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2018 Health Insurance Market Report

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Executive Summary

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

Approximately 46 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). Comprehensive health insurance membership as a percentage of Utah residents continues to decline and the comprehensive health insurance industry now only serves about 24 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.

The total number of consumer complaints received by the Insurance Department increased from 2008 to 2009, remained stable from 2009 to 2011, followed by a significant increase from 2012 to 2016, and then declined during 2017. The increase in complaints appears to be due to recent changes in government regulations. In addition to complaints, during 2009 to 2017, consumers contacted the Insurance Department in greater numbers. Many consumers called with questions and concerns regarding 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), while most of the increase during 2016 was due to an increase in complaints related to long-term care premium increases and issues related to the Federally Facilitated Marketplace (FFM). During 2017 there was a general decline in the total number of complaints and confirmed complaints, but there was a significant increase in unconfirmed complaints. While the Insurance Department is receiving an increasing volume of complaints, we are less likely to have the resources available to resolve the presented issue. This is due to an increase in consumer complaints where the Insurance Department does not have authority to resolve the complaint under the Utah Insurance Code, such as complaints related to long-term care premium increases or drug treatment and mental health facilities. Another important trend over the last three years has been an increase in the number of complaints related to the issue of balance billing, where a health care provider bills the patient for the difference between the provider's charge and the amount paid by health insurance. Balance billing complaints accounted for about 10 percent of all consumer complaints during 2015 to 2017. The recent changes in federal regulations, the increasing uncertainty surrounding health insurance coverage, and the withdrawal of Molina Healthcare of Utah from the FFM have been difficult for many consumers and they are contacting the Insurance Department for assistance.

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). The number of independent reviews remained relatively stable during 2012 to 2014, followed by a significant increase during 2015 and 2016, and then remained stable during 2017. From 2015 to 2017, the number of requests for independent reviews increased by over 43 percent. The growth in the number of independent reviews 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 2008 to 2017. Most of this change has been due to a decrease in the number of small and very small foreign comprehensive health insurers. In contrast, while there has been some shifting within the market as part of the full implementation of the ACA including health insurers leaving the market, the total number of large and medium insurers has generally remained stable or increased. Large domestic comprehensive health insurers continue to account for more than 80 percent of the market. The number of medium insurers has increased during this period. Financial stress in the market continues to make it difficult for some insurers to participate in the comprehensive market and to sustain participation in the FFM. From 2014 to 2017, the number of comprehensive health insurers participating in the FFM declined from six to three.

From 2008 to 2017, the number of Utah residents covered by comprehensive health insurance as a relative percentage of Utah's population has declined by about 8.4 percent. Comprehensive health insurance membership has averaged about 812,000 members over the last 10 years. There was a decline in the number of members in the comprehensive market during 2017. This appears to be due to changes in the individual and small group markets. Premium increases and market uncertainty appear to be the primary drivers of this change.

From 2014 to 2016, membership in the individual market grew significantly. Most of this growth was driven by the federal individual mandate which required 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. During 2017, the individual market declined by over 32,000 members. This decline occurred among individuals with Off-Exchange plans who pay the full cost of any premium increases in the individual market, and do not receive any subsidies under the ACA to make coverage more affordable. Membership in FFM plans, where most members have premium subsidies, did not experience the same change. Consumers and health insurers were experiencing significant market uncertainty during 2017, such as the question of how rising health care costs and changes to government regulations and the ACA would affect consumers, as well as the ending of CSR payments and the possibility of the repeal of the ACA.

Membership in the small group market declined during 2016 and 2017. This decline in small group membership followed premium increases in the small group market during 2016 and 2017. It is also 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.

Large group membership declined during 2014 to 2016, and was stable during 2017. This change appears 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 increased from 2016 to 2017. The average premium per member per month increased from \$300 during 2016 to \$330 during 2017, an increase of 10 percent. Over the last ten years, increases in premium per member per month have averaged 4.9 percent per year, while increases in losses per member per month have averaged 5.7 percent per year.

Comprehensive health insurers reported high loss ratios during 2014 through 2016, 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 to produce reasonable projections, 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. During 2016, comprehensive health insurers had more claim experience to work with, but there was still considerable market uncertainty which made pricing their products more difficult. Comprehensive health insurers reported these higher loss ratios primarily in the individual market. During 2017, the combination of more accurate pricing information and higher rates that more precisely represented their actual risk experience resulted in improved loss ratios in the individual market. Higher premium income helped health insurers cover the cost of health care services that health insurers were paying out for their members. 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 loss of -0.1 percent in net income after expenses over the last ten years, with comprehensive health insurers reporting an average gain of 3.4 percent in net income after expenses during 2017.

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 non-ACA compliant coverage at lower premiums, and the ACA compliant pool that included members who were previously insured on a policy that had been rated due to significant health issues, or who were uninsured or uninsurable, and had pent up demand for health care. Comprehensive health insurers had priced products under the assumption that that all insured members would be moving into the ACA compliant pool; and were expecting higher risk corridor 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 Insurance Department in 2015.

The second year, 2015, 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. 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 third year, 2016, of the full implementation of the ACA was financially challenging for comprehensive health insurers. Utah's core health insurers experienced slightly lower losses in underwriting and net income during 2016 compared to 2015. Comprehensive health insurers had more claim experience to price their products, but market uncertainty continued to make pricing difficult and many health insurers were still unable to collect enough premium income to cover their losses, and similar to 2015, comprehensive health insurers did not receive any additional payments from the federal risk corridor program.

From 2014 to 2016, 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. Several comprehensive health insurers withdrew from the FFM due to concerns that these losses were not sustainable.

The fourth year, 2017, of the full implementation of the ACA was a mixture of financial and regulatory challenges combined with an increase in financial stability. Regulatory uncertainty such as the possible repeal of the ACA, elimination of the cost-sharing reduction (CSR) payments, and reductions in advertising for the FFM created higher market uncertainty for both consumers and health insurers than would normally have existed under the ACA as written.

During October 2017, the federal government ended the CSR payment program, which required health insurers to rate 2018 rates higher than they would have been had the CSR payments continued. The combination of higher premium revenue and more accurate pricing information for health insurers led to the beginning of a financial recovery. Health insurers reported better financial results during 2017 than they did during the first three years of the full implementation of ACA, suggesting that health insurers may be returning to profitability.

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 § 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 several sources, such as 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

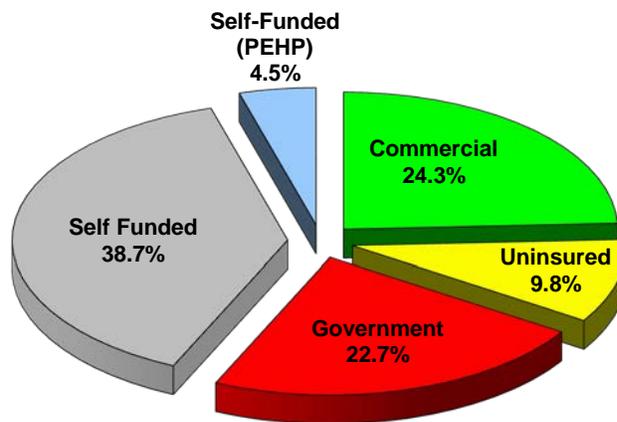
provided will vary from comprehensive major medical health insurance to specified limited health insurance benefits such as dental, vision, or specified disease.

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 2017



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 2017 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 nearly twenty-three percent of Utah residents were covered by government plans, over forty-three percent were covered by self-funded plans, about twenty-four percent were covered by commercial health insurance, and nearly ten percent were uninsured (see Table 1).

Table 1. Estimate of Health Insurance Coverage for 2017

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans	703,277	22.7%
Medicare	371,770	12.0%
Medicaid	298,251	9.6%
Children’s Health Insurance Program (CHIP)	19,651	0.6%
Primary Care Network (PCN)	13,605	0.4%
Employer Sponsored Self-Funded Plans	1,340,238	43.2%
Plans Administered by Commercial Insurers	708,093	22.8%
Public Employee Health Program (PEHP)	139,377	4.5%
Federal Employee Health Benefit Plan (FEHBP)	114,497	3.7%
Other Known Self-Funded Plans	63,236	2.0%
Other Self-Funded Plans (Estimated)	315,035	10.2%
Commercial Health Insurance Plans	754,318	24.3%
Group	548,326	17.7%
Individual	205,992	6.6%
Uninsured	304,000	9.8%
Total	3,101,833	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 2017 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 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 1,381 commercial fraternal, life, health, and property and casualty insurers licensed with the Insurance Department at the end of 2017. Of these, three hundred and forty-two commercial insurers reported commercial health insurance business in Utah on their 2017 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 6.0 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 76 percent of Utah’s commercial health insurance market is domestic. These 29 domestic insurers are much more representative of the Utah market as about 81 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 89 and net income of 3.5 percent. Utah’s commercial health insurance market is highly concentrated among ten domestic commercial health insurers, which account for about 74 percent of the commercial health insurance market. These ten commercial health insurers represent about 98 percent of the domestic market. They had a loss ratio of 89 and net income of 3.3 percent. The remaining two percent of the domestic market consists of life insurers and limited health plans.

There are 313 foreign insurers in Utah’s commercial health insurance market, most of which are life insurers. These foreign insurers account for about 24 percent of Utah’s market. Foreign insurers had a loss ratio of 76 for Utah business. Net income was 6.0 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 2017

Insurer Type	Company Count	Utah Operations			National Operations	
		Direct Earned Premium	Market Share	Loss Ratio	Total Revenue	Net Income (% Rev)
Domestic Insurers						
Health	10	\$4,887,481,484	74.30%	88.95	\$5,517,832,940	3.3%
Life	14	\$112,526,612	1.71%	81.99	\$632,832,449	4.7%
Limited Health Plan	5	\$9,590,014	0.15%	55.86	\$9,837,501	7.0%
Total Domestic	29	\$5,009,598,110	76.16%	88.73	\$6,160,502,890	3.5%
Foreign Insurers						
Fraternal	11	\$1,397,441	0.02%	50.26	\$12,848,596,160	4.9%
Life	256	\$1,486,409,234	22.60%	76.39	\$748,551,051,852	4.9%
Property & Casualty	46	\$80,383,425	1.22%	60.76	\$137,254,306,321	12.1%
Total Foreign	313	\$1,568,190,100	23.84%	75.56	\$898,653,954,333	6.0%
Utah Insurers						
Fraternal	11	\$1,397,441	0.02%	50.26	\$12,848,596,160	4.9%
Health	10	\$4,887,481,484	74.30%	88.95	\$5,517,832,940	3.3%
Life	270	\$1,598,935,846	24.31%	76.78	\$749,183,884,301	4.9%
Limited Health Plan	5	\$9,590,014	0.15%	55.86	\$9,837,501	4.9%
Property & Casualty	46	\$80,383,425	1.22%	60.76	\$137,254,306,321	7.0%
Total Utah	342	\$6,577,788,210	100.00%	85.59	\$904,814,457,223	6.0%

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 342 commercial health insurers who reported accident & health premium in Utah for 2017.

