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Insurance Department

TODD E. KISER
Insurance Commissioner

2016 Health Insurance Market Report

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For questions about this report contact:

Jeffrey E. Hawley, Ph.D.
Research Analyst
Health & Life Insurance Division
Utah Insurance Department
Suite 3110 State Office Building
PO Box 146901
Salt Lake City, Utah 84114-6901
801-538-9684
jhawley@utah.gov

Nancy Askerlund
Director
Health & Life Insurance Division
Utah Insurance Department
Suite 3110 State Office Building
PO Box 146901
Salt Lake City, Utah 84114
801-537-9293
naskerlund@utah.gov

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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 49 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves over 27 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 continuing to receive good consumer service from Utah's commercial health insurers. The numbers of consumer complaints received by the Insurance Department declined during 2006 to 2008 and increased from 2009 to 2015. The increase in complaints from 2009 to 2015 appears to be due to the combined impact of the economic recession and recent changes in government regulations. In addition to complaints, during 2009 to 2015, consumers contacted the Insurance Department in greater numbers with questions and concerns regarding 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 and the implementation of the Patient Protection and Affordable Care Act (ACA). Other consumers had 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 exchange for small employers and the federal health exchange for individuals. There was a significant increase in the number of complaints from 2014 to 2015, with the number of complaints increasing by over 39 percent. Most of this increase appears to be due to consumers concerns related to their coverage in the Federally-Facilitated Marketplace (FFM).

In addition to consumer complaints, the Utah Insurance Department receives and processes requests from consumers for an independent review of their denied claims by an Independent Review Organization (IRO). The number of independent reviews remained relatively stable during 2012 to 2014, followed by a significant increase in 2015. From 2014 to 2015, the number of requests for independent reviews increased by over 60 percent. This increase may be due to an increased awareness among consumers that an independent review is an option for them.

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 number of Utah residents with comprehensive health insurance, the cost of comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers has declined from 2006 to 2015. Most of this change has been due to a decrease in the number of small and very small foreign comprehensive health insurers. In contrast, the total number of large and medium insurers has remained fairly stable. Large domestic comprehensive health insurers continue to account for more than 80 percent of the market and provide a solid pool of commercial health insurers. The number of medium insurers has also remained relatively stable, but there has been a shift from domestic to foreign insurers during this period. For example, in 2006, medium insurers were primarily domestic, while by 2013, medium size insurers were primarily foreign. From 2013 to 2014, there was some turnover among medium size insurers and several new domestic insurers entered the market to participate in the FFM. During 2014 and 2015, as part of the first two years of the full implementation of the ACA, there was some market shifting with a decline in the number of small insurers and an increase in the number of domestic medium insurers, including several new insurers that entered the market to participate in the FFM. However, financial stress in the market is making it increasingly difficult for some insurers to participate in the comprehensive market and to sustain participation in the FFM.

From 2006 to 2015, the number of Utah residents covered by comprehensive health insurance has seen periods of decline followed by periods of increase. However, these membership fluctuations have remained relatively stable, with membership averaging about 830,000 members over the last 10 years. Comprehensive health insurance membership increased from 2006 to 2008, declined during 2009, remained relatively stable during 2010, declined during 2011 and 2012, and then increased from 2013 to 2015.

The changes from 2009 to 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.

During 2014, the number of members in the individual market grew by about 46,000 members, an increase of over 29 percent, followed by a similar, but smaller increase during 2015. Individual membership grew by over 22,000 during 2015, an increase of about 11 percent. Most of this growth appears to be driven by the federal individual mandate which requires everyone to maintain health insurance, the availability of the FFM, and changes to health insurance regulations, including guaranteed issue and community rating, which have made it easier for Utah residents to get and keep coverage in the individual market. Small group membership increased slightly from 2014 to 2015. Large group membership declined from 2014 to 2015. These changes in the employer markets appear to be due to some employer groups moving to self-funding arrangements, although one cannot rule out the possibility of some shifting to the individual market.

Comprehensive health insurance premium per member per month remained stable from 2014 to 2015. The average premium per member per month increased from $277 during 2014 to $280 during 2015, an increase of 1.1 percent. Over the last ten years, increases in premium per member per month have averaged 4.3 percent per year, while increases in losses per member per month have averaged 6.1 percent per year.

Comprehensive health insurers reported high loss ratios during 2014 and 2015, as premiums, even after payments from the various reinsurance and risk adjustment programs under the ACA, were not sufficient to cover the healthcare costs of their insured members. The shift to ACA compliant plans, changes in rating methods, and expanded coverage for higher risk individuals, combined with lower than expected payments from the federal risk corridor program, have all contributed to these higher loss ratios. Comprehensive health insurers in both 2014 and 2015 had limited claim history to work with, were unable to underwrite for insurance risk on an individual basis, and 2014 rates were set prior to the creation of “transitional plans” which prevented insurers from making rate adjustments prior to 2014. Comprehensive health insurers reported these higher loss ratios primarily in the individual market. In contrast, health care costs and loss ratios in the small and large group market were more in line with market trends.

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 0.6 percent in net income after expenses over the last ten years, with comprehensive health insurers reporting an average net loss of -8.8 percent in net income after expenses during 2015.

The first year of the full implementation of the ACA was financially difficult for Utah’s core comprehensive health insurers and most experienced a net loss in underwriting and net income during 2014. Comprehensive health insurers had limited claim history to work with and underpriced the claim costs of covering their members under the new ACA regulations. Another factor was receiving lower than expected payments from the federal risk corridor program. And finally, the creation of transitional plans essentially created two risk pools: the transitional pool where healthy people could maintain coverage at lower premiums, and the ACA compliant pool that included members who were previously uninsured, or uninsurable, and had pent up demand for health care. Comprehensive health insurers had priced products under the assumption that that all their insured members would be moving into the ACA compliant pool; and were expecting higher payments to assist with the increased costs of covering higher risk individuals under the ACA. Arches Health Plans was particularly hit hard by these three factors during 2014 and was taken into receivership by the Utah Insurance Department in 2015.

The second year of the full implementation of the ACA was more difficult for Utah’s health insurance market than the first. Utah’s core health insurers experienced significant losses in underwriting and net income during 2015. Comprehensive health insurers still did not have a full year’s claim experience to price their products and were unable to generate enough premium income to cover their losses. Also, changes to the federal risk corridor program meant comprehensive health insurers did not receive the additional payments that were expected under the program that would have helped them cover their costs, and the transitional plans still had not moved into the ACA compliant pool.

The combination of not having enough information to adequately price their products, the creation of transitional plans, and not receiving the additional payments from the federal risk corridor program as expected produced higher losses for health insurers participating in the individual market and the FFM. Three comprehensive health insurers, including two national companies, withdrew from the FFM due to concerns that these losses were not sustainable.

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 57).

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 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 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 benefits (such as Medicaid and Medicare), limited primary health benefits (such as county health clinics), or limited specialized health benefits (such as Wee Care).

Employer sponsored self-funded health benefit plans are plans sponsored by an employer to provide health 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 insurance 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.

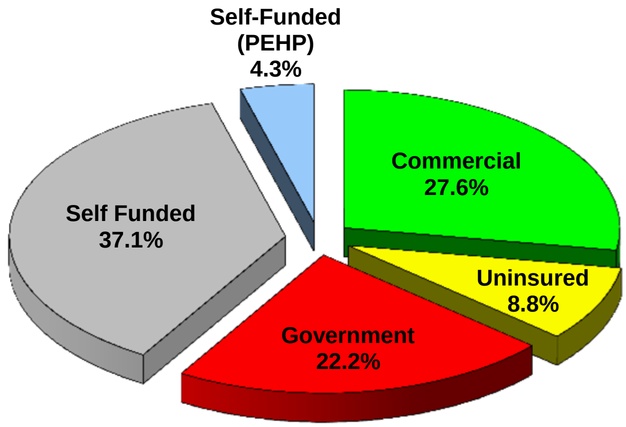
Commercial health insurance plans are plans marketed by an insurance company to provide health insurance benefits to insured persons. These plans are funded by the premiums collected from insured employers and individuals. The risk of financial loss is borne by the insurance company. Commercial insurance 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 benefits 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 2015



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 U.S. Census Bureau.

Note: The estimate of the 2015 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 health 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 about twenty-two percent of Utah residents were covered by government plans, about forty-one percent were covered by self-funded plans, over twenty-seven percent were covered by commercial health insurance, and nearly nine percent were uninsured (see Table 1).

Table 1. Estimate of Health Insurance Coverage for 2015

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans	**665,882**	**22.2%**
Medicare	340,968	11.4%
Medicaid	295,123	9.9%
Children’s Health Insurance Program (CHIP)	16,588	0.6%
Primary Care Network (PCN)	13,203	0.4%
Employer Sponsored Self-Funded Plans	**1,238,828**	**41.4%**
Plans Administered by Commercial Insurers	634,745	21.2%
Public Employee Health Program (PEHP)	128,232	4.3%
Federal Employee Health Benefit Plan (FEHBP)	102,459	3.4%
Other Known Self-Funded Plans	62,027	2.1%
Other Self-Funded Plans (Estimated)	311,365	10.4%
Commercial Health Insurance Plans	**826,109**	**27.6%**
Group	599,182	20.0%
Individual	226,927	7.6%
Uninsured	**265,100**	**8.8%**
Total	**2,995,919**	**100.0%**

Data Sources: Centers for Medicare & Medicaid Services, Deseret Mutual Benefit Administrators, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the U.S. Census Bureau.

Note: The estimate of the 2015 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. Loss ratios calculated in this report use the traditional loss ratio methodology rather than the NAIC medical loss ratio methodology that adjusts for taxes and fees, as these new ratios are not applicable to all types of commercial health insurance.

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 1,391 commercial fraternal, life, health, and property and casualty insurers licensed with the Insurance Department at the end of 2015. Of these, three hundred and thirty-two commercial insurers reported commercial health insurance business in Utah on their 2015 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 86 and net income of 5.7 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 78 percent of Utah's commercial health insurance market is domestic. These 27 domestic insurers are much more representative of the Utah market as about 85 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 93 and net income of -6.7 percent. Utah's commercial health insurance market is highly concentrated among nine domestic commercial health insurers, which account for about 76 percent of the commercial health insurance market. These nine commercial health insurers represent about 98 percent of the domestic market. They had a loss ratio of 93 and net income of -9.1%. The remaining two percent of the domestic market consists of life insurers and limited health plans.

There are 305 foreign insurers in Utah's commercial health insurance market, most of which are life insurers. These foreign insurers account for about 22 percent of Utah's market. Foreign insurers had a loss ratio of nearly 77 for Utah business. Net income was 5.8 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 2015

		Utah Operations			National Operations	
Insurer Type	**Company Count**	**Direct Earned Premium**	**Market Share**	**Loss Ratio**	**Total Revenue**	**Net Income (% Rev)**
Domestic Insurers						
Health	9	$4,330,060,494	75.89%	93.13	$4,563,356,759	-9.1%
Life	13	$92,488,634	1.62%	79.79	$640,455,867	10.3%
Limited Health Plan	5	$8,792,476	0.15%	59.23	$8,885,430	4.5%
Total Domestic	**27**	**$4,431,341,604**	**77.67%**	**92.78**	**$5,212,698,056**	**-6.7%**
Foreign Insurers						
Fraternal	11	$1,349,217	0.02%	91.50	$13,368,536,193	7.0%
Life	254	$1,207,819,559	21.17%	77.44	$696,188,357,925	5.1%
Property & Casualty	40	$65,126,553	1.14%	60.51	$119,487,006,362	9.5%
Total Foreign	**305**	**$1,274,295,329**	**22.33%**	**76.59**	**$829,043,900,480**	**5.8%**
Utah Insurers						
Fraternal	11	$1,349,217	0.02%	91.50	$13,368,536,193	7.0%
Health	9	$4,330,060,494	75.89%	93.13	$4,563,356,759	-9.1%
Life	267	$1,300,308,193	22.79%	77.60	$696,828,813,792	5.1%
Limited Health Plan	5	$8,792,476	0.15%	59.23	$8,885,430	4.5%
Property & Casualty	40	$65,126,553	1.14%	60.51	$119,487,006,362	9.5%
Total Utah	**332**	**$5,705,636,933**	**100.00%**	**86.16**	**$834,256,598,536**	**5.7%**

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 332 commercial health insurers who reported accident & health premium in Utah for 2015.

The top four policy types by market share were comprehensive health insurance (48 percent), Medicare Advantage products (17 percent), Medicaid/CHIP (10 percent) and the Federal Employee Health Benefit Plan (FEHBP) (8 percent) (see Table 3). The results of the survey differ slightly from the total accident & health reported on the 2015 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 2015

Policy Type	Company Count [a]	Member Count [b]	Direct Earned Premium	Market Share	Loss Ratio
Comprehensive	39	826,109	$2,767,877,369	48.49%	95.34
Hospital-Medical-Surgical	28	3,943	$1,619,298	0.03%	74.94
Medicare Supplement	85	68,987	$135,878,366	2.38%	76.33
Medicare Advantage	11	116,561	$962,047,728	16.85%	91.14
Medicare Drug Plan	18	94,016	$85,339,315	1.49%	78.61
Dental Only	87	773,499	$269,298,835	4.72%	67.41
Vision Only	36	568,826	$28,299,390	0.50%	67.08
FEHBP	5	80,594	$449,281,102	7.87%	92.40
Medicaid/CHIP	3	209,111	$557,602,720	9.77%	87.22
Stop-Loss	41	468,760	$140,070,917	2.45%	71.88
Disability Income	135	345,772	$150,500,030	2.64%	70.92
Long-Term Care	73	39,104	$42,323,424	0.74%	77.60
Credit A&H	29	115,210	$10,089,698	0.18%	25.08
All Other A&H	194	-	$108,377,710	1.89%	50.62
Total Accident & Health	**332**	**-**	**$5,708,605,902**	**100.00%**	**89.12**

Data Source: Utah Accident & Health Survey

Note: The Federal Employee Health Benefit Plans (FEHBP), Medicare, and Medicaid business reported here may include 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) within the Health and Life Division.

