The Difficulty of Legislating Premium Rate Increases

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While the eventual fate of healthcare reform is still very much in question, an important topic has emerged in the last few weeks that is as crucial to the healthcare conversation as it is complex: the question of how to understand—and what, if anything, to do about—rising premium rates. This topic has actually been a sleeper item in the reform bills for some time, with attempts to legislate premium increases included in the bills passed in Congress by both the House[1] and by the Senate.[2] This week, the president announced his plan to give the federal government newfound control over premium rate increases. Here is an excerpt:

> **Strengthen Oversight of Insurance Premium Increases.** Both the House and Senate bills include significant reforms to make insurance fair, accessible, and affordable to all people, regardless of pre-existing conditions. One essential policy is "rate review" meaning that health insurers must submit their proposed premium increases to the State authority or Secretary for review. The President's Proposal strengthens this policy by ensuring that, if a rate increase is unreasonable and unjustified, health insurers must lower premiums, provide rebates, or take other actions to make premiums affordable. A new Health Insurance Rate Authority will be created to provide needed oversight at the Federal level and help States determine how rate review will be enforced and monitor insurance market behavior.[3]

Whether putting price constraints or controls on insurance premiums actually works to control healthcare costs is a highly debatable question. The rising cost of healthcare continues to be a complex matter that involves far more factors than just the top-line trend number. Before pinning hopes on such controls, it is important to understand the inherent complexity of the healthcare cost trend and premium rate increases.

CAUSES OF HEALTH INSURANCE PREMIUM RATE INCREASES

In the normal course of health insurance pricing, premium rates are developed so as to provide for future medical care costs, administrative expenses, and other insurance company revenue needs. For the rating of most comprehensive healthcare coverage today, estimates of future medical care costs are made by actuaries or underwriters using information about past benefit costs and the characteristics of the people insured, along with measures of past and future changes in such costs. Premium rate increases (or decreases) reflect changes in the expected costs for the upcoming year over those previously built into the current rates.

There are many specific reasons why premium rates change year to year. These reasons can be grouped generally into five major categories:

1. **Premium True-up:** Correction (upward or downward) needed to current premium rates in order to align new rates with actual claims and other revenue needs
2. **Benefit Cost Trend:** Incorporation of changes to reflect the cost of the benefits in the future
    a. **Unit Cost Trend** (provider payment rate changes)
        i. *Medical Inflation* (price changes for a fixed market basket of medical services)
        ii. *Net Impact of Provider Contracts* (difference between change in provider payment rates and medical inflation)
    b. **Utilization Trend** (change in number of services used)

1 The healthcare reform bill that recently passed in the House of Representatives, the Affordable Health Care for America Act (H.R. 3962), contains a provision with new regulations and potential restrictions of premium rate increases for health insurance that applies to plans participating in the health insurance exchange. The provision reads: "The Secretary of Health and Human Services, in conjunction with States, shall establish a process for the annual review of increases in premiums for health insurance coverage. Such process shall require health insurance issuers to submit a justification for any premium increases prior to implementation of the increase." U.S. House of Representatives. H.R. 3962. Retrieved Feb. 24, 2010, from http://docs.house.gov/rules/health/111_ahcaa.pdf.

2 The bill passed in December 2009 by the Senate contains a provision aimed at controlling the rising cost of healthcare in a section titled "Ensuring that consumers get value for their dollars." It reads: "The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage…a State, through its Commissioner of Insurance, shall (A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and (B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases." U.S. Senate. The Patient Protection and Affordable Care Act. Retrieved Feb. 24, 2010, from http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm.

3 U.S. White House. The President's proposal puts American families and small business owners in control of their own health care. Retrieved Feb. 24, 2010, from http://www.whitehouse.gov/health-care-meeting/proposal.

c. **Mix/Intensity of Services Trend** (change in composition of services used by consumers)

d. **Cost-sharing Leverage** (change in impact over time of fixed dollar copays and deductibles on benefit costs)

3. **Member Changes:** Recognition of changes in the characteristics of members covered in the future period to which the new premium rates apply (e.g., age and gender mix), compared with those members covered currently (types of changes for which there is no differentiation in the premium rates themselves)

4. **Plan Changes:** Reflection of the impact of changes in benefit design or provisions

