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Health Insurance 101 – How Are Premiums Developed for Individuals and Small Groups?

Health insurance premiums are based on a number of factors that reflect the cost of providing care to individuals. In Massachusetts, the bulk of health insurance premiums pay for the cost of care. Increases in premium rates reflect the growth in the prices charged for prescription drugs and medical services, changes to the utilization of medical services and prescription drugs, new requirements by government to cover particular mandated benefits, and payments to cover government fees, assessments or taxes. To protect individuals and small employers (those with 50 or fewer employees), state and federal law prohibits health plans from charging a higher premium to individuals based on their health status. This means that the cost of care is shared by those without significant medical expenses and those who have greater health risks and medical expenses. Additionally, the benefit design and the levels of cost sharing (deductibles, co-insurance), including state and federal requirements on what minimum benefits must be provided or any limitations on cost sharing, can affect the cost of coverage.

With both employers and the state looking to bend the health care cost curve, understanding what makes up the monthly premium and how rates are developed are important components for understanding changes in health insurance premiums. This policy brief outlines the key factors health plans consider in developing premiums and provides an overview of how rate increases may vary across the marketplace.

Developing the Base Rate

The base rate can be thought of as a dollar amount that the health plan needs to charge an average customer. In developing the base rate, health plans utilize the previous year's medical claims, along with projections for the rate of growth in the cost of care, costs to administer the plan, and state and federal taxes and assessments. Essentially, the base rate reflects the underlying factors contributing to rising health care costs, and increases in those factors translate into increases in premiums.

The Cost of Care – Nearly 90% of the Premium Dollar

Massachusetts has the nation's most stringent standards for how the premium dollar is spent, requiring in the individual and small group markets that at least 88 cents of every premium dollar is spent on health care services for patients, including doctor visits, diagnostic tests, prescription drugs and hospital stays. 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. Federal and state laws prescribe what is considered a medical expense. Increases in the prices of these services are the most significant factor contributing to premium increases. This includes:

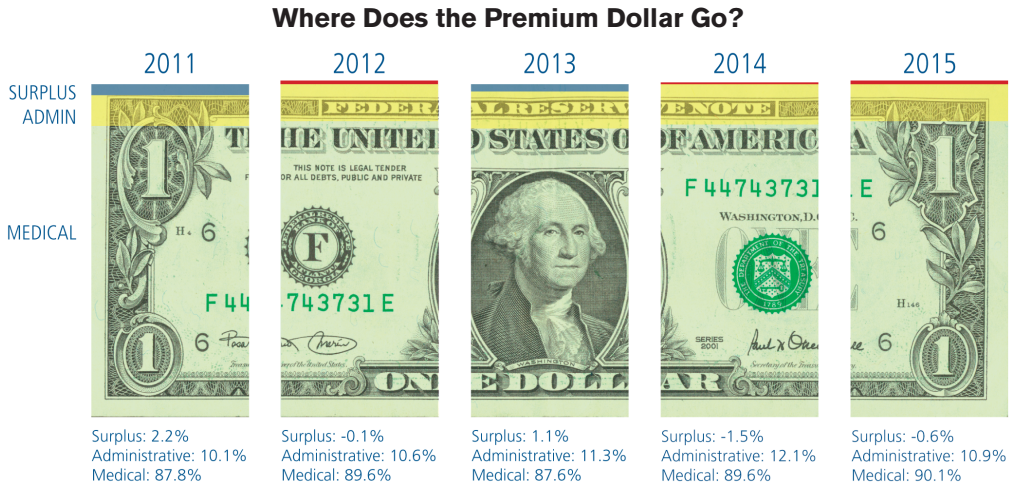
Increases in prescription drug prices: Rising prices for prescription drugs have been a major factor in the growth in health care spending. The state's Center for Health Information and Analysis' (CHIA) annual reports on the *Performance of the Massachusetts Health Care System* found that pharmacy spending grew by 13.5 percent in 2014 and 10.2 percent in 2015, and the Attorney General's examination on specialty drugs noted, "Even after accounting for all discounts and rebates, growth in the health plans' spending on prescription drugs has significantly outpaced overall health care spending growth."