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 approximately 7,000 consumer inquires on average each year (see Table 4). However, this trend is increasing and just over the past three years consumer inquiries have increased to nearly 9,000 on average each year. 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: 2006 - 2015

Consumer Inquiries	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Telephone (in/out)	7,125	5,180	4,201	4,528	3,400	3,885	5,151	5,563	4,202	4,369
Walk-in	33	16	26	27	24	19	22	20	24	20
Other (in/out)	616	825	1,119	805	1,094	1,808	2,382	3,173	4,436	5,156
Total Inquires	**7,774**	**6,021**	**5,346**	**5,360**	**4,518**	**5,712**	**7,555**	**8,756**	**8,662**	**9,545**

Data Source: Utah Insurance Department

Note: The “Other” category includes all correspondence including email activity processed by OCHA Staff related to consumer inquires.

When a consumer inquiry involves a possible violation by a commercial health insurance company of Utah insurance regulations, or federal regulations the Insurance Department is mandated to regulate, 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 two types: confirmed and unconfirmed.

Confirmed Complaints. Confirmed 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.

Unconfirmed Complaints. Unconfirmed 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 or that 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. 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 declined during 2006 to 2008 and then increased during 2009 to 2015. The number of confirmed complaints remained relatively stable from 2006 to 2012, except for 2007, where the number of confirmed complaints was significantly lower than the trend. The number of confirmed complaints increased significantly from 2013 to 2015. The number of unconfirmed complaints remained relatively constant from 2006 to 2008, with a slight decline during 2007, followed by a period of increase starting in 2009. Unconfirmed complaints remained relatively stable from 2011 to 2014 and then increased significantly during 2015. From 2014 to 2015, the number of consumer complaints increased by more than 39 percent (see Table 5).

Table 5. Complaints Filed with OCHA by Type: 2006 - 2015

	Total		Confirmed		Unconfirmed	
Year	**Count**	**Percent of Total**	**Count**	**Percent of Total**	**Count**	**Percent of Total**
2006	107	100.0%	39	36.4%	68	63.6%
2007	72	100.0%	18	25.0%	54	75.0%
2008	106	100.0%	44	41.5%	62	58.5%
2009	139	100.0%	51	36.7%	88	63.3%
2010	145	100.0%	48	33.1%	97	66.9%
2011	144	100.0%	43	29.9%	101	70.1%
2012	161	100.0%	53	32.9%	108	67.1%
2013	180	100.0%	80	44.4%	100	55.6%
2014	201	100.0%	101	50.2%	100	49.8%
2015	280	100.0%	136	48.6%	144	51.4%
Average	**153**	**100.0%**	**61**	**39.9%**	**92**	**60.1%**

Data Source: Utah Insurance Department

Note: Estimates may not total exactly due to rounding.

The OCHA staff and the Utah health insurance industry work diligently to resolve consumer concerns before they rise to the level of a formal written complaint. The trend towards an increase in the number of complaints is likely due to the combined impact of the economic recession and the changes in government regulations. During 2009 to 2015, consumers contacted the Insurance Department in greater numbers. Many consumers called with questions and concerns regarding the options under COBRA, including premium subsidies provided through the American Recovery and Reinvestment Act (ARRA), the economic problems related to their health insurance coverage that were created by the recession, and the implementation of the Patient Protection and Affordable Care Act (ACA). 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 exchange for small employers and the federal health exchange for individuals. Most of the increase during 2015 was due to an increase in the number of complaints related to the Federally-Facilitated Marketplace (FFM).

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, over 59 percent of all consumer complaints are due to claim handling issues, while policyholder services and marketing & sales issues account for the remainder (see Table 6).

Table 6. Complaints Filed with OCHA by Reason: 2006 - 2015

	Total		Claim Handling		Policyholder Services		Marketing & Sales	
Year	**Count [a]**	**Percent of Total**	**Count**	**Percent of Total**	**Count**	**Percent of Total**	**Count**	**Percent of Total**
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%
2013	180	100.0%	132	73.3%	39	21.7%	9	5.0%
2014	201	100.0%	118	58.7%	77	38.3%	6	3.0%
2015	280	100.0%	174	62.1%	89	31.8%	17	6.1%
Average	**154**	**100.0%**	**91**	**59.1%**	**42**	**27.3%**	**21**	**13.6%**

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 2006 to 2015 (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: 2006 - 2015

		Total		Confirmed		Unconfirmed	
Year	**Direct Earned Premium**	**Count**	**Ratio**	**Count**	**Ratio**	**Count**	**Ratio**
2006	$3,017,726,661	107	0.04	39	0.01	68	0.02
2007	$3,427,887,843	72	0.02	18	0.01	54	0.02
2008	$3,789,597,619	106	0.03	44	0.01	62	0.02
2009	$4,041,549,106	139	0.03	51	0.01	88	0.02
2010	$4,273,396,253	145	0.03	48	0.01	97	0.02
2011	$4,475,227,723	144	0.03	43	0.01	101	0.02
2012	$4,529,016,267	161	0.04	53	0.01	108	0.02
2013	$5,052,971,179	180	0.04	80	0.02	100	0.02
2014	$5,467,438,932	201	0.04	101	0.02	100	0.02
2015	$5,705,636,933	280	0.05	136	0.02	144	0.03
Average	**$4,378,044,852**	**153**	**0.03**	**61**	**0.01**	**92**	**0.02**

Data Sources: NAIC Financial Database and Utah Insurance Department

Note: Estimates may not total exactly due to rounding.

As Table 7 shows, the average complaint ratio for the commercial market is about 0.03 for all complaints, about 0.01 for confirmed and about 0.02 for unconfirmed complaints. Using this average as a benchmark, the complaint ratios for 2015 are higher than the ten-year average.

Table 8 reports individual complaint ratios for commercial health insurance companies during 2015. The averages in Table 7 can be used to give perspective to these individual ratios. For example, a commercial health insurer with a confirmed 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 2015

			Total [a]		Confirmed		Unconfirmed	
Company Name	**Direct Earned Premium**	**Market Share**	**Count**	**Ratio**	**Count**	**Ratio**	**Count**	**Ratio**
Aetna Life Ins Co	$78,063,009	1.37%	4	0.05	2	0.03	2	0.03
Aetna Health of Utah, Inc	$288,576,727	5.06%	29	0.10	18	0.06	11	0.04
American Family Life Assur Co	$23,651,070	0.41%	4	0.17	1	0.04	3	0.13
American General Life Ins Co	$2,107,622	0.04%	1	0.47	-	-	1	0.47
American Heritage Life Ins Co	$6,234,332	0.11%	1	0.16	1	0.16	-	-
Arches Health Plans	$136,071,129	2.38%	21	0.15	11	0.08	10	0.07
Bankers Life & Casualty Co	$3,234,789	0.06%	1	0.31	-	-	1	0.31
BridgeSpan Health Co	$16,226,204	0.28%	4	0.25	1	0.06	3	0.18
Chesapeake Life Ins Co	$1,907,959	0.03%	3	1.57	1	0.52	2	1.05
Cigna Health & Life Ins Co	$78,462,196	1.38%	4	0.05	2	0.03	2	0.03
CMFG Life Ins Co	$8,882,870	0.16%	1	0.11	-	-	1	0.11
Continental America Ins Co	$4,337,247	0.08%	1	0.23	1	0.23	-	-
Delta Dental Ins Co	$19,913,307	0.35%	4	0.20	2	0.10	2	0.10
Educators Mutual Ins Association	$32,887,801	0.58%	4	0.12	2	0.06	2	0.06
Equitable Life & Casualty Ins Co	$5,785,952	0.10%	3	0.52	-	-	3	0.52
Genworth Life Ins Co	$8,214,456	0.14%	1	0.12	-	-	1	0.12
HCC Life Ins Co	$12,435,725	0.22%	10	0.80	6	0.48	4	0.32
Humana Ins Co	$108,522,633	1.90%	23	0.21	17	0.16	6	0.06
Humana Medical Plan of UT Inc	$69,126,202	1.21%	19	0.27	11	0.16	8	0.12
HumanaDental Ins Co	$7,529,442	0.13%	4	0.53	3	0.40	1	0.13
Metropolitan Life Ins Co	$45,737,035	0.80%	3	0.07	1	0.02	2	0.04
Molina Healthcare of UT Inc	$344,089,763	6.03%	9	0.03	2	0.01	7	0.02
Mutual Of Omaha Ins Co	$5,778,281	0.10%	1	0.17	-	-	1	0.17
National Union Fire Ins Co Of Pitts	$8,330,951	0.15%	1	0.12	1	0.12	-	-
Premier Access Ins Co	$27,091,089	0.47%	2	0.07	2	0.07	-	-
Principal Life Ins Co	$8,647,710	0.15%	2	0.23	-	-	2	0.23
Prudential Ins Co Of America	$7,226,933	0.13%	2	0.28	-	-	2	0.28
Regence BCBS of UT	$1,086,154,533	19.04%	31	0.03	10	0.01	21	0.02
SelectHealth Inc	$1,911,597,073	33.50%	45	0.02	18	0.01	27	0.01
Standard Ins Co	$12,249,936	0.21%	1	0.08	-	-	1	0.08
Total Dental Administrators of UT	$1,821,955	0.03%	1	0.55	1	0.55	-	-
Transamerica Life Ins Co	$10,373,205	0.18%	1	0.10	1	0.10	-	-
Transamerica Premier Life Ins Co	$2,418,769	0.04%	1	0.41	-	-	1	0.41
Union Security Ins Co	$2,079,055	0.04%	1	0.48	1	0.48	-	-
United American Ins Co	$3,755,847	0.07%	1	0.27	1	0.27	-	-
UnitedHealthcare Ins Co	$327,791,827	5.75%	25	0.08	15	0.05	10	0.03
Unum Life Ins Co Of America	$17,097,097	0.30%	2	0.12	-	-	2	0.12
Washington National Ins Co	$7,338,350	0.13%	1	0.14	-	-	1	0.14
Top 38 companies with complaints [b]	**$4,741,750,081**	**83.11%**	**272**	**0.06**	**132**	**0.03**	**140**	**0.03**
Remaining 5 companies with complaints [c]	$1,328,179	0.02%	8	6.02	4	3.01	4	3.01
Companies without complaints	$962,558,673	16.87%	-	-	-	-	-	-
Total Commercial Market	**$5,705,636,933**	**100.00%**	**280**	**0.05**	**136**	**0.02**	**144**	**0.03**

Data Sources: NAIC Financial Database and Utah Insurance Department

Note: Estimates may not total exactly due to rounding.

[a] Total complaints includes Confirmed and Unconfirmed.
[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.

Independent Reviews by an Independent Review Organization

In addition to consumer complaints, the Insurance Department receives and processes requests from consumers for an independent review of their denied claims by an Independent Review Organization (IRO). An independent review may be filed after the consumer has exhausted the standard claim appeals process with their commercial health insurer.

When the Insurance Department receives a request for an independent review of a denied claim, it is assigned to an Independent Review Organization for review. Independent Review Organizations conduct an independent review of certain classes of claims denied by commercial health insurers. Not all denied claims are eligible for an independent review. The independent review primarily focuses on claims where health care services were denied, but were medically necessary or experimental. For example, a claim that was denied because it was not a covered benefit under the consumer's health benefit plan would not be eligible for an independent review, however, a claim that was denied because the insurer determined it was experimental or not medically necessary might be eligible for a review.

The independent review process produces one of three outcomes: not eligible, overturned, or upheld.

Not eligible. The denied claim did not meet the minimum eligibility criteria to be reviewed. Not all denied claims are eligible for independent review. In most cases, a denied claim must involve a question of medical necessity or health care services that are experimental or investigational.

Overturned. The IRO reviewer reverses the decision made by the commercial health insurer and rules in favor of the consumer. The health insurer is asked to cover the health care services in the claim under the terms of the health benefit plan policy.

Upheld. The IRO reviewer agrees with the original decision made by the commercial health insurer and determines that the insurer acted appropriately. No other appeals are possible.

As shown in Table 9, the Insurance Department receives about 77 requests for an independent review each year. On average, about 75 percent of these requests are eligible for a review. During 2015, the Insurance Department received 111 requests for an independent review. This is an increase of over 60 percent compared to the number of requests over the previous 3 years. Of those, eighty-one requests (73 percent) were eligible for an independent review (see Table 9). The large growth in the number of independent reviews may be due to greater consumer awareness of the program and may continue to grow as public awareness of the independent review program increases.

