



Policymakers are considering implementing additional premium-oversight mechanisms as part of health reform efforts. Any such efforts should be based on actuarial principles and should incorporate the appropriate processes to evaluate premiums and premium increases.

An individual health insurance contract is a significant promise to pay future medical claims. To fulfill this promise, a health insurer must remain financially viable, that is, it must be adequately capitalized. Sound financial management depends on sound plan design, appropriate cost controls, administrative efficiency, a sound investment strategy, continued marketplace competitiveness, effective marketing and sales, and premiums corresponding to the claims that can be expected from the insurer's policyholders. State insurance authorities are responsible for ensuring that insurers are adequately capitalized to meet their obligations.

### Premiums Are Set to Cover Projected Medical Claims and Expenses

Premiums for health insurance policies in the individual market are set to adequately pay projected claims, administrative expenses, margins for adverse deviations, profit/contribution to surplus, premium taxes and other applicable state taxes and fees, and federal taxes on earnings. How these components are factored into setting premiums varies according to the regulatory framework and specific market competition and therefore premium levels will also vary.

The largest factor in the setting of premiums is projected claims. In the individual market, the percent of premiums used to pay

claims typically ranges from about 70 percent to 85 percent. Administrative expenses, which include marketing/commissions and enrollment, provider and medical management, billing and claims processing, customer service, and corporate compliance and overhead activities, typically make up about 10 percent to 20 percent of premiums.<sup>1</sup> To protect plan solvency in the event that plan expenditures exceed premiums, insurers are required to carry surplus (also referred to as risk capital) to cover any shortfall. Risk charges and profits, averaging about 3 to 5 percent of premiums, fund this surplus. Federal income taxes and state taxes and fees average about 2 to 3 percent of premiums.

Over the long term, if the insurance carrier cannot charge premiums that support its profit and surplus requirements, it cannot remain in the market. Over the short term, inadequate premiums can be funded by drawing on surplus. If the carrier is earning sufficient profits in other lines of business, those profits can help offset losses. This type of cross subsidy is not a long-term solution, however, because insurers cannot rely on profits from other lines of business indefinitely.

### Premiums Reflect the Underlying Medical Costs of the Enrollee Population

Projected claims, and therefore premiums, depend on the medical costs of the insured

#### ADDITIONAL RESOURCES

Administrative Expenses  
[http://www.actuary.org/pdf/health/admin\\_expenses\\_sept09.pdf](http://www.actuary.org/pdf/health/admin_expenses_sept09.pdf)

Minimum Loss Ratios  
[http://www.actuary.org/pdf/health/loss\\_feb10.pdf](http://www.actuary.org/pdf/health/loss_feb10.pdf)

The Individual Medical Insurance Market: A Guide for Policymakers  
[http://www.actuary.org/pdf/health/med\\_market\\_1008.pdf](http://www.actuary.org/pdf/health/med_market_1008.pdf)

<sup>1</sup>Administrative expenses are typically higher relative to premiums for individual and small-group health insurance products than for large-group products. One reason for this is the lower benefit levels in the individual and small group markets. In addition, many activities undertaken by insurers in the individual and small-group markets are undertaken more directly by employers in the large-group market. More information on insurer administrative functions and expenses is available in the Academy's papers, *Critical Issues in Health Reform: Administrative Expenses* (September 2009) and *Critical Issues in Health Reform: Minimum Loss Ratios* (February 2010).



population. If an insurance plan attracts a disproportionate share of individuals with higher-than-average expected medical costs, otherwise known as adverse selection, then premiums will be higher than average to reflect these higher costs.

Various rules and regulations that apply to health insurance markets also affect premiums. The most common state premium-rating approach for the individual market is to permit premiums to vary not only by characteristics such as age and gender, but also by the individual's health status at the time of issue. Even with this approach, however, there may be some limitations on premium variations. For instance, several states limit the extent to which premiums can vary according to health status. Certain states have implemented more restrictive rating requirements, and prohibit rating variations by health status altogether.

