Issue BRIEF

Understanding How Health Insurance Premiums Are Regulated

September 2006

This issue brief covers the following topics:

Introduction

When setting commercial health insurance premiums, legislators and health insurance regulators must grapple with two key sets of issues: What is a fair way to distribute premiums—should all enrollees be charged the same price, or should people who are likely to use more health care pay higher premiums? And how can regulators and lawmakers ensure that the overall price of health insurance is reasonable, that the majority of premium dollars are actually used for health care claims (instead of for administration or for profits), and that insurers have enough money to pay their claims?

FamiliesUSA
The Voice for Health Care Consumers

In this piece, we first discuss how much authority the states and the federal government have when it comes to regulating health insurance premiums. We go on to discuss the many factors insurers use when setting premiums, some of the ways states have regulated premiums charged to people in the small group and individual markets, how states have controlled the overall price of health insurance premiums, and the processes states use to review variation in and overall prices of premiums.

Who Regulates What?

State Rate Regulation:

States have the authority to regulate the following types of insurance:

- individually purchased insurance, known as insurance purchased in the "individual market,"
- employer-based plans that are fully funded, and
- MEWAs that are either fully-funded or self-funded.

Generally, states do *not* have the authority to regulate other private, employer-based plans that are self-funded.

States take steps to ensure that health plans will be able to pay their enrollees' claims for all of the types of health insurance that they regulate. But states do more to regulate the premiums charged to small employers and to individuals than those charged to large businesses. This is because, policymakers reason, large employers with more than 50 workers have enough clout to negotiate insurance premiums on their own. Any group of 50 or more is likely to include a range of people who are healthy and less healthy, so the costs for one large group may not be significantly different from another.

Fully Funded Coverage, Self-Funded Coverage, and MEWAs

An employer that "fully funds" health insurance enters into a contract with a health insurance company to handle health benefits for its workers. The employer pays premiums to an insurer, and, in exchange, the insurer pays health care claims and bears the risk for claims.

In contrast, an employer who "self-funds" health insurance directly pays the health care claims for its employees. Employers who self-fund may also pay a third party administrator to administer health benefits and/or pay a stop-loss insurer to cover a portion of claims that exceed a certain dollar threshold.

Multiple Employee Welfare Arrangements—MEWAs—are programs designed to provide welfare benefits (such as health coverage) to the employees of two or more employers. They may be either fully funded or self-funded.

In contrast, employers with fewer than 50 workers, and individuals, have less bargaining clout. Insurers may not want to sell policies to small groups and individuals with high health care expenses and, without regulation, they may price policies at unaffordable rates. As a result, most states restrict premium variation in the small group market through rate regulation using the mechanisms described in this paper. Some states also regulate premium rates in the individual market.

A Word about MEWAS and Discretionary Associations

Under the federal Employee Retirement Income Security Act (ERISA), states *cannot* regulate employers' self-funded health benefit programs. However, Multiple Employee Welfare Arrangements (MEWAs) are an exception to this rule. Under a 1983 amendment to ERISA, states are allowed to regulate both self-funded and fully funded MEWAs. To assist in this effort, states may enter into cooperative agreements with the federal Department of Labor to enforce requirements that MEWAs be adequately funded. What's more, some states prohibit the sale of self-funded MEWAs entirely. (For details about federal and state powers over MEWAs, visit the Department of Labor's Web site at http://www.dol.gov/ebsa/publications/mewas.html.)

Other groups, such as associations that are not established by employers, may also sell health insurance. This type of insurance is known as "discretionary association health insurance." States do have the power to regulate discretionary association health insurance. However, state laws that protect consumers from rating and marketing problems in these plans vary greatly—some states take a proactive role, and other states require insurers to follow only minimal requirements. For example, some states require discretionary association health insurers to follow only the rules of the state where the association is domiciled (usually, where it is headquartered), while other states require such insurers to also follow the rules of states where members live or work. For more information about discretionary association health insurers, see our report titled "The Illusion of Group Health Insurance: Discretionary Associations," available online at http://www.familiesusa.org/assets/pdfs/Disc_brief_summary350f.pdf.

Federal Rate Regulation

As mentioned above, states cannot regulate self-funded health plans (with the exception of MEWAs). Self-funded health plans sponsored by private employers are regulated by the federal government under the provisions of the Employee Retirement Income Security Act, ERISA. But this law does not regulate premiums. In fact, no federal laws or regulations restrict the amount that a private employer can be charged for a health plan. However, as described below, there is another federal law (HIPAA) that prohibits employers and employee-based health plans from discriminating against individual employees due to health status. What's more, ERISA also requires employers to administer benefits in a responsible manner, and this law applies to both fully funded and self-funded plans.

- The Health Insurance Portability and Accountability Act (HIPAA) prohibits discrimination in premiums charged to employees and their dependents based on health status. In other words, within an employer's plan, premiums must be the same for groups of "similarly situated" employees. (Groups of employees may be considered "similarly situated," for example, if they are all full-time workers, or if they have the same job classification, or if they have all

worked at the same business for at least a certain amount of time.) Employees in one group may be charged a different premium than employees in another group. However, an individual employee cannot be singled out based on his or her health status and charged a higher premium than someone else in the same group. And an employer or insurance carrier cannot classify employees based on their health status and charge them higher premiums—an employee in poor health cannot be charged more than an employee in good health.[1]

Under ERISA, employers have a fiduciary responsibility to administer employee benefit plans (including health plans) solely in the interest of participants and beneficiaries. Their exclusive purpose should be to provide benefits and to pay plan expenses.

