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

Recently, the Center for Health Information and Analysis (CHIA) released its 2017 *Annual Report on the Performance of the Massachusetts Health Care System*. Its initial analysis of health care spending in 2016 concluded that costs grew 2.8 percent, less than the growth of 4.8 percent in 2015 and 4.2 percent in 2014, and 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).

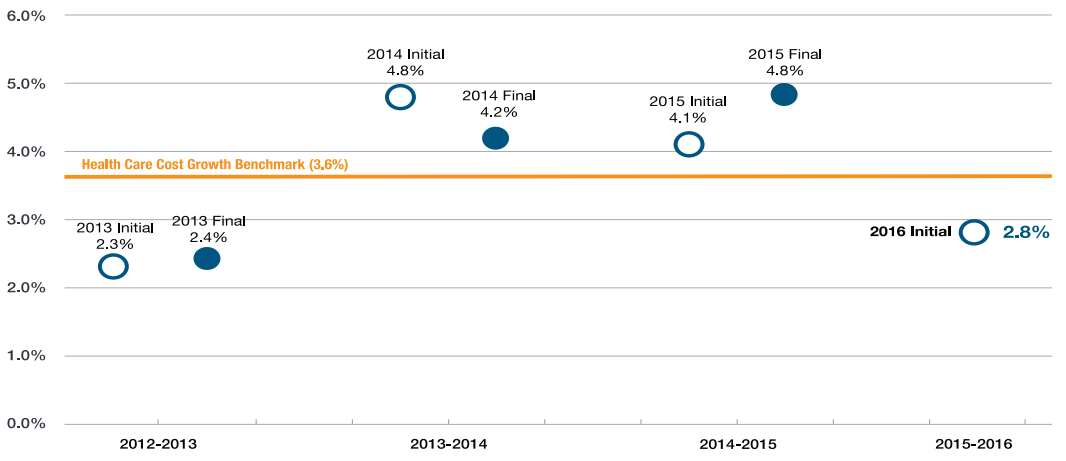
Some may ask, "If the cost benchmark increases 2.8 percent, why are premium costs higher?"

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.

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. In 2016, the Commission set the benchmark at 3.6 percent.

Per Capita Total Health Care Expenditures Growth, 2012-2016



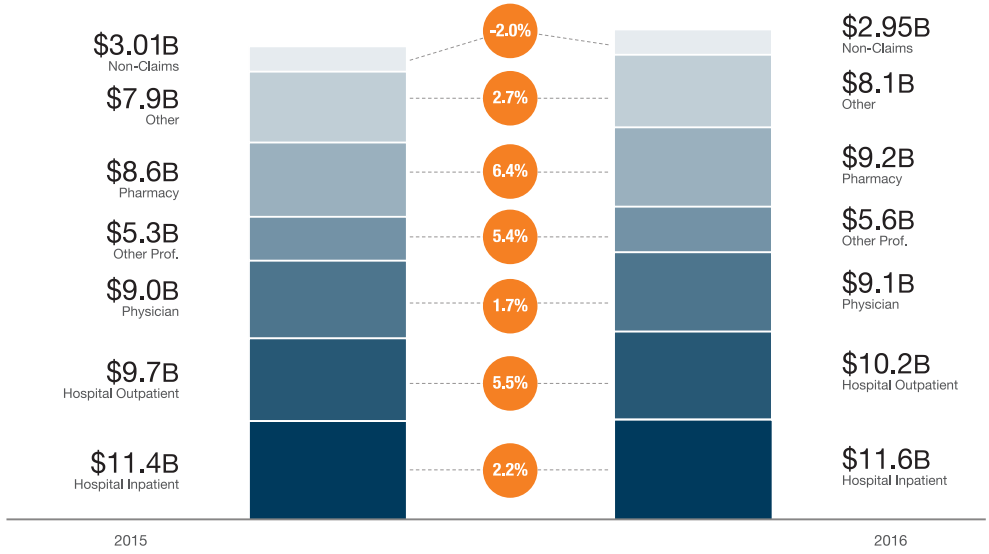
Source: Total Health Care Expenditures from payer-reported data to CHIA and other public sources. Inflation from the U.S. Bureau of Labor Statistics: Consumer Price Index 12-Month Percent Change. Gross State Product from U.S. Bureau of Economic Analysis: GDP by State in Current Dollars.

THCE encompasses health care expenditures for Massachusetts residents from 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?

