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Affordable Care Act

An Advocate's Guide to Analyzing Insurers' Financial Health

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Each year, as rate review season begins, consumers, regulators, and policymakers will be reviewing how well health insurance companies fared financially in the previous year: How much money are health insurers making and will they need to raise premium rates to remain financially viable?

In two types of documents, insurers share public information about their financial health: **proposed rate filings** (how the insurer is justifying an increase) and **year-end annual statements** (data on a company's finances over time and more specifically during the last year).

We have previously written about how to read and challenge rate filings.[1] Here we explain how to find and understand some important financial indicators from an insurer's annual financial statement. Consumer advocates can use these indicators to determine whether an insurer's financial health merits the insurer's request to raise premium rates, or on the other hand, whether insurers could do more to keep rates affordable and benefit the community.

Four indicators are key to determining an insurer's financial health

The four indicators we discuss show how much money an insurer made, how much it has in reserves, and whether that's the right amount for the insurer to stay solvent. Together, these indicators point to the financial health of an insurer. If an insurer is doing well according to these indicators, advocates can challenge premium increases by pointing out that insurers might not need the extra money.

Indicators

Indicators of a company's profitability: How much money an insurer made per premium dollar after expenses:

1. **Net income to net premium ratio:** Looks at money from all sources (including investments).
2. **Net underwriting gain to net premium ratio:** Looks at money from premiums alone.

Indicators of a company's assets

3. **Total capital and surplus:** How much capital and surplus the insurer has accumulated over time. Capital and surplus comprise a company's assets minus its liabilities (its financial obligations)—in other words, the overall worth of the company.
4. **Capital to remain financially viable:** How much capital and surplus the insurer holds above what regulators consider to be necessary in order to be financially viable (this indicator is known as the "ratio of adjusted capital to authorized control level risk-based capital")

Consumer advocates can play an important role in preserving the affordability of health insurance by challenging unfair premium increases. This guide will help advocates assess the financial status of health insurers and use that knowledge to bolster their arguments for lower rates.

How much is too much? How much profit should health insurance companies make?

Unfortunately, there is no agreed-upon guidepost for how much money a for-profit insurer should be allowed to make. (Nonprofit insurers can be held to more stringent standards.)[2]

Federal rules limit the percentage of money that insurers receive from enrollee premium payments (known as "premium dollars") that are spent on administrative expenses (such as marketing, for example). Insurers are required to spend 80 to 85 percent of after-tax premium dollars on medical care and quality improvement. But beyond this 80-85 percent threshold, there is no federal law preventing for-profit insurers from raising premiums purely for profit's sake.

During the rate review process, advocates must convince regulators to strongly consider consumers' need for affordable premiums, especially when an increase in rates will give the insurer more money than it needs and more than is appropriate for the benefits that it offers. *See the detailed "More on rate review" sidebar at the end of this paper.*

Rate review timeline for 2016

The Affordable Care Act requires a process for the annual review of potentially unreasonably high rate increases. If a state does not establish an effective process to review rate increases, the Centers for Medicare and Medicaid Services (CMS), a division of HHS, will perform the review.

- **May 15 or up to June 5, 2015, in some states:** Health insurance companies offering individual (non-group) or small-group plans must file their proposed rates for plans (those that will be offered in 2016) by May 15 with state and federal regulators.
- **June 1 or up to June 19, 2015, in some states:** By June 1, state regulators or CMS will post justifications of rate increases under review for public comment.[3]
- **Late summer/early fall:** Regulators and plans will be finalizing the rates.
- **October 30 or November 1, 2015:** Final rates must be publicly posted. This is just prior to the start of open enrollment for 2016. (See http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-Key-Dates-QHP-Certification-in-the-FFM-Rate-Review-and-3Rs-final.pdf.)

The rigor of laws governing rate review vary by state. Some states will review all proposed rates and reject those they consider unreasonable; others have rate review processes in theory but reject very few proposed rates. At the other extreme, in states that do not have an effective review process, CMS will review proposed rate increases of 10 percent or more this year, consider the rates in deciding whether a company can sell its product in the federal marketplace, and post notices about increases it considers unjustified. The federal government cannot, however, require a company to lower its rates.

