Health Insurance Premiums, the Underwriting Cycle, and Carrier Surpluses

In addition to insurer surplus, insurer TAC may include funds borrowed from a parent company or affiliate (called surplus notes) and statutory reserves. Some analysts argue that it may not be appropriate to compare surplus of a subsidiary of a parent company to the surplus of an entity that is part of a holding company structure; for example, a local insurer operating as a wholly owned subsidiary of a parent company may just hold the statutory minimum surplus levels and get cash infusions from the parent company when necessary; the timing of dividends to the parent company could also affect surplus calculations.

Insurers continually raise the issue of holding higher reserves against catastrophic acts of terrorism. There is no way to gauge how high surplus should be for such events. The 109th Congress may consider whether to provide tax incentives for surplus insurers in the same way that it did for property casualty insurers after the September 11th attacks.

One such effort, the Maryland/D.C. Collaborative for Healthcare Information, seeks to operationalize a secure, HIPAA-compliant, community data exchange infrastructure across the State of Maryland and Washington, D.C., region. The Collaborative ultimately will link data from all the components in the Maryland/D.C. health care delivery chain—physician offices, hospitals, clinics, labs, imaging centers, nursing homes, payers, and patients—to securely and appropriately exchange health information. CanFirst indicated support for this initiative in its January 2005 announcement.

In its most recent expenditure report, the Maryland Health Care Commission reported that medical expenses incurred by third-party payers increased 6 percent, but insurers’ premium growth increased 8 percent overall and nearly 10 percent per capita. 1 The faster growth of total premiums reflects a steep increase in insurers’ administrative expenses plus the net cost of insurance—more than 17 percent in 2003, which in Maryland, as in many other States, reflects rising levels of insurer surplus.

Insurers accumulate surplus from annual underwriting gains—direct premiums that exceed medical and administrative costs. Insurers hold surplus against unexpected changes in health care costs or returns on assets, or to finance expenditures on capital assets (such as information technology) or strategic initiatives (new product launches or acquisitions). Some insurers also finance community benefit initiatives from surplus. 1 This spotlight report examines recent changes in surplus among Maryland insurers and the implications for premium increases over the next several years.

The Underwriting Cycle

Historically, insurers have tended to accumulate surplus over a period of about 3 years, and then lose surplus over the next few years (see trends for Blue Cross Blue Shield (BCBS) in Figure 1). Called an underwriting cycle, insurers’ characteristic pattern of underwriting gains and losses is largely explained by competition. In periods of underwriting gains, some insurers may seek to build market share by reducing premiums. Other insurers will follow suit to protect their market share. As premiums fall relative to health care costs, many insurers may experience underwriting losses. Premiums will continue to decline relative to medical benefits until a lead insurer with market power raises premiums to restore at least “break even” revenues. As other insurers follow suit, premiums will rise relative to medical benefits, and insurers will try to take underwriting gains to offset the “bad years.” Eventually, the cycle will repeat, as one or more insurers will attempt to gain market share at the top of the cycle. If health care costs are rising during the underwriting cycle, consumers may experience the cycle only as changes in average premium growth.
Nationally, a number of changes in health insurance markets have converged to encourage greater concentration. As health care costs have risen, insurers have focused on reducing administrative costs to constrain the growth of premiums. By acquiring or merging with competitors, they may spread fixed costs over greater premium volume to reduce administrative costs relative to premiums. In addition, for-profit health insurance companies are a growing segment of the market nationally and in Maryland. Capital markets reward for-profit companies for growth, and again, acquiring or merging with competitors is a simple way to achieve rapid growth. The most significant changes in Maryland’s health insurance market have been mergers and acquisitions—not net new entry. Most other States have had a similar experience.6

Trends in Maryland

Insurers in Maryland have posted underwriting gains averaging 4 to 12 percent each year since 1999 (Figure 2), maintaining surplus of 19 to 27 percent of premium each year, and largely offsetting reductions in administrative costs.7 While insurers drove average administrative costs for group coverage from 22 percent of premiums in 1999 to 19 percent in 2001 to just more than 15 percent in 2003, consumers have felt little benefit. Instead, insurers have used underwriting gains to build surplus during the upswing of the underwriting cycle, not to reduce premiums.

