

## Counter-Analysis of the NAIC 2024 Health Insurance Industry Report – The Self-Licking Ice Cream Cone that is US Healthcare



Health insurers' razor-thin profit margins in 2024 were not an inevitable result of medical necessity – they were the result of deliberate choices to maintain enormous administrative overhead. In 2024, insurers spent over \$130 billion on administrative costs while reporting only \$9.3 billion in net income. These figures reveal that low margins are self-inflicted- insurers protect excessive overhead spending, creating a narrative of financial hardship that obscures how their own business decisions drive down profits.

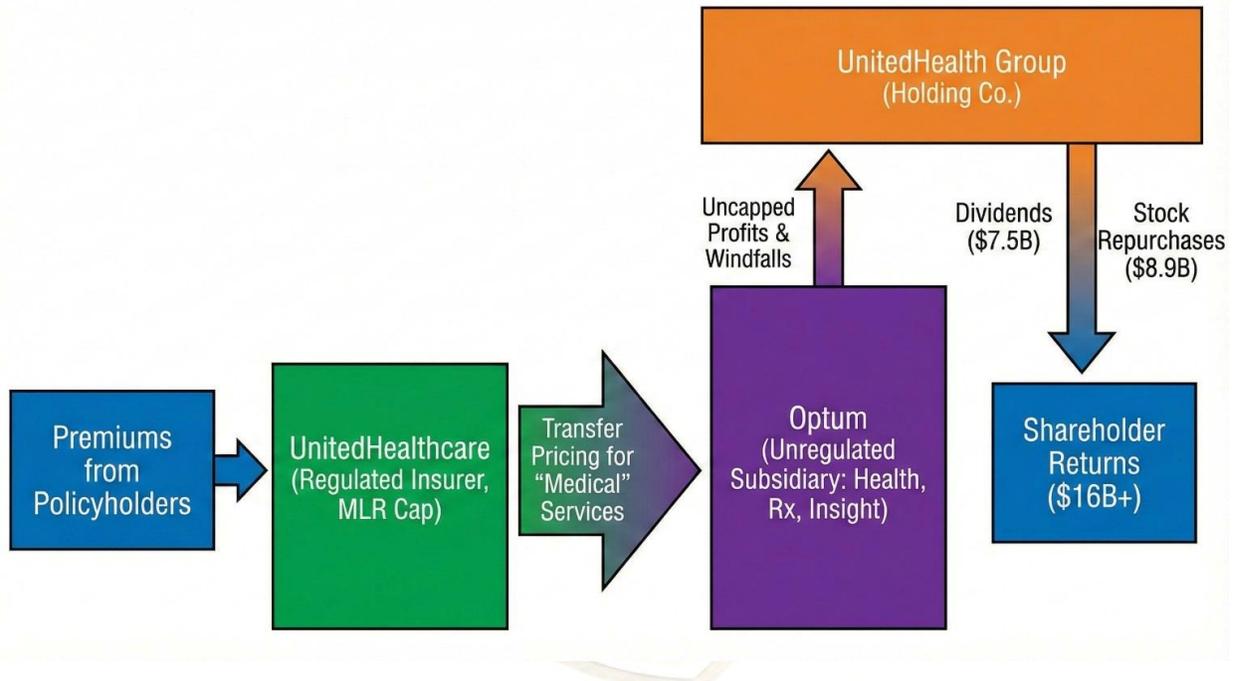
### Manufactured Crisis- Revenue-Rich, Overhead-Addicted

The health insurance industry's financial results show a manufacturing crisis. In 2024, U.S. health insurers collected roughly \$1.15 trillion in premiums (5.9% higher than 2023) and spent about \$130.7 billion on administrative and overhead costs – an amount over 14 times larger than their mere \$9.263 billion in net income. This extreme imbalance means insurers are revenue-rich yet overhead-addicted. They claim a profit squeeze, but that squeeze is artificial- companies choose to let bloated bureaucratic costs and corporate expenses devour the bulk of premium dollars. The industry's profit margin fell to just 0.8% in 2024, the lowest in a decade, but this was a direct consequence of how insurers allocate money internally – not an unavoidable result of patient care needs.

Insurers present this situation as a hardship driven by external forces, but the data tells a different story. Premium revenues actually rose significantly (nearly \$64 billion year-over-year), and total spending on medical claims also rose (~\$85 billion increase). Despite this growth, insurers barely broke even because administrative spending ballooned, eroding all the gains. Rather than trim overhead, insurers allowed administrative costs to rise in step with premiums, ensuring that internal expenses consumed most of the new revenue. In essence, the industry generated plenty of money – but then spent it on itself, leaving profits low by choice. This dynamic creates an *illusion of crisis*- companies point to slim margins as if they reflect healthcare necessities, when in truth those slim margins are engineered by preserving hefty overhead outlays.

*The diagram below illustrates how an insurer's funds circulate internally rather than benefiting patients.* For example, a company like UnitedHealthcare (the insurance arm) pays billions to its own sister companies (such as Optum, which provides services) at inflated

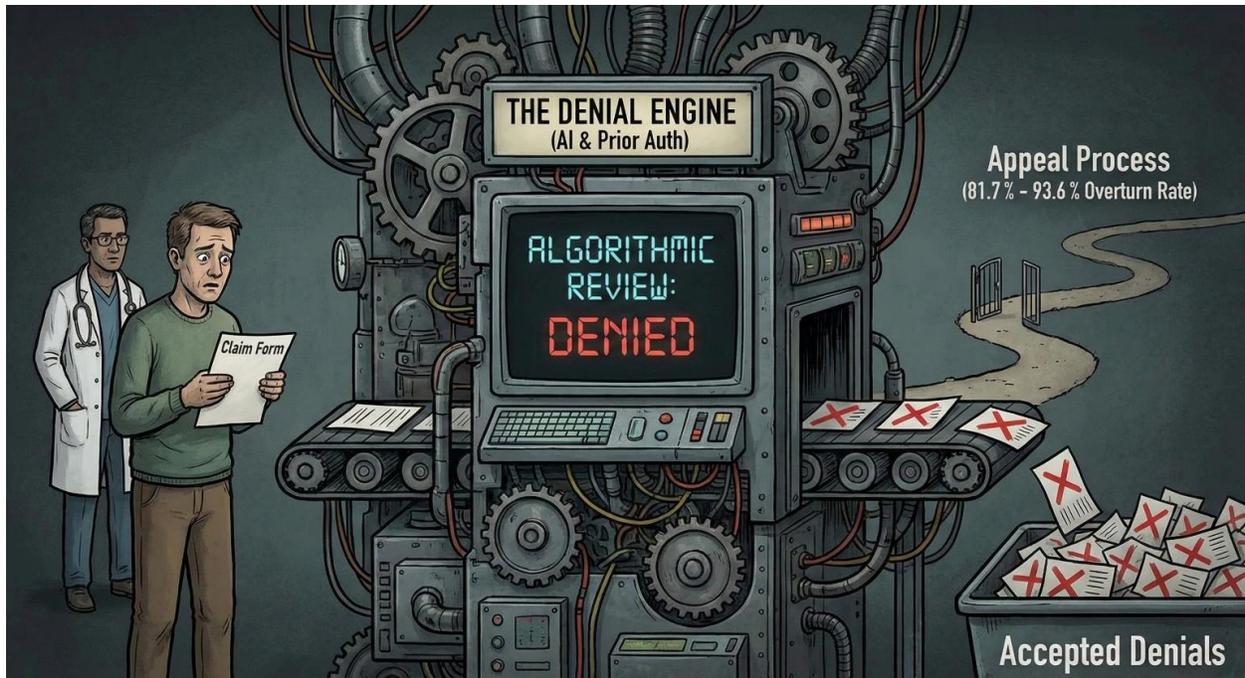
prices, counting those payments as medical "costs." The funds then flow up to the holding company and its shareholders as profit. This internal money loop means an insurer can technically show a tiny profit in its regulated insurance division while enriching its parent corporation. The hardship narrative ignores this reality – insurers are not truly struggling; they are shifting profits into less regulated buckets. The "Manufactured Crisis" is exposed by the stark ratio of overhead to income- companies *choose* to spend lavishly on administration and affiliated services, then claim they barely stay profitable.



