.05
Medicare Supplement	84	50,646	$102,136,774	2.25%	71.32
Medicare Advantage	15	94,532	$843,082,383	18.60%	88.54
Medicare Drug Plan	20	79,645	$102,756,369	2.27%	79.01
Dental Only	91	561,437	$175,825,570	3.88%	81.97
Vision Only	36	380,078	$19,217,076	0.42%	68.43
FEHBP	3	73,504	$381,292,814	8.41%	94.95
Medicare	0	0	-	0.00%	0.00
Medicaid/CHIP	2	79,038	$187,393,075	4.13%	76.48
Stop Loss	41	385,949	$97,368,353	2.15%	74.76
Disability Income	152	444,078	$132,953,824	2.93%	78.03
Long-Term Care	75	39,267	$39,799,843	0.88%	55.29
Credit A&H	33	90,842	$8,408,863	0.19%	32.45
All Other A&H	197	-	$115,806,597	2.55%	57.63
Total Accident & Health	**341**	**-**	**$4,532,869,415**	**100.00%**	**83.29**

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. Estimates may not total exactly due to rounding.

[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 the grievance process
- Analyzing and monitoring federal and state regulations that apply to health care consumers

OCHA typically processes more than 5,000 consumer inquires 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. Number of Consumer Inquiries Handled by OCHA Staff: 2003 - 2012

Consumer Inquiries	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Telephone (in/out)	10,054	9,213	8,633	7,125	5,180	4,201	4,528	3,400	3,885	5,151
Walk-in	75	83	43	33	16	26	27	24	19	22
Other (in/out)	999	1,217	736	616	825	1,119	805	1,094	1,808	2,382
Total Inquires	**11,128**	**10,513**	**9,412**	**7,774**	**6,021**	**5,346**	**5,360**	**4,518**	**5,712**	**7,555**

Data Source: Utah Insurance Department

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 found to be acting within the bounds of the law. In these situations, 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 remained relatively constant from 2003 to 2005, declined during 2006 to 2008, and was followed by a period of steady increase from 2009 to 2012. The number of justified complaints has remained relatively stable from 2003 to 2012, except for 2007, where the number of justified complaints was significantly lower than the trend. The number of question of fact complaints has fluctuated or remained relatively constant since 2003. The number of unjustified complaints has remained constant from 2003 to 2006, with a slight decline during 2007, followed by a steady increase from 2008 to 2012.

The overall trend towards fewer complaints from 2003 to 2008 was primarily due to an 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 was a positive trend for the industry. The increase in the number of complaints from 2009 to 2012 is likely due the combined impact of the economic recession and the changes in government regulations. During 2009 to 2012, consumers contacted the Insurance Department in greater numbers. Many consumers called with questions and concerns regarding the new options under COBRA, including premium subsidies provided through the American Recovery and Reinvestment Act (ARRA) and economic problems related to their health insurance coverage that were created by the recession. Other consumers had questions and concerns related to changes to their health insurance coverage and how their claims were paid, some of which was connected to changes in state and federal health regulations, and the state health insurance exchange for small employers.

Table 5. Complaints Filed with OCHA by Type: 2003 - 2012

	Total		Justified		Question of Fact		Unjustified	
Year	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
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%
2008	106	100.0%	44	41.5%	7	6.6%	55	51.9%
2009	139	100.0%	51	36.7%	22	15.8%	66	47.5%
2010	145	100.0%	48	33.1%	18	12.4%	79	54.5%
2011	144	100.0%	43	29.9%	28	19.4%	73	50.7%
2012	161	100.0%	53	32.9%	9	5.6%	99	61.5%
Average	**125**	**100.0%**	**43**	**34.4%**	**16**	**12.8%**	**66**	**52.8%**

Data Source: Utah Insurance Department

Note: Estimates 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, about fifty-six percent of all consumer complaints are due to claim handing issues, while policyholder services and marketing & sales issues account for the remainder (see Table 6).

Table 6. Complaints Filed with OCHA by Reason: 2003 - 2012

	Total [a]		Claim Handling		Policyholder Services		Marketing & Sales	
Year	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
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%
2008	106	100.0%	68	64.2%	27	25.5%	11	10.4%
2009	139	100.0%	81	58.3%	54	38.8%	4	2.9%
2010	145	100.0%	70	48.3%	7	4.8%	68	46.9%
2011	144	100.0%	83	57.6%	54	37.5%	7	4.9%
2012	162	100.0%	111	68.5%	26	16.0%	25	15.4%
Average	**125**	**100.0%**	**70**	**56.0%**	**35**	**28.0%**	**20**	**16.0%**

Data Source: Utah Insurance Department

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

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

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 2003 to 2012 (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: 2003 - 2012

		Total		Justified		Question of Fact		Unjustified	
Year	Direct Earned Premium	Count	Ratio	Count	Ratio	Count	Ratio	Count	Ratio
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
2008	$3,789,597,619	106	0.03	44	0.01	7	< 0.01	55	0.01
2009	$4,041,549,106	139	0.03	51	0.01	22	0.01	66	0.02
2010	$4,273,396,253	145	0.03	48	0.01	18	< 0.01	79	0.02
2011	$4,475,227,723	144	0.03	43	0.01	28	0.01	73	0.02
2012	$4,529,016,267	161	0.04	53	0.01	9	< 0.01	99	0.02
Average	**$3,437,558,948**	**125**	**0.04**	**43**	**0.01**	**16**	**< 0.01**	**66**	**0.02**

Data Sources: NAIC Financial Database and Utah Insurance Department

Note: Estimates may not total exactly due to rounding.

As discussed previously, the total number of complaints remained relatively constant from 2003 to 2005, declined during 2006 to 2008, and was followed by a period of steady increase from 2009 to 2012. The lower number of question of fact complaints is part of a concerted effort by OCHA staff and the Utah health insurance industry to reduce the number of these kinds of complaints, while the recent increases seemed to be connected to changes in the economy and government policies related to COBRA and state and federal health regulations.

However, the number of justified 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 0.04 for all complaints, about 0.01 for justified, less than 0.01 for question of fact complaints, and about 0.02 for unjustified complaints. Using this average as a benchmark, the complaint ratios for 2012 are lower than or equal to their ten-year average.

Table 8 reports individual complaint ratios for commercial health insurance companies during 2012. 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 0.01 has a higher than average number of complaints, while a ratio of less than 0.01 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 2012

Company Name	Direct Earned Premium	Market Share	Total [a] Count	Total [a] Ratio	Justified Count	Justified Ratio	Question Of Fact Count	Question Of Fact Ratio
Ace American Ins Co	$30,010,023	0.66%	1	0.03	-	-	-	-
Aetna Life Ins Co	$62,375,982	1.38%	2	0.03	1	0.02	1	0.02
Altius Health Plans Inc	$381,967,149	8.43%	14	0.04	4	0.01	-	-
American Family Life Assur Co of Col	$26,829,528	0.59%	2	0.07	2	0.07	-	-
American Heritage Life Ins Co	$3,341,915	0.07%	1	0.30	-	-	-	-
Bankers Life & Casualty Co	$4,197,595	0.09%	2	0.48	-	-	-	-
Chesapeake Life Ins Co	$1,200,947	0.03%	1	0.83	-	-	-	-
Cigna Health & Life Ins Co	$22,384,930	0.49%	2	0.09	1	0.04	1	0.04
Companion Life Ins Co	$17,075,763	0.38%	1	0.06	-	-	-	-
Continental Life Ins Co Brentwood	$1,121,057	0.02%	1	0.89	1	0.89	-	-
Educators Health Plans Health Inc	$7,271,382	0.16%	1	0.14	-	-	-	-
Educators Mutual Ins Association	$32,044,823	0.71%	1	0.03	-	-	1	0.03
Equitable Life & Casualty Ins Co	$4,602,383	0.10%	2	0.43	-	-	-	-
Gerber Life Ins Co	$2,498,900	0.06%	1	0.40	-	-	-	-
Hartford Life & Accident Ins Co	$31,814,188	0.70%	1	0.03	-	-	-	-
Humana Ins Co	$212,620,897	4.69%	29	0.14	12	0.06	-	-
John Hancock Life Ins Co USA	$4,334,384	0.10%	2	0.46	-	-	-	-
Lincoln National Life Ins Co	$10,241,097	0.23%	2	0.20	-	-	-	-
Metropolitan Life Ins Co	$38,724,949	0.86%	1	0.03	-	-	-	-
Mutual Of Omaha Ins Co	$5,142,190	0.11%	2	0.39	-	-	-	-
Pan American Life Ins Co	$4,860,015	0.11%	1	0.21	1	0.21	-	-
Prudential Ins Co Of America	$10,963,014	0.24%	1	0.09	-	-	-	-
Regence BCBS of UT	$998,293,493	22.04%	22	0.02	6	0.01	1	< 0.01
Reliance Standard Life Ins Co	$4,113,018	0.09%	1	0.24	-	-	-	-
SelectHealth Benefit Assurance Co Inc	$3,970,497	0.09%	1	0.25	-	-	-	-
SelectHealth Inc	$1,159,257,408	25.60%	25	0.02	8	0.01	-	-
Senior Health Ins Co of PA	$1,010,222	0.02%	1	0.99	1	0.99	-	-
Sentinel Security Life Ins Co	$1,251,889	0.03%	1	0.80	-	-	-	-
Standard Life & Accident Ins Co	$3,619,476	0.08%	1	0.28	1	0.28	-	-
Time Ins Co	$6,377,956	0.14%	1	0.16	1	0.16	-	-
Union Security Ins Co	$4,279,930	0.09%	1	0.23	1	0.23	-	-
United States Fire Ins Co	$1,578,907	0.03%	3	1.90	-	-	1	0.63
UnitedHealthcare Ins Co	$263,112,125	5.81%	22	0.08	9	0.03	3	0.01
Unum Life Ins Co Of America	$12,996,121	0.29%	2	0.15	2	0.15	-	-
Washington National Ins Co	$7,082,040	0.16%	2	0.28	-	-	-	-
Top 35 companies with complaints [b]	**$3,382,566,193**	**74.69%**	**154**	**0.05**	**51**	**0.02**	**8**	**< 0.01**
Remaining 6 companies with complaints [c]	$1,086,229	0.02%	7	6.44	2	1.84	1	0.92
Companies without complaints	$1,145,363,845	25.29%	-	-	-	-	-	-
Total Commercial Market	**$4,529,016,267**	**100.00%**	**161**	**0.04**	**53**	**0.01**	**9**	**< 0.01**

Data Sources: NAIC Financial Database and Utah Insurance Department

Note: Estimates may not total exactly due to rounding.

