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

While the two distinct measures of health care costs are often conflated, the Massachusetts health care cost growth benchmark and the process for determining annual health plan premiums are not the same. The cost benchmark is a retrospective, full system-wide measure of **total** health care spending in the Commonwealth over a 12-month period, based on data collected from public and private sources, including the state's All Payer Claims Database, Medicare, and Medicaid. Conversely, health insurance premiums are developed prospectively, based on a particular health plan's fully insured membership and claims experience, to reflect the anticipated cost and utilization of health care services for the upcoming year. This policy brief outlines how health care spending is calculated and evaluated against the state's cost growth benchmark, how health insurance premiums are developed, and the differences between the two.

How Is the State Cost Benchmark Calculated?

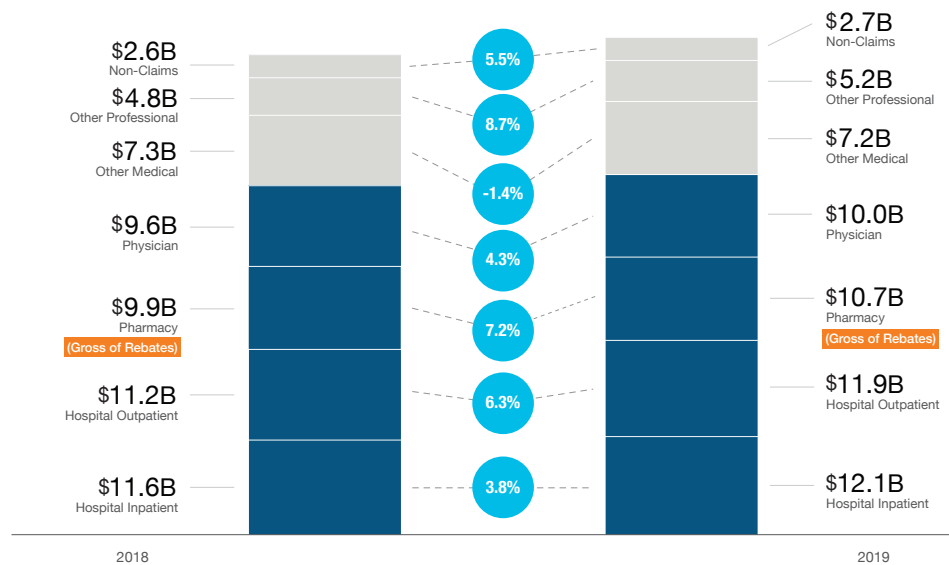
A key provision of the state's 2012 Payment Reform Law, Chapter 224 of the Acts of 2012, was the establishment of a health care cost growth benchmark. The health care cost growth benchmark, determined by the Health Policy Commission (HPC) through an annual process that allows for public participation, is intended to serve as a statewide target for the rate of growth of total health care expenditures. Under the law, the Center for Health Information and Analysis (CHIA) is charged with calculating Total Health Care Expenditures (THCE) in Massachusetts each year and comparing the total annual growth in spending on health care services against the health care cost growth benchmark. This process is intended to provide transparency on the health care cost drivers in the state, with the goal of keeping health care spending growth in line with growth in the state's overall economy. The Commonwealth's health care cost growth benchmark has been set at 3.1% since 2018.

What Factors Contribute to Increases in Total Health Care Expenditures?

Health care spending in Massachusetts totaled \$64.1 billion in 2019. THCE grew by 4.3% between 2018 and 2019, according to the 2020 *Annual Report on the Performance of the Massachusetts Health Care System* issued by CHIA in March 2021. Spending growth accelerated across all broad categories of health care services between 2018 and 2019. Hospital spending, pharmacy expenditures, and physician services remained the largest drivers of THCE growth. The increased cost of health care services in each of these categories exceeded the state's cost growth benchmark in 2019.

- Hospital services accounted for the largest share of overall THCE spending in 2019, with inpatient and outpatient expenses together totaling \$24 billion. Hospital outpatient spending increased by **6.3%** to \$11.9 billion in 2019. Hospital inpatient costs increased by **3.8%** to \$12.1 billion.
- Consistent with prior years, prescription drug spending was the largest component of medical expenditure growth, accounting for 26.4% of the increased spending. Gross pharmacy spending experienced the highest growth among the four largest service categories and increased by **7.2%** in 2019, over one percentage point higher than in 2018 (6%).
- Spending for physician services increased by **4.3%** to total \$10 billion in 2019.
- Spending for other professional services, which includes care provided by non-physician, licensed practitioners (such as nurse practitioner or psychologist), increased by **8.7%**, to \$5.2 billion in 2019.

Total Health Care Expenditures by Service Category, 2018-2019: Gross of Prescription Drug Rebates



Source: CHIA's 2020 Annual Report on the Performance of the Massachusetts Health Care System, March 2021

How Are Health Insurance Premiums Developed?

Health plan premiums that will become effective for coverage offered in the 2022 calendar year have been proposed and will be finalized by the Division of Insurance (DOI) in the coming weeks. Health plans in Massachusetts are required to file actuarially sound premium rates with the DOI for each product available to individuals and small groups in the merged market on a quarterly basis. Filings are developed by actuaries based on comprehensive quantitative member claims data from a recent historical experience period to ensure that rates are calculated using allowed rating factors and are neither inadequate nor excessive based on the projected experience for a future time period.

