

## Health Insurance Premiums and Cost Drivers in Minnesota, 2008

In both Minnesota and the U.S., the cost of private health insurance has been growing faster than the economy, wages and incomes. These rapid cost increases have likely contributed to the recent decline in the percentage of Minnesotans who have health insurance through an employer.<sup>1</sup> In turn, this erosion of private coverage has resulted in both a higher number of uninsured Minnesotans and higher enrollment and costs in government-funded insurance programs. Concern about the sustainability of these trends is one factor that has led to calls for federal and state health reform.

This issue brief updates the Health Economics Program's annual analysis of trends in premiums and cost drivers in Minnesota's private health insurance market.<sup>2</sup> Key findings of this analysis for 2008 include the following:

- Total spending per enrollee (health plan plus enrollee out of pocket cost) increased by 5.1 percent in 2008.
- Continuing recent trends, the enrollee out of pocket costs grew faster than health plan spending (9.3 percent vs. 4.4 percent). Enrollees' share of spending in 2008 accounted for 15.6 percent of total spending, up from just over 10 percent in 2000.
- Health insurance premium growth slowed to 4.7 percent per enrollee, compared to 8.4 percent in 2007.
- As in previous years, the primary drivers of health plan spending growth were physician services and hospital services (both inpatient and outpatient), which together accounted for over three quarters of health plan spending growth from 2006 to 2008.
- The gap between health care cost growth and other economic indicators narrowed in 2008.

As a result of adjustments to historical data, this issue brief includes minor revisions to some results for previous years.

### Cost Trends and Premiums

Figure 1 illustrates the trend in total health spending per enrollee (health plan plus enrollee out of pocket cost). As shown in the figure, total health spending increased by 5.1 percent in 2008 (from \$4,119 to \$4,331). Compared to the average growth rate of 9.5 percent per year over the previous decade, this represents moderate growth. However, total health care cost per enrollee in 2008 was 2.4 times higher than it was in 1998.



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Health plans and employers have historically used a variety of techniques to contain growth in health insurance premiums. One strategy that has been used increasingly in recent years is to raise the share of costs that enrollees are responsible for (e.g., by increasing deductibles). Figure 1 illustrates this trend by showing the growth in health plans' cost and enrollee costs separately. While health plans' share of spending increased by 4.4 percent in 2008, the share that enrollees were responsible for rose by 9.3 percent, more than double the rate of growth of health plan cost. 2008 was the sixth consecutive year in which cost sharing for enrollees grew faster than health plans' cost, raising the share of total spending paid for by enrollees to 15.6 percent. Particularly in light of other economic pressures being faced by consumers, the sustainability of enrollee out of pocket cost trends continues to be a concern.