[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 51 percent of the commercial health insurance market in the state of Utah (see Table 3) and affects approximately 28 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 82 percent of the comprehensive health insurance market is served by domestic insurers and is highly concentrated among 9 insurers. Forty-eight foreign insurers represent the remaining market share. Premiums were higher for domestic insurers than foreign insurers with $256 per member per month for domestics and $212 per member per month for foreign. Loss ratios were lower for foreign insurers (see Table 9).

Table 9. Total Comprehensive Market by Domicile for 2012

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [a]
Domestic	9	620,617	$1,900,047,109	81.74%	84.23	$256
Foreign	48	169,189	$424,514,426	18.26%	80.82	$212
Total	**57**	**789,806**	**$2,324,561,535**	**100.00%**	**83.61**	**$247**

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 has 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 ($269) than individual policies ($157). This is probably due to differences in underwriting practices. In individually underwritten policies, insurers have more ability to set rates based on health status and applicants may be declined if they do not meet the insurer's underwriting 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 (see Table 10).

Table 10. Total Comprehensive Market by Group Size for 2012

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Total Individual [c]	41	156,426	$295,795,808	12.72%	79.62	$157
Small Group (2-50)	18	212,591	$573,509,644	24.67%	77.46	$238
Large Group (50+)	27	420,789	$1,455,256,083	62.60%	86.84	$284
Total Group	33	633,380	$2,028,765,727	87.28%	84.19	$269
Total Comprehensive	**57**	**789,806**	**$2,324,561,535**	**100.00%**	**83.61**	**$247**

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] Total Individual includes both individual and conversion policies.

Comprehensive Market by Plan Types

In this report, comprehensive health insurance plans are classified into four major plan types: Fee for Service (FFS), Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), and Health Maintenance Organization with Point of Service features (HMO with POS). 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 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.

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. An 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 plan type offered by a licensed HMO. An 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, an HMO with POS functions like a standard HMO.

HMO, HMO with POS, and PPO plans are considered managed care plans. FFS plans typically do not involve any form of managed care. Over 97 percent of Utah's comprehensive health insurance market involves some type of managed care; with over 64 percent of the comprehensive health market in an HMO or HMO with POS. Less than 3 percent of the market had a FFS plan (see Table 11).

Table 11. Total Comprehensive Market by Plan Type for 2012

Plan Type	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Fee for Service	36	17,021	$59,483,014	2.56%	80.46	$282
Preferred Provider Organization	34	273,791	$767,908,584	33.03%	78.44	$239
Health Maintenance Organization	5	176,088	$485,656,072	20.89%	85.25	$229
HMO with Point of Service features [c]	2	322,906	$1,011,513,865	43.51%	86.92	$261
Total	**57**	**789,806**	**$2,324,561,535**	**100.00%**	**83.61**	**$247**

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 FFS plans compared to the other plan types, while HMO plans were the lowest among traditional insurance products. 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 some plans have lower premiums than other plans may be the higher deductible and fewer benefits. 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.

Comprehensive Market by Insurance Code Exemptions

As part of the ongoing health care reform efforts, state and federal governments have created specialized plans that are exempt from certain state and federal insurance regulations. Creating limited exemptions to specific statutes is a tool legislatures use to encourage commercial health insurers to provide new insurance products that may meet the needs of specific segments of the market or may provide coverage for people who would not purchase coverage under normal market conditions. Table 12 describes some of the new plans that have been created as a result of either state or federal legislation and for which comprehensive health insurers have reported enrollment in Utah (see Table 12).

Please note that insurers have not created products for every exemption now available under the Utah Insurance Code. For example, as of Dec 31. 2012, none of the commercial health insurers reported plans that omitted at least one or more benefit mandate as permitted under Utah Code Annotated (U.C.A.) § 31A-30-109(2). The data presented in this report only includes plans with insurance code exemptions that have a statutory reporting requirement under U.C.A. § 31A-2-201.2 and commercial health insurers have reported data for that particular limited exemption to the Utah Insurance Department.

Table 12. Total Comprehensive Market by Insurance Code Exemptions for 2012

Plan Type	Company Count	Member Count	Percent of Members
Traditional Defined Benefit Market	57	781,980	99.01%
Standard Plan (no exemptions)	57	474,934	60.13%
Federally Qualified High Deductible HSA Eligible	11	150,382	19.04%
Limited Exemption (U.C.A. § 31A-22-618.5)	1	156,659	19.84%
Utah NetCare (U.C.A. § 31A-22-724)	2	5	< 0.01%
Small Employer Defined Contribution Market [a]	4	7,826	0.99%
Standard Plan (no exemptions)	3	1,743	0.22%
Federally Qualified High Deductible HSA Eligible	2	3,299	0.42%
Limited Exemptions (U.C.A. § 31A-22-618.5)	1	2,784	0.35%
Total Comprehensive Market	57	789,806	100.00%
Standard Plan (no exemptions)	57	476,677	60.35%
Federal Qualified High Deductible HSA Eligible	11	153,681	19.46%
Limited Exemptions (U.C.A. § 31A-22-618.5)	1	159,443	20.19%
Utah NetCare (U.C.A. § 31A-22-724)	2	5	< 0.01%
Total	**57**	**789,806**	**100.00%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2012.

[a] There were 290 employers participating in the Defined Contribution Market at the end of 2012.

Defined Benefit Plans verses Defined Contribution Plans. Defined Benefit Plans are the traditional way health benefit plan sponsors (usually employers) fund health insurance. For example, the employer defines the benefits available in the plans that employees may select from. The employer will then pay a predetermined percentage of the plan's cost on behalf of the employee and the employee pays the rest. Defined Contribution Plans are an alternate funding strategy employers use to offer health benefits to their employees. Rather than defining the benefits that can be selected, the employer provides a fixed or "defined" amount of money that can be used to purchase a health insurance plan. Employees may then use this "defined contribution" to choose a health insurance plan independent of the employer.

In Utah's comprehensive health insurance market, most health benefit plans have been offered as Defined Benefit Plans. However, with the creation of the Small Employer Defined Contribution Market (see U.C.A. 63M-1-2504), employees may purchase health insurance plans through a defined contribution arrangement, where participating employers provide a defined contribution towards the purchase of a health insurance plan offered in the Small Employer Defined Contribution Market. Employees may either use the defined contribution alone or may add their own money to purchase a plan that is appropriate for them. There are 290 employers, 7,826 members (about 1 percent of the market) and 4 comprehensive health insurers participating in the Small Employer Defined Contribution Market.

Standard Plans. Standard plans are simply the typical health benefit plan that operates under the current statutory requirements of the Utah insurance code and do not qualify for or make use of any of the new state or federal insurance code statutory exemptions. Most health benefit plans in Utah's health insurance market are Standard Plans. There are 476,677 members (about 60 percent of the market) enrolled in Standard Plans.

Federally Qualified High Deductible HSA Eligible Plans. A HSA Eligible High Deductible Health Plan (HDHP) is a specialized type of insurance product authorized by the federal government. High deductible health plans are health benefit 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 an 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 individual) and only the employer can deposit funds into the account. There are 153,681 members (about 19 percent of the market) enrolled in Federally Qualified High Deductible HSA Eligible Plans.

Limited Exemption Plans under U.C.A. § 31A-22-618.5. As U.C.A. § 31A-22-618.5(1) states: "The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets." This statute provides a variety of options that allow comprehensive health insurers to create products that are exempt from certain standard requirements. For example, insurers with at least one standard HMO or PPO product in Utah may also offer more specialized HMO or PPO products that are exempt from certain regulations that normally apply to HMO and PPO products. These options can increase the range of health benefit plans available to certain areas of Utah's comprehensive health insurance market. There are 159,443 members (about 20 percent of the market) enrolled in Limited Exemption Plans under U.C.A. § 31A-22-618.5. All of these members were enrolled in an HMO product with a Point of Service feature that is exempt from the standard limitation on point of service products under Subsection 31A-8-408(3) through (6) (see U.C.A. § 31A-8-408), which is one of the options available under U.C.A. § 31A-22-618.5.

