Drivers of Premium Increases and Review of Health Insurance Rates

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Summary

In general, the premiums charged by health insurance companies represent actuarial estimates of the amount that would be required to cover three main components: (1) the expected cost of the health benefits covered under the plan, (2) the business administrative costs of operating the plan, and (3) a profit. The final premium calculation often is adjusted upward or downward to reflect several factors, such as making up for a previous financial loss, that are often referred to as the "underwriting cycle."

Health insurance premiums have been trending up, while the value of coverage generally has been trending down. Specifically, the year-over-year percentage increase by month in private health insurance premiums has averaged around 4.4% between 2004 and 2010, but has accelerated some since 2009, ranging from 4.8% to 5.5%. At the same time, cost-sharing requirements have generally increased. For example, a typical family of four with private employer-sponsored health benefits has seen its out-of-pocket cost sharing increase between 5.4% and 10.5% annually between 2006 and 2010.

Of the main components that constitute the premium amount, health benefits expenses represented about 85% of that amount in 2010. Publicly available data indicate that medical costs have steadily risen over the past several years, but the rate of growth in these expenses slowed between 2008 and 2010. The data also suggest that the rise in medical costs is primarily attributable to the price of services, not increased utilization.

The rise in the cost of health insurance has received considerable attention by Congress and resulted in calls for more regulation. The regulation of private health insurance has traditionally been under the jurisdiction of the states. Most states have used their regulatory authority over the business of insurance to require the filing of health insurance documents containing rate information for one or more insurance market segments or plan types.

Under the Patient Protection and Affordable Care Act (P.L. 111-148, ACA, as amended), the federal government will assume a role in private health insurance rate reviews by providing grants to states and requiring health insurance companies to provide justifications for proposed rate increases determined to be unreasonable. However, ACA does not authorize the federal government to decline or bar implementation of proposed rate increases; such authority still is retained by the states. On May 23, 2011, Health and Human Services (HHS) issued the final rule implementing the rate review provisions in ACA. The rule clarified which proposed rate increases would be subject to review (i.e., defining "unreasonable" rate increase), established a process for rate review to be conducted either by the state or HHS, and specified notice requirements to inform the public about the process and outcome of the rate reviews.

This report provides an overview of the concepts, regulation, and available public data regarding private health insurance premiums. Specifically, this report analyzes the four broad components of health insurance premiums: medical claims, administrative costs, profit, and the underwriting cycle. Finally, the report discusses state requirements to review health insurance rates, and rate review provisions under federal health reform.

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Introduction

Health insurance premiums represent a contractually agreed upon amount to be paid for a defined set of health benefits during a defined period of time (usually a year). Premiums are typically paid in monthly installments by policyholders (individual coverage) and enrollees (group coverage). Premiums may vary for different individuals with the same health benefits package from the same insurance company. Each variation is referred to as a premium rate. Rating methodologies generally vary between health insurance market segments and may have additional state-specific variation due to differences in state rate regulations.[1] Typically, the following methods are used by market segment:

- **Individual health insurance market.** Rates may vary by age and sex and may also be underwritten, meaning that the insurance carrier assesses the health status of the insurance applicant and uses it to set the rate according to the health risk of that individual.
- **Small group market.** What is called a "manual rate" is first calculated estimating the costs by the age and sex of the employees, geographic location, number of employees, and the type of health insurance product.[2] Most states also permit the manual rate to be adjusted by a health status factor.
- **Large group market**. Premium rates are determined either from an individual group's medical claims history (referred to as "experience") or from a blended average of manual rates calculated from the members of the group and from the group's experience.[3]

Health insurance premium rates are actuarial estimates of the cost of covering a risk pool of individuals under a particular health benefits package for a particular period of time.[4] Generally, the more generous the benefits package (i.e., large, open networks of providers and low cost-sharing requirements including deductibles) the higher the premiums will be. Just as premiums must be adequate to pay for expected health care use, they also must be sufficient to compensate insurance carriers for taking on the financial risk associated with providing coverage.

[1] The three private health insurance market segments are individual, small group, and large group. They are defined at §2791(e) of the Public Health Service Act (PHSA). The term "individual market" means health insurance coverage offered to individuals (and potentially their dependents) that is not in connection with a group health plan. The determination of whether an employer is large or small depends on its average employment level for the year. Prior to ACA, the PHSA defined a small group in terms of 2-50 employees, and a large group in terms of 51 or more employees. Section 1304(b) of ACA amended these definitions so that a small employer is one with 1-100 employees and a large employer has 101 or more employees. However, Section 1304(b)(3) of ACA allows states to continue to define an employer with up to 50 employees as a ''small employer'' until 2016.

[2] The term "insurance product type" refers to substantive differences in plan design (e.g., no deductible versus a high deductible) that would reasonably be expected to affect the utilization of medical care.

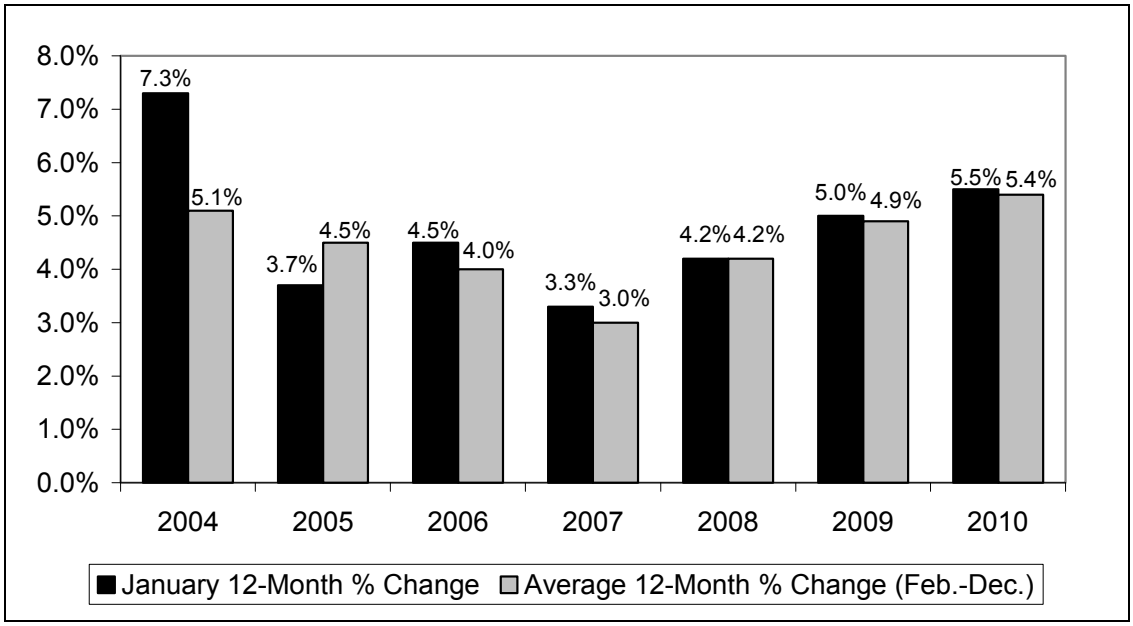
[3] For more information on the use of different health insurance rating methodologies, see John Bertko, "Health Insurance Market Rating Practices," September 2008, available at http://www.rand.org/pubs/testimonies/CT315/.

[4] Health insurance actuaries apply mathematical expertise, statistical knowledge, economic and financial analyses, and problem-solving skills to help health insurance companies evaluate ways to manage risk. For more information on actuarial science, see American Academy of Actuaries, "Becoming an actuary," 2010, available at http://www.actuary.org/becoming.asp.

The final premium rate calculation often is adjusted to reflect several other factors, such as making up for a previous financial loss and providing excess capital to manage various risks generally regulated under state solvency standards. State regulators have adopted solvency standards to protect consumers by requiring insurance companies to keep certain reserves of capital to protect against asset risks, underwriting or insurance risk, and business risks.[5] Without this required safety net of reserved cash, a health insurance company could go bankrupt if it experiences unforeseen losses, thus resulting in its consumers being placed at full financial risk for their medical claims.

Data from the Bureau of Labor Statistics' (BLS's) Producer Price Index (PPI) for health insurance companies indicates that the year-over-year percentage increase by month in private health insurance premiums has averaged around 4.4% between 2004 and 2010, but has accelerated some since 2009, ranging from 4.8%-5.5% (**Figure 1**).[6]

Figure 1. Year-Over-Year Percentage Change in Premiums for January and Average for All Other Months, 2004-2010



Source: U.S. Department of Labor, Bureau of Labor Statistics (BLS), "Producer Price Index Industry Data," 2010, available at http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?series_id=PCU524114524114.

[5] The term "asset risk" means the potential for a default of principal and interest or loss in fair value of assets such as bonds, loans, real estate, and stock. The term "underwriting or insurance risk" refers to the risk that medical expenses will exceed the premiums collected. The term "business risk" refers to the variety of general operational risks to the insurance company such as unexpected increases in labor costs and exposure to litigation. For a general overview of solvency standards, see National Association of Insurance Commissioners, "Risk-Based Capital General Overview," July 2009, available at http://www.naic.org/documents/committees_e_capad_RBCoverview.pdf.

[6] In the case of employer group coverage, the PPI survey takes into account the amount paid by the employer. Year-over-year refers to a comparison of prices to the same time period in the previous year, such as a month or quarter. For example, comparing the percent change in prices in January 2009 to the prices in January 2010. This type of analysis is appropriate for health insurance because coverage typically begins on the first of each month and the duration of the coverage is typically a year.