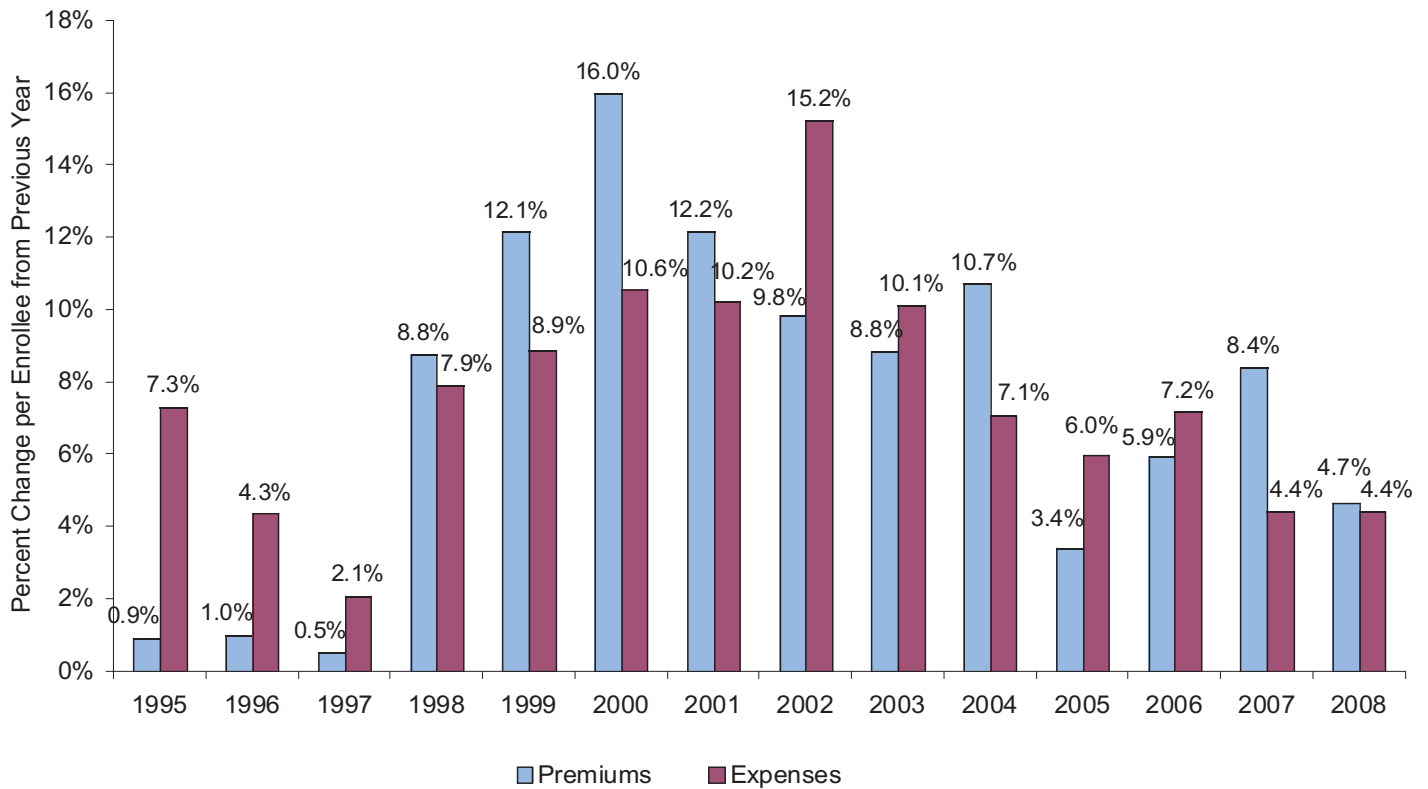
Figure 1  
Trend in Total Cost and Health Plan and Enrollee Cost Sharing  
(\$ per privately insured person)



Items may not sum to total due to rounding  
Source: Minnesota Department of Health, Health Economics Program

Figure 2 shows the trends in private health insurance premiums and underlying costs (expenditures by health plans, including both medical costs and administrative spending) per enrollee in Minnesota. As shown in the figure, growth in health insurance premiums per enrollee slowed to 4.7 percent in 2008, while costs remained at 2007 growth levels (4.4 percent). Compared to the recent past, premium and cost growth in 2008 were modest -- about half the average annual rate of growth for the previous ten years. National trends in premium growth were similar (4.7 percent growth).<sup>3</sup>