In the Absence of Regulation, What Factors Do Insurers Use to Set Premiums?

Without laws that limit how much insurers can charge, insurers typically charge higher premiums to people who buy individual health insurance policies based on the factors listed below. For groups such as small employers who purchase insurance, while insurers cannot charge higher premiums to particular group members or employees, they can and do examine the characteristics of group members and use these same factors to charge the group a higher premium.

- Health status: Known as "medical underwriting," many insurers use information reported by the individual, as well as medical records, to charge higher premiums to people whom they believe will have higher health care expenses. And because many states exercise little or no oversight over insurers' underwriting decisions, consumers do not have much recourse when challenging the insurers' judgments about their health status and premiums.
- Prior health care claims: At renewal, an insurer can raise its premium based on the amount of health care the person used the previous year. To avoid these increases, people sometimes delay or forgo seeking certain types of treatment, such as therapy.
- Age: Insurers charge older people higher premiums than younger people and can raise their premiums as enrollees get older.
- Gender: Insurers often set higher premiums for women of childbearing age than they do for men. However, for older individuals, insurers may charge more for men than women.
- Particular types of business or industry: For example, insurers often charge people in higher-risk occupations, such as the construction trades, higher premiums than they charge to people in lower-risk occupations, such as office workers.
- Geographical location: Insurers charge higher premiums for residents and workers in locations where health care expenses are typically higher.
- Group size: The smaller the group or company seeking insurance, the higher the premiums.
- Family composition: Insurers often set lower premiums for a parent with a child than they do for a couple. Similarly, they may set different premiums for other kinds of families.
- Duration of insurance: Insurers may set higher premiums for people who have been insured by a company for a longer period of time. Insurance companies reason that if an

extended period of time has passed since they initially set their premiums based on a person's health status, the person's health has likely worsened over time, and he or she should thus be charged more.

- Lifestyle or participation in wellness activities: Insurers have long charged higher premiums to smokers than nonsmokers. In recent years, they have also begun to charge higher premiums for obese enrollees and lower rates to people who participate in health plan "wellness programs."

What Have States Done to Regulate Variation in Premiums?

The Small Group Market

Almost all states have passed laws that limit variation in insurance premiums or that prohibit insurers from using some of the factors listed above to set premiums for small groups (usually, groups of 2 to 50 people). As of 2005, only a few states had *not* restricted variation in insurer premiums in the small group market: Alabama, the District of Columbia, Hawaii, and Pennsylvania (for carriers other than Blue Cross/Blue Shield and HMOs).

The Individual Market

Regulation of premiums charged to individuals is less common. According to a 2005 survey, 18 states limited variation in premiums or prohibited the use of some of the factors listed above in setting premiums for individuals. The other 32 states and the District of Columbia had no such rating limits in the individual insurance market.[2]

Techniques States Use to Limit Premium Variation in the Individual and Small Group Markets

States can use three approaches to limit variation in premiums: 1) rate bands, 2) pure community rating, and 3) adjusted community rating.

1) **Rate bands** set limits on the amounts that insurers can vary premiums based on health status. Rate bands also list and limit other factors that insurers can consider when setting premiums. Typically, insurers will establish an "index rate" or average premium. A rate band essentially sets a floor below and a ceiling above that index rate. That is, a rate band limits the amount by which an insurer can increase premiums above the index rate for people who are in poor health, as well as how much an insurer can discount premiums below the index rate for people who are in excellent health.

   Example: If a state allows an insurer to vary premiums from the index rate by plus or minus 25 percent, the total variation between the lowest and highest premium will be about 67 percent.

   The math: The index rate for monthly premiums in Plan A is $400. In a state that allows rates to vary plus or minus 25 percent based on health status, a healthy person may have premiums as low as $300, and a sick person may have premiums as high as $500. $500 is about 67 percent higher than $300.

Similarly, states may set a maximum amount that insurers can vary premium rates from the index rate based on age or on another factor from the bulleted list on page 4. To calculate the total variation allowed in the insurer's premiums, multiply the amounts that premiums can vary for *each* factor.

> **Example**: Plan A charges older people premiums that are four times as high as premiums charged to people aged 20. Sally is 60 years old and has health problems. Jane is healthy and age 20. Sally's premiums are 1.67 times higher than Jane's due to her health, and four times higher than Jane's due to her age. All together, her premiums are (4 x 1.67 =) 6.68 times higher than Jane's premiums. Therefore, if Jane is charged $300, Sally will be charged about $2,000 per month.

Finally, some states allow insurers to set different premiums for different "classes of business." These include groupings of small employers that are expected to have expenses for claims and administration that are significantly different from other businesses. These differences may result from different systems used to market and sell plans to employers, the transfer of the class of business from another insurer, or when insurance is provided through an association of small businesses rather than for one business. For example, in some states, insurance policies offered to associations of small businesses are priced independently from insurance products offered to individual small businesses. In addition, in some states, carriers may price HMOs that they offer to small businesses independently from PPOs that they offer to small businesses.

For small groups, the following states use rate bands that allow limited variation based on health and allow limited variation based on other factors: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan (for most commercial carriers, but not for nonprofits or HMOs), Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island (for insurance carriers that used health status before June 1, 2000), South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia (only for certain policies), West Virginia, Wisconsin, and Wyoming.[3]

In the individual market, the following states use rate bands: Iowa, Idaho, Kentucky, Louisiana, Minnesota, New Hampshire, New Mexico, Nevada, Ohio (on standard products), South Dakota, and Utah.[4]

States that use rate bands also often limit price increases for individuals and groups that renew their policies. For example, at renewal, states that use rate bands often prohibit increases of more than 10 or 15 percent based on the group's health status or claims experience.[5] This means that, if an insured person's health status has worsened, his or her premiums will not suddenly wildly increase.

