

Summary of the NH Insurance Department Cycle I Premium Rate Review Grant Activities

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During 2011 and into 2012, the New Hampshire Insurance Department (NHID) contracted with actuarial and health policy experts in order to better understand health insurance premium cost drivers and to identify strategies for improving the NHID premium rate review process. These contracts were funded entirely by a grant provided by the U.S. Department of Health and Human Services.

In work under the grant, contractors were specifically charged with:

- Improving the process and transparency of insurance company rate applications;
- Assisting the NHID in conducting the state's first annual public hearing on health insurance rate increases and producing a report on the findings;
- Exploring the meaning and nature of cost shifting;
- Investigating potential relationships between public payer hospital reimbursement and prices paid by commercial insurance companies (carriers); and
- Assessing hospital costs and infrastructure.

The contractors included Gorman Actuarial, Compass Health Analytics, the New Hampshire Center for Public Policy Studies, the University of Massachusetts Medical School Center for Health Law and Economics, and Susan Palmer Terry.

Gorman Actuarial analyzed the current premium rate review process in New Hampshire and several other states. Gorman's recommendations for improving the rate review process included collecting the rate filing information in a standardized format to facilitate comparisons of key rate filings across carriers and over time, developing additional objective criteria for disapprovals, and improving the transparency and quality of information available to consumers. The NHID is currently working through the New Hampshire rulemaking process to implement these recommendations.

Compass Health Analytics assisted the NHID with New Hampshire's first public rate review hearing. The NHID is required under RSA 420-G:14-a to hold an annual public hearing concerning premium rates in the health insurance market and to identify the factors, including health care costs and cost trends, that have contributed to rate increases during the prior year. New Hampshire's major health insurance companies, including Anthem Health Plans of New Hampshire, Harvard Pilgrim Health Care, Cigna, New Hampshire Health Plan, and MVP Health Plan of New Hampshire testified at the hearing.

The key findings from the public hearing and research performed by Compass Health Analytics include:

- For a fixed benefit package, per-person premiums grew 14 percent.
- The average level of benefit coverage in policies sold dropped ten percent.
- Employers decided to reduce benefits more than the trends revealed in the insurance company rate filings. Based on the filings, the trended increase in revenues was 8.4 percent.
- The offsetting drop in benefits and the increase in costs resulted in average per-person carrier premium revenue increases of only 2.6 percent.

Testimony at the hearing focused on medical claims costs using three factors: unit cost, increases in utilization, and increases in the service mix or intensity (new services like PET scans and Remicade). Rapid medical claims cost growth in the years leading up to 2010 was the main driver of carrier cost projections and premium levels for 2010. During the period of 2007-2009, increases averaged over ten percent per year. Outpatient costs for surgery, laboratory, and IV infusion therapy were cited as the most significant driver of claims costs and the impact on premium levels. For example, Anthem testified that less than \$21,000 was billed in 2004 for Remicade, but during 2010 the total was over \$23,000,000.

In 2010, the increases in aggregate provider payments were substantially less than in 2009. 2009 recorded an increase of just under nine percent, but only a three percent increase in 2010. The actual price paid for the same service increased by an average of 5.4 percent, but there was a reduction in the service mix or intensity of care, equal to 2.2 percent. This means that for a specific item or service, the price increased, but patients were more likely to receive something less expensive. The shift in services mitigated the increase in prices, resulting in an aggregate increase in payments between the two opposing trends.

As a percentage of premiums, most of the health insurance dollars go toward paying medical care claims. The administrative cost percentage is generally higher for smaller groups (or individual policies) largely due to fixed administrative costs that are spread over fewer members. In 2010, the overall percentage of premiums that went to claims was just under 86 percent. This is less than in 2009, when the total was closer to 88 percent. All markets saw reductions between 2009 and 2010:

- Large group dropped from 88.9 to 87.2 percent
- Small group dropped from 91.5 to 87.5 percent
- Non-group/individual dropped from 63.3 to 62.5 percent

Projected carrier administrative costs grew at the same rate as premiums, but actual spending grew faster. The increases were led by higher wages, salaries, and benefits. Actual carrier administrative spending grew by one percentage point to 10.9 percent. The actual expense amounts (not including taxes and assessments) grew by 12.5 percent, from \$37.26 to \$41.92 per member per month.