Table 9. Requests for Independent Reviews by Eligibility: 2012 - 2015

	Total		Not Eligible		Eligible	
Year	**Count**	**Percent of Total**	**Count**	**Percent of Total**	**Count**	**Percent of Total**
2012	61	100.0%	13	21.3%	48	78.7%
2013	66	100.0%	16	24.2%	50	75.8%
2014	69	100.0%	16	23.2%	53	76.8%
2015	111	100.0%	30	27.0%	81	73.0%
Average	**77**	**100.0%**	**19**	**24.7%**	**58**	**75.3%**

Data Source: Utah Insurance Department

Note: Estimates may not total exactly due to rounding. Data year 2012 includes data from Dec. 2011, the first month Independent Reviews began.

The Insurance Department also tracks the reason for the request for an independent review. As shown in Table 10, on average, over 55 percent of all requests for independent reviews are for medical necessity; with contract denial accounting for over 23 percent and experimental and investigational accounting for the remaining 20 percent (see Table 10).

Table 10. Requests for Independent Reviews by Reason: 2012 - 2015

	Total		Contract Denial		Experimental / Investigational		Medical Necessity	
Year	**Count [a]**	**Percent of Total**	**Count**	**Percent of Total**	**Count**	**Percent of Total**	**Count**	**Percent of Total**
2012	61	100.0%	20	32.8%	13	21.3%	28	45.9%
2013	68	100.0%	18	26.5%	14	20.6%	36	52.9%
2014	69	100.0%	1	1.4%	6	8.7%	62	89.9%
2015	111	100.0%	33	29.7%	32	28.8%	46	41.4%
Average	**77**	**100.0%**	**18**	**23.4%**	**16**	**20.8%**	**43**	**55.8%**

Data Source: Utah Insurance Department

Note: Estimates may not total exactly due to rounding. Data year 2012 includes data from Dec. 2011, the first month Independent Reviews began.

[a] An independent review may have more than one reason code, so totals may be slightly higher than the actual number of independent reviews.

As mentioned previously, not all requests for an independent review are eligible for an independent review, regardless of the reason for the request. On average, about 75 percent of independent reviews are eligible. During 2015, about 73 percent of requests for an independent review were eligible. Out of the requests eligible for an independent review, more than 61 percent were upheld, while over 38 percent were overturned. On average, nearly 64 percent of independent reviews were upheld and over 36 percent were overturned (see Table 11).

Table 11. IRO Decisions by Outcome: 2012 - 2015

	Total Eligible		Upheld		Overturned	
Year	**Count**	**Percent of Total**	**Count**	**Percent of Total**	**Count**	**Percent of Total**
2012	48	100.0%	30	62.5%	18	37.5%
2013	50	100.0%	38	76.0%	12	24.0%
2014	53	100.0%	30	56.6%	23	43.4%
2015	81	100.0%	50	61.7%	31	38.3%
Average	**58**	**100.0%**	**37**	**63.8%**	**21**	**36.2%**

Data Source: Utah Insurance Department

Note: Estimates may not total exactly due to rounding. Data year 2012 includes data from Dec. 2011, the first month Independent Reviews began.

Utah's Comprehensive Health Insurance Market

Comprehensive health insurance makes up approximately 49 percent of the commercial health insurance market in the state of Utah (see Table 3) and affects approximately 27 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 types, 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 84 percent of the comprehensive health insurance market is served by domestic insurers and is highly concentrated among twelve insurers. Twenty-seven foreign insurers represent the remaining market share. Premiums were higher for domestic insurers than foreign insurers with $283 per member per month for domestics and $268 per member per month for foreign. Loss ratios were lower for foreign insurers (see Table 12).

Table 12. Total Comprehensive Market by Domicile for 2015

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [a]
Domestic	12	684,535	$2,334,104,748	84.33%	97.48	$283
Foreign	27	141,574	$433,772,621	15.67%	83.83	$268
Total	**39**	**826,109**	**$2,767,877,369**	**100.00%**	**95.34**	**$280**

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 or a group. 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 1 to 50 eligible employees are classified as small employer groups. Groups with 51 or more eligible employees are classified as large employer groups.

Prior to the passage of the Patient Protection and Affordable Care Act (ACA), individual and small group policy rates were primarily set on the health status of the individual or the small employer group, and there were no federal regulations limiting how health insurers set their rates. As of 2014, individual, small group, and large group policies are all underwritten without taking individual health status into account, a practice also called community rating. Under community rating, rates are set so that the insurance risk is spread over the entire community of insured members and individuals pay similar rates regardless of health status.

Under the ACA, rates are set by adjusted community rating, without regard to health status or gender. The only factors that may be used in setting rates are the number of individuals or family members enrolled in the health benefit plan, geographic area (some geographic areas have higher medical costs than others), age (older adults have higher health care costs than younger adults, but the top rating tier cannot be more than the 3 times the bottom tier), and tobacco use (rates for tobacco users cannot be more than 1.5 times the rate of non-tobacco users). These changes mean that traditional rating factors such as health status and gender are no longer used. These changes have the most impact on the individual market, where rates were primarily based on the health status of an individual.

In 2015, large group policies reported higher premium per member per month ($317) than either small group ($274) or individual policies ($223). Loss ratios were significantly higher for individual policies than group policies (see Table 13).

Table 13. Total Comprehensive Market by Group Size for 2015

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Total Individual	30	226,927	$630,263,193	22.77%	127.69	$223
Small Group (1-50)	11	192,306	$624,673,037	22.57%	89.96	$274
Large Group (51+)	21	406,876	$1,512,941,139	54.66%	84.09	$317
Total Group	21	599,182	$2,137,614,176	77.23%	85.81	$303
Total Comprehensive	**39**	**826,109**	**$2,767,877,369**	**100.00%**	**95.34**	**$280**

Data Source: Utah Accident & Health Survey

[a] Company count column does not add up to total because an insurer may have more than one plan type.
[b] Direct earned premium per member per month

Comprehensive health insurers did not have a full year's claim experience under the provisions of the ACA to use when pricing their products for the individual market during 2015 and were setting rates based on the assumption that the federal risk corridor program would provide additional premium income to offset their higher losses. However, due to congressional acts in 2013 and the lack of funding in the federal risk corridor program, comprehensive health insurers did not receive the additional payments to offset these losses and experienced very high losses for a second consecutive year.

This can be seen in the significantly higher loss ratio in the individual market, which shows that health insurers underpriced the costs of covering higher risk members in the individual market. In contrast, premium costs and loss ratios in the small and large group market were more in line with market trends. The combination of not having enough information to adequately price their products and not receiving the additional payments from the federal risk corridor program as expected produced higher losses for comprehensive health insurers participating in the individual market and the Federally-Facilitated Marketplace (FFM). Three individual comprehensive health insurers withdrew from the FFM due to concerns that these losses were not sustainable.

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). There has been a significant decline in the number of Fee for Service plan options.

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 may be denied, or be reimbursed at a lower rate. Regardless, members must pay a larger portion of the cost for health care services when obtaining services from health care providers outside of the network. PPO plans usually include deductibles, co-pays, or coinsurance. In today’s market, PPO plans resemble HMO plans and many PPO plans are not providing services outside of the provider network, except for emergencies.

A Health Maintenance Organization plan (HMO) refers to a health insurance plan where policyholders pay a fixed monthly fee for comprehensive major medical coverage. An HMO plan provides services through a network of health care providers that have negotiated a fee schedule with the HMO. Members enrolled in the plan generally pay a deductible and fixed co-pay for health care 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, but at a lower reimbursement rate resulting in members bearing a much larger portion of the cost for health care services in addition to the fixed co-pay and deductibles.

HMO, HMO with POS, and PPO plans are considered managed care plans. FFS plans typically do not involve any form of managed care. Nearly 98 percent of Utah’s comprehensive health insurance market involves some type of managed care; with over 66 percent of the comprehensive health market in an HMO or HMO with POS. Over 2 percent of the market had a FFS plan (see Table 14).

Table 14. Total Comprehensive Market by Plan Type for 2015

Plan Type	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Fee for Service	22	15,018	$58,867,213	2.13%	83.35	$329
Preferred Provider Organization	21	248,071	$862,702,333	31.17%	83.87	$294
Health Maintenance Organization	7	267,842	$836,335,353	30.22%	111.89	$258
HMO with Point of Service features [c]	3	295,178	$1,009,972,470	36.49%	82.14	$287
Total	**39**	**826,109**	**$2,767,877,369**	**100.00%**	**95.34**	**$280**

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. The higher loss ratio for HMO plans was due to the higher number of HMO plans in the individual market which experienced higher losses during 2015. 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 a 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. Another cost control measure used by insurers is the breadth of the provider network. Some plans have very narrow networks, limiting the number of providers a member may use to obtain covered services. The insurer utilizes narrow networks to negotiate with providers to drive more members to a small provider community. These narrow network plans result in lower negotiated provider reimbursements and lower member premiums.

Comprehensive Market by Regulatory Type

As part of the ongoing health care reform efforts, state and federal governments have created specialized plans that must conform to certain state and federal insurance regulations. Requiring compliance 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. Tables 15-17 describe some of the regulatory types that have been created as a result of either state or federal legislation and for which comprehensive health insurers have reported enrollment in Utah.

ACA Compliant Plans vs Non-ACA Compliant Plans. ACA compliant plans are comprehensive health insurance plans that are in full compliance with the federal regulations that have been established for health benefit plans under the Patient Protection and Affordable Care Act (ACA). Non-ACA complaint plans are comprehensive health insurance plans that have qualified for some type of exemption from part of the ACA regulations, termed either grandfathered plans or transitional plans. The majority (about 72 percent) of the comprehensive market were enrolled in ACA compliant plans (see Table 15).

Off-Exchange Plans. In addition to ACA compliance, plans can be further divided into "Off-Exchange" or "On-Exchange" plans. An Off-Exchange plan refers to health benefit plans that are sold outside of the state or federal exchanges. In other words, they are sold directly to individuals and employer groups by the commercial health insurer independent of a health exchange. On-Exchange plans refer to health benefit plans that are sold on one of Utah's health exchanges, Avenue H SHOP or the Federally-Facilitated Marketplace (FFM). Most (84 percent) of the comprehensive market were enrolled in Off-Exchange plans. Off-Exchange membership was enrolled in both ACA compliant plans (67 percent) and Non-ACA complaint plans (33 percent).

Avenue H Small Business Health Options Program Exchange. The Avenue H Small Employer Health Options Program or Avenue H SHOP is Utah's exchange for small employer groups where employers can offer their employees a defined contribution plan. 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 can 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, through Avenue H SHOP employees may purchase health insurance plans through a defined contribution arrangement (see U.C.A. § 63N-111-104), where participating employers provide a defined contribution towards the purchase of a health insurance plan offered through Avenue H SHOP. Employees may either use the defined contribution alone or may add their own money to purchase a plan that is appropriate for them. There were 718 employers, 14,913 members (about 2 percent of the market), and 3 comprehensive health insurers participating in the Avenue H SHOP exchange (see Table 15). Avenue H SHOP currently offers ACA compliant plans. Prior to 2014, Avenue H SHOP offered non-ACA compliant plans, some of which have continued under the ACA transitional rules.

Federally-Facilitated Marketplace (FFM). The Federally Facilitated Marketplace (FFM) is Utah's health exchange for individuals. Policies sold through the FFM are rated using adjusted community rating and may be eligible for federal subsidies and income support for purchasing insurance. In 2015, there were 115,434 members (about 14 percent of the market) and 6 comprehensive health insurers participating in the FFM (see Table 15). All of the policies sold through the FFM were ACA compliant plans.

Table 15. Total Comprehensive Market by ACA Market Segment for 2015

Market Segment by Group Size	Company Count [a]	Member Count	Percent of Members
Individual	**30**	**226,927**	**27.5%**
Non-ACA Compliant			
Off-Exchange	23	66,237	8.0%
ACA Compliant			
Off-Exchange	10	45,256	5.5%
Federally-Facilitated Marketplace	6	115,434	14.0%
Small Group	**11**	**192,306**	**23.3%**
Non-ACA Compliant			
Off-Exchange	9	62,848	7.6%
Avenue H SHOP	1	2,396	0.3%
ACA Compliant			
Off-Exchange	10	114,545	13.9%
Avenue H SHOP	3	12,517	1.5%
Large Group	**21**	**406,876**	**49.3%**
Non-ACA Compliant			
Off-Exchange	14	100,975	12.2%
ACA Compliant			
Off-Exchange	11	305,901	37.0%
Total	**39**	**826,109**	**100.0%**
Non-ACA Compliant			
Off-Exchange	30	230,060	27.8%
Avenue H SHOP	1	2,396	0.3%
ACA Compliant			
Off-Exchange	20	465,702	56.4%
Avenue H SHOP	3	12,517	1.5%
Federally-Facilitated Marketplace	6	115,434	14.0%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2015. There were 718 employers participating in the Avenue H SHOP Marketplace at the end of 2015.

[a] Company count includes all insurers that reported claims, premium or membership for each market segment. Company count column does not add up to total because an insurer may have more than one market segment.

Metal Tier Plans (Actuarial Value). ACA compliant plans also can be classified by actuarial value. Below is a summary of membership with actuarial value of plans on Avenue H SHOP and the FFM. Actuarial value is a method to measure the relative cost-sharing value of health benefit plans. For example, a Gold plan covers approximately 80 percent of the eligible health care costs under the health benefit plan. The member is responsible for the rest. By comparison, a Bronze plan only covers about 60 percent of the eligible health care costs under the health benefit plan, and the member is responsible for a higher portion of the cost. Health benefit plans with a higher actuarial value are usually more expensive and those with a lower actuarial value are usually less expensive. However, the cost that individual consumers pay may differ significantly depending on their individual circumstances.