The top four policy types by market share were comprehensive health insurance (46 percent), Medicare Advantage products (19 percent), Medicaid/CHIP (10 percent) and the Federal Employee Health Benefit Plan (FEHBP) (9 percent) (see Table 3). The results of the survey differ slightly from the total accident & health reported on the 2017 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 2017

Policy Type	Company Count^a	Member Count^b	Direct Earned Premium	Market Share	Loss Ratio
Comprehensive	37	754,318	\$3,020,205,133	45.90%	89.07
Hospital-Medical-Surgical	30	5,860	\$1,919,096	0.03%	60.15
Medicare Supplement	95	79,436	\$161,642,547	2.46%	74.64
Medicare Advantage	10	131,221	\$1,262,156,130	19.18%	85.05
Medicare Drug Plan	16	103,400	\$81,127,182	1.23%	78.51
Dental Only	82	883,046	\$233,392,422	3.55%	79.35
Vision Only	39	717,642	\$35,623,043	0.54%	66.19
FEHBP	6	114,497	\$589,239,264	8.96%	92.48
Medicaid/CHIP	3	203,907	\$637,475,402	9.69%	86.32
Stop-Loss	46	625,174	\$205,785,395	3.13%	79.76
Disability Income	139	499,169	\$174,835,312	2.66%	65.77
Long-Term Care	73	35,787	\$43,263,596	0.66%	80.69
Credit A&H	25	140,480	\$8,035,540	0.12%	29.49
All Other A&H	193	-	\$124,683,061	1.90%	48.55
Total Accident & Health	342	-	\$6,579,383,123	100.00%	85.57

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 more than 7,500 consumer inquires on average each year (see Table 4). However, this trend has been increasing and consumer inquiries have increased to over 10,000 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: 2008 - 2017

Consumer Inquiries	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Telephone (in/out)	4,201	4,528	3,400	3,885	5,151	5,563	4,202	4,369	6,892	5,685
Walk-in	26	27	24	19	22	20	24	20	18	14
Other (in/out)	1,119	805	1,094	1,808	2,382	3,173	4,436	5,156	4,117	4,753
Total Inquires	5,346	5,360	4,518	5,712	7,555	8,756	8,662	9,545	11,027	10,452

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 increased from 2008 to 2009, and then remained stable from 2009 to 2011, followed by a significant increase from 2012 to 2016, and then declined during 2017. The number of confirmed complaints remained relatively stable from 2008 to 2012, and then increased significantly from 2013 to 2016, and then declined during 2017. The number of unconfirmed complaints increased from 2008 to 2010, and then remained relatively constant from 2011 to 2014, followed by a significant increase from 2015 to 2017 (see Table 5).

Table 5. Complaints Filed with OCHA by Type: 2008 - 2017

Year	Total		Confirmed		Unconfirmed	
	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
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%
2016	344	100.0%	140	40.7%	204	59.3%
2017	324	100.0%	85	26.2%	239	73.8%
Average	202	100.0%	78	38.6%	124	61.4%

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 changes in government regulations. During 2009 to 2017, consumers contacted the Insurance Department in greater numbers. Many consumers called with questions and concerns regarding 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 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), while most of the increase during 2016 was due to an increase in complaints related to long-term care premium increases and issues related to the Federally Facilitated Marketplace (FFM). During 2017 there was a general decline in the total number of complaints and confirmed complaints, but there was a significant increase in unconfirmed complaints. While the Insurance Department is receiving an increasing volume of complaints, we are less likely to have the resources available to resolve the presented issue. This is due to an increase in consumer complaints where the Insurance Department does not have authority to resolve the complaint under the Utah Insurance Code, such as complaints related to long-term care premium increases or drug treatment and mental health facilities. Another important trend over the last three years has been an increase in the number of complaints related to the issue of balance billing, where a health care provider bills the patient for the difference between the provider's charge and the amount paid by health insurance. Balance billing complaints accounted for about 10 percent of all consumer complaints during 2015 to 2017. The recent changes in federal regulations, the increasing uncertainty surrounding health insurance coverage, and the withdrawal of Molina Healthcare of Utah from the FFM have been difficult for many consumers and they are contacting the Insurance Department for assistance.

Table 6. Complaints Filed with OCHA by Reason: 2008 - 2017

Year	Total		Claim Handling		Policyholder Services		Marketing & Sales	
	Count ^a	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
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%
2016	344	100.0%	200	58.1%	130	37.8%	14	4.1%
2017	334	100.0%	239	71.6%	90	26.9%	5	1.5%
Average	204	100.0%	128	62.8%	59	28.9%	17	8.3%

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.

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, nearly 63 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).

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 2008 to 2017 (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: 2008 - 2017

Year	Direct Earned Premium	Total		Confirmed		Unconfirmed	
		Count	Ratio	Count	Ratio	Count	Ratio
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
2016	\$6,215,575,220	344	0.06	140	0.02	204	0.03
2017	\$6,577,788,210	324	0.05	85	0.01	239	0.04
Average	\$5,012,819,744	202	0.04	78	0.02	124	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 0.04 for all complaints, about 0.02 for confirmed and about 0.02 for unconfirmed complaints. Using this average as a benchmark, the complaint ratios for 2017 are higher for total and unconfirmed complaints, and lower for confirmed complaints than the ten-year average.

Table 8 reports individual complaint ratios for commercial health insurance companies during 2017. 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 2017

Company Name	Direct Earned Premium	Market Share	Total ^a		Confirmed		Unconfirmed	
			Count	Ratio	Count	Ratio	Count	Ratio
Ace American Ins Co	\$35,547,733	0.54%	2	0.06	-	-	2	0.06
Aetna Health of Utah Inc	\$249,479,618	3.79%	8	0.03	3	0.01	5	0.02
Aetna Life Ins Co	\$186,569,352	2.84%	5	0.03	2	0.01	3	0.02
Alpha Dental of UT Inc	\$1,338,779	0.02%	2	1.49	-	-	2	1.49
American Family Life Assurance Co	\$22,746,279	0.35%	1	0.04	-	-	1	0.04
American Gen Life Ins Co	\$1,557,548	0.02%	1	0.64	-	-	1	0.64
Bankers Life & Casualty Co	\$3,164,122	0.05%	2	0.63	-	-	2	0.63
Chesapeake Life Ins Co	\$2,944,474	0.04%	1	0.34	-	-	1	0.34
Cigna Health & Life Ins Co	\$124,945,650	1.90%	3	0.02	-	-	3	0.02
Companion Life Ins Co	\$15,902,583	0.24%	1	0.06	-	-	1	0.06
Continental Casualty Co	\$1,104,368	0.02%	1	0.91	-	-	1	0.91
Continental Life Ins Co Brentwood	\$1,146,179	0.02%	1	0.87	-	-	1	0.87
Delta Dental Ins Co	\$24,800,563	0.38%	3	0.12	1	0.04	2	0.08
Educators Mutual Ins Association	\$30,419,533	0.46%	1	0.03	-	-	1	0.03
Equitable Life & Casualty Ins Co	\$5,870,797	0.09%	1	0.17	-	-	1	0.17
Family Heritage Life Ins Co Of America	\$4,011,165	0.06%	2	0.50	1	0.25	1	0.25
Fidelity Security Life Ins Co	\$9,328,672	0.14%	2	0.21	2	0.21	-	-
Guardian Life Ins Co Of America	\$10,566,690	0.16%	2	0.19	1	0.09	1	0.09
Humana Ins Co	\$50,305,245	0.76%	21	0.42	9	0.18	12	0.24
Humana Medical Plan of UT Inc	\$39,856,601	0.61%	2	0.05	1	0.03	1	0.03
Humanadental Ins Co	\$4,814,561	0.07%	1	0.21	-	-	1	0.21
LifeMap Assurance Co	\$11,078,292	0.17%	1	0.09	1	0.09	-	-
Lincoln National Life Ins Co	\$15,871,426	0.24%	1	0.06	1	0.06	-	-
Metropolitan Life Ins Co	\$48,419,673	0.74%	5	0.10	-	-	5	0.10
Molina Healthcare of UT Inc	\$535,365,667	8.14%	115	0.21	33	0.06	82	0.15
Physicians Mutual Ins Co	\$1,526,667	0.02%	1	0.66	-	-	1	0.66
Principal Life Ins Co	\$13,042,760	0.20%	2	0.15	-	-	2	0.15
Prudential Ins Co Of America	\$7,731,288	0.12%	3	0.39	-	-	3	0.39
Regence BCBS of UT	\$1,036,975,926	15.76%	23	0.02	5	0.00	18	0.02
SelectHealth Inc	\$2,234,329,625	33.97%	51	0.02	8	0.00	43	0.02
Total Dental Administrators of UT	\$1,834,547	0.03%	3	1.64	-	-	3	1.64
United American Ins Co	\$2,118,645	0.03%	1	0.47	1	0.47	-	-
UnitedHealthcare Ins Co	\$414,462,246	6.30%	26	0.06	6	0.01	20	0.05
UnitedHealthcare Life Ins Co	\$1,118,753	0.02%	2	1.79	1	0.89	1	0.89
University of UT Health Plans	\$51,085,757	0.78%	4	0.08	2	0.04	2	0.04
Washington National Ins Co	\$7,571,784	0.12%	1	0.13	1	0.13	-	-
Top 36 companies with complaints ^b	\$5,208,953,568	79.19%	302	0.06	79	0.02	223	0.04
Remaining 10 companies with complaints ^c	\$3,909,343	0.06%	22	5.63	6	1.53	16	4.09
Companies without complaints ^d	\$1,364,925,299	20.75%	-	-	-	-	-	-
Total Commercial Market	\$6,577,788,210	100.00%	324	0.05	85	0.01	239	0.04

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 complaints that had 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.^d There were 296 companies without complaints.

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 insurance 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, on average, about 104 requests for an independent review each year. About 73 percent of these requests are eligible for a review. During 2017, the Insurance Department received 159 requests for an independent review. This is an increase of about 43 percent compared to the number of requests received during 2015, and more than double the number of requests received each year from 2012 to 2014. Of the 159 requests for an independent review received during 2017, about 78 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 - 2017

Year	Total		Not Eligible		Eligible	
	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%
2016	157	100.0%	55	35.0%	102	65.0%
2017	159	100.0%	35	22.0%	124	78.0%
Average	104	100.0%	28	26.9%	76	73.1%

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, nearly 60 percent of all requests for independent reviews are for medical necessity; with experimental and investigational accounting for 23 percent and contract denial accounting for the remaining 17 percent (see Table 10).