Unfortunately, in the individual market, many states do not prohibit insurers from reexamining health status (re-underwriting) or increasing premiums based on the duration of coverage. So, even if consumers enroll in reasonably priced policies, they can find themselves unable to afford renewing their policies if they have become ill or have other health problems.[6]

Example: Kansas limits price increases based on claims experience, but insurers can consider other factors when increasing premiums. On renewal, Kansas allows group insurers to increase premiums based on only three factors: 1) a business trend rate—that is, if the price of an insurance product increases by a certain amount for all small groups; 2) a change in the characteristic of a particular group—for example, if the group's members are now older on average; and 3) a group's utilization (the medical claims of the particular group). The adjustment for utilization cannot be more than 15 percent annually. Taking all three factors into account, premiums for a group cannot be increased by more than 75 percent annually. In addition, the Insurance Department reviews insurers' rates and the insurers' past cost experience.

The Insurance Department reports that without the law, some companies would use steeper increases—the Department has negotiated with companies to moderate proposed premiums or to implement premium increases over a several year period instead of all at once.[7]

2) **Pure community rating** requires insurers to set the same premiums for everyone in a community. Plans cannot vary premiums at all based on health status, claims history, or age, but they may be allowed to vary premiums within a state based on geographical location and/or family composition.

Two states, New York and Vermont, use pure community rating in both the individual and small group markets. In addition, the following states use pure community rating in the individual market for certain health plans only: New Jersey (for "standard" plans—see the example on p.10), and Pennsylvania (for some Blue Cross plans and HMOs only).[8]

3) **Adjusted community rating** likewise prohibits insurers from varying premiums in a community based on health status or claims history, but it does allow insurers to vary rates (within limits) based on more factors than geography and family composition.

- The following states use adjusted community rating in the small group market: Connecticut, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Oregon, Pennsylvania (only for some Blue Cross/Blue Shield plans and HMOs), Rhode Island (for insurance carriers after June 1, 2000), and Washington.
- The following states use adjusted community rating in the individual market: Maine, Massachusetts, Michigan (for Blue Cross and HMOs), New Jersey (for plans that do not include all of the mandated benefits of the standard community-rated plans, called "Basic and Essential"), and Oregon.[9]

States with community rating and adjusted community rating do not allow pricing based on health status. This means that medical underwriting is not allowed either when policies are issued or when they are renewed.

Example: New Jersey's use of adjusted community rating in the small group market New Jersey applies the rules listed below to all small employers, including businesses that consist of only two employees who may be related (such as a husband and wife), as long as each works more than 25 hours per week.

- New Jersey uses adjusted community rating in the small employer market. It does not allow insurers to vary premiums based on health. However, it does allow insurers to

vary premiums based on the following three factors only: gender, age, and geographical location. Taking all three of these factors into account, the most that insurers can vary their premiums from one small employer to another is 2:1. That is, for a given package of benefits, an insurer cannot charge one small employer more than twice the premium it charges to another small employer.

- Insurers[10] in the small employer market must also sell "standardized" plans to small businesses, with those standards promulgated by state regulation. ("Standardized" plans in the small employer market offer more benefits than the mandated minimum benefits that all state-licensed insurers must provide.) This allows employers to readily compare prices and to understand what they are purchasing. It also allows regulators to deal efficiently with complaints about coverage, because they know exactly what is covered—they don't have to review a specific plan to see whether or how a particular condition is covered.
- Insurers can vary the deductibles and copayments that they charge, but they must follow the state's standards regarding the benefits they offer.
- Insurers can offer additional benefits by selling riders to their policies. They can also use a rider to offer a plan with fewer benefits than a particular "standardized" plan, although such plans must still offer the minimum mandated benefits required by state law.
- Insurers must demonstrate that they use at least 75 percent of premium dollars to pay medical claims. At the beginning of the year, when insurers set their premiums, they file a statement showing what they expect to spend on medical claims. At the end of the year, if the amount spent on medical claims is less than 75 percent of collected premiums, they must issue refunds to enrollees in their health plans to make up the difference.

According to the Managing Actuary of the New Jersey Department of Banking and Insurance, the state's system has been effective in providing coverage to small businesses. It covers about 920,000 people out of a population of about 8.5 million. The small group market is stable in New Jersey, and the percentage of businesses that offer insurance to their workers is higher than the national average. For example, in 2002, 45.7% of New Jersey firms that employed fewer than 10 workers offered health insurance, compared to a national average of 36.8% for firms of this size.[11]

Community rating and adjusted community rating are particularly helpful in limiting variation in premiums for the smallest employers.