Utah NetCare Plans (U.C.A. § 31A-22-724). Utah NetCare plans were created by the Utah Legislature in 2009 and became available in Utah during 2010. Utah NetCare plans are designed as an alternative option to COBRA and Utah mini-COBRA when an employee qualifies to extend the employer's group health plan. The Utah NetCare plan offers an employee who was previously insured on the employer's plan coverage at an expected cost lower than the average health plan in Utah. Utah NetCare plans usually do not have the same benefits as the employee's previous health benefit plan. There are 5 members (less than 0.01 percent of the market) enrolled in Utah Netcare Plans. Utah Netcare Plans will no longer be an option in Utah starting in 2014 due to changes made to the Utah Insurance Code during the 2013 legislative session.

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. As shown in Table 13, from 2003 to 2007, the number of comprehensive health insurers fluctuated but remain relatively stable during this period, and then starting in 2008, the number of comprehensive health insurers dropped, followed by a period of decline from 2009 to 2012. For example, in 2003, there were 76 commercial health insurance companies that reported comprehensive health insurance. By 2008, this number had dropped to 65, and as of 2012, there were 57 insurers who reported currently having comprehensive health insurance business in Utah. This decline is primarily among very small foreign insurers with less than $1 million dollars in premium. In contrast, the number of large and medium insurers has remained fairly stable.

Table 13. Changes in the Number of Comprehensive Health Insurers: 2003 - 2012

Insurer Category	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	*Net Change*
Domestic Insurers											
Greater than 100 Million	3	3	3	3	3	3	3	3	3	3	*0*
Between 10 and 100 Million	4	4	3	4	3	1	2	2	0	0	*-4*
Between 1 and 10 Million	2	3	4	3	5	5	5	4	4	4	*+2*
Less than 1 Million	1	1	1	2	1	1	2	2	4	2	*+1*
Total Domestic	**10**	**11**	**11**	**12**	**12**	**10**	**12**	**11**	**11**	**9**	***-1***
Foreign Insurers											
Greater than 100 Million	0	0	1	1	1	1	1	1	1	1	*+1*
Between 10 and 100 Million	1	1	1	2	3	4	4	4	4	6	*+5*
Between 1 and 10 Million	11	11	10	9	12	12	10	10	11	9	*-2*
Less than 1 Million	54	53	55	55	46	38	38	36	32	32	*-22*
Total Foreign	**66**	**65**	**67**	**67**	**62**	**55**	**53**	**51**	**48**	**48**	***-18***
All Insurers											
Greater than 100 Million	3	3	4	4	4	4	4	4	4	4	*+1*
Between 10 and 100 Million	5	5	4	6	6	5	6	6	4	6	*+1*
Between 1 and 10 Million	13	14	14	12	17	17	15	14	15	13	*0*
Less than 1 Million	55	54	56	57	47	39	40	38	36	34	*-21*
Total Utah	**76**	**76**	**78**	**79**	**74**	**65**	**65**	**62**	**59**	**57**	***-19***

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 very small comprehensive health insurers; particularly foreign insurers with less than 1 million dollars in comprehensive health insurance premium (see Table 13). In many cases, these very small foreign comprehensive health insurers are providing coverage for "non-situated" policies, which are 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 they sold a health insurance policy to a company that has an employee who 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 very small 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 32 for a list of the relative market shares of Utah's comprehensive health insurers).

In contrast, from 2003 to 2012, there has been little change in the number of large and medium sized comprehensive health insurers in the comprehensive health insurance market (see Table 13). Large comprehensive health insurers represent the core of the comprehensive health insurance market. These large insurers provide a solid pool of comprehensive health insurers and account for more than 80 percent of the market share. These insurers are financially solvent and provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market.

However, while the total number of medium insurers (between 10 to 100 million in premium) has also remained relatively stable over the last 10 years, there has been a shift from domestic to foreign insurers during this period. For example, in 2003, medium insurers were primarily domestic, while by 2012 medium size insurers are primarily foreign.

Foreign insurers now make up the core of the medium sized comprehensive health insurer market. In 2011, two medium domestic insurers reduced in size and then left the market, and then two small foreign insurers increased to medium size insurers during 2012, appearing to take their place. This shift means Utah's domestic market now has large and small players, but no medium insurers, with the medium size niche of the market populated by foreign insurers.

***Trends in the cost of insurance*.** Utah's comprehensive health insurance premiums continue to increase, but the rate of increase has slowed over the last five years. For example, from 2003 to 2012, the average premium per member per month for comprehensive health insurance has increased on average about 5.8 percent per year. In 2012, the average premium per

member per month for comprehensive health insurance was 2.9 percent higher than in 2011. Utah's rate of increase, in comparison with national employer data, appears to be following a national trend (see Table 14). This suggests that Utah's health insurance market continues to experience similar cost pressures as other parts of the country.

Table 14. Comprehensive Premium Compared to National Economic Trends: 2003 - 2012

	Comprehensive Premium in Utah				National Economic Trends
Year	Total Premium [a]	Premium PMPM [b]	Premium PMPY [c]	Annual Percent Change	Health Insurance Premium Annual Percent Change [d]
2003	$1,405,078,420	$149	$1,788	12.0%	13.3%
2004	$1,515,423,760	$162	$1,944	8.7%	9.7%
2005	$1,617,045,445	$171	$2,052	5.6%	9.3%
2006	$1,890,464,682	$192	$2,304	12.3%	5.5%
2007	$2,100,879,121	$204	$2,448	6.3%	5.5%
2008	$2,256,417,328	$214	$2,568	4.9%	4.7%
2009	$2,259,733,442	$221	$2,652	3.3%	5.5%
2010	$2,286,538,356	$229	$2,748	3.6%	3.0%
2011	$2,380,689,142	$240	$2,880	4.8%	9.5%
2012	$2,324,561,535	$247	$2,964	2.9%	4.5%

Data Sources: Utah premium data are from the Utah Accident & Health Survey from 2003 to 2012. The national trend data used as a comparison comes from the 2012 Kaiser/HRET Employer Health Benefits Survey.

[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 family coverage under 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, are continuing to increase. For example, from 2003 to 2012, the average losses per member per month for comprehensive health insurance has increased about 5.7 percent per year. In 2012, the average losses per member per month for comprehensive health insurance was 0.1 percent higher than in 2011 (see Table 15). The rate of increase in national health care costs has slowed over the last five years. This appears to be due in part to downward pricing pressure from the recession and slow economic recovery (Martin, Lassman, Whittle, Catlin, and the National Health Expenditure Accounts Team, 2011; Cuckler, Sisko, Keehan, Smith, Madison, Poisal, Wolfe, Lizonitz, and Stone, 2013).

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 utilization from consumer demand, litigation, new technologies, unnecessary care, and medical inflation also appear to be important factors (PriceWaterhouseCoopers, 2002; PriceWaterhouseCoopers, 2006; PriceWaterhouseCoopers, 2008a). Other studies have also found evidence of excess spending in the areas of defensive medicine, inefficient claims processing, and treatment of preventable health conditions (PriceWaterhouseCoopers, 2008b).

The rising cost of health care creates significant economic pressure on comprehensive insurers. For example, if Utah's comprehensive insurers had kept premiums at 2003 levels and costs had continued to increase, by 2012, the industry's loss ratio would be approximately 138. In other words, the industry would be paying out nearly $1.38 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 15. Comprehensive Losses Compared to National Health Care Spending: 2003 - 2012

	Comprehensive Losses in Utah				National Health Care Expenditures (in Millions of Dollars)			
Year	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
2003	84.06	$125	$1,500	13.6%	$1,778,017	8.6%	$615,741	9.7%
2004	86.12	$134	$1,608	7.2%	$1,905,746	7.2%	$659,957	7.2%
2005	81.61	$139	$1,668	3.7%	$2,035,377	6.8%	$703,218	6.6%
2006	81.69	$157	$1,884	12.9%	$2,166,731	6.5%	$740,217	5.3%
2007	81.10	$166	$1,992	5.7%	$2,302,925	6.3%	$777,652	5.1%
2008	83.81	$179	$2,148	7.8%	$2,411,693	4.7%	$807,811	3.9%
2009	85.17	$189	$2,268	5.6%	$2,504,235	3.8%	$833,074	3.1%
2010	84.32	$193	$2,316	2.1%	$2,599,000	3.8%	$859,624	3.2%
2011	85.94	$206	$2,472	6.7%	$2,692,781	3.6%	$888,765	3.4%
2012	83.61	$206	$2,475	0.1%	$2,793,394	3.7%	$916,959	3.2%

Data Sources: Utah loss data are from the Utah Accident & Health Survey from 2003 to 2012. The National Health Care Expenditure data are from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (2013).

[a] Ratio of direct incurred losses to direct earned premium
[b] Direct incurred losses per member per months
[c] Direct incurred losses per member per year

For Utah employers and consumers, this trend towards higher premiums means that health care continues to get more expensive. For a single individual, the average premium per member per year increased from $1,788 in 2003 to $2,964 in 2012. This is an increase of over 65 percent over the last ten 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, 2012). 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 to reduce costs. 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 16).