Table 10. Requests for Independent Reviews by Reason: 2012 - 2017

Year	Total		Contract Denial		Experimental / Investigational		Medical Necessity	
	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%
2016	157	100.0%	27	17.2%	42	26.8%	88	56.1%
2017	159	100.0%	13	8.2%	41	25.8%	105	66.0%
Average	104	100.0%	18	17.30%	24	23.1%	62	59.6%

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. Contract denials may include rescissions. Rescissions are rare and not broken out as a separate category.

^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 73 percent of independent reviews are eligible. During 2017, about 78 percent of requests for an independent review were eligible. Out of the requests eligible for an independent review, over 44 percent were upheld, while nearly 56 percent were overturned. The 56 percent of company decisions being overturned is a significant increase from years past. On average, about 55 percent of independent reviews are upheld and nearly 45 percent are overturned (see Table 11).

Table 11. IRO Decisions by Outcome: 2012 - 2017

Year	Total Eligible		Upheld		Overturned	
	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%
2016	102	100.0%	52	51.0%	50	49.0%
2017	124	100.0%	55	44.4%	69	55.6%
Average	76	100.0%	42	55.3%	34	44.7%

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 46 percent of the commercial health insurance market in the state of Utah (see Table 3) and affects approximately 24 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 83 percent of the comprehensive health insurance market is served by domestic insurers and is highly concentrated among twelve insurers. Twenty-five foreign insurers represent the remaining market share. Premiums in Utah were slightly higher for foreign insurers than domestic with \$339 per member per month for foreign and \$327 per member per month for domestics. Loss ratios were lower for foreign insurers (see Table 12).

Table 12. Total Comprehensive Market by Domicile for 2017

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM ^a
Domestic	12	617,161	\$2,483,453,141	82.23%	90.71	\$327
Foreign	25	137,157	\$536,751,992	17.77%	81.53	\$339
Total	37	754,318	\$3,020,205,133	100.00%	89.07	\$330

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 policy 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. 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. Group policies may also be sold to individuals with common interests, such as association 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 as required by state law. There were no federal regulations limiting how health insurers set their rates. With the enactment of the ACA, individual, small group, and large group policies are now 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 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 2017, large group policies reported higher premium per member per month (\$352) than either small group (\$319) or individual policies (\$301). Loss ratios were significantly higher for individual policies than group policies (see Table 13).

Table 13. Total Comprehensive Market by Group Size for 2017

Group Size	Company Count ^a	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM ^b
Total Individual	24	205,992	\$806,411,785	26.70%	103.97	\$301
Small Group (1-50)	10	173,004	\$672,561,418	22.27%	81.72	\$319
Large Group (51+)	22	375,322	\$1,541,231,930	51.03%	84.49	\$352
Total Group	22	548,326	\$2,213,793,348	73.30%	83.65	\$341
Total Comprehensive	37	754,318	\$3,020,205,133	100.00%	89.07	\$330

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

Prior to 2016, 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 and were setting rates based on the assumption that the federal risk corridor program would provide additional premium income to offset their higher losses. Rating for 2016 was the first year that companies had a full year's claim experience to work with, but there was still significant market uncertainty that made it difficult to price their products and premiums remained insufficient to cover their losses. Also, 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 during 2014 through 2016. During 2017, comprehensive health insurers had more accurate pricing information to work with and this, combined with higher rates that more precisely represented their actual risk experience, resulted in improved loss ratios in the individual market. Higher premium income helped health insurers cover the cost of health care services that they were paying out for their members. In October, the federal government eliminated the cost-sharing reduction payment program, which required health insurers to raise rates in 2018 higher than they would have been.

Comprehensive Market by Plan Types

In this report, comprehensive health insurance plans are classified into five major plan types: Fee for Service (FFS), Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), 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 (FFS) plan refers to a traditional indemnity plan. Under a FFS plan, members can use any health care provider they choose (as long as the services are a covered benefit on the insurance contract). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges).

A Preferred Provider Organization (PPO) plan 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.

An Exclusive Provider Organization (EPO) plan refers to a health plan that is similar to a PPO in that it offers a network of “preferred” providers that have contracted to provide health care services for a reduced fee. However, unlike a PPO, members may not use providers outside of the network providers and must only use network providers exclusively. EPO plans are similar to HMO plans in that services are usually limited to an exclusive set of network providers, except in the case of an emergency.

A Health Maintenance Organization (HMO) plan refers to a health insurance plan that 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 (HMO with POS) plan 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, PPO, and EPO plans are considered managed care plans. FFS plans typically do not involve any form of managed care. About 96 percent of Utah’s comprehensive health insurance market involves some type of managed care; with about 64 percent of the comprehensive health market in an HMO or HMO with POS. Nearly 4 percent of the market had a FFS plan (see Table 14).

Table 14. Total Comprehensive Market by Plan Type for 2017

Plan Type	Company Count^a	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM^b
Fee for Service	20	20,051	\$115,995,492	3.84%	89.04	\$496
Preferred Provider Organization	22	237,760	\$939,575,746	31.11%	78.48	\$347
Exclusive Provider Organization	2	5,138	\$29,833,684	0.99%	128.72	\$460
Health Maintenance Organization	5	268,340	\$1,037,600,204	34.36%	96.49	\$305
HMO with Point of Service features ^c	2	223,029	\$897,200,007	29.71%	90.28	\$326
Total	37	754,318	\$3,020,205,133	100.00%	89.07	\$330

Data Source: Utah Accident & Health Survey

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

^b Direct earned premium per member per month

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

Premium per member per month was higher for FFS plans compared to the other plan types, while HMO plans were the lowest among traditional insurance products. Caution should be used in drawing conclusions from this data, however. This comparison does not control for differences in plan structure, covered benefits, health status, or demographics. For example, one reason some plans have lower premiums than other plans may be 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, the federal government has created specialized plans that must conform to certain 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 compliant 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 79 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 (78 percent) of the comprehensive market were enrolled in Off-Exchange plans. The higher percentage of Off-Exchange plans is due to large employer groups not having an exchange option and small employer groups having a limited enrollment (6 percent) in Avenue H SHOP. Most (74 percent) of the individual market were enrolled in the FFM. Off-Exchange membership was enrolled in both ACA compliant plans (74 percent) and Non-ACA compliant plans (26 percent).

Avenue H Small Business Health Options Program Exchange. The Avenue H Small Employer Health Options Program or Avenue H SHOP was Utah’s exchange for small employer groups where employers can offer their employees a defined contribution plan. Avenue H SHOP stopped accepting new enrollment on December 1, 2017. 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 and then pays a predetermined portion of the plan’s costs. 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 purchased health insurance plans through a defined contribution arrangement (see Utah Code § 63N-111-

104), where participating employers provided a defined contribution towards the purchase of a health insurance plan offered through Avenue H SHOP. Employees were able to either use the defined contribution alone or may add their own money to purchase a plan that is appropriate for them. There were 10,720 members (about 1.4 percent of the market) and 2 comprehensive health insurers participating in the Avenue H SHOP exchange (see Table 15). Avenue H SHOP offered ACA compliant plans until December 1, 2017. 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 community rating and may be eligible for federal subsidies and income support for purchasing insurance. In 2017, there were 151,622 members (over 20 percent of the market) and 3 comprehensive health insurers participating in the FFM during 2017 (see Table 15). All of the policies sold through the FFM are ACA compliant plans.

Table 15. Total Comprehensive Market by ACA Market Segment for 2017

Market Segment by Group Size	Company Count^a	Member Count	Percent of Members
Individual	24	205,992	27.3%
<i>Non-ACA Compliant</i>			
Off-Exchange	22	24,691	3.3%
<i>ACA Compliant</i>			
Off-Exchange	9	29,679	3.9%
Federally Facilitated Marketplace	3	151,622	20.1%
Small Group	10	173,004	22.9%
<i>Non-ACA Compliant</i>			
Off-Exchange	8	41,552	5.5%
Avenue H SHOP	1	1,794	0.2%
<i>ACA Compliant</i>			
Off-Exchange	10	120,732	16.0%
Avenue H SHOP	2	8,926	1.2%
Large Group	22	375,322	49.8%
<i>Non-ACA Compliant</i>			
Off-Exchange	14	88,846	11.8%
<i>ACA Compliant</i>			
Off-Exchange	14	286,476	38.0%
Total	37	754,318	100.0%
<i>Non-ACA Compliant</i>			
Off-Exchange	27	155,089	20.6%
Avenue H SHOP	1	1,794	0.2%
<i>ACA Compliant</i>			
Off-Exchange	20	436,887	57.9%
Avenue H SHOP	2	8,926	1.2%
Federally Facilitated Marketplace	3	151,622	20.1%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2017.

^a 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 (71.7 percent), followed by Bronze plans (22.7 percent), Gold plans (4 percent), and Catastrophic plans (less than 1 percent). Under the ACA, Catastrophic plans are only available in the individual market to individuals under the age of 30 or those with a hardship exemption. A small segment of Avenue H SHOP members (1 percent) were enrolled in non-ACA compliant plans. Non-ACA complaint plans are not categorized into metal tiers (see Table 16).

Table 16. Metal Tier Plans on Avenue H SHOP and Federally Facilitated Marketplace for 2017

Market Segment by Exchange	Member Count	Percent of Members
Avenue H SHOP	10,720	6.6%
Platinum (90% AV)	0	0.0%
Gold (80% AV)	5,070	3.1%
Silver (70% AV)	2,042	1.3%
Bronze (60% AV)	1,814	1.1%
Non-ACA (no metal)	1,794	1.1%
Federally Facilitated Marketplace	151,622	93.4%
Platinum (90% AV)	0	0.0%
Gold (80% AV)	1,766	1.1%
Silver (70% AV)	114,339	70.4%
Bronze (60% AV)	35,083	21.6%
Catastrophic	434	0.3%
Total (Avenue H SHOP and FFM)	162,342	100.0%
Platinum (90% AV)	0	0.0%
Gold (80% AV)	6,836	4.2%
Silver (70% AV)	116,381	71.7%
Bronze (60% AV)	36,897	22.7%
Catastrophic	434	0.3%
Non-ACA (no metal)	1,794	1.1%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2017. There were 2 commercial health insurers participating in the Avenue H SHOP exchange during 2017. There were 3 commercial health insurers participating in the Federally Facilitated Marketplace during 2017.