Where to find health insurers' annual financial statements

Advocates and regulators may want to look both at the insurer's financial history, shown through the annual statements we describe here, and at the proposed rate filing in order to get a full picture of whether a rate increase is warranted. For the annual statement, you can use the National Association of Insurance Commissioners database (below). To obtain the proposed rate filing, check with your state insurance department to learn where it is posted.

The National Association of Insurance Commissioners (NAIC) provides financial information about all insurers on its "Consumer Information Source" (https://eapps.naic.org/cis/). Individuals and organizations can download five annual statements for free (there is a fee for additional statements).

How to navigate the NAIC site

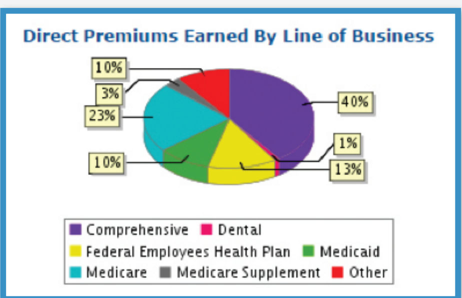
- **Search the name of the company.** If you do not find an exact match, try entering part of the name (e.g., Kaiser instead of Kaiser Permanente.) If you know the company number, use that to search instead.
- **For business type, select "All."** This will give you both "health" companies and "life, accident, and health" companies.
- **Now you will view a list of companies by home office.** The company you are interested in may have its home office in a different state. You may need to check with your insurance department or look at other documents from that health insurer (such as its rate filing) to find out where the company that you are interested in has its home office.
- **When you have identified the company, you can download graphs and annual statements.** To view graphs that show how the company's premium income has grown over the past three years, how its assets have grown, and how some of the ratios we discuss have changed, select "financial information" and then "get financial profile." Or you can view the past year's annual statement, which includes some historical information for the past five years, by selecting "Get pdf statement data."

Getting started by using NAIC's graphs

Before you delve into the details of the annual financial statement, use the snapshot graphs from the insurer's "financial profile" page to get an overview of how the company has been doing over the last three years.

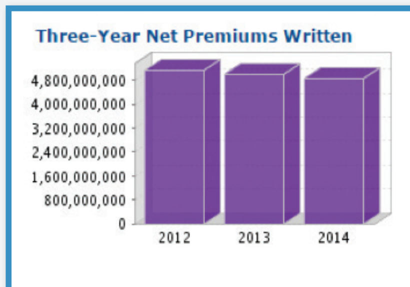
To help you understand this, here are a few screenshots of how NAIC presents a particular insurer's financial profile. (Since our goal in this paper is simply to explain how to find and analyze data, we will call this Company X rather than its real name.)

National Association of Insurance Commissioners financial profile for Company "X"



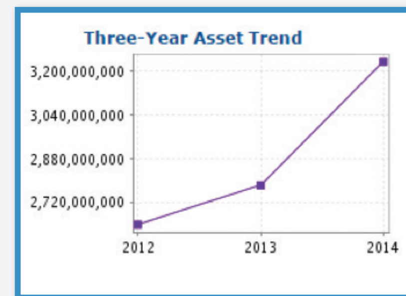
Direct Premiums Earned by Line of Business

Company X sold lots of different types of health insurance, but comprehensive coverage in the group or individual market was a large share of its business.



Three-Year Net Premiums Written

In each of the last three years, Company X has sold or renewed slightly less insurance (expressed in premium dollars) than the previous year.



Three-Year Asset Trend

This graph, however, shows that Company X's assets have increased.

Three-Year Income/Loss Trend

You can see how Company X made more money in health insurance premiums than its expenses (underwriting gain) and that, despite earning slightly less from investments in 2014 than in 2012, in each of the three years, the company earned more income after expenses than the previous year (net income).

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Now that you have that overview, you can dig in deeper by using the insurer's annual statement itself.

What to look at in a health insurer's annual financial statement:

Some companies sell health insurance only, and they file health annual statements. Others sell more types of insurance, so they may file a life, health, and accident annual statement instead.

Regardless, the statements contain similar information, as explained below.

Profitability Indicator #1: Net Income to Net Premium Ratio

How much money did the insurance company make per premium dollar?

