



What's Behind Health Insurance Rate Increases? An Examination of What Insurers Reported to the Federal Government in 2013–2014

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Abstract The Affordable Care Act requires health insurers to justify rate increases that are 10 percent or more for nongrandfathered plans in the individual and small-group markets. Analyzing these filings for renewals taking effect from mid-2013 through mid-2014, this brief finds that the average rate increase submitted for review was 13 percent. Insurers attributed the great bulk of these larger rate increases to routine factors such as trends in medical costs. Most insurers did not attribute any portion of these medical cost trends to factors related to the Affordable Care Act. The ACA-related factors mentioned most often were nonmedical: the new federal taxes on insurers, and the fee for the transitional reinsurance program. On average, insurers that quantified any ACA impact attributed about a third to these new ACA assessments.

OVERVIEW

The Affordable Care Act requires health insurers in the individual and small-group markets to explain their rationale for premium rate increases of 10 percent or more for 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 from July 2013 to June 2014 and were for products covering at least 150 people. Medical costs were the main drivers of these increases, including both increased use of medical services and higher unit prices. Rising administrative overhead and profits were a smaller factor. In most of these rate filings, which were submitted just before the major provisions of the Affordable Care Act took effect, insurers attributed a portion of the increase to new taxes and fees under the law. However, among the insurers that quantified this impact, less than 5 percentage points of their increases were because of these ACA-related factors.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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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 greater than 10 percent;
- how the increase is allocated across medical services, administrative services, and underwriting gains and losses;
- whether rate increases are being driven by regulatory factors, such as new mandated benefits or governmental taxes and fees.

An insurer must submit a separate rate filing for each nongrandfathered individual or small-group policy that requests an increase of 10 percent or more. 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 2013 to June 2014 and enrollment of more than 150 members. This resulted in a final dataset of 47 unique rate filings in the individual market and 66 in the small-group market.² It is important to note that these filings do not cover the new “ACA-compliant” policies that insurers began to sell in 2014. Because those are new policies, they were not subject to the requirement to justify rate increases.

SIZE OF AND REASONS FOR RATE INCREASES

For the year beginning July 2013, the average annual increase submitted for review by individual-market insurers was \$395, and the average for small-group insurers was \$616 (Exhibit 1). (These averages reflect only rate increases of more than 10 percent.) In each market, this represented an average overall rate increase of 13 percent over these insurers’ prior-year premiums.

Exhibit 1. Components of Requested Rate Increases Greater Than 10 Percent, July 2013–June 2014

Component of increase	Individual market (n=47)		Small-group market (n=66)	
	Average annual \$	% of increase	Average annual \$	% of increase
Requested premium increase:	\$395		\$616	
Administrative expense	\$76	19%	\$153	25%
Profit	(\$11)	-3%	(\$18)	-3%
Medical expense:	\$330	83%	\$482	78%
Utilization	\$108	27%	\$190	31%
Unit costs	\$132	33%	\$248	40%
Other trend factors	\$89	23%	\$43	7%

Source: Authors’ analysis of U.S. Department of Health and Human Services data, for plans covering at least 150 people.

Medical and Administrative Costs

Exhibit 1 shows the medical and overhead cost components of these rate increases. Overall, increased medical expenses accounted for more than three-quarters of these requested rate increases. The remainder was attributed to increased administrative expense. In each market segment, insurers with larger rate increases reduced their operating profits slightly.

These insurers reported that the projected increase in medical expenses was attributed to a variety of factors, including greater utilization of services, higher unit costs for these services, and adjusting for underpredicting medical costs in the previous year. Although medical factors differed between the two market segments, in general, medical prices were reported as a stronger driver of medical costs than utilization.

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. In this section, we focus on insurers' narrative explanations that relate to the Affordable Care Act. Of the 113 filings in the study sample, 69 percent attributed some portion of their rate increase to taxes or fees that the federal government began to assess in 2014.³ These include an insurance premium tax totaling \$8 billion and a transitional reinsurance assessment of \$12 billion, both of which were allocated among insurers according to market share. These fees apply to policies in effect any time in 2014, even if the rate increase took effect in 2013. Rates that take effect before 2014 are proportionately less affected by these fees than those that take effect in 2014.