Table 16. Changes in Comprehensive Premium and Per Capita Income: 2003 - 2012

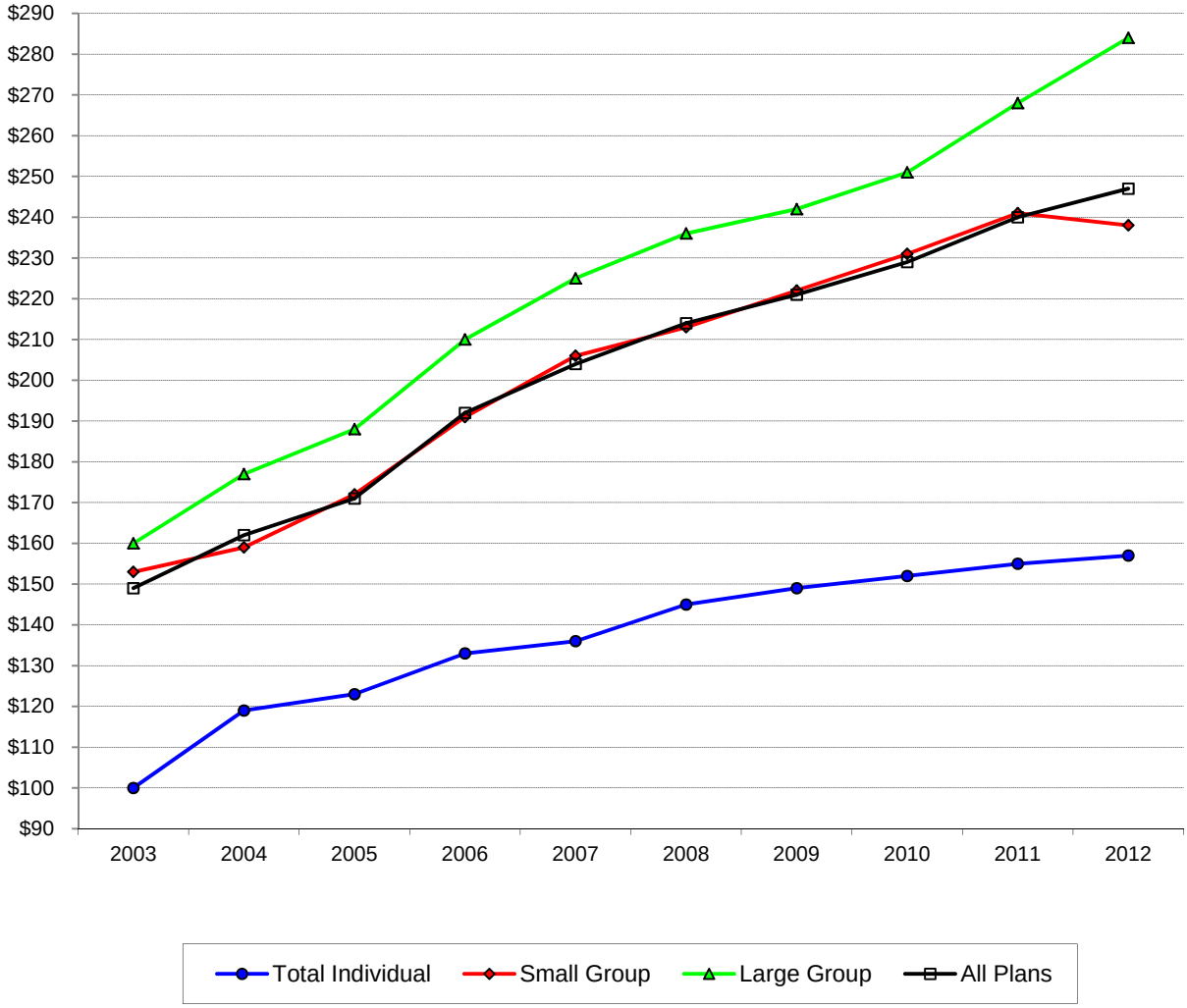
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Premium PMPY [a]	$1,788	$1,944	$2,052	$2,304	$2,448	$2,568	$2,652	$2,748	$2,880	$2,964
Percent change in Premium	12.0%	8.7%	5.6%	12.3%	6.3%	4.9%	3.3%	3.6%	4.8%	2.9%
Per Capita Income in Utah	$26,051	$27,254	$29,104	$31,035	$32,761	$34,025	$31,778	$32,121	$33,509	$34,585
Percent change in Income	1.2%	4.6%	6.8%	6.6%	5.6%	3.9%	-6.6%	1.1%	4.3%	3.2%

Data Sources: Utah premium data are from the Utah Accident & Health Survey. Per capita income data are from the Economic Outlook Report for 2013, Utah Governor's Office of Management and Budget.

[a] Direct earned premium per member per year

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 (see Figure 2). 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).

Figure 2. Comprehensive Premium PMPM by Group Size: 2003 - 2012



Data Source: Utah Accident & Health Survey

Increases in large group plan premiums have had the most impact on the premium trends in the market over the last ten 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.

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 17). For example, during 2012, the average premium for Utah's comprehensive health insurers was approximately $247 per member per month. In contrast, the average premium for commercial health insurers reporting comprehensive health insurance to the NAIC financial database was

approximately $320 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 17. Comparison of Utah Premium to National Premium: 2003 - 2012

	Utah Estimate		National Estimate	
Year	Premium PMPM for Comprehensive Health Insurance [a]	Annual Percent Change	Premium PMPM for Comprehensive Health Insurance	Annual Percent Change
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%
2008	$214	4.9%	$274	5.8%
2009	$221	3.3%	$286	4.4%
2010	$229	3.6%	$299	4.5%
2011	$240	4.8%	$311	4.0%
2012	$247	2.9%	$320	2.9%

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.

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 (5.8 percent for Utah, 5.4 percent for comprehensive insurers reporting to the NAIC).

Trends in the number of members. Since 2003, the number of residents insured by comprehensive health insurance as a relative percentage of Utah's total population has declined by about 7 percent. During this same time period Utah's population has increased by about 20 percent.

As shown in Table 18, from 2003 to 2012, the individual market has increased in step with population growth, generally maintaining their relative distribution in Utah's population, while the small and large group markets have declined. The largest change occurred in the large group market, which declined about 4.8 percent. In absolute numbers, however, comprehensive membership has remained relatively stable over the last ten years, averaging about 829,000 members (around 1/3 of Utah's population in any given year). Year to year changes, both increases and decreases, have been less than 52,000 members. Membership has increased during periods of economic growth and declined during periods of economic recession. Membership declined from 2003 to 2005, increased from 2006 to 2008, declined during 2009, remained relatively stable during 2010, followed by a period of decline during 2011 and 2012 (see Table 18).

The reasons for these trends in membership are complex. Various market forces are in operation. The decline in the number of comprehensive health insurers could have contributed to some of the decline in membership (see Table 13), but this is unlikely. It is more likely that the recent increases in the cost of health care and insurance premiums, along with periods of economic recession, 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 19) and can be observed somewhat in the available data.

First, there has been a small but steady increase in the number of residents with individual plans and this increase has kept pace with population growth. 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. It's also possible that employees who may have lost coverage due to the recession have turned to individual coverage to insure themselves.

Second, the number of members in the small group market declined from 2009 to 2011, followed by a significant increase in membership during 2012. This data suggests that prior to 2009 small employers had been maintaining insurance coverage despite the rising premiums in Utah's comprehensive market, which was a positive trend for Utah's small group market. The decline in membership from 2009 to 2011 may represent the economic stress of the recession and the slow economic recovery has made it harder for small employers to maintain coverage. However, the significant increase in small group membership during 2012 suggests some economic strength may be returning to the small group market, as the economy improves and jobs with health benefits return. Slower growth in health care costs may also have been a contributing factor.

Table 18. Changes in Comprehensive Membership by Group Size: 2003 – 2012

Group Size	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	*Net Change* [a]
Individual & Conversion	131,551	134,853	137,961	145,065	144,244	148,649	142,878	139,185	157,707	156,426	*+24,875*
Percent of population [b]	**5.5%**	**5.5%**	**5.5%**	**5.6%**	**5.5%**	**5.5%**	**5.2%**	**5.0%**	**5.6%**	**5.5%**	***0.0%***
Small Group	224,872	233,098	223,556	228,905	237,378	234,726	208,551	198,784	192,995	212,591	*-12,281*
Percent of population	**9.5%**	**9.6%**	**8.9%**	**8.9%**	**9.0%**	**8.7%**	**7.6%**	**7.2%**	**6.9%**	**7.5%**	***-2.0%***
Large Group	465,842	428,129	442,495	468,877	494,233	496,798	477,158	492,561	470,910	420,789	*-45,053*
Percent of population	**19.6%**	**17.6%**	**17.7%**	**18.2%**	**18.7%**	**18.5%**	**17.5%**	**17.8%**	**16.7%**	**14.8%**	***-4.8%***
Total Group	690,714	661,227	666,051	697,782	731,611	731,524	685,709	691,345	663,905	633,380	*-57,334*
Percent of population	**29.1%**	**27.2%**	**26.6%**	**27.1%**	**27.8%**	**27.2%**	**25.1%**	**24.9%**	**23.6%**	**22.2%**	***-6.9%***
Total Comprehensive	822,265	796,080	804,012	842,847	875,855	880,173	828,587	830,530	821,612	789,806	*-32,459*
Percent of population	**34.7%**	**32.8%**	**32.1%**	**32.7%**	**33.2%**	**32.7%**	**30.3%**	**29.9%**	**29.2%**	**27.7%**	***-7.0%***
Utah Population	2,372,457	2,430,224	2,505,844	2,576,228	2,636,077	2,691,122	2,731,558	2,774,663	2,813,923	2,852,589	*+480,132*
Percent of population	**100.0%**	**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: Estimates may not add up exactly to totals due to rounding.