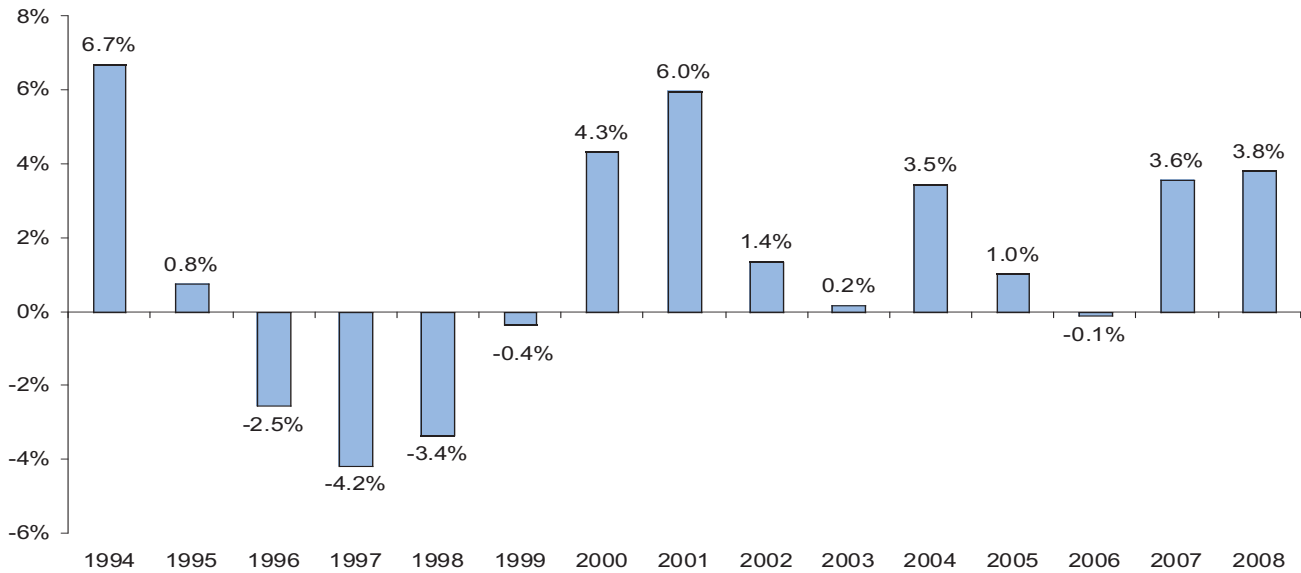
Figure 2  
Private Health Insurance Premium and Spending Trends per Enrollee



Source: Minnesota Department of Health, Health Economics Program

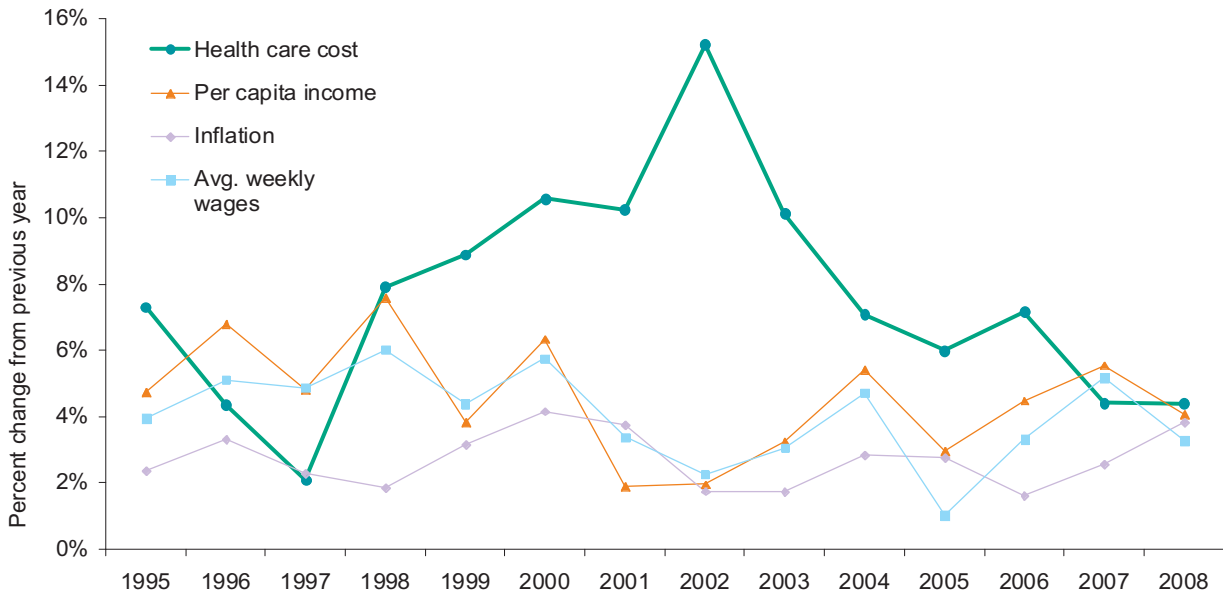
For a variety of reasons, such as uncertainty about projected claims and competition for market share among health plans, the amount of premiums charged by health plans exceeds costs in some years and falls below it in others. This phenomenon, known as the underwriting cycle, is illustrated in Figure 3, which measures the difference between health plans' premiums and spending per member as a percent of premiums. As shown in the figure, premium levels in 2008 were solidly above underlying cost for the second consecutive year. As a result, premium growth in Minnesota may continue to be modest in next few years. However, the analysis in Figure 2 does not include other factors, such as investment income or losses, that also affect health plans' overall financial performance.