Profits have been consistently above the national average for Anthem and consistently negative for the other carriers. This pattern of large positive margins for Anthem and losses for the other three large carriers occurred in four of the five years from 2006-2010. Assumptions vary significantly by carrier, with Anthem testifying to a six percent target and Harvard Pilgrim a one to two percent target. NH carrier profits averaged 1.8 percent of premium revenue in 2010, compared to a national average of 3.1 percent. Anthem's underwriting gain was 6.6 percent.

The concept of “cost shifting” between public and private payers was raised by several of those who testified at the Department’s annual public rate hearing. For example, Anthem testified that cost shifting from government payers to private payers increases Anthem’s prices by 18 percent. The prevalence of the cost shifting notion stems in part from reports produced by the **New Hampshire Center for Public Policy Studies (NHCPPS)**, among others, showing commercial payments exceeding hospital expenses (or costs), while payments from Medicare and Medicaid are lower than hospital expenses.

Many people assume there is a causal relationship between these distinct payment levels - that hospitals actively “shift” costs between payers, by increasing the price paid by commercial insurance companies in response to the lower payments they receive from Medicare or Medicaid. In work not performed on behalf of the Department, NHCPPS estimated that between 2004 and 2009, the “cost shift” as a percent of the total premium paid in the private market had grown from 18 to 20 percent. The NHCPPS published data showing that private insurers paid almost 150 percent of hospital costs, whereas Medicare paid 83 percent and Medicaid paid 52 percent.

The primary objective of the analyses performed on behalf of the Department by the **University of Massachusetts Medical School Center for Health Law and Economics (UMMS)** and **NHCPPS** was to determine if there is evidence of an association between hospital price discrimination (in economic terms, a system in which different people pay different prices for the same service) and the volume of patients covered by public payers. Based on quantitative analysis, NHCPPS concluded that variation in prices paid by health insurance companies to hospitals is not explained by differences in the quality of care, the complexity of the population served, payer mix, levels of market competition or the penetration of managed care. NHCPPS also reported that the public share of a hospital’s revenues was the single best predictor of the level of “cost-shifting” per private pay discharge. These findings were not considered mutually exclusive, as the actual price for care is shown to be distinct from the proportion of hospital costs (expenses) that are shifted among payers.

UMMS analyzed the data from various perspectives, looking for associations between hospital prices and a number of factors, including payer mix. Reviewing prices and complexity of care, UMMS determined that without adjusting for case mix (a measure of resource intensity), average inpatient commercial prices had a percent variance of 300 percent. After adjusting for case mix, inpatient price variation was 117 percent. Outpatient commercial prices varied by 141 percent prior to a case mix adjustment, and after the adjustment, prices varied by 113 percent. These findings support the notion that resource intensity explains a substantial portion of the variation in price, but wide variation still exists even after adjusting for case mix.

The UMMS analysis found statistically significant positive correlations between price and the following variables, indicating that as inpatient commercial prices increase these variables also tend to increase:

- Occupancy rate
- Hospital cost per commercial discharge
- Medicare percent of inpatient charges
- Case mix index for commercial discharges and for all discharges.

Lower outpatient commercial prices were associated with a higher percent of:

- Medicaid inpatient days
- Medicaid inpatient discharges

No significant relationships were found between commercial prices and the proportion of free care or reduced fee care provided by hospitals. There was no clear evidence that payer mix and inpatient prices were related. The only significant positive correlation found was percent of Medicare inpatient charges, and an outlier value seemed to drive this result.

No other significant correlations were found between inpatient price and:

- Medicare percent of discharges or days
- Medicaid percent of discharges, day, or charges
- Uninsured percent of charges.

These findings were consistent with other research identified by the UMMS.

Given that hospital systems are the largest component of medical claims costs, the Department hired **Susan Palmer Terry (SPT)** to perform an analysis to help the Department better understand the variation among hospitals and to inventory this sector of the delivery system. Among SPT's findings: 57 percent of hospital costs are personnel-related. Part-time employees make up 35 percent of all hospital employees, but substantial variation exists; for example, 65 percent of the employees at Exeter Hospital and 50 percent at Wentworth-Douglass are part-time. Among the larger NH hospitals, the percentage of costs that are indirect ranges from a low of forty percent to a high of 56 percent. Nursing salary levels were 26 percent greater in Manchester, and 33 percent greater in Lebanon, where Dartmouth Hitchcock Medical Center resides, than in Conway or Rochester/Dover. At 57 percent of the total expenses, personnel costs exceed capital costs (six percent) by almost ten times.