[a] "Net Change" measures the difference in the absolute number of members from 2003 to 2012 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 20 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 19. Changes in Comprehensive Membership by Plan Type: 2003 – 2012

Plan Type [a]	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	*Net Change* [b]
FFS	93,385	90,840	70,811	74,624	89,014	96,422	106,485	28,097	17,722	17,021	*-76,364*
Percent of population [c]	**3.9%**	**3.7%**	**2.8%**	**2.9%**	**3.4%**	**3.6%**	**3.9%**	**1.0%**	**0.6%**	**0.6%**	***-3.3%***
PPO	167,239	165,030	168,760	183,175	185,512	204,460	206,072	269,521	268,784	273,791	*+106,552*
Percent of population	**7.0%**	**6.8%**	**6.7%**	**7.1%**	**7.0%**	**7.6%**	**7.5%**	**9.7%**	**9.6%**	**9.6%**	***+2.6%***
HMO	416,952	403,965	406,842	410,963	248,468	195,897	135,064	170,008	223,334	176,088	*-240,864*
Percent of population	**17.6%**	**16.6%**	**16.2%**	**16.0%**	**9.4%**	**7.3%**	**4.9%**	**6.1%**	**7.9%**	**6.2%**	***-11.4%***
HMO with POS	143,994	136,244	151,116	166,929	346,993	378,206	380,685	362,904	311,772	322,906	+178,912
Percent of population	**6.1%**	**5.6%**	**6.0%**	**6.5%**	**13.2%**	**14.1%**	**13.9%**	**13.1%**	**11.1%**	**11.3%**	***+5.2%***
Other	695	1	6,483[d]	7,156[d]	5,868[d]	5,188[d]	281	0	0	0	*-695*
Percent of population	**< 0.1%**	**< 0.1%**	**0.3%**	**0.3%**	**0.2%**	**0.2%**	**< 0.1%**	**0.0%**	**0.0%**	**0.0%**	**< -0.1%**
Total Comprehensive	822,265	796,080	804,012	842,847	875,855	880,173	828,587	830,530	821,612	789,806	*-32,459*
Percent of population	**34.7%**	**32.8%**	**32.1%**	**32.7%**	**33.2%**	**32.7%**	**30.3%**	**29.9%**	**29.2%**	**27.7%**	***-7.0%***
Utah Population	2,372,457	2,430,224	2,505,844	2,576,228	2,636,077	2,691,122	2,731,558	2,774,663	2,813,923	2,852,589	*+480,132*
Percent of population	**100.0%**	**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: Estimates may not add up exactly to totals due to rounding. Estimate totals may differ from previous reports due to category changes.

[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

[b] "Net Change" measures the difference in the absolute number of members from 2003 to 2012 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 20 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] 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.

Third, from 2004 to 2008, large group membership grew steadily, declined during 2009, increased during 2010, and the returned to 2009 levels during 2011. However, in 2012, there was significant decline in membership due to several blocks of business moving from fully insured health benefit plans to self-funded health benefit plans. In most cases, these groups remained with the same health insurer as before, but the insurer stopped providing a fully insured plan and started providing administrative services for a large employer's self-funded plan. The data suggests that this change is not an increase in the uninsured, but rather a shift by large employers from fully insured to self-funded health benefit plans.

Data on Utah's uninsured suggests that Utah's uninsured did not increase during 2012. According to the Behavioral Risk Factor Surveillance System Survey for 2012, Utah's uninsured rate was estimated to be 13.2 percent, which is basically unchanged from the 13.4 percent estimate for 2011 (Office of Public Health Assessment, 2012; Office of Public Health Assessment, 2013). Earlier data from the Utah Health Status Survey suggests that Utah's uninsured rate increased from 9.1 percent to 11.2 percent from 2003 to 2009 (Office of Public Health Assessment, 2006a; Office of Public Health Assessment, 2006b; Office of Public Health Assessment, 2007; Office of Public Health Assessment, 2008; Office of Public Health Assessment, 2009; Office of Public Health Assessment, 2010), which may have been a factor in earlier changes in comprehensive membership.

Table 20. Changes in Government Sponsored Health Benefit Plans: 2003 – 2012

Plan Type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	*Net Change* [a]
Medicare	220,221	226,749	231,263	238,286	252,572	264,086	271,773	280,838	290,319	304,202	*+83,981*
Medicaid	156,031	171,302	179,299	174,800	159,849	164,119	195,257	221,954	244,724	257,691	*+101,660*
CHIP	23,761	31,010	28,311	35,248	24,747	35,060	40,742	42,068	37,700	36,893	*+13,132*
PCN	17,228	16,499	18,311	16,043	17,795	18,505	24,103	14,946	16,780	16,734	*-494*
HIPUtah	2,854	2,999	3,143	3,346	3,505	3,621	3,839	4,158	3,688	3,381	*+527*
Federal HIPUtah	-	-	-	-	-	-	-	-	649	1,168	*+1,168*
Government Plans	420,095	448,559	460,327	467,723	458,468	485,391	535,714	563,964	593,860	620,069	*+199,974*
As percent of population [b]	**17.7%**	**18.5%**	**18.4%**	**18.2%**	**17.4%**	**18.0%**	**19.6%**	**20.3%**	**21.1%**	**21.7%**	***+4.0%***

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

Note: Estimates may not total exactly due to rounding. This table reports the following Government Sponsored Health Benefit Plans in Utah: Medicare, Medicaid, Children's Health Insurance Program (CHIP), Primary Care Network (PCN), Utah Comprehensive Health Insurance Pool (HIPUtah), and the Federal Pre-Existing Condition Insurance Plan (Federal HIPUtah).

[a] "Net Change" measures the difference in the absolute number of members from 2003 to 2012 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 20 percent over this period.

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

The available data on Utah's government sponsored health benefit plans shows a steady increase in membership (see Table 20), but this increase can only account for part of the decline in the commercial market and could be connected to other factors such as changes in the

economy, increases in the uninsured rate, and population increases. Most of the increases are in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

As for plan types, prior to 2007, most comprehensive market membership was in HMO plans, which accounted for nearly 50 percent of the market, with PPO and HMO with POS plans hovering a close second, and FFS plans last. However, in 2007, a large portion of the HMO population moved to HMO with POS plans (see Table 19). This was due in part to a one-time restructuring of the market place. This restructuring had two components. First, there was an increase in membership. Nearly half of this increase was due to two new foreign insurers entering Utah's comprehensive health insurance market and acquiring new members. Most of the remaining increase occurred 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 were positive changes in Utah's health insurance market and suggest that Utah's commercial health insurance market can be 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. This was followed by a smaller increase in members during 2008.

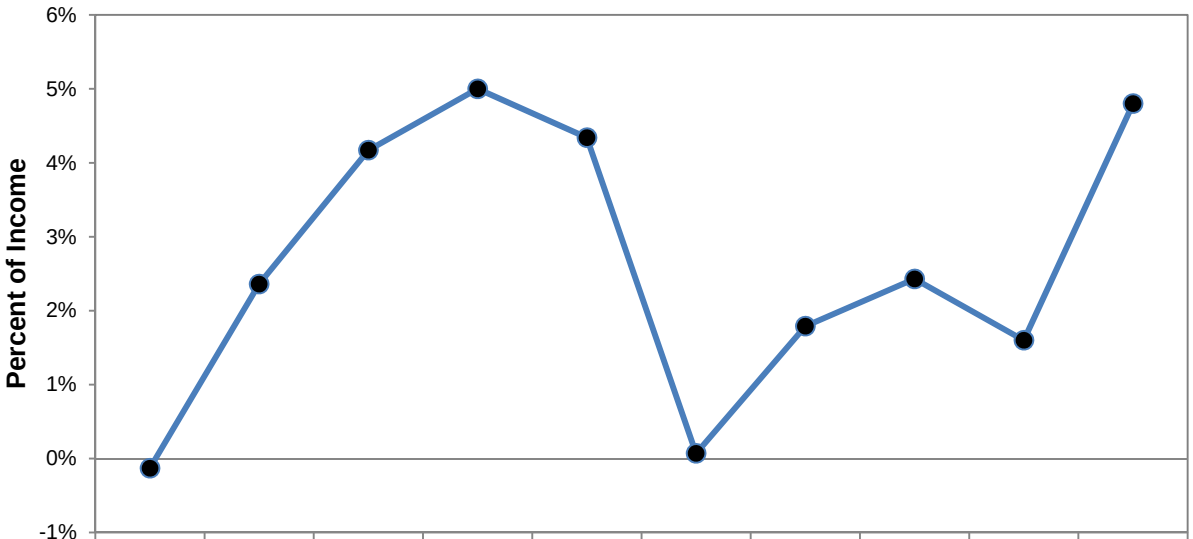
The data also suggests a shift away from FFS plans to PPO plans during 2009 to 2012. FFS plans, as a percentage of Utah's population, declined from 3.9% during 2009 to about 0.6% during 2012. The change in FFS plan membership is consistent with national surveys that also have found a decline in FFS plans. For example, the Kaiser Employer Health Benefits Survey for also reported lower estimates of insured membership in FFS plans during this period (Kaiser/HRET, 2011; Kaiser/HRET, 2012; Kaiser/HRET, 2013). This may be due to rising health care costs, with consumers, employers, and insured moving towards less expensive managed care options such as PPO plans, HMO plans, and HMO with POS plans. Conversations with commercial health insurers also suggest that the shift from FFS plans to PPO plans may be due to rational economic behavior by consumers who are choosing lower cost managed care options like PPO plans over FFS plans as a result of rising health care costs and difficult economic conditions.