Limiting the extent to which premiums can vary, as well as prohibiting insurers to deny or limit coverage to individuals with preexisting health conditions, can affect the degree of adverse selection. For instance, limiting or prohibiting premium variations by health status or other characteristics correlated with health spending can raise the premiums for younger and healthier individuals, relative to what they would pay if health status could be used as a rating factor. This could cause younger and healthier individuals to opt out of coverage, leaving a higher-cost insured population. Similarly, guaranteed-issue provisions, applicable to all carriers or only those designated as

a carrier of last resort, can exacerbate adverse selection concerns by giving individuals the ability and incentive to delay purchasing insurance until they require health care services. The greater the degree of adverse selection, the higher the average premiums.

### Premium Increases Reflect Medical Spending Growth and Other Factors

Premiums for plans in the individual health insurance market typically increase every year due to increases in claim costs. Numerous factors affect how average claim costs for a particular plan and insurer might change from year to year, and how those changes in claim costs that are factored into a plan's premiums can vary from insurer to insurer.<sup>2</sup>

- **External factors driving medical-cost increases**—These factors, which are common to all health insurance markets, are those that reflect increases in the per-unit cost of health services (e.g., the price for a given physician visit) as well as increases in utilization.
- **Policy duration (for medically underwritten business)**—Medical costs can be relatively low during the first year of a policy, in part due to the application of medical underwriting. However, they are likely to increase annually after the year of issue as individuals develop health conditions and incur more claims. Insurers can spread these increases over all premiums for the length of time a typical policy will be in force (including the initial premiums)

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<sup>2</sup>See the Academy's issue brief, *The Individual Medical Insurance Market: A Guide for Policymakers* (October 2008) for more details on the factors affecting premium increases.

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or they can set the initial premiums low and impose higher premium increases to reflect expected increases each year.

- **Policyholder lapses/changes in enrollment mix**—Adverse selection concerns arise not only at issue, but also at renewal. If a healthier individual can purchase a new policy at a lower premium compared to the renewal premium, then the average medical costs and premiums of the individuals retaining coverage would increase over time.
- **Leveraging effect of deductible**—When total health spending increases but the deductible level is held constant, the deductible each year represents a smaller share of claims. Therefore, the plan's claims will increase more on a percentage basis than the increase in total spending. This increase in claims, and the associated increase in premiums, is referred to as deductible leveraging and the higher the deductible, the greater the leveraging effect will be, all other things being equal. Higher deductible plans, however, typically attract individuals with lower expected claims, including those who increase their deductible levels in order to reduce their premium increase. This can offset the increases resulting from deductible leveraging of higher deductible plans.
- **Correction of prior estimates**—As data on actual medical spending emerge, premiums may need to be adjusted up or down to correct for any under- or over-estimates of medical trend. Setting premiums too low has a compounding effect when the next premium increase is calculated. Premium increases for the coming year reflect not only expected medical trend in the next year, but also any understatement of trend up to that point.<sup>3</sup>

## Risk-Based Capital Protects Insurer Solvency

Private insurers need to accumulate and hold reserves to be adequately capitalized. Focusing on the affordability and accessibility of health insurance without also considering these capital requirements could result in the insolvency of private insurers. The recent financial insolvencies of non-insurance institutions underscore the need to ensure adequate funding of risks.

A health insurer requires capital to mitigate the risk that insurance claims and expenses will exceed insurance premium revenues, jeopardizing financial solvency. In other words, holding risk capital increases the probability that an insurer will have enough funds to meet its financial obligations, even when costs exceed priced-for levels. Recognizing the importance of risk capital, the National Association of Insurance Commissioners (NAIC) developed minimum capital standards—or risk-based capital (RBC) requirements—that vary according to the amount and types of risks assumed by an insurer. These requirements are based on historical experience, taking into account the factors related to previous insurer insolvencies. A typical minimum risk capital requirement for a health insurer might be 25 percent of annual premiums or more.<sup>4</sup> Premiums must be adequate both to cover current costs and to fund (through after-tax risk/profit charges) any required growth in risk capital.