\*Figure- Funds flow within a vertically integrated insurer (e.g., UnitedHealth Group). The insurance subsidiary (left) pays its own provider/PBM subsidiaries (Optum, center) high fees that are counted as costs, and those dollars ultimately return as parent-company profits (right), benefiting shareholders.\*

Another aspect of this overhead addiction is the investment in denial engines – complex systems and processes aimed at limiting payouts for care. Insurers allocate part of their \$130+ billion in overhead to mechanisms that make it harder to spend on medical claims. These include automated claim-denial software and armies of staff to contest payments. For instance, one major insurer's internal system denied over 300,000 claims in just two months, with company doctors signing off in an average of 1.2 seconds per claim – essentially rubber-stamping algorithmic denials. This kind of machinery (often depicted as a literal "denial engine") soaks up administrative resources to block or delay patient payments, reducing medical expenditures and contributing to the façade of low margins. The result is a self-perpetuating cycle: high overhead funds, aggressive cost-containment and billing tactics, which, in turn, keep reported medical costs (and thus profit margins) within a narrow band. Insurers then point to those low margins as evidence of prudent management

or tough economics, when in fact they have constructed an elaborate bureaucracy to siphon funds away from care.



\*Figure- "Denial Engine" – Insurers build automated systems that churn through claims, issuing rapid-fire denials. This machinery is part of the administrative overhead. It reduces payouts (making profit margins appear tight) while often requiring patients and doctors to navigate appeals.\*

In short, the "crisis" of low insurer profits is largely self-imposed. The industry remains flush with revenue, but executives have elected to consume it through massive administrative spending and intercompany payments. This strategy protects their ecosystem of overhead – including large corporate salaries, marketing, billing departments, and profit-shifting arrangements – at the expense of the bottom line. It allows companies to plead poverty and justify premium hikes or policy changes, all while *huge sums circulate within their own walls*. The evidence debunks the idea that medical costs alone forced margins down; insurers created the financial squeeze by gorging on overhead.

Razor-Thin Margin Depends on a Single Choice- Protect Overhead

The industry's razor-thin margin in 2024 was not a foregone conclusion of doing business – it was the *result of a strategic choice to protect overhead expenses above all else*. Insurers actively deploy various "friction engines" that inflate administrative costs and divert funds, thereby keeping their reported profits low. Key mechanisms include upcoding, algorithmic

claim denials, and vertical profit-shifting. Each of these is a deliberate practice that requires substantial administrative infrastructure, and each serves to preserve or increase insurer revenue at the cost of honest accounting-

- **Upcoding (Inflating Diagnoses for Payouts)**- Insurers have strong incentives to make patients *appear sicker* on paper in order to collect higher payments, especially in Medicare Advantage plans. This practice, known as upcoding, is widespread – nearly every major insurer has been accused of exaggerating diagnoses to boost revenue. By investing in data analytics and coding teams, insurers can raise risk scores and thus increase incoming premiums from Medicare and other payers. Upcoding artificially increases medical cost reports (since those extra payments must be spent on "care") while padding the company's top line. It is an administrative strategy that uses technicalities to generate profit, contributing to overhead (all those coders and consultants) and simultaneously justifying higher expenditure. Regulators have taken note – even the CMS Director has flagged upcoding as a target for audits – yet insurers engage in it because it *indirectly preserves margin* by increasing revenue that must be cycled into claims or internal costs. The result is more money moving through the system, much of it captured as overhead or kept within the insurer's orbit.
- **Algorithmic Denials (Friction by Design)**- Many insurers employ automated systems to deny claims en masse, creating barriers for payments that would otherwise count as medical expenses. This is a conscious administrative tactic- insurers spend on IT systems and staff to comb through claims and reject them on technical or minor grounds, betting that a portion of patients and providers will not appeal. For example, Cigna's automated review system was shown to deny large batches of claims with lightning speed (often without a physician honestly reviewing the case). These denial algorithms are essentially *machines that generate friction*, forcing policyholders to fight for coverage. From the insurer's perspective, every denied or delayed claim is money saved (or at least deferred) – but implementing this strategy requires significant overhead investment (software, medical director salaries, call centers to handle complaints, etc.). By inflating administrative efforts aimed at denying or downsizing claims, insurers reduce their payout ratio and keep margins low, all while claiming that high medical costs are squeezing them. It is a perverse engine where insurers spend money to avoid spending money, and it directly contributes to the narrative of tight margins by artificially capping what they pay for care.
- **Vertical Profit-Shifting (Internal Deals to Retain Profit)**- Over the past decade, insurers have aggressively reorganized into vertically integrated conglomerates – they own

provider groups, pharmacies, labs, and other services. This structure enables a potent accounting trick- an insurer can pay its own subsidiary an inflated price for services and log that as a medical cost, which counts toward the required Medical Loss Ratio (the legal minimum percentage of premium spent on care). Because the provider is part of the same parent company, the inflated payment is essentially profit in disguise – it flows right back to the insurer's corporate parent as revenue. This tactic requires setting up and managing these internal transactions (a substantial administrative endeavor), but it shifts profits out of the regulated insurance entity's ledger and into affiliated businesses. The regulated insurance arm then shows expenses near the MLR threshold (80–85% of premium) and only a thin profit, while the parent company quietly keeps the excess in-house. A Health Affairs study found that integrated insurers can raise internal payment rates "without delivering additional care," padding their reported medical spending while retaining earnings internally. For example, UnitedHealth Group's intercompany payments (labeled as "eliminations" in financial reports) more than doubled from \$58.5 billion to \$136.4 billion over five years – a staggering amount of money moved among its own subsidiaries. These internal transfers act as a pressure valve to release profits- instead of letting the insurance division show a high margin (which would trigger rebates to consumers under the ACA rules), integrated companies find ways to spend excess premium dollars within their own network. They might pay a captive physician group twice the market rate for a procedure. On paper, that looks like higher medical costs (satisfying regulators), but in reality the extra payment comes back to the parent company's provider arm as income. This vertical self-dealing is a deliberate strategy to inflate overhead and "loss" expenses so that the insurer segment's margin stays low, all while the organization as a whole remains very profitable. It is a choice – one that depends on complex corporate structures and administrative logistics – and it is a primary reason the industry's reported margins are so slim.

Each of these tactics contributes to administrative bloat and creates "friction" in the system – either by making billing/coding more complex or by cycling funds in non-transparent ways. The common theme is that insurers have decided to prioritize these mechanisms over straightforward efficiency. They *could* simplify operations, pay only fair market rates, and approve necessary care promptly – which would lower administrative costs – but doing so would actually raise their visible profit margins (and force rebates or invite scrutiny). Instead, they protect their overhead. The razor-thin margin is a direct result of protecting these costly behaviors. In 2024, when profits shrank drastically, it was not just because "medical costs went up" – it was because insurers *let* administrative expenditures and internal markups absorb all potential gains. The industry's low margin is a policy

choice- insurers choose to spend on denial algorithms, elaborate coding, and intra-company fees rather than allow that money to become profit or consumer savings.