In summary, the number of members with comprehensive health insurance declined from 2009 to 2012. This decline appears to be connected to the significant changes in the economy starting in 2008. Specifically, as the economic recession increased in severity, the number of employed individuals declined. When individuals lose their jobs, they also lose their benefits, including health insurance benefits. Thus, the decline in membership probably reflects the increase in the unemployed during this period. The idea that insurance coverage declined as employment declined is further supported by increases in those with government sponsored benefits (see Table 20) and the uninsured. This change in membership was also fairly uniform and was spread out over many insurers and included losses by some insurers and gains by other insurers. Our best information suggests that this decline says more about the difficult economic conditions in Utah during the current recession, than it does about the state of Utah's health insurance industry. However, this challenging economic climate is probably making it more difficult for commercial insurers to grow their business.

Financial trends. To measure the current financial condition of the market, the financial results of the major 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 more than 80 percent of the comprehensive health insurance market, 2) they receive more than 65 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 3).

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 financial gain of 2.7 percent in net income per year over the last 10 years. During 2012, these companies reported an average net income per year of 4.8 percent. According to the NAIC, the industry average for net income after expenses for health insurers during 2012 was 2.6 percent, which suggests that Utah's comprehensive health insurers performed above the industry average during 2012. Despite the recent economic recession, 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.

Figure 3. Income After Expenses For Comprehensive Health Insurers: 2003 – 2012



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Income	-0.1%	2.4%	4.2%	5.0%	4.3%	0.1%	1.8%	2.4%	1.6%	4.8%

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 major managed care health insurers that have been operating in Utah from 2003 to 2012. Results are rounded to the nearest 0.1 percent.

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 0.9 percent of the commercial health insurance market in Utah (see Table 3). Long-term care insurers provide coverage for about 39,267 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 seventy-five foreign insurers account for over 95 percent of the market, with only two domestic insurers providing long-term care coverage (see Table 21). Loss ratios were higher for the foreign insurers than for the domestic insurers.

Table 21. Total Long-Term Care Market by Domicile for 2012

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	2	1,324	$1,944,649	4.89%	54.28
Foreign	73	37,943	$37,855,194	95.11%	55.34
Total	**75**	**39,267**	**$39,799,843**	**100.00%**	**55.29**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

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 26 companies reported group business. Group business includes small group and large group business and refers to groups of 2 or more members. Loss ratios were higher for individual policies than for group policies (see Table 22).

Table 22. Total Long-Term Care Market by Group Size for 2012

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Individual	69	21,709	$32,662,839	82.07%	58.45
Group	26	17,558	$7,137,004	17.93%	40.83
Total	**75**	**39,267**	**$39,799,843**	**100.00%**	**55.29**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

[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

As Utah's population has grown, the number of individuals over the age of 65 has increased. As we age, the cost of health care, particularly end of life care, increases. As a result, the role of long-term care insurance coverage has grown in importance for older Utah residents.

Long-Term Care membership by age. Commercial health insurers reported 38,648 members with long-term care insurance in Utah during 2012. Fifty-two percent of the membership were under age 65, while the remaining 48 percent were sixty-five or older (see Table 23).

Table 23. Long-Term Care Membership by Age for 2012

Age	Member Count	Percent
Age 0-59	13,890	35.37%
Age 60-64	6,420	16.35%
Age 65-69	6,365	16.21%
Age 70-74	4,628	11.79%
Age 75-79	3,517	8.96%
Age 80-84	2,598	6.62%
Age 85+	1,849	4.71%
Total Members	**39,267**	**100.00%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

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 relatively 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 about 20 percent of Utah's accident & health insurance market, with approximately 2.1 percent of the market share in Medicare Supplement coverage and about 18.3 percent of the market share in Medicare Advantage coverage. Approximately 4.9 percent of Utah residents had coverage under a Medicare Supplement or Medicare Advantage product, with about 1.6 percent in Medicare Supplement product and about 3.3 percent in a Medicare Advantage product. Medicare Part D products account for about 2.2 percent of Utah's accident & health insurance market and provide coverage for approximately 2.6 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-eight foreign insurers account for about 61 percent of the market, with six domestic insurers covering the remaining 39 percent (see Table 24).

Table 24. Total Medicare Supplement Market by Domicile for 2012

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	6	16,720	$40,296,161	39.45%	62.08
Foreign	78	33,926	$61,840,613	60.55%	77.34
Total	**84**	**50,646**	**$102,136,774**	**100.00%**	**71.32**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Advantage by domicile. Utah's Medicare Advantage market is divided between domestic and foreign insurers. Six domestic insurers account for over 86 percent of the market, with nine foreign insurers accounting for the remaining 14 percent (see Table 25).

Table 25. Total Medicare Advantage Market by Domicile for 2012

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	6	80,976	$721,557,148	85.59%	89.00
Foreign	9	13,556	$121,525,235	14.41%	85.80
Total	**15**	**94,532**	**$843,082,383**	**100.00%**	**88.54**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Part D by domicile. Twenty commercial health insurers reported Medicare Part D business during 2012. Most of the coverage was provided by foreign insurers, which accounted for nearly 91 percent of the market. Only two domestic companies reported Medicare Part D business for 2012 (see Table 26).

Table 26. Total Medicare Part D Market by Domicile for 2012

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	2	6,393	$8,882,561	8.64%	67.10
Foreign	18	73,252	$93,873,808	91.36%	80.14
Total	**20**	**79,645**	**$102,756,369**	**100.00%**	**79.01**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Products by Age

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. Eighty-four commercial health insurers reported 50,646 members with Medicare Supplement coverage in Utah during 2012. Nearly all (99 percent) of the residents with coverage were over age 65. This is probably due to Medicare's eligibility requirements, which requires most people to be age 65 or older in order to receive coverage (see Table 27).

Table 27. Medicare Supplement Membership by Age for 2012

Age	Insured Members	Percent
Age 0-64	368	0.73%
Age 65 and Older	50,278	99.27%
Total Members	**50,646**	**100.00%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Advantage membership by age. Fifteen commercial health insurers reported 94,532 members with Medicare Advantage coverage in Utah during 2012. Most (86 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 (see Table 28).

Table 28. Medicare Advantage Membership by Age for 2012

Age	Insured Members	Percent
Age 0-64	13,739	14.53%
Age 65 and Older	80,793	85.47%
Total Members	**94,532**	**100.00%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Part D membership by age. Twenty commercial health insurers reported 79,645 members with Medicare Part D Drug Plan coverage in Utah during 2012. Most (80 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 (see Table 29).

Table 29. Medicare Part D Membership by Age for 2012

Age	Insured Members	Percent
Age 0-64	16,177	20.31%
Age 65 and Older	63,468	79.69%
Total Members	**79,645**	**100.00%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Products by Plan Type

Medicare Supplement membership by plan type. Commercial health insurers reported 50,646 members with Medicare Supplement in Utah during 2012. Commercial health insurers reported members in one of 16 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 30).

The most commonly reported Medicare Supplement plan was Plan F with 59.0 percent of the membership. The next closest plans were Medicare Supplement Plan C, with 8.0 percent; Medicare Supplement Plan J, with 6.6 percent; Medicare Supplement Plan G, with 6.5 percent; Medicare Supplement plan N, with 4.7 percent; Pre-Standardized Plans, with 4.0 percent; and Medicare Supplement Plan D, with 3.1 percent. All other plans had 3.0 percent of the membership or less, with two plans having less than 150 members (see Table 30).

Table 30. Medicare Supplement Membership by Plan Type for 2012

Plan Type	Members	Percent
Plan A	871	1.72%
Plan B	570	1.13%
Plan C	4,044	7.98%
Plan D	1,589	3.14%
Plan E	535	1.06%
Plan F	29,921	59.08%
Plan F (High Deductible Plan)	492	0.97%
Plan G	3,283	6.48%
Plan H	596	1.18%
Plan I	542	1.07%
Plan J	3,324	6.56%
Plan J (High Deductible Plan)	0	0.00%
Plan K	267	0.53%
Plan L	177	0.35%
Plan M	4	0.01%
Plan N	2,371	4.68%
Pre-Standardized Plans	2,060	4.07%
Total Members	**50,646**	**100.00%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Advantage membership by plan type. Commercial health insurers reported 94,532 members with Medicare Advantage (full Medicare replacement policies) in Utah during 2012. Medicare Advantage plans (which completely replace Medicare and bear the full risk of loss) come in one of five major plan types.

During 2012, most of the membership was covered under a Health Maintenance Organization plan, with 75 percent of the membership. The second most common was a Preferred Provider Organization plan, with 24 percent of the membership. The third most common was a Private Fee-for-Service plan, with 1 percent of the membership. None of the companies reported membership in plans with Medical Savings Accounts or Special Needs Plans (see Table 31).