Example 2: New Hampshire, which has experimented both with rate bands and with adjusted community rating, provides an illustration of this. In 2003, the state dropped its adjusted community rating system and decided to use rate bands instead. The Center on Budget and Policy Priorities describes the problems this caused:

> Under the law that New Hampshire enacted in 2003, health insurers in the state were permitted (beginning in 2004) to vary small business health insurance premiums substantially, based on the health and age of workers, firm size, geographic location, the firm's industry, and other factors.[3] Some firms in New Hampshire with disproportionately younger or healthier workers saw their premiums decrease or remain flat. Many other small firms, however, particularly the smallest firms with less healthy workers and those that were located in high cost areas of the state, had their premiums skyrocket when they renewed their health insurance plans. Due to the large premium increases faced by these small businesses, New Hampshire repealed the 2003 law in 2005 and essentially returned to its prior community rating system.[12]

The National Association of Insurance Commissioners (NAIC) Model Law for Adjusted Community Rating

Created in 1996, the NAIC model law, known as the Small Employer and Individual Health Insurance Availability Model Act, uses adjusted community rating for both small groups and individuals. (A previous model act, now obsolete, used rate bands.) For both the individual and small group market, insurers can vary premiums based only on geographical location, family composition, and age. Five-year age bands are used for the small group market, and one-year age bands are used in the individual market. Taking all factors into account, after a transition period of several years, the model allows a total range in premiums of no more than 2:1. While this is still a large variation in premiums, keep in mind that in a state without rate regulation, the range in premiums is sometimes 13:1 or higher.[13]

The model also proposes a reinsurance system. Participating insurance carriers pay assessments and, in turn, another insurer "reinsures" for high-cost claims so that the original insurer will not pay more than $10,000 per year for any individual.

How Do States Choose between Using Rate Bands and Community Rating?

States must balance several policy goals and questions of fairness in determining how to price health insurance:

- How much should an employer's health insurance costs change when the employer hires older workers or a worker with a chronic health condition? Rate bands proscribe an amount by which premiums can vary based on these factors. Pure community rating does not allow premiums to vary at all based on these factors.
- Should the community as a whole pay equally for health care, or should those who are in poor health who are likely to use more services pay more? Pure community rating distributes health care costs equally among those in a given insurance plan.
- Is the goal of health insurance to get the greatest number of people covered? If so, people who are young and relatively healthy may be more likely to purchase insurance if it is priced lower for them than for people who are older and sicker. They will not want to pay premiums that exceed their expected average health costs. Rate bands allow premiums to be based on both age and health, while adjusted community rating allows premiums to vary based on age but not health.
- On the other hand, many consumer advocates believe that the goal of health insurance is to make insurance readily available to people who most need health care. Under that contention, pricing insurance at one rate for the whole community (community rating) makes insurance more affordable to people who need health care and avoids price discrimination (and perhaps employment discrimination) based on factors that individuals cannot control.

Adding premium subsidies under either rate structure can also help to make insurance affordable.

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How Have States Controlled the Overall Price of Health Insurance Premiums?

States generally use three mechanisms to control the overall price of health insurance and to make sure that most of the money collected by insurance companies is actually used for medical care.

Establishing a Medical Loss Ratio

States may set a minimum percentage of premium dollars that must be spent on medical care (as opposed to administrative costs), called a medical loss ratio. When insurers initially set their premiums, they must estimate what they will spend on medical claims over the course of the year. In some states, if an insurer's expenses for medical claims are lower than anticipated and it does not meet the medical loss ratio, the insurer must refund the excess premium dollars to consumers at the end of the year.

Example: New Jersey requires individual and small group insurers to spend at least 75 percent of premium dollars on medical care. At the beginning of the year, when insurers set their premiums, they file a certification that medical claims will exceed 75 percent of premiums. At the end of the year, if the amount spent on medical claims is less than 75 percent of collected premiums, they must issue refunds to enrollees in their health plans to make up the difference.

The New Jersey Insurance Department reports that this is an easy system for the state to administer—insurers know whether they have met the standard, and they process refunds when they do not. What's more, in recent years, the small group market has been competitive, and on average, insurers actually have a higher medical loss ratio than the minimum 75 percent—they spend about 80 percent of premium dollars on medical care. However, not all carriers meet the threshold, and some carriers do issue refunds in the small group market.

The individual market is less competitive, so the medical loss ratio has therefore helped control premiums, largely by requiring insurers to set premiums to meet a loss ratio of 75 percent. Also, some insurers have been required to issue refunds.[14]

Requiring Actuarial Soundness

States may require that premiums be "actuarially sound." This means that insurers must follow standards, such as those set by the American Academy of Actuaries and the Actuarial Standards Board, to determine if premiums can reasonably be expected to cover losses and if the plan has adequate financial reserves. The test for actuarial soundness in health insurance often includes a medical loss ratio, but insurers may be allowed to make further adjustments to premiums based on their predictions of medical inflation over a several year period, anticipated swings in the economy, the mix of businesses that they serve, and other factors. States that require actuarially sound premiums generally require insurers to file forms and memoranda explaining how their rates are calculated, and these filings are subject to review by the state's insurance department.

Example: Kansas requires actuarial soundness, and the state has developed guidelines governing this

practice. Insurers must file their proposed premium rates with the state. Because the state uses a stringent review process, insurers do not usually implement premium increases until the department places the new rates on file. In practice, the examiner for the Kansas Insurance Department often asks insurers to lower their proposed premium increases based on his analysis of insurance company's filings.[15]

Overseeing and Preventing Adverse Selection

States try to assure that the health insurance market does not separate healthier individuals into some plans and sicker individuals into other plans, a process known as "adverse selection." When adverse selection does occur, premiums for plans with a disproportionate number of unhealthy enrollees may go into a "death spiral," becoming ever more expensive as healthier people go elsewhere for insurance. States attempt to control adverse selection by overseeing plans' marketing practices and by prohibiting insurers from increasing the premiums they charge to individual policyholders or from moving policyholders into different plans when they become sick, a practice known as re-underwriting.