Figure 3  
Difference Between Commercial Premiums and Spending Per Member, as Percent of Premium



Source: Minnesota Department of Health, Health Economics Program

Figure 4  
Trends in Key Minnesota Health Care Cost and Economic Indicators



Note: "Health care cost" is MN privately insured spending on health care services per person. It does not include enrollee out of pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance.

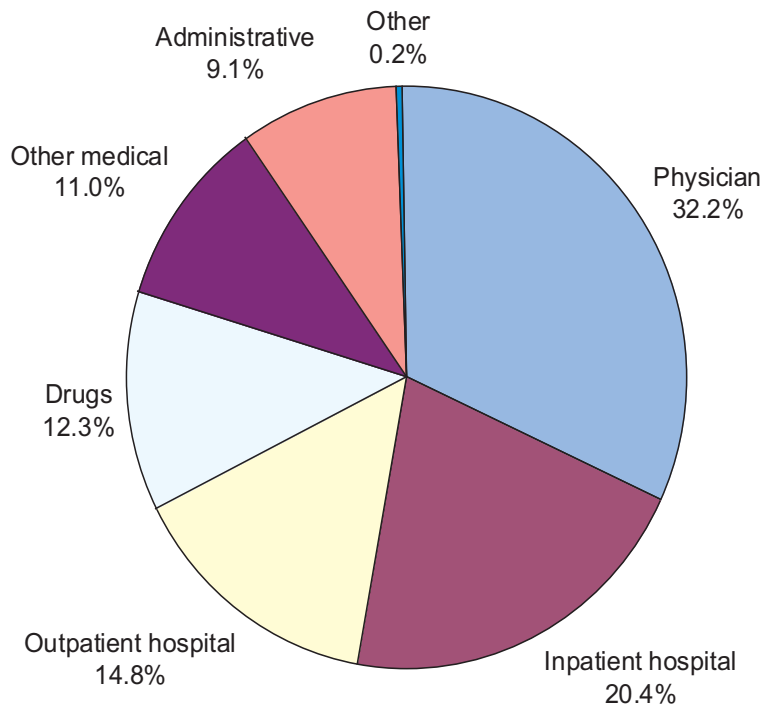
Sources: Health care cost data from Minnesota Department of Health, Health Economics Program; per capita personal income data from U.S. Department of Commerce, Bureau of Economic Analysis; inflation data from U.S. Bureau of Labor Statistics (Consumer Price Index); average weekly wages from Minnesota Department of Employment and Economic Development

Figure 4 compares the trend in private health insurance cost per enrollee to trends in inflation, per capita income, and average weekly wages in Minnesota. As shown in the figure, cost growth in 2007 and 2008 was more in line with these other economic indicators than in the recent past. Still, health plan spending per enrollee in 2008 grew about 34 percent faster than average wages, 15 percent faster than inflation and 9 percent faster than per capita income.

## Drivers of Spending Growth

A key question in understanding health insurance spending trends relates to which types of health care services are contributing the most to spending growth. As a first step in this analysis, Figure 5 illustrates the distribution of total spending by service. In 2008, physician and hospital services (inpatient and outpatient combined) each accounted for approximately one-third of spending (32.2 percent and 35.2 percent, respectively); prescription drugs accounted for an additional 12.3 percent of spending. About 9 percent was spent on health plan administrative costs.

Figure 5  
Distribution of Private Health Insurance Spending by Service, 2008

