



OnPoint: Issue Brief

A Publication by the Massachusetts Association of Health Plans

Volume XII, October 2018

Written by Elizabeth Murphy

The Cost Benchmark v. Health Insurance Premiums: What's the Difference?

Recently, the Center for Health Information and Analysis (CHIA) released its 2018 *Annual Report on the Performance of the Massachusetts Health Care System*. Its initial analysis of health care spending in 2017 concluded that costs grew by just 1.6 percent from 2016 to 2017, less than the growth of 2.8 percent in 2016, and a full two percentage points below the Commonwealth's health care cost growth benchmark of 3.6 percent established as part of the state's 2012 Payment Reform law (Chapter 224 of the Acts of 2012).

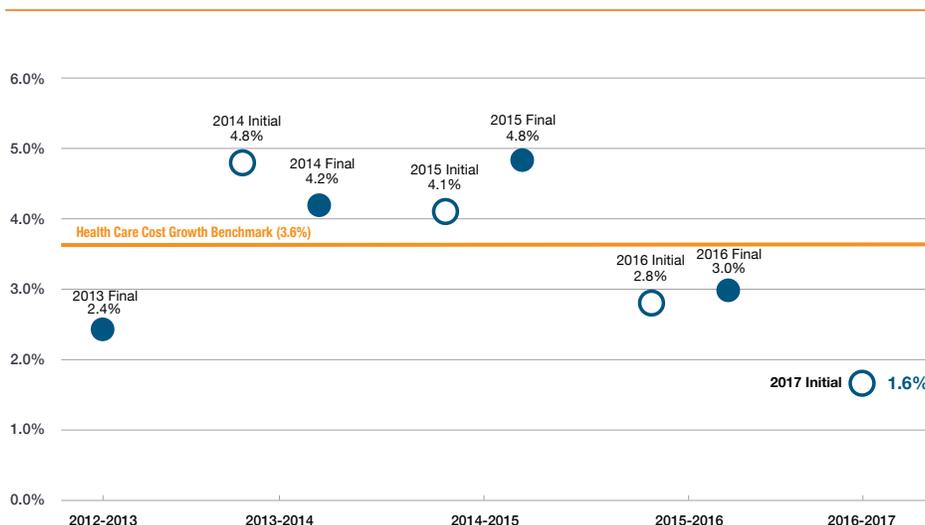
Some may ask, "If health care spending increased by only 1.6 percent, why are premium increases higher?"

The cost benchmark is a yearly full system-wide measure of total health care spending from public and private sources, examining growth in spending on hospital stays, doctor visits, prescription drugs, and health insurance premiums on a retrospective basis. This policy brief outlines how the cost benchmark is calculated, how health insurance premiums are developed, and the differences between the two. This policy brief updates one originally released in 2017.

How is the State Cost Benchmark Calculated?

A key provision of Chapter 224 was the establishment of a cost benchmark against which the annual change in health care spending is evaluated. Under the law, CHIA is charged with calculating Total Health Care Expenditures (THCE) and comparing its per capita growth with the health care cost growth benchmark, as determined by the Health Policy Commission. For 2017, the Commission set the benchmark at 3.6 percent.

Per Capita Total Health Care Expenditures Growth, 2013-2017



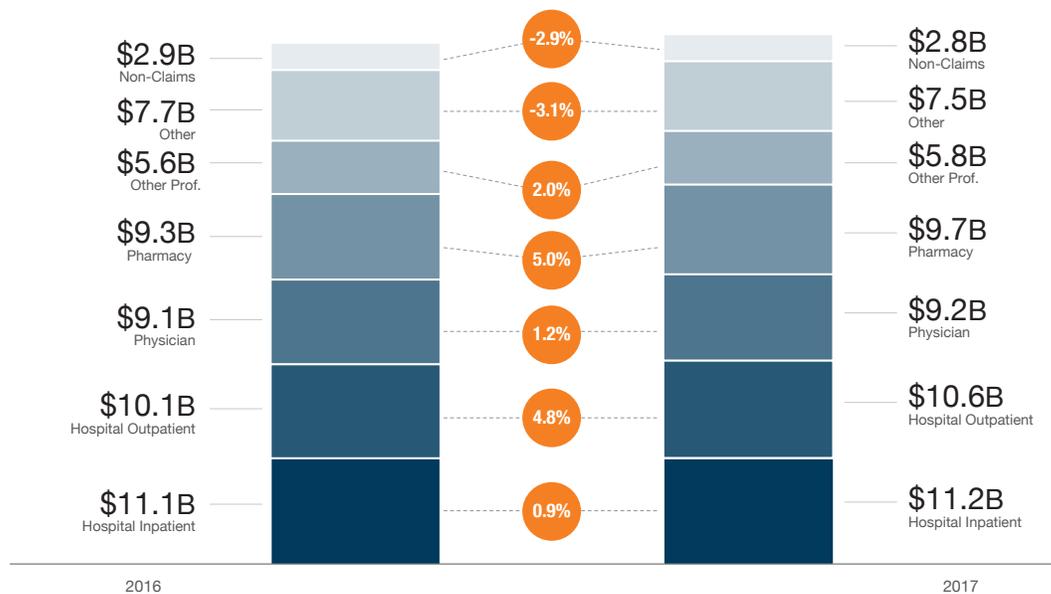
Source: Total Health Care Expenditures from payer-reported data to CHIA (Center for Health Information and Analysis) and other public sources. Inflation from U.S. Bureau of Labor Statistics: Consumer Price Index 12-Month Percent Change. Gross State Product from U.S. Bureau of Economic Analysis: GDP by State in Current Dollars.