### Sensitivity Test- Overhead Cuts and Profit Windfalls

What would happen if insurers *did* the opposite – if they reined in even a small portion of their administrative spending? A simple sensitivity analysis shows that the industry's solvency would improve dramatically without touching one cent of medical care. By cutting overhead, insurers could boost profit margins to normal levels *without raising premiums or reducing benefits*. The table below models several scenarios based on 2024 figures (approximately \$1.16 trillion in premiums, \$130.7 billion in admin costs, and \$9.3 billion in net income) -

Admin Reduction Scenario	Overhead Cut	Freed Funds (≈)	New Net Income (≈)	Resulting Profit Margin
Status Quo (2024)	0% (no cut)	\$0	\$9.3 billion	0.8% (actual)
Moderate Trim – 5% cut in admin	\$6.5 billion	\$6.5 billion	\$15.8 billion	~1.4% (about double)
Meaningful Cut– 10% cut in admin	\$13 billion	\$13.1 billion	\$22.4 billion	~1.9% (approaching 2%)
Bold Cut – 20% cut in admin	\$26 billion	\$26.1 billion	\$35.4 billion	~3.0% (robust margin)

Even a 5% reduction in overhead expenses (a relatively modest efficiency gain) would free up around \$6½ billion – immediately boosting industry profits by that same amount. The profit margin would roughly double from 0.8% to about 1.4%, all else equal. A 10% cut in admin fat (about \$13 billion saved) would nearly triple net income, pushing margins to roughly 2% – which is actually in line with the industry's historical average profit margin of ~2.2%. In other words, simply *reverting to a leaner overhead structure* could restore profitability to normal levels. A more aggressive streamlining – say, a 20% reduction in administrative waste – would yield on the order of \$26 billion in savings, quadrupling net income and elevating margins to a very healthy ~3%. Notably, none of these scenarios requires charging customers more or cutting medical services. The improvements come *solely* from reducing internal expenditures that add little or no value to patient care.

These findings underscore how sensitive the bottom line is to administrative bloat. When insurers claim that their margins are under strain due to factors like drug prices or hospital costs, they neglect to mention that a small trim of their overhead budget would solve the problem. The industry's solvency is not at risk – in fact, it could be dramatically strengthened simply by operating more efficiently. This is entirely feasible, as ample evidence shows that much of U.S. insurance overhead is excess. Studies by the National Academy of Medicine

and others estimate that half or more of insurance administrative costs do not contribute value ("excess BIR costs"). Cutting 5–10% of overhead is well within reach; it barely scratches the surface of the estimated excess. Put differently, insurers incur \$0.50 or more in waste for every \$1.00 they spend on administration, according to some experts. Our sensitivity test only asks them to remove a fraction of that waste, with enormous gains to stability and profitability in return.

It is also critical to note that these profit gains from overhead reduction could be achieved *without* any negative impact on patient care or provider reimbursement. The money saved comes out of bureaucracy, not benefits. In fact, if insurers streamlined operations, consumers might indirectly benefit (through smaller premium increases or larger rebates), while companies would see higher margins. The solvency "crisis" evaporates once we recognize that insurers have this lever at their disposal. They could protect their margins not by raising prices on customers, but by tightening their own belts. The fact that margins remain razor-thin suggests that, so far, insurers have chosen not to pull this lever.

*The contrast between regulated insurance profits and total shareholder returns highlights this choice.* For example, while insurers' official profit margins lingered around 1%, large parent companies were thriving. UnitedHealth Group, the largest insurer, reported over \$400 billion in revenue in 2024 and delivered generous returns to shareholders through dividends and stock buybacks. Its insurance subsidiary's low margin did not tell the whole story of financial health. In general, holding companies enjoy far higher earnings than the thin margins reported in their insurance units, because those holding companies benefit from all the ancillary profits (from provider groups, pharmacy benefits, etc.) that never show up as "insurance" income. This reality is visualized below, where the regulated net income of insurance operations is dwarfed by the ultimate returns flowing to shareholders. It underscores that the apparent razor-thin margins are a product of accounting boundaries, not a lack of cash generation.

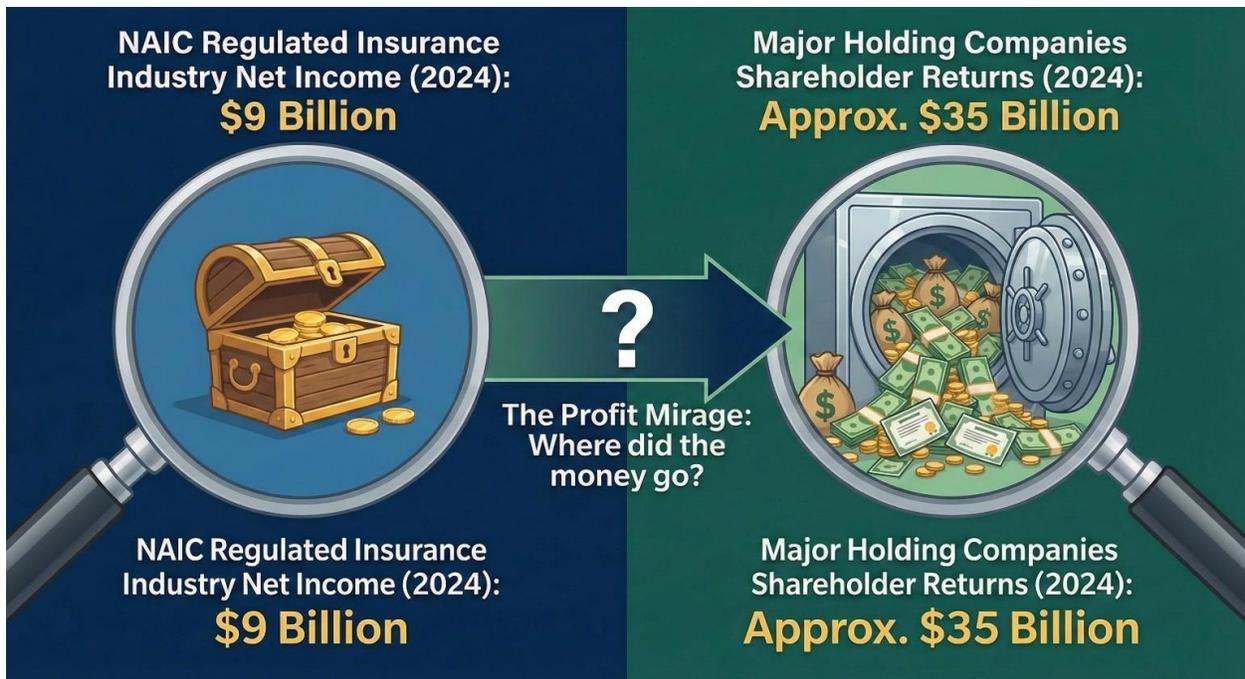
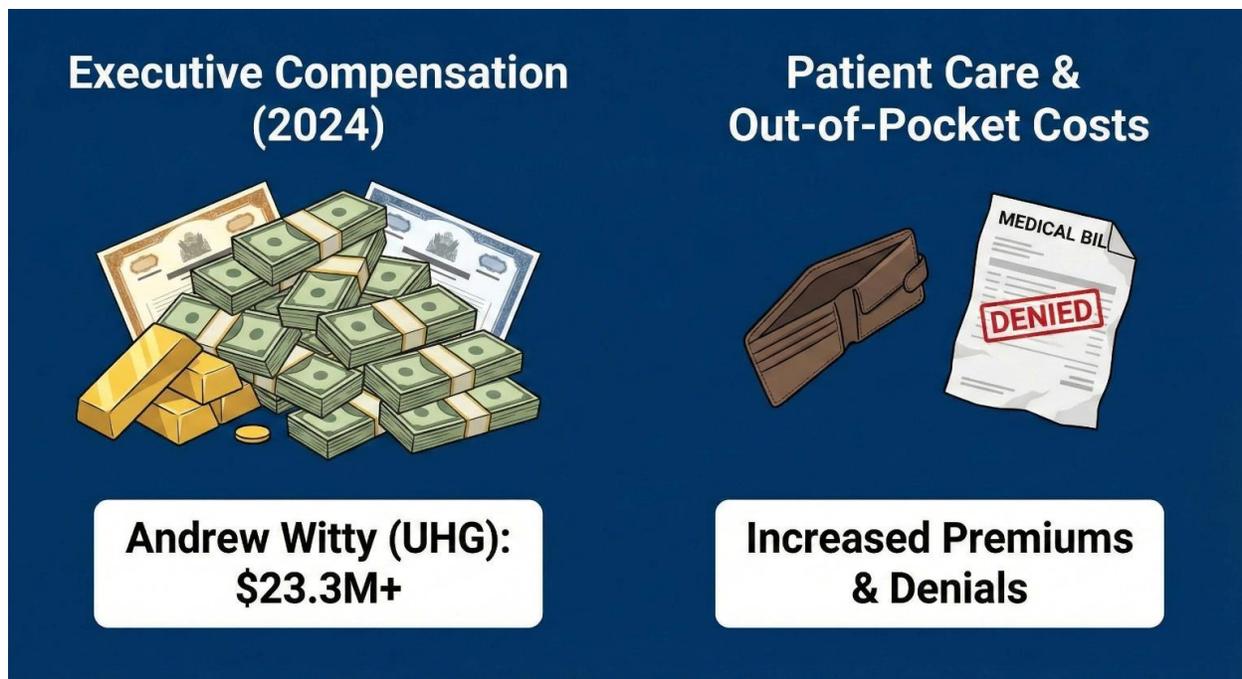


