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Colorado's Health Insurance Market

Health insurance is a method of paying or receiving reimbursement for health care costs from covered services. Health insurance companies spread the costs and risk of covered health care services across all members of a plan in exchange for premiums and other cost-sharing mechanisms, such as deductibles and copayments. These rates are actuarially determined and set at a level that covers the estimated health care costs incurred by all members of the group. This issue brief provides an overview of the health insurance market in Colorado and federal and state health insurance regulations.

Health Insurance Markets

Coloradans can obtain health insurance through the individual, employer group, government-sponsored, or self-funded markets. Each market offers various levels of coverage and costs, and are funded by a combination of state and federal mechanisms.

Individual market

The individual market offers plans to individuals and families who are not purchasing health insurance through an employer and are not eligible for government-sponsored plans. In the individual market, covered persons pay the premium and may choose to purchase health insurance directly from an insurer, through an insurance broker, or through the state's health insurance exchange, Connect for Health Colorado. Connect for Health Colorado allows consumers in the individual market to compare health plans, determine eligibility for financial assistance, and apply for certain public health programs.

Employer group market

The employer market includes plans offered to individuals and families by employers in either the small or large group market. **Small group employers** have no more than 100 employees and typically contract with one or more health insurance companies to provide several plans for employees to choose from. Small employers often arrange for health coverage for their employees using an insurance broker, but may also purchase directly from an insurer or through Connect for Health Colorado via the Small Business Health Options Program. Self-employed Coloradans may also purchase health insurance through the small group market. **Large group employers** have more than 100 employees and typically arrange plans through an insurance broker who provides employees with a selection of plans to choose from. Beginning January 1, 2026, Senate Bill 24-073 reduces the small group market cap to no more than 50 employees, and the large group market minimum will begin at 51 employees.

Government-sponsored market

The government-sponsored market includes Medicaid, Child Health Plan Plus (CHP+), and Medicare. State and federal governments fund these plans to provide low and no-cost health

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insurance to eligible Coloradans based on factors such as age, income, and health risks. Colorado's Medicaid program, Health First Colorado, is jointly funded by the state and the federal government and predominantly provides coverage for low-income individuals. Similarly, CHP+ is jointly funded and provides low-cost insurance for eligible children and pregnant people based on household income. Medicare is a federal health insurance program primarily for senior citizens and individuals with certain medical conditions. The government-sponsored market also has plans for certain military members and veterans.

Self-funded market

Self-funded health plans are typically offered by large employers, but can be offered by employers of any size. The employer sets a pool of funds in reserve and assumes the risk for health benefit claims. Benefits and claims are administered by either a third-party administrator or insurance company that has contracted with the employer. Employers who use self-funded health plans often purchase stop-loss insurance, which is a separate insurance policy that limits the organizations' overall liability if employee health costs exceed a certain amount. Self-funded plans are subject to federal law and regulations under the Employee Retirement Income Security Act (ERISA) of 1974, rather than state law.

Federal Requirements under ACA

The federal Affordable Care Act (ACA) made numerous changes to the insurance market, including eligibility expansion for Medicaid enrollees. Several key changes under the ACA and how they apply to the different types of health insurance are discussed below.

Guaranteed issue

The ACA requires health insurers to offer coverage to any individual or group that applies, and to renew coverage at the option of the covered individual or plan sponsor. Issuance of insurance may be limited by insurers to a predetermined open enrollment period each year and special enrollment periods for qualifying life events. Prior to the ACA, ERISA required that all employees in a self-funded group be allowed to participate in the employer's health plan.

Pre-existing conditions

Under the ACA, health insurers are prohibited from charging higher rates, applying coverage limitations, or rejecting applicants due to a pre-existing condition. Establishment of lifetime or annual limits on most benefits is also prohibited.

Rating regulations

The ACA requires health insurers in the individual and small group employer markets to set premiums through a modified community rating method. This method sets rates based on data from the entire insurable population, rather than geographically-specific premiums determined by a region's demographics, health status, or claims history. Rates are permitted to vary based on an enrollee's age and tobacco use. Health insurers in the large group employer market may take into account additional information, such as the organizations' industry classification and claims history, when setting premiums.

Limits on state mandated benefits

Under the ACA, if state law mandates that individual or small group plans provide a new benefit, the federal Department of Health and Human Services (HHS) services must determine whether it constitutes an essential health benefit. If it does not, the law is subject to state defrayal, meaning the state is required to pay for the additional costs incurred by insurers to provide the benefit.

State Regulation of Health Insurance

The Division of Insurance (DOI) in the Colorado Department of Regulatory Agencies regulates the Colorado insurance industry, including health insurance, by:

- monitoring insurance companies for compliance with state and federal law;
- analyzing the financial health of insurance companies;
- reviewing insurance premiums and policies; and
- ensuring a competitive marketplace for companies and consumers.

Authority

The DOI regulates all fully insured health plans offered in Colorado, including in the individual and employer group markets. However, it does not have jurisdiction over government-sponsored or self-funded health plans. Consumers can determine whether their health insurance plan is regulated by the DOI by checking their insurance card for "CO-DOI."

Rate and cost reviews

Further, the DOI ensures that health insurers comply with the ACA by conducting an annual review to assess premium reasonability and administrative spending ratios. Health insurers are limited in the percentage of premiums that can go toward administrative and non-medical expenses. Specifically, insurers must spend at least 85 percent in the large group market or at least 80 percent in small group and individual markets on health care costs and quality improvement activities. If they do not meet these thresholds, insurers must issue rebates to customers.

Lastly, the DOI ensures that the state complies with the ACA by submitting new mandated coverage laws to HHS for review. In the event that a state defrayal is required, the DOI would review and make the payments to individual and small group plans. This has not yet occurred as the HHS infrequently determines that a benefit is not essential and because several state laws are drafted to be conditional upon HHS's determination, and do not take effect if it would cost the state.

Parity

The DOI enforces both federal and state parity laws for individual, employer-sponsored, Health First Colorado, CHP+, and certain other government-sponsored health plans. These parity laws mandate that health insurance companies provide the same level of coverage for mental health, behavioral health, and substance use disorder services as they do for medical and surgical care. Insurers are prohibited from placing more restrictive limits on these services—such as higher copayments, fewer covered visits, stricter preauthorization requirements, or limited access to in-network providers. The DOI also oversees and reviews appeals from individuals who believe their mental or behavioral health benefits have been unfairly denied.