A majority of members on the two exchanges were enrolled in Silver plans (64 percent), followed by Gold plans (18 percent), Bronze plans (16 percent), Platinum plans (1 percent), and Catastrophic plans (less than 1 percent). Under the ACA, Catastrophic plans are only available in the individual market. A small segment of Avenue H SHOP members (2 percent) were enrolled in non-ACA compliant plans that did not have a metal tier (see Table 16).

Table 16. Metal Tier Plans on Avenue H SHOP and Federally-Facilitated Marketplace for 2015

Market Segment by Exchange	Member Count	Percent of Members
Avenue H SHOP	**14,913**	**11.4%**
Platinum (90% AV)	0	0.0%
Gold (80% AV)	7,203	5.5%
Silver (70% AV)	3,581	2.7%
Bronze (60% AV)	1,733	1.3%
Non-ACA (no metal)	2,396	1.8%
Federally-Facilitated Marketplace	**115,434**	**88.6%**
Platinum (90% AV)	851	0.7%
Gold (80% AV)	15,894	12.2%
Silver (70% AV)	79,401	60.9%
Bronze (60% AV)	18,866	14.5%
Catastrophic	422	0.3%
Total (Avenue H SHOP and FFM)	**130,347**	**100.0%**
Platinum (90% AV)	851	0.7%
Gold (80% AV)	23,097	17.7%
Silver (70% AV)	82,982	63.7%
Bronze (60% AV)	20,599	15.8%
Catastrophic	422	0.3%
Non-ACA (no metal)	2,396	1.8%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2015. There were 718 employers and 3 commercial health insurers participating in the Avenue H SHOP exchange at the end of 2015. There were 6 commercial health insurers participating in the Federally-Facilitated Marketplace at the end of 2015.

HSA-Qualified High Deductible Health Plans. HSA-Qualified High Deductible Health Plans are high deductible health plans that can to be combined with a savings account called a Health Savings Account (HSA). The deductible levels of these plans are set by federal statute and plans must comply with federal guidelines in order to qualify for use with an 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 were 254,993 members (about 31 percent of the market) enrolled in HSA-Qualified High Deductible Health Plans (see Table 17).

Standard Plans. Standard plans are simply the typical health benefit plan that operates under the current statutory requirements of the Utah insurance code and does not qualify for or make use of any of features available under HSA-Qualified High Deductible Health Plans. Most health benefit plans in Utah's health insurance market are Standard Plans. There were 571,116 members (about 69 percent of the market) enrolled in Standard Plans (see Table 17).

Table 17. HSA-Qualified High Deductible Health Plans for 2015

Market Segment by Group Size	Member Count	Percent of Members
Individual	**226,927**	**27.5%**
HSA-Qualified High Deductible Health Plan	68,070	8.2%
Standard Plan	158,857	19.2%
Small Group	**192,306**	**23.3%**
HSA-Qualified High Deductible Health Plan	57,422	7.0%
Standard Plan	134,884	16.3%
Large Group	**406,876**	**49.3%**
HSA-Qualified High Deductible Health Plan	129,501	15.7%
Standard Plan	277,375	33.6%
Total	**826,109**	**100.0%**
HSA-Qualified High Deductible Health Plan	254,993	30.9%
Standard Plan	571,116	69.1%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2015.

Membership in HSA-Qualified High Deductible Health Plans has been grown rapidly in Utah. In 2006, about 2.6 percent of the comprehensive health insurance market was enrolled in an HSA-Qualified High Deductible Health Plan. Since 2006, the percentage of the comprehensive membership covered by an HSA-Qualified High Deductible Health Plan has increased by 2.8 percent per year on average. As of 2015, HSA-Qualified High Deductible Health Plan membership accounts for about 31 percent of the market.

Comprehensive Market Trends

This section reports on four significant trends in Utah's comprehensive health insurance market: the number of insurers, the number of insured members, the cost of insurance, 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 18, the number of comprehensive health insurers has declined from 2006 to 2015. In 2006, there were 79 commercial health insurance companies that reported comprehensive health insurance. By 2010, this number had dropped to 62, and as of 2015, there were 39 insurers who reported having comprehensive health insurance business in Utah. This decline is primarily among very small foreign insurers with less than $1 million dollars in premium, although small insurers have also contributed to this decline in recent years. In contrast, the number of medium and large insurers has remained fairly stable. These carriers account for over 95 percent of the market share over time. As part of the first two years of the full implementation of the ACA, there was some market shifting with a decline in the number of small insurers and an increase in the number domestic medium insurers, including several new insurers that entered the market to participate in the Federally-Facilitated Marketplace (FFM). However, financial stress in the market is making it increasingly difficult for some insurers to participate in the comprehensive market and to sustain participation in the FFM.

Table 18. Changes in the Number of Comprehensive Health Insurers: 2006 - 2015

Insurer Category	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	*Net Change*
Domestic Insurers											
Greater than 100 Million	3	3	3	3	3	3	3	3	3	4	*+1*
Between 10 and 100 Million	4	3	1	2	2	0	0	0	2	4	*0*
Between 1 and 10 Million	3	5	5	5	4	4	4	4	5	3	*0*
Less than 1 Million	2	1	1	2	2	4	2	1	1	1	*-1*
Total Domestic	**12**	**12**	**10**	**12**	**11**	**11**	**9**	**8**	**11**	**12**	***0***
Foreign Insurers											
Greater than 100 Million	1	1	1	1	1	1	1	1	1	1	*0*
Between 10 and 100 Million	2	3	4	4	4	4	6	6	5	5	*+3*
Between 1 and 10 Million	9	12	12	10	10	11	9	7	5	3	*-6*
Less than 1 Million	55	46	38	38	36	32	32	29	27	18	*-37*
Total Foreign	**67**	**62**	**55**	**53**	**51**	**48**	**48**	**43**	**38**	**27**	***-40***
All Insurers											
Greater than 100 Million	4	4	4	4	4	4	4	4	4	5	*+1*
Between 10 and 100 Million	6	6	5	6	6	4	6	6	7	9	*+3*
Between 1 and 10 Million	12	17	17	15	14	15	13	11	10	6	*-6*
Less than 1 Million	57	47	39	40	38	36	34	30	28	19	*-38*
Total Utah	**79**	**74**	**65**	**65**	**62**	**59**	**57**	**51**	**49**	**39**	***-40***

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.

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 18). 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 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. 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. 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.

The number of large comprehensive health insurers grew to 5 during 2015 when Arches Health Plans temporarily grew from a medium to large insurer, but the company was liquated in late 2015 due to solvency issues (see Table 18). 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.

The total number of medium insurers (between 10 to 100 million in premiums) has remained relatively stable from 2006 to 2013. There has also been some shifting and turnover among medium insurers, followed by a general increase in the number of medium insurers during 2014 and 2015. For example, in 2006, medium insurers were primarily domestic. By 2013 medium size insurers were primarily foreign. 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. From 2013 to 2015, there was some turnover and several new medium sized insurers entered the marketplace, including several new domestic insurers that entered the market to participate in the FFM.

With the addition of several new medium sized insurers and the continuing decline in the number of small and very small insurers, the market is becoming more concentrated at the top, with more large and medium insurers and fewer small and very small insurers. Increased federal regulation and higher costs of doing business due to these regulations may make it harder for small and very small insurers to participate.

Trends in the number of members. Since 2006, the number of residents insured by comprehensive health insurance as a relative percentage of Utah's total population has declined by about 5.1 percent. During this same time period, Utah's population has increased by about 16 percent. In absolute numbers, comprehensive membership has remained relatively stable over the last ten years, averaging about 830,000 members (nearly 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 increased from 2006 to 2008, declined during 2009, remained relatively stable during 2010, declined during 2011 and 2012, and then increased during 2013, 2014 and 2015 (see Table 19).

One of the most significant changes was the increase in membership in the individual market. In the past, 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. During 2014, the number of members in the individual market grew by about 46,000 members, an increase of over 29 percent. During 2015, individual membership grew again by over 22,000 members, an increase of about 11 percent. As a result, the individual market is now larger than the small group market. Most of this growth appears to be driven by the federal individual mandate which requires most persons to maintain health insurance, the availability of coverage through the FFM, where persons whose income is between 100 percent and 400 percent of the federal poverty level receive subsidies to make coverage more affordable, and changes to health insurance regulations, including guaranteed issue and community rating, which have made it easier for Utah residents to get and keep coverage in the individual market.

From 2006 to 2008, small group membership remained relatively stable. The data suggests that during this period small employers maintained insurance coverage despite the rising premiums in Utah's comprehensive market, which was a positive trend for Utah's small group market. Starting in 2009, the number of members in the small group market declined from 2009 to 2011. This decline was likely due to the economic stress of the recession and the slow economic recovery that made it harder for small employers to maintain coverage. Small group membership increased during 2012 as the economy improved and jobs with health benefits became more available again. However, the gains in the small group market were lost as small group membership declined during 2013 and 2014. Membership increased during 2015. It is possible that some small group membership may have shifted to the individual market, and healthy small groups have moved to self-funded health benefit plan arrangements to circumvent several of the ACA provisions.

From 2006 to 2008, large group membership grew steadily, declined during 2009, increased during 2010, and then returned to 2009 levels during 2011. In 2012, there was a significant decline in membership due to several blocks of business moving from fully insured health benefit plans to self-funded health benefit plans. During 2013, the large group market made a slight recovery and increased membership, followed by another similar decline during 2014 and 2015. These changes may be due to some employers moving to self-funding arrangements, although one cannot rule out the possibility of some shifting to the individual market. ACA regulations, including the employer mandate to offer health insurance, may be increasing self-funded membership as well.

Table 19. Changes in Comprehensive Membership by Group Size: 2006 - 2015

Group Size	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	*Net Change* [a]
Individual	145,065	144,244	148,649	142,878	139,185	157,707	156,426	158,047	204,601	226,927	*+81,862*
Percent of population [b]	**5.6%**	**5.5%**	**5.5%**	**5.2%**	**5.0%**	**5.6%**	**5.5%**	**5.4%**	**7.0%**	**7.6%**	***+2.0%***
Small Group	228,905	237,378	234,726	208,551	198,784	192,995	212,591	195,398	187,580	192,306	*-36,599*
Percent of population	**8.9%**	**9.0%**	**8.7%**	**7.6%**	**7.2%**	**6.9%**	**7.5%**	**6.7%**	**6.4%**	**6.4%**	***-2.5%***
Large Group	468,877	494,233	496,798	477,158	492,561	470,910	420,789	439,873	418,070	406,876	*-62,001*
Percent of population	**18.2%**	**18.7%**	**18.5%**	**17.5%**	**17.8%**	**16.7%**	**14.8%**	**15.2%**	**14.2%**	**13.6%**	***-4.6%***
Total Group	697,782	731,611	731,524	685,709	691,345	663,905	633,380	635,271	605,650	599,182	*-98,600*
Percent of population	**27.1%**	**27.8%**	**27.2%**	**25.1%**	**24.9%**	**23.6%**	**22.2%**	**21.9%**	**20.6%**	**20.0%**	***-7.10%***
Total Comprehensive	842,847	875,855	880,173	828,587	830,530	821,612	789,806	793,318	810,251	826,109	*-16,738*
Percent of population	**32.7%**	**33.2%**	**32.7%**	**30.3%**	**29.9%**	**29.2%**	**27.7%**	**27.3%**	**27.5%**	**27.6%**	***-5.10%***
Utah Population	2,576,228	2,636,077	2,691,122	2,731,558	2,774,663	2,813,923	2,852,589	2,900,872	2,942,902	2,995,919	*+419,691*
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, Utah Population Estimates Committee and the U.S. Census Bureau.

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 2006 to 2015 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 16 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 20. Changes in Comprehensive Membership by Plan Type: 2006 - 2015

Plan Type [a]	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	*Net Change* [b]
FFS	74,624	89,014	96,422	106,485	28,097	17,722	17,021	14,135	19,971	15,018	*-59,606*
Percent of population [c]	**2.9%**	**3.4%**	**3.6%**	**3.9%**	**1.0%**	**0.6%**	**0.6%**	**0.5%**	**0.7%**	**0.5%**	***-2.4%***
PPO	183,175	185,512	204,460	206,072	269,521	268,784	273,791	288,683	251,606	248,071	*+64,896*
Percent of population	**7.1%**	**7.0%**	**7.6%**	**7.5%**	**9.7%**	**9.6%**	**9.6%**	**10.0%**	**8.5%**	**8.3%**	***+1.2%***
HMO	410,963	248,468	195,897	135,064	170,008	223,334	176,088	181,002	243,636	267,842	*-143,121*
Percent of population	**16.0%**	**9.4%**	**7.3%**	**4.9%**	**6.1%**	**7.9%**	**6.2%**	**6.2%**	**8.3%**	**8.9%**	***-7.1%***
HMO with POS	166,929	346,993	378,206	380,685	362,904	311,772	322,906	309,498	295,038	295,178	*+128,249*
Percent of population	**6.5%**	**13.2%**	**14.1%**	**13.9%**	**13.1%**	**11.1%**	**11.3%**	**10.7%**	**10.0%**	**9.9%**	***+3.4%***
Other	7,156[d]	5,868[d]	5,188[d]	281	0	0	0	0	0	0	*-7,156*
Percent of population	**0.3%**	**0.2%**	**0.2%**	**< 0.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	***-0.3%***
Total Comprehensive	842,847	875,855	880,173	828,587	830,530	821,612	789,806	793,318	810,251	826,109	*-16,738*
Percent of population	**32.7%**	**33.2%**	**32.7%**	**30.3%**	**29.9%**	**29.2%**	**27.7%**	**27.3%**	**27.5%**	**27.6%**	***-5.1%***
Utah Population	2,576,228	2,636,077	2,691,122	2,731,558	2,774,663	2,813,923	2,852,589	2,900,872	2,942,902	2,995,919	*+419,691*
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, Utah Population Estimates Committee, and the U.S. Census Bureau.

