Department of Regulatory Agencies

Division of Insurance
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Factors Affecting Health Insurance Premiums in 2010

Rating Factors Allowed by Law in Colorado – State law specifies which factors an insurance company can review in order to adjust health care premiums each year. These "rating factors" vary in each of Colorado's three insurance markets – large group, small group and individual. Companies adjust premiums according to the way the factors affect a particular employer or individual. For instance, a small employer with three employees over age 50 is affected by the age factor more than an employer with one 30 year old and two employees over age 50.

Large Group Employer (50+ employees): Insurers can adjust premiums based on anything. Previous claims of the group are the biggest factors in premiums, whether it's a new policy or a renewal.

***Small Group Employer (1-50 employees)*:** Insurers can adjust premiums based on age, geography, tobacco use, type of industry, family size, and a plan's benefit structure.

Individual Coverage: Insurers can adjust premiums based on age, health status, tobacco, geography, a plan's benefit design. The health status and age factors typically affect new policies the most. Some companies add a predetermined impact for the length of time a consumer has a policy.

Additional Factors Insurance Companies Review When Developing a Premium Rate Companies review many other factors that reflect changes in costs related to the delivery of health care services, or the behavior of the broader population, not just a particular employer or individual.

1. ***Experience of an entire group of policyholders***
   Definition: number of claims made by all policyholders that have similar plans over a year
   a. Premiums are adjusted based on actual claims vs. previous year estimate of claims. If an insurance company makes a "bad guess" about claims, it will adjust premiums to cover additional costs.

2. ***Medical Trend***
   Definition: increase in the costs and number of health care services provided to policyholders
   a. Costs - Costs reflect the estimated change in the price per health care service delivered, including:
      i. Contracts with doctors
      ii. Hospital charges
      iii. Laboratory services
      iv. Pharmacy – production and dispensing
      v. Diagnostic imaging (x-rays, cat scans, MRI, etc…)
   b. Utilization – Utilization measures the frequency with which individuals use the health care system. It can be affected by several factors.
      1. Aging population
      2. Overall decrease of the population's health (i.e. obesity)
      3. Changes in provider treatment patterns
         a. Increase in diagnostic imaging
         b. Increase in lab tests
         c. Increase in outpatient surgery

3. ***Insurance Trend***

Definition - Increase in costs associated with current policies and their benefit structures

a. Deductible Leveraging – This process involves an adjustment in premium to cover the decreased value of a deductible or co-pay. This occurs when a deductible or other cost sharing payment stays constant over several years. After the first year, the deductible loses value because medical inflation continues, but the cost sharing does not increase. For instance, a $1000 deductible won't cover as much health care the second year. Carriers make up for this decreased value by raising premiums.
b. Underwriting Wear Off – This adjustment in premium covers increased costs associated with an individual's pre-existing condition. In the individual market, an insurance carrier can only increase a person's rate once because of a pre-existing condition, unless the individual changes plans. The costs of covering a pre-existing condition increases every year. Carriers adjust premiums to cover these increased costs.

4. ***Aggressive Pricing***

Definition: Offering lower premiums to new customers to make coverage more attractive
Carriers will adjust premiums for current policyholders to cover the loss of revenue from the new customers. Typically, the discounted premiums are adjusted to higher levels over the next few years.

5. ***Business Operations***

Definition: Costs incurred through general business operations

a. Information technology systems
b. Reinsurance contracts – Reinsurance covers the highest claims a company may incur, but does not want to pay.
c. Payroll and benefits

6. ***Cost-shifting***

Definition: Adjustment in premiums due to the uncompensated care of the uninsured or the inadequate payments received from public programs such as Medicare and Medicaid.
For example, if an uninsured patient cannot pay a provider, that provider will increase charges for privately insured patients in order to recoup the costs of the uncompensated care of the uninsured.

7. ***Federal Health Care Reform Requirements***

Definition: Variety of new requirements mandated in federal law 2010 including:

a. No denials for children under 19 with pre-existing conditions
b. No rescissions except for fraud
c. No lifetime limits
d. Restricted annual limits
e. Dependent coverage up to age 26

8. ***New State mandates***

Definition: New requirements mandated in state law 2010

a. Maternity coverage in individual market
b. No gender rating in individual market