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## The Rural Implications of Geographic Rating of Health Insurance Premiums

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### INTRODUCTION

In 2014, the Patient Protection and Affordable Care Act (ACA) will eliminate the practice of medical underwriting in the individual and small group markets, require guarantee issue to consumers regardless of health status, and reduce the number of factors that health plans may use to vary premium rates. These rating factors will include age (maximum difference of 3 to 1); tobacco use (maximum 1.5 to 1 difference), family composition, and geographic region. Under law and the implementing regulations states will devise the Affordable Insurance Exchange rules that will specify the extent to which health plans may vary rates across rating areas.

Prior national research suggests that rural residents pay higher premiums for their health coverage than do urban residents when benefit design is held constant.<sup>1</sup> However, it is unclear whether this difference has been the result of higher administrative cost loading on rural premiums; unhealthier rural populations in experience-rated plans; geographic rating of health premiums; or, some combination of these factors. Rural health experts have speculated that geographic rating under ACA could have a substantial impact on health insurance premiums in rural communities.<sup>2</sup> However, there is limited information about how geographic rating has been applied to rural versus urban areas. Nor is it clear what the rural implications of continued geographic rating might be under ACA.

This brief examines how and to what extent states allow health plans to vary premiums by geographic rating area and, using insurance data from selected

states, assesses the direction and magnitude of variations in rural and urban geographic rating factors. We conclude with a discussion of strategies that federal and state policymakers might use to help ensure that premium variations based on geography are justified.

#### Key Points

**There is no clear pattern of geographic rating factors favoring rural or urban areas.**

**This lack of a clear pattern suggests that health plans may use geographic rating for business purposes other than adjusting for underlying cost/price differences.**

**Geographic rating could reduce insurance risk pooling and be used as a proxy for experience rating.**

**To limit the effect of market segmentation resulting from geographic rating, rate bands could be imposed on area rating factors.**

### BACKGROUND

#### Geographic Rating

Geographic adjustment of premiums is a common practice in the individual and small group health insurance markets in the U.S. Geographic rating provisions in state and federal law allow insurers to adjust premiums to reflect regional differences in the cost of medical care.<sup>1</sup> The National Association of

<sup>1</sup> While a discussion of geographic variation in medical costs and health care spending is beyond the scope of this paper, work by the Dartmouth Atlas Project, the Congressional

Insurance Commissioners (NAIC) substantiates the use of geographic location in calculating premiums, noting:

The cost of delivering care varies dramatically from one area to another, and insurers often vary their rates by county or by ZIP code using the employer’s business address in the small group market, or the applicant’s home address in the individual market. Safe harbors for geography have been set for each state, depending on the variation in medical costs within the state, and range from no variation in the District of Columbia to 1.9:1 in Florida.<sup>6</sup>

## State Regulation of Geographic Rating

Most state laws permit some form of geographic rating in their individual and small group health insurance markets.<sup>6-7</sup> Typically, states that allow geographic rating have designated the number and boundaries of geographic zones for health insurance rating purposes (i.e. by county or ZIP code). Under the ACA, states will continue to perform this function and must establish one or more rating areas, subject to review by the Secretary of the Department of Health and Human Services (DHHS). If the state’s rating areas are not approved, the Secretary may establish rating areas for that state.<sup>8</sup>

At present, there is a range of state insurance regulatory environments in which commercial insurers calculate and apply area rating factors. Table 1 summarizes current state regulatory approaches in the individual and small group health insurance markets. The 50 states and D.C. use four main types of rate regulation in their individual and small group health insurance markets: actuarial justification, rating bands, adjusted community rating, and “pure” community rating.<sup>6</sup> When not expressly prohibited by state law, it is possible for insurers to engage in geographic rating under each of these regulatory scenarios.