Figure- Comparison of insurance subsidiaries' reported net income vs. their holding companies' overall shareholder returns. The regulated insurance margin (left bar) is kept low (~0–2%), while the parent company (right bar) realizes a much larger effective profit when including all subsidiaries and internal transfers. This gap illustrates how insurers' true financial strength is obscured by the low margins they report for the insurance business alone.

Moreover, a substantial portion of "administrative costs" goes into executive compensation and corporate overhead that benefit the company's leaders, not patients. Insurers pay their top executives tens of millions of dollars and invest in corporate amenities, marketing campaigns, and lobbying – all of which are counted in that overhead figure. Meanwhile, many patients face high out-of-pocket costs and medical bills they struggle to pay. If insurers redirected even a slice of the funds currently used for sky-high executive bonuses into reducing premiums or improving coverage, it would have a noticeable positive effect for consumers. The following graphic starkly contrasts CEO pay packages with the financial burdens on patients. It highlights how insurers choose to spend on enriching executives and maintaining corporate luxuries, even as they report slim margins. Cutting these excesses would not only improve margins but also reallocate resources to reduce patient costs.



*Figure- Health insurance executive compensation vs. patient cost burden. Insurer CEOs and executives (left) receive compensation packages in the tens of millions, contributing to administrative costs. Meanwhile, patients' (right) shoulder rising premiums, deductibles, and medical debt. Reducing extravagant administrative expenses, such as executive pay, could improve insurer finances and relieve some pressure on consumers, without reducing actual medical care.*

In sum, this sensitivity analysis obliterates the notion that insurers' low margins are an unchangeable reality imposed by outside forces. The margins are low by design. If industry leaders or regulators truly wanted to improve financial outcomes without harming consumers, the straightforward solution is to trim the fat – the \$130+ billion administrative budget – by a modest percentage. The fact that this hasn't happened indicates that insurers prefer to keep indulging in that \$130 billion "self-licking ice cream cone" of overhead (as we'll conclude below) and then lament their meager 1% profits. It is a willful choice, not an inevitability.

#### Liquidity and Surplus- Wealth Sits in Plain Sight

Despite the doom-and-gloom narrative of razor-thin margins, the health insurance industry's balance sheets tell a story of considerable wealth and resilience. The financial cushions that insurers have accumulated are hiding in plain sight-

- Abundant Liquid Assets- Health insurers entered 2025 with enormous liquid reserves. The industry's liquid assets and receivables rose to \$442.6 billion by the end

of 2024. These are cash and assets that can be easily converted to cash, such as short-term investments and money owed to insurers. Against current liabilities of about \$258.0 billion, the sector had a liquidity ratio of **\*\*171%\*\***. In practical terms, insurers collectively had 1.7 times more ready cash than needed to cover their short-term obligations – an even stronger position than the prior year's also-healthy 169%. This is hardly the portrait of companies on the brink. On the contrary, it shows that insurers are sitting on deep reserves. They can pay claims and debts as they come due with ease and still have nearly half again as much surplus liquidity. The narrative of financial stress is hard to reconcile with nearly half a trillion dollars in liquid assets available.

- **Growing Capital and Surplus** - The industry's core capital base increased in 2024, despite low profits. Health insurers' aggregate capital and surplus rose 1.1% to \$213.4 billion by year-end, up from \$211.2 billion in 2023. This growth happened during the very year portrayed as one of hardship. How did surplus grow when net income was only \$9.2 billion? The numbers show insurers added capital through means other than profits- they received \$12.6 billion in new paid-in capital from parent companies or investors (a sign of confidence, injecting money into the business), and even saw \$1.1 billion in unrealized gains on investments. These inflows outweighed payments and allowed the surplus to inch up. Crucially, the industry chose to boost its capital buffers at a time when it could have alternatively lowered premiums or at least not increased them as much. Regulators require insurers to hold certain surplus for solvency, but the fact that surplus grew (not shrank) in 2024 indicates that the companies were financially secure enough to retain and even add to their rainy-day funds. A genuinely struggling industry would be burning through surplus, not adding to it. In health insurance, wealth accumulates, not erodes.
- **Hefty Dividend Payouts**- Perhaps the most apparent contradiction in the "we are barely getting by" storyline is the scale of dividends insurers paid out to their owners. In 2024, health insurance entities paid about \$19.3 billion in dividends to parent companies or shareholders. This was more than twice the industry's total net income that year. Essentially, after paying all claims and expenses, insurers still found *twice as much money as their profits* to send upwards to holding companies or investors. Those dividends are voluntary distributions of excess capital. If times were truly tight, insurers could have retained that \$19.3 billion to shore up margins or capital. Instead, they paid it out, confident enough in their financial position to reward shareholders generously. This undermines any narrative of desperation – companies that can afford to pay billions in dividends are not in existential peril. In fact, such payouts

suggest that the low profit margin at the insurance subsidiary level is not the whole story of the value being extracted from the business. Shareholders saw significant returns, even as consumers were told insurers were struggling to break even.

Taken together, these facts reveal that the insurance industry's money has not disappeared at all – it has just been parked in different places. High administrative spending made the operating profit look small, but meanwhile, assets and capital piled up, and owners took substantial payouts. The industry remains highly solvent. It holds *ample funds* to pay claims and then some. Its regulated entities maintain strong capital positions (meeting and exceeding requirements).