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 2006 to 2015 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 16 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.

Prior to 2007, most of the comprehensive market membership was in HMO plans, which accounted for nearly 50 percent of the market, with PPO and HMO with POS plans 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 20). This was due in part to a one-time restructuring of the marketplace. 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 2013. FFS plans, as a percentage of Utah's population, declined from 3.9 percent during 2009 to about 0.5 percent during 2013. The change in FFS plan membership is consistent with national surveys that have also found a decline in FFS plans. For example, the Kaiser Employer Health Benefits Survey also reported lower estimates of insured membership in FFS plans during this period (Kaiser/HRET, 2011; Kaiser/HRET, 2012; Kaiser/HRET, 2013, Kaiser/HRET, 2014). 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.

During 2014, the number of members in FFS and HMO plans increased, while PPO and HMO with POS plans decreased. The increase in FFS plans was small, increasing from about 0.5 percent during 2013 to 0.7 percent during 2014. HMO plans increased from 6.2 percent during 2013 to 8.3 percent of Utah residents during 2014. The data suggest that this increase was due to a shift from PPO and HMO with POS plans to HMO plans, with most of the shift coming from PPO plans.

During 2015, the number of members in FFS plans decreased again, while HMO plans increased. PPO and HMO with POS plans remained relatively stable. The decrease in FFS plans was small, declining from 0.7 percent during 2014 to 0.5 during 2015. HMO plans increased from 8.3 percent during 2014 to 8.9 percent during 2015.

Data on Utah's government sponsored health benefit plans shows a steady increase in membership (see Table 21). Most of the increases are in Medicare and Medicaid. During 2014, there was a large shift from the Children's Health Insurance Program (CHIP) to Medicaid. This was due to changes required by the ACA, which required states to shift children in families with incomes between 100 percent and 138 percent of the federal poverty level out of CHIP and into Medicaid.

Table 21. Changes in Government Sponsored Health Benefit Plans: 2006 - 2015

Plan Type	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	*Net Change* [a]
Medicare	238,286	252,572	264,086	271,773	280,838	290,319	304,202	317,413	329,943	340,968	*+102,682*
Medicaid	174,800	159,849	164,119	195,257	221,954	244,724	257,691	268,393	287,736	295,123	*+120,323*
CHIP	35,248	24,747	35,060	40,742	42,068	37,700	36,893	35,343	15,760	16,588	*-18,660*
PCN	16,043	17,795	18,505	24,103	14,946	16,780	16,734	16,134	14,021	13,203	*-2,840*
HIPUtah	3,346	3,505	3,621	3,839	4,158	3,688	3,381	2,900	-	-	*-3,346*
Federal HIPUtah	-	-	-	-	-	649	1,168	-	-	-	*+0*
Government Plans	467,723	458,468	485,391	535,714	563,964	593,860	620,069	640,183	647,460	665,882	*+198,159*
As percent of population [b]	**18.2%**	**17.4%**	**18.0%**	**19.6%**	**20.3%**	**21.1%**	**21.7%**	**22.1%**	**22.0%**	**22.2%**	***+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). The Federal HIPUtah program ended in 2013. The HIPUtah ended in 2014.

[a] "Net Change" measures the difference in the absolute number of members from 2006 to 2015 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 16 percent over this period.
[b] "As percent of population" measures the relative percentage of Utah's total population in each particular year.

Data from the Behavior Risk Factor Surveillance System (BRFSS) published by the Utah Health Department estimates Utah's uninsured rate to be 8.8 percent for 2015 (Office of Public Health Assessment, 2016). Previously, Utah's uninsured rate was estimated to be 10.3 for 2014, 11.6 for 2013, 13.2 percent for 2012, and 13.4 percent for 2011 (Office of Public Health Assessment, 2012; Office of Public Health Assessment, 2013, Office of Public Health Assessment, 2014, Office of Public Health Assessment, 2015). 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).

Data from the Census Bureau's American Community Survey estimates Utah's uninsured rate to be 14 percent in 2013, 12.5 percent in 2014, and 10.5 percent in 2015 (Barnett & Vornovitsky, 2016). Both the BRFSS and the Census Bureau's estimates suggest that Utah's uninsured rate has declined over the last five years, with the most recent Census estimate putting Utah's uninsured rate at 10.5 percent.

Trends in the cost of insurance. Utah's comprehensive health insurance premiums continue to increase. For example, from 2006 to 2015, the average premium per member per month for comprehensive health insurance has increased on average about 4.3 percent per year. In 2015, the average premium per member per month for comprehensive health insurance was 1.1 percent higher than in 2014. Utah's rate of increase, in comparison with national employer data, appears to be following a national trend (see Table 22).

Table 22. Comprehensive Premium Compared to National Economic Trends: 2006 - 2015

	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]
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%
2013	$2,423,407,576	$259	$3,108	4.9%	3.8%
2014	$2,670,928,970	$277	$3,324	6.9%	3.0%
2015	$2,767,877,369	$280	$3,360	1.1%	4.2%

Data Sources: Utah premium data are from the Utah Accident & Health Survey from 2006 to 2015. The national trend data used as a comparison comes from the 2015 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.

Utah's health insurance market continues to experience similar cost pressures as other parts of the country. 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 2006 to 2015, the average losses per member per month for comprehensive health insurance have increased about 6.1 percent per year. In 2015, the average losses per member per month for comprehensive health insurance were 9.4 percent higher than in 2014 (see Table 23).

Nationally, these costs have been 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). Multiple cost drivers are involved and no single factor appears to be driving costs (Ginsburg, Hughes, Alder, Burke, Hoagland, Jennings, & Lieberman, 2012). Government mandates, increased utilization from consumer demand, litigation, new technologies, unnecessary care, and medical inflation 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, treatment of preventable health conditions, and unnecessary medical spending (PriceWaterhouseCoopers, 2008b; Institute of Medicine, 2012).

Table 23. Comprehensive Losses Compared to National Health Care Spending: 2006 - 2015

	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
2006	81.69	$157	$1,884	12.9%	$2,156,516	6.5%	$737,559	5.1%
2007	81.10	$166	$1,992	5.7%	$2,295,650	6.5%	$776,628	5.3%
2008	83.81	$179	$2,148	7.8%	$2,399,061	4.5%	$803,020	3.4%
2009	85.17	$189	$2,268	5.6%	$2,494,669	4.0%	$832,551	3.7%
2010	84.32	$193	$2,316	2.1%	$2,596,405	4.1%	$863,064	3.7%
2011	85.94	$206	$2,472	6.7%	$2,687,902	3.5%	$895,098	3.7%
2012	83.61	$206	$2,475	0.1%	$2,795,403	4.0%	$925,133	3.4%
2013	83.54	$216	$2,592	4.7%	$2,877,574	2.9%	$944,901	2.1%
2014	87.96	$244	$2,928	13.0%	$3,029,255	5.3%	$999,990	5.8%
2015	95.34	$267	$3,204	9.4%	$3,205,556	5.8%	$1,072,056	7.2%

Data Sources: Utah loss data are from the Utah Accident & Health Survey from 2006 to 2015. The National Health Care Expenditure data are from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (2015). NHE historical data were used for 2006 to 2015.

[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

The rate of increase in national health care costs slowed during 2008 to 2013. This was 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). National health care spending grew faster during 2014 compared to the previous five years. This growth was driven primarily by the major coverage expansions under the ACA, particularly for Medicaid and private health insurance (Martin, Hartman, Benson, Catlin, and the National Health Expenditure Accounts Team, 2015).

Growth in national health costs for employer groups was modest during 2014 (Claxton, Rae, Panchal, Whitmore, Damico, and Kenward, 2014; Kaiser/HRET, 2015), while costs in the individual market increased significantly as people shifted to ACA compliant plans, and as previously uninsured or higher risk individuals obtained insurance in the individual market. National health costs for employer groups were stable during 2015 (Claxton, Rae, Panchal, Whitmore, Damico, Kenward, and Long, 2015; Kaiser/HRET, 2016) continuing a pattern of more modest growth.

Estimates based on National Health Expenditure data suggest that health care spending growth may average 5.8 percent during 2014-2024. This future growth reflects the effect of the ACA's coverage expansions, economic growth, and an aging population (Keehna, Cuckler, Sisko, Madison, Smith, Stone, Poisal, Wolfe, and Lizonitz, 2015).

The rising cost of health care continues to create significant economic pressure on comprehensive health insurers. For example, if Utah's comprehensive health insurers had kept premiums at 2006 levels and costs had continued to increase, by 2015, the industry's loss ratio would be approximately 139. In other words, the industry would be paying out nearly $1.39 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.

For Utah employers and consumers, this trend towards higher premiums means that health care continues to be expensive. For a single individual, the average premium per member per year increased from $2,304 in 2006 to $3,360 in 2015 (without taking into account any advance premium tax credits an individual may have received). This is an increase of about 46 percent over the last ten years. Both consumers and employers are being impacted by these increases. In most cases, employers pay a significant portion of this premium. Nationally, employers pay more than two-thirds of the premium cost (Kaiser/HRET, 2016). However, many employers are responding to the rising cost of health care by increasing the employee's portion of the premium, reducing benefits, increasing deductibles and cost sharing, or looking at new plan designs to reduce costs. These changes continue to be difficult for many consumers to absorb because the rate of increase in consumer income has not kept pace with the rate of increase in health care costs and, as a result, many consumers continue to struggle with the cost of using their health insurance to obtain necessary health care (see Table 24).

Table 24. Changes in Comprehensive Premium and Per Capita Income: 2006 - 2015

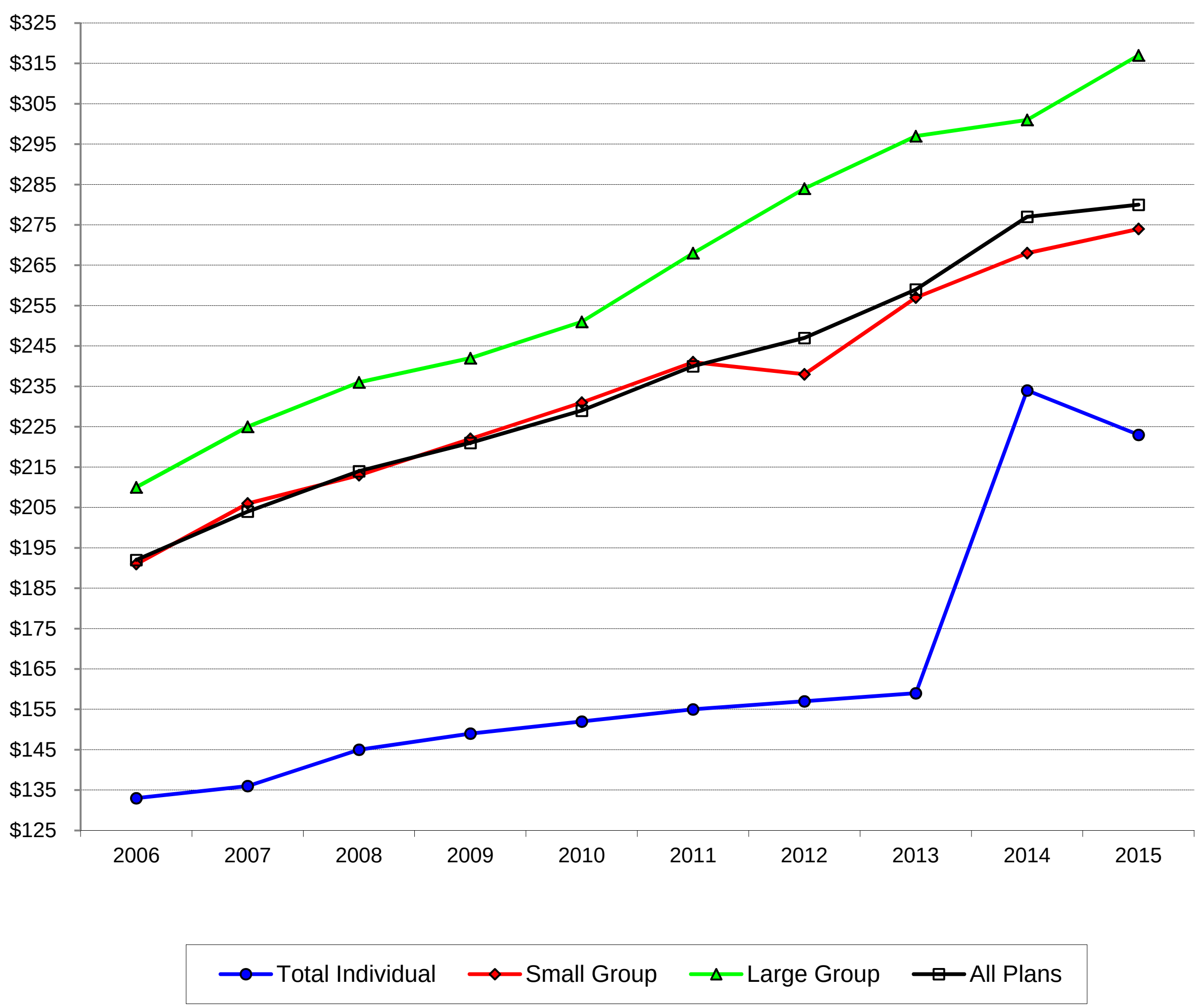
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Premium PMPY [a]	$2,304	$2,448	$2,568	$2,652	$2,748	$2,880	$2,964	$3,108	$3,324	$3,360
Percent change in Premium	12.3%	6.3%	4.9%	3.3%	3.6%	4.8%	2.9%	4.9%	6.9%	1.1%
Per Capita Income in Utah	$31,786	$33,643	$34,512	$32,428	$32,614	$34,415	$35,995	$36,542	$37,664e	$38,641f
Percent change in Income	8.1%	5.8%	2.6%	-6.0%	0.6%	5.5%	4.6%	1.5%	3.1%	2.6%

Data Sources: Utah premium data are from the Utah Accident & Health Survey. Per capita income data are from the 2016 Economic Report to the Governor, David Eccles School of Business and the Utah Governor's Office of Management and Budget.