Notes: The year-over-year percentage change is isolated for January because most group plans are sold for 12-month durations beginning on January 1 of each year. Individual market health insurance products are sold monthly and usually for a 12-month duration. Thus, the average monthly year-over-year % change for February through December is presented. The indexes for this industry measure the change in the total premium (employee and employer contribution) paid to the insurer plus the return on the invested portion of the premium. For more information on the survey methodology, see U.S. Department of Labor, Bureau of Labor Statistics (BLS), "Producer Price Index for the Direct Health and Medical Insurance Carriers Industry – NAICS 524114," September 2005, available at http://www.bls.gov/ppi/ppimedicalinsurance.htm.

The year-to-year increases in the PPI may not appear significant, but there are four relevant contextual factors to take into consideration.

- First, premium increases can be much higher in the individual and small group markets, where the smaller risk pools can result in distortions in the average health care costs covered by premiums, due to outlier policyholders or members. In other words, if there are only a few healthy persons to help pay for a sick person, the premiums (all else being equal) will be higher than if that sick person was in a larger risk pool with many healthy persons.
- Second, in the employer group market, the worker share of premiums has been increasing even more because employer subsidies have been trending down incrementally.[7] The employer and workers shares vary according to coverage tier: self-only, employee-plus-one, and family. However, in the past few years employers have shifted incrementally more of that cost to workers. For example, the average worker share of the total premium for group coverage (for self-only coverage) was 15.3% in 2008 and grew to 17.0% by 2011 (**Table 1**).
- Third, as premiums have gone up, the value of the coverage has gone down in terms of higher cost sharing requirements, including deductibles (see the **Appendix**).
- Fourth, real income (i.e., income adjusted for inflation), both per capita and family, has decreased in the past several years. Real income for adults (age 16 and older) *declined* 4.6%, from an average of $40,389 in 2007 to $38,543 in 2010. Similarly, average family income *declined* 6.6%, from $73,426 to 68,599 for the same period.[8] As a result, incomes are not keeping up with premium increases, and a greater proportion of incomes are being consumed by health insurance premiums.[9]

[7] The most recent exception is this trend is for 2010-2011, when the employer share of the total premium increased slightly.

[8] CRS analysis of data from the Annual Social and Economic (ASEC) supplement to the Current Population Survey (CPS).

[9] Cathy Schoen et al., "State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs," *The Commonwealth Fund*, November 2011.

Table 1. Average Employer and Worker Shares of Total Premiums, by Tier of Coverage, 2008-2011

	2008	2009	2010	2011
Self-Only Coverage				
Employer Share	84.7%	83.9%	82.2%	83.0%
Worker Share	15.3%	16.1%	17.8%	17.0%
Family of Four Coverage				
Employer Share	73.5%	73.7%	71.0%	72.6%
Worker Share	26.5%	26.3%	29.0%	27.4%

Source: *Employer Health Benefits, 2011*, Kaiser Family Foundation/Health Research and Educational Trust, September 2011.

The growth of health insurance premiums (and out-of-pocket costs) for individuals and families has been the focus of considerable congressional attention.[10] Using available public data, this report explores the potential drivers of the growth trend in health insurance premiums.[11]

Drivers of Premium Increases

In general, the premiums charged by health insurance companies represent the estimated amount that would be required to cover initially three major components: (1) the expected cost of the health benefits covered, (2) the administrative costs of operating the coverage, and (3) a profit margin consistent with the strategic business goals of the company.[12] The fourth and final component to the premium calculation involves adjustments upward or downward to reflect several miscellaneous factors, such as responding to prior gains or losses, strategically responding to competitors (i.e., pricing lower to gain market share), hedging against uncertainty risks created by a changing regulatory environment, and other factors often collectively described as the underwriting cycle.

[10] For example, see Senate Health, Education, Labor and Pensions Committee, "The Affordable Care Act: The Impact of Health Insurance Reform on Health Care Consumers," January 27, 2011; Senate Health, Education, Labor and Pensions Committee, "Health Reform and Health Insurance Premiums: Empowering States to Serve Consumers," August 2, 2011; and House Committee on Small Business, "New Medical Loss Ratios: Increasing Health Care Value or Just Eliminating Jobs?," December 15, 2011.

[11] The health insurance company financial data that could most directly demonstrate specific plan level medical and administrative expenses that drive premiums generally is proprietary and confidential. Regulatory filings such as those with the Securities and Exchange Commission or the state insurance commissioners are reported at the legal entity or parent organization level. In other words, aggregate financial data for an entire company or the company within a state do not reflect the variations in both premiums and costs observed in each of the multiple plans offered by a single organization.

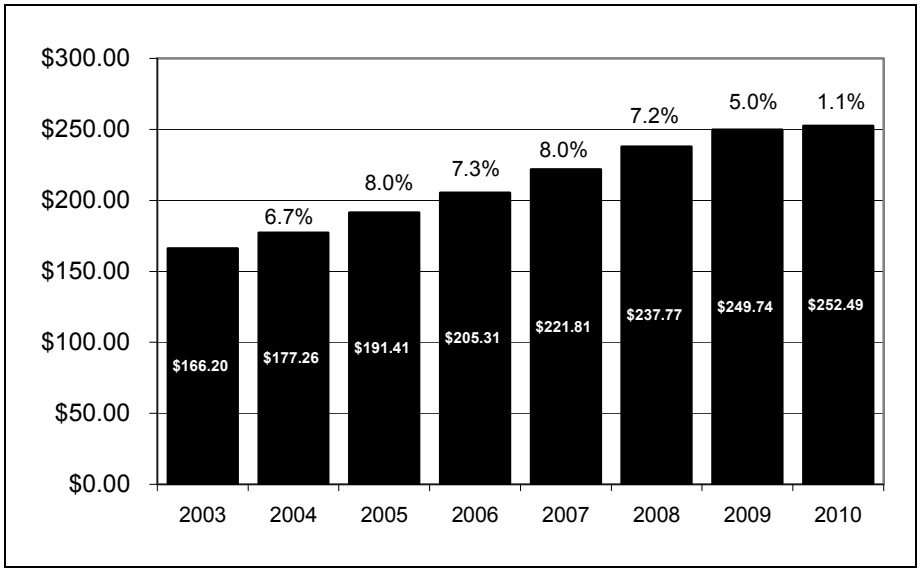
[12] Cost is the product of the price of health benefits and the utilization of those benefits. Profit margin is a financial ratio used to assess the profitability of a firm. It equals revenue minus expenses divided by revenue. Different organizations have different strategic business goals that can also change over time. Maximizing profit may not always be the goal for a given time period. For example, a for-profit company may accept lower profit margins for a period of time in order to gain more market share by offering a better price compared to the firm's competitors. While non-profit insurers do not seek to generate profit in the conventional sense, they have an incentive to reduce expenses in order to invest retained earnings back into the organization for capital expenditures such as purchasing additional information technology, expanding customer service operations, or other administrative activities.

Health Benefits Expenses

Health benefits expenses equal the aggregate products of unit prices for health services times utilization of health services (e.g., hospital visits) or health items, such as prescription drugs. Health benefits expenses represent the largest component of premiums. According to the aggregate health insurance industry statements of revenue and expenses submitted to the National Association of Insurance Commissioners (NAIC) in 2010, health benefits represented about 85% of premiums.[13]

Health benefits expenses on a per member per month (PMPM)[14] basis have trended upwards between 2003 and 2010 in aggregate for the health insurance industry,[15] as illustrated in **Figure 2**. The annual percentage increase in total health benefits expenses, typically referred to as medical trend, has generally been over 7% per year during most of that time period, but the rate of growth was 5.0% between 2008 and 2009, and only 1.1% between 2009 and 2010. The medical trend of a particular plan or policy can vary substantively based on such factors as the relative health status of the enrollees and policyholders, differences in coverage policy, differences in the use of managed care techniques, geographic differences, use of restrictive versus open provider networks, and various organizational factors, such as being for-profit or non-profit.

Figure 2. Per Member Per Month (PMPM) and Annual Percentage Increases in Health Benefits Expenses for the Health Insurance Industry, 2003-2010



Source: Debra Donahue, "Medical Expense Trend Declines in 2010," September 23, 2011, available at http://www.markfarrah.com/healthcarebs.asp?article=103.

[13] Rounded to the nearest tenth of a percent. Not all health insurance companies are required to report to NAIC. Most notably self-insured employer groups nationwide and health maintenance organizations in California do not report to the NAIC. National Association of Insurance Commissioners, "Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2010," 2011.

[14] The term "member month" refers to each month of coverage for an enrollee or policyholder; thus a member for a full year would have 12 member months. PMPM calculations are often used for health insurance financial statistics because enrollments and premium payments are generally made on a monthly basis.

[15] The health benefit expenses are nominal amounts (i.e., not adjusted for inflation).

Notes: This study was based on a representative sample of 356 health plans and insurance products from 171 different companies. Only companies that filed Health Annual Statements with the National Association of Insurance Commissioners for each year displayed were included in this analysis. Excluded from the dataset were California HMOs and self-insured health plans that are not required to file Annual Statements with the National Association of Insurance Commissioners (NAIC) and specialty, non-medical plans such as dental insurers. The health benefit expenses are nominal amounts; i.e., not adjusted for inflation.