Furthermore, it remains lucrative for investors, as evidenced by dividend flows. So when insurers insist that financial pressures are forcing premium increases or policy changes, one must question- if there is so much cash on hand and so much being funneled to shareholders, where is the absolute pressure? The supposed lean times seem to affect only the "net income" metric in isolation, not the overall financial health or wealth distribution of these companies.

In plain sight, the NAIC report itself documents this robustness. It notes that cash flow from operations, while down, was still positive, and that assets grew faster than liabilities in 2024. The liquidity ratio, which improved to 171%, means insurers are even better positioned to meet short-term demands. Moreover, that slight uptick in capital and surplus to over \$213 billion means policyholders' reserves (the cushion ensuring claims will be paid even in bad times) are at record levels. No regulator or consumer reading these figures should believe the industry is anywhere near insolvency. By standard financial measures, insurers are flush. They have engineered their income statements to look tight by overspending internally and then moving money out as dividends. The wealth remains – "sitting in plain sight" on balance sheets and in owners' pockets – even as the narrative focuses on the thinnest slice of the picture.

#### Narrative Engineering- Language That Erases the Decision-Maker

How do insurers and their allies present these facts to the public and regulators? Often, it is through carefully crafted language that control is obscured. The NAIC 2024 analysis commentary exemplifies this kind of narrative engineering. It consistently uses passive voice and impersonal constructions that remove the decision-maker from the equation, framing outcomes as if they were natural disasters or inevitable trends rather than results of corporate choices.

For instance, the report states that *"higher medical loss ratios are being passed on to consumers through increased premiums"*. This phrasing makes it sound as if premium

hikes *happen* to consumers, as an almost mechanical consequence of loss ratios – notably avoiding the fact that insurers actively choose to raise those premiums. The sentence lacks an agent; it does not say who is passing on the costs. A more straightforward way to say this would be, "insurers raised premiums by about 6% to cover their higher loss ratios." However, the NAIC commentary does not say that. Using the passive voice ("are being passed on") spares the industry of direct responsibility in the reader's mind. The focus shifts to the abstract concept of "medical loss ratios" rather than the companies that set prices.

Similarly, the NAIC summary describes 2024 as *"a challenging year for the health insurance sector driven primarily by increased medical costs and record high utilization"*. Note how this explanation attributes the drop in profit to external factors – medical costs went up, people used more healthcare – and implies insurers were passive victims of these trends. It does not mention that insurers decided to spend more on administration, or that they failed to adjust premiums adequately, or that they paid billions to affiliates. The wording "driven primarily by increased medical costs" neatly erases any hint that insurer management decisions played a role. It was not that "insurers spent more on overhead and kept profits low;" instead, the story is "costs went up, so profits went down." This framing aligns perfectly with the industry's preferred narrative- blame the hospitals, blame the patients using care, but never shine a light on internal choices.

Another example of subtle narrative engineering is the commentary on the combined ratio. The report notes- *"the combined ratio increased to just over 100% due to a 2.3-point increase in the loss ratio to 89%, partially offset by the increase in administrative expenses, which consequently resulted in a modest 0.4-point decrease in the expense ratio to 11.2%."* \*. This sentence is quite convoluted, but the striking part is how it portrays the role of administrative expenses. It says increased administrative expenses *resulted in* a decrease in the expense ratio – a counterintuitive statement at first glance. What NAIC means is that administrative costs grew slightly slower than premiums, so, as a percentage (the "expense ratio"), they dipped slightly. However, the phrasing "offset by the increase in administrative expenses" almost makes it sound like rising admin costs were a helpful counterbalance! It is an odd bit of spin, highlighting a "modest decrease" in the expense ratio as if it is a positive development, when in fact the dollars spent on overhead still went up. Describing it this way downplays the significance of administrative spending. The casual reader might not realize that even at 11.2% of premiums, administrative expenses amounted to well over \$130 billion. That fact is nowhere plainly stated in the prose. Instead, we get an obscure discussion of basis points that draws attention away from the sheer scale of overhead.

Throughout the report, the language frequently lacks active subjects when describing less flattering actions. Premiums "have risen" by X%, but it rarely says "insurers increased

premiums." Benefits "increased 8.9%", as if the benefits themselves decided to cost more, rather than insurers agreeing to higher provider rates or more claims being approved. This style is not accidental. It frames everything as systemic or inevitable, rather than as a series of business decisions. The effect is that the decision-makers are invisible. One could read the NAIC analysis and come away thinking the poor insurers were swept along by forces beyond anyone's control – costs, utilization, regulations – doing their best to stay afloat. In reality, as our counter-analysis shows, insurers made specific choices (such as spending huge sums on administration and internal transactions) that led to the outcomes we see. However, the passive phrasing and focus on external drivers cleverly erase that agency.

This kind of language matters because it shapes policy discourse. If regulators and lawmakers hear repeatedly that "expenses increased" and "margins fell" in impersonal terms, they may overlook the possibility that insurers could manage expenses more effectively. Passive language engineers the narrative to remove blame or responsibility. It is a classic technique in crisis communications and bureaucratic reporting- talk about what happened, but not about *who caused it*. The NAIC, perhaps unintentionally, adopted the industry's voice in this commentary. The choice of words mirrors how an insurance CEO might explain away bad results on an earnings call – "higher utilization hurt our margins" – rather than directly acknowledging "we chose to allocate money here and that impacted margins."

In summary, the NAIC's 2024 industry analysis uses language that whitewashes the role of insurer decision-makers. Employing passive constructions and emphasizing external factors, it creates a narrative in which outcomes seem almost natural. However, strip away the euphemisms, and a clearer picture emerges- insurers raised premiums, insurers spent more on overhead, insurers decided to channel money internally – and these choices led to low profits. The report could have said that plainly. Instead, it said everything else. This is narrative engineering, and it serves to *protect the industry's image by shielding it from direct accountability in its own financial story*.

Visual Persuasion- Profit Panic on Page 2, Overhead Silence on Page 1

Numbers and words are not the only tools used to shape the narrative – visuals play a decisive role as well. In the NAIC's 2024 analysis, the way charts and graphs are presented (and what is not) emphasizes the "profit panic" message while keeping the issue of administrative bloat largely out of sight. There is a striking contrast between the front-and-center visuals highlighting declining profits and the absence of any prominent visuals spotlighting overwhelming overhead costs.

Right at the start of the report, on page 2, Figure 1 delivers an alarming image- a decade-long chart showing net income plunging to its lowest point in 10 years. The profit margin line for 2024 drops to 0.8%, a dramatic decline from prior years. This graph visually screams "crisis!" – and it appears at the very beginning, setting the tone. The message a reader gets is that insurers' profits have collapsed. By design or not, this primes the audience to sympathize with the industry's predicament or to expect bad news, which can then justify changes like premium hikes. In essence, the profit panic is on full display- big bold bars and lines trending downward, likely colored in attention-grabbing tones, ensuring that the reader's first impression is about how poorly the insurers are doing financially.

Now compare that to how administrative expenses are visualized – or rather, how they are not. On page 1, where the overview table and bullet points reside, there is total silence about overhead costs. The summary bullets mention premiums, medical expenses, loss ratios, and surplus changes, but not a single mention of administrative spending. No bullet says "Administrative expenses totaled \$X (representing Y% of premium)" – even though that number is crucial to understanding the profit squeeze. It is omitted from the quick highlights. Moreover, throughout the report, there is no dedicated chart that focuses on administrative cost trends, despite the prominence given to profit or loss ratios. Figures 3 through 10 in the later pages include various breakdowns (by line of business, loss ratio components, etc.), and the admin expense ratio might be a small part of those charts, but nowhere do we see a big, bold graphic screaming "Overhead- \$130 Billion" the way we see "Profit at Decade Low."