SPT also determined that per capita personnel costs, rather than decreasing, actually increase by a percentage point or two as the size of the hospital increases. This may be less true for the for-profit hospitals, whose large margins are partially explained by the fact that back office functions (billing, coding, accounting, information services and other activities) are done in Virginia for all HCA hospitals. Ambulatory surgery,

radiology and laboratory are services that are generally profitable because they are routine and bring in large numbers of commercially insured patients. Depending on the demographic makeup of the local community, hospitals will invest in providing these services, impacting their hospital costs accordingly.

Finally, SPT determined that hospital charity care in 2010 was 2.5% of hospital expenses and another 2.8 percent of expenses were considered bad debt.

Based on the findings to date, the NHID has the following observations:

Transparency. To better understand health insurance premium cost drivers, policymakers will need improved standardized data.

Engaging the public. The first public hearing provided insightful expert testimony, but was poorly attended by members of the public. Similarly, the NHID routinely produces various reports on medical care costs that are well received by experts and industry participants, but receive limited press coverage or consumer participation. Actively reaching out to the public is just as important as transparency.

Cost shifting does not explain price variation. The studies performed on behalf of the Department have not yielded evidence of a causal relationship between cost shifting and price for hospital services. This does not mean that hospital prices paid by commercial insurance companies are unaffected by lower payments from public payers; rather, the evidence suggests that factors other than public payer payment levels have a more significant impact on prices. The reason some hospitals have high or low prices is something (or a combination of things) other than payer mix. Therefore, it seems unlikely that eliminating all public payer shortfalls or price discrimination would result in substantially lower commercial rates for hospital care.

Health care economics is complex and at times counterintuitive. Individual hospital expenses or costs, and payer mix vary extensively. As a result, the proportions of costs paid for by commercial payers vary extensively.

- Policymakers and consumers must recognize that personnel costs are the largest hospital expense
- As hospitals employ more physicians, hospital personnel costs will increase. Whether this is a net increase or decrease in cost to the health system and a driver of health insurance premiums increases was not determined in these studies.
- For better or worse, decisions by hospital administrators directly impact hospital costs.

There are notable associations between hospital prices and other hospital measures, but most are not highly intuitive. New Hampshire does not have a competitive insurance market with many different carriers, nor does it have a competitive hospital market. However, a more competitive insurance market with many different carriers sharing market share equally would be unlikely to directly result in lower health

insurance premiums because each of those carriers would be more likely to pay higher prices for medical care services. Reducing the market share of any of New Hampshire's major carriers in order to increase the market share to a new competitor would mean that each of the current major carriers would have a weaker bargaining position with health care providers when reimbursement rates are negotiated. The Department has produced two studies showing that the deep discounts from charges that some carriers have obtained from hospitals are restricted to the carriers with substantial market share in New Hampshire.

Coverage levels are eroding as cost-sharing increases. Health insurance coverage levels are eroding quickly, leaving patients and providers with more financial responsibility. The typical benefit design will evolve to accommodate reductions in coverage beyond increased cost sharing. This trend will change what consumers expect to receive from health insurance and how they access the health care delivery system.

Payment reform. Payment reform is a necessary step to control premium increases and address inequities in the health care delivery system. Medicare reimbursement policies will continue to influence provider strategies, and in turn, commercial insurance payment systems. Any payment reform solution for the purpose of commercial insurance cost containment will need to adequately consider compatibility with the systems used by Medicare.

Premium Rate Review Cycle II Activities

The NHID will continue to explore opportunities to improve the premium rate review process and transparency. The following initiatives are currently taking place:

- Implementation of changes to rate filing rules, including the introduction of a standard filing template.
- Development of a model to determine how our insurance markets will shift under health reform.
- An analysis of market forces, the ACA, and New Hampshire statutes to determine the likelihood of a major shift to the self-funded market, and solutions for addressing related market disruptions.
- Improvements to the NHCHIS claims database and other information sources available to the NHID and the public.
- Analysis and identification of solutions for redundant or unnecessary statutes and regulations.
- Expansion of efforts to improve medical cost and health insurance transparency, including continuing public hearings.
- An analysis of opportunities for provider payment reform.

Complete reports are available on the Insurance Department website. Comments or questions should be submitted to Tyler Brannen, NHID Health Policy Analyst – Tyler.Brannen@ins.nh.gov.