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Issue Brief

What's Behind Health Insurance Rate Increases?

An Examination of What Insurers Reported to the Federal Government in 2012–2013

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Abstract: The Affordable Care Act requires health insurers to justify rate increases of 10 percent or more for nongrandfathered plans in the individual and small-group markets. Analyzing these filings for rates taking effect from mid-2012 through mid-2013, insurers attributed the great bulk—three-quarters or more—of these larger rate increases to routine factors such as trends in medical costs. Insurers attributed only a very small portion of these medical cost trends to factors related to the Affordable Care Act. The ACA-related factor mentioned most often, but only in a third of the rate filings in this study, was the requirement to cover women's preventive and contraceptive services without patient cost-sharing. But, the insurers who point to this requirement or other ACA-related costs attributed only about 1 percentage point of their rate increases to the health reform law.

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OVERVIEW

Many unhappy things in life are inevitable: death, taxes, and increasing health insurance rates. Perhaps because of their inevitability, each of these misfortunes regularly receives heightened scrutiny. Currently, the issue of increasing health insurance rates is being hotly debated.

The federal government does not regulate health insurance rates, but it is pursuing a policy of transparency that provides more insight into what drives rate increases. Since September 2011, the Department of Health and Human Services (DHHS), under authority from the Affordable Care Act, has required health insurers in the individual and small-group markets to explain the rationale for rate increases of 10 percent or more in their nongrandfathered products. (A nongrandfathered health plan is one that was introduced or that changed substantially after the Affordable Care Act was signed on March 23, 2010.) The federal government does not have authority to refuse insurers' rate increases, but it issues a determination of whether it considers requested increases to be justified in the minority

of states that lack the authority or decline to make this determination themselves.[1]

These explanations provide a valuable resource for understanding the factors that drive large increases in health insurers' rates. In this issue brief, we analyze filings for rate increases of 10 percent or more that took effect between July 2012 and June 2013, and were for products covering at least 150 people. We found that medical costs were the main drivers of these larger increases, based both on increasing use of medical services and higher unit prices. Rising administrative overhead and profits were a much smaller factor, and were much less present in the individual market and among nonprofit insurers. In about half of these rate filings, insurers attributed a portion of the increase to new taxes and benefit mandates under the Affordable Care Act. However, among the insurers that quantified this impact, only about 1 percentage point of their increases were because of ACA-related factors.

Size of Rate Increases

For the year beginning July 2012, the average annual increase requested by insurers in this sample was $648 (Exhibit 1). This represents an average overall rate increase of 19 percent over these insurers' prior-year premiums.[4] The sample includes only insurers in the individual market requesting rate increases of 10 percent or more for nongrandfathered plans covering at least 150 people.

In the small-group market (Exhibit 2), rate increases averaged $729 annually among insurers requesting increases of 10 percent or more for nongrandfathered plans covering at least 150 people. This increase represents an average of 15 percent over these insurers' prior-year premiums.

About this Study

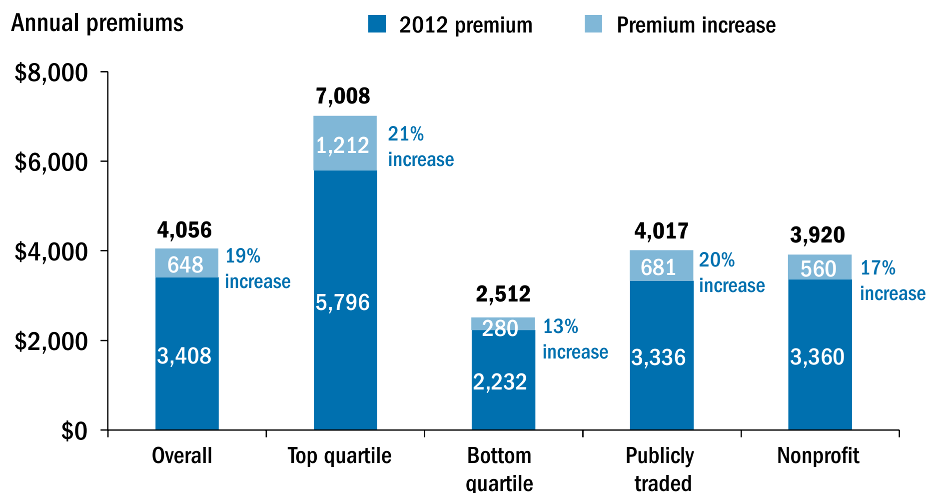
The researchers collected insurer data from the U.S. Department of Health and Human Services that explain:

- why insurers seek rate increases;
- how the increase is allocated across medical services, administrative services, and underwriting gain and loss;
- what kinds of medical services are causing medical claims to increase, specifically, hospital inpatient, outpatient, and professional services, etc.;
- to what extent increases in medical claims are being driven by more services versus the unit cost of services; and
- whether rate increases are being driven by other cost factors, such as changes in covered benefits or patient cost-sharing, complying with new regulations, or making up for incorrect cost predictions in the prior year.