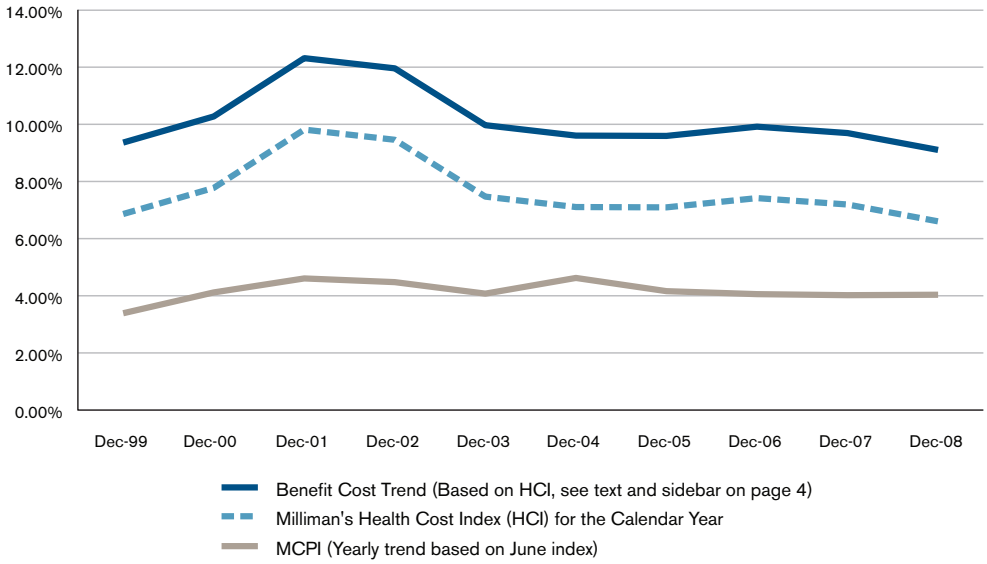
5. **Insurer/Administrator Retention Changes:** Inclusion of needed or desired adjustment to the insurer retention component of premium rates (principally health plan administrative costs, taxes, and profits)

There may be other causes or components that can be identified, but these five categories capture the primary reasons for premium rate changes. Within these five categories, the first and second (premium true-up and benefit cost trend) are typically the primary drivers of year-to-year premium rate increases. As a component of benefit cost trend, medical inflation is usually one of the most important contributors. However, it is not the only component of benefit cost trend, and benefit cost trend is but one of the five major causes of premium rate increases.

BENEFIT COST TREND VS. MEDICAL INFLATION

Medical inflation is commonly measured by the medical care component of the Consumer Price Index (MCPI), a publicly available statistic published regularly by the Bureau of Labor Statistics. Changes in the MCPI reflect price inflation in charges for a fixed market basket of medical goods and services. The MCPI does not reflect actual payment rates of insurers (or Medicare or Medicaid) to providers, locally or nationally, nor does it measure the actual market basket mix of services for a particular healthcare plan or geographic area. In addition, it does not reflect ongoing changes in the mix and/or intensity of medical care services used by consumers, nor does it measure changes in the volume of services utilized by them.

FIGURE 1: BENEFIT COST TREND COMPARED WITH MEDICAL INFLATION (PAST DECADE)



The gap between benefit cost trends and medical inflation has varied significantly from one year to the next. For this reason, holding health plans to a specific MCPI-based or other predetermined inflation threshold could be especially problematic in certain years. Figure 1 compares the benefit cost trend applicable to a typical large-group health insurance plan with the MCPI during the same period. Over the last decade, benefit cost trends for such a plan have been substantially higher than medical inflation, although the spread between them has been lower recently.

We have used the Milliman Health Cost Index™[4] (HCI) as the basis for measuring healthcare cost trends. We then adapted it to provide an illustration of the corresponding overall benefit cost trends for a typical large-group preferred provider organization (PPO) in the market over the 10-year period (see notes in "How did we use the HCI to illustrate benefit costs?" sidebar on page 4). The HCI is used by insurers as a tool to help measure and evaluate the average rate of increase in benefit costs for various healthcare benefit plans and can be used to analyze industry-wide trends. It captures not only inflation, but also changes in the net overall effect of provider contracts (nationwide), utilization, and mix and intensity of services. As adjusted for the illustrative large-group plan of benefits, it reflects the cost-share leveraging for this particular PPO plan of benefits, and it removes the dampening effects of lower per capita trends for Medicaid and the uninsured.

4 Available at http://www.milliman.com/expertise/healthcare/products-tools/health-cost-index/.

5 Fox, Will & Pickering, John (Dec. 2008). Hospital & physician cost shift: Payment level comparison of Medicare, Medicaid, and commercial payers. Milliman. Retrieved Feb. 24, 2010, from http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf.

WHAT ABOUT BENEFIT COST TRENDS?

Simplistically limiting premium rate increases to some predetermined inflation index fails to recognize the fundamental elements involved in setting health insurance rates, and would likely have severe consequences within a short period of time. A more appropriate and meaningful question concerns the level of the benefit cost trends themselves.

Perhaps the most apparent component of the cost trend involves changes in unit costs over time. Examples include physician fees, hospital case rates, and diagnostic lab fees. Medical inflation in the economy is one cause for changes in unit cost levels, but there are also a host of other factors contributing to such changes. Some of these other contributors exert upward pressure on unit costs, while for others it is downward; some are either local or specific to the providers involved, while others are more global in nature. They vary from year to year, both in magnitude and sometimes even in direction.

For a particular healthcare plan operating in its service area, the unit costs it can negotiate are affected not only by direct cost factors (e.g., local wage levels for nurses) but also by factors affecting the negotiation or contracting process between health plan and provider. For example, low unit costs accepted from certain payors may cause a provider to demand relatively higher payment rates from other payors.[5] To further complicate matters, experience has shown that intense pressure on payment rates to providers can lead to steps by those providers to otherwise offset the loss of unit reimbursement through changes in practice patterns affecting access and/or the volume and mix of patient services. The bottom line is that unit cost trends in healthcare reflect a host of variables beyond simply medical inflation.