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Budget Office, and other researchers demonstrates that variations in cost are driven by a number of compounding factors, including local differences in the supply of available resources (e.g. hospital beds, specialist physicians and diagnostic equipment), utilization of services, regional practice patterns, quality of care, payer mix and payment incentives, provider prices, and patient health status and demographics.<sup>3-5</sup>

States that use actuarial justification typically have no rating limitations set in law, but require insurers to submit data that demonstrates a correlation between case characteristics (e.g., geographic area) and increased medical claims costs when proposing changes that vary rates in excess of safe harbors adopted by the NAIC. Alternatively, many states have adopted rating bands, particularly in the small group market, that typically set explicit limits on the amount of premium variation that can be attributed to a given case characteristic such as geographic area. Adjusted community rating laws prohibit the use of health status or claims experience in setting premiums, although other case characteristics such as age, gender, group size, industry or geography may be used. A small number of adjusted community rating states, including Vermont and Rhode Island explicitly prohibit rating based on geography, while the one “pure” community rating state (New York) precludes the use of any case characteristics other than geography to set premiums.<sup>6</sup>

Within these four broad regulatory approaches, there is substantial variation in states’ rate review processes. Over half of all states have established “prior approval” requirements, where the state has the authority to prospectively approve, disapprove or modify rate requests.<sup>9</sup> However, this authority is often constrained by requirements that insurance regulators review and disapprove rates within a specified time period, usually 30-60 days. Other states retrospectively evaluate requests and insurers’ justification for them, but cannot disapprove proposed rate increases prior to implementation.<sup>10-11</sup> States that use these approaches can take action if rate requests are later found to be unreasonable, though retrospective regulation often relies on consumer complaints to indicate a problem.<sup>11</sup> Some states only require certain market participants to undergo the rate review process (i.e. non-profit Blue Cross Blue Shield plans or HMOs) while exempting other commercial carriers.<sup>10</sup> Other states require filings for informational purposes only.<sup>ii</sup>

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<sup>ii</sup> Missouri, Montana, and Wyoming are the only states without filing requirements for individual and group plans. Alabama, Georgia, and Mississippi require filings for informational purposes only.<sup>9</sup>

**Table 1.** State Regulation of the Individual and Small-Group Markets

Regulatory Approach	Description
Actuarial Justification	No rating factors are explicitly prohibited by law. States may require actuarial justification of premium increases or differential premium assessment. These justifications may be required prospectively (before rates apply) or retrospectively in response to consumer concerns.
Rating Bands	States permit premium variation based on specified factors; however, they establish rating bands that set the maximum variation that is permitted for each factor. For example, age may be used as a rating factor with a 3:1 band, meaning that premiums for the highest age group may be no more than three times that of the lowest group. Health status/claims experience could be one of the permitted rating factors subject to a band.
Adjusted Community Rating	States explicitly prohibit rating based on health status or claims experience, yet permit premium variations based on other factors, including age, sex, and geography (permitted in most community-rated states). The allowable rating factors may or may not be subject to rate bands.
Pure Community Rating	One state (New York) requires pure community rating of premiums, so that rates are the same regardless of health or demographic characteristics. In New York, the only rating factor permitted is geography.

Source: National Association of Insurance Commissioners<sup>6</sup>

## HOW DO HEALTH PLANS' RURAL AND URBAN RATING FACTORS COMPARE?

To assess whether and how geographically determined differences in premium rating factors might affect insurance premiums in rural versus urban areas, we analyzed the factors that private health plans in eight states use to rate rural and urban premiums and products. Data collection was a considerable challenge, as rate review information is publicly available in only a handful of state insurance departments. Even in states that provide such transparency, area rating factors are not always included because plans may not incorporate area rating factors into the calculation of premiums. In some states insurers are permitted to treat area rating factors and other filing data as proprietary information.

In addition to searching state websites, we contacted state insurance department staff and were able to obtain county-level area rating factors for insurers operating in: Florida, Maine, Minnesota, New York, North Carolina, Pennsylvania, and Wisconsin. Our sample of 39 plans included a variety of plan types (e.g., HMO, POS, PPO, conventional indemnity) offered from 2005 to 2011 in the individual (18 plans) and small group (21 plans) health insurance markets. We classified each county for which we had rating factors

as rural or urban based on the 2003 Rural-Urban Continuum Codes<sup>12</sup> and examined rural-urban differences in average rating factors within each state.