Unit Prices

The unit price of health services and prescription drugs is determined through a contract negotiation process between health insurance companies, health providers, medical device companies, and drug manufacturers or distributors. There is evidence of considerable geographic variation in provider, but not prescription drug pricing.[16] For example, the Center for Studying Health System Change (HSC) found significant differences in payment rates to hospitals and physicians among the eight markets it studied during site visits to nationally representative metropolitan areas during 2010. Average payments for inpatient hospital care, as a percentage of Medicare, ranged from 147% in Miami to 210% in San Francisco. For physician payments as a percentage of Medicare, it ranged from 82% in Miami to 176% in rural Wisconsin.[17] HSC attributed the variation in prices paid by insurers to differences in provider bargaining power. Another study in six California markets between October and December 2008 found that physician group practice integration with hospital systems, hospital mergers, the desire for broad provider choice, growing physician shortages, and a regulatory environment that favors providers all contributed to a price negotiation advantage for some providers.[18]

The power of providers in negotiating higher unit prices has been recognized by some state insurance commissioners that perform premium rate reviews. For example, in the reformed Massachusetts market, the Division of Insurance approved (on appeal) a premium rate increase for Fallon Community Health Plan after finding that, among other things, "individuals and employer groups demand that Fallon provide options that include access to every doctor and hospital, including local providers, as well as access to larger tertiary systems."[19] The Massachusetts Division of Insurance Appeals Board concluded that "[m]arketplace realities mean that Fallon sometimes has no choice but to contract with higher cost providers." Similarly, an investigation by the state Attorney General concluded that large providers with brand-name recognition have considerable leverage over health insurance companies when negotiating prices, and that price increases have accounted for the majority of the medical trend in Massachusetts.[20]

[16] Drug prices generally involve national-level negotiations between pharmacy benefit managers working on behalf of health insurers and drug manufacturers or distributors. By limiting the number of negotiating entities and make the negotiations more national in scope, the geographic variation of prescription drug prices is limited. By contrast, the pricing of health services involves health insurance companies negotiating at the local level with thousands of individual providers, provider groups, agencies, long-term care facilities, and hospitals.

[17] P. Ginsburg, "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," November 2010, available at http://www.hschange.com/CONTENT/1162/#ib2.

[18] R. Berenson, P. Ginsburg, and N. Kemper, "Unchecked Provider Clout In California Foreshadows Challenges To Health Reform," *Health Affairs*, vol. 29, no. 4.

[19] *Fallon Community Health Plan v. Division of Insurance*, Docket No. R2010-07, August 6, 2010.

[20] Office of Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers," January 2010.

Health care services and items in the United States generally lack unit price transparency because they are considered proprietary contractual negotiations between payers and providers.[21] Moreover, standard measures of producer price inflation, such as the PPI, are inappropriate to examine the unit price inflation among privately insured persons because they include prices paid by consumers that are uninsured or are in government programs (e.g., Medicare and Medicaid). However, one survey by Segal Consulting projected that the annual price inflation for hospitals will increase 7.2% for 2012 (2012 estimates from insurers are based on provider-contracted rates set before the coverage year begins).[22] In addition, Segal projected that the annual price inflation for physicians and prescription drugs in 2012 would be 4.6% and 5.5%, respectively.

Health Service Utilization

Conventional wisdom states that the aging of the American population is the primary driver of increased demand for health services and prescriptions drugs experienced by health insurers.[23] On its face, this seems logical given that the elderly have the highest utilization of health care.[24] However, the overall age distribution of the population actually shifts very slowly over time. Indeed, the median age of the U.S. population is projected to increase just 1.8 years, from 36.9 in 2010 to 38.7 in 2030.[25] In terms of risk based on age, the Medicare program assists the private health insurance market by assuming the liability of coverage for most persons age 65 and older. Ultimately, what matters for the insurer is not merely the general population trends, but the specific age distribution of the risk pool being insured. Moreover, studies have found that while aging does have an impact on rising health care utilization, other factors such as advances in costly medical technology and medical practice patterns drive demand more.[26]

Without countervailing regulations, health insurance companies have a financial incentive to restrain utilization. Generally, the less they pay in health benefits, the higher their profits will be. Health insurance companies can implement a number of different management techniques or limitations on coverage to restrain health care utilization. Traditional utilization management techniques include utilization review, case management, and physician gatekeeping.[27] Insurers

[21] Congressional Budget Office, "Increasing Transparency in the Pricing of Health Care Services and Pharmaceuticals," June 5, 2008.

[22] Segal Consulting, "2012 Segal Health Plan Cost Trend Survey," September 15, 2011, available at http://www.segalco.com/publications-and-resources/multiemployer-publications/surveys-studies/?id=1733.

[23] U. Reinhardt, "Does The Aging Of The Population Really Drive The Demand For Health Care?" Health Affairs, 2003, vol. 22, no. 6 (hereafter cited as "Aging").

[24] Steven Cohen and William Yu, "The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2005–2006," Agency for Healthcare Research and Quality, February 2009.

[25] U.S. Census Bureau, National Population Projections Table 12. Projections of the Population by Age and Sex for the United States: 2010 to 2050, 2008. Available at http://www.census.gov/population/www/projections/summarytables.html.

[26] See B. Strunk, P. Ginsburg, and M. Banker, "The Effect Of Population Aging On Future Hospital Demand," Health Affairs, Web Exclusive, vol. 25, no. 3; and "Aging."

[27] Utilization review includes prospective reviews, often called prior authorization (PA), that attempt to constrain health care costs by reducing unnecessary or inappropriate medical care before the care takes place. For example, a plan might conduct a preadmission review to certify the need for a hospitalization and assign an initial length of stay. Case management includes care coordination and the use of evidence-based medicine to ensure the highest probability of positive outcomes in a cost effective manner. For example, for a member with heart disease, a plan might coordinate between a primary care physician and a cardiologist to ensure that there is no duplication in services, such as prescribing the same drug twice. Physician gatekeeping means requiring that a plan member get a referral from a primary care physician before being able to see a higher-cost specialist. For more information on utilization (continued...)

may also attempt to limit the use of high-priced or high-utilizing health care providers through their network contracting process. Since the cost sharing is lower for in-network providers, the plan can financially incentivize its members to use lower-cost providers by contracting only with them.[28] Finally, insurers may choose to not cover a particular procedure, use of a technology, or prescription drug.

Generally, utilization management techniques and restrictive benefits became prevalent in the late 1980s, but their use has been waning since the mid-1990s, in the face of strong consumer resistance to anything other than case management, where coordination between providers and evidence based medicine are used to improve outcomes.[29] For example, in the employer group market, enrollment in health maintenance organizations (HMOs), the most restrictive type of plan, dropped from 31% in 1996 to 17% in 2011, while less restrictive preferred provider organization (PPO)/point of service (POS)[30] plans increased from 42% to 65% during the same time period.[31] In the individual (non-group) market, 2009 data from American's Health Insurance Plans (AHIP) indicate that 82.8% of members with single coverage and 72.9% with family coverage elect a PPO/POS plan, with less than 2% electing HMO or similarly restrictive plans.[32]

As the market has moved away from health insurance products with strong utilization management programs and limited provider networks, utilization of health services and prescription drugs has consistently increased every year, as measured in population-based surveys and gross sales figures.[33] These trends in gross measures of service utilization could be explained by increases in the total population or the number of persons that are insured. In other words, per insured member service utilization may not be increasing. However, studies where researchers have had access to claims data and provider payment rates have found that most of the increase in health benefits expenditures, other than certain outpatient procedures and prescription drugs, are attributable to increases in unit prices, not to increases in the utilization per insured member.[34]

(...continued)

management, see T. Wickizer and D. Lessler, "Utilization Management: Issues, Effects, and Future Prospects," *Annual Review of Public Health*, 2002, vol. 23.

[28] J. Zwanziger and G. Melnick, "Can Managed Care Plans Control Health Care Costs?" Health Affairs, Summer 1996, vol. 15, no. 2.

[29] CRS Report R40834, *The Market Structure of the Health Insurance Industry*.

[30] Generally speaking, enrollees in PPO and POS plans have more choice of providers in that they can go out-of-network (OON) and pay more cost sharing than they would for an in-network provider. By contract, HMO enrollees generally would have to pay all or substantially all of the cost for OON services.

[31] Kaiser Family Foundation and Health Research Educational Trust, "Employer Health Benefits 2011 Annual Survey," September 2011.

[32] America's Health Insurance Plans, "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," October 2009.

[33] For example, see Susan M. Schappert and Elizabeth A. Rechtsteiner, "Ambulatory Medical Care Utilization Estimates for 2006," August 2008, available at http://www.cdc.gov/nchs/data/nhsr/nhsr008.pdf; Avalere and the American Hospital Association, "Trends Affecting Hospitals and Health Systems," 2010, available http://www.aha.org/aha/research-and-trends/chartbook/ch3.html; and IMS Health, "Top Therapeutic Classes by U.S. Dispensed Prescriptions," April 2010, available at http://www.imshealth.com/.

[34] Milliman, Inc., "2010 Milliman Medical Index," May 2010, available at http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2010.pdf; T. Reuters, "Trends in Spending for Physician Services Among the Privately Insured, 2004 and 2008," April 2010; M. Bundorf, A. Royalty, and L. Baker, "Health Care Cost Growth Among The Privately Insured," *Health Affairs*, vol. 28, no. 5; and L. Wier, R. Henke, and B. Friedman, "Diagnostic Groups with Rapidly Increasing Costs, by Payer, 2001–2007," June 2010, available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb91.jsp.