HSA-Qualified High Deductible Health Plans. HSA-Qualified High Deductible Health Plans are high deductible health plans that can 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 230,092 members (over 30 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 524,226 members (nearly 70 percent of the market) enrolled in Standard Plans (see Table 17).

Table 17. HSA-Qualified High Deductible Health Plans for 2017

Market Segment by Group Size	Member Count	Percent of Members
Individual	205,992	27.3%
HSA-Qualified High Deductible Health Plan	37,745	5.0%
Standard Plan	168,247	22.3%
Small Group	173,004	22.9%
HSA-Qualified High Deductible Health Plan	57,151	7.6%
Standard Plan	115,853	15.4%
Large Group	375,322	49.8%
HSA-Qualified High Deductible Health Plan	135,196	17.9%
Standard Plan	240,126	31.8%
Total	754,318	100.0%
HSA-Qualified High Deductible Health Plan	230,092	30.5%
Standard Plan	524,226	69.5%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2017.

Membership in HSA-Qualified High Deductible Health Plans has grown rapidly in Utah. In 2008, about 5.2 percent of the comprehensive health insurance market was enrolled in an HSA-Qualified High Deductible Health Plan. Since 2008, the percentage of the comprehensive membership covered by an HSA-Qualified High Deductible Health Plan has increased by 2.5 percent per year on average. As of 2017, HSA-Qualified High Deductible Health Plan membership accounts for about 30 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 2008 to 2017. In 2008, there were 65 commercial health insurance companies that reported comprehensive health insurance. By 2013, this number had dropped to 51, and as of 2017, there were 37 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 last four years of the full implementation of the ACA, there was some market shifting including several new insurers that entered the market to participate in the Federally Facilitated Marketplace (FFM). However, financial stress and regulatory uncertainty in the market continues to make it difficult for some insurers to sustain participation in the comprehensive market and the FFM. From 2014 to 2017, the number of health insurers participating in the FFM declined from six to three.

Table 18. Changes in the Number of Comprehensive Health Insurers: 2008 - 2017

Insurer Category	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Net Change
Domestic Insurers											
Greater than 100 Million	3	3	3	3	3	3	3	4	4	3	0
Between 10 and 100 Million	1	2	2	0	0	0	2	4	4	5	+4
Between 1 and 10 Million	5	5	4	4	4	4	5	3	5	3	-2
Less than 1 Million	1	2	2	4	2	1	1	1	0	1	0
Total Domestic	10	12	11	11	9	8	11	12	13	12	+2
Foreign Insurers											
Greater than 100 Million	1	1	1	1	1	1	1	1	1	1	0
Between 10 and 100 Million	4	4	4	4	6	6	5	5	5	5	+1
Between 1 and 10 Million	12	10	10	11	9	7	5	3	2	2	-10
Less than 1 Million	38	38	36	32	32	29	27	18	17	17	-21
Total Foreign	55	53	51	48	48	43	38	27	25	25	-30
All Insurers											
Greater than 100 Million	4	4	4	4	4	4	4	5	5	4	+0
Between 10 and 100 Million	5	6	6	4	6	6	7	9	9	10	+5
Between 1 and 10 Million	17	15	14	15	13	11	10	6	7	5	-12
Less than 1 Million	39	40	38	36	34	30	28	19	17	18	-21
Total Utah	65	65	62	59	57	51	49	39	38	37	-28

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.

Molina Healthcare of Utah entered the market to participate in the FFM during 2016, and was a key participant in the FFM during 2017, but financial challenges led to Molina leaving the FFM by the end of 2017. Large comprehensive health insurers represent the core of the comprehensive health insurance market. These large insurers account for more than 80 percent of the market share. These insurers 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) remained relatively stable from 2008 to 2013, although there was a temporary decline in the number of domestic medium insurers and an increase in the number of foreign medium insurers. From 2013 to 2017, there was some turnover and several new medium sized insurers entered the market, 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 2008, the number of residents insured by comprehensive health insurance as a relative percentage of Utah's total population has declined by about 8.4 percent. During this same time period, Utah's population has increased by about 15 percent. In absolute numbers, comprehensive membership has averaged about 812,000 members over the last ten years (about 28 percent of Utah's population in any given year). Year to year changes have been less than 52,000 members (see Table 19). There was a decline in the number of members in the comprehensive market during 2017. This appears to be due to changes in the individual and small group markets. Premium increases and market uncertainty appear to be the primary drivers of this change.

Starting in 2014, the number of members in the individual market began to grow significantly. Membership increased by more than 80,000 during 2014 through 2016. Most of this growth was driven by the federal individual mandate which required 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. During 2017, this pattern changed. The individual market declined by over 32,000 members. This appears to be due to several factors. This decline occurred among individuals with Off-Exchange plans who pay the full cost of any premium increases in the individual market, and do not receive any subsidies under the ACA to make coverage more affordable. Membership in FFM plans, where most members have premium subsidies, did not experience the same change. Other factors may include significant market uncertainty during 2017 regarding rising health care costs and how changes to government regulations and the ACA would affect consumers, such as the ending of CSR payments and the possibility of repeal of the ACA. This decline is also consistent with the increase in the uninsured rate during 2017.

Membership in the small group market declined during 2016 and 2017. This decline in small group membership followed premium increases in the small group market during 2016 and 2017. It is also possible that some small group membership may have shifted to the individual market, and healthy small groups may have moved to self-funded health benefit plan arrangements to circumvent several of the ACA provisions. The number of members covered by Stop-Loss policies that were issued to small group self-funded plans increased from less than 2,000 during 2014 to over 9,600 during 2017.

Large group membership declined during 2012, due to several blocks of business shifting to self-funded health benefit plans. During 2013, the large group market made a slight recovery and increased membership, followed by a period of decline from 2014 to 2016. Large group membership was stable during 2017. These changes are probably 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 are most likely increasing self-funded arrangements as well.

Table 19. Changes in Comprehensive Membership by Group Size: 2008 - 2017

Group Size	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Net Change^a
Individual	148,649	142,878	139,185	157,707	156,426	158,047	204,601	226,927	238,637	205,992	+57,343
Percent of population ^b	5.5%	5.2%	5.0%	5.6%	5.5%	5.4%	7.0%	7.6%	7.8%	6.6%	+1.1%
Small Group	234,726	208,551	198,784	192,995	212,591	195,398	187,580	192,306	177,948	173,004	-61,722
Percent of population	8.7%	7.6%	7.2%	6.9%	7.5%	6.7%	6.4%	6.4%	5.8%	5.6%	-3.1%
Large Group	496,798	477,158	492,561	470,910	420,789	439,873	418,070	406,876	375,818	375,322	-121,476
Percent of population	18.5%	17.5%	17.8%	16.7%	14.8%	15.2%	14.2%	13.6%	12.3%	12.1%	-6.4%
Total Group	731,524	685,709	691,345	663,905	633,380	635,271	605,650	599,182	553,766	548,326	-183,198
Percent of population	27.2%	25.1%	24.9%	23.6%	22.2%	21.9%	20.6%	20.0%	18.1%	17.7%	-9.5%
Total Comprehensive	880,173	828,587	830,530	821,612	789,806	793,318	810,251	826,109	792,403	754,318	-125,855
Percent of population	32.7%	30.3%	29.9%	29.2%	27.7%	27.3%	27.5%	27.6%	26.0%	24.3%	-8.4%
Utah Population	2,691,122	2,731,558	2,774,663	2,813,923	2,852,589	2,900,872	2,942,902	2,995,919	3,051,217	3,101,833	+410,711
Percent of population	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 2008 to 2017 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 15 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: 2008 - 2017

Plan Type^a	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Net Change^b
FFS	96,422	106,485	28,097	17,722	17,021	14,135	19,971	15,018	21,621	20,051	-76,371
Percent of population ^c	3.6%	3.9%	1.0%	0.6%	0.6%	0.5%	0.7%	0.5%	0.7%	0.6%	-3.0%
PPO	204,460	206,072	269,521	268,784	273,791	288,683	251,606	248,071	234,642	237,760	+33,300
Percent of population	7.6%	7.5%	9.7%	9.6%	9.6%	10.0%	8.5%	8.3%	7.7%	7.7%	+0.1%
EPO	-	-	-	-	-	-	-	-	4,052	5,138	+5,138
Percent of population ^c	-	-	-	-	-	-	-	-	0.1%	0.2%	+0.2%
HMO	195,897	135,064	170,008	223,334	176,088	181,002	243,636	267,842	294,663	268,340	+72,443
Percent of population	7.3%	4.9%	6.1%	7.9%	6.2%	6.2%	8.3%	8.9%	9.7%	8.7%	+1.4%
HMO with POS	378,206	380,685	362,904	311,772	322,906	309,498	295,038	295,178	237,425	223,029	-155,177
Percent of population	14.1%	13.9%	13.1%	11.1%	11.3%	10.7%	10.0%	9.9%	7.8%	7.2%	-6.9%
Other	5,188 ^d	281	0	0	0	0	0	0	0	0	-5,188
Percent of population	0.2%	< 0.1%	0.0%	-0.2%							
Total Comprehensive	880,173	828,587	830,530	821,612	789,806	793,318	810,251	826,109	792,403	754,318	-125,855
Percent of population	32.7%	30.3%	29.9%	29.2%	27.7%	27.3%	27.5%	27.6%	26.0%	24.3%	-8.4%
Utah Population	2,691,122	2,731,558	2,774,663	2,813,923	2,852,589	2,900,872	2,942,902	2,995,919	3,051,217	3,101,833	+410,711
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, EPO = Exclusive 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 2008 to 2017 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 15 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.

In 2008, most of the comprehensive market was in HMO with POS plans, which accounted for over 43 percent of the market, with HMO plans and PPO plans sharing second place with each type reporting over 20 percent of the market, and the remainder in FFS plans. This pattern continued during 2009.

From 2009 to 2013, there was a significant shift away from FFS plans to PPO plans. 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 suggests 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.

During 2016, the number of members in FFS and HMO plans increased, while PPO and HMO with POS plans decreased. The increase in HMO plans appears to be due to a shift from HMO to POS plans to HMO plans within the market. HMO plans increased from 8.9 percent during 2015 to 9.7 percent during 2016. A number of new EPO plans also entered the market during 2016, but their market share was very small.

During 2017, the total number of members in the comprehensive market decreased by nearly 5 percent. Most of this change was due to reductions in the number of members in HMO and HMO with POS plans. The decline in the number of members in HMO plans accounted for the majority of the change, while the decline in the number of members in HMO with POS plans accounted for most the remaining change. The number of members in PPO and EPO plans increased, while HMO, HMO with POS, and FFS plans decreased. HMO plan membership declined by 8.9 percent. HMO with POS plan membership declined by 6.1 percent. EPO plan membership increased, but EPO plan market share continues to be very small.