A separate rate-increase filing was required for each nongrandfathered individual or small-group policy that an insurer sells in each state, if the insurer seeks an increase of 10 percent or more.[2] Insurers may pool several similar products into a single rate filing if they differ only by branding or by cost-sharing features, for instance.

We limited the study sample to rate filings with effective dates from July 2012 to June 2013 and enrollment of more than 150 members. This resulted in a final dataset of 163 unique rate filings by 122 insurers in the individual market and 148 filings by 105 insurers in the small-group market.[3] While market share statistics are not readily available, these filings reflect only about 5 percent to 10 percent of the total enrollment in these market segments nationwide.

Exhibit 1. Individual Plan Premium Increases of 10 Percent or More, 2013



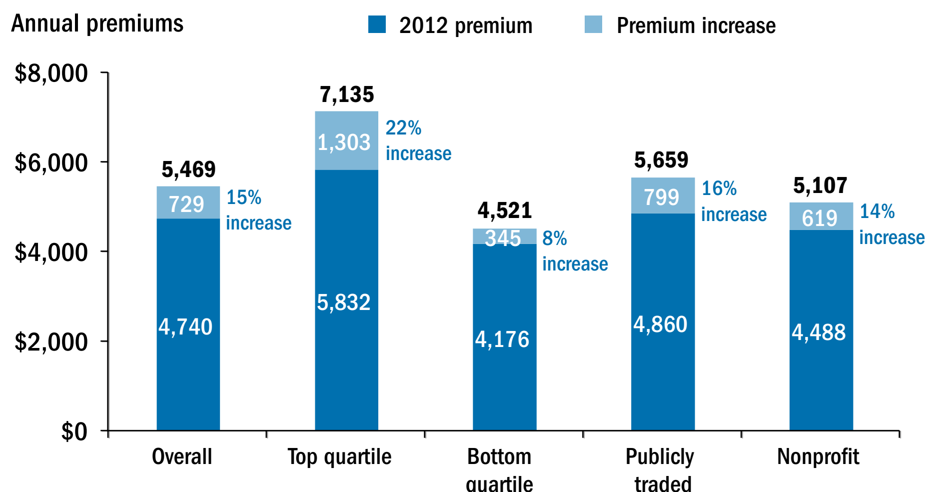
Source: Authors' analysis of Centers for Medicare and Medicaid Services data.

Among the year's sample of 311 filings, Exhibit 3 shows that review was still pending for 196 (63%) as of December 2012 when our data were acquired. The remainder were either reviewed by state or federal regulators, or withdrawn by insurers. Because withdrawal usually occurs in response to regulators' concerns about reasonableness of the rate request, we consider withdrawals similar to negative reviews. Thus, we group the review dispositions into two categories: approved and not approved.

Among 115 resolved filings, regulators approved 79 percent (Exhibit 3). Approval rates did not vary significantly by insurers' corporate traits, such as whether they were nonprofit or publicly traded.

Approved filings accounted for roughly 4 percent to 5 percent of total enrollment in the individual and small-group markets nationally,[5] but these percentages varied widely by state. Twenty states had no approved increases of 10 percent or more in this study sample in either market segment. In other states, products with large rate increases that were approved accounted for less than 1 percent to half or more of total enrollment in the relevant market segments, with the largest market impacts occurring in

Exhibit 2. Small-Group Plan Premium Increases of 10 Percent or More, 2013



Source: Authors' analysis of Centers for Medicare and Medicaid Services data.

Exhibit 3. Regulatory Review of Health Insurers' Rate Increase Filings, 2012–2013

	State Review	Federal Review	Total
Total filings	284	27	311
Pending	174	22	196
Resolved	*110*	*5*	*115*
Approved	91 (83%)	0 (0%)	91 (79%)
Unreasonable	6 (5%)	5 (100%)	11 (10%)
Withdrawn	13 (12%)	0 (0%)	13 (11%)

Source: Authors' analysis of Centers for Medicare and Medicaid Services data.

