HEALTH INSURANCE 101

UNDERSTANDING HEALTH CARE PREMIUMS

Health insurance providers recently filed proposed premium rates and product offerings for the 2019 plan year. The filings will undergo a review by the Department of Financial Services. There is also an opportunity for the public to comment—with those comments also reviewed by the department—and 2019 final rates will be determined and are expected to be announced in early August.

Health care premiums and medical costs are inextricably linked. The cost of health insurance is the direct result of the underlying cost of care. This issue brief looks at what goes into health insurance premiums and offers some policy recommendations for addressing health care cost drivers.

What are the Major Cost Drivers?

- **Prescription Drug Costs**: The growth in prescription drug costs slowed slightly in 2016 — for the first time in many years. While that is good news, prescription costs are continuing to rise and remain one of the biggest components of premiums. Moreover, these increases are taking place across all types of pharmaceuticals — specialty, brand name and generic drugs. Also, pharmaceutical manufacturers can — and do — increase prices multiple times a year with no regulatory approval process.

- **Provider Costs**: Hospital and physician costs continue to rise as well. Combined, hospital and physician costs represented more than 50 percent of total health care spending in 2016. Provider consolidation also plays a role in increasing costs. As hospitals and physicians merge and form alliances, they increase market share and strengthen their ability to leverage higher reimbursements from health plans. Studies looking at these arrangements show they clearly lead to higher prices.

- **Mandated Benefits**: Every state-regulated health insurance policy sold in New York state must include or “make available” coverage for more than three dozen specific treatments or services. Excluding the expected services such as doctors’ visits, maternity care and hospitalizations, many of these mandated benefits are for services, treatments, or screenings that go beyond the evidence-based guidelines recommended by major national health organizations. While the cost of some of these benefits in isolation may be relatively small, the collective impact of mandates drives up the cost of insurance coverage for New York employers and consumers.

- **Health Insurance Taxes**: New York currently collects $5 billion dollars annually in taxes on health plans. These include the Health Care Reform Act (HCRA) patient services assessment and covered lives assessment. There is also a 1.75% premium tax on commercial health insurance policies and the Department of Financial Services’ Section 206 “assessments” that fund the operations of the department. Collectively, taxes on private health insurance rank third highest in the state, with only personal income taxes and sales taxes higher.

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 New York, the bulk of the health insurance premium dollar pays 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 use 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 100 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.

Developing the Base Rate

The base rate can be thought of as a dollar amount that the health plan needs to cover the cost of care for an average customer. In developing the base rate, health plans use 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 — the Premium Dollar

New York has one of the nation's most stringent standards for how the premium dollar is spent, requiring in the individual and small group markets that at least 82 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 for several years. After significant increases in prescription costs — 12.4 percent in 2014 and 8.9 percent in 2015, 2016 saw a decline in the rate of growth, with drug prices increasing a modest 1.3 percent.[i] The key reason given for this slowing in growth of costs in 2016 is a decline in spending for drugs used to treat hepatitis C, fewer new drugs being introduced, and slower price growth for both generic and brand name drugs. While spending has slowed, prescription drugs continue to represent a significant portion of national health expenditures, accounting for 10 percent of health care costs in 2016. [ii]

- **Increases in provider prices:** Spending on hospital care increased 4.7 percent in 2016, which was slower than the 5.7 percent rate in 2015, but still represented an overall increase. Similarly, spending for physician and clinical care grew more slowly in 2016 than in 2015 — 5.4 percent versus 5.9 percent. It is important to note, however, this is a slowing in the rate of growth. Spending on hospital care services represented 32 percent of total health care expenditures in 2016, while physician and clinical services accounted for 20 percent.[iii] What is notable is that while spending for provider services went up, utilization of most health care services remained unchanged or declined.[iv]

  Thanks to the Affordable Care Act (ACA), 2014 and 2015 saw significant increases in the number of people enrolled in health insurance, which resulted in an increase in utilization of services. In 2016, enrollment growth slowed, as did utilization of hospital services. Costs continued to rise (albeit at a slower pace), which would indicate an increase in "per unit" costs for services. A report from the New York State Health Foundation from December 2016 highlighted that hospital market share provides the ability to leverage

negotiations, allowing providers to raise the underlying "unit cost" for services and playing a key factor in higher prices.[v]

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

Other factors must be included in the calculation of premiums in New York. Among these are the high number of mandated benefits in New York and taxes imposed on health insurers in this state.