[a] Direct earned premium per member per year
e = estimate
f = forecast

Prior to 2014, premium increases were relatively uniform among different group types. Premium increases were larger among small and large group plans, while individual plans reported lower increases over time. In 2014, that pattern changed. Under the ACA, policies are underwritten using adjusted community rating, which means that the insurance risk is spread over the entire community of insured members regardless of health status. This means that the cost of covering higher risk and lower risk individuals tends to average out, which can be beneficial to individuals with higher health care costs. Starting in 2014, the individual market began using a form of adjusted community rating to set rates, which included covering individuals with higher costs. As part of this change, individual premium per member per month increased by about 47 percent during 2014. In contrast, increases in small group premiums per member per month and large group premiums per member per month were more in line with market trends. Premiums during 2015 remained relatively stable with more moderate rate increases as consumers and comprehensive health insurers sought to create more affordable health insurance options (see Figure 2).

Figure 2. Comprehensive Premium PMPM by Group Size: 2006 - 2015



Data Source: Utah Accident & Health Survey

One of the primary reasons for the increase in individual premium per member per month was the shift in the individual market to the adjusted community rating required by ACA compliant plans and expanded coverage for higher risk individuals from 2013 to 2015. The mixture of market demographics of products and insured members within the individual market changed significantly and there was rapid growth in the FFM as more people moved from non-ACA to ACA complaint plans.

Also, comprehensive health insurers did not have a full year's claim experience to use when pricing their products during 2014 and 2015. Comprehensive health insurers usually base their rates on previous experience in the market and current market trends. Due to the nature of the new ACA marketplace, comprehensive health insurers did not have all of the information they needed to price their products. This made it difficult to set rates that would cover their actual costs. Comprehensive health insurers were also basing their rates on the assumption that they would be receiving additional premium income from the federal risk corridor program to help manage the costs of covering high risk individuals. However, due to changes to the federal risk corridor program made by the United States Congress, comprehensive health insurers did not receive the additional payments that were expected under the program that would have helped them cover their costs.

As a result, many comprehensive health insurers in the individual market experienced significant losses during 2015. This can be seen in the significantly higher loss ratio in the individual market, which suggests that health insurers underpriced the costs of covering higher risk members in the individual market. In contrast, costs and loss ratios in the small and large group market were more in line with market trends.

Over the last ten years, increases in large group plan premiums have had the most impact on the premium trends in the market. This is primarily due to the fact that more Utah residents in the comprehensive health insurance market are covered by large group plans than by any other type. As a result, changes in this category have had a larger impact on market averages than changes in the individual or small group markets. This is changing, and the individual market may have a larger impact on the market average than in the past.

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 25). For example, during 2015, the average premium for Utah's comprehensive health insurers was approximately $280 per member per month. In contrast, the average premium for commercial health insurers reporting comprehensive health insurance to the NAIC financial database was approximately $364 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 25. Comparison of Utah Premium to National Premium: 2006 - 2015

	Utah Estimate		National Estimate	
Year	Premium PMPM for Comprehensive Health Insurance [a]	Annual Percent Change	Premium PMPM for Comprehensive Health Insurance	Annual Percent Change
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%
2013	$259	4.9%	$324	1.3%
2014	$277	6.9%	$348	7.4%
2015	$280	1.1%	$364	4.6%

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. This comparison does not control for differences in plan structure, covered benefits, health status, or demographics.

However, the premiums that consumers actually pay may differ significantly from the market average depending on their individual circumstances and plan choice. Furthermore, although Utah's premiums may be lower by this measure, Utah's premiums are increasing at rates that are very similar to comprehensive health insurers nationally (4.3 percent for Utah, 4.5 percent for comprehensive health insurers reporting to the NAIC), and continue to be financially challenging for many consumers.

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) a majority of their revenues come from Utah business, and 3) their business model is that of a comprehensive health insurer. These companies are Utah's best examples of 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).

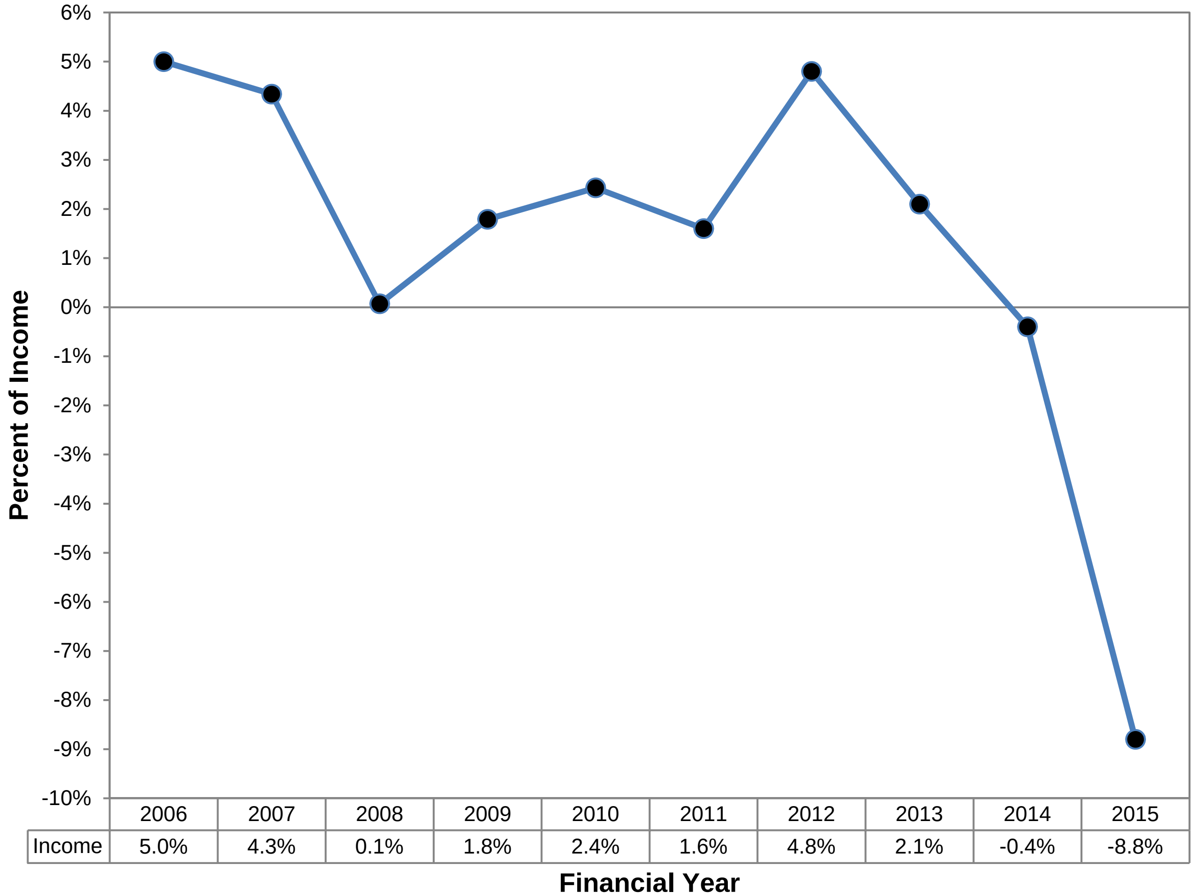
Comprehensive health insurers, whether for-profit or non-profit, need enough income after expenses to fund state-mandated reserve requirements, to reinvest in new equipment and new markets, and to acquire and maintain needed capital. The results of this index indicate that Utah's comprehensive health insurance market has experienced an average financial gain of 0.6 percent in net income per year over the last 10 years. During 2015, these companies reported an average loss in net income of -8.8 percent. According to the NAIC, the industry average for net income after expenses for health insurers during 2015 was 0.4 percent, which indicates that Utah's comprehensive health insurers performed significantly lower than the industry average during 2015.

The first year of the full implementation of the ACA was particularly difficult for Utah's core health insurers and most experienced a net loss in underwriting and net income during 2014. Comprehensive health insurers had limited claim history to work with and underpriced the claim costs of covering their members under the new ACA regulations. Another factor was receiving lower than expected payments from the federal risk corridor program. Nationally, health insurers only received about 12.6 percent of the expected payments from the federal risk corridor program for 2014 (Centers for Medicare & Medicaid Services, 2015). Comprehensive health insurers were expecting higher payments to assist with the increased costs of covering higher risk individuals under the ACA. Arches Health Plans was particularly hit hard by both of these factors during 2014 and was taken into receivership by the Utah Insurance Department in 2015.

The second year of the full implementation of the ACA was financially more difficult than the first. Utah's core health insurers continued to experience significant losses in underwriting and net income during 2015. Comprehensive health insurers still did not have a full year's claim experience to price their products and were unable generate enough premium income to cover their losses. Also, changes to the federal risk corridor program meant comprehensive health insurers did not receive the additional payments that were expected under the program that would help them cover their costs.

The combination of not having enough information to adequately price their products and not receiving the additional payments from the federal risk corridor program as expected produced higher losses for health insurers participating in the individual market and the FFM. Three comprehensive health insurers withdrew from the FFM due to concerns that these losses were not sustainable.

Figure 3. Income After Expenses For Comprehensive Health Insurers: 2006 - 2015



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Income	5.0%	4.3%	0.1%	1.8%	2.4%	1.6%	4.8%	2.1%	-0.4%	-8.8%

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 2006 to 2015. Results are rounded to the nearest 0.1 percent.

Utah's Stop-Loss Insurance Market

Stop-loss insurance provides protection against unexpected or catastrophic claims. Stop-loss insurance makes up approximately 2 percent of the commercial health insurance market in the state of Utah (see Table 3). This section focuses on medical stop-loss insurance that provides insurance coverage for self-funded employer health benefit plans, and is sold as an accident & health insurance product in Utah's commercial health insurance market. The following analysis of the medical stop-loss market examines various aspects of the market including market trends, state of domicile, group size, and coverage attachment points.

Stop-Loss Insurance Market Trends

Under the ACA, commercial and self-funded health benefit plans no longer have annual or life-time limits, which can increase the risk exposure for commercial and self-funded health benefit plans. Since 2010, the number of members covered by stop-loss has increased, for example, stop-loss membership more than doubled from 2010 to 2015 (see Table 26). The removal of annual or life-time limits appears to be increasing the demand for stop-loss coverage.

Table 26. Total Stop-Loss Market: 2006 - 2015

Year	Company Count	Member Count	Direct Earned Premium	Loss Ratio
2006	43	158,965	$65,520,254	55.52
2007	38	240,536	$74,570,845	58.14
2008	43	203,331	$74,844,505	59.70
2009	47	178,267	$74,499,908	65.12
2010	42	167,625	$76,532,097	63.21
2011	43	223,375	$82,209,026	86.30
2012	41	385,949	$97,368,353	74.76
2013	37	393,157	$110,554,917	68.17
2014	38	483,290	$116,769,903	65.35
2015	41	468,760	$140,070,917	71.88
Average	**41**	**290,326**	**$91,294,073**	**66.82**

Data Source: Utah Accident & Health Survey

Stop-Loss Insurance 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 68 percent of the stop-loss insurance market was served by 37 foreign insurers, with 4 domestic insurers covering the remaining 32 percent of the market. Premiums were similar for domestic insurers and foreign insurers with $26 per member per month for domestics and $26 per member per month for foreign. Loss ratios were slightly lower for foreign insurers (see Table 27).

Table 27. Total Stop-Loss Market by Domicile for 2015

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [a]
Domestic	4	142,103	$44,354,537	31.67%	73.52	$26
Foreign	37	326,657	$95,716,380	68.33%	71.11	$26
Total	**41**	**468,760**	**$140,070,917**	**100.00%**	**71.88**	**$26**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

[a] Direct earned premium per member per month

Stop-Loss Insurance Market by Group Size

Stop-loss insurance plans are sold to self-funded employer plans. Some self-funded employer plans, especially small employers, purchase stop-loss insurance plans with lower attachment points to reduce their financial risk. Data was collected for three group sizes: Small Group (1 to 50 eligible employees), Large Group (51 to 100 eligible employees), and Large Group (101 or more eligible employees). Utah currently caps small group at 50 eligible employees.