THCE encompasses health care expenditures for Massachusetts residents from both public and private sources, including all categories of medical and pharmaceutical expenses and all non-claims related payments to providers; all patient cost-sharing amounts, such as deductibles and copayments; and the cost of administering private health insurance. It does not include out-of-pocket payments for goods and services not covered by insurance, such as over-the-counter medicines, and it also excludes other categories of expenditures such as vision and dental care.

What Factors Contribute to Increases in Total Health Care Expenditures?

In 2017, THCE grew 1.6 percent, below the 3.6 percent cost growth benchmark set by the Health Policy Commission. Pharmacy and hospital outpatient spending remained the largest drivers of THCE growth. Hospital services accounted for the largest share of overall THCE spending in 2017, with inpatient and outpatient expenses increasing by 0.9 percent and 4.8 percent, respectively, from 2016. According to the CHIA annual report, hospital outpatient spending was the largest component of total medical expenditure growth, accounting for 38.4 percent of new spending. Consistent with prior years, prescription drug spending rose the fastest among service categories in 2017, increasing by 5 percent to a total of \$9.7 billion; this spending accounted for 36.5 percent of THCE growth. Spending for physician services increased slightly in 2017 by 1.2 percent and other professional services spending increased by 2 percent.

Total Health Care Expenditures by Service Category, 2016-2017

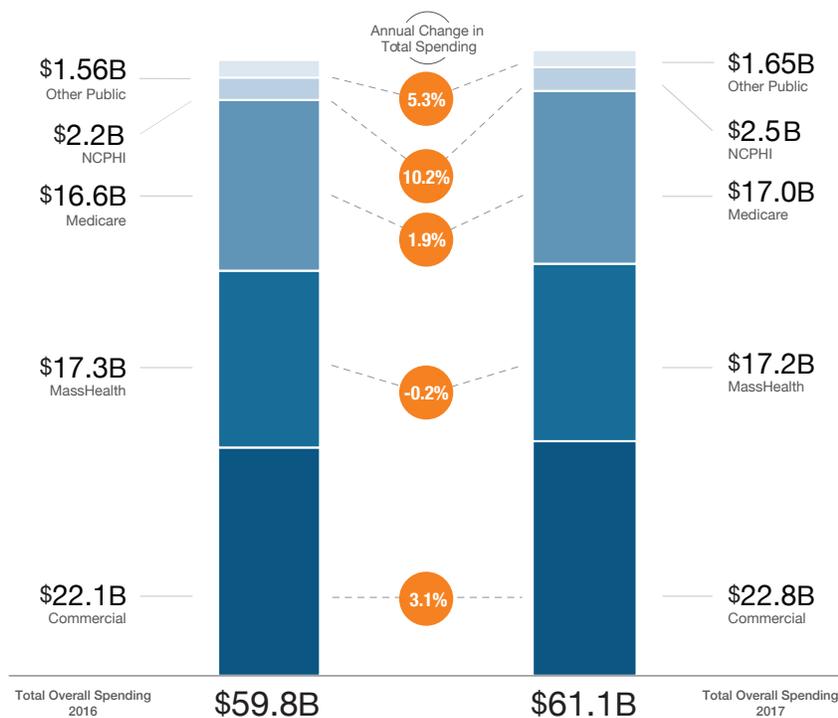


Source: Payer-reported TME data to CHIA and other public sources.

HEALTH CARE SPENDING INCREASED IN ALL BUT ONE CLAIMS-BASED SERVICE CATEGORIES, WITH THE HIGHEST GROWTH IN THE PHARMACY AND HOSPITAL OUTPATIENT SPENDING CATEGORIES.