Example: In Florida, an insurer reportedly moved individuals from one block of business to another and then raised their premiums by as much as 200 percent when they tried to renew their policies. In 2002, the Florida Department of Financial Services suspended the company's license.[16]

Florida now prohibits the following:

"(10) Any pricing structure that results, or is reasonably expected to result, in rate escalations resulting in a death spiral, which is a rate escalation caused by segmenting healthy and unhealthy lives resulting in an ultimate pool of primarily less healthy insureds, is considered a predatory pricing structure and constitutes unfair discrimination as provided in s. 626.9541(1)(g). The Financial Services Commission may adopt rules to define other unfairly discriminatory or predatory health insurance rating practices."

To further guard against adverse selection and encourage plans to accept groups and individuals with all levels of health care needs, some states have established "reinsurance pools" that assist insurers in paying claims for the highest-cost enrollees. In these situations, an insurance carrier pays an assessment (sometimes the state also contributes) to a reinsurance carrier, who pays any of the insurer's claims that exceed a certain dollar threshold. Thirty states either allow insurers to voluntarily participate in a reinsurance pool or require that they participate in a reinsurance pool. The states that do *not* use reinsurance are as follows: Alabama, Arkansas, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, Pennsylvania, South Dakota, Virginia, Washington, West Virginia, and Wisconsin.[17]

Example: In the Idaho Small Employer Health Reinsurance Program, in 2006, insurers are responsible for the first $13,000 in claims for each worker that they reinsure. Under the "standard" plan that small employers most commonly purchase, for the next $87,000 in claims, the insurer pays 10 percent, and the reinsurer pays the remaining 90 percent. The level of reinsurance coverage may be changed at the recommendation of the program's Board to reflect increases in costs and utilization within the standard market in Idaho. Insurers pay premiums to the reinsurance carrier and, in addition, all small-group insurers can be assessed a fee if the premiums fall short of actual reinsurance expenditures.[18]

Example: The Healthy New York program uses reinsurance to make coverage more affordable to employers of low-wage and middle-wage workers and more affordable to low-income individuals who purchase insurance on their own. Employers of low- and middle-wage workers, sole proprietors, and low-wage individuals can buy coverage through participating HMOs. The HMOs are responsible for the first $5,000 of each enrollee's claims. After that, the HMOs pay 10 percent of claims, and the reinsurer pays 90 percent of claims, up to $75,000 for any enrollee in a calendar year. The state itself pays for the reinsurance.[19]

Other Mechanisms

A handful of other states have used additional approaches to regulate and oversee the costs of health insurance:

- Plan Standardization

  A few states have established standardized plans in the small group market that must all offer consumers the same set of benefits. This allows states and consumers to more easily compare the prices of insurance policies. Maryland and New Jersey are among the states that use this mechanism.

  Example: Under law, insurance carriers in Maryland can sell the Comprehensive Standard Health Benefit Plan only to groups of 2-50. Benefits provided by the plan must be at least equal to those offered by a federally qualified HMO, and the average premium cost across all insurers may not exceed 10 percent of Maryland's average annual wage. (Insurers can sell riders to the standard policy for an additional fee.) If the average rates for the standard policy exceed the 10 percent threshold, the Maryland Health Care Commission must increase cost-sharing or reduce benefits. Insurers use adjusted community rating to set premiums, and policies are issued with no medical underwriting. While this has held down costs, the commission did have to reduce benefits this year to bring premiums within the 10 percent cap.[20]

- Setting a Maximum Surplus

  While it is common for insurers to set *minimum* amounts that plans must hold in reserve in order to make sure that the plan is solvent and can pay its claims, a few states have set *maximum* amounts that nonprofit insurers can accumulate in surplus. In these states, if nonprofit health insurers accumulate more than the maximum surplus, they must return any additional amounts either to policyholders (in the form of lower premiums) or to the community (by funding other health initiatives).

  States with maximum surplus limits for nonprofit insurance carriers generally, or for Blue Cross Blue Shield in particular, are as follows: Hawaii, Michigan, New Hampshire, and Pennsylvania.[21]

What Processes Do States Use to Review Variation in, and Overall Prices of, Premiums?

Some states require strict "prior approval" of proposed premiums. In these states, the insurer files documents showing its proposed premiums and explaining why higher premiums are justified given the expected costs of medical claims, administration, and other factors. The insurer cannot actually begin charging the proposed rates until the state's department of insurance approves them.

A larger number of states with prior approval laws on the books include provisions to "deem" proposed premiums as approved if the state does not respond by a given time. Insurers can begin charging their new rates after that time, but the state can always challenge the ratings and require revisions later.[22]

Still other states allow insurers to "file and use" a premium rate structure. In these states, the insurer files documents showing its proposed premiums, but it need not wait for state approval before it begins charging those premiums. The state may eventually review all premium filings, a sample of premium filings, certain filings in response to a complaint, or premiums that appear to be unusually high or low compared to other insurers. If the state determines that the premiums are not in compliance with state requirements or were not based on sound actuarial principles, the state may require the insurer to make prospective or retroactive adjustments.

States may also perform "market conduct examinations" of insurers. Market conduct examinations can be used to look at the products sold by a health insurance company, the agents' sale practices, claims payment, underwriting standards, complaint data, a company's internal oversight procedures, and the premiums charged. The National Association of Insurance Commissioners has developed suggested procedures for market conduct examinations. However, according to a Government Accounting Office (GAO) report, many states do not use the procedures, examine only a small fraction of insurers each year, and do not coordinate their reviews with other states (which would allow them to get the benefit of another state's findings about a company that operates in several jurisdictions).[23]

State insurance departments generally respond to consumer complaints about rates, as well as other complaints that consumers may have about their insurance plans. On receipt of a complaint, most states review whether the premiums for that consumer are consistent with the approved rates for the insurer. Using statutes about discrimination or unfair competition and practices, some insurance departments also respond to individual complaints about underwriting decisions. These responses may take the form of mediation with the insurance carrier, or through providing additional information to correct the insurance carrier's perception of the individual's medical condition.