Mandated Benefits

While all states have a set of benefits that must be included in all "comprehensive" insurance policies, New York holds the somewhat dubious distinction of having more than three dozen specific treatments or services that are mandated to be included or "made available" in every state-regulated health insurance policy sold in the state. Moreover, each year state lawmakers vote to impose new coverage requirements for health plans, even when the proposed coverage falls outside the parameters of evidence-based guidelines recommended by major national health organizations. There are proposals to expand the benefits that health plans must pay for, such as coverage of service animals (including the costs of acquisition, training, feeding, and veterinary care), and coverage of screening for ovarian cancer (although no such screening test is currently approved by the federal Food and Drug Administration). Others place restrictions or prohibitions on cost-sharing (this is generally any deductibles, coinsurance and copayments that a consumer would pay when receiving a health care service, and is not part of the monthly premium). Currently, there are 92 of these bills under consideration.

While the cost of some of these benefits in isolation may be relatively small, the collective impact of mandates drives up the cost of insurance coverage for New York consumers. Moreover, because mandated benefits pertain only to fully-insured policies, which are purchased either by individuals who purchase coverage on their own or receive it through a small business, the cost of mandates falls disproportionately on small employers. Expanding existing mandated benefits forces small employers to include benefits they and their workforce may not want or need, exacerbating the challenge they face to find affordable health care options.

Large companies typically "self-insure," providing employee health benefits by directly paying health care claims to providers. Because the federal Employee Retirement Income Security Act (ERISA) governs these policies, they are not subject to state mandated benefits. Included in ERISA is a provision preventing states from deeming employee health benefit plans to be in the business of insurance for the purpose of state oversight, which preempts states from regulating these plans. Today, more than 50 percent of the commercial market in New York is covered under a self-insured plan.

Administrative Expenses

As noted previously, New York requires that health plans spend at least 82 cents of every premium dollar in the individual and small group markets directly on health care services. That leaves the remainder to be allocated to the health plan's administrative expenses. These expenses include costs that the health plan can control, but also include non-controllable costs as well.

- **Controllable Costs:** Administrative costs include the day-to-day business activities of providing health coverage to members. Examples of this are enrolling and billing members and employers, paying claims to providers and commissions paid to brokers. Things such as paying for supplies and vendors, rent and upkeep for facilities, and employee salaries and benefits also fall under the umbrella of administrative costs. However, other administrative costs — such as investments in new technology and information systems, care management programs to assist members with chronic diseases, complex conditions or recent illnesses, wellness programs and other similar offerings — have a benefit for a plan's members even though they are not direct medical care.

- **Non-Controllable Costs:** Administrative expenses also include as government taxes and assessments. The burden of health care taxes in New York is significant. Taxes on private health insurance rank third highest, with only personal income taxes and sales taxes higher. New York's Health Care Reform Act, passed in 1997,

imposed two specific taxes on health care in the state — the patient services assessment, a 9.86% surcharge on inpatient and outpatient hospital charges and other medical services, and a covered lives assessment, a "sales tax" on every health insurance policy. Together, these assessments on health care add up to $5 billion annually. New York also collects a 1.75% premium tax on commercial health insurance policies and the Department of Financial Services' Section 206 "assessments" that fund the operations of the department.

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.

Understanding the New York Individual and Small Group Markets

New York insurance law is designed to protect individuals and small businesses from wide fluctuations in rates. New York made a series of policy decisions in the 1990s[vi] 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"). Federal and state laws permit health plans to utilize a limited number of rating factors that can vary premiums in the marketplace.

Why Do Premiums Vary?

When the Department of Financial Services released the proposed 2019 premiums, it announced the "weighted average" — for each individual plan's application as well as a statewide average. For example, the statewide weighted average increase in premiums for individual coverage was 24 percent, but the weighted average for different health plans may vary. Likewise, premiums for different products within a plan might also vary from the average.

Premiums 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. Further, there are a number of factors that can result in an employer's or consumer's premium differing from the average rate change. Factors that account for pricing variations include:

- **Benefit Design:** Because one size does not fit all, health plans offer a wide range of products. Starting with the "metal tiers" developed under the ACA — Platinum. Gold, Silver and Bronze — there are also numerous variations of benefit design that can be offered. Products offered by health plans may offer differing networks of providers, or they may have different cost-sharing structures whereby a consumer may opt to pay a higher monthly premium and lower out-of-pocket costs for health care services versus lower premiums that are coupled with higher co-payments, co-insurance or deductibles. A variety of benefit designs offers consumers flexibility to choose the plan that best meets their health and budget needs.