Administrative Costs

In addition to paying for medical claims, premiums are expected to cover the operational costs of the insurance company. Health insurance companies generally are complex organizations requiring specialized human resources and information technology to perform the functions of developing, marketing, and operating a health plan or insurance policy. **Table 2** provides a summary review of administrative functions in health insurance plans.

Table 2. Summary of Health Insurance Administrative Functions

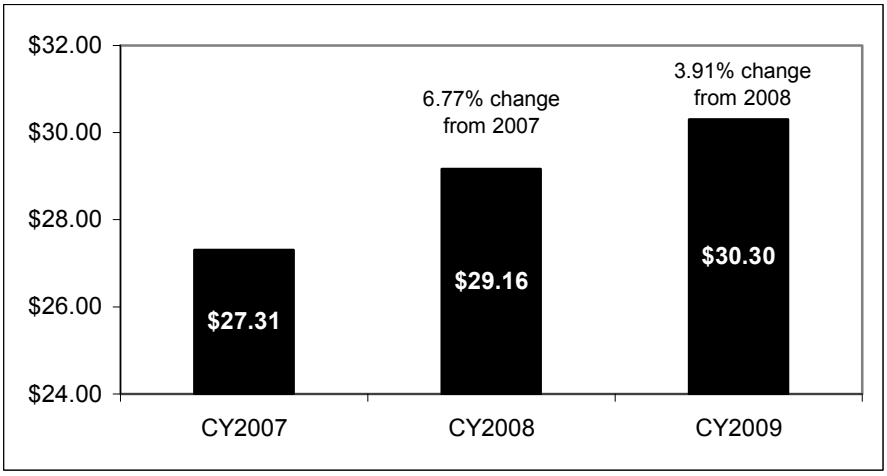
Account and Member Administration	Corporate Services	Marketing and Sales	Provider & Medical Management
Claims processing	Finance and accounting	Market research	Provider contracting
Member enrollment	Actuarial	Advertising	Utilization management
Customer service	Risk management	Sales to employer groups	Quality improvement
Information technology	Legal and compliance	Sales to individuals	Wellness programs
Member communications	Executives/management	Promotions	Pharmacy management
Account management	Governance (Board)	Underwriting	Provider services

Source: Adapted from the work of Sherlock Company on administrative costs in health plans, available at http://www.sherlockco.com/.

Insurance companies report administrative costs, on a per member per month (PMPM) basis, in regulatory filings. Such data indicate a relatively stable trend, with average costs per company increasing about $3 PMPM from 2007 to 2009 (**Figure 3**).

Figure 3. Average Health Insurer Administrative Costs Per Company, 2007-2009

Per Member Per Month



Source: HighlineData's Insurance Analyst Pro database of health insurer regulatory filings.

Notes: Includes 673 different legal entities reporting in all three years with at least 1,000 enrollees. Legal entities with less than 1,000 enrollees were excluded because they typically were startup companies with outlier cost structures. A legal entity refers to an incorporated business licensed to sell insurance. Many large corporate parent organizations have multiple legal entities. For example, Aetna has 16 different companies within this dataset.

However, while *average* administrative costs have been relatively consistent, there is more substantial variation across the companies observed. Specialty firms (e.g., dental only, behavioral health) generally report below $10 PMPM in administrative costs, and companies with an emphasis on non-group insurance often report more than $100 PMPM in such costs. Administrative expenses have been found to vary by market segment, with non-group insurance costing the highest and large group the lowest.[35] This is attributable to factors such as enrollment size. While group plans can sell to multiple individuals (for example, through an employer's human resources department), non-group insurance must be sold one-by-one to each person, thus increase marketing and sales costs.

A company with multiple products generally prices each product separately. As an example from a different industry, a car company does not have one price for each of its vehicles. It charges separate prices for each car model, even if the different models are sold in the same year. Similarly, premium rates are calculated at the health insurance product level (i.e., the health plan or policy that a person, family, or employer purchases), not at the company or corporate parent levels (i.e., the corporate entity that sells the insurance product).[36] So additional variation might be observed within each company if product level data were publicly available.

These data are also limited by the fact that many health insurance companies have multiple non-insurance businesses. For example, the United Health Group (UHG) includes the information technology and consulting firm Ingenix and the pharmacy benefits manager (PBM) Prescription Solutions in addition to its health insurance benefits business segment.[37] The inherent complexity of a large conglomerate may create unique challenges for accurate cost accounting down to the individual plans and insurance products sold within the organization. These challenges could create barriers to fair and comprehensive regulation of administrative costs across different types of health insurance companies (i.e., small local and regional non-profit insurers versus large national investor-owned, for-profit insurers).

There is no consensus benchmark for what is an appropriate amount of administrative costs. Nevertheless, several industry executives of the publicly traded for-profit firms believe that administrative costs can come down as evidenced in the summary of recent earnings conference calls provided in **Table 3**.

[35] Douglas Sherlock, "Administrative Expenses of Health Plans," 2009.

[36] For example, United Health Group is the corporate parent of Golden Rule Insurance Company, which sells several different individual insurance policy products each with their own premium rate calculations. For more information, see Golden Rule Insurance Company, "UnitedHealthOne[SM] Personal Health Insurance Plans for Individuals and Families," 2010, available at https://www.uhone.com/FileHandler.ashx?FileName=38960LC8-G201008.pdf.

[37] Ingenix itself is a conglomerate that includes the health policy firm the Lewin Group and the actuarial consulting firm Reden & Anders. For more information, see United Health Group "Annual Report for the Fiscal Year Ended December 31, 2009," Form 10-K filing with the Securities and Exchange Commission, available at http://www.unitedhealthgroup.com/invest/2009/UNH-2009-10-K.pdf.

Table 3. Quotes from Health Insurance Executives About Administrative Costs

Executive's Name and Organization	Quotes Concerning Administrative Costs
Allen Wise, CEO of Coventry Health Care	*During 2009, we spent time addressing the administrative cost structure for these areas and improvement will continue during 2010. While I can't predict where changes in government involvement will go there are certain things we can and must do everyday. We can better manage our cost structure and we will. This includes both medical and [selling, general, and administrative (SG&A) expenses].*
James Bloem, Senior Vice President and CFO of Humana	*Our cross-functional administrative costs committee has developed processes which assure that these administrative cost reduction efforts are not just one time events, but rather an ongoing source of both improved cost competitiveness and savings-funded initiatives.*
Michael Neidorff, Chairman, President, and CEO of Centene Corporation	*Further [general and administrative (G&A) expense] reduction beyond 2010 remains a top priority, and our ongoing systems investments should enable us to accomplish this goal.*
Angela Braly, Chair, President, and CEO of Wellpoint Inc.	*Another key to our continued success in the future will be the ability to generate even greater administrative efficiency as an organization. We currently have one of the leading SG&A cost structures within our industry, and we have plans and programs in place to further improve upon this position.*
Ronald Williams, CEO of Aetna	*As we go forward in 2011, we understand the need to bring our SG&A down.*

Sources: Allen Wise, "Coventry 4th Quarter 2009 Earnings Call," February 9, 2010, available at http://seekingalpha.com/article/187560-coventry-health-care-inc-q4-2009-earnings-call-transcript?page=-1&find=coventry. James Bloem, "Humana 4th Quarter 2010 Earnings Call," February 7, 2011, available at http://seekingalpha.com/article/251330-humana-s-ceo-discusses-q4-2010-results-earnings-call-transcript. Michael Neidorff, "Centene 4th Quarter 2009 Earnings Call," February 9, 2010, available at http://seekingalpha.com/article/187587-centene-corporation-q4-2009-earnings-call-transcript?page=-1. Wayne DeVeydt, "Wellpoint 4th Quarter Earnings Call," January 27, 2010, available at http://seekingalpha.com/article/184862-wellpoint-inc-q4-2009-earnings-call-transcript?page=-1. Ronald Williams, "Aetna 2nd Quarter 2010 Earnings Call," July 29, 2010, available at http://seekingalpha.com/article/217209-aetna-q2-2010-earnings-call-transcript.

Note: The term "SG&A" means selling, general, and administrative and is reported on the income statement, it is the sum of all direct and indirect selling expenses and all general and administrative expenses of a company.

Health Insurance Company Profits

The average profit margin for the health insurance industry has consistently been low; therefore, profit typically represents the smallest component of health insurance premiums. According to financial data submitted to the NAIC, the average profit margin (net income divided by total revenues) for the health insurance industry was 3.5% in 2010.[38] Because of the membership scale associated with more profitable health insurers, it is unlikely that reductions in net income would have a substantive impact on premiums for individual members. For example, if WellPoint's entire 2010 net income of $2.89 billion were rebated back to its 2010 members, it would result in a monthly credit of $7.22 per member.[39]

[38] National Association of Insurance Commissioners, "Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2010," 2011.

[39] Net income in 2010 of $2,887,100,000 divided by 2010 membership of 33,300,000 equals $86.70 (rounded) divided by 12 months equals $7.22 (rounded) per member per month.