While Total Health Care Expenditures paid on behalf of Massachusetts insured residents increased by 1.6 percent from 2016 to 2017, Medicare spending increased by 1.9 percent and MassHealth experienced a spending decline of 0.2 percent to \$17.2 billion, driven in part by a 2.4 percent decrease in program enrollment. Conversely, spending for commercial health care members grew by 3.1 percent, impacting premium growth.

Components of Total Health Care Expenditures, 2016-2017



Source: Payer-reported TME data to CHIA and other public sources.

How are Health Insurance Premiums Developed?

Health insurance premiums are based on a number of factors that reflect the cost of providing care to individuals. In Massachusetts, close to 90 percent of the premium dollar pays for the cost of care, which includes doctor visits, hospital stays, prescription drugs, and other services that benefit patients. Increases in the prices of these medical services are the most significant factor contributing to the growth in premiums. For the individual and small group markets, state law requires that at least 88 cents of every premium dollar is spent on health care services, which are defined by federal and state laws. If health plans fail to meet these standards, state law also requires that they issue rebates to employers and individuals, ensuring that the bulk of the premium dollar is spent on medical care.

The remainder of the premium dollar is allocated to the health plan's administrative expenses and government fees. Administrative costs include enrolling and billing members and employers, paying claims to providers, broker commissions, investments in new technology and information systems, and certain care management programs to assist members with chronic diseases, complex conditions, or recent illnesses. Administrative expenses also include reporting requirements mandated by state and federal agencies, as well as government taxes and assessments on the health plans. Finally, the administrative portion of the premium dollar may include a small surplus which is typically directed into health plan reserves – money set aside to pay for unanticipated claims costs to ensure that medical claims are paid on behalf of members to hospitals, doctors and others.

Taken together, these elements comprise the average change in premium rates. For small businesses and individuals, premium increases may vary across the marketplace based on:

- An overall risk profile of the carrier's merged market membership, meaning how healthy or sick that membership is and what the expected utilization for the membership will be over the coming year. This profile varies from carrier to carrier;
- An individual's health plan benefit design and levels of cost sharing;
- The prices carriers negotiate for prescription drugs and reimbursement rates to providers for medical services;
- Anticipated risk adjustment payments and other assessments, taxes or fees imposed by government;
- Mandated benefits imposed by government;
- Application of a limited number of rating factors that can result in an employer's or consumer's premium differing from the average rate change, including a person's age, family size, geographic location, the type of industry in which they work, the size of the employer group, and whether the employer is part of a group purchasing cooperative.¹

In 2017, as in previous years, the vast majority of premium dollars collected were used to pay for members' medical care. Health plans utilized the remainder to pay for claims administration, broker fees, customer service, and government taxes and assessments.

How Do Changes in the Cost Benchmark and Premium Rates Differ?

The cost benchmark provides a retrospective view of spending in the previous year and represents a statewide average that includes commercial health care spending, as well as spending on public programs including Medicare and Medicaid. In fact, spending by government programs accounts for roughly 60 percent of total health care spending. Reimbursement rates for these programs are regulated by government, with payment levels below what pharmaceutical manufacturers, hospitals, physicians and others service providers charge in the commercial market. As a result, commercial premiums may differ from the benchmark, in part, because of the difference in reimbursement rates.

Health Insurance premiums are set prospectively, reflecting the anticipated cost and use of services for the upcoming year. While premiums take into account the factors contributing to changes in the cost benchmark, such as increases in the prices charged for prescription drugs and medical services, they must also consider potential changes in the utilization of services, any new treatments or therapies that may be anticipated in the coming year, new requirements by government to cover particular mandated benefits, and payments to cover government fees, assessments or taxes. Additionally, as noted above, benefit design, levels of cost sharing, and adjustments due to geographic location, the size of the group, and other factors will also affect and vary the premium rate from one group to another, and may result in premiums charged to some individuals and employers that exceed the benchmark.

Conclusion

The health care cost benchmark is an important measure to ensure that health care spending does not increase faster than the state's economy and was not intended to apply as a cap on individual segments of the health care sector. In 2017, Medicare spending grew by 1.9 percent, Medicaid spending decreased by 0.2 percent, and commercial spending grew by 3.1 percent. By its nature, the benchmark allows health care spending to grow and is just one component that health plans utilize in developing premiums. The growth in spending should not be construed as a representation of an average premium increase for a particular year given the additional factors that are applied as part of premium development as discussed above.

We'd like to acknowledge and thank our team of reviewers: Ann Chamberlin LaBelle, Elizabeth Leahy, Lora Pellegrini, and Stefani Reardon.

Footnotes

1. The Affordable Care Act places limitations on acceptable rating factors, permitting only the use of family structure, geographic area, age and tobacco use, and prohibiting state-specific rating factors. Recently, the federal government granted Massachusetts an extension of the transitional waiver so that the existing state rating factors would be phased out by January 1, 2020.