The National Association of Insurance Commissioners (NAIC) has established standards by which all insurers measure the capital that they hold using a formula that considers their balance sheet and asset risk, as well as their underwriting, credit, and business risk. This measure defines each insurer’s “total adjusted capital” (TAC) as well as its “authorized control level” (ACL) risk-based capital. If an insurer’s TAC falls to 200 percent of ACL (called the “company action level”), the insurer regulatory may intervene to place the insurer under regulatory control as an early precaution against the insurer becoming insolvent.8

While analysts do not agree on the appropriate level for TAC, most would argue that a well-managed carrier should not let TAC drop to 200 percent of ACL. Most insurers in the United States hold surpluses in the range of 350 to 400 percent, even at the low point in the underwriting cycle. In Maryland, health insurers have more than doubled their surplus or TAC since 1999. Aggregate TAC in Maryland increased from $773 million in 1999, to $1.7 billion in 2003 (Figure 3). In 2003, Maryland insurers’ capital assets averaged nearly seven times ACL. In part, this reflects the importance of the CareFirst affiliates in Maryland’s market and the highest minimum that Blue Cross Blue Shield (BCBS) Association sets for its member companies—375 percent of ACL, nearly twice the minimum level of surplus held by other health insurers in the market.7 Nevertheless, among Maryland companies, the CareFirst affiliates did not hold the highest levels of TAC relative to ACL in 2003 (Figure 4).8

Like insurance regulators in every State, the Maryland Insurance Administration (MIA) requires all insurers in Maryland to hold capital as a buffer against unanticipated medical expenses as well as swings in the value of their invested capital. Surplus generally accounts for all or most of this capital.9

![Figure 2: Average Underwriting Gain and Administrative Cost Trend as a Percent of Premiums for Group Coverage, Maryland Insurers, 1999–2003](image)

Source: Mathematica Policy Research tabulation of data from the Maryland Insurance Administration. Annual data are trimmed to omit anomalous reporting. Administrative cost trend is calculated as a moving average.

![Figure 3: Total Adjusted Capital Relative to Regulatory Levels, Maryland Insurers, 1999–2003](image)


It is hard to say precisely when surpluses become too large. Insurance regulators in general err on the side of caution in encouraging carriers to maintain large surpluses. In a purely competitive market, with many insurers of similar size, a regulatory preference for large surpluses makes sense: the market will require insurers to spend down surplus in the course of normal competition. However, in more concentrated markets, it may have unanticipated negative impacts. A regulatory bias toward large surpluses may increase the consumer cost of insurance without securing greater market stability. Large competing insurers may spend down surplus as they grapple for market share, and large surpluses may provide greater opportunity for such “price wars” to occur. It is unlikely that either a large competitor would abandon a well-regulated market or that a new competitor would enter a highly concentrated market.

Some States have worked with large nonprofit insurers, in particular, to direct high surpluses toward broader health care initiatives. For example, Massachusetts has established formal community benefit guidelines for nonprofit HMOs in the State. In December 2004, BCBS of Massachusetts pledged $50 million to the Massachusetts Health Collaborative (MHC), a nonprofit effort to expand use of electronic health records in Massachusetts.10 In January 2005, CareFirst announced a $92 million initiative intended to address its community benefit obligations; of this amount, $60 million would be a reduction in premiums against anticipated 2005 levels. In January 2005, CareFirst announced a $92 million initiative intended to address its community benefit obligations; of this amount, $60 million would be a reduction in premiums against anticipated 2005 levels. In early February 2005, the State of Pennsylvania formalized the prospective “community activities” of the four Pennsylvania Blue plans (though the Commissioner of Insurance ruled that the plans were not operating “with inefficient or excess surplus”). The plans agreed to commit $150 million annually to a 6-year community health reinvestment program, including $85 million to support basic health coverage for low-income and uninsured residents, and $65 million for other community activities related to health care.