Health insurance premiums are developed prospectively, reflecting the anticipated cost and utilization of services for the upcoming year. Components which are required by state and federal law to factor into the rate development include membership, premium revenue, claims and utilization experience, the impact of changes in medical service costs, the effect of benefit changes on rates, administrative expenses, and the anticipated impact of risk adjustment and other assessments on health plans. Each plan must also employ a medical and pharmacy trend in rate development to project costs for inpatient and outpatient hospital-based care, physician services, and prescription drug costs. Rates are actuarially sound if projected premiums are adequate to provide for all anticipated costs, including direct health care benefits, administrative expenses, taxes and assessments, and required reserves.

In Massachusetts, close to 90% of the premium dollar pays for the cost of direct 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 be spent on health care services. 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 enrollment and billing of members and employers, payment of 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.

The Premium Dollar, Divided by Commercial Health Care Expenditures in 2019



Source: CHIA Data from 2020 Annual Report on the Performance of the Massachusetts Health Care System; data from Division of Insurance 2019 Annual Comprehensive Financial Statement

Finally, the administrative portion of the premium dollar may include a small surplus that 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.

In Massachusetts, health plans undergo a robust rate review process and are subject to significant scrutiny when their rates are filed. The DOI will only approve rates when it is satisfied that those actuarial assumptions are valid, and the rates requested are appropriate given the expected trend and claims costs anticipated.

In 2019, 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 Total Health Care Expenditures and Premium Rates Differ?

1. Health insurance premium rates approved through the rate review process conducted by the DOI apply only to the fully insured commercial market in Massachusetts and include only costs associated with health care services delivered within the commercial market.

Total Health Care Expenditures represents the average growth in spending on health care services in all health insurance markets, including commercial health care spending, as well as spending on public programs including Medicare and Medicaid. The state methodology for calculating THCE includes health care expenditures for Massachusetts residents enrolled in fully insured commercial health insurance coverage and insurance provided through the federal and state government. THCE incorporates data 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 excludes other categories of expenditures such as vision and dental care.

However, health insurance premium rates approved do not apply to the majority of insured residents in Massachusetts, who receive coverage through Medicare or MassHealth or are enrolled in self-insured health plans through their employer. Therefore, the premium increases for a particular Massachusetts resident will vary depending on the insurance market in which that member is enrolled. A more appropriate measure of the portion of increased costs due to health care services delivered to fully insured members is total commercial spending.

Total health care spending for commercial coverage grew by **5.7%** from 2018 to 2019, faster than the statewide average growth of 4.3%. Overall spending by Health Maintenance Organization plans, which accounted for almost half of commercial spending, increased by 11.6% to \$11.2 billion in 2019. The rate of growth in Medicare spending (5.2%) and MassHealth spending (2.8%) was slower. Reimbursement rates for these programs are regulated by the government, with payment levels set below what pharmaceutical manufacturers, hospitals, physicians, and other 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.

Total spending growth on behalf of commercial members was greater than the statewide average of 4.3% from 2018 to 2019. Hospital outpatient spending increased by **8.1%**, to \$6.4 billion. Physician services spending increased by **5.3%**, to \$6.3 billion. Gross pharmacy spending increased by **6%**.

2. Health insurance premium rate filings do not cover the same time frame as the THCE reporting and cost benchmark analysis.

As discussed above, the cost benchmark evaluation is retrospective. Therefore, the THCE calculation summarizes the state's spending over a past 12-month period. For example, the state's 2019 THCE calculations utilized claims data from the 2019 calendar year.

Conversely, health insurance rates are developed prospectively, months in advance of implementation, and must anticipate future utilization of health care services. The premium rates approved in summer 2021 will not become effective until January 1, 2022, and will remain in place throughout the 2022 calendar year. Health plans analyze the most recent claims experience available to project trends so that premiums will reflect an accurate estimation of the period for which they will be effective. Therefore, each commercial health plan in Massachusetts filed proposed premium rates with the DOI on July 1 that reflect claims submitted and paid to providers for health care services delivered in the first half of 2021 and during the 2020 calendar year.

Commercial insurance premiums increased by only **2.2%** in 2019, despite the significant increases in commercial health care spending, according to CHIA.

3. Health insurance premium rates must be developed based on an individual health plan's historic claims experience.

Total Health Care Expenditures, and commercial health care spending totals, include health care spending across all health plans. A health plan's premiums reflect the actual cost of providing health care services to that health plan's enrollees. Each health plan must anticipate potential changes to the costs and use of services for the future time period, such as increases in the prices charged for prescription drugs and medical services, potential changes in the utilization of covered 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 due to cover government fees, assessments, or taxes.

As a result of the COVID-19 pandemic, health plans are experiencing unprecedented additional uncertainty in developing projections to calculate premium rates, requiring assumptions about future membership, utilization, and cost trends. Premium rates filed for 2022 provide a best estimate of what the utilization of health care services will be for the upcoming year.

The premium rates approved and made public by the DOI are an average of the rate changes that will impact that health plan's membership. For small businesses and individuals enrolled in commercial health insurance products, premium increases will vary across the marketplace depending on:

- The overall risk profile of a health plan'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 health plan to health plan;
- An individual's plan benefit design and level of cost sharing;
- The prices a health plan pays 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; and
- Application of a limited number of rating factors that can result in an employer's or consumer's premium.

Conclusion

The health care cost benchmark is valuable for measuring health care spending increases in comparison to growth in the state's economy. However, growth in health care spending across the Commonwealth 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.