Data on government sponsored health benefit plans in Utah 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: 2008 - 2017

Plan Type	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Net Change^a
Medicare	264,086	271,773	280,838	290,319	304,202	317,413	329,943	340,968	355,492	371,770	+107,684
Medicaid	164,119	195,257	221,954	244,724	257,691	268,393	287,736	295,123	297,552	298,251	+134,132
CHIP	35,060	40,742	42,068	37,700	36,893	35,343	15,760	16,588	18,577	19,651	-15,409
PCN	18,505	24,103	14,946	16,780	16,734	16,134	14,021	13,203	17,304	13,605	-4,900
HIPUtah	3,621	3,839	4,158	3,688	3,381	2,900	-	-	-	-	-3,621
Federal HIPUtah	-	-	-	649	1,168	-	-	-	-	-	+0
Government Plans	485,391	535,714	563,964	593,860	620,069	640,183	647,460	665,882	688,925	703,277	+217,886
As percent of population^b	18.0%	19.6%	20.3%	21.1%	21.7%	22.1%	22.0%	22.2%	22.6%	22.7%	+4.7%

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 program ended in 2014.

^a “Net Change” measures the difference in the absolute number of members from 2008 to 2017 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 15 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 Department of Health estimates Utah’s uninsured rate to be 9.8 percent for 2017 (Office of Public Health Assessment, 2018). Previously, Utah’s uninsured rate was estimated to be 8.7 percent for 2016, 8.8 percent for 2015, 10.3 percent for 2014, 11.6 percent for 2013, and 13.2 percent for 2012 (Office of Public Health Assessment, 2017, Office of Public Health Assessment, 2016, Office of Public Health Assessment, 2015, Office of Public Health Assessment, 2014, Office of Public Health Assessment, 2013).

Data from the Census Bureau’s American Community Survey estimates Utah’s uninsured rate to be 9.2 percent for 2017 (Berchick, Hood, and Barnett, 2018), 8.8 percent for 2016, 10.5 percent for 2015, 12.5 percent for 2014, and 14 percent in 2013 (Barnett & Berchick, 2017; Barnett & Vornovitsky, 2016). Both the BRFSS and the Census Bureau’s estimates suggest that Utah’s uninsured rate declined significantly from 2013 to 2016 and then increased from 2016 to 2017.

Trends in the cost of insurance. Utah’s comprehensive health insurance premiums continue to increase. For example, from 2008 to 2017, the average premium per member per month for comprehensive health insurance has increased on average about 4.9 percent per year. In 2017, the average premium per member per month for comprehensive health insurance was 10 percent higher than in 2016. This increase was significantly higher than in the past. Utah’s overall 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: 2008 - 2017

Year	Comprehensive Premium in Utah				National Economic Trends
	Total Premium ^a	Premium PMPM ^b	Premium PMPY ^c	Annual Percent Change	Health Insurance Premium Annual Percent Change ^d
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%
2016	\$2,929,832,909	\$300	\$3,600	7.1%	3.4%
2017	\$3,020,205,133	\$330	\$3,960	10.0%	3.4%

Data Sources: Utah premium data are from the Utah Accident & Health Survey from 2008 to 2017. The national trend data used as a comparison comes from the 2017 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 significant cost pressures that are similar to 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 2008 to 2017, the average losses per member per month for comprehensive health insurance have increased about 5.7 percent per year. In 2017, the average losses per member per month for comprehensive health insurance were 5.4 percent higher than in 2016 (see Table 23).

Nationally, health care costs are being driven by multiple factors, including changes in medical technology, pharmaceutical costs, government regulations, payment models, demographics, lifestyle choices, and general inflation (PriceWaterhouseCoopers, 2018). Utilization of health care services and unit prices of health care continue to be important factors (PriceWaterhouseCoopers, 2017). Other studies have also found evidence of excess spending in the areas of defensive medicine, inefficient claims processing and unnecessary medical spending (PriceWaterhouseCoopers, 2008; Institute of Medicine, 2012). Coverage expansions under the ACA and increases in retail prescription drug costs have also affected the cost of health care (Hartman, Martin, Espinosa, Catlin, and the National Health Expenditure Accounts Team, 2018). Prescription drug spending is growing faster than other types of health care spending (American

Academy of Actuaries, 2018). Increases in the price of health care, particularly the price of prescription drugs has become a key area of focus as a way to manage rising healthcare costs (PriceWaterhouseCoopers, 2017; PriceWaterhouseCoopers, 2018).

Table 23. Comprehensive Losses Compared to National Health Care Spending: 2008 - 2017

Year	Comprehensive Losses in Utah				National Health Care Expenditures (in Millions of Dollars)			
	Loss Ratio ^a	Losses PMPM ^b	Losses PMPY ^c	Annual Percent Change	Total NHE (All Sources)	Annual Percent Change	NHE for Private Health Insurance Only	Annual Percent Change
2008	83.81	\$179	\$2,148	7.8%	\$2,399,261	4.5%	\$802,857	3.4%
2009	85.17	\$189	\$2,268	5.6%	\$2,495,554	4.0%	\$832,901	3.7%
2010	84.32	\$193	\$2,316	2.1%	\$2,598,598	4.1%	\$864,321	3.8%
2011	85.94	\$206	\$2,472	6.7%	\$2,690,650	3.5%	\$898,514	4.0%
2012	83.61	\$206	\$2,475	0.1%	\$2,798,025	4.0%	\$929,619	3.5%
2013	83.54	\$216	\$2,592	4.7%	\$2,881,823	3.0%	\$947,148	1.9%
2014	87.96	\$244	\$2,928	13.0%	\$3,030,942	5.2%	\$1,000,745	5.7%
2015	95.34	\$267	\$3,204	9.4%	\$3,205,913	5.8%	\$1,069,772	6.9%
2016	92.92	\$279	\$3,348	4.5%	\$3,361,068	4.8%	\$1,136,394	6.2%
2017	89.07	\$294	\$3,528	5.4%	\$3,492,077	3.9%	\$1,183,910	4.2%

Data Sources: Utah loss data are from the Utah Accident & Health Survey from 2008 to 2017. The National Health Care Expenditure data are from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (2018). NHE historical data were used for 2008 to 2017.

^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 continuing a pattern of more modest growth (Claxton, Rae, Panchal, Whitmore, Damico, Kenward, and Long, 2015; Kaiser/HRET, 2016). Growth in health spending was slower during 2016. This change was broad based, as spending by payer and by service decelerated. Slower enrollment trends under the ACA also contributed to this slowdown (Hartman, Martin, Espinosa, Catlin, and the National Health Expenditure Accounts Team, 2018). Health care spending slowed during 2017. This slower growth was primarily due to reductions in the use and intensity of healthcare services for hospital care, physician services, and retail drugs (Martin, Hartman, Washington, Catlin, and the National Health Expenditure Accounts Team, 2018).

Estimates based on national health expenditure data suggests that health care spending is expected to grow about 5.6 percent per year during 2016 to 2025. This future growth reflects the effect of changes in insurance coverage, economic growth, and an aging population (Keehan, Stone, Poisal, Cuckler, Sisko, Smith, Madison, Wolfe, and Lizonitz, 2017).

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 2008 levels and costs had continued to increase, by 2017, the industry’s loss ratio would be approximately 137. In other words, the industry would be paying out nearly \$1.37 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 \$2,568 in 2008 to \$3,960 in 2017 (without taking into account any advance premium tax credits an individual may have received). This is an increase of about 54 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, 2018). 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 (Kaiser/HRET, 2018). 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: 2008 - 2017

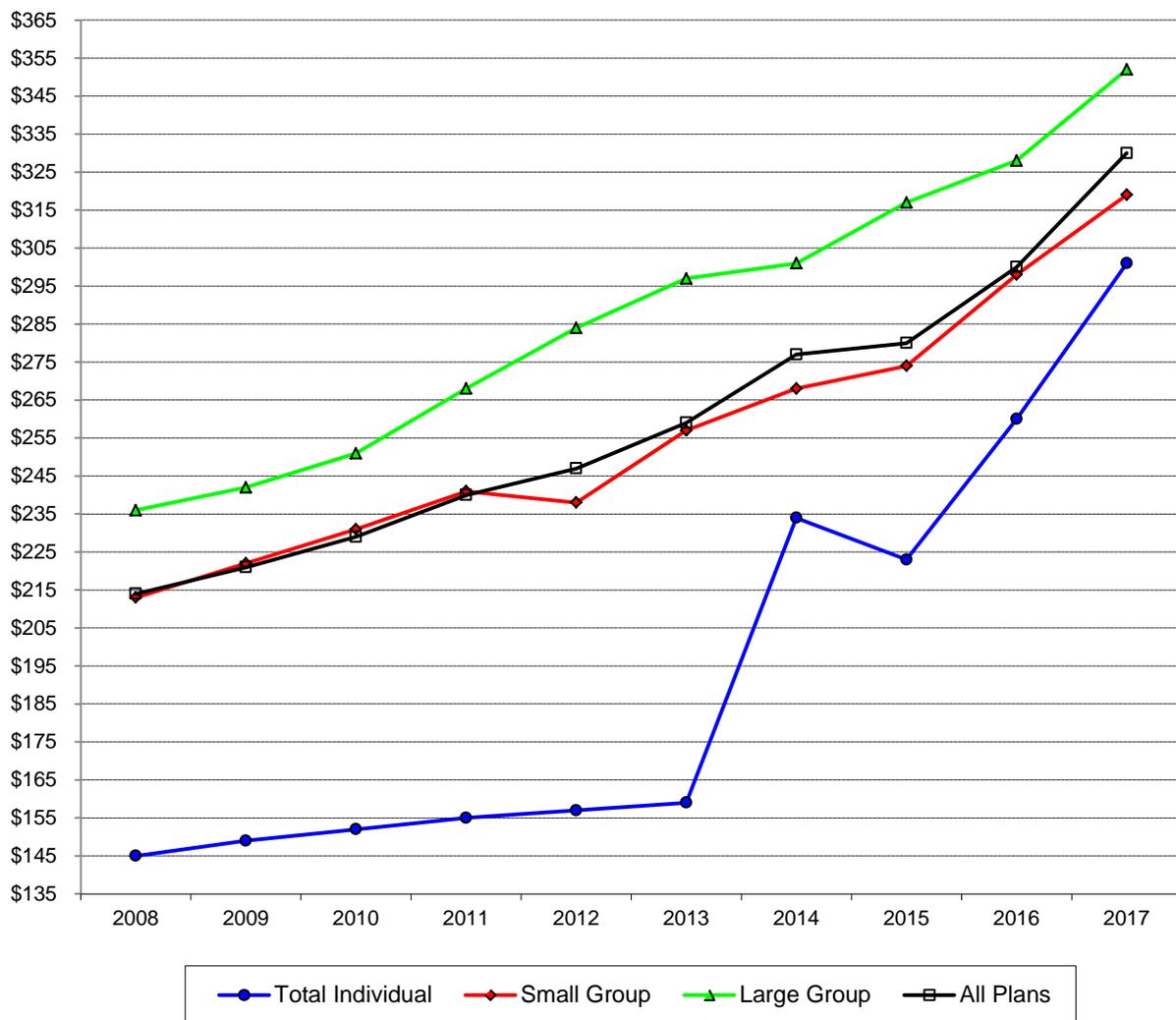
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Premium PMPY ^a	\$2,568	\$2,652	\$2,748	\$2,880	\$2,964	\$3,108	\$3,324	\$3,360	\$3,600	\$3,960
Percent change in Premium	4.9%	3.3%	3.6%	4.8%	2.9%	4.9%	6.9%	1.1%	7.1%	10.0%
Per Capita Income in Utah	\$33,932	\$31,619	\$31,683	\$33,705	\$35,545	\$36,058	\$37,685	\$39,699	\$40,925	\$42,691 ^e
Percent change in Income	2.9%	-6.8%	0.2%	6.4%	5.5%	1.4%	4.5%	5.3%	3.1%	4.3%