Connecticut (62% of small-group market); Idaho (48% of individual market); Maine (26% of small-group market); Maryland (41% of small-group market); Ohio and Indiana (38% of individual market); Washington (28% of individual market); and West Virginia (29% of small-group market).

Reasons for Increases

Medical and Administrative Costs

Exhibit 4 shows the medical and overhead cost components of these rate increases. Overall, increased medical expenses accounted for the entire average amount of rate increases requested in the individual market, but only 72 percent of requested rate increases in the small-group market. In the individual market, insurers that filed for larger rate increases reported that the average expected medical costs increased slightly more than the average overall rate increase ($673 vs. $648). Accordingly, individual insurers reduced their overhead for administrative expense and profits by $25 annually per member. In the small-group market, higher administrative expenses and profits each accounted for 14 percent of the premium increase (or a total of 28 percent), on average.

These insurers reported that a quarter (26%) in the individual market to a third (31%) in the small-group market of the projected medical expense increase was attributed to increased use of medical services, while over half (57%–58%) of the average medical expense increase was attributed to higher unit costs for these services.[6] Thus, price rather than utilization of medical care is the larger driver.

Individual insurers attributed 42 percent of increased medical costs to the need to adjust for under-predicting medical costs in the previous rating year, rather than to expected increases in the coming year. In contrast, small-group insurers attributed only 11 percent of their increase, on average, to under-predicting medical costs in the prior year.

Medical costs accounted for the bulk of the increase in both bottom and top quartiles. However, there were some differences by market segment for administrative costs. In the individual market, insurers in the bottom quartile reduced their overhead load by an average of $78, so that their projected medical costs were 28 percent greater than their total rate increase. In the small-group market, administrative costs accounted for a noticeably larger portion of the increase (20%) in the bottom quartile than did profits, which accounted for 8 percent of the increase.

As shown in Exhibit 4, these patterns also differed by insurers' profit status.[7] On average, in the individual market, nonprofit insurers with large rate increases sought increases that were $121 lower than that those sought by publicly traded insurers. Much of this lower increase was attributable to lower adjustments (by an average $126) for underestimating the prior year's medical expenses. In the small-group market, nonprofit insurers requested increases that were, on average, $180 lower than publicly traded insurers. Lower increases in administrative costs and profits—by $144—were primary drivers behind nonprofit insurers' lower overall premium increase relative to publicly traded insurers

Costs Related to the Affordable Care Act

In addition to this quantitative information, the filings include detailed narrative explanations by insurers about the factors driving the rate increases. We next focus on insurers' narrative explanations that relate to the Affordable Care Act. Of the 311 filings in our study sample, half (155) attributed some portion of their rate increase to the ACA's regulatory requirements other than medical-loss ratio rules.[8] The proportion was lower in the individual market (39%) than the small-group market (62%). This finding is somewhat surprising, given that the health reform law is expected to have a greater impact on individual insurance.

Insurers pointed to several different aspects of the Affordable Care Act, but not to guaranteed issue, which requires insurers to issue a health plan to any applicant, or community rating, which bans the practice of charging higher premiums based on health status and other characteristics, because these provisions do not take effect until 2014.

Insurers' filings did, however, identify the ACA provisions relating to preventive and contraceptive services for women. Effective August 1, 2012, all insurers must cover a specified set of benefits, not subject to copayments or deductibles, including: annual check-ups, screening for sexually transmitted disease,

Exhibit 4. Components of Larger Rate Increases, 2012–2013

Individual Market	Overall	n=163	Top Quartile	n=40	Bottom Quartile	n=41	Nonprofit Insurers	n=60	Publicly Traded	n=82
Components of Increase	Annual $ PMPM	% of Total premium/ Medical increase	Annual $ PMPM	% of Total premium/ Medical increase	Annual $ PMPM	% of Total premium/ Medical increase	Annual $ PMPM	% of Total premium/ Medical increase	Annual $ PMPM	% of Total premium/ Medical increase
Requested Premium Increase:	$648		$1,212		$280		$560		$681	
Admin. Expense	$78	12%	$152	13%	$24	9%	$38	7%	$90	13%
Profit	($103)	-16%	($21)	-2%	($102)	-36%	($74)	-13%	($135)	-20%
Medical Expense:	$673	104%	$1,080	89%	$358	128%	$596	106%	$726	107%
Utilization	$172	26%	$297	27%	$67	19%	$160	27%	$164	23%
Unit costs	$381	57%	$624	58%	$188	52%	$315	53%	$414	57%
Other trend factors	$120	18%	$159	15%	$104	29%	$121	20%	$147	20%
Adjust for prior year	$280	42%	$376	35%	$121	34%	$207	35%	$333	46%