Table 31. Medicare Advantage Membership by Plan Type for 2012

Plan Type	Members	Percent
Private Fee-for-Service	1,094	1.16%
Preferred Provider Organization	22,910	24.24%
Health Maintenance Organization	70,528	74.61%
Medical Savings Account	0	0.00%
Special Needs Plan	0	0.00%
Total Members	**94,532**	**100.00%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

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 51 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves approximately 28 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 remained relatively constant from 2003 to 2005, declined during 2006 to 2008, and increased from 2009 to 2012. The increase in complaints from 2009 to 2012 appears to be due to the combined impact of the economic recession and the changes in government regulations. During 2009 to 2012, consumers contacted the Insurance Department in greater numbers, and many of those calls were questions and concerns regarding the new options under COBRA, questions and concerns related to changes to their health insurance coverage and how their claims were paid, some of which were connected to changes in state and federal health regulations, and the state health insurance exchange for small employers.

Over the last ten 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 has declined from 2003 to 2012. For example, the number of comprehensive health insurers remained fairly constant from 2003 to 2007, and then declined from 2008 to 2012. Most of this change was due to a decrease in the number of very small foreign comprehensive health insurers with less than $1 million in premium. In contrast, the total number of large and medium insurers has remained fairly stable. Large domestic comprehensive health insurers account for more than 80 percent of the market and provide a solid pool of commercial health insurers. However, while the number of medium insurers has remained relatively stable, there has been a shift from domestic to foreign insurers during this period. For example, in 2003, medium insurers were primarily domestic, while by 2012 medium size insurers are primarily foreign. These core large and medium health insurers provide the majority of Utah's comprehensive health insurance coverage, are financially solvent, and provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market.

Like the rest of the United States, Utah's comprehensive health insurance market continues to experience increases in the costs of health insurance. For example, the average premium per member per month increased from $240 during 2011 to $247 during 2012, an increase of 2.9 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, over the last ten years, increases in premium per member per month have averaged 5.8 percent per year, while increases in losses per member per month have averaged 5.7 percent per year. Overall, the data suggests that while premiums have fluctuated year to year, there is consistent pricing pressure on health care costs which has remained constant over the last ten years. These pricing pressures are not unique to Utah and are being driven by trends in national health care costs 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 premium for comprehensive health insurance coverage was $320 per member per month during 2012. 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.

From 2003 to 2012, the number of Utah residents covered by comprehensive health insurance has seen periods of decline followed by periods of increase. However, the membership fluctuations have hovered close to an average of 829,000 over the last 10 years. Comprehensive health insurance membership declined from 2003 to 2005, increased from 2006 to 2008, declined during 2009, remained relatively stable during 2010, followed by a period of decline during 2011 and 2012. The changes during 2009, 2010, and 2011 appear to be connected to the economic recession with the number of commercially insured members declining as unemployment started to increase during 2009. During 2012, the decline in membership appears to be a shift from fully insured to self-funded health benefit plans rather than an increase in the uninsured. This is consistent with the current trends in the uninsured and the number of residents covered by government sponsored health benefit plans which may also be factors in this change.

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 top insurers in the comprehensive health insurance industry have experienced an average financial gain of 2.6 percent in net income after expenses over the last ten years, with comprehensive health insurers reporting an average of 4.8 percent in net income after expenses during 2012. 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).

References

Cuckler, G. A., Sisko, A. M., Keehan, S. P., Smith, S. D., Madison, A. J., Poisal, J. A., Wolfe, C. J., Lizonitz, J. M., and Stone, D. A. (2013). National health expenditure projections, 2012-22: Slow growth until coverage expands and economy improves. Health Affairs, 32 (10), 1-12. Available at: http://content.healthaffairs.org/content/early/2013/09/13/hlthaff.2013.0721.full.html

Council of Economic Advisors (CEA). (2012). Economic Report to the Governor. Salt Lake City, UT: Governor's Office of Economic Planning and Budget.

Council of Economic Advisors (CEA). (2013). Economic Outlook 2013. Salt Lake City, UT: Governor's Office of Economic Planning and Budget.

Ginsburg, P. B., Strunk, B. C., Banker, M. I., and Cookson, J. P. (2006). Tracking health care costs: Continued stability but at high rates in 2005. Health Affairs, Web exclusive, 3 October 2006. Available at: http://content.healthaffairs.org/cgi/reprint/hlthaff.25.w486v1

Kaiser/HRET. (2011). Employer Health Benefits: 2010 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Education Trust.

Kaiser/HRET. (2012). Employer Health Benefits: 2011 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Education Trust.

Kaiser/HRET. (2013). Employer Health Benefits: 2012 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Education Trust.

Martin, A., Lassman, D., Whittle, L., Catlin, A., and the National Health Expenditure Accounts Team. (2011). Recession contributes to slowest annual rate of increase in health spending in five decades. Health Affairs, 30 (1), 11-22.

Office of Public Health Assessment. (2006a). Health Insurance Coverage (2004 Utah Health Status Survey Report). Salt Lake City, UT: Utah Department of Health.

Office of Public Health Assessment. (2006b). Overview of the 2005 Health Status Survey (2005 Health Status Survey Report). Salt Lake City, UT: Utah Department of Health.

Office of Public Health Assessment. (2007). Utah Health Status Survey (Cheatsheet_2006-Final). Salt Lake City, UT: Utah Department of Health.

Office of Public Health Assessment. (2008). Utah Health Status Survey (Cheatsheet_2007-Final). Salt Lake City, UT: Utah Department of Health.

Office of Public Health Assessment. (2009). Utah Health Status Survey (Cheatsheet_2008-Final). Salt Lake City, UT: Utah Department of Health.

Office of Public Health Assessment. (2010). Utah Behavioral Risk Factor Surveillance System (Uninsured Cheatsheet_2009). Salt Lake City, UT: Utah Department of Health.

Office of Public Health Assessment. (2012). Utah Behavioral Risk Factor Surveillance System (Highlights_2011). Salt Lake City, UT: Utah Department of Health.

Office of Public Health Assessment. (2013). Utah Behavioral Risk Factor Surveillance System (Highlights_2012). Salt Lake City, UT: Utah Department of Health.

PriceWaterhouseCoopers. (2002). The Factors Fueling Rising Healthcare Costs. Washington, DC: American Association of Health Plans.

PriceWaterhouseCoopers. (2006). The Factors Fueling Rising Healthcare Costs 2006. Washington, DC: American Association of Health Plans.

PriceWaterhouseCoopers. (2008a). The Factors Fueling Rising Healthcare Costs 2008. Washington, DC: American Association of Health Plans.

PriceWaterhouseCoopers. (2008b). The Price of Excess: Identifying Waste in Healthcare Spending. Washington, DC: PriceWaterhouseCoopers' Health Research Institute.

Strunk, B. C., and Ginsburg, P. B. (2003). Tracking health care costs: Trends stabilize but remain high in 2002. Health Affairs, 22 (4), 266-274.

Strunk, B. C., and Ginsburg, P. B. (2004). Tracking health care costs: Trends turn downward in 2003. Health Affairs, Web exclusive, 9 June 2004. Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.354/DC1

Strunk, B. C., Ginsburg, P. B., and Gabel, J. R. (2002). Tracking health care costs: Growth accelerates again in 2001. Health Affairs, 21 (6), 299-310.

Strunk, B. C., Ginsburg, P. B., and Cookson, J. P. (2005). Tracking health care costs: Declining growth trend pauses in 2004. Health Affairs, Web exclusive, 21 June 2005. Available at: http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.286v1

Appendix

Recommendations

As requested by the Utah Legislature and in the current policy environment, the Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market.

1) Continue to support the development of, and the requirement to use, electronic data interchange standards for the clinical health information exchange (cHIE) and electronic health records.

2) Improve data quality of the administrative claims in the All Payers Claim Database (APCD) so that it can be used for risk adjustment and rate transparency in the individual and small group insurance markets.

3) Develop and implement effective protocols to prevent disease and improve the health of children through school wellness programs that encourage increased physical activity, nutritional education, and school meals with healthy food choices.

4) Increase access to primary and behavioral health care by encouraging the education and use of health care professionals who can effectively provide lower level medical treatment.

5) Include education and training on the nature of health care and health insurance costs in 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.

6) Support the development of value-based reimbursement (VBR) and end of life care payment reforms that promote higher quality health care at a lower price.