Data Sources: Utah premium data are from the Utah Accident & Health Survey. Per capita income data are from the 2018 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

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 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 community rating to set rates, which included covering individuals with higher costs which has increased rates significantly. As part of this change, individual premium per member per month increased by nearly 16 percent during 2017. 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 (see Figure 2). As individual premiums have increased, the average individual premium per member per month is approaching the market average.

Figure 2. Comprehensive Premium PMPM by Group Size: 2008 - 2017



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 community rating required by ACA compliant plans and expanded coverage for higher risk individuals from 2013 to 2017. 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 compliant 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. During 2016, comprehensive health insurers had more claim experience to work with, but there was still considerable market uncertainty which made pricing their products difficult.

During 2017, comprehensive health insurers continued to experience significant market uncertainty, but using the more accurate pricing information now available, health insurers were able to demonstrate that higher premium rates were required to cover the actual risk that health insurers were experiencing. As a result of these recent rate increases, many comprehensive health insurers in the individual market experienced significantly lower loss ratios during 2017, and the general financial stability of health insurers in Utah has improved. During October 2017, the federal government ended the 2018 CSR payment program, which required health insurers to raise rates higher than they would have been had the CSR payments continued

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 is having a much 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 2017, the average premium for Utah's comprehensive health insurers was approximately \$330 per member per month. In contrast, the average premium for commercial health insurers reporting comprehensive health insurance to the NAIC financial database was approximately \$423 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. Utah also has fewer health insurance mandates than many other states.

Table 25. Comparison of Utah Premium to National Premium: 2008 - 2017

Year	Utah Estimate		National Estimate	
	Premium PMPM for Comprehensive Health Insurance ^a	Annual Percent Change	Premium PMPM for Comprehensive Health Insurance	Annual Percent Change
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%
2016	\$300	7.1%	\$389	6.9%
2017	\$330	10.0%	\$423	8.7%

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

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

^a Premium per member per month is the average premium per person per month for comprehensive health insurance. This is the estimated cost of health insurance for all types of hospital and medical coverage on a per person basis. A division into single and family rates is not possible using data from the Utah Accident & Health Survey or the NAIC Financial Database. 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 (4.9 percent for Utah, 4.9 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 loss of -0.1 percent in net income per year over the last 10 years. During 2017, these companies reported an average gain in net income of 3.4 percent. According to the NAIC, the industry average for net income after expenses for health insurers during 2017 was 2.1 percent, which indicates that Utah's comprehensive health insurers performed slightly better than the industry average during 2017.

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, 2015, 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. 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.

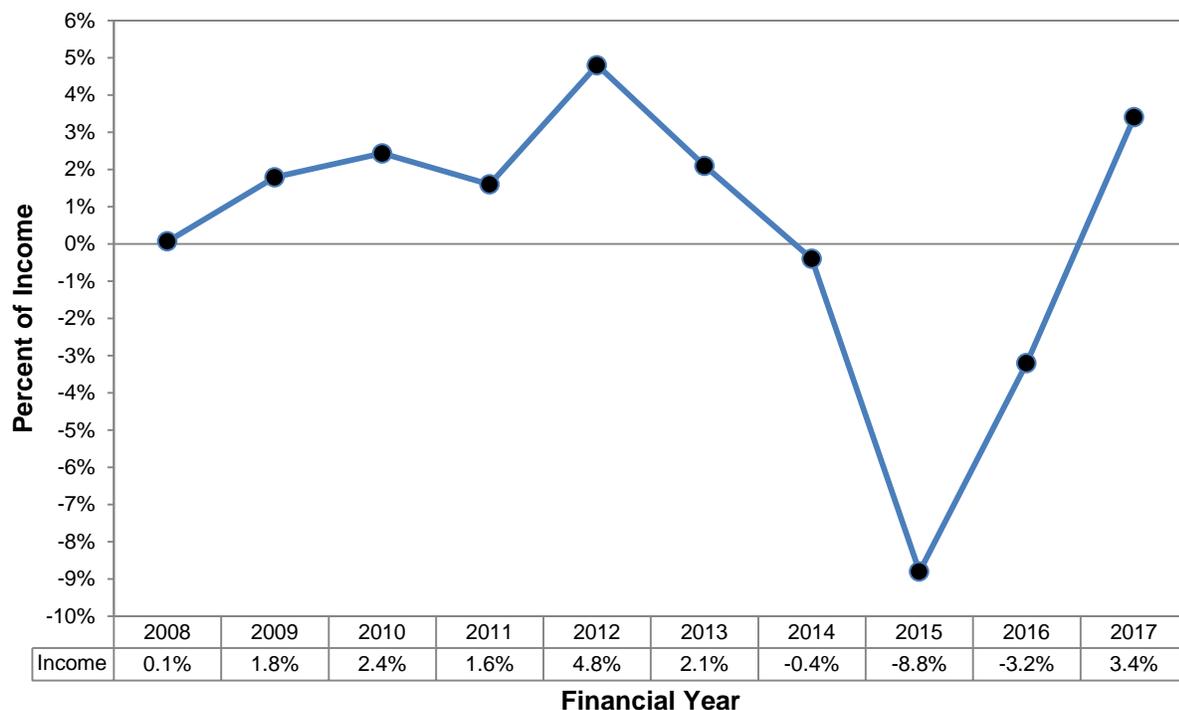
The third year, 2016, of the full implementation of the ACA was financially challenging for comprehensive health insurers. Utah's core health insurers experienced slightly lower losses in underwriting and net income during 2016 compared to 2015. Comprehensive health insurers had more claim experience to price their products, but market uncertainty continued to make pricing difficult and many health insurers were still unable to collect enough premium income to cover their losses, and similar to 2015, comprehensive health insurers did not receive any additional payments from the federal risk corridor program.

From 2014 through 2016, 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. Several comprehensive health insurers withdrew from the FFM due to concerns that these losses were not sustainable.

The fourth year, 2017, of the full implementation of the ACA was a mixture of financial and regulatory challenges combined with an increase in financial stability. Regulatory uncertainty such as the possible repeal of the ACA, elimination of the cost-sharing reduction (CSR) payments, and reductions in advertising for the FFM created higher market uncertainty for both consumers and health insurers than would normally have existed under the ACA as written.

During October 2017, the federal government ended the 2018 CSR payment program, which required health insurers to raise rates higher than they would have been had the CSR payments continued. The combination of higher premium revenue and more accurate pricing information for health insurers led to the beginning of a financial recovery. Health insurers reported better financial results during 2017 than they did during the first three years of the full implementation of the ACA, suggesting that health insurers may be returning to profitability.

Figure 3. Income After Expenses For Comprehensive Health Insurers: 2008 - 2017



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 2008 to 2017. 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 3 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 may not have annual or life-time limits on essential health care benefits, 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 significantly, for example, stop-loss membership nearly tripled from 2010 to 2016 (see Table 26). Since the full implementation of the ACA, there appears to be an increased demand for stop-loss coverage. Stop-loss membership increased by over 156,000 from 2015 to 2017, which suggests increased demand by self-funded employers who are looking for a way to manage risk and health care costs.

Table 26. Total Stop-Loss Market: 2008 – 2017

Year	Company Count	Member Count	Direct Earned Premium	Loss Ratio
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
2016	44	607,058	\$171,862,070	82.86
2017	46	625,174	\$205,785,395	79.76
Average	42	373,599	\$115,049,709	71.71

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.

Approximately 74 percent of the stop-loss insurance market was served by 41 foreign insurers, with 5 domestic insurers covering the remaining 26 percent of the market. Premiums were slightly higher for domestic insurers with \$31 per member per month and \$27 per member per month for foreign insurers. Loss ratios were lower for foreign insurers (see Table 27).

Table 27. Total Stop-Loss Market by Domicile for 2017

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM^a
Domestic	5	152,712	\$54,337,911	26.41%	86.92	\$31
Foreign	41	472,462	\$151,447,484	73.59%	73.59	\$27
Total	46	625,174	\$205,785,395	100.00%	79.76	\$28

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).

Table 28. Total Stop-Loss Market by Group Size for 2017

Group Size	Company Count^a	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM^b
Small Group (1-50)	11	9,679	\$9,569,064	4.65%	104.29	\$111
Large Group (51-100)	16	17,320	\$10,241,101	4.98%	80.16	\$51
Large Group (101 +)	38	598,175	\$185,975,230	90.37%	78.48	\$27
Total Stop Loss	46	625,174	\$205,785,395	100.00%	79.76	\$28

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) had the highest premium and loss ratio. Large Group (51 to 100) had a higher premium and loss ratio than Large Group (101 or more). The higher premiums are 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 plan: 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 plan 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 reimburses the self-funded employer plan.