In order to make a compelling case that an insurer's proposed rate increases are too high, you'll want to demonstrate that an insurer's profits are too high when compared to other insurers—you can do that by comparing one company's profits and premium rates against another's.

First, let's start by looking at one insurer's net income—how much they received from all sources, including enrollee's premium payments (premium dollars) as well as income from investments. The purple line in this graph shows you how much this insurer's net income changed over three years (it didn't—you can see how the line is mostly flat). But you may want to know how one company's net income compares to another company's income, and to make a fair comparison, you'll need to take the size of each company into account. One way to account for variations in size is to examine how much income the company earned compared to each premium dollar it received.

Definition of net income to net premium ratio

Of course, premiums are not an insurer's only source of income; health insurers also receive income from investments. The "net income to net premium" ratio compares how much money an insurer took in overall after expenses (net income) to how much it received from premiums (net premiums). This gives us a single number that makes it easy to compare the profitability of businesses of differing sizes.

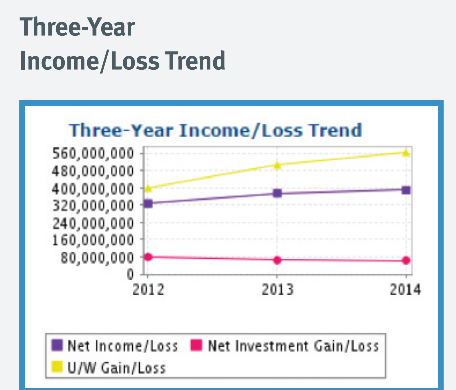
For example, a ratio of 5 percent would mean that, for each premium dollar collected, after factoring in an insurer's income from investments and how much it spent on expenses, the insurer earned 5 cents beyond its expenses. That ratio is not on the annual financial statement—you'll need to calculate it yourself (see below).

- **Net income** is the amount of an insurer's profit—income from all sources (minus expenses for items such as medical care, administration, certain taxes including federal income tax, and the amount they must contribute to reserves to assure their future solvency).
- **Net premiums** is the total amount of money that insurers collected for that year from premium payments made by enrollees (also known as "premium dollars") minus any amounts the insurer paid to policyholders as rebates due to the medical loss ratio requirement (See "How much is too much?" section at the end of this paper for more).

To calculate the ratio and then express it as a percentage, you'll need to divide Net Premium by Net Income and then multiply by 100, like this:

Net income $ / Net premium $ X 100

Example: Let's say a health insurer with net income of $400 million collected $5 billion in health insurance premiums. Net income $400,000,000/net premium $5,000,000,000=.08, or 8 percent.



Where to find the data:

- **Net income** in the "health annual statement" used by companies that sell only health insurance: page 4, line 32.
- **Net income** in the "annual statement" for life and accident and health companies (used by companies that sell several types of insurance): page 4, line 35.
- **Net premium** in the health annual statement: page 4, line 2.
- **Net premium** in the annual statement for life, accident, and health companies: page 4, line 1.

Understanding this indicator: What to look for

If the ratio is positive (e.g., .08 or 8 percent), the insurer is earning money beyond its expenses.

If the ratio is negative, (e.g., -.01 or -1 percent), the insurer lost money this year.

For-profit insurers typically earn a net income to net premium ratio between 3 percent and 5 percent.[4] Thus, a ratio above 5 percent should raise questions for advocates and regulators about whether premiums are excessive. A net income to net premium gain of 1 percent probably will not raise concerns for advocates. But the current year's ratio is only part of the story.