Small-Group Market	Overall	n=148	Top Quartile	n=37	Bottom Quartile	n=37	Nonprofit Insurers	n=48	Publicly Traded	n=75
Components of Increase	Annual $ PMPM	% of Total premium/ Medical increase	Annual $ PMPM	% of Total premium/ Medical increase	Annual $ PMPM	% of Total premium/ Medical increase	Annual $ PMPM	% of Total premium/ Medical increase	Annual $ PMPM	% of Total premium/ Medical increase
Requested Premium Increase:	$729	16%	$1,303		$345		$619		$799	
Admin. Expense	$105	14%	$189	14%	$68	20%	$61	10%	$130	16%
Profit	$100	14%	$239	18%	$27	8%	$33	5%	$108	14%
Medical Expense:	$524	72%	$875	67%	$250	72%	$525	85%	$561	70%
Utilization	$162	31%	$246	28%	$88	35%	$176	34%	$184	33%
Unit costs	$303	58%	$517	59%	$149	59%	$327	62%	$276	49%
Other trend factors	$59	11%	$112	13%	$13	5%	$21	4%	$101	18%
Adjust for prior year	$68	11%	$215	25%	($72)	-29%	$140	27%	$61	11%

Note: This sample is based on filings for products with at least 150 members, and effective dates of July 2012–July 2013.
Source: Authors' analysis of Centers for Medicare and Medicaid Services data.

FDA-approved contraceptives, and domestic violence counseling. The extent to which this benefit mandate affects an insurer's rate depends on several factors, such as: whether the insurer previously covered these benefits, with or without patient cost-sharing; whether the state previously allowed insurers to rate men and women separately; and when a particular rating period takes effect.

Accordingly, insurers varied in the extent to which they attributed a portion of their rate increase to the mandate for women's preventive services. Of the 94 filings that mentioned it, 65 specified the actual financial impact, with amounts ranging from zero (in three individual market filings) to 4.5 percent of premium, with a median of 0.8 percent. These financial impact specifications were similar in both market segments.

In their filings, insurers also pointed to two types of taxes or fees that the federal government begins to assess in 2014:[9] an insurance premium tax totaling $8 billion, and a reinsurance assessment of $12 billion, both of which are allocated according to market share. In general, these fees combined are expected to amount to about 2 percent to 3 percent of typical insurers' premiums.[10] These fees apply to policies in effect any time in 2014, rather than only at the point that they are renewed in 2014. Therefore, these fees variably impact rate filings that take effect in 2013.

Of the 116 filings that took effect in 2012, only 3 percent mentioned these fees, whereas over a quarter (29%) of the rate filings that took effect in 2013 did. Also, most of the 2012 filings that mentioned the fees specified a tiny impact (0.1% of premium), whereas the 2013 filings specified impacts as high as 2.9 percent, with a median of 1.5 percent of premium.

In addition to these specific provisions, several insurers pointed to more general impact related to the law. Several filings (mostly by Humana and Cigna) noted that provisions that became effective earlier, such as covering children until age 26 and increasing caps on lifetime and annual limits, contributed to a portion of the medical cost trend in this subsequent year. One national insurer (United Healthcare and its affiliates Oxford Health Plans and Golden Rule) with 30 rate filings anticipated future effects of the law: it attributed a portion of its increase to concerns that the law will reduce provider payments under Medicare and Medicaid, causing providers to increase the amount they charge privately insured patients. This insurer did not state that such cost-shifting had already happened, and recent literature questions the extent to which it tends to occur.[11]

Overall, the Affordable Care Act's benefit mandates and insurer fees had only a minor effect on insurers' larger rate increases prior to 2014. Although half of these filings attributed some part of their increase to the ACA, half did not. More important, the impact was small. Even combined, the effect of these provisions ranged from about 3 percent to one-third of a percent with a median of 1 percent among those insurers specifying any impact and excluding high and low outlier values.