There is substantial variation in health insurance company profits due to differences in the size of the companies, their willingness to aggressively manage health costs, and other business goals of the organization. Wellpoint, a large (33.3 million members) investor-owned, national for-profit company, emphasizes reduced costs and value for its investors.[40] In 2010, Wellpoint had $2.89 billion in net income (profits after taxes). By contrast, Blue Cross Blue Shield of Rhode Island (BCBS-RI), a mid-sized (approximately 600,000 members) non-profit company operating in one state with a community mission, took a $14.1 million loss in 2010.[41]

The Underwriting Cycle

The health insurance underwriting cycle refers to the tendency for health insurance premiums and insurer profitability to cycle over certain time intervals.[42] (This is a different, but related, concept to medical underwriting, which is the process by which an insurer estimates the insurance risks and potential medical costs associated with an applicant for insurance based on characteristics of that applicant.) Upturns and downturns in the underwriting cycle are basically the outcome of adjustments to premiums that reflect past experience, expectations of future losses, business strategy, attempts to mitigate possible impacts of regulatory changes, and the changing demands of plan participants and policyholders (e.g., demand for large and open provider networks). For example, a health insurance company may charge premiums above the anticipated amount necessary for the current plan year's costs because the insurer lost money on the product in previous years. This will start an up cycle in profitability until it prices itself out of the competitive market, thus forcing a cut in premiums and ultimately profit margins. Alternatively, the insurer may have a business strategy to obtain as much market share as possible. To do this, the insurer reduces premiums below competitors, even if it reduces profit margins or results in a temporary loss. Once the insurer commands the desired market share, it increases premiums to achieve the desired maximum profit margin that the market will allow.

Adding to the complexity, the insurance company often may attempt to subsidize one policy or plan with profits from another. To illustrate this, **Table 4** provides an example of one insurance carrier's actual premium and medical loss experience in one state between 2007 and 2009. The table was abstracted from a premium rate increase request for 2010 for individual market blocks of business with and without maternity coverage from Anthem Blue Cross Life and Health Insurance Company (hereafter referred to as "Anthem") submitted to the California Department of Insurance. For the years 2007 through 2009, the table presents the actual per member per month (PMPM) premiums charged, the PMPM claims experience, the medical loss ratio (the percentage of premiums spent on medical claims), the total member months, and the gain or loss on medical expenses by the maternity and non-maternity blocks of business in the individual (non-group) market. Member months are used to reflect enrollment based metrics because individuals can join or leave a plan or policy on a monthly basis. Thus, having a member for 6 months versus the full year (12 member months) would be meaningful in terms of total premiums collected and likely claims experience.

[40] Wellpoint, 2010 Summary Annual Report," April 2011.

[41] Blue Cross Blue Shield of Rhode Island, "2010 Annual Report," March 2011.

[42] See Alice Rosenblatt, "The Underwriting Cycle: The Rule Of Six," *Health Affairs*, vol. 23, no. 6; and R. Kipp, J. Cookson, and L. Mattie, "Health Insurance Underwriting Cycle Effect on Health Plan Premiums and Profitability," April 10, 2003.

Anthem's maternity coverage policies had an operational gain in 2007, with relatively few policyholders (in member months). However, these policies operated at a loss in 2008 and 2009 despite a higher number of policyholders. Based on this trend, Anthem projected nearly a $14.2 million loss for 2010 on the maternity block of business. What are some of the options for Anthem or any other insurance company in a situation like this? It could increase premiums in the maternity coverage policies to $320 PMPM to match expected claims costs PMPM for 2010, but that would be nearly a 74% increase from premiums in 2009. Alternatively, Anthem could eliminate the maternity coverage policies, seek out non-premium sources of revenue (e.g., investment income), aggressively implement managed care methods to reduce costs, or make up for the losses in this product with gains from another product line.[43] The latter option is what is suggested by this data. In other words, losses from the maternity coverage are financially cancelled out for the company by gains from the policies sold without maternity coverage.

Table 4. Anthem Individual Health Insurance Rates for Policies in California

With or Without Maternity Coverage

Coverage	Actual or projected	Year	Premium PMPM	Claims PMPM	Medical Loss Ratio	Member Months	Gain/Loss on Medical Expenses
Maternity Coverage	Actual	2007	$179	$108	60%	12,141	$862,011.00
	Actual	2008	$184	$217	118%	64,348	-$2,123,484.00
	Actual	2009	$184	$268	146%	105,490	-$8,861,160.00
	Projected	2010	$195	$320	164%	113,340	-$14,167,500.00
No Maternity Coverage	Actual	2007	$116	$309	266%	89	-$17,177.00
	Actual	2008	$130	$66	51%	61,271	$3,921,344.00
	Actual	2009	$141	$86	61%	205,371	$11,295,405.00
	Projected	2010	$154	$111	72%	329,486	$14,167,898.00

Source: Anthem Blue Cross Life and Health Insurance Company, "Rate for Individual Policies," submitted to the California Department of Insurance June 30, 2010, available at http://www.insurance.ca.gov/0250-insurers/IndHlthRateFilings/upload/AnthemCHDPPF201002158.pdf.

Notes: The acronym PMPM stands for per member per month. The term "medical loss ratio" means the percentage of premium revenue spent on medical claims. The term "member month" refers to each month of coverage for an enrollee or policyholder, thus a member for a full year would have 12 member months. Gain/Loss on medical expenses refers to the gain or loss experienced from paying medical claims out of premium revenues. This calculation does not involve other financial factors such as administrative costs.

Review of Health Insurance Rates

The regulation of private health insurance has traditionally been under the jurisdiction of the states.[44] Most states have used their regulatory authority over the business of insurance to require the filing of health insurance documents containing rate information for one or more market

[43] Investment income refers to income received from investment assets (before taxes) such as bonds, stocks, mutual funds, loans and other investments (less related expenses).

[44] For additional information about state and federal regulation of private health insurance, see CRS Report RL32237, *Health Insurance: A Primer*.

segments or plan types.[45] Under the Patient Protection and Affordable Care Act (P.L. 111-148, ACA, as amended), the federal government assumed a role in health insurance rate reviews by providing grant funding to states for such reviews and requiring, among other things, that insurers justify rate increases under certain circumstances.

State Rate Filing and Reviews

As the primary regulators of health insurance, states oversee many aspects of the industry concerning the insurance products offered in the market and the entities that sell insurance. One fundamental area in which states exercise regulatory authority is through the imposition of rate and form filing requirements. "Form" refers to the language in the insurance contract and typically is required when a new plan is offered in the market (or changes are made to that plan). "Rate" refers to the price of a unit of insurance.[46] Rates are filed with the initial form and usually must be filed each time an insurance carrier proposes to change rates for a plan (or if changes in the form filing affect rates).

Not all states actually conduct rate reviews. For those states that do, the purpose is threefold: to ensure that rates are sufficient (to guard against insolvency), but not too high (must be actuarially justified), nor unfairly discriminatory (variation in rates must be based on differences in expected claims). There is substantive variation in state regulation of health insurance rates. Some states collect rates for informational purposes only or as part of their form filing requirements. Over half of states have "prior approval" requirements, where insurance companies must file proposed rate changes and the state has the authority to approve, disapprove or modify the request. However, prior approval authority typically also includes a deeming period; if the state does not take any action and the deeming period elapses, the filing become effective. Under such a scenario, prior approval requirements may effectively work just like "file and use." File and use requires insurers to file rates with the state, which become effective either immediately or on a date specified in the filing. Under either of these scenarios, the state may disapprove a rate filing if it does not meet a certain compliance standard, such as a minimum anticipated medical loss ratio. Several states have file and use requirements. One state has "use and file," which means the filing becomes effective when used, though the insurer is required to file rates with the state. (A list of rate filing requirements by state is provided in **Table 5**.)

[45] CRS analysis of state law and regulations from a search of CyberRegs, available at http://www.cyberregs.com/. Also see National Association of Insurance Commissioners, "NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act," May 12, 2010 (hereafter cited as "NAIC Response"). For the purposes of this discussion, the District of Columbia is considered a state. Only Missouri, Montana, and Wyoming have no filing requirements for individual and group plans. Three states (Alabama, Georgia, and Mississippi) require filings for informational purposes only. The term "market segment" generally refers to individual, small group, and large group markets. The term "plan type" generally refers to the way health benefits are provided and financed, such as through indemnity insurance or preferred provider organizations.

[46] In any given state, the rate may vary according to the rating factors allowed by the state. For example, rates in the individual market may be prohibited from varying based on health factors, but may be allowed to vary based on age, sex, or other risk factors. The permissible variation in rates establishes theoretical parameters. The actual premiums charged for a set of insurance policies may not span the spectrum of allowed rates; it depends on who applies and accepts coverage.

Table 5. State Rate Filing Requirements, by Market Segment, 2010

State	No Requirement	File with Form	Information Only	Use and File	File and Use	Prior Approval
Alabama			I, S, L			
Alaska						I, S, L
Arizona	S, L		I			
Arkansas	S, L					I
California					I, S, L	
Colorado						I, S, L
Connecticut						I, S, L
Delaware					I, S, L	
Florida						I, S, L
Georgia			I, S, L			
Hawaii						I, S, L
Idaho	S, L				I	
Illinois	S, L	I				
Indiana					S, L	I
Iowa						I, S, L
Kansas					I, S, L	
Kentucky					I, S, L	
Louisiana					I, S, L	
Maine					I, S, L[a]	
Maryland						I, S, L
Massachusetts	S[b], L[b]					I
Michigan	S, L				I	
Minnesota						I, S, L
Mississippi			I, S, L			
Missouri	I, S, L					
Montana	I, S, L					
Nebraska		S, L			I	
Nevada	S, L				I	
New Hampshire					L	I, S
New Jersey	S[c], L[c]					I
New Mexico						I, S,L
New York[d]					I, S, L[a]	10/1/2010 forward
North Carolina						I, S, L

State	No Requirement	File with Form	Information Only	Use and File	File and Use	Prior Approval
North Dakota						I, S, L
Ohio						I, S, L
Oklahoma		I, S, L				
Oregon					L	I, S
Pennsylvania						I, S, L
Rhode Island						I, S, L
South Carolina	S, L					I
South Dakota	S, L				I	
Tennessee						I, S, L
Texas					I, S, L	
Utah					I, S, L	
Vermont						I, S, L
Virginia			S, L			I
Washington						I, S, L
West Virginia						I, S, L
Wisconsin				I, S, L		
Wyoming	I, S, L					
Washington D.C.						I, S, L

Sources: National Association of Insurance Commissioners (NAIC), "State Rate Filing Requirements by Market Segment ," February 2009; National Association of Insurance Commissioners, "NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act," May 12, 2010; and New York State, Office of the Governor, "Governor Paterson Signs Landmark Health Insurance Reform Legislation," June 9, 2010.