Finally, some states use public hearings to gather input on proposed premium increases for some insurers.

> **Example**: Rhode Island law requires the health insurance commissioner to hold public hearings on proposed premiums in the individual market. The insurer must establish that the proposed premiums are "consistent with the proper conduct of its business and with the interest of the public." Insurers must also demonstrate that they have made efforts to enhance the affordability of their products. Along with the Insurance Commissioner, the Insurance Advocacy Office of the Rhode Island Attorney General's Office receives a copy of the premium rate filing and may be a witness at the hearing. Sometimes, members of the public also comment.
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> In the past few years, the hearings have resulted in some lowering of proposed premiums for individual insurance. For example, in 2004, Blue Cross did not meet the standard of affordability and was consequently denied a rate increase. In 2006, an order reduced the proposed premium for "direct pay" products of Blue Cross by two percent.

The hearing process itself may also entail some costs for subscribers: The insurer may be required to pay for the costs of the hearing, including the testimony of expert witnesses, and may eventually pass these administrative expenses on to consumers in their premiums. So, whether the process saves consumers money in the long run depends on the amount of premium reductions it achieves compared to the expense of the review process. In Rhode Island's recent experience, hearings and rate reviews have produced a net gain for consumers. For example, the most recent Blue Cross hearing cost about $800,000 and saved consumers about $2 million in premiums. That hearing was unusually expensive, though. Typical hearings cost between $200,000 and $400,000.[24]

Conclusion

States can play a very important role when it comes to limiting health insurance premiums. By establishing rules that govern such premiums, they limit insurers' ability to charge one group or individual premiums that are exorbitantly high compared to the premiums they charge to other groups or individuals.

To help control the overall price of insurance, states can require that the majority of premium dollars be used for medical care, regularly examine insurers' premiums, and make sure that all insurers enroll a fair mix of healthy and less healthy individuals. States also can make it easier for consumers to compare prices by requiring insurers to offer a standard package of benefits. Besides requiring that all insurers have adequate reserves to pay claims, states can require that nonprofit insurers limit their surpluses and spend any excess revenue on community health care needs.

Consumers and consumer advocates can contact their state insurance departments to learn about what their state does to control health insurance premiums and how the state examines those premiums. They may be able to participate in hearings about an insurer's proposed premiums or about a nonprofit insurer's surplus. When needed, they can advocate for stronger rating laws and for premium assistance programs or other public subsidies to make insurance affordable to people with low incomes or those with high health care needs.

Understanding Rate Regulation in Your State: Questions to Ask Your Insurance Department

What are your state's rules about how premiums can vary among small businesses or other small groups?

- Does your state prohibit insurers from charging higher premiums based on the health status of the group's members or based on their prior medical claims? (That is, does your state use "community rating" or "adjusted community rating"?)
- What factors can insurers consider when setting a small group's premiums? For example, do insurers consider age, sex, type of business, or geographical location? Why has your state chosen to allow insurers to use these factors? What is the maximum amount that premiums can vary based on each factor?
- Is there an overall limit on the amount that premiums can vary? For example, in some states, premiums charged to one group cannot be more than twice as high as the premiums charged to another group. In contrast, without rules, some groups are charged premiums that are 10 or 13 times as high as others.
- Does your state limit the amount that insurers can raise a group's premiums each year? What are the rules about price increases at renewal?
- Similarly, what are the rules about how much premiums can vary for individuals in your state? Do the same rate rules apply to both small groups and to people who purchase policies as individuals?
- Does your state require insurers to use at least a certain percentage of their premium dollars (e.g., 75 percent) for medical claims as opposed to administrative and marketing costs? (This percentage is known as a "medical loss ratio.")

How does the state review insurers' premiums?

- Must insurers file proposed premiums, and the justification for their proposed increases, with the state?
- Does the state review and approve these filings before the charges go into effect? If not, at what intervals does the state review an insurer's rates?
- Does the insurance department investigate premiums in response to consumer complaints?
- Can consumer organizations participate in hearings about premiums?

How well does the insurance department think that the state's rules are controlling insurance costs?

- Do insurers ever issue refunds when they find that their premiums are higher than they need to be to cover claims and expenses?
- How often does the state require insurers to lower premiums from what the insurer proposed?

- How does your state compare to others with regard to the number of uninsured, whether employers offer and employees accept insurance, typical premiums, and whether an adequate number of insurance carriers are serving the individual and small group markets?

Nonprofit insurers are generally required by law to operate for the benefit of subscribers or the public, and not for profit. Nonetheless, they take in revenues that exceed their expenses. All insurers need to keep some money in reserve in case they suddenly face large claims, but how much money is it appropriate for a nonprofit insurer to keep?

- Does your state have rules about the maximum amount that nonprofit insurers can accumulate as surplus?
- If not, what are nonprofit insurers required to do in exchange for their tax exemptions?