Table 29. Stop-Loss Membership by Specific Attachment Points for 2017

Attachment Point	Small Group (1 – 50)		Large Group (51 – 100)		Large Group (101 or more)		Total	
	Member Count ^a	Percent of Total	Member Count	Percent of Total	Member Count	Percent of Total	Member Count	Percent of Total
NONE	10	< 0.1%	566	0.1%	6,046	1.0%	6,622	1.1%
\$10,000	1,445	0.2%	749	0.1%	390	0.1%	2,584	0.4%
\$20,000	1,704	0.3%	347	0.1%	10,869	1.7%	12,920	2.1%
\$30,000	2,641	0.4%	7,217	1.2%	14,702	2.4%	24,560	3.9%
\$40,000	902	0.1%	1,692	0.3%	10,047	1.6%	12,641	2.0%
\$50,000	302	< 0.1%	1,482	0.2%	34,609	5.5%	36,393	5.8%
\$60,000	27	< 0.1%	-	-	6,626	1.1%	6,653	1.1%
\$70,000	-	-	1,470	0.2%	33,326	5.3%	34,796	5.6%
\$80,000	-	-	445	0.1%	7,459	1.2%	7,904	1.3%
\$90,000	-	-	212	< 0.1%	2,460	0.4%	2,672	0.4%
\$100,000	2,648	0.4%	3,140	0.5%	82,176	13.1%	87,964	14.1%
\$200,000	-	-	-	-	124,820	20.0%	124,820	20.0%
\$300,000	-	-	-	-	47,662	7.6%	47,662	7.6%
\$400,000	-	-	-	-	43,015	6.9%	43,015	6.9%
\$500,000	-	-	-	-	51,479	8.2%	51,479	8.2%
\$600,000	-	-	-	-	4,239	0.7%	4,239	0.7%
\$700,000	-	-	-	-	20,582	3.3%	20,582	3.3%
\$800,000	-	-	-	-	1,093	0.2%	1,093	0.2%
\$900,000	-	-	-	-	1,552	0.2%	1,552	0.2%
\$1,000,000	-	-	-	-	81,981	13.1%	81,981	13.1%
\$2,000,000 or more	-	-	-	-	13,042	2.1%	13,042	2.1%
Total	9,679	1.5%	17,320	2.8%	598,175	95.7%	625,174	100.0%

Data Source: Utah Insurance Department

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

^a Under Utah Code § 31A-43-301, a small group stop-loss policy is required to have a specific attachment point that is at least \$10,000. During 2017, there was one stop-loss insurer that incorrectly issued a policy without specific attachment point coverage to a small group with 10 members. This was eventually corrected by the stop-loss insurer.

Nearly 99 percent of the total stop-loss membership included some kind of specific attachment point coverage. Over 76 percent reported a specific attachment point of \$100,000 or more, with nearly 24 percent reporting a specific attachment point of less than \$100,000. Over 72 percent of the of Small Group (1 to 50) membership had a specific attachment point of \$60,000 or less, while about 27 percent had a specific attachment point of \$100,000. All of Large Group (51 to 100) membership had a specific attachment point of \$100,000 or less, and about 70 percent had a specific attachment point less of \$50,000 or less. Nearly 79 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, which accounted for about 20 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 2017

Attachment Point	Small Group (1 – 50)		Large Group (51 – 100)		Large Group (101 or more)		Total	
	Member Count	Percent of Total	Member Count	Percent of Total	Member Count	Percent of Total	Member Count	Percent of Total
NONE	-	-	350	0.1%	152,986	24.5%	153,336	24.5%
85% to 89%	204	< 0.1%	-	-	47,913	7.7%	48,117	7.7%
90% to 94%	45	< 0.1%	-	-	-	-	45	< 0.1%
95% to 99%	-	-	-	-	-	-	-	-
100% to 104%	2,836	0.5%	1,323	0.2%	1,568	0.3%	5,727	0.9%
105% to 109%	-	-	-	-	25	< 0.1%	25	< 0.1%
110% to 114%	2,360	0.4%	177	< 0.1%	17,982	2.9%	20,519	3.3%
115% to 119%	-	-	-	-	33,468	5.4%	33,468	5.4%
120% to 124%	775	0.1%	503	0.1%	11,993	1.9%	13,271	2.1%
125% to 129%	3,459	0.6%	14,880	2.4%	331,049	53.0%	349,388	55.9%
130% or more	-	-	87	< 0.1%	1,191	0.2%	1,278	0.2%
Total	9,679	1.5%	17,320	2.8%	598,175	95.7%	625,174	100.0%

Data Source: Utah Insurance Department

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

A majority (about 75 percent) of the stop-loss membership included some kind of aggregate stop-loss coverage, with the rest (about 25 percent) reporting “none”. The most commonly reported aggregate attachment point was between 125% and 129% and accounted for approximately 56 percent of the stop-loss membership, with about 19 percent spread out between 85% to 124%, and less than 1 percent at 130% or more. All of the Small Group (1 to 50) membership reported aggregate stop-loss, as did more than 99 percent of the Large Group (51 to 100) and over 75 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, 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 35,787 members, or approximately 1.2 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 96 percent of the market, with only two domestic insurers providing long-term care coverage (see Table 31). Loss ratios were significantly higher for the domestic insurers than for the foreign insurers.

Table 31. Total Long-Term Care Market by Domicile for 2017

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	2	913	\$1,644,401	3.80%	170.97
Foreign	71	34,874	\$41,619,195	96.20%	77.12
Total	73	35,787	\$43,263,596	100.00%	80.69

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.

Most long-term care insurers reported individual business, while only 27 companies reported group business. Loss ratios were higher for individual policies than for group policies (see Table 32). A large number of individual carriers had higher claim costs during 2017, which resulted in higher loss ratios.

Table 32. Total Long-Term Care Market by Group Size for 2017

Group Size	Company Count^a	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Individual	66	20,656	\$32,511,526	75.15%	90.67
Group	27	15,131	\$10,752,070	24.85%	50.69
Total	73	35,787	\$43,263,596	100.00%	80.69

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 35,787 members with long-term care insurance in Utah during 2017. Nearly forty-five percent of the members were under age 65 and over fifty-five percent were sixty-five or older (see Table 33).

Table 33. Long-Term Care Membership by Age for 2017

Age	Member Count	Percent
Age 0-59	11,391	31.8%
Age 60-64	4,174	11.7%
Age 65-69	5,685	15.9%
Age 70-74	5,012	14.0%
Age 75-79	3,903	10.9%
Age 80-84	2,871	8.0%
Age 85+	2,751	7.7%
Total Members	35,787	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 nearly 22 percent of Utah's accident & health insurance market, with approximately 2.5 percent of the market share in Medicare Supplement coverage and about 19.2 percent of the market share in Medicare Advantage coverage. Approximately 6.8 percent of Utah residents had coverage under a Medicare Supplement or Medicare Advantage product, with about 2.6 percent in Medicare Supplement product and about 4.2 percent in a Medicare Advantage product. Medicare Part D products account for about 1.2 percent of Utah's accident & health insurance market and provide coverage for approximately 3.3 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. Eighty-six foreign insurers account for nearly 69 percent of the market, with nine domestic insurers providing the remaining 31 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 2017

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	9	20,753	\$50,490,898	31.24%	68.19
Foreign	86	58,683	\$111,151,649	68.76%	77.56
Total	95	79,436	\$161,642,547	100.00%	74.64

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 (90.2 percent) of the coverage provided by domestic insurers, and the remaining 9.8 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 2017

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	6	118,342	\$1,138,236,952	90.18%	85.64
Foreign	4	12,879	\$123,919,178	9.82%	79.67
Total	10	131,221	\$1,262,156,130	100.00%	85.05

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Part D by domicile. Nearly 91 percent of Utah’s Medicare Part D coverage is provided for by foreign insurers. Domestic companies provide the remaining 9 percent (see Table 36). Loss ratios were slightly higher for domestic insurers.

Table 36. Total Medicare Part D Market by Domicile for 2017

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	3	4,715	\$7,614,225	9.39%	79.38
Foreign	13	98,685	\$73,512,957	90.61%	78.42
Total	16	103,400	\$81,127,182	100.00%	78.51

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. Ninety-five commercial health insurers reported 79,436 members with Medicare Supplement coverage. Nearly all (97 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). Additionally, Utah does not mandate that insurers offer Medicare Supplement coverage to those individuals who are eligible for Medicare for reason other than age, such as end-stage renal disease.

Table 37. Medicare Supplement Membership by Age for 2017

Age	Member Count	Percent
Age 0-64	2,133	2.7%
Age 65 and Older	77,303	97.3%
Total Members	79,436	100.0%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Advantage membership by age. Ten commercial health insurers reported 131,221 members with Medicare Advantage coverage. Most (84 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). Additionally, Utah does not mandate that insurers offer Medicare Advantage coverage to those individuals who are eligible for Medicare for reason other than age, such as end-stage renal disease.

Table 38. Medicare Advantage Membership by Age for 2017

Age	Member Count	Percent
Age 0-64	20,421	15.6%
Age 65 and Older	110,800	84.4%
Total Members	131,221	100.0%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Part D membership by age. Sixteen commercial health insurers reported 103,400 members with Medicare Part D Drug Plan coverage. Most (87 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 2017

Age	Member Count	Percent
Age 0-64	13,796	13.3%
Age 65 and Older	89,604	86.7%
Total Members	103,400	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 79,436 members with Medicare Supplement in Utah during 2017 (see Table 40). 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).

Table 40. Medicare Supplement Membership by Plan Type for 2017

Plan Type	Member Count	Percent
Plan A	738	0.9%
Plan B	347	0.4%
Plan C	2,310	2.9%
Plan D	839	1.1%
Plan E	327	0.4%
Plan F	48,495	61.0%
Plan F (High Deductible Plan)	1,240	1.6%
Plan G	12,028	15.1%
Plan H	439	0.6%
Plan I	302	0.4%
Plan J	2,283	2.9%
Plan J (High Deductible Plan)	-	-
Plan K	655	0.8%
Plan L	323	0.4%
Plan M	2	< 0.1%
Plan N	8,453	10.6%
Pre-Standardized Plans	655	0.8%
Total Members	79,436	100.0%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

The most commonly reported Medicare Supplement plan was Plan F with 61 percent of the membership. The next closest plans were Medicare Supplement Plan G, with 15.1 percent; Medicare Supplement Plan N, with 10.6 percent; Medicare Supplement Plan C, with 2.9 percent; Medicare Supplement Plan J, with 2.9 percent; All other plans had less than 2 percent of the membership (see Table 40).

Medicare Advantage membership by plan type. Commercial health insurers reported 131,221 members with Medicare Advantage (full Medicare replacement policies) in Utah during 2017. Medicare Advantage plans (which completely replace Medicare and bear the full risk of loss) are available in one of five major plan types.