Implications

As the underwriting cycle depresses underwriting gains, Maryland insurers may draw down surpluses over the next several years. Moreover, with growing concentration in Maryland’s market, it is possible that the underwriting cycle in Maryland has become longer and shallower as well, and insurers could respond to lesser market volatility by holding lower surplus throughout the underwriting cycle.7 If so, and if health care cost growth slows, Maryland employers could begin to see some benefits from the market concentration that has occurred in the past decade. Both lower administrative costs and reduction of the current, relatively high levels of surplus that most insurers are holding may yield substantially lower premium increases than in recent years.

High surplus offers insurers a competitive advantage: they can use surplus to protect market share against carriers that may try to enter the market. With such high surplus, Maryland carriers are poised to respond aggressively to the threat of market entry, and also to competitors that may try to take market share. As in recent years, new carriers may enter by acquisition, but additional competitors would hesitate to enter a market where the largest carriers are holding such high levels of surplus.

![Figure 4: Total Adjusted Capital as a Percent of ACL Risk-Based Capital: Selected Major Health Insurers in Maryland, 2003](image)


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7 The regulatory action level (ACL) is the lower 25th percentile of the distribution of risk-based capital required by the NAIC. That is, 75 percent of all insurers have greater than 200 percent of ACL. In 2003, for example, the ACL for health insurers was 216 percent.

8 Assessing regulatory standards for community benefit activities is an increasingly important policy issue in many States and the Federal government. However, this is beyond the scope of this paper.

9 See, for example, Mathematica Policy Research analysis of public data from the Maryland Insurance Administration.

10 See “Insurance plans agree to provide $50 million for community health programs,” Health Care News, January 21, 2005.
Nationally, a number of changes in health insurance markets have converged to encourage greater concentration. As health care costs have risen, insurers have focused on reducing administrative costs to constrain the growth of premiums. By acquiring or merging with competitors, they may spread fixed costs over greater premium volume to reduce administrative costs relative to premiums. In addition, for-profit health insurance companies are a growing segment of the market nationally and in Maryland. Capital markets reward for-profit companies for growth, and, again, acquiring or merging with competitors is a simple way to achieve rapid growth. The most significant changes in Maryland’s health insurance market have been mergers and acquisitions—not net new entry. Most other States have had a similar experience.6

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MHCC is an independent, regulatory commission administratively located within the Maryland Department of Health and Mental Hygiene. Since 1990, the underwriting cycle has lengthened slightly and the difference between the high and low points of the cycle has diminished. This change may relate to increased concentration in health insurance markets: as fewer and larger insurers dominate the market, smaller insurers may “shadow price” the larger firms rather than setting the lowest feasible price, which might invite more business than they could manage. Without competitive behavior intended to take market share, an underwriting cycle may not be triggered or may be relatively weak if it does occur. Because regulatory practice in all States in general presumes competition among many insurers, the growing concentration of health insurance markets is a national concern. One recent study identified Maryland among seven States where the five major national carriers controlled approximately 90 percent of the privately insured market.

Until a lead insurer with market power raises premiums to restore at least “break even” revenues. As other insurers follow suit, premiums will rise relative to medical benefits, and insurers will try to take underwriting gains to offset the “bad years.” Eventually, the cycle will repeat, as one or more insurers will attempt to gain market share at the top of the cycle. If health care costs are rising during the underwriting cycle, consumers may experience the cycle only as changes in average premium growth.

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Average health insurance premiums in Maryland for large and small insured groups have risen in double digits for the last several years. The growth in premiums has reflected the growth of health care costs in general, and the cost of medical benefits paid by private insurers, in particular. However, the growth in medical expenses has slowed in recent years, while insured group premiums in Maryland have increased at nearly the same double-digit rate.

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