Notes: I – Individual Market. S – Small Group Market. L – Large Group Market. "Form" refers to the language in the insurance contract and typically is required when a new plan is offered in the market (or changes are made to that plan). Rates are filed with the initial form and usually must be filed each time an insurance carrier proposes to change rates for a plan, but the rates are generally not reviewed. "Informational" refers to rate filing requirements where the data is collected and kept by the state, but is not reviewed. "Use and file" means the filing becomes effective when used, though the insurer is required to file rates with the state, which may be reviewed retrospectively. "File and use" refers to requirements where the insurer must file rates with the state, which become effective either immediately or on a date specified in the filing. File and use state may review the rates retrospectively after the effective date. In this case, states usually base their review on claims and financial data submitted by the insurer to examine if the rates were appropriate for the actual claims experience. "Prior approval" refers to requirements where insurers must file rates with the state, and the state has the authority to approve the filing or disapprove it before the effective date. NAIC rate review information is for the 50 states and the District of Columbia.

a. If insurer does not meet medical loss ratio standards, the rate filing is subjected to prior approval.

b. Insurers must still provide actuarial certification.

c. State imposes medical loss ratio requirements.

d. On May 9, 2010, then and now former New York Governor David A. Paterson signed into law Governor's Program Bill No. 278, which reinstates the New York State Insurance Department's former authority to review and approve health insurance premium increases before they take effect. The law applies to all rate increases taking effect on or after October 1, 2010.

Limits on publicly accessible rate review data make comprehensive uniform comparisons between states elusive. Only 13 states have public Internet access to rate filings or summary statistics on rates.[47] Moreover, there is considerable variation in how states with rate review regulations make their information public. For example, the Maine Bureau of Insurance posts rate filings only for insurers that are called to present their requested increase at a public hearing, whereas the Oregon Insurance Division publicly provides a list of average rate increase requests and approvals by regulated entities and provides access to individual rate filings and approvals.[48]

In terms of approvals of rate increases, there is considerable variation between states. For example, Oregon approved 68.3% of recent requested rate increases, whereas Massachusetts approved only 14.2%.[49] These differences are likely due to both differences in regulatory standards, geographic variation in health insurance markets, health services utilization patterns, and health provider payment rates. The available public information suggests that states approve, adjust, or reject requests for rate increases primarily based on an analysis of cost trends in relation to rate increases approved in prior years, and that the approved rates can be double-digit percentage increases from the previous year.[50] To illustrate, consider the case of Regence Blue Cross Blue Shield of Oregon, which requested an average annual increase of 26.4% for its individual health plans but was approved for a 17.3% increase effective January 1, 2010.[51] Despite medical costs increasing 12.6% from the prior year and a financial loss of 9.7% ($15,476,565) on these policies over the period of May 1, 2008, through April 30, 2009, Oregon decided that the lower rate increase was appropriate because Regence had received an approved average rate increase of 26.5% on the same policies for the previous year.[52] By contrast, Health Net Health Plan of Oregon's individual health plans requested and received a significant average annual rate increase of 22.8% effective on October 1, 2009.[53] Oregon believed that the increase was justified because Health Net lost money on these policies each year between 2005 and 2008

[47] Those states are CO, CT, FL, IL, ME, NE, NJ, NC, OH, OR, PA, RI, and WI. See "NAIC Response."

[48] Maine Bureau of Insurance, "Filings," May 14, 2010, available at http://www.maine.gov/pfr/insurance/filings/filings.htm; and Oregon Insurance Division, "Summary of Recent Rate Request Decisions," May 11, 2010, available at http://insurance.oregon.gov/insurer/rates_forms/health_rate_filings/rate-request-summary.pdf. The Oregon Health Rate Filings and Public Comments database is available at http://www4.cbs.state.or.us/ex/ins/filing/.

[49] Oregon Insurance Division, "Summary of Recent Rate Request Decisions," May 11, 2010, available at http://insurance.oregon.gov/insurer/rates_forms/health_rate_filings/rate-request-summary.pdf; and Massachusetts Office of Consumer Affairs and Business Regulation, Division of Insurance, "Patrick-Murray Administration's Division of Insurance Announces Decision on Rate Increase Submissions from Health Insurers," April 1, 2010, available at http://www.mass.gov/?pageID=ocapressrelease&L=1&L0=Home&sid=Eoca&b=pressrelease&f=20100401_hirates&csid=Eoca.

[50] CRS analysis of Colorado Department of Regulatory Agencies, "Annual Report of the Commission of Insurance to the Colorado General Assembly on 2009 Health Insurance," April 1, 2010; Florida Office of Insurance Regulation, "Accident & Health Rate Change Summary 2010 Year to Date," May 03, 2010; North Dakota Insurance Department, "Blue Cross Blue Shield of North Dakota's (BCBS) rate increases requested and approved since 2001," April 9, 2010, available at http://www.nd.gov/ndins/uploads/resources/583/bcbs-chart-web.pdf; Oregon Department of Consumer Business and Services, "Health Insurance in Oregon," January 2010; and Rhode Island Health Insurance Commissioner, "Rate Factor Decisions Announced," March 18, 2010, available at http://www.ohic.ri.gov/2010%20RateFactorReview.php.

[51] Oregon Insurance Division, "Rate Filing Decision Summary Regence BlueCross BlueShield of Oregon Individual Health Insurance," November 13, 2009, available at http://insurance.oregon.gov/insurer/rates_forms/health_rate_filings/health-rate-filing-search.html.

[52] Ibid.

[53] Oregon Insurance Division, "Rate Filing Decision Summary Health Net Health Plan of Oregon, Inc. Individual Health Plans," July 24, 2009, available at http://insurance.oregon.gov/insurer/rates_forms/health_rate_filings/health-rate-filing-search.html.

(in aggregate $1,436,505) and it had received average rate increases less than the average increase in medical costs for four of the past five years.[54]

Federal Rate Review Under ACA

The Patient Protection and Affordable Care Act (P.L. 111-148, ACA, as amended) includes provisions to increase transparency of proposed rate increases, but it does not go as far as to include a formal approval process for proposed increases. Specifically, the Health and Human Services (HHS) Secretary must, in conjunction with the states, establish a process for the annual review of "unreasonable" increases in rates for health insurance coverage beginning in the 2010 plan year.[55] The term "unreasonable" is not defined by the law and presents a challenge in preventing unintended consequences such as providing additional market leverage to large, national for-profit companies over small, local non-profit insurers.[56] The complexity of making such a determination generally requires analysis of multiple factors by actuaries and accountants. Such a review generally does not lend itself to the use of simplistic benchmarks such as merely prohibiting double-digit percentage rate increases. As the National Association of Insurance Commissioners (NAIC) notes:

> The process should identify "potentially unreasonable" increases, with further review by states and/or the HHS Secretary to determine any mitigating or exacerbating factors and decide whether the increase is actually unreasonable. Any increase that is necessary to avoid a future financial loss on the block of business is usually considered reasonable, unless there are compelling reasons to determine that it is unreasonable. Rates that produce a financial loss can affect consumers by impairing the financial soundness of the insurer, reducing the insurer's incentive to provide good customer service, reducing the insurer's incentive to continue providing coverage and shifting costs to other blocks of business.[57]

Health insurance issuers will be required to submit to the HHS Secretary, and the relevant state, a justification for an unreasonable premium increase prior to implementation of the premium, and the HHS Secretary will publicly disclose the information.[58] The justification requirement does not provide the HHS Secretary with the authority to prohibit the plan from implementing the rate increase. In other words, this is a "sunshine" provision designed to publicly expose premium increases determined to be unreasonable. On December 23, 2010, the HHS Secretary issued a notice of proposed rulemaking for the ACA rate review provisions, with a comment period ending

[54] Ibid.

[55] §1003 ACA: §2794(a) Public Health Service Act (PHSA). On April 14, 2010, the HHS Secretary issued a public request for information on the provisions at §2794 PHSA including defining the term "unreasonable," available at http://edocket.access.gpo.gov/2010/2010-8600.htm.

[56] Wall Street analysts at Credit Suisse stated that they "believe winners and losers will emerge in managed care. Winners will have access to public-equity capital and invest strategically to offset margin compression by taking market share from 1,200 insurers that may not survive." See Investors' Soapbox PM, "Healthy Picks in Managed Care: Credit Suisse likes UnitedHealth Group, WellPoint, Coventry and Humana," August 17, 2010.

[57] See "NAIC Response."