### Findings

The rural-urban distribution of area rating factors in our sample was quite heterogeneous, with no clear pattern of higher rating factors in rural versus urban areas. Among carriers in these states, there is little consistency in the geographic rating of a given county, with some carriers rating a county high relative to other areas where the plan is offered, and other carriers rating a county low relative to other areas where the plan is offered. Moreover, we found in some instances that carriers rated an area differently across their product line.

When we compared the range of area rating factors used across all rural counties in a state to the range of factors used across all urban counties in that state we found a great deal of overlap, with premiums in some rural and urban areas rated identically. For example, in Maine, rural area rating factors ranged from 0.78 to 1.50, and urban area rating factors ranged from 0.78 to 1.30. In Oregon, rural area rating factors ranged from 0.71 to 1.32, and urban area rating factors ranged from 0.67 to 1.32. In Minnesota area factors ranged from 0.91 to 1.24 for both rural and urban counties.

When we compared average area rating factors across entire states, we found no consistent rural-urban differences. In some states, rural counties as a whole are assigned the highest average area rating factors, while in other states urban counties are rated higher. In four of the eight states in our sample (Maine, New York, North Carolina, and Oregon) rural counties have a higher overall average area rating factor. In three of the states (Florida, Pennsylvania, and Wisconsin), urban areas have a higher average area rating factor. And in one state (Minnesota), rural and urban counties have the same average area rating factors.

The lack of a clear pattern in area rating factors, especially within specific counties where health plans may employ both higher and lower factors (and may vary rating factors for an area across their own products) suggests that health plans may use geographic rating for business purposes other than adjusting for underlying cost/price differences. For example, health plans may adjust area factors downward to gain market share in a particular rating area. The suggestion that insurers may flexibly use the geographic rating for a variety of business purposes is supported by a 2009 study of health insurance premiums conducted by the Commissioner of Insurance in Colorado which found that geographic rating factors did not reflect insurers' actual costs.<sup>13</sup> In this study health care costs and carriers' rating factors were compared across rating areas. Although health care costs in the MSAs they examined were quite different, there was little correlation between the carriers' geographic rating of the areas under study and area costs, with rating inconsistencies observed in both directions for each area.

Although the data from our eight-state sample on rating factors were not linked to premiums or costs, the findings are consistent with those of the Colorado study. If geographic rating factors were based exclusively on the health care costs of a region, we would not expect to find such variation across insurance plans. In addition, we find no clear-cut pattern of rural-urban difference in the application of area rating factors. In some cases rural areas had higher rating factors, in other cases urban areas were higher, and in still other cases the two were identical.

While our eight-state sample did not reveal any clear pattern of higher rating in rural areas, this finding is not inconsistent with prior research that has found higher average premiums in rural areas<sup>1</sup> because, as discussed

below, area rating factors are only one component of premium costs. The interplay of market competition, provider rates, level of health system efficiency, and the health status of a geographic population is difficult to disentangle. For example, costs could be high in a specific region of a state for any combination of pricing, practice pattern, and/or health care need factors, making efforts to measure and actuarially justify or refute the basis for a rating factor especially challenging.

## IMPLICATIONS FOR GEOGRAPHIC RATING UNDER THE ACA

By imposing limits on medical underwriting, permitting only a small number of adjustments to community rating, and establishing Affordable Insurance Exchanges, the ACA seeks to reduce market segmentation and increase risk pooling in the individual and small group markets. At the same time, the ACA allows insurers to use geographic rating factors to adjust premiums to reflect variations in medical costs across rating areas attributable to such factors as differences in labor and other operating costs, the relative strength of their network/provider agreements in a given area, and/or cost shifts associated with high Medicare or Medicaid enrollment and lower payments from these sources. The benefit of geographic rating is that it provides insurers with marketing flexibility and can help ensure that insurance purchasers in low cost areas benefit from the efficiencies of their local health care system. It may also encourage more insurers to offer plans in high cost areas that they would otherwise avoid if these costs could only be recouped across their entire coverage area. On the other hand, geographic rating may also undermine the incentives for health plans to encourage efficiency among health care providers in high-cost areas.