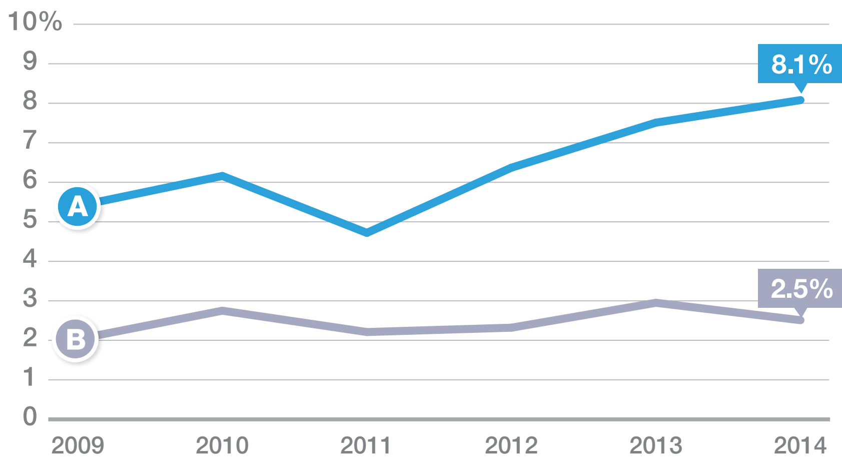
- Check the company's trend line—how the ratios have changed for the past few years.
- Check to see how one insurer compares to another in your state.
- Look at whether the insurer needs to build income or not, given the amount of capital it already has (explained in Indicators #3 and #4 below).

Example of indicator #1: net income to net premium ratio

In Figure 1, we used the last five years of annual statement data to graph the net income per premium dollar of Company A and Company B in Figure 1. These are examples of two scenarios that you're likely to find.

As you can see from Figure 1, Company A's earnings per premium dollar were less in 2011, but since then its profits have risen a lot—more each year than Company B.

Figure 1. Net Income/net premium income ratio



Source: Families USA

Profitability Indicator #2: Net Underwriting Gain to Net Premium Ratio

How much money did the insurance company make from premiums alone per premium dollar?

This is another indicator of the profitability that can be useful when comparing insurers of differing sizes. "Underwriting gain" refers to the amount of money an insurer has retained from premiums paid by enrollees after the company paid medical claims, underwriting expenses, administrative expenses, and most taxes (but before paying federal income taxes).

The yellow line on this graph shows the company's underwriting gain over three years. But underwriting gain alone doesn't tell the whole story.

Advocates can determine how much a company earned from each premium dollar the insurer collected in order to better compare the profitability of companies if premiums were their only source of income—the net underwriting gain to net premium ratio.

For example, a net underwriting gain to net premium ratio of 5 percent means that, for each premium dollar collected, after medical, underwriting, and other expenses, the insurer was able to keep 5 cents before federal income tax.

As with the previous indicator, expressing this as a ratio (or percentage) allows you to compare one company's gain per premium dollar with another company of a different size. This will help you make the case that a company is out of line with others in the market or with accepted norms. We show you how to calculate it below.

Definition of net underwriting gain to net premium ratio

Net underwriting gain is the amount of money insurers retain from premiums after paying medical claims called "incurred losses," underwriting expenses, administrative expenses, and most taxes (but not federal income tax). *(Note that in computing net income, companies subtract their federal income tax from income, but in computing their net underwriting gain, they do not.)* It differs from net income (explained in Indicator 1) in that it only includes **money gained from premiums**; not from investments. The ratio of net underwriting gain to net premium earned demonstrates a company's profitability if premiums were its only source of income.

Where to find the data:

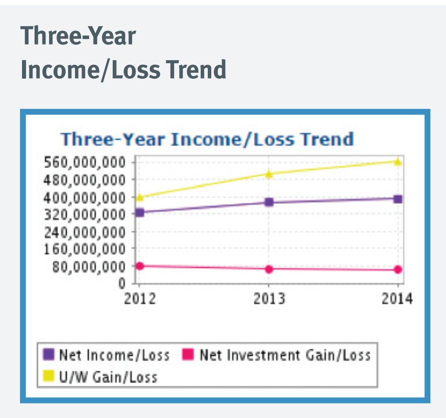
- Annual statement for health insurance companies: page 4, line 24 (look for "underwriting gain").
- Annual statement for life, accident, and health companies: Schedule H, page 37, line 14.

To calculate the ratio and then express it as a percentage, you'll need to divide net underwriting gain by net premium and then multiply by 100, like this:

Net underwriting gain $ / Net premium $ X 100

Example: Let's say a health insurer with net underwriting gain of $600 million collected $5 billion in health insurance premiums. Net underwriting gain $600,000,000/net premium $5,000,000,000=.12, or 12 percent.