[58] §1003 ACA: §2794(a)(2) PHSA. Per §2791(b)(2) PHSA, the term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a state and that is subject to state law which regulates insurance within the meaning of Section 514(b)(2) of the Employee Retirement Income Security Act of 1974. The term does not include a group health plan, which includes self-insured plans. The term "self insured" refers to group benefits plans (usually sponsored by employers) that take on the insurance risk, rather than contracting with an insurance company to take on the insurance risk (fully insured plans).

February 22, 2011.[59] The HHS Secretary proposes that when the average increase, alone or in combination with prior increases in the preceding 12-month period, is 10% or more then the rates will be subject to more review to determine if they are unreasonable. The proposed regulation stipulates that HHS would be adopting a state's determination of what an unreasonable rate increase is if the state has an effective rate review program. The proposed regulation specifies that a state's rate review program would be considered effective if the state has the legal authority to obtain the data and documentation necessary to conduct an effective examination. Further, the state must have the ability to review the data and documentation submitted in support of the proposed rate increases, including an examination of the reasonableness of the actuarial assumptions used by the insurer, the validity of historical data underlying the assumptions, and the insurer's accuracy with past projections. If the state does not have an effective rate review program, the Secretary proposes that HHS would conduct the review. HHS would determine that a rate increase is unreasonable if:

- **The rate increase is excessive.** The premium charged would be considered excessive if it is unreasonably high in relation to the benefits provided. HHS would consider if the rate increase results in a projected future loss ratio below the medical loss ratio standard required under Section 2718 of the PHSA. HHS would also consider if any of the assumptions on which the rate increase is based are not supported by evidence or do not support an increase of the magnitude being proposed.
- **The rate increase is unjustified.** Health insurance issuers would be required to provide certain data and documentation to HHS supporting the proposed rate increase. If the data and documentation submitted are incomplete or inadequate then the proposed increase would be determined to be unreasonable.
- **The rate increase is unfairly discriminatory.** A proposed rate increase would be unfairly discriminatory if it results in premium differences within similar risk categories that are not permissible under applicable state law or, if no state law applies, do not reasonably correspond to differences in expected costs.[60]

To support the premium rate review process, ACA requires the HHS Secretary to carry out a program of grants to the states. These grants have an appropriation of $250 million for states to use during the five-year period beginning with FY2010.[61] On August 12, 2010, HHS announced that 42 states and the District of Columbia were awarded $43 million in grants during the first cycle of funding. On February 24, 2011, HHS announced a second cycle of funding of approximately $200 million, for which states will be given multiple opportunities to apply for funds. "On September 20, 2011, HHS awarded $109 million to 28 States and the District of Columbia."[62]

[59] 75 FR 81004-81029.

[60] A "risk category" is a classification of a group of insured individuals who share common characteristics, such as age or geographic location, and are covered under a single insurance product.

[61] §1003 ACA: §2794(c) PHSA.

[62] HHS, "Rate Review Works: Early Achievements of Health Insurance Rate Review Grants," September 2011, p. 3, available at http://www.healthcare.gov/law/resources/reports/rate-review09202011a.pdf.

Final Rule on Rate Review

CMS published the final rule implementing the rate review provisions in ACA in the *Federal Register* on May 23, 2011.[63] The final rule clarifies which proposed rate increases would be subject to review (i.e., defining "unreasonable" rate increase), establishes a process for rate review to be conducted either by the state or CMS, and specifies notice requirements to inform the public about the process and outcome of the rate reviews. The final rule also includes a comment period,[64] for which it solicits comments on whether individual and small group health coverage sold through associations should be subject to ACA's rate review requirements.

The final regulations implementing the ACA rate review provisions are not intended as a substitution for existing and future state review of rates. Throughout the final rule, CMS refers to the ongoing authority of states to impose filing requirements and conduct their own review of rates.

Definition of "Unreasonable" Rate Increase

Beginning on or after September 1, 2011, a proposed rate increase will be tentatively considered unreasonable, and therefore subject to review under ACA, if the increase either is 10% or more (over a 12-month period beginning on September 1), or meets or exceeds the state-specific threshold (applicable to a 12-month period beginning on September 1). The 10% threshold is for transitional purposes only, until the state-specific thresholds are established. In developing a state-specific threshold, the HHS Secretary will consult with a state and may review relevant information provided by other stakeholders. The rate review process (described below) will determine whether or not the proposed rate increase is unreasonable, and relevant information about each review conducted will be published online.

Preliminary Justification

For each proposed rate increase subject to review, a health insurance issuer must submit a Preliminary Justification, which is composed of the following:

- Part I—a summary of the proposed rate increase, including claims experience, utilization and cost trend projections, changes in benefits, claims and non-claims costs, current and projected premiums, and a three-year history of rate increases for the insurance product.
- Part II—a justification for the rate increase, including description of data and assumptions used, explanation of primary factors driving rate increase, and description of overall experience of the insurance product, including expenses and loss ratios.
- Part III—a rate filing document. (Instructions regarding the compliance with Part III will be provided through CMS guidance.)

[63] Rate Increase Disclosure and Review, *Federal Register*, Vol. 76, No. 99, May 23, 2011.

[64] The comment period ended on July 18, 2011.

Parts I and II must be submitted to CMS and the applicable state (in a state that already has a mechanism in place to accept rate submissions from issuers). Part III must be submitted to CMS. In addition to the data and documentation components described above, CMS may request additional information if the insurer's submission is insufficient for making a determination. Parts I and II will be posted on the CMS website, with a disclaimer that describes the purpose of the Preliminary Justification. CMS also will provide information through its website regarding the process by which the public may submit comments on the rate reviews that CMS conducts.

Rate Reviews Conducted by State or CMS

Reviews of the proposed rate increases will be conducted either by a state or CMS.

A state will conduct the review if it has an "Effective Rate Review Program" (described below), and it discloses to CMS its analysis for making the determination whether or not a rate increase is actually unreasonable. CMS will accept the state's determination and post the state's decision online. If the rate is determined to be unreasonable and the issuer is allowed under law to implement the proposed increase, CMS will provide the state's determination and explanation to the relevant issuer.

CMS will conduct the review if the state does not have an Effective Rate Review Program. Under this scenario, CMS will apply three tests to determine whether a proposed rate increase is unreasonable or not:

- Is it excessive? Will the proposed increase lead to premiums that are unreasonably high in relation to the benefits provided?
- Is it unjustified? Are the data and documentation provided by an issuer incomplete, insufficient, or otherwise lacking in relevant information that reasonableness of the proposed rate increase may not be determined?
- Is it unfairly discriminatory? Will the proposed rate increase lead to premium differences among insureds that share similar risk profiles that either are not allowed under state law, or do not comport with differences in expected costs?

After completion of each rate review, CMS will post its final determination on its website and provide explanation to the relevant issuer.

As discussed above, a state will conduct the rate review if it has an Effective Rate Review Program. CMS will evaluate (and may re-evaluate) whether a state has such a program in place, according to the following criteria:

- The state collects data and documentation from issuers that are sufficient enough to examine (1) the validity of assumptions used to develop the proposed rate increase, and (2) past projections and actual experience.
- The state conducts effective, timely reviews of such data and documentation.
- The state's review process includes the examinations described above, which takes into account factors specified in the rule that may impact rates (factors such as medical trend, benefit and cost-sharing changes, and others).
- The state's review of rates is based on statutory or regulatory standards.

A state with an Effective Rate Review Program will be required to publish on its website Parts I and II of the Preliminary Justification for proposed rate increases. Moreover, the state must establish a mechanism to receive comments from the public regarding those proposed increases.

CMS reviewed all available state regulatory documentation and met with state insurance regulators to determine if a state had an Effective Rate Review Program. As of July 1, 2011, 40 States, the District of Columbia, and the U.S. Virgin Islands have effective review for all insurance markets and issuers (see **Table 6**).

Table 6. States Determined by CMS to have an Effective Rate Review Program

December 9, 2011

State	Effective Rate Review Program for Individual Market	Effective Rate Review Program for Small Group Market
Alabama	No	No
Alaska	Yes	Yes
Arizona	No	No
Arkansas	Yes	Yes
California	Yes	Yes
Colorado	Yes	Yes
Connecticut	Yes	Yes
Delaware	Yes	Yes
District of Columbia	Yes	Yes
Florida	Yes	Yes
Georgia	Yes	Yes
Hawaii	Yes	Yes
Idaho	Yes	Yes
Illinois	Yes	Yes
Indiana	Yes	Yes
Iowa	Yes	Yes
Kansas	Yes	Yes
Kentucky	Yes	Yes
Louisiana	No	No
Maine	Yes	Yes
Maryland	Yes	Yes
Massachusetts	Yes	Yes
Michigan	Yes	Yes
Minnesota	Yes	Yes
Mississippi	Yes	Yes
Missouri	No	No
Montana	No	No

State	Effective Rate Review Program for Individual Market	Effective Rate Review Program for Small Group Market
Nebraska	Yes	Yes
Nevada	Yes	Yes
New Hampshire	Yes	Yes
New Jersey	Yes	Yes
New Mexico	Yes	Yes
New York	Yes	Yes
North Carolina	Yes	Yes
North Dakota	Yes	Yes
Ohio	Yes	Yes
Oklahoma	Yes	Yes
Oregon	Yes	Yes
Pennsylvania	Yes	No
Rhode Island	Yes	Yes
South Carolina	Yes	Yes
South Dakota	Yes	Yes
Tennessee	Yes	Yes
Texas	Yes	Yes
Utah	Yes	Yes
Vermont	Yes	Yes
Virginia	Yes	No
Washington	Yes	Yes
West Virginia	Yes	Yes
Wisconsin	Yes	Yes
Wyoming	No	No
American Samoa	No	No
Guam	Yes	Yes
Northern Marianas Islands	No	No
Puerto Rico	Yes	Yes
Virgin Islands	Yes	Yes

Source: Center for Consumer Information & Insurance Oversight, Centers for Medicare and Medicaid Services, "List of Effective Rate Review Programs," December 9, 2011.