Table 28. Total Stop-Loss Market by Group Size for 2015

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Small Group (1-50)	7	2,657	$2,709,503	1.93%	49.57	$125
Large Group (51-100)	12	4,644	$6,932,444	4.95%	55.47	$176
Large Group (101 +)	34	461,459	$130,428,970	93.12%	73.21	$24
Total Stop Loss	**41**	**468,760**	**$140,070,917**	**100.00%**	**71.88**	**$26**

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 type.
[b] Direct earned premium per member per month

Small Group (1 to 50) and Large Group (51 to 100) had higher premiums and lower loss ratios than Large Group (101 or more). This is probably due to differences in stop-loss coverage attachment points, with Small Group (1 to 50) and Large Group (51 to 100) reporting lower specific attachment points (see Table 28). Specific stop-loss is often more expensive than aggregate stop-loss and accounts for more of the premium.

Stop-Loss Insurance Market by Attachment Points

Stop-loss insurance includes two types of coverage, specific and aggregate. These two types of coverage work together to protect a self-funded employer group: specific stop-loss provides protection against the severity of unexpected claims, and aggregate stop-loss provides protection against the frequency of unexpected claims.

Specific stop-loss. Specific stop-loss (also known as individual stop-loss) provides protection for the employer group against extreme claims costs for a single covered individual. Specific stop-loss coverage includes a specified limit, or attachment point, when a stop-loss insurance policy will pay for an individual or a claim. The attachment point (also known as individual stop-loss deductible) is the dollar amount at which specific stop-loss protection begins to pay.

Table 29. Stop-Loss Membership by Specific Attachment Points for 2015

	Small Group (1 – 50)		Large Group (51 – 100)		Large Group (101 or more)		Total	
Attachment Point	**Member Count**	**Percent of Total**	**Member Count**	**Percent of Total**	**Member Count**	**Percent of Total**	**Member Count**	**Percent of Total**
NONE	-	-	443	0.1%	9,534	2.0%	9,977	2.1%
$10,000	1,873	0.4%	-	-	267	0.1%	2,140	0.5%
$20,000	182	< 0.1%	633	0.1%	358	0.1%	1,173	0.3%
$30,000	286	0.1%	356	0.1%	2,750	0.6%	3,392	0.7%
$40,000	104	< 0.1%	103	< 0.1%	2,597	0.6%	2,804	0.6%
$50,000	212	< 0.1%	424	0.1%	22,189	4.7%	22,825	4.9%
$60,000	-	-	428	0.1%	2,897	0.6%	3,325	0.7%
$70,000	-	-	-	-	11,349	2.4%	11,349	2.4%
$80,000	-	-	-	-	2,135	0.5%	2,135	0.5%
$90,000	-	-	-	-	709	0.2%	709	0.2%
$100,000	-	-	2,257	0.5%	89,374	19.1%	91,631	19.5%
$200,000	-	-	-	-	121,935	26.0%	121,935	26.0%
$300,000	-	-	-	-	46,061	9.8%	46,061	9.8%
$400,000	-	-	-	-	27,774	5.9%	27,774	5.9%
$500,000	-	-	-	-	54,175	11.6%	54,175	11.6%
$600,000	-	-	-	-	21,929	4.7%	21,929	4.7%
$700,000	-	-	-	-	1,184	0.3%	1,184	0.3%
$800,000	-	-	-	-	-	-	-	-
$900,000	-	-	-	-	-	-	-	-
$1,000,000	-	-	-	-	44,013	9.4%	44,013	9.4%
$2,000,000 or more	-	-	-	-	229	< 0.1%	229	< 0.1%
Total	**2,657**	**0.6%**	**4,644**	**1.0%**	**461,459**	**98.4%**	**468,760**	**100.0%**

Data Source: Utah Insurance Department

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

Nearly 98 percent of the total stop-loss membership included some kind of specific attachment point coverage. Over 87 percent reported a specific attachment point of $100,000 or more, with nearly 13 percent reporting a specific attachment point of less than $100,000.

All of the of Small Group (1 to 50) membership had a specific attachment point of $50,000 or less, whereas all of Large Group (51 to 100) membership had a specific attachment point of $100,000 or less, and about 51 percent had a specific attachment point less of $60,000 or less. Over 88 percent of Large Group (101 or more) membership had a specific attachment point of $100,000 or more. The most common specific attachment point in Large Group (101 or more) membership was $200,000 or more, which accounted for over 26 percent of the stop-loss membership (see Table 29).

Aggregate stop-loss. Aggregate stop-loss provides protection for a self-funded employer group against an unusually high level of excess claim costs that affect the entire employer group. Under a typical stop-loss policy, the aggregate attachment point (also known as aggregate deductible or aggregate attachment factor) is the threshold at which the stop-loss carrier begins to pay for eligible medical expenses during a given contract period. This threshold, commonly referred to as an aggregate margin, is usually expressed as a percentage of expected claims. For example, an attachment point of 125 percent means the stop-loss coverage starts to pay when the percentage of excess claims reaches 25 percent above the 100 percent of expected claim costs.

Table 30. Stop-Loss Membership by Aggregate Attachment Points for 2015

	Small Group (1 – 50)		Large Group (51 – 100)		Large Group (101 or more)		Total	
Attachment Point	**Member Count**	**Percent of Total**	**Member Count**	**Percent of Total**	**Member Count**	**Percent of Total**	**Member Count**	**Percent of Total**
NONE	-	-	307	0.1%	154,280	32.9%	154,587	33.0%
85% to 89%	-	-	-	-	44,389	9.5%	44,389	9.5%
90% to 94%	-	-	-	-	582	0.1%	582	0.1%
95% to 99%	-	-	-	-	545	0.1%	545	0.1%
100% to 104%	-	-	-	-	133	< 0.1%	133	< 0.1%
105% to 109%	-	-	-	-	15	< 0.1%	15	< 0.1%
110% to 114%	-	-	354	0.1%	10,572	2.3%	10,926	2.3%
115% to 119%	15	< 0.1%	-	-	19,315	4.1%	19,330	4.1%
120% to 124%	163	< 0.1%	2,304	0.5%	8,884	1.9%	11,351	2.4%
125% to 129%	2,439	0.5%	1,679	0.4%	220,957	47.1%	225,075	48.0%
130% or more	40	< 0.1%	-	-	1,787	0.4%	1,827	0.4%
Total	**2,657**	**0.6%**	**4,644**	**1.0%**	**461,459**	**98.4%**	**468,760**	**100.0%**

Data Source: Utah Insurance Department

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

A majority (about 67 percent) of the stop-loss membership included some kind of aggregate stop-loss coverage, with the rest (about 33 percent) reporting “none”. The most commonly reported aggregate attachment point was between 125% and 129% and accounted for approximate 48 percent of the stop-loss membership, with 19 percent spread out between 85% to 124%, and less than 1 percent above 129%. All of the Small Group (1 to 50) membership reported aggregate stop-loss, as did more than 93 percent of the Large Group (51 to 100) and nearly 67 percent of the Large Group (101 or more) categories (see Table 30).

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, or assisted living facility, or at home. 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 0.7 percent of the commercial health insurance market in Utah (see Table 3). Long-term care insurers provide coverage for about 39,104 members, or approximately1.3 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. Seventy-one foreign insurers account for over 95 percent of the market, with only two domestic insurers providing long-term care coverage (see Table 31). Loss ratios were higher for the foreign insurers than for the domestic insurers.

Table 31. Total Long-Term Care Market by Domicile for 2015

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	2	1,057	$1,954,595	4.62%	42.53
Foreign	71	38,047	$40,368,829	95.38%	79.30
Total	**73**	**39,104**	**$42,323,424**	**100.00%**	**77.60**

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 32).

Table 32. Total Long-Term Care Market by Group Size for 2015

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Individual	66	21,322	$34,285,514	81.01%	77.95
Group	26	17,782	$8,037,910	18.99%	76.08
Total	**73**	**39,104**	**$42,323,424**	**100.00%**	**77.60**

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 39,104 members with long-term care insurance in Utah during 2015. Nearly forty-nine percent of the members were under age 65 and over fifty-one percent were sixty-five or older (see Table 33).

Table 33. Long-Term Care Membership by Age for 2015

Age	Member Count	Percent
Age 0-59	14,247	36.4%
Age 60-64	4,753	12.2%
Age 65-69	6,071	15.5%
Age 70-74	4,897	12.5%
Age 75-79	3,871	9.9%
Age 80-84	2,808	7.2%
Age 85+	2,457	6.3%
Total Members	**39,104**	**100.0%**

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.

Another important Medicare product is Medicare Part D. Medicare Part D 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 Part D is also included in many Medicare Advantage policies.

Medicare Supplement and Medicare Advantage products account for more than 19 percent of Utah's accident & health insurance market, with approximately 2 percent of the market share in Medicare Supplement coverage and nearly17 percent of the market share in Medicare Advantage coverage. Approximately 6.2 percent of Utah residents had coverage under a Medicare Supplement or Medicare Advantage product, with about 2.3 percent in Medicare Supplement product and about 3.9 percent in a Medicare Advantage product. Medicare Part D products account for about 1.5 percent of Utah's accident & health insurance market and provide coverage for approximately 3.1 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. The majority of Utah's Medicare Supplement coverage is provided by foreign insurers. Seventy-eight foreign insurers account for over 67 percent of the market, with seven domestic insurers providing the remaining 33 percent (see Table 34). Loss ratios were higher for the foreign insurers than for the domestic insurers.

Table 34. Total Medicare Supplement Market by Domicile for 2015

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	7	19,057	$44,376,980	32.66%	69.66
Foreign	78	49,930	$91,501,386	67.34%	79.56
Total	**85**	**68,987**	**$135,878,366**	**100.00%**	**76.33**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Advantage by domicile. Utah's Medicare Advantage market has more domestic than foreign insurers, with most (93.4 percent) of the coverage provided by domestic insurers, and the remaining 6.6 percent provided by foreign insurers (see Table 35). Loss ratios were higher for domestic insurers than foreign insurers.

Table 35. Total Medicare Advantage Market by Domicile for 2015

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	6	109,513	$898,655,150	93.41%	92.08
Foreign	5	7,048	$63,392,578	6.59%	77.71
Total	**11**	**116,561**	**$962,047,728**	**100.00%**	**91.14**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Part D by domicile. Nearly 90 percent of Utah's Medicare Part D coverage is provided for by foreign insurers. Domestic companies provide the remaining 10 percent (see Table 36). Loss ratios were slightly higher for domestic insurers.

Table 36. Total Medicare Part D Market by Domicile for 2015

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	3	5,312	$8,616,898	10.10%	82.05
Foreign	15	88,704	$76,722,417	89.90%	78.22
Total	**18**	**94,016**	**$85,339,315**	**100.00%**	**78.61**

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-five commercial health insurers reported 68,897 members with Medicare Supplement coverage. 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 37).

Table 37. Medicare Supplement Membership by Age for 2015

Age	Member Count	Percent
Age 0-64	446	0.6%
Age 65 and Older	68,541	99.4%
Total Members	**68,987**	**100.0%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Advantage membership by age. Eleven commercial health insurers reported 116,561 members with Medicare Advantage coverage. Most (88 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 38).

Table 38. Medicare Advantage Membership by Age for 2015

Age	Member Count	Percent
Age 0-64	14,500	12.4%
Age 65 and Older	102,061	87.6%
Total Members	**116,561**	**100.0%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Part D membership by age. Nineteen commercial health insurers reported 94,106 members with Medicare Part D Drug Plan coverage. Most (89 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 39).

Table 39. Medicare Part D Membership by Age for 2015

Age	Member Count	Percent
Age 0-64	10,651	11.3%
Age 65 and Older	83,365	88.7%
Total Members	**94,016**	**100.0%**

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 68,987 members with Medicare Supplement in Utah during 2015. 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).

The most commonly reported Medicare Supplement plan was Plan F with 64.7 percent of the membership. The next closest plans were Medicare Supplement Plan N, with 9.0 percent; Medicare Supplement Plan G, with 7.8 percent; Medicare Supplement Plan C, with 4.1 percent; Medicare Supplement Plan J, with 3.8 percent; All other plans had less than 3.0 percent of the membership (see Table 40).

Table 40. Medicare Supplement Membership by Plan Type for 2015

Plan Type	Member Count	Percent
Plan A	753	1.1%
Plan B	727	1.1%
Plan C	2,858	4.1%
Plan D	1,096	1.6%
Plan E	404	0.6%
Plan F	44,630	64.7%
Plan F (High Deductible Plan)	1,419	2.1%
Plan G	5,371	7.8%
Plan H	444	0.6%
Plan I	366	0.5%
Plan J	2,635	3.8%
Plan J (High Deductible Plan)	3	< 0.1%
Plan K	621	0.9%
Plan L	334	0.5%
Plan M	2	< 0.1%
Plan N	6,234	9.0%
Pre-Standardized Plans	1,090	1.6%
Total Members	**68,987**	**100.0%**

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 116,561 members with Medicare Advantage (full Medicare replacement policies) in Utah during 2015. Medicare Advantage plans (which completely replace Medicare and bear the full risk of loss) are available in one of five major plan types.