- **Age:** While some states allow health plans to vary premium rates based on a person's age, family size, geography and tobacco usage, New York's rule are much more stringent. For example, because as we get older we utilize more health care services, most states charge older individuals more than rates charged to younger individuals. However, New York's Community Rating Law does not allow any pricing variation based on age. This means a 60-year-old pays the same monthly premium as a 26-year-old.

- **Geography:** Rates 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 New York to another, that also may result in a premium change.

- **Family Size:** Premiums may be adjusted based on the size of the family and the number of people covered under the policy. As a general rule, 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. New York also permits "family size" that reflects two adults and one adult and children.

- **Risk Adjustment:** The ACA established a "risk adjustment program" that requires the redistribution of funds from health plans with lower-risk (healthier) members to those with higher-risk (sicker or higher cost) enrollees. Risk adjustment was intended to stabilize premiums across the individual and small group markets. As each plan must calculate its anticipated payment for the premium year, risk adjustment becomes another factor that contributes to rate variation.

Providing Cost Relief By Addressing Cost Drivers

Affordability is the most pressing health care issue for employers and consumers. Health plans in New York have a proud history of working with lawmakers and state policy makers to protect affordability and expand access to health care for consumers across the state. However, additional steps should be taken to address rising health care costs and adopt measures to make health care more affordable for employers and consumers. Actions that policymakers should consider include:

- **Address Runaway Drug Prices:** Breakthrough medications offer tremendous clinical benefits for patients, but drug manufacturers should not get a blank check to price drugs at exorbitant rates without the public and policymakers understanding how those prices are established. Today, the prices set by pharmaceutical companies are a mystery. An important first step would be transparency of prescription drug prices in making health care more affordable and understanding whether employers and consumers are getting value for the prices being charged.

- **Ensure Provider Consolidations Benefit Employers and Consumers:** The ongoing mergers, acquisitions and affiliations among hospitals, physicians and other providers have and will continue to reshape the health care system for years to come. While some have suggested that these transactions will result in better integration and improved quality for patients, at the national level there is a growing body of research among policy experts that provider consolidation merely leads to enhanced bargaining power with no notable improvement in the quality of care for patients. State policymakers should monitor closely whether the benefits providers articulate relative to lower costs, better quality and greater clinical integration when joining together are actually realized. Ensuring a robust process for reviewing changes and their impact on the marketplace is essential to ensure that employers and consumers benefit from these transactions through lower costs and better quality.

- **Assess Proposed Benefit Mandates:** Created in 2007, the New York State Health Care Quality and Cost Containment Commission was charged with analyzing the cost and efficacy of proposed mandated benefits. Unfortunately, the Commission has never been seated. While specific mandates may be well-intentioned, they add to the cost of health care and force employers to include benefits they and their workforce may not want or need, exacerbating the challenge they face to find affordable health care options. Until the Commission has been convened, no new mandated benefits should be adopted.

Instead of concentrating on premiums, the attention should focus on addressing the underlying cost drivers that factor into premiums. Protecting the advances New York has made in expanding coverage requires that all participants in the health care system — providers, pharmaceutical companies, health plans and state government — are focused on and accountable for controlling their costs.

[i] Centers for Medicare & Medicaid Services; National Health Expenditure Data
[ii] "National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions"; Health Affairs; January 2018 37:1
[iii] "National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions"; Health Affairs; January 2018 37:1
[iv] Health Care Cost Institute, 2016 Health Care Cost and Utilization Report; January 2018
[v] "Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement"; New York State Health Foundation; December 2016.
[vi] In 1992, New York enacted legislation that required individual and small group policies sold in the state to be community rated and be available on an open enrollment basis. In 1996, the state made changes to the Guaranteed Issue and Open Enrollment Law to require plans offering coverage to New Yorkers purchasing health insurance on their own — the "non-group" or "direct-pay" market — a choice of either an HMO plan an HMO/POS plan, both with a standardized set of benefits. In 2011, broadened the definition of small group from 50 up to 100 employees, with that change taking effect in 2016.

This issue brief was prepared by the New York Health Plan Association (HPA). Established for the purpose of promoting the development of managed health care plans within New York State, HPA is an industry voice for health care plans across the state. HPA's 28 member health plans share a commitment to meeting the health care needs of New York's residents.