In fact, any visualization of the expense ratio (the percentage of premium going to admin) is relatively muted. It might be a thin line at the bottom of a graph or a slice of a stacked bar in a figure, with other things in focus. For example, a chart of combined ratio components would have a sliver for the ~11% expense ratio, probably not highlighted. The lack of an explicit, standalone visual for the administrative load means that a casual reader could easily finish the report without grasping how enormous the overhead burden really is. The visuals essentially obscure the administrative bloat by not drawing attention to it.

This omission is a form of visual persuasion by silence. By choosing what to show prominently (profits down) and what to bury (overhead high), the report subtly guides readers' perceptions. It is an age-old tactic- *show them what supports your narrative, do not show them what does not*. A chart illustrating that insurers spent 11–12% of every premium dollar on overhead (translating to \$130 billion total) could provoke uncomfortable questions – such as, why not trim that? So that chart never takes the spotlight. Instead, the visuals direct the audience to sympathize with the marginalized plight and perhaps conclude, "No wonder premiums went up."

Furthermore, consider the sequencing- Page 1's text and table tell the story of rising costs and stable (even growing) enrollment and premium revenue, but they do not visually depict the cost breakdown. Page 2's figure immediately dramatizes the outcome (profit collapse). The reader sees the problem (tiny profits) before they ever see a breakdown of causes. By the time overhead is mentioned in passing (several pages in, as a footnote to combined ratios), the emotional impact has already been made by the earlier visuals. This is a brilliant presentation – it frames the issue as *urgent and not the insurers' fault* at a visceral level.

Our counter-report, in contrast, seeks to put visuals to what was left unseen. One crucial visual missing from NAIC's analysis is a depiction of the industry's vertical integration structure – a factor that heavily influences where money flows. Below is a figure that fills this gap, illustrating how a typical insurance holding company is organized and how that structure can hide profits. Insurers like UnitedHealth Group, Aetna/CVS, and Anthem (Elevance), among others, are not just insurers; they also own provider networks, pharmacies, data companies, and more. This vertical integration means the company can shift money internally (as discussed earlier), but NAIC's visuals did not map this out for readers.

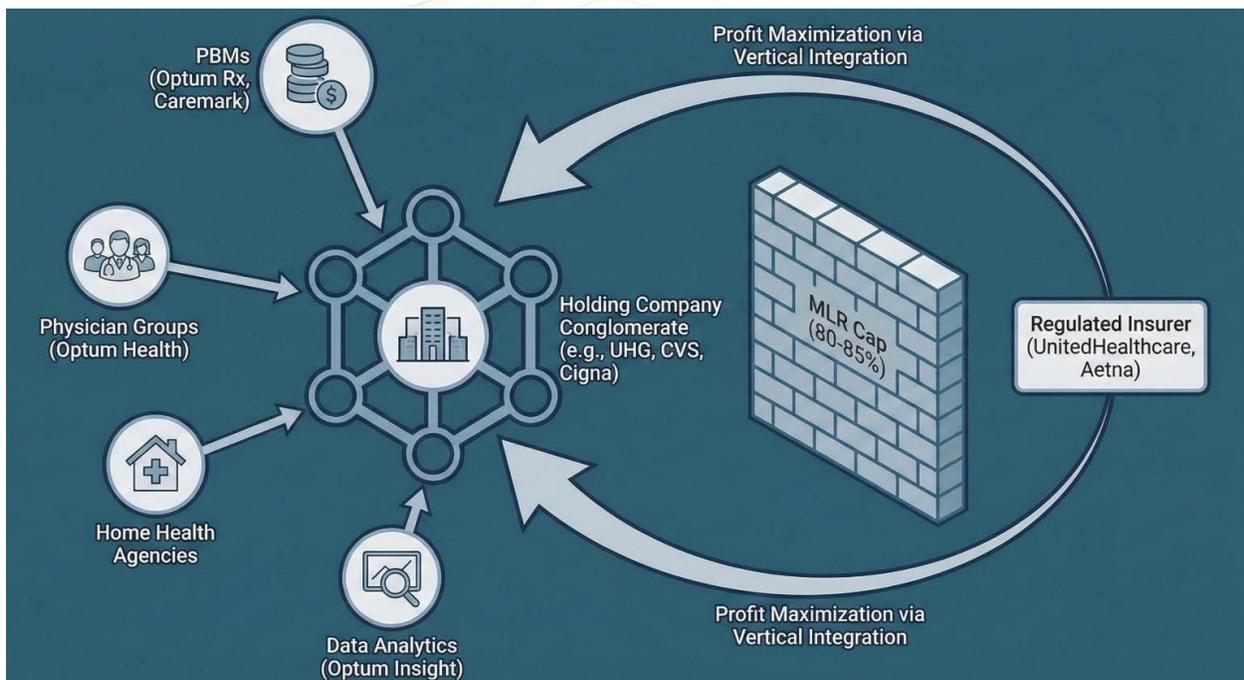


Figure- Typical vertical integration structure of a health insurance holding company. The holding company (top) owns a regulated insurance subsidiary (left) and various non-insurance subsidiaries such as provider groups, pharmacy benefit managers, clinics, or data services (right). Premium revenue flows into the insurer, and a large portion is then paid out to the sister companies for services. This structure allows profit to move within the

*enterprise. Such diagrams were absent in the NAIC report, but they are key to understanding how insurers allocate costs and profits.*

By not showing a diagram like the one above, the original analysis left out context that would help explain *why* profit margins are so low despite high revenues. A visual of the corporate structure makes it clear: the insurance arm's thin margin may be a small fraction of an illusion created by internal transfers. However, when regulators do not present this, the public conversation stays focused on the idea that "medical costs = high, insurer profit = low, oh dear!" The selective use of graphics in the NAIC report – emphasizing the "profit panic" and omitting visuals of overhead and corporate structure – effectively supports the narrative that the industry wants to tell.

In summary, the NAIC's visual choices contributed to obscuring the role of administrative spending. They gave center stage to the symptom (low profits) in a dramatic way, while keeping the cause (giant overhead and profit-shifting practices) mostly offstage. For a truly balanced view, one would expect equal visual weight for how each premium dollar was spent (showing the slice that went to admin) and for how the corporate web funnels funds around. Nevertheless, that transparency is precisely what is missing. The result is a set of graphics that, intentionally or not, persuade the audience to focus on the insurers' apparent financial plight and ignore their self-imposed spending choices.

#### The Alignment of Narrator and Subject

Why would a regulatory body's analysis end up mirroring industry talking points so closely? The answer may lie in a cultural alignment between the narrator (regulators/analysts) and the subject (the insurance industry). This section – nicknamed the "Treadstone 71 Cultural Nexus" – suggests that regulators have, over time, internalized many of the industry's assumptions and perspectives. The NAIC, composed of state insurance commissioners, often works closely with the companies, relies on industry data, and even sees issues through a similar lens. The result is that the regulators' narrative aligns with the industry's, sometimes to the point of echoing it, especially on complex issues such as vertical integration and Medical Loss Ratio (MLR) rules.

One clear example of this alignment is how vertical integration's impact on MLR is handled. As discussed, vertical integration allows insurers to bypass the spirit of MLR rules by counting payments to themselves as medical expenses. This is a well-known loophole – health policy experts and think tanks have flagged it as a problem. However, the NAIC commentary for 2024 does not raise an eyebrow about this practice. It does not question the stunning growth in "other" costs, or non-claims costs, which could be internal transfers. It does not highlight that insurers owning provider networks can game the system. In fact, the

NAIC analysis nowhere mentions the MLR loophole. This silence suggests that regulators have accepted the industry's structure as a given and are not challenging its use to manipulate financial results.