List of Comprehensive Health Insurers

Table 32. List of Comprehensive Health Insurers during 2012

Company Name	State of Domicile	Direct Earned Premium	Market Share	Loss Ratio
SelectHealth, Inc.	UT	$1,141,114,111	49.09%	86.81
Regence BlueCross BlueShield of Utah	UT	$391,634,558	16.85%	75.94
Altius Health Plans, Inc.	UT	$348,568,454	15.00%	85.13
UnitedHealthcare Insurance Company	CT	$208,746,215	8.98%	72.27
Humana Insurance Company	WI	$82,087,878	3.53%	87.37
Aetna Life Insurance Company	CT	$36,883,577	1.59%	86.32
Connecticut General Life Insurance Company	CT	$32,693,585	1.41%	92.78
Cigna Health and Life Insurance Company	CT	$14,196,662	0.61%	80.46
Sterling Life Insurance Company	IL	$12,543,801	0.54%	135.02
Health Care Service Corporation, a Mutual Legal Re	IL	$11,314,561	0.49%	73.30
Educators Health Plans, Health, Inc.	UT	$6,208,822	0.27%	84.01
Deseret Mutual Insurance Company	UT	$5,914,334	0.25%	99.95
Time Insurance Company	WI	$5,743,835	0.25%	79.87
WMI Mutual Insurance Company	UT	$4,900,236	0.21%	77.72
Trustmark Life Insurance Company	IL	$4,373,741	0.19%	76.06
State Farm Mutual Automobile Insurance Company	IL	$3,316,293	0.14%	76.87
The MEGA Life and Health Insurance Company	OK	$2,915,127	0.13%	138.97
American Medical Security Life Insurance Company	WI	$1,647,900	0.07%	67.37
BEST Life and Health Insurance Company	TX	$1,483,769	0.06%	76.61
UnitedHealthcare of Utah, Inc.	UT	$1,278,550	0.06%	53.71
American National Life Insurance Company of Texas	TX	$1,236,305	0.05%	115.28
Mid-West National Life Insurance Company	TX	$1,143,354	0.05%	71.98
Fidelity Life Association, A Legal Reserve Life Ins	IL	$1,091,905	0.05%	-31.99
New York Life Insurance Company	NY	$868,153	0.04%	120.99
National Foundation Life Insurance Company	TX	$548,738	0.02%	99.51
Educators Mutual Insurance Association	UT	$428,044	0.02%	0.64
Standard Security Life Insurance Company of New York	NY	$347,223	0.01%	31.90
John Alden Life Insurance Company	WI	$268,461	0.01%	62.42
Golden Rule Insurance Company	IN	$238,553	0.01%	92.43
BCS Insurance Company	OH	$235,644	0.01%	50.77
The United States Business of The Great-West Life	MI	$117,336	0.01%	-0.08
Madison National Life Insurance Company	WI	$114,174	< 0.01%	408.25
Standard Life and Accident Insurance Company	TX	$69,279	< 0.01%	18.02
World Insurance Company	NE	$67,758	< 0.01%	155.56
The Prudential Insurance Company of America	NJ	$52,162	< 0.01%	43.59
Celtic Insurance Company	IL	$32,204	< 0.01%	261.15
Freedom Life Insurance Company of America	TX	$30,936	< 0.01%	84.81
Reserve National Insurance Company	OK	$19,932	< 0.01%	6.76
American National Insurance Company	TX	$19,792	< 0.01%	187.16
The Pyramid Life Insurance Company	KS	$19,301	< 0.01%	36.30
AXA Equitable Life Insurance	NY	$19,242	< 0.01%	2.96
American Republic Insurance Company	IA	$9,198	< 0.01%	137.95
LifeSecure Insurance Company	MI	$7,455	< 0.01%	5.67
Life of America Insurance Company	TX	$5,737	< 0.01%	-45.63
Fidelity Security Life Insurance Company	MO	$3,049	< 0.01%	129.65
Metropolitan Life Insurance Company	NY	$1,916	< 0.01%	9.24

Principal Life Insurance Company	IA	$1,308	< 0.01%	170.11
The Guardian Life Insurance Company of America	NY	$1,304	< 0.01%	1,475.92
Union Security Insurance Company	KS	$351	< 0.01%	-776.35
Transamerica Life Insurance Company	IA	$322	< 0.01%	0.00
Centre Life Insurance Company	MA	$163	< 0.01%	57.06
American Alternative Insurance Corporation	DE	$77	< 0.01%	-1,058.44
Bridgespan Health Company [a]	UT	$0	< 0.01%	NA
The Chesapeake Life Insurance Company [a]	OK	$0	< 0.01%	NA
Pan-American Life Insurance Company [a]	LA	$0	< 0.01%	NA
Guarantee Trust Life Insurance Company [a]	IL	$0	< 0.01%	NA
Trustmark Insurance Company [a]	IL	-$3,850	< 0.01%	-730.65
All Comprehensive Health Insurers	**57**	**$2,324,561,535**	**100.00%**	**83.61**

Data Source: Utah Accident & Health Survey

[a] Company reported claims, premium or membership for comprehensive hospital & medical, but did not report positive direct earned premium.

List of Health Insurance Mandates in Utah

Coverage Mandates

Required by Federal statute:

1. Dependent coverage from the moment of birth or adoption (31A-22-610)
2. Coverage through a noncustodial parent (31A-22-610.5; Social Security Act)
3. Open enrollment for child coverage ordered by a court (31A-22-610.5; Social Security Act)
4. Medicare supplemental insurance, including preexisting conditions provision (31A-22-620; NAIC Standard; Title XVIII of the Social Security Amendment, 1965)
5. Individual and small group guaranteed renewability (31A-30-107; 31A-30-107.1; Health Insurance Portability and Accountability Act, 1997; PHSA 2703; Patient Protection and Affordable Care Act, 2010)
6. Individual and small group limit on exclusions and preexisting conditions (31A-30-107; 31A-30-107.1; 31A-30-107.5; Preexisting condition limitations as required by Federal statute)
7. Small group portability and individual guaranteed issue (31A-30-108; Health Insurance Portability and Accountability Act, 1997; PHSA 2702; Patient Protection and Affordable Care Act, 2010)
8. Maternity coverage on groups of 15 or more employees (Pregnancy Discrimination Act, Public Law 95-555, 1978)
9. COBRA benefits for employees of employer with 20 or more employees (Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, 1985)
10. Preexisting conditions (31A-22-605.1; PHSA 2704; Patient Protection and Affordable Care Act, 2010)
11. Limitation on the use of preexisting condition exclusions for individuals 19 and under (PHSA 2704; Patient Protection and Affordable Care Act, 2010)
12. Limitation of annual and lifetime limits for essential benefits (PHSA 2711 PHSA 2704; Patient Protection and Affordable Care Act, 2010)
13. Coverage for preventative health services (PHSA 2713; Patient Protection and Affordable Care Act, 2010)
14. Coverage for children up to age 26, including married children (31A-22-610.5; PHSA 2714; Patient Protection and Affordable Care Act, 2010)

Required by State statute:

1. Policy provision standards (31A-22-605)
2. Extension of policy for a dependent child with a disability (31A-22-611)
3. Conversion privileges for an insured former spouse (31A-22-612)
4. Mini-COBRA benefits for employees of employer with less than 20 employees (31A-22-722; State expansion of Federal COBRA requirements)
5. Alternative Coverage (31A-22-724)
6. Provisions pertaining to armed forces (31A-22-717)
7. Court order coverage for minor children outside service area (31A-8-502)

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. OB/GYN as primary care physician (31A-22-624)
4. Catastrophic coverage of mental health conditions (31A-22-625; Mental Health Parity and Addition Equity Act, 2008)
5. Preauthorization of emergency medical services (31A-22-627; Federal Patient Bill of Rights Plus Act)
6. Mastectomy provisions (31A-22-630; 31A-22-719; Women's Health & Cancer Rights Act, 1996)
7. Alcohol and drug dependency treatment (31A-22-715; ACA)

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. Diabetes coverage (31A-22-626)
4. Standing referral to a specialist (31A-22-628)

Provider Mandates

Required by Federal statute:

None

Required by State statute:

1. Preferred provider contract provisions (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-2-201.2 requires that the Utah Insurance Department produce an annual evaluation of the health insurance market. The statutory requirements for this evaluation are shown below:

(1) Each year the commissioner shall:
- (a) conduct an evaluation of the state's health insurance market;
- (b) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1 of each year; and
- (c) publish the findings of the evaluation on the department website.

(2) The evaluation required by this section shall:
- (a) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of the state, and includes an analysis of:
  - (i) the availability and marketing of individual and group products;
  - (ii) rate changes;
  - (iii) coverage and demographic changes;
  - (iv) benefit trends;
  - (v) market share changes; and
  - (vi) accessibility;
- (b) assess complaint ratios and trends within the health insurance market, which assessment shall include complaint data from the Office of Consumer Health Assistance within the department;
- (c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statues; and
- (d) include claims loss ratio data for each health insurance company doing business in the state.

(3) When preparing the evaluation required by this section, the commissioner shall include a report of:
- (a) the types of health benefit plans sold in the Health Insurance Exchange created in section 63M-1-2504;
- (b) the number of insurers participating in the defined contribution arrangement health benefit plans in the Health Insurance Exchange; and
- (c) the number of employers and covered lives in the defined contribution arrangement market in the Health Insurance Exchange; and
- (d) the number of lives covered by health benefit plans that do not include state mandates as permitted by Subsection 31A-30-109(2).

(4) When preparing the evaluation and report 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.

(5) The commissioner may adopt administrative rules for the purpose of collecting the data required by this section, taking into account the business confidentiality of the insurers.

(6) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

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. 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 was collected for years 2003 to 2012. The data includes information on approximately 350 companies each year.

The survey includes five major components: accident & health insurance, marketing of accident & health insurance, Medicare supplemental insurance, Long Term Care insurance, administration of self-funded plans, as well as comprehensive 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.

During 2010, the Utah Accident & Health Survey was reorganized and expanded to include more detailed measures of the comprehensive health insurance market including the new Small Employer Defined Contribution Market, analysis of certain types of benefit plans, and measures of certain types of insurance code mandates.

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.

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

Commercial health insurer: An 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.

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.

Employer sponsored self-funded health benefit plan: The key feature of these plans is that 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.