Three-Year Income/Loss Trend



Understanding this indicator: What to look for

Consumer advocates may feel strongly that premiums should be set high enough only to cover medical claims and the company's administrative expenses, rather than for the company to build assets or profit—especially if the insurer is incorporated as a nonprofit company. On the other hand, for-profit insurers are only likely to continue marketing policies in an area if they are making profits from their business, so advocates will need to weigh what they consider appropriate as they comment to regulators.

Advocates should question rising trend lines that show that an insurance company which already has plenty of capital and surplus (defined on page 10) is building ever-larger underwriting gains per premium dollar (see figure 2, Company A to see what this trend looks like). But even a flat trend line merits scrutiny—advocates can question underwriting gains that remain on the same high levels as previous years if consumers cannot afford their premiums.

Lastly, be aware that companies may use different pricing strategies for different years. For example, insurers may deliberately set premiums low some years in order to gain market share and then hike premiums dramatically in a future year. So you might see a trend line that drops for the first few years and then sharply rises in subsequent years. In order to determine if the dips indicated a problem or a deliberate strategy, you may need to bring other information to bear (such as your knowledge of whether insurers in your state were competing for a new line of business).

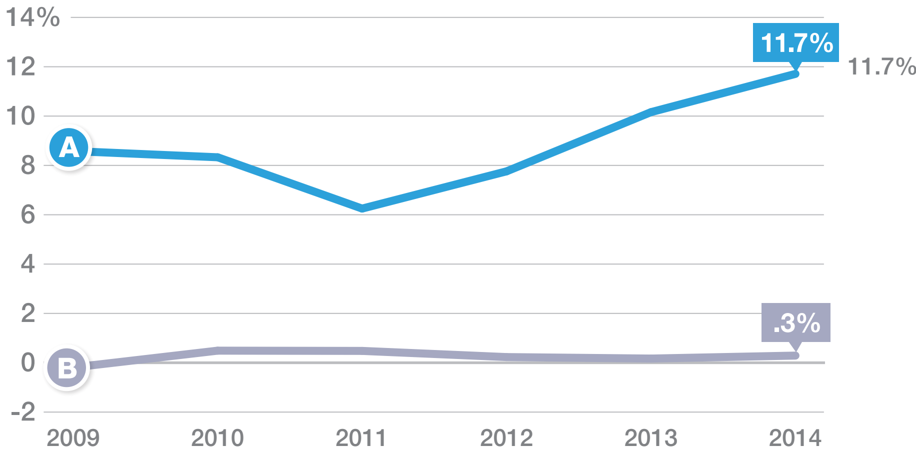
Example of indicator #2: net underwriting gain to net premium ratio

This graph shows that Company A's underwriting gains per premium dollar have increased even more than its net income per premium dollar (the amount shown on the previous graph). Premiums are more than covering the company's expenses and, in 2014, Company A profited nearly 12 cents for each premium dollar that it collected. You can see this because Company A's profit for 2014 is 11.7 percent above each premium dollar collected (or 11.7 cents).

In contrast, Company B is maintaining an underwriting gain which is just a fraction above premiums—the line is flat, and the gain is low on the scale. This is the kind of trend line that you would hope to see for a nonprofit insurer.[5]

(Note that net underwriting gain/net premium may be higher than net income/net premium for a variety of reasons—for example, because federal income tax payments are subtracted in computing net income but not in computing net underwriting gains.)

Figure 2. Net underwriting gain/net premium income



Source: Families USA

Asset Indicator #3: Total Capital and Surplus

The overall worth of the company after financial obligations

Capital and surplus comprise a company's assets minus its liabilities (its financial obligations)—the overall worth of the company. In other words, if the company were to end its operations and put its assets (stock, surplus notes, property, and other investments) up for sale, this indicator shows the worth (total value) of those assets. It does not include the amount that the insurer is required to keep in reserve in order to pay anticipated claims. Capital and surplus can accumulate over the years.