Regulators arguably have become acculturated to the idea that "85% loss ratio is the law, so if it is met, all is well." If insurers meet that threshold by paying their own subsidiaries inflated prices, the regulators' reports do not call it out; they treat it as legitimate medical spending because, technically, it is within the rules. This is precisely the *alignment of perspective*- the regulator sees through the same lens as the industry, considering those internal payments just part of doing business. In reality, as we have shown, those practices distort actual spending and profit allocation. A more critical or independent narrative would spotlight that. However, culturally, it appears the NAIC community and insurers are on the same page, so the narrative stays *comfortably within conventional bounds*.

There is also the revolving door and shared expertise. Many state insurance regulators either come from the insurance industry or later work for it, and they often interact with industry representatives through committees and conferences. Over time, regulatory staff may adopt industry framings without even realizing it, simply because they hear them so often. For example, insurers frequently claim that the MLR requirement ironically forces them to increase spending (the argument goes that if they become too efficient, they would have to pay rebates, so they would rather spend internally). The narrative we saw in the FREOPP analysis calls MLR a distortion that "turns insurers from cost-managers into cost-inflaters". You might expect regulators to push back on that notion – after all, MLR intended to protect consumers from excessive overhead. However, instead, we see regulators broadly acknowledging higher costs (as NAIC did) and not emphasizing efficiency. This alignment in mindset – perhaps acknowledging privately that "Yes, MLR does incentivize more spending" – can lead to a kind of *regulatory shrug*- they report what happened but do not aggressively question why overhead was not cut. Essentially, the watchdog is napping, not because it is lazy, but because it has been trained to view the situation as usual.

The "Treadstone 71" metaphor evokes a deep-cover operation – here, it is as if the industry's narrative has infiltrated regulatory discourse so profoundly that it is indistinguishable from the regulator's own perspective. One might say regulators have become the cultural kin of the insurers, speaking the same language. This is evident in the official analysis, which treated vertical profit-shifting as a non-issue. Meanwhile, independent analyses in outlets like *Health Affairs* and the *Center for American Progress* have been quite blunt about it- they call these practices a loophole that needs closing, and show hypothetical examples of how an insurer can double-charge itself for a test to boost reported costs. Those independent voices are essentially saying, "If-then- if an insurer owns a provider, then it can charge more

and count it as cost, and we should guard against that." Regulators, however, have not prominently echoed that concern. The NAIC did not issue warnings about internal pricing, nor did it propose adjustments in how to account for related-party transactions in that commentary. The alignment of narrator and subject means the regulator's storyline is missing chapters that might cast the industry in a more culpable light.

Another angle is how regulators accept vertical integration as a given reality. The NAIC report notes changes in enrollment and related factors, but does not delve into how consolidation and integration might be affecting cost structures. From a culturally aligned perspective, vertical integration is seen as a means of efficiency or diversification, not as a way to exploit rules potentially. Regulators, perhaps, even believe some of the industry's justifications- for example, that owning providers helps coordinate care (which can be true, but it also helps coordinate profits). The cultural nexus here is that the regulator and the industry share an understanding or narrative about what integration means – likely focusing on potential benefits and ignoring the downsides for transparency and cost.

In practical terms, this alignment has consequences. If regulators do not call out things like upcoding or algorithmic denials in their big-picture analyses, it signals that those issues are not high on the oversight agenda. Moreover, indeed, it took external pressures (media reports, lawsuits) to bring something like Cigna's denial algorithm practices to broader attention – not a flag in a regulator's annual report. Similarly, CMS is tackling upcoding in Medicare Advantage, but state regulators overseeing commercial insurers seldom highlight it in their own reports, even though it inflates premiums for everyone. The narrative alignment leads to blind spots- areas where regulators ought to question insurer behavior, but instead they almost *defend* it by omission or by adopting the insurer's framing.

Ultimately, the "Treadstone 71" effect implies a need for an outside perspective to break the echo chamber. Our counter-report is precisely that – injecting a viewpoint that the NAIC's culturally-aligned commentary glossed over. Regulators are supposed to be on the public's side, ensuring fair play, but if they culturally and linguistically align with the industry, the public narrative suffers. To protect consumers, regulators must maintain a critical distance from industry rhetoric. In 2024's case, that distance was not very apparent. The NAIC analysis reads as if it were written by the industry's PR team in parts, especially in its lack of critique of vertical cost-shifting and its acceptance of overhead levels. Recognizing this alignment is the first step to correcting it- Regulators need to reassert independent analysis, questioning the choices insurers make instead of narrating as if those choices do not exist.

If-Then Assessment- Administrative Cuts vs. Premium Hikes

To drive home the point that solutions exist, we present an if-then scenario analysis. This straightforward assessment shows that if regulators (or insurers themselves) enforce administrative cost cuts, then profit margins improve significantly without any need to raise premiums or cut healthcare services. Conversely, if overhead is left untamed, then the only ways to boost margins are less palatable (premium hikes or reductions in care spending). The logic is simple and uses the data we have-

- If insurers reduce their administrative expenses, then their profit margin will rise. As calculated in our sensitivity test, trimming overhead by even 5–10% would raise margins from under 1% to around 1.5–2%. This improvement happens *without* any increase in premiums. The reason- every dollar not spent on unnecessary admin is a dollar added to net income (or available for other uses like lowering premiums). This scenario is a win-win: if insurers become more efficient, they become more profitable and/or can offer better prices. The key takeaway is that insurer solvency and profitability can be secured by cutting waste, not by charging people more.
- If regulators set stricter rules or targets for administrative spending, then insurers would be forced to find efficiencies rather than simply passing costs on. For example, regulators could refine the MLR rules to exclude certain internal transactions or cap what counts as "quality improvement" spending. They could also shine a brighter light on administrative cost ratios in public reporting, effectively shaming companies that operate with outsize overhead. If such measures were implemented, then insurers would quickly find ways to meet them – likely by doing precisely what we suggest- slashing unnecessary overhead. They might streamline claim processing, curb executive bonuses, or simplify plan offerings to cut marketing expenses. The outcome would be the same as above- margins improve without hurting consumers. In fact, if done right, consumers benefit because insurers would not need to jack up premiums as much. This scenario is: if regulators demand leaner administration, insurers will adapt, *and everyone is better off (except perhaps a few executives who lose some perks)*. The industry would remain profitable, arguably more sustainably so.
- If, however, insurers insist on protecting every dollar of their current administrative spending (the status quo), then any attempt to improve margins will likely involve raising premiums or reducing claim payouts. This is the flip side- an *if-then* that serves as a warning. If overhead is treated as untouchable, then something else has to give for profits to rise. Typically, that means higher premiums (shifting the burden to consumers) or stricter claim approval (shifting the burden to providers and patients). We have seen this play out: insurers unwilling to cut overhead have filed for

premium increases each year, citing medical cost trends. That is basically choosing the path of charging more instead of spending less on themselves. Our analysis suggests this is not a necessity but a choice. Therefore, regulators and consumers should push back- *if an insurer claims they must raise premiums due to low margins, then the response should be to scrutinize their administrative costs first.* Low margins in a high-revenue business often indicate inefficiency or internal profit shifting, not a true need for additional revenue.