Increases in provider unit prices: Multiple state reports have found that provider unit prices remain the most significant factor driving up health care costs. The increases in the rates that hospitals, doctors and other providers charge contribute to increases in premiums. While some providers have negotiated contract increases of two (2) percent to three (3) percent, those increases are built off well-documented high reimbursement rates. When combined with increased patient volume being directed to higher-cost institutions, the net result is higher costs than would have occurred if the provider started at a lower basis.

While a two or three percent increase may seem reasonable without context, it actually results in hundreds of millions of additional costs that need to be accounted for in the insurer's base rates. In fact, the Health Policy Commission has noted that Massachusetts' commercial spending is 6 percent above national levels and, according to the Special Commission on Provider Price Variation's March 2017 report, **"approximately 50 percent of spending growth is explained by growth in unit prices."** More consolidation among providers has the potential to increase further the already significant negotiating power of the highest-cost hospitals and physicians, which will put added pressure on premiums.

Providing meaningful relief for individuals and small businesses from rising health care costs requires addressing these factors.

In addition to price increases, **greater use of services** and **care increasingly being provided at these higher-cost institutions** contributes to rising premiums, because as people use more services, health insurance premiums increase to cover those costs. State and federal laws mandating coverage of specific services (known as **Mandated Benefits**) also contribute to increases in premiums. CHIA's 2016 report on existing mandated benefits estimated that mandated benefits accounted for nearly 6.5 cents of every premium dollar.

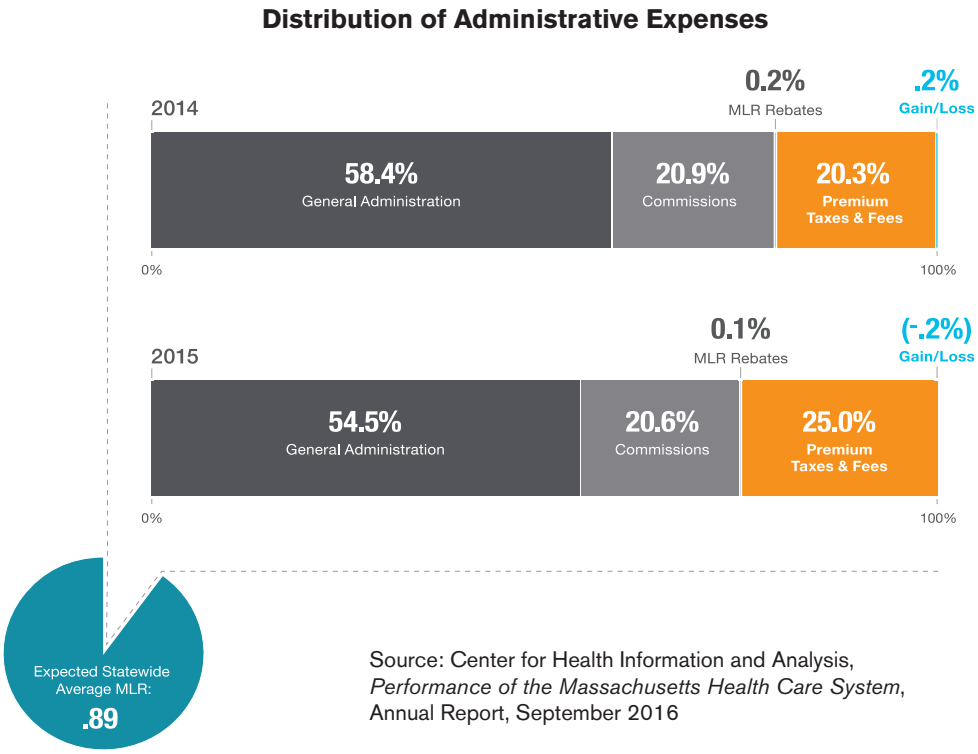


Source: Data is based on statements filed by plans with the MA Division of Insurance for five of the MA-based MAHP member commercial plans. Due to rounding, some totals may not add up to 100 percent.

Administrative Expenses – Roughly 10% of the Premium Dollar

Roughly 10 cents of every 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 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. Since passage of the Commonwealth's Health Care Reform Law in 2006, Massachusetts has enacted nine (9) new assessments, totaling nearly $2.5 billion, and CHIA's 2016 annual cost trends report noted that taxes and fees on health plans more than tripled between 2013 and 2015.