## Principles for Premium Oversight

Effective premium-oversight mechanisms should be based on actuarial principles. The principles outlined below highlight the criteria for a viable, sustainable, and competitive insurance market.

- **Health insurance premiums must be adequate to pay projected claims, expenses, and supporting risk charges.**

<sup>3</sup>Note that any premium increases due to a correction of medical-trend assumptions are not intended to recoup any past losses. Rather, they are done to meet premium adequacy requirements on a prospective basis.

<sup>4</sup>More detail on RBC requirements and the impact on expense charges is available in the Academy paper, *Critical Issues in Health Reform: Administrative Expenses* (September 2009).

A fundamental actuarial principle is that premiums must be adequate to pay projected expenditures, and that these expenditures depend on many factors, including the underlying medical costs of the enrollee population. It is important to understand the reasons for the increases in claims and expenses. Claims can increase due to many factors, including increases in provider payment levels, increases in utilization, and the introduction of new technologies.

- **Premium oversight should be done in conjunction with insurer solvency oversight.** Premium oversight that focuses solely on the goal of limiting premium increases has the potential to ignore premium adequacy. If premiums or premium increases are held to levels at which health plans are unable to fully meet their commitments for claim payments, necessary administrative expenses, and reserve and capital funding, solvency problems could arise and plans could be forced to leave the market. Considering reform options that affect insurer solvency along with premium rating oversight will help ensure that premiums are adequate and plan solvency is maintained.
- **Premium oversight requires strong actuarial representation.** Actuaries and actuarial principles have key roles both in the premium-development process and in current regulatory oversight. Participation by actuaries in a formalized manner in any new regulatory oversight mechanisms will help ensure adherence to actuarial principles. In particular, actuaries have expertise in evaluating pricing risks as well as in identifying the potential volatility of such risks.
- **Appropriate RBC levels must be in place.** Current RBC formulas would need to be modified to recognize any additional risks brought about by a universal premium

setting regulation. Currently, RBC requirements for health insurance business subject to state premium review are higher than for business not subject to premium review (generally, individual versus group business). This difference reflects the inability to secure state approval of adequate premiums on a timely basis in the individual market. If all individual and small-group business premiums are to be subject to review, RBC should be modified to reflect the increased risks borne by insurers due to delayed premium approval.

- **Premiums should be self supporting and not subsidized by other lines of business.** Requiring or expecting other lines of business to subsidize health insurance business would result in other policyholders subsidizing the medical costs of those with health insurance. It may also put an insurer that operates in only one market at a competitive disadvantage since it would not have another line of business from which to obtain subsidies.
- **The premium-review process should be transparent and equitable for all insurers.** Regardless of whether regulatory oversight is conducted at a federal or state level, insurers competing for the same participants must be subject to the same oversight process and rules. Deviation from such consistency would result in a less competitive marketplace.
- **The premium-review process should allow for adequate premiums that appropriately reflect past experience.** As described previously, if medical trend is larger than expected, then premiums for the coming year would need to be increased to reflect not only expected medical trend in the next year, but also any understatement of trend up to that point. If the prior year's premiums proved too conservative, then the premium increase would be less than it would be otherwise.

If insurers are not allowed to incorporate these kinds of adjustments, they will set premiums more conservatively.

- **The premium-review process needs to be coordinated between state and federal regulatory entities.** In most circumstances, premiums in the individual market are filed for “approval” purposes and premiums in the group market are filed for “informational” purposes. Requiring full state and federal review and approval of all individual and small group premiums would significantly increase a state’s workload. The resulting premium-review process must accommodate timely implementation of appropriate premium

increases. The timing of an approval is critical, since premium calculations are based on an expected effective date; if approval is delayed a premium shortfall will develop. If states become backlogged, a process should be established whereby after a certain period of time, premiums are deemed to be approved.

Furthermore, it would be inefficient to have an insurer’s request for a premium increase subject to both a state and federal approval process. Procedures should be put in place to clarify which regulatory entity has approval authority and the extent of that authority.