Policy Implications

Rate increases of 10 percent or more by insurers with more than 150 members averaged 15 percent in the small-group market and 19 percent in the individual markets for annual rates taking effect from mid-2012 through mid-2013. These larger rate requests affected fewer than 10 percent of the people in these market segments, and approved increases affected fewer than 5 percent of subscribers, nationally. These averages varied widely, however, among states and across quartiles of the insurance market.

In general, insurers attributed the great bulk—three-quarters or more—of their larger rate increases to routine factors like increased utilization of medical services and rising medical care prices. This was true both in the top quarter and bottom quarter of these rate filings. Insurers attributed only a very small portion of these medical cost trends to factors related to the Affordable Care Act. The ACA-related factor mentioned most often, but only by a third of the rate filings in this study, was the requirement to cover women's preventive and contraceptive services without patient cost-sharing. But, the insurers pointing to this benefit

mandate attributed roughly only a 1 percentage point increase to this new cost. Some insurers attributed a portion of their rate increases to ACA provisions that took effect in prior years, such as increasing caps on lifetime and annual limits.

About half of the rate filings that took effect in 2013 attributed a portion of their increase to the new taxes and fees imposed by the law starting in 2014. However, some insurers attributed a full year's worth of these fees, amounting to about 3 percent of premiums, even though their rate filing covered only a few months of 2014.

Nongrandfathered insurance policies in the individual and small-group markets that take effect or renew starting January 1, 2014, will be subject to several major regulatory provisions, including guaranteed issue, community rating, and essential health benefits. Starting in 2014, insurers also will be required to report all nongrandfathered rate increases—not just those amounting to 10 percent or more—in the individual and small-group markets. These rate filings will be a valuable source of information about the extent to which these new market rules affect insurance rates.

Notes

[1] The Henry J. Kaiser Family Foundation, "Quantifying the Effects of Health Insurance Rate Review" (Menlo Park, Calif.: Kaiser Family Foundation, Oct. 2012); and Center for Consumer Information and Insurance Oversight, *2012 Annual Rate Review Report: Rate Review Saves Estimated $1 Billion for Consumers* (Washington, D.C.: Centers for Medicare and Medicaid Services, Sept. 11, 2012).

[2] Some insurers also appear to have filed rate increases for grandfathered plans, but there is no clear indication in the dataset which ones these are, so we analyze all federal rate increase filings, recognizing that rates for many nongrandfathered products are not included.

[3] We combined rate filings by each insurer within a state when the filings had identical rate increases and medical costs, since this indicates the filings probably cover products in the same rating pool that are being sold under different names or product types (e.g., PPO vs. HMO or HSA vs. non-HSA). We also treated Time Insurance and John Alden Insurance as the same company within the same state, since they are both owned by Assurant Health and their filings were identical to each other in each of 14 states. Of the 122 individual market insurers, 82 filed for one unique product, 31 had two filings (either for separate products, or different filings for the same product), six insurers had three filings, three insurers had four filings, and one issuer filed for five products in the individual market. Of the 105 insurers in the small-group market, 69 filed for one unique product, 28 had two filings (either for separate products, or different filings for the same product), 10 insurers had three filings, four filed for four products, and one filed for five small-group products.

[4] The bottom quartile average is lower than the 10 percent filing threshold because it reflects the premium average over the course of a year rather than the highest premium during the year, and some insurers increase premiums quarterly rather than once a year.

[5] These are only rough estimates because total market size was determined from 2011 data. Also, note that insurers must report large rate increases only for nongrandfathered products, but we do not have data on the market size for grandfathered products. Therefore, our market share figures substantially underestimate the total number of commercially insured people affected by rate increases of 10 percent or more.

[6] The remaining portion (11%–18%) was attributed to other cost factors such as changes in patient cost-sharing and in covered benefits.

[7] We based each insurer's profit status on the status of its parent organization, in situations where the two differed.

[8] We do not include insurers' mentions of the ACA's medical loss ratio regulation because its main effect is to reduce rather than increase rates, by limiting insurers' overhead profits and administrative costs.

[9] In addition to these two, the ACA also imposes a fee of $1 per person in 2012 and $2 per person in 2013 to fund comparative effectiveness research.

[10] There are important variations based on nonprofit status, and based on particular market segments such as Medicaid. See M. Doucet and J. Yahnke, *ACA Health Insurer Fee: Estimated Impact on the U.S. Health Insurance Industry* (Brookfield, Wis.: Milliman, April 2012).

[11] C. White, "Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates," *Health Affairs,* May 2013 32(5):935–43.

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