The difficulty of disentangling cost differences associated with underlying prices or operating costs and those that are driven by population-based health characteristics and needs raises the potential that geographic rating could also reduce insurance risk pooling and could be used as a proxy for experience rating. Area rating factors, particularly at the zip code level, can be used to allocate the costs of areas of high levels of health care need (inner cities, impoverished rural areas) onto the populations of those areas, rather than broadly distributing the costs associated with this higher need across larger populations. Segmenting communities through geographic rating could



undermine the intent of the ACA to distribute risk broadly.

Whether geographic rating allows insurers to adjust premiums to reflect real differences in the cost of medical care, or is used as a proxy for loading costs onto populations deemed high risk by insurers, some geographic areas (both rural and urban) will be winners and others losers. In the context of an insurance mandate, these adjustments will place differential burdens on consumers. In some cases, a poor region with a relatively unhealthy population may have higher premiums as a result of geographic rating, making coverage less affordable for some, although the subsidies available under ACA will level the premium costs for those that are eligible.

One option to limit the effect of market segmentation resulting from geographic rating (whether based on price or experience) is to impose rate bands on area rating factors, such as the “safe harbors” developed by the NAIC. The ACA does not explicitly set limits on the extent to which premiums may vary by geography as it does for age and tobacco use. Some states currently impose rate bands on area factors and have the authority under ACA to set, maintain, or amend their rate bands through state-level insurance regulation. In addition to reducing market segmentation, rate bands would create incentives on the part of payers to press for lower prices or other economies from providers in high cost areas, as the extent to which these costs could be passed on to premium payers would be limited.

Sophisticated state and federal oversight of geographic rating practices by health plans will be needed to prevent the use of geographic rating as a form of medical underwriting, or even as a means to gain market share in competitive areas and cost-shift to other areas. Currently, the ACA leaves the setting of geographic rating areas to individual states, subject to review by the Secretary of HHS. Through a review of state laws, HHS identified 43 states with existing rate review programs in either the individual or small group markets or both. The Department expects these states to be able to carry out effective rate reviews, though in states that lack the necessary resources or statutory authority HHS will conduct the reviews instead.<sup>14</sup> However, state regulators report that the rate review process requires substantial local, technical knowledge of the health care market and nuanced professional judgment<sup>11</sup> and research has found that many states lack the resource capacity and sufficient number of

trained actuaries to review all filed rates.<sup>10</sup> Indeed, a recent report notes that while explicit legislative authority to conduct rate reviews is critical, a state’s statutory authority often conveys little about how rate reviews are actually conducted in practice, as “regulatory resources and a culture of active review” are equally important in determining the rigor of a state’s rate review process.<sup>10</sup>

Given the varying capacity and processes that states have to engage in meaningful premium rate review, technical assistance and support from HHS will be critical. To strengthen the states’ rate review processes, the ACA appropriated to the Secretary of HHS \$250 million in “premium review grants” to be awarded during the 5-year period beginning with fiscal year 2010.<sup>15</sup> To bolster transparency, the grants will be used, among other functions, to establish “medical reimbursement data centers” to develop, and regularly update, “fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates.”<sup>16</sup> Ensuring that these data centers are widespread, adequately staffed, and have access to ongoing technical assistance from regulatory experts will be critical to limiting rate distortions or other unintended consequences of geographic rating.

To date, HHS has awarded approximately \$152 million in premium review grants to 43 states and the District of Columbia.<sup>17</sup> States are using the funding to (1) pursue additional legislative authority for ensuring that proposed rate increases are justified; (2) expand the scope of their current premium review processes (e.g., by reviewing and pre-approving rate increases for additional health insurance products offered in their State); (3) require companies to report more information through new, standardized processes; (4) increase transparency of the premium review process by providing easy-to-understand, consumer-friendly information about changes to health insurance premiums; and (5) develop and upgrade existing technology to streamline data-sharing and ensure that information is quickly disseminated to consumers.<sup>18</sup>

## REFERENCES

1. Gabel J, McDevitt R, Gandolfo L, et al. Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down. *Health Aff (Millwood)*. 2006; 25(3): 832-843.