Final Justification

Upon receipt of a determination that a proposed rate increase is unreasonable, the health insurance issuer may:

- Decline to implement the proposed increase or choose to implement a smaller increase. The issuer must notify CMS of either action. However, if the smaller rate increase still meets or exceeds the applicable threshold, the issuer must submit a new Preliminary Justification for that smaller proposed increase.

or

- Implement the rate increase that was determined to be unreasonable, if allowed under law. In this case, the issuer must (1) submit Final Justification to CMS (which will be posted on the CMS website for three years), (2) post on the issuer's website: Parts I and II of the Preliminary Justification, the determination and explanation from the rate review conducted by the state or CMS, and the issuer's Final Justification; and (3) make this information available on the issuer's website for at least three years. The Final Justification must be consistent with the Preliminary Justification in terms of the information submitted to justify the rate increase.

CMS Impact Analysis

The final rule includes analysis conducted by CMS on the potential impact of the rule on health insurance issuers and enrollees, rate filings, and administrative costs. Those analyses are summarized below.

Given that the rate review requirements apply to all individual and small group coverage (with the exception of grandfathered health plans),[65] CMS collected and analyzed data on the number of insurance carriers that offer products in those markets, many of which operate in both the individual and small group markets. CMS estimated that 417 issuers potentially would be impacted by the rate review requirements. By market segment, 311 issuers could be affected in the individual market; 342 issuers in the small group market. With respect to enrollees, this would translate to nearly 35 million enrollees potentially affected by rate review (approximately 11 million in the individual market and 24 million in the small group market).

CMS also estimated the number of rate filings that potentially would be subject to review and require justification, and developed low-, middle-, and high-range estimates for both the individual and small group markets.

- For 2011, CMS estimated the number of rate filings in the individual health insurance market that would be subject to review and require the submission of a justification report could range from a low of 279 filings to a high of 819 filings. These estimates represent 40%-67% of all filings in the individual market for 2011.
- For the small group market, CMS estimated a low of 189 filings could be subject to review and require justification, and a high of 940 filings. These estimates represent 20%-32% of all filings in the small group market for 2011.

[65] Grandfathered health plans are group health plans and health insurance coverage (including coverage from the individual health insurance market) in which at least one person was enrolled since the date of ACA's enactment (March 23, 2010). Grandfathered plans are exempt from a majority of ACA's market reforms. For additional information about grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)*.

CMS also estimated the potential administrative costs to issuers related to rate review under ACA. Similar to the analysis on the number of affected rate filings, CMS developed low-, middle-, and high-range estimates of potential administrative costs, based on the 417 issuers estimated to be affected by the rate review requirements (see above). **Table 7** displays the estimated costs for developing and providing justification reports, retention of records, and online notification requirements (as discussed in the final rule).

Table 7. Estimated Administrative Costs to Issuers Related to the Rate Review Provisions in ACA, Year One

	Estimated total cost	Estimated average cost per issuer
Low-Range Assumptions		
One-Time Costs	$10,425,000	$25,000
Ongoing Costs	561,600	1,347
Total Year One Costs	10,986,600	26,347
Mid-Range Estimates		
One-Time Costs	12,510,000	30,000
Ongoing Costs	2,142,800	5,139
Total Year One Costs	14,652,800	35,139
High-Range Estimates		
One-Time Costs	14,595,00	35,000
Ongoing Costs	5,513,600	13,222
Total Year One Costs	20,108,600	48,222

Source: Rate Increase Disclosure and Review, *Federal Register*, Vol. 76, No. 99, May 23, 2011.

Note: Estimated costs are stated in 2010 dollars. Estimated total cost for all issuers that are responsible for reporting.

Appendix. Private Health Insurance Cost-Sharing

Other Insurance Costs Not Included in the Premium

Health insurance premiums generally represent only a part of the insured individual's or family's costs incurred under a given benefits plan for health services and prescription drugs. While enrollees and policyholders pay premiums irrespective of health service use, they typically are responsible for cost sharing in the form of deductibles, flat dollar co-payments, and/or percentage co-insurance only when services are used.[66] Increased cost sharing has been viewed by some as a method of shifting costs to those who are utilizing the services, thus limiting the shared risk and constraining premium growth.[67] On the other hand, increasing cost-sharing reduces the value of the coverage at the same time premiums are going up. Essentially individuals and families end up paying more for less, due to exposure to higher out-of-pocket costs.

Similar to the observed increases in premiums, cost-sharing expenses have been increasing.[68] Thus, some individuals may be able to afford purchasing the insurance, but not be able to afford the cost of utilizing health care services despite being insured. From a consumer perspective, deductibles have the most impact because coverage does not start until the enrollee spends more than the deductible amount. As illustrated in **Figure A-1**, average deductibles generally have been increasing the past few years, across plan types in both the group and non-group markets. Comprehensive data on other benefit designs such as drug co-payments and hospital co-insurance are not publicly available. However, the Milliman Medical Index estimates that for a typical family of four with private employer group coverage, out-of-pocket cost sharing has increased between 5.4% and 10.5% annually between 2006 and 2010.[69]

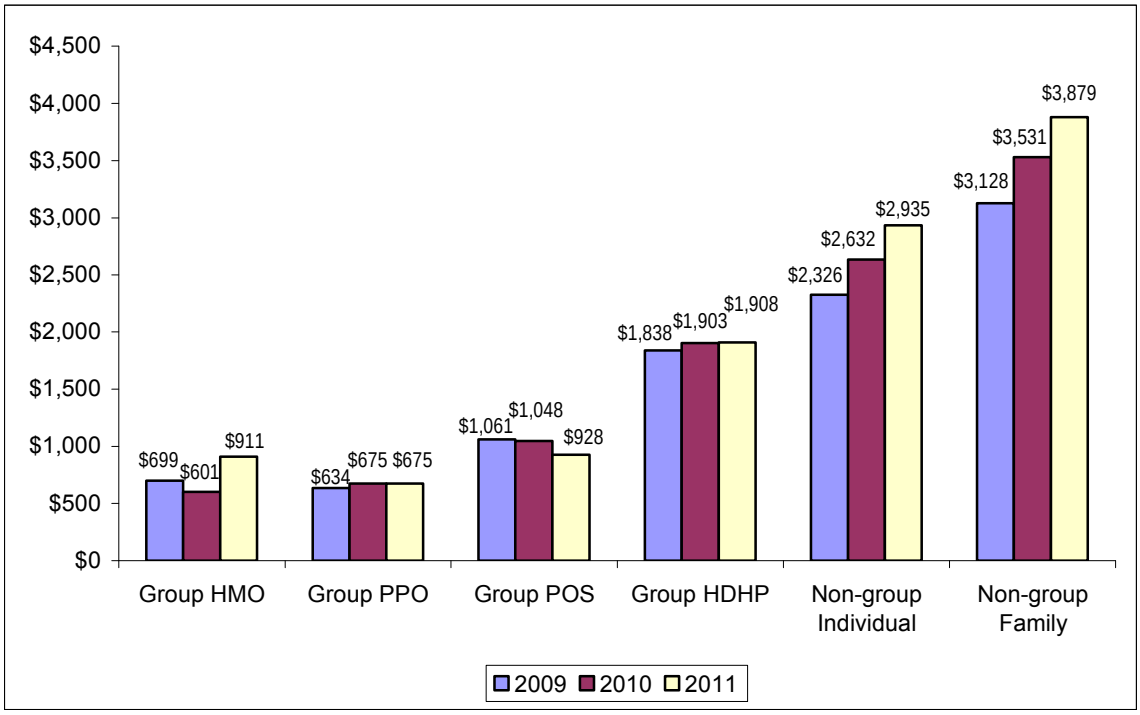
[66] The term "deductible" means a fixed dollar amount during the benefit period that an insured person pays before the insurer starts to make payments for covered medical services. In other words, there is 100% cost sharing until the deductible amount has been reached. (Though some plans may not apply certain services to the deductible requirement, such as well-child visits, to not discourage the use of such services.) The term "flat dollar co-payments" means medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. The term "percentage co-insurance" means of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount was paid. Thus is the co-insurance is 10% and the medical service is $100 then the member or policyholder would pay $10.

[67] T. Bodenheimer, "High and Rising Health Care Costs. Part 1: Seeking an Explanation," *Annals of Internal Medicine*, vol. 142, no. 10, 2010.

[68] J. Gabel et al., "Trends in Underinsurance and the Affordability of Employer Coverage, 2004-2007," *Health Affairs*, Web Exclusive, vol. 28, no. 4.

[69] Milliman Inc., "2010 Milliman Medical Index," May 2010.

Figure A-1. Average Deductibles, by Health Insurance Plan Type, 2009-2011



Source: For group health plans, Kaiser/HRET Survey of Employer-Sponsored Health Benefits available at http://ehbs.kff.org/. For non-group health plans, "The Cost and Benefits of Individual and Family Health Insurance Plans," eHealthInsurance.

Notes: HMO means a health maintenance organization. PPO means a preferred provider plan. POS means a point of service plan. HDHP means high deductible health plan.

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