Sixty-three insurance filings quantified the impact of these ACA taxes and fees. Of these, the average full-year rate impact was 4.5 percent—about a third of their overall rate increase on average.⁴ Insurers were fairly consistent in the way they calculated the rate impact of these new assessments.⁵ They attributed about half of the impact to the ACA's new insurance tax and about half to the transitional reinsurance fee, which declines in the subsequent two years and sunsets after three years. Thus, the initial impact of the ACA's permanent insurance tax is less than 2.5 percent.⁶ Insurers are also eligible to receive reinsurance payments for their high-cost claims during 2014, but none of these insurers projected any reduction in claims costs or premium rates based on reinsurance. Overall, the Affordable Care Act's requirements had only a moderate impact on insurers' larger rate increases in 2013 and 2014 for existing coverage.

About half of these filings also mentioned the ACA's regulation of medical loss ratios (MLRs). The ACA requires individual and small-group insurers to spend at least 80 percent of their premiums on medical claims or quality improvement, limiting administrative overhead and profits to no more than 20 percent. Of the 58 filings that mention this aspect of rate setting, about a third were ambiguous regarding the impact of the MLR rule, stating only that they expected to comply with the rule. Thirty-six filings indicated a specific expected medical loss ratio. Of these, about a third—13 filings—targeted the 80 percent limit.⁷ The remaining 23 filings expected to report MLRs of 82 percent or more.

This suggests that the MLR rule is having some restraining effect on larger rate increases. Some insurers appear to be setting their rates as high as they can within the limits of the rule, suggesting that without it they might seek even higher increases. However, only a minority of insurers seeking higher rate increases are doing this.

SUMMARY AND IMPLICATIONS

This study finds that rate increases of 10 percent or more (by insurers with more than 150 members) averaged 13 percent in the individual and small-group markets, for renewals taking effect from mid-2013 through mid-2014. Insurers attributed the great bulk of these larger rate increases to routine factors like trends in medical costs, driven by increased utilization of medical services and rising medical costs. Insurers did not attribute any substantial portion of these medical cost trends to factors related to the Affordable Care Act. The only ACA-related factor that insurers mentioned frequently was new taxes and fees that started in 2014. Insurers that quantified any ACA impact attributed an average of 4.5 percent of their renewal rates—about a third of their overall rate increases—to these new assessments, but about half of that amount is based on the transitional reinsurance program that sunsets after another two years. Prior to that, insurers may receive some significant reinsurance payments that will help to lower next year's increases or produce consumer rebates in the current year.

Insurance policies in the individual and small-group markets that are not renewals of existing policies became subject to several major regulatory provisions on January 1, 2014, including guaranteed issue, community rating, and essential health benefits. When these new ACA-compliant policies are renewed for 2015, these rate filings also will be a valuable source of information about how these new market rules affect insurance rates.

NOTES

- ¹ Kaiser Family Foundation, *Quantifying the Effects of Health Insurance Rate Review* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Oct. 2012); U.S. Center for Consumer Information & Insurance Oversight, *2012 Annual Rate Review Report: Rate Review Saves Estimated \$1 Billion for Consumers* (Baltimore, Md.: CCIIO).
- ² 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.
- ³ In addition to these two, the ACA also imposes a fee of \$2 per person to fund comparative effectiveness research.
- ⁴ For the 39 filings that were in effect for only part of 2014, we annualized to reflect the rate effect assuming a full year's impact. This is a somewhat imprecise estimation because it assumes that subscribers renew at consistent intervals throughout the year, which often is not the case.
- ⁵ There was some variation, however, because of two factors: 1) insurers are allowed to “gross up” these fees to reflect the fact that states typically collect an additional premium tax, which varies among states and among different types of insurers; and 2) some fees are calculated based on members rather than premiums, and so their impact on premiums will vary according to the size of the base premium.
- ⁶ However, this tax is scheduled to increase over the next four years, to reach between 2.8% and 3.7% of premium, depending on assumptions about base premium increases and other factors. C. Carlson, *Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans* (Milwaukee: Oliver Wyman, 2011).
- ⁷ This includes all insurers that projected an MLR up to 81 percent.

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Editorial support was provided by Deborah Lorber.



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