Where to find the data:

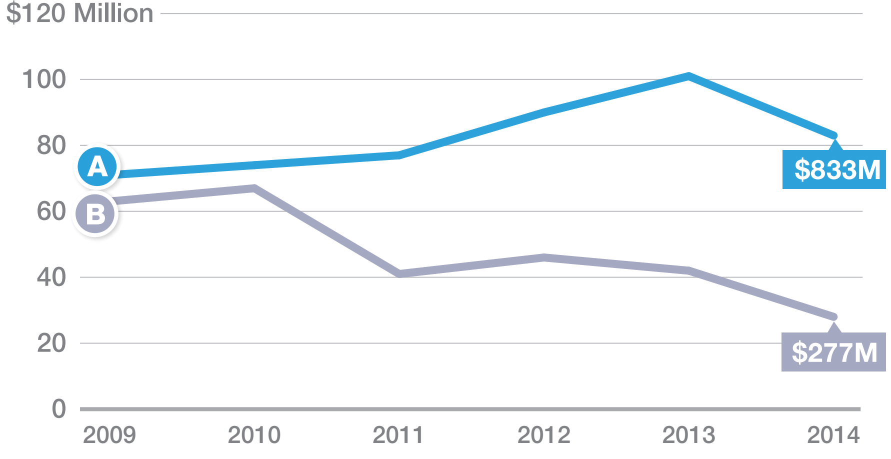
- Annual statement for health insurance companies: Liabilities, capital, and surplus page of the statement, page 3, line 33.
- Annual statement for life, accident, and health companies: Summary of operations page of the statement, page 4, line 55.

Understanding this indicator: What to look for

You can look at one company's capital and surplus over time, and how the changes in one company's fortunes compare to the trends for other companies. Be aware that a company's holdings may change in any given year based on ups and downs in the stock market or in other investments that have no direct relationship to health insurance premiums. Also, capital and surplus may be reduced due to dividends paid to stockholders. (In many cases, the insurer's sole stockholder is its parent company.) Stockholder dividends are shown on page 5, line 46 of the annual statement for health insurance companies and on page 4, line 52 of the annual statement for life, accident, and health companies. But since companies have varying needs for capital, this measure may not be as useful to consumer advocates as the ratio we describe under #4 below.

Example: Both Company A and Company B had declining surplus in 2014. Over five years, Company A experienced ups and downs in capital and surplus while Company B experienced a decline. If you want to probe further into the financial statements, you might find that the decline occurred because of a decline in the worth of investments or you might find that it was because of dividends paid out to stockholders.

Figure 3. Total capital and surplus



Source: Families USA

Asset Indicator #4: Ratio of Adjusted Capital to Authorized Control Level Risk-Based Capital

A model law of the National Association of Insurance Commissioners provides the formula for how much capital health insurers should hold, given the risks of their business, to ensure that they will have more than enough assets to cover unforeseen expenses.[6] But some insurers have far more than is required, and this helps you know there is room for scrutiny.

- **Risk-based capital:** Shows whether an insurer has enough money to protect its policyholders. To be financially sound, regulators require an insurance company to have a certain amount of "risk-based capital" – that is, enough capital to pay claims and protect an insurance company's solvency given the risks of its business. The amount of risk-based capital that an insurer is required to keep on hand depends on the size of the company, and what amount of risk it takes on.
- **Authorized control level:** There is a point at which an insurance regulator would take control of a company when it is in financial danger (that is, it doesn't have sufficient capital) in order to make sure the company is able to pay members' claims. This is known as the "authorized control level."
- **Adjusted capital:** The amount that the company actually holds.

Where to find the data:

- Annual statement for health insurance companies: In the five-year historical data page, look for total adjusted capital on page 29, line 14. Look for authorized control level risk-based capital on line 15.
- Annual statement for life, accident, and health companies: page 22, lines 30 and 31.

To calculate the ratio, you'll need to divide Authorized Control Level Risk-Based Capital by Total Adjusted Capital, like this:

Authorized Control Level Risk-Based Capital $ / Total Adjusted Capital $

Example: Let's say a health insurer with authorized control level risk-based capital of $830,000,000 actually held total adjusted capital of $180,000,000. Authorized control level RBC $830,000,000/adjusted capital $180,000,000=4.6. Or you can multiply by 100 to express it as a percentage (e.g., 460 percent).

In this example, the insurer has 4.6 times the amount of capital that would cause a regulator to take control of the company.