Each year, the Center calculates an initial THCE trend for the prior calendar year, which is then updated with more complete data the following year. For example, the initial assessment of 2014-2015 THCE per capita growth, reported in September 2016, indicated an increase of 4.1 percent. Updated with final data, THCE per capita growth in 2015 was revised to an increase of 4.8 percent.

Health Care Expenditures by Service Category, 2015-2016



HEALTH CARE SPENDING INCREASED IN ALL CLAIMS-BASED SERVICE CATEGORIES, RANGING FROM 1.7 % TO 6.4%.

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

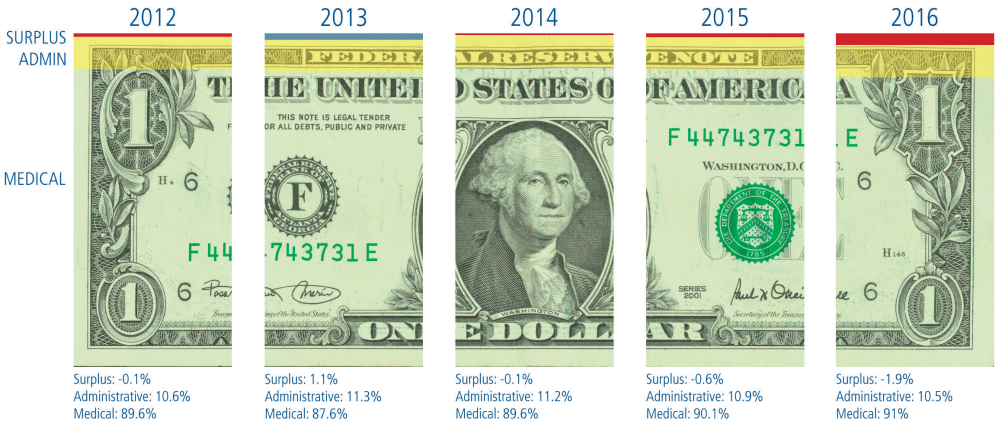
Notes: Excludes net cost of private health insurance; for insurance categories where THCE primarily utilizes MassHealth capitation amounts to determine total spending (i.e., SCO, One Care, and PACE), CHIA estimates expenditures by service category by multiplying MassHealth-provided expenditure amounts by the total share of spending in each service category as reported by payers in TME; for commercial non-TME filers, CHIA estimates the share of spending by service category by multiplying the estimate for total commercial non-TME filer expenditures by the share of spending in each category for all commercial full-claim and partial-claim members; public insurers do not submit data to CHIA utilizing the same service category definitions as private payers use to submit TME data. When calculating expenditures in each service category, CHIA crosswalks Medicare, MassHealth, and VA data into TME service categories. Percent changes are calculated based on non-rounded expenditure amounts.

In 2016, THCE grew 2.8 percent, below the 3.6 percent cost growth benchmark set by the Health Policy Commission. Hospital services accounted for the largest share of overall THCE spending in 2016, with inpatient and outpatient expenses increasing by 2.2 percent and 5.5 percent, respectively, from 2015. Prescription drug spending rose the fastest among service categories in 2016, increasing 6.4 percent. Spending for physician services increased slightly in 2016 by 1.7 percent and other professional services spending increased by 5.4 percent. According to the CHIA annual report, excluding non-claims payments, the mix of spending by service categories reported was similar to data reported at the national level.

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, nearly 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.



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 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 on health plans and employers, totaling nearly $2.5 billion, and the Center's 2017 annual cost trends report noted that taxes and fees on health plans accounted for 21.6 percent of administrative expenses.

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.

Taken together, these elements comprise the average change in premium rates. However, premium increases may vary across the marketplace based on:

- A carrier's membership profile and expected overall utilization;
- The prices carriers negotiate for prescription drugs and reimbursement rates with providers for medical services;
- Anticipated risk adjustment payments and other assessments, taxes, or fees;
- 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]

Further, benefit design and levels of cost sharing will also affect and vary the premium rate from one group to another.

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. Spending by government programs, including Medicare, Medicaid, and the Veterans Health Administration, 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.

Further, 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. By its nature, the benchmark allows health care spending to grow and is one component that health plans utilize in developing premiums. The cost benchmark has been a helpful tool in efforts to moderate increases in the prices of some health care services. However, reducing the overall cost of health care and lowering premiums for employers and consumers require additional statutory tools beyond the cost benchmark to address high prices that have existed in our marketplace and have contributed to increases in health insurance premiums.

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 the state an extension of the transitional waiver so that the existing state rating factors would be phased out by January 1, 2020.