- If administrative cuts were made, then insurers would not only stabilize margins but possibly create room to lower premiums or enhance benefits. It is worth considering the positive feedback loop- if overhead dropped and margins rose to a comfortable level, insurers might feel competitive pressure (or regulatory pressure) to share some of those gains with customers. In a scenario where one insurer cuts fat and starts earning a 3% margin, that firm could choose to reduce premium rates slightly to gain market share, knowing it can afford to while still making 2% profit. That would push others to follow suit. If one breaks the mold, then the market could shift in favor of consumers. This is not fantasy – it is precisely how normal competitive markets work when not distorted. The reason it has not happened is that all major insurers are locked into the same high-overhead model (and MLR rules perversely encourage spending over cutting, as discussed). However, if regulators tweak incentives such that efficiency is rewarded, then the competitive dynamic could change. In short, *if efficiency is encouraged, then competition might lead to premium relief.*

In all these if-then scenarios, the key theme is that administrative costs are the lever. They are the variables that can be controlled. Medical costs have some fixed realities (people get sick, drugs can be expensive, etc.), but admin costs are entirely within insurers' power to manage. If insurers choose to exercise that power responsibly, then much of the current angst over thin margins disappears. If regulators demand it, then insurers will have to comply or lose out. Furthermore, if neither party acts, then the default path is unfortunately more of the same- premiums go up, or coverage gets tighter, hurting consumers – all to feed an ever-growing overhead.

The scenario analysis demonstrates that we are not stuck with the status quo. There is a plausible, even straightforward, path to better outcomes. It hinges on a simple conditional- If administrative excess is curbed, then everyone (except perhaps some entrenched interests) wins. The numbers back this up, and the logic is sound. Now it is a matter of will – do regulators and insurers have the will to make this a reality? Because if they do, the narrative of low margins can finally shift to one of regained efficiency and consumer value.

Indictment- A \$130 Billion Self-Licking Ice Cream Cone

At the end of this forensic analysis, the verdict is clear- the health insurance industry's administrative spending is a \$130 billion self-licking ice cream cone – a gigantic, self-perpetuating construct that exists to feed itself at the expense of transparency and truth. This overhead machine does not just happen to exist; it was built and maintained by conscious design, and it is culpable for many of the issues disguised as "unfortunate outcomes" in the NAIC's report. We summarize the indictment as follows-

- Administrative Bloat Enables Denial Engines- Insurers have funneled billions into creating systems that *deny and deflect care*. This includes algorithm-driven claim denials, onerous pre-authorization requirements, and other bureaucratic hurdles. These denial engines are part and parcel of the administrative complex. They reduce payouts (which insurers like), but they also require massive upkeep – software, personnel, protocols – which keeps administrative costs high. It is a closed loop: overhead funds the denial machinery, and the denial machinery, in turn, keeps medical expenses in check so that insurers can maintain the appearance of needing all that overhead.
- Meanwhile, patients and doctors experience these processes as frustration and obstruction. The industry effectively spends a chunk of its \$130 billion overhead to make itself less effective at paying for care, a paradox that only makes sense when you realize the goal is to protect profits and avoid payouts. It is a self-licking cone because the more they invest in denial infrastructure, the more they can justify keeping it to themselves (to save costs). Our evidence showed how extreme this gets – automated systems denying hundreds of thousands of claims with barely a glance. That is money spent not to spend money, a hallmark of a self-serving bureaucracy.
- Overhead Protects Shareholder Payouts and Executive Gains - The structure ensures that, despite low reported margins, shareholders and executives still get their spoils. Companies paid out \$19+ billion in dividends in a "bad" year. CEOs of major insurers routinely earn \$15, \$20, or even \$30 million a year in compensation. These rewards remain lavish because the overhead system shields them. High administrative budgets can include large salaries and corporate expenses, which are counted as costs rather than profits. The self-licking ice cream cone *feeds those who run it* – it takes premium dollars and circulates a good portion to corporate leadership and owners, labeling it as "necessary expense" or "return on investment," depending on the path. One might call it an overhead siphon- money moves from policyholders' premiums into the pockets of executives and investors, but on the books it is not profit (which would be more obvious and potentially embarrassing in a year of slim margins); it is buried in operating costs or paid out from surplus. The indictment here

is that the low-profit-margin narrative conveniently conceals how well the insiders are actually doing. If an insurance company only had a 1% margin, one might think, "tighten belts all around." However, the same company's CEO received a significant raise, and stockholders saw growing dividends. That is not a company in distress – that is a company using *accounting fiction* to mask where the money is going.

- Accounting Fiction Disguises Solvency and Profitability-Through vertical integration and clever accounting, insurers have created a *fiction* that they are barely solvent when, in fact, they are robust. As documented, internal transactions allow profits to vanish from the insurer's ledger and reappear elsewhere as costs or affiliate income. This circular money flow is the epitome of a self-licking ice cream cone – it is the system feeding itself. The insurer pays its own subsidiary (licking itself), records a high medical ratio (tasty for regulators), and the money comes back to the parent company (the cone is intact). It is a closed system where, unless you look at the consolidated holding company, you would think the insurer is just scraping by. Our analysis highlighted how a test can cost \$100, but an insurer that owns the clinic might pay \$200 and count \$200 as a medical cost – essentially double-counting to inflate costs and hide profit inside the organization. This is an accounting sleight of hand that regulators have yet to solve. It disguises actual solvency (the parent firm is extremely solvent, even if the insurance arm appears average) and true profitability (profits are recognized in unregulated segments). It is almost elegant in a devious way- meet the letter of the MLR law by spending more, but keep the extra spending in the family. The indictment is that insurers are using this fiction to claim "we only made 0.8%" when, in reality, the enterprise might be earning a far higher return on each healthcare dollar once all internal flows are considered.

In calling this a \$130 billion self-licking ice cream cone, we emphasize the sheer scale of resources devoted to this self-serving cycle. Over \$130 billion a year is not healing the sick or lowering premiums – it is essentially cycling through a loop of denial management, billing complexity, internal profiteering, and narrative maintenance. Yes, some administration is necessary (enrolling members, customer service, etc.), but not to this extent. The excess exists because it serves a purpose- it keeps regulators at bay (by satisfying formal requirements), it keeps profits flowing to those in control (through indirect means), and it keeps the justification alive for why premiums must keep rising ("look how low our margins are!").

This is an indictment of the industry's business model. The low profit margins are not a defense; they are *evidence of the scheme*. A consistently narrow margin amid large cash flows is a red flag that money is being spent in ways that do not directly benefit the customer.

It is a sign of a self-licking bureaucracy – one that, like a metaphorical ice cream cone, exists solely to sustain itself. If you removed the need for such excessive overhead, the whole 'barely-getting-by' narrative would collapse.

The NAIC 2024 Annual Health Insurance Industry Analysis, when deconstructed, reveals a reality very different from the surface story. The industry is not simply weathering a tough year of high costs; it is actively orchestrating its financial results through enormous administrative spending and internal transfers. The real story is that insurers could easily afford to improve their margins or lower premiums – they choose not to. Instead, they have built a \$130 billion engine that justifies its own existence by keeping margins low and calling that prudence. It is a self-licking ice cream cone of overhead and obfuscation. Breaking this cycle will require regulators to see through the narrative and demand change, and for the public to understand that when they pay their premiums, a large chunk is not going to care about this self-serving loop. The indictment is clear- the health insurance industry's woes are essentially of its own making, and it is time to stop letting a bloated administrative complex disguise itself as a victim of circumstance. The cone does not need more ice cream (premiums); it needs to stop licking itself. Only then can we have an honest conversation about costs and value in healthcare.