Understanding this indicator: What to look for

A regulator's concerns are triggered by a ratio of 3 or lower (this may also be expressed as a percentage, e.g., 300 percent or lower). The Centers for Medicare and Medicaid Services (CMS) requires cooperative health plans to maintain a ratio of at least 5 (500 percent).

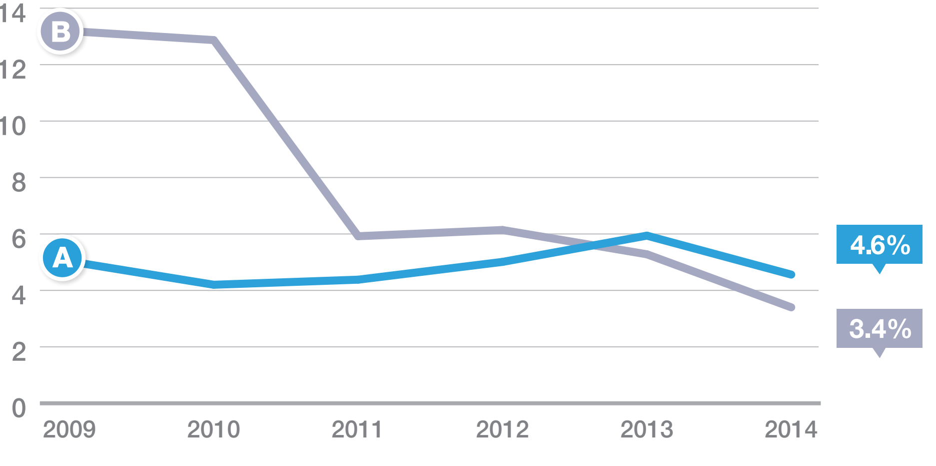
If a nonprofit insurer shows a ratio that is significantly higher than 3 or 5 (for example 7), you can question whether that insurer is accumulating too much money to be true to the public's interest. (See the sources in endnote 2 for examples of state decisions about excessive surplus levels of nonprofits.) If the insurer is a for-profit company, you can question whether a for-profit insurer that is hiking premiums really needs to do so given its risk-based capital ratio, the amount of money that insurers need to stay solvent. They should have enough, but not too much, and the risk-based capital ratio allows you to gauge this amount.

As mentioned, the National Association of Insurance Commissioners' model law provides the formula for how much capital health insurers should hold, given the risks of their business, to ensure that they will have more than enough assets to cover unforeseen expenses.[7] Regulators take control of a company when its adjusted capital dips to the authorized control level; they watch companies that have less than three times the authorized control level and ask them to submit plans to improve their financial position.

You may want to examine net underwriting gain to net premium again now that you know the company's overall financial position. If the company has more adjusted capital than it needs, why should it be allowed to continue increasing its profits by raising premiums? Even if a company's ratio has recently declined to look more reasonable, you still may want to ask questions. For example, a for-profit company may have paid dividends to stockholders, bringing its capital and surplus down; but advocates may want to make the case that the company should use some of its excess capital and surplus to lower premiums as well.

Example: For-profit Company A has held to a fairly steady adjusted capital to authorized control level risk-based capital ratio, one high enough to allay regulatory concerns (as we explained earlier). On the other hand, Company B, a nonprofit, had far more in capital and surplus in 2009 than it required (and far more than may be appropriate for a nonprofit), and it spent down substantially in 2011. In 2014, Company A's capital and surplus was slightly above required levels, but if it continues to decline, regulators will be concerned.

Figure 4. Adjusted capital/authorized control level RBC



Source: Families USA

More on Rate Review: How Much Can Advocates Limit Profits During Rate Review?

How much is too much?

As noted earlier, there is no agreed-upon guidepost for how much money a for-profit insurer should be allowed to make (nonprofits can be held to more stringent standards). According to federal regulations, a rate increase is excessive if "the increase causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided."[8]

Federal rules limit the percentage of money that insurers receive from enrollee premium payments (known as "premium dollars") that are spent on administrative expenses (such as marketing, for example).

All insurers (both for-profit and nonprofit) are required to spend 80 to 85 percent of premium dollars on medical care and quality improvement. If they go below this amount by spending too much on other expenses (such as administrative expenses), insurers must issue rebates to enrollees. But if insurers stay within the 80-85 percent threshold, there are no federal rules that prohibit a for-profit insurer from raising premiums purely for profit's sake (on the state level, however, this varies because some states have stronger rules).