Source: Center for Health Information and Analysis, *Performance of the Massachusetts Health Care System*, Annual Report, September 2016

The administrative portion of the premium dollar also includes a small surplus (or profit). This amount is typically directed into health plan reserves – money set aside to ensure that medical claims are paid for catastrophic medical expenses or if a natural or man-made disaster or some other unforeseen event were to occur – although most health plans have operated at or below breakeven in recent years.

Like medical expenses, what is accounted for as administrative spending is prescribed by federal and state laws. However, Massachusetts standards are significantly more stringent than federal law or requirements in other states, as the Commonwealth restricts increases in health plan administrative expenses to no more than the New England medical CPI and limits health plan profits to no more than 1.9 percent.

Risk Adjustment

The payments that health plans must make in accordance with risk adjustment also factor into the development of premium rates. Established through the Affordable Care Act (ACA), the risk adjustment program requires the redistribution of funds from health plans with lower-risk members to those with higher-risk enrollees.

Risk adjustment was intended to stabilize premiums across the individual and small group markets as states implemented the ACA's market reform rules. Unfortunately, risk adjustment in Massachusetts has had the opposite effect, requiring the transfer of millions of premium dollars among health plans in an unpredictable manner. The volatility and market instability created by risk adjustment have contributed to premium increases.

One factor contributing to these premium increases is that health plans must project potential risk adjustment payments nearly three years before the actual payment amount is known and incorporate those predictions into rate filings. As an example, consider the process for setting 2017 premium rates: in 2016, health plans must set and file rates for 2017, which include a projection of 2017 risk adjustment liability; in 2017, health plans issue products based on the rate filings made the previous year; in 2018, the health plans learn what their preliminary risk adjustment liability was for 2017; and in 2019, after an audit process, health plans learn their final risk adjustment liability for 2017. So health plans that file rates in 2016 cannot know whether their rates were too high or too low until 2019, a full three years (and three more rate filing cycles) later.

Compounding this challenge is the wide fluctuation in the risk adjustment simulations health plans receive from the state each quarter estimating each health plan's potential payments. This creates significant difficulties in accurately projecting final payments and amounts to be included in the premium. Accounting for a potential payment of tens of millions of dollars in risk adjustment can put severe upward pressure on premiums.

Taken together, these elements comprise the average change in premium rates. However, premium increases may vary across the marketplace based on each health plan's membership, the prices they negotiate for prescription drugs and reimbursement rates with providers for medical services, and their anticipated risk adjustment payments. As noted below, there are a limited number of factors that can result in an employer's or consumer's premium differing from the average rate change.

Understanding the Massachusetts Individual and Small Group Markets

Massachusetts insurance law is designed to protect individuals and small businesses from wide fluctuations in rates. The Commonwealth made a series of policy decisions in the 1990s[1] to prohibit health plans from denying individuals coverage due to their medical condition, guaranteeing that individuals and employers would have access to coverage regardless of health status and prohibiting health plans from charging more to individuals or groups based on their health status (known as "medical underwriting"). As part of the state's 2006 health reform law, the Commonwealth merged the individual and small group markets, requiring all employers with 50 or fewer employees to be grouped with individuals purchasing coverage on their own (i.e., the "non-group" market). These changes limit how much rates may vary among small businesses, and prohibit health plans from charging companies lower premiums based on a healthy workforce or charging individuals more because of their medical conditions. Despite these restrictions, federal and state laws permit health plans to utilize a limited number of rating factors that can vary premiums in the marketplace.

Factors Contributing to Differences in Premiums

The Affordable Care Act permits health plans to vary premium rates based on a person's age, family size, geography and tobacco usage. For example, most individual consumers will experience a premium increase each year, because as we get older we utilize more health care services. However, state law restricts the rates charged to older individuals compared to younger individuals, so that the rates charged to older individuals are no more than twice what younger individuals may be charged. This is known as the 2:1 age rating band. Federal law permits states to use a 3:1 age band, but Massachusetts has adopted a more limited age band.