Annotated Bibliography

Federal Regulation and Oversight of Employer-Based Health Plans

Employee Benefits Security Administration (EBSA), U.S. Department of Labor. www.dol.gov/ebsa. The EBSA protects the integrity of pensions, health plans, and other employee benefits. Its Web site provides information for consumers, employers, and other audiences about federal laws concerning employer-based health care. Enrollees can go to the EBSA Web site to complain if a health plan run by an employer (such as a self-insured plan or a MEWA) cannot pay its claims, or with other issues.

How Insurance Departments Oversee Insurance Company Behavior

Links to state insurance department Web sites can be found on the Web site for the National Association of Insurance Commissioners at www.naic.org. Visitors can also find information on model state laws, which can be purchased online.

U.S. Government Accounting Office, Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation, GAO-03-433, (Washington: Government Accounting Office, September 2003), available online at http://www.gao.gov/new.items/d03433.pdf.

Rate Bands and Community Rating

Mila Kofman and Karen Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change* (Washington: Georgetown University, April 2006), available online at http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf. This report provides an overview of current insurance regulation and discusses proposals the U.S. Congress is considering in 2006. It also contains a helpful table that summarizes states' small group rating rules on page 14.

Georgetown University Health Policy Institute, *Summary of Key Consumer Protections in Individual Health Insurance Markets* (Washington: Georgetown University, April 2004), available online at http://www.healthinsuranceinfo.net/newsyoucanuse/discrimination_limits.pdf. This table summarizes states' rating rules for the individual market, as well as information on whether insurance is guaranteed issue, whether pre-existing conditions can be excluded, and other ways states make coverage available to individuals.

Susan Laudcina et al, *State Legislative Health Care and Insurance Issues: 2005 Survey of Plans* (Washington: Blue Cross and Blue Shield Association, 2005). This report contains charts that list the states that use community rating, those that use rate bands, and the dates that the laws regarding these measures were passed.

Denise Harris and Kathleen Stoll, *Protecting Consumers from Unfair Rate Hikes: The Need for Regulation of Health Insurance Renewal Premium Increases* (Washington: Families USA, 2003), available online at http://www.familiesusa.org/assets/pdfs/Rate_Hikes_Revised_Feb_2003ca7a.pdf. This issue brief explains how insurers may raise prices by re-underwriting at renewal and how state and fed-

eral policymakers can stop this practice.

Edwin Park, *Lessons from New Hampshire: Senate Health Bill Could Drive up Health Insurance Premiums for Many Small Businesses* (Washington: Center on Budget and Policy Priorities, April 26, 2006), available online at http://www.cbpp.org/4-26-06health.pdf#search=%22Lessons%20from%20New %20Hampshire%22. This report was written while the U.S. Senate was considering the Enzi bill. It explains how premiums increased for certain businesses in New Hampshire when the state switched from adjusted community rating to rate bands. The experience was so negative that the state later switched back to adjusted community rating.

Mary Beth Senkewicz, *Senate Health Bill Would Preempt States' Small Group Rating Rules* (Washington: Center on Budget and Policy Priorities, April 26, 2006), available online at http://www.cbpp.org/4-26-06health2.pdf#search=%22Lessons%20from%20New%20Hampshire%22. This report was written while the U.S. Senate was considering the Enzi bill. It explains how rate bands work and shows that they may still allow large variations in premiums.

Alan C. Monheit, Joel C. **Cantor,** Margaret Koller, and Kimberley S. Fox, "**Community Rating and Sustainable Individual Health Insurance Markets in New Jersey,**" *Health Affairs*, Vol. 23, No. 4 (July/August 2004), pp. 167-175, available online at

http://content.healthaffairs.org/cgi/content/abstract/23/4/167. This article discusses the problems with community rating for the individual market in New Jersey.

Joel Cantor, *Small Business Health Insurance in New Jersey: Issues and Options* (Rutgers Center for State Health Policy, conducted for the New Jersey Appleseed Forum, April 2005), available online at http://www.cshp.rutgers.edu/presentations/Appleseed%20Small%20Business%20Forum%20APRIL%202005%20FINAL.pdf. The presentation includes state-by-state data on premium prices.

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Donald Cohn, Enrique Martinez-Vidal, and Deborah Chollet, *More Answers on Reinsurance* (Washington: State Health Coverage Initiative of AcademyHealth, June 2005), available online at http://www.statecoverage.net/pdf/infocus0605.pdf.

Capping the Surpluses of Nonprofit Insurers

Deborah Chollet et al, *Opportunities and Capacity for Community Benefit: GHMSI's Potential Role in the National Capital Area, Final Report* (Washington: Mathematica Policy Research, Inc., December 2, 2004), available online at http://www.mathematica-mpr.com/publications/PDFs/CareFirst.pdf.

The Lewin Group, *Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market, Preliminary Findings* (presentation for the Rhode Island Health Insurance Commission,

March 7, 2006), available online at http://www.dbr.state.ri.us/pdf_forms/insur/HI-060307_Lewin_Prelim_Reserves.pdf.

Endnotes

[1] 26 CFR §54.9802-1T

[2] Ibid. The 31 states that do not use rate bands, community rating, or adjusted community rating in the individual market are as follows: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Wisconsin, and Wyoming.

[3] Mila Kofman and Karen Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change* (Washington: Georgetown University Health Policy Institute, April 2006), available online at http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf.

[4]*Summary of Key Consumer Protections in Individual Health Insurance Markets* (Washington: Georgetown Health Policy Institute, April 2004), available online at http://www.healthinsuranceinfo.net/newsyoucanuse/discrimination_limits.pdf.

A December 2005 Blue Cross survey differs slightly in its categorization of state rating laws. It does not include New Hampshire as using rate bands but adds West Virginia as a state that does.