During 2017, most of the membership was covered under a Health Maintenance Organization plan, with about 79 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 nearly 5 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 2017

Plan Type	Member Count	Percent
Private Fee-for-Service	6,182	4.7%
Preferred Provider Organization	20,683	15.8%
Health Maintenance Organization	104,356	79.5%
Medical Savings Account	0	0.0%
Special Needs Plan	0	0.0%
Total Members	131,221	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 46 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). Comprehensive health insurance membership as a percentage of Utah residents continues to decline and the comprehensive health insurance industry now only serves about 24 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.

The total number of consumer complaints received by the Insurance Department increased from 2008 to 2009, remained stable from 2009 to 2011, followed by a significant increase from 2012 to 2016, and then declined during 2017. The increase in complaints appears to be due to recent changes in government regulations. In addition to complaints, during 2009 to 2017, consumers contacted the Insurance Department in greater numbers. Many consumers called with questions and concerns regarding 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), while most of the increase during 2016 was due to an increase in complaints related to long-term care premium increases and issues related to the Federally Facilitated Marketplace (FFM). During 2017 there was a general decline in the total number of complaints and confirmed complaints, but there was a significant increase in unconfirmed complaints. While the Insurance Department is receiving an increasing volume of complaints, we are less likely to have the resources available to resolve the presented issue. This is due to an increase in consumer complaints where the Insurance Department does not have authority to resolve the complaint under the Utah Insurance Code, such as complaints related to long-term care premium increases or drug treatment and mental health facilities. Another important trend over the last three years has been an increase in the number of complaints related to the issue of balance billing, where a health care provider bills the patient for the difference between the provider's charge and the amount paid by health insurance. Balance billing complaints accounted for about 10 percent of all consumer complaints during 2015 to 2017. The recent changes in federal regulations, the increasing uncertainty surrounding health insurance coverage, and the withdrawal of Molina Healthcare of Utah from the FFM have been difficult for many consumers and they are contacting the Insurance Department for assistance.

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). The number of independent reviews remained relatively stable during 2012 to 2014, followed by a significant increase during 2015 and 2016, and then remained stable during 2017. From 2015 to 2017, the number of requests for independent reviews increased by over 43 percent. The growth in the number of independent reviews 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 2008 to 2017. Most of this change has been due to a decrease in the number of small and very small foreign comprehensive health insurers. In contrast, while there has been some shifting within the market as part of the full implementation of the ACA including health insurers leaving the market, the total number of large and medium insurers has generally remained stable or increased. Large domestic comprehensive health insurers continue to account for more than 80 percent of the market. The number of medium insurers has increased during this period. Financial stress in the market continues to make it difficult for some insurers to participate in the comprehensive market and to sustain participation in the FFM. From 2014 to 2017, the number of comprehensive health insurers participating in the FFM declined from six to three.

From 2008 to 2017, the number of Utah residents covered by comprehensive health insurance as a relative percentage of Utah's population has declined by about 8.4 percent. Comprehensive health insurance membership has averaged about 812,000 members over the last 10 years. There was a decline in the number of members in the comprehensive market during 2017. This appears to be due to changes in the individual and small group markets. Premium increases and market uncertainty appear to be the primary drivers of this change.

From 2014 to 2016, membership in the individual market grew significantly. Most of this growth was driven by the federal individual mandate which required 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. During 2017, the individual market declined by over 32,000 members. This decline occurred among individuals with Off-Exchange plans who pay the full cost of any premium increases in the individual market, and do not receive any subsidies under the ACA to make coverage more affordable. Membership in FFM plans, where most members have premium subsidies, did not experience the same change. Consumers and health insurers were experiencing significant market uncertainty during 2017, such as the question of how rising health care costs and changes to government regulations and the ACA would affect consumers, as well as the ending of CSR payments and the possibility of the repeal of the ACA.

Membership in the small group market declined during 2016 and 2017. This decline in small group membership followed premium increases in the small group market during 2016 and 2017. It is also 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.

Large group membership declined during 2014 to 2016, and was stable during 2017. This change appears 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 increased from 2016 to 2017. The average premium per member per month increased from \$300 during 2016 to \$330 during 2017, an increase of 10 percent. Over the last ten years, increases in premium per member per month have averaged 4.9 percent per year, while increases in losses per member per month have averaged 5.7 percent per year.

Comprehensive health insurers reported high loss ratios during 2014 through 2016, 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 to produce reasonable projections, 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. During 2016, comprehensive health insurers had more claim experience to work with, but there was still considerable market uncertainty which made pricing their products more difficult. Comprehensive health insurers reported these higher loss ratios primarily in the individual market. During 2017, the combination of more accurate pricing information and higher rates that more precisely represented their actual risk experience resulted in improved loss ratios in the individual market. Higher premium income helped health insurers cover the cost of health care services that health insurers were paying out for their members. 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 loss of -0.1 percent in net income after expenses over the last ten years, with comprehensive health insurers reporting an average gain of 3.4 percent in net income after expenses during 2017.

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 non-ACA compliant coverage at lower premiums, and the ACA compliant pool that included members who were previously insured on a policy that had been rated due to significant health issues, or who were uninsured or uninsurable, and had pent up demand for health care. Comprehensive health insurers had priced products under the assumption that that all insured members would be moving into the ACA compliant pool; and were expecting higher risk corridor 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 Insurance Department in 2015.

The second year, 2015, 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. 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 third year, 2016, of the full implementation of the ACA was financially challenging for comprehensive health insurers. Utah's core health insurers experienced slightly lower losses in underwriting and net income during 2016 compared to 2015. Comprehensive health insurers had more claim experience to price their products, but market uncertainty continued to make pricing difficult and many health insurers were still unable to collect enough premium income to cover their losses, and similar to 2015, comprehensive health insurers did not receive any additional payments from the federal risk corridor program.

From 2014 to 2016, 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. Several comprehensive health insurers withdrew from the FFM due to concerns that these losses were not sustainable.

The fourth year, 2017, of the full implementation of the ACA was a mixture of financial and regulatory challenges combined with an increase in financial stability. Regulatory uncertainty such as the possible repeal of the ACA, elimination of the cost-sharing reduction (CSR) payments, and reductions in advertising for the FFM created higher market uncertainty for both consumers and health insurers than would normally have existed under the ACA as written.

During October 2017, the federal government ended the CSR payment program, which required health insurers to rate 2018 rates higher than they would have been had the CSR payments continued. The combination of higher premium revenue and more accurate pricing information for health insurers led to the beginning of a financial recovery. Health insurers reported better financial results during 2017 than they did during the first three years of the full implementation of ACA, suggesting that health insurers may be returning to profitability.

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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) Address issues between insurers and health care providers regarding the practice of balance billing to patients who have received care during an emergency situation, and when a patient is not given the choice of provider when receiving care at a contracted facility.
- 2) Require insurers to extend product offerings to Medicare recipients who are eligible both by age and by disability.
- 3) 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.
- 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) Improve data quality of the administrative claims in the All Payers Claim Database (APCD) and develop tools to increase transparency in health care costs.
- 6) 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.
- 7) Improve 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.

List of Comprehensive Health Insurers

Table 42. List of Comprehensive Health Insurers during 2017

Company Name	State of Domicile	Direct Earned Premium	Market Share	Loss Ratio
SelectHealth, Inc.	UT	\$1,656,523,762	54.85%	94.14
Regence BlueCross BlueShield of Utah	UT	\$454,460,213	15.05%	80.39
UnitedHealthcare Insurance Company	CT	\$321,951,943	10.66%	74.04
Molina Healthcare of Utah, Inc.	UT	\$180,431,176	5.97%	96.23
Aetna Life Insurance Company	CT	\$94,067,267	3.11%	86.17
Aetna Health of Utah Inc.	UT	\$80,740,972	2.67%	78.36
Cigna Health & Life Insurance Company	CT	\$67,735,147	2.24%	99.93
University of Utah Health Insurance Plans	UT	\$51,085,759	1.69%	88.45
National Health Insurance Company	TX	\$22,484,252	0.74%	123.09
UnitedHealthcare of Utah, Inc.	UT	\$17,086,939	0.57%	88.41
Health Care Service Corporation, a Mutual Legal Re	IL	\$15,029,897	0.50%	75.86
Deseret Mutual Insurance Company	UT	\$14,373,034	0.48%	69.47
HSA Health Insurance Company	UT	\$12,320,723	0.41%	69.59
Humana Insurance Company	WI	\$10,865,523	0.36%	69.83
Educators Health Plans Life, Accident and Health,	UT	\$7,499,424	0.25%	89.20
WMI Mutual Insurance Company	UT	\$6,834,865	0.23%	63.76
State Farm Mutual Automobile Insurance Company	IL	\$2,933,447	0.10%	70.89
Educators Mutual Insurance Association	UT	\$1,921,566	0.06%	67.93
UnitedHealthcare Life Insurance Company	WI	\$1,020,016	0.03%	120.16
American National Life Insurance Company of Texas	TX	\$364,091	< 0.01%	40.45
Bridgespan Health Company	UT	\$174,708	< 0.01%	-132.60
4 Ever Life Insurance Company	IL	\$133,809	< 0.01%	168.55
Freedom Life Insurance Company of America	TX	\$30,473	< 0.01%	34.88
Connecticut General Life Insurance Company	CT	\$28,269	< 0.01%	21.85
The Prudential Insurance Company of America	NJ	\$23,562	< 0.01%	126.22
Pyramid Life Insurance Company, The	KS	\$16,203	< 0.01%	4.28
American National Insurance Company	TX	\$15,219	< 0.01%	284.62
Standard Life and Accident Insurance Company	TX	\$12,516	< 0.01%	11.35
National Foundation Life Insurance Company	TX	\$11,432	< 0.01%	0.00
Golden Rule Insurance Company	IN	\$11,415	< 0.01%	189.83
AXA Equitable Life Insurance Company	NY	\$9,707	< 0.01%	0.45
Trustmark Insurance Company	IL	\$5,032	< 0.01%	1.21
Metropolitan Life Insurance Company	NY	\$1,323	< 0.01%	-0.23
Reserve National Insurance Company	OK	\$889	< 0.01%	0.00
Transamerica Life Insurance Company	IA	\$327	< 0.01%	0.00
Centre Life Insurance Company	MA	\$176	< 0.01%	0.00
Guardian Life Insurance Company	NY	\$57	< 0.01%	0.00
All Comprehensive Health Insurers	37	\$3,020,205,133	100.00%	89.07

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)
7. Insurance coverage for autism spectrum disorder (31A-22-642)

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 and substance abuse (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)
9. Diagnosis and treatment for autism spectrum disorder (31A-22-642)

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 § 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 statutes; and
 - (d) include claims loss ratio data for each health insurance company doing business in the state.
- (3) 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.
- (4) 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.
- (5) 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 2008 to 2017. The data includes information on approximately 330 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 refers 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.