Rates also may vary depending on geographic location, reflecting that provider prices and the use of medical services, as well as the number of hospitals, physicians and other providers available in an area, may contribute to higher spending in one region of the state as compared to another. As a result, if an individual were to move from one area of the Commonwealth to another, that also may result in a premium change.

Additionally, premiums may be adjusted based on the size of the family and the number of people covered under the policy. Under the ACA, premiums are based on coverage for each adult on the policy plus the three oldest covered children under the age of 21. This factor means premiums for a family will be higher than premiums for an individual. The law also allows premiums to be adjusted 1.5 times for an individual who smokes as compared to a non-smoker. However, no insurer in Massachusetts currently uses a tobacco factor when setting premiums.

Massachusetts also allows health plans to consider other factors, such as the type of industry, the size of the group or whether the employer is part of a group purchasing cooperative, although the state's specific rating factors will be eliminated by January 1, 2019 as part of the Affordable Care Act.[2]

Affordable Care Act Permitted Rating Factors		Massachusetts Rating Factors	
• Age • Family Size	• Geography • Tobacco Usage	• Age • Family Size • Industry • Participation Rate	• Geography • Tobacco Usage • Wellness • Group Size • Benefit Level • Group Purchasing Cooperative

Some Examples*

To demonstrate how premiums may vary across the marketplace, we provide a set of examples utilizing a base rate of $350.

The first example shows two small employers with the same number of employees, operating in the same industry located in Boston, with the same participation level in the health plan. However, the average employee age for the first employer is 48 years old and the average employee age for the second employer is 30 years old (the age factor for a group also depends heavily on the distribution of members by age). In this example, for the first employer the premium for individual coverage would be $702, while the premium for individual coverage for the second employer would be $586. The $116 difference in the premiums between the two groups is due to the age and contract distribution between the two employers, and the difference would be greater for family coverage.

	Employer 1	Employer 2
Base Rate	$350	$350
Industry Factor	1.00	1.00
Participation Rate	1.00	1.00
Geography Factor	1.01	1.01
Group Size Factor	0.99	0.99
Age/Contract Distribution Factor	2.01	1.68
Individual Rate	$350 x1.00 x1.00 x1.01 x0.99 x2.01 = $702.01	$350 x1.00 x1.00 x1.01 x0.99 x1.68 = $586.75

The second example shows two individuals, age 27 and age 57. In the first instance, the premium is based on these individuals living in Boston, with a monthly premium of $444 for the younger individual and a premium of $779 for the older individual. The second instance is calculated based on living in Western Massachusetts, with a monthly premium of $413 for the younger individual and a premium of $725 for the older individual. As these examples show, in addition to age, geographic area can drive significant premium differences, with medical costs expected to vary in different parts of the state. Further, because these individuals are not obtaining coverage through an employer, the group size factor is adjusted slightly to reflect non-group coverage.

Boston

	Individual 1—Age 27	Individual 2—Age 57
Base Rate	$350	$350
Industry Factor	N/A	N/A
Participation Rate	N/A	N/A
Geography Factor	1.01	1.01
Group Size Factor	1.03	1.03
Age Factor	1.22	2.14
Individual Rate	$350 x1.01 x1.03 x1.22 = $444.21	$350 x1.01 x1.03 x2.14 = $779.91

Western Massachusetts

	Individual 1 – Age 27	Individual 2 – Age 57
Base Rate	$350	$350
Industry Factor	N/A	N/A
Participation Rate	N/A	N/A
Geography Factor	0.94	0.94
Group Size Factor	1.03	1.03
Age Factor	1.22	2.14
Individual Rate	$350 x0.94 x1.03 x1.22 = $413.42	$350 x0.94 x1.03 x2.14 = $725.86

* Note: These examples do not reflect actual rates or rating factors — for illustrative purposes only

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Footnotes

1. In 1991, Massachusetts enacted changes to the small group law, so that companies with fewer than 25 employees could not be turned down for insurance, and later expanded the definition of small group to include companies with up to 50 employees. In 1996, the state made changes to the non-group market to ensure that coverage would be accessible to all individuals regardless of health status.

2. 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. The federal government granted the state a transitional waiver to phase out the existing state rating factors by January 1, 2019. The Governor has continued to advocate for additional flexibility on the state's rating factors and other provisions of the ACA affecting the Commonwealth.