For nonprofit insurers, however, the case is clearer that they should operate in the interest of their enrollees and the community, and should not be accumulating excess wealth—and regulators recognize this. In fact, some regulators and courts have ordered nonprofit insurers to limit surplus— the wealth or capital that exceeds what the insurer needs to pay claims and assure the company's solvency— and to even give back excess surplus to the community.[9]

The advocate's goal in rate review

The advocate's goal is therefore to convince regulators to give strong consideration to the consumer's need for affordable premiums when they decide whether to approve proposed rates, and to determine that unaffordable premiums are unreasonably high especially when the insurer has more than enough money to operate its business.

Conclusion

Consumer advocates, as well as regulators, can get lots of useful information from health insurers' annual statements that will help put an insurer's proposed rates into context. While the statements may seem overwhelming at first glance, concentrating on the lines and ratios we list above should make the task much easier.

Each spring and summer, as insurers post their proposed premium rates for next year, consumer advocates around the country will play an invaluable role in speaking up for people who need premiums to be affordable. Materials from Families USA (www.familiesusa.org) and from Consumers Union (www.consumersunion.org) can help you get started and connect with experienced advocates in other states who have had success in bringing down premium rates.

Endnotes

[1] Families USA, *Rate Review: How to Challenge Unreasonable Health Insurance Premium Increases*, May 2015, http://familiesusa.org/rate-review.

[2] Chad Terhune, “With billions in the bank, Blue Shield of California loses its state tax exempt status,” Los Angeles Times, March 8, 2015,http://www.latimes.com/business/la-fi-blue-shield-california-20150318-story.html#page=1; Larry Kirsch, et al., How Much Is Too Much? Have Nonprofit Blue Cross Blue Shield Plans Amassed Too Much Surplus? (San Francisco: Consumers Union, July 2010), http://consumersunion.org/wp-content/uploads/2014/04/surplus_report.pdf ; “HCSC Members Want a Piece of $5 Billion,” Courthouse News Service, May 21, 2014, http://www.courthousenews.com/2014/05/21/68071.htm, and D.C. Department of Insurance Securities and Banking, *Decision and Order: Surplus Review and Determination for Group Hospital and Medical Services Inc, Order #14 -MIE-012*, December 30 2014, accessed on 5/12/2015 at http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/Order14-MIE-12.pdf.

[3] 45 Code of Federal Regulations, Sections 154.101 through 154.301 and Center for Consumer Information and Oversight, Center for Medicare and Medicaid Services, Insurance Standards Bulletin, April 14, 2015, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-on-rate-review-timeline-final.pdf. States can set earlier deadlines.

[4] American Academy of Actuaries, *Premium Setting in the Individual Market*, March 2010, http://actuary.org/files/publications/premiums_settings_mar2010.pdf.

[5] Nonprofit health insurers should limit their gains to stay true to their nonprofit missions. They are not designed to provide a return for investors, but may instead be incorporated as nonprofit mutual companies for the benefit of their policyholders or as charitable and benevolent organizations, for example.

[6] “Risk-Based Capital” page of the National Association of Insurance Commissioners website, updated February 27, 2015, http://www.naic.org/cipr_topics/topic_risk_based_capital.htm and National Association of Insurance Commissioners, *Risk-Based Insurers Model Act*, 2012, http://www.naic.org/store/free/MDL-312.pdf.

[7] “Risk-Based Capital” page of the National Association of Insurance Commissioners website, updated February 27, 2015, http://www.naic.org/cipr_topics/topic_risk_based_capital.htm and National Association of Insurance Commissioners, R*isk Based Insurers Model Act*, 2012, http://www.naic.org/store/free/MDL-312.pdf.

[8] 45 Code of Federal Regulations, Section 154.205.

[9] See endnote two for examples.

A selected list of relevant publications to date:

Rate Review: How to Challenge Unreasonable Health Insurance Premium Increases (May 2015)

States Making Progress on Rate Review (October 2011)

For a more current list, visit:
www.familiesusa.org/publications

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