Changes in the healthcare utilization of insured members and the mix and intensity of the services provided to them are the next two components of trend. Together with unit cost changes, they constitute the trend in overall medical costs (health plan benefits plus member cost-sharing amounts). But these factors can be hard to control, because they are often at the discretion of the physician and depend on practice patterns and member demand. Managed care, appropriately oriented, attempts to shape that discretion in a way that simultaneously pursues quality and cost effectiveness. Various Milliman and other studies[6] suggest that 20% to 30% or even more of the total medical care that is provided today is unnecessary. But the public and the medical community have often lacked the will to weed out this waste. The desire may be strong for lower healthcare costs (and premiums), and there has been general discussion about new approaches that attempt to control utilization, such as accountable care organizations[7] and the medical home, but consensus on approach and progress toward comprehensive management of the delivery of medical care services to patients remains limited.

Finally, benefit cost trends are composed of overall medical trends and cost-share leveraging. The overall cost of medical care increases with unit costs, utilization, and mix/intensity. Assuming the mix of services remains constant and that fixed dollar member cost-sharing provisions (e.g., copays, deductibles, and out-of-pocket limits) remain the same, the health insurance plan will pay a greater percentage of the total cost year after year. This means that benefit costs will increase more rapidly than overall medical costs, for the same plan of healthcare benefits (the impact of any change in the plan of benefits would have a separate and distinct impact, upward or downward depending on the changes made). The excess of the increase in benefit costs over that of overall medical costs is termed cost-share leveraging. The impact of this cost-share leveraging on benefit cost trends can be eliminated, but only by adjusting benefit provisions each year (e.g., raising copays and deductibles) such that cost-sharing is a constant percentage of the total cost of care.

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CONCLUSION

We can all agree on the need to control rising healthcare costs. With costs approaching $17,000 per year[8] for a typical family of four, healthcare is already out of reach for many and continuing to become less and less affordable. But if efforts to control the rising cost of healthcare are to succeed, they must start with a realistic understanding of what is driving the increase.

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6 More at www.milliman.com/hcr

7 Parke, Robert & Fitch, Kate (Oct. 13, 2009). Accountable care organizations: The new provider model? Milliman on Healthcare. Retrieved Feb. 24, 2010, from http://www.milliman.com/perspective/healthreform/accountable-care-organizations-new.php.

8 2009 Milliman Medical Index. May 2009. Available at http://www.milliman.com/expertise/healthcare/publications/mmi/pdfs/milliman-medical-index-2009.pdf.

How Did We Use the HCI to Illustrate Benefit Costs?

In order to illustrate the order of magnitude of benefit cost trends during the past decade for a typical large-group healthcare plan, an adjustment has been made to the Health Cost Index (HCI) in order to approximate the level of the difference between private plan trends and those for Medicaid and the uninsured (see Health Cost Index*), and for the impact of the presence of health plan options and the benefit provisions of a typical PPO plan (see Milliman Medical Index**). The latter reflects the leveraging effects of the fixed-dollar cost-sharing provisions on the underlying heath cost trends, producing insured benefit cost trends. The adjustment reflects the average impact of the factors involved over the time period; the exact difference is likely to vary year by year, and to have been somewhat greater in at least some of the years during this period.

Why is this adjustment necessary? The HCI estimates provider revenue (for hospitals, physicians, pharmacies, etc.) to capture changes in healthcare costs per capita for the non-Medicare population. It reflects both insurer and patient payments overall for the non-Medicare population. Because the HCI captures population-wide average forces in healthcare trends, certain factors that affect a subpopulation (e.g., a particular large-group healthcare plan or a particular insurer's small-employer pool of healthcare plans) can differ. Data underlying the HCI excludes care associated with the Medicare population; however, it includes the uninsured and Medicaid populations (and certain other smaller government programs). Per capita healthcare cost trends for the Medicaid population tend over time to be lower than those for private health insurance plans, which is due to governmental constraints placed on provider fee levels and their increases. Likewise, trends in revenue generated on behalf of the uninsured tend to be lower than for insured plans, especially during difficult economic times.

In addition, the effects of adverse selection occur, at least to some extent, almost continuously, because individuals with knowledge of their healthcare needs typically have choices as to maintaining coverage and in selecting specific benefit plans, and are thereby able to choose the most advantageous combination of benefits versus premiums. Further, benefit cost trends differ from overall healthcare trends, because insurer and patient payments under the healthcare plan may not increase at the same rates (e.g., higher trends in insurer benefit payments than in patient cost-share payments, which are due to the leveraging effects of fixed-dollar patient deductibles, copays, and limits on out-of-pocket payments).

* More at *http://www.milliman.com/expertise/healthcare/products-tools/health-cost-index/*.

** 2009 Milliman Medical Index. May 2009. Available at *http://www.milliman.com/expertise/healthcare/publications/mmi/pdfs/milliman-medical-index-2009.pdf*.