During 2015, most of the membership was covered under a Health Maintenance Organization plan, with about 83 percent of the membership. The second most common was a Preferred Provider Organization plan, with nearly 16 percent of the membership. The third most common was a Private Fee-for-Service plan, with less than 1 percent of the membership. None of the companies reported membership in plans with Medical Savings Accounts or Special Needs Plans (see Table 41).

Table 41. Medicare Advantage Membership by Plan Type for 2015

Plan Type	Member Count	Percent
Private Fee-for-Service	473	0.4%
Preferred Provider Organization	18,808	16.1%
Health Maintenance Organization	97,280	83.5%
Medical Savings Account	0	0.0%
Special Needs Plan	0	0.0%
Total Members	**116,561**	**100.0%**

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 49 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves over 27 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 continuing to receive good consumer service from Utah's commercial health insurers. The numbers of consumer complaints received by the Insurance Department declined during 2006 to 2008 and increased from 2009 to 2015. The increase in complaints from 2009 to 2015 appears to be due to the combined impact of the economic recession and recent changes in government regulations. In addition to complaints, during 2009 to 2015, consumers contacted the Insurance Department in greater numbers with questions and concerns regarding 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 and the implementation of the Patient Protection and Affordable Care Act (ACA). Other consumers had 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 exchange for small employers and the federal health exchange for individuals. There was a significant increase in the number of complaints from 2014 to 2015, with the number of complaints increasing by over 39 percent. Most of this increase appears to be due to consumers concerns related to their coverage in the Federally-Facilitated Marketplace (FFM).

In addition to consumer complaints, the Utah Insurance Department receives and processes requests from consumers for an independent review of their denied claims by an Independent Review Organization (IRO). The number of independent reviews remained relatively stable during 2012 to 2014, followed by a significant increase in 2015. From 2014 to 2015, the number of requests for independent reviews increased by over 60 percent. This increase may be due to an increased awareness among consumers that an independent review is an option for them.

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 number of Utah residents with comprehensive health insurance, the cost of comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers has declined from 2006 to 2015. Most of this change has been due to a decrease in the number of small and very small foreign comprehensive health insurers. In contrast, the total number of large and medium insurers has remained fairly stable. Large domestic comprehensive health insurers continue to account for more than 80 percent of the market and provide a solid pool of commercial health insurers. The number of medium insurers has also remained relatively stable, but there has been a shift from domestic to foreign insurers during this period. For example, in 2006, medium insurers were primarily domestic, while by 2013, medium size insurers were primarily foreign. From 2013 to 2014, there was some turnover among medium size insurers and several new domestic insurers entered the market to participate in the FFM. During 2014 and 2015, as part of the first two years of the full implementation of the ACA, there was some market shifting with a decline in the number of small insurers and an increase in the number of domestic medium insurers, including several new insurers that entered the market to participate in the FFM. However, financial stress in the market is making it increasingly difficult for some insurers to participate in the comprehensive market and to sustain participation in the FFM.

From 2006 to 2015, the number of Utah residents covered by comprehensive health insurance has seen periods of decline followed by periods of increase. However, these membership fluctuations have remained relatively stable, with membership averaging about 830,000 members over the last 10 years. Comprehensive health insurance membership increased from 2006 to 2008, declined during 2009, remained relatively stable during 2010, declined during 2011 and 2012, and then increased from 2013 to 2015.

The changes from 2009 to 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.

During 2014, the number of members in the individual market grew by about 46,000 members, an increase of over 29 percent, followed by a similar, but smaller increase during 2015. Individual membership grew by over 22,000 during 2015, an increase of about 11 percent. Most of this growth appears to be driven by the federal individual mandate which requires everyone to maintain health insurance, the availability of the FFM, and changes to health insurance regulations, including guaranteed issue and community rating, which have made it easier for Utah residents to get and keep coverage in the individual market. Small group membership increased slightly from 2014 to 2015. Large group membership declined from 2014 to 2015. These changes in the employer markets appear to be due to some employer groups moving to self-funding arrangements, although one cannot rule out the possibility of some shifting to the individual market.

Comprehensive health insurance premium per member per month remained stable from 2014 to 2015. The average premium per member per month increased from $277 during 2014 to $280 during 2015, an increase of 1.1 percent. Over the last ten years, increases in premium per member per month have averaged 4.3 percent per year, while increases in losses per member per month have averaged 6.1 percent per year.

Comprehensive health insurers reported high loss ratios during 2014 and 2015, as premiums, even after payments from the various reinsurance and risk adjustment programs under the ACA, were not sufficient to cover the healthcare costs of their insured members. The shift to ACA compliant plans, changes in rating methods, and expanded coverage for higher risk individuals, combined with lower than expected payments from the federal risk corridor program, have all contributed to these higher loss ratios. Comprehensive health insurers in both 2014 and 2015 had limited claim history to work with, were unable to underwrite for insurance risk on an individual basis, and 2014 rates were set prior to the creation of "transitional plans" which prevented insurers from making rate adjustments prior to 2014. Comprehensive health insurers reported these higher loss ratios primarily in the individual market. In contrast, health care costs and loss ratios in the small and large group market were more in line with market trends.

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 0.6 percent in net income after expenses over the last ten years, with comprehensive health insurers reporting an average net loss of -8.8 percent in net income after expenses during 2015.

The first year of the full implementation of the ACA was financially difficult for Utah's core comprehensive health insurers and most experienced a net loss in underwriting and net income during 2014. Comprehensive health insurers had limited claim history to work with and underpriced the claim costs of covering their members under the new ACA regulations. Another factor was receiving lower than expected payments from the federal risk corridor program. And finally, the creation of transitional plans essentially created two risk pools: the transitional pool where healthy people could maintain coverage at lower premiums, and the ACA compliant pool that included members who were previously uninsured, or uninsurable, and had pent up demand for health care. Comprehensive health insurers had priced products under the assumption that that all their insured members would be moving into the ACA compliant pool; and were expecting higher payments to assist with the increased costs of covering higher risk individuals under the ACA. Arches Health Plans was particularly hit hard by these three factors during 2014 and was taken into receivership by the Utah Insurance Department in 2015.

The second year of the full implementation of the ACA was more difficult for Utah's health insurance market than the first. Utah's core health insurers experienced significant losses in underwriting and net income during 2015. Comprehensive health insurers still did not have a full year's claim experience to price their products and were unable to generate enough premium income to cover their losses. Also, changes to the federal risk corridor program meant comprehensive health insurers did not receive the additional payments that were expected under the program that would have helped them cover their costs, and the transitional plans still had not moved into the ACA compliant pool.

The combination of not having enough information to adequately price their products, the creation of transitional plans, and not receiving the additional payments from the federal risk corridor program as expected produced higher losses for health insurers participating in the individual market and the FFM. Three comprehensive health insurers, including two national companies, withdrew from the FFM due to concerns that these losses were not sustainable.

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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) to increase transparency in health care costs.

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 health care 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 research and 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 42. List of Comprehensive Health Insurers during 2015

Company Name	State of Domicile	Direct Earned Premium	Market Share	Loss Ratio
SelectHealth, Inc.	UT	$1,420,639,461	51.33%	99.37
Regence BlueCross BlueShield of Utah	UT	$467,315,985	16.88%	83.62
UnitedHealthcare Insurance Company	CT	$244,288,321	8.83%	75.86
Aetna Health of Utah, Inc.	UT	$219,014,950	7.91%	87.85
Arches Health Plans	UT	$136,071,129	4.92%	131.23
Humana Insurance Company	WI	$58,284,485	2.11%	117.21
Aetna Life Insurance Company	CT	$51,697,219	1.87%	67.96
Cigna Health & Life Insurance Company	CT	$39,069,585	1.41%	91.17
Humana Medical Plan of Utah, Inc.	UT	$24,986,762	0.90%	97.14
National Health Insurance Company	TX	$17,720,890	0.64%	107.57
Molina Healthcare of Utah, Inc.	UT	$16,439,201	0.59%	94.71
BridgeSpan Health Company	UT	$15,423,557	0.56%	211.92
Health Care Service Corporation, a Mutual Legal Re	IL	$15,124,992	0.55%	80.32
UnitedHealthcare of Utah, Inc.	UT	$13,732,763	0.50%	81.40
Deseret Mutual Insurance Company	UT	$9,824,217	0.35%	96.81
WMI Mutual Insurance Company	UT	$6,140,491	0.22%	88.29
Educators Health Plans Life, Accident and Health,	UT	$4,087,300	0.15%	73.35
State Farm Mutual Automobile Insurance Company	IL	$2,709,922	0.10%	91.20
Time Insurance Company	WI	$2,679,201	0.10%	88.42
United Healthcare Life Insurance Company	WI	$1,387,190	0.05%	152.82
American National Life Insurance Company of Texas	TX	$499,686	0.02%	120.96
Educators Mutual Insurance Association	UT	$428,932	0.02%	61.93
Trustmark Life Insurance Company	IL	$62,342	< 0.01%	0.89
John Alden Life Insurance Company	WI	$55,597	< 0.01%	355.74
Prudential Insurance Company of America	NJ	$31,630	< 0.01%	189.22
Connecticut General Life Insurance Company	CT	$30,915	< 0.01%	97.76
Standard Life and Accident Insurance Company	TX	$23,838	< 0.01%	159.61
Freedom Life Insurance Company of America	TX	$23,603	< 0.01%	55.02
Pyramid Life Insurance Company, The	KS	$22,959	< 0.01%	76.44
American National Insurance Company	TX	$20,598	< 0.01%	276.65
AXA Equitable Life Insurance Company	NY	$14,406	< 0.01%	439.64
Golden Rule Insurance Company	IN	$7,864	< 0.01%	-153.97
National Foundation Life Insurance Company	TX	$7,584	< 0.01%	-
Trustmark Insurance Company	IL	$5,432	< 0.01%	24.69
Reserve National Insurance Company	OK	$3,240	< 0.01%	17.47
Metropolitan Life Insurance Company	NY	$553	< 0.01%	-9.76
Transamerica Life Insurance Company	IA	$367	< 0.01%	995.10
Centre Life Insurance Company	MA	$158	< 0.01%	213.92
The Guardian Life Insurance Company of America	NY	$44	< 0.01%	-
All Comprehensive Health Insurers	**39**	**$2,767,877,369**	**100.00%**	**95.34**

Data Source: Utah Accident & Health Survey

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; 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; Health Insurance Portability and Accountability Act, 1997; Patient Protection and Affordable Care Act, 2010)
7. Small group portability and individual guaranteed issue (31A-30-108; Health Insurance Portability and Accountability Act, 1997; 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; Health Insurance Portability and Accountability Act, 1997; Patient Protection and Affordable Care Act, 2010)
11. Limitation on the use of preexisting condition exclusions for individuals 19 and under (Patient Protection and Affordable Care Act, 2010)
12. Limitation of annual and lifetime limits for essential benefits (Patient Protection and Affordable Care Act, 2010)
13. Coverage for preventative health services (Patient Protection and Affordable Care Act, 2010)
14. Coverage for children up to age 26, including married children (31A-22-610.5; Patient Protection and Affordable Care Act, 2010)
15. Coverage for individuals participating in approved clinical trials (Patient Protection and Affordable Care Act, 2010)
16. Comprehensive health insurance coverage, coverage of essential health benefits and actuarial value (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. Mini-COBRA benefits for employees of employer with less than 20 employees (31A-22-722)
4. Provisions pertaining to armed forces (31A-22-717)
5. Court order coverage for minor children outside service area (31A-8-502)
6. Rural health care (31A-8-501)

Benefit Mandates

Required by Federal statute:

1. Maternity stay minimum limits (31A-22-610.2; Newborn & Mothers Health Protection Act, 1997)
2. Pediatric vaccines – level of benefit (31A-22-610.5, Omnibus Budget Reconciliation Act, 1993)
3. Catastrophic coverage of mental health conditions (31A-22-625; Mental Health Parity and Addition Equity Act, 2008)
4. Coverage of emergency medical services (31A-22-627; Federal Patient Bill of Rights Plus Act, Patient Protection and Affordable Care Act, 2010)
5. Mastectomy provisions (31A-22-630; 31A-22-719; Women's Health & Cancer Rights Act, 1996)
6. Alcohol and drug dependency treatment (31A-22-715; Patient Protection and Affordable Care Act, 2010)

Required by State statute:

1. $4,000 minimum adoption indemnity benefit (31A-22-610.1)
2. Coordination of benefits with workers' compensation claim (31A-22-619.6)
3. Dietary products for inborn metabolic errors (31A-22-623)
4. Access to OB/GYNs, pediatricians as primary care physician (31A-22-624)
5. Diabetes coverage (31A-22-626)
6. Standing referral to a specialist (31A-22-628)
7. Coverage for prosthetic devices (31A-22-638)
8. Cancer treatment parity (31A-22-641)

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 63N-11-104;
- (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.

(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.

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 2006 to 2015. 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 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.

During 2014, the Utah Accident & Health Survey was expanded to include more detailed measures of the comprehensive health insurance market including measures of ACA compliant and Non-ACA compliant plans, Avenue H SHOP and the Federally-Facilitated Marketplace (FFM).

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.

Loss Ratios vs MLR. The loss ratios used in this report differ from the NAIC medical loss ratio (MLR) methodology that adjusts for taxes and fees. This report uses the traditional loss ratio methodology, incurred claims divided by earned premium. The MLR methodology is designed for use with comprehensive health insurance business and cannot be applied all other types of accident & health insurance. Using the traditional loss ratio allows us to compare all types of accident & 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 by 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.