[5] However, the overall price increase in a group's premiums may be much higher than this because states allow additional increases based on the trend in insurance prices (for example, because the price of health care has increased) and based on changes in the age, gender, or other characteristics of the group's membership.

[6] Denise Harris and Kathleen Stoll, *Protecting Consumers from Unfair Rate Hikes: The Need for Regulation of Health Insurance Renewal Premium Increases* (Washington: Families USA, 2003).

[7] Source: Personal communication with Craig Van Aalst, Policy Examiner, Kansas Insurance Department, June 7, 2006.

[8] Kofman and Pollitz, *Health Insurance Regulation by States*, and Georgetown University, *Summary of Key Protections*, op. cit., and personal communication with those states' insurance departments, August 3, 2006. In Michigan, Blue Cross must accept individual enrollees throughout the year under a community rating system, while HMOs must accept individual enrollees without regard to health status only during one 30-day period each calendar year.

[9] Kofman and Pollitz, op. cit.

[10] While we use the term "insurers" in this paper, New Jersey prefers the term "carriers" because it includes both indemnity insurers and HMOs.

[11] Medical Expenditure Panel Survey data as cited in Joel Cantor, S*mall Business Health Insurance in New Jersey: Issues and Options* (New Brunswick, NJ: Rutgers Center for State Health Policy for the New Jersey Appleseed Forum, April 2005).

[12] Edwin Park, *Lessons from New Hampshire: Senate Health Bill Could Drive up Health Insurance Premiums for Many Small Businesses* (Washington: Center on Budget and Policy Priorities, April 26, 2006).

[13] Review and comparison of premiums posted on www.carefirst.com on July 21, 2006, for CareFirst BlueCross BlueShield policies for two different hypothetical people: 1) an older woman in Washington, D.C. who qualifies for HIPAA (that is, she must be sold a policy even if she is in poor health), and 2) a young man in a medically underwritten policy (that is, he will not be sold a policy unless he is in good health). The older woman's premiums were 13 times as high as the young man's.

[14] The Actuary further explains, "In the SEH [small employer health] market, prices are set by competition. Currently, competition seems to set the price at a loss ratio of about 80 percent. [Insurance] Carriers can still pay claims and administrative expenses and make a nice profit at an 80 percent loss ratio. But some carriers may set their loss ratio closer to 75 percent, giving up market share for more profit on each policy. Because claims are not predictable, the loss ratio may fall below 75 percent because claims are less than expected. The refund formula in this case limits the extra profits that the carrier gets in this good year. The carrier (involuntarily) shares its good fortune with the policyholder. The IHC [individual health coverage] market is not as competitive. If there was not a 75 percent minimum loss ratio requirement, a carrier might set its premiums higher, to attain a loss ratio of 70 percent or 65 percent. Frankly, many carriers do not care whether they sell any individual policies or not. And, with a lower loss ratio, they might get a higher profit on each policy they sell. So, the 75 percent loss ratio requirement actually establishes a maximum that the carrier can charge in this non-competitive market. This is what we mean when we say that the loss ratio keeps premiums down in the IHC market. Refunds in the IHC market are just a natural consequence of this pricing—if a carrier is pricing to have a loss ratio of 75 percent, it is likely (under simple assumptions, a 50-50 chance) that experience will be better than expected and a refund will be paid." (Source: Personal correspondence with Neil Vance, Chief Actuary, New Jersey Department of Insurance, August 3, 2006.)

[15] Personal communication with Craig Van Aalst, Policy Examiner, Kansas Insurance Department, June 7, 2006, and Guidelines for Filing of Rates for Individual Health Insurance, available online at http://www.ksinsurance.org/legal/regulations/

Model_Laws/Ref%2040-4-1%20-%20Health%20Rate%20Filing%20.htm.

[16] See Florida Department of Financial Services, "Gallagher Orders United Wisconsin to Stop Doing Business for Unfair Underwriting Practices" (Tallahassee: Florida Department of Financial Services press release, July 25, 2002, available online at http://www.fldfs.com/pressoffice/ViewMediaRelease.asp?ID=1243).

[17] Laudcino, op cit.

[18] Personal correspondence with Joan Krosch, *Health Care Policy Program Specialist*, Idaho Department of Insurance, August 4, 2006.

[19] Cohn, Vidal, and Chollet, *More Answers on Reinsurance* (Washington: State Health Coverage Initiative of Academy Health, June 2005), available online at http://www.statecoverage.net/pdf/infocus0605.pdf; and personal correspondence with Mary Sabo, New York State Insurance Department, August 4, 2006.

[20] Information from the Maryland Health Care Commission Web site, http://mhcc.maryland.gov/, accessed on June 29, 2006.

[21] The Lewin Group, *Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market*, Preliminary Findings, presentation to the Rhode Island Insurance Commissioner, March 7, 2006, available online at http://www.dbr.state.ri.us/pdf_forms/insur/HI-0307_Lewin_Prelim_Reserves.pdf.

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[23] U.S. Government Accounting Office, Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation, GAO-03-433 (Washington: U.S. Government Accounting Office, September 2003), available online at http://www.gao.gov/new.items/d03433.pdf.

[24] Rhode Island General Law Section 27-19-6; Rhode Island Office of the Health Insurance Commissioner, Department of Business Regulation, Hearing Decision and Order February 20, 2006 and Hearing Decision and Order November 23, 2004; personal communication with John Cogan, Executive Assistant for Policy and Program Review, Office of the Health Insurance Commissioner, Rhode Island, August 3, 2006.

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