2. Coburn AF, MacKinney AC, McBride T, et al. *Assuring Health Coverage for Rural People through Health Reform*. Columbia, MO: Rural Policy Research Institute, RUPRI Health Panel; October 2009. <http://www.rwjf.org/files/research/50808.pdf>
3. Dartmouth Atlas Project. *The Dartmouth atlas of health care*. [Web Page]. 2012. Available at: <http://www.dartmouthatlas.org/> Accessed May 5, 2011.
4. Congressional Budget Office. *Geographic variation in health care spending*. [Web Page]. 2008, February. Available at: <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/89xx/doc8972/02-15-geoghealth.pdf> Accessed September 6, 2011.
5. The Henry J. Kaiser Family Foundation. *Explaining Health Care Reform: How Do Health Care Costs Vary by Region?* (Publication #8030). Washington, DC: Kaiser Family Foundation; December 2009. Available at: <http://www.kff.org/healthreform/upload/8030.pdf>
6. National Association of Insurance Commissioners (NAIC) and the Center for Insurance Policy & Research. *Health insurance rate regulation*. [Web Page]. 2011. Available at: [http://www.naic.org/documents/topics\\_health\\_insurance\\_rate\\_regulation\\_brief.pdf](http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf) Accessed May 1, 2011.
7. Kofman M, Pollitz K. *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change*. Washington, DC: Georgetown University, Health Policy Institute; April 2006. Available at: <http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf>
8. Public Health Services Act (PHSA) as amended by the Patient Protection and Affordable Care Act (ACA). Section Title I, Subtitle C, Part 1, Section 1201.
9. Newsom M, Fernandez B. *Private Health Insurance Premiums and Rate Reviews*. Washington, DC: Congressional Research Service; 2011. Available at: [http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1793&context=key\\_workplace](http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1793&context=key_workplace)
10. The Henry J. Kaiser Family Foundation. *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable*. (Publication #8122). Washington, DC: Kaiser Family Foundation; December 2010. Available at: <http://www.kff.org/healthreform/upload/8122.pdf>
11. National Association of Insurance Commissioners (NAIC) and the Center for Insurance Policy & Research. *NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act*. [Web Page] 2010, May 12. Available at: [http://www.naic.org/documents/committees\\_e\\_hrsi\\_hs\\_response\\_rr\\_adopted.pdf](http://www.naic.org/documents/committees_e_hrsi_hs_response_rr_adopted.pdf) Accessed May 1, 2011.
12. U.S. Department of Agriculture, Economic Research Service (USDA-ERS). *2003 Rural-Urban Continuum Codes (Data set)*. [Web Page]. 2004, November 3. Available at: <http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes/> Accessed May 1, 2011.
13. Colorado State Commissioner of Insurance. *Pueblo Health Insurance Study, January 1, 2003 to December 31, 2006*. Denver, CO: Commissioner of Insurance; January 2009. Available at: <http://www.dora.state.co.us/Insurance/legi/legiPuebloReport011509.pdf>
14. U.S. Department of Health and Human Services. *Rate Increase Disclosure and Review: Proposed Rule*. 75 Federal Register 246: pp. 81004-81029.
15. Public Health Services Act (PHSA) section 2794(c) as amended by the Patient Protection and Affordable Care Act (ACA). Section Title I, Subtitle C, Part 1, Section 1003.
16. Public Health Services Act (PHSA) section 2794(d)(1) as amended by the Patient Protection and Affordable Care Act (ACA). Section Title I, Subtitle C, Part 1, Section 1003.
17. The Kaiser Family Foundation statehealthfacts.org. Data source: Cycle I Grants: *Health Insurance Premium Review Grants*, HealthCare.gov, August 2010; Cycle II Grants: *Rate Review Works: Early Achievements of Health Insurance Rate Review Grants*, HealthCare.gov, September 20, 2011. Available at: <http://www.statehealthfacts.org/comparemaptable.jsp?i=1000&cat=17>.
18. HealthCare.gov. *Health insurance premium grants: Detailed state by state summary of proposed activities. Fact Sheet*. [Web Page]. 2010, August. Available at: <http://www.healthcare.gov/news/factsheets/2010/08/rateschart.html> Accessed May 1, 2011.

## ABOUT SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at [www.shadac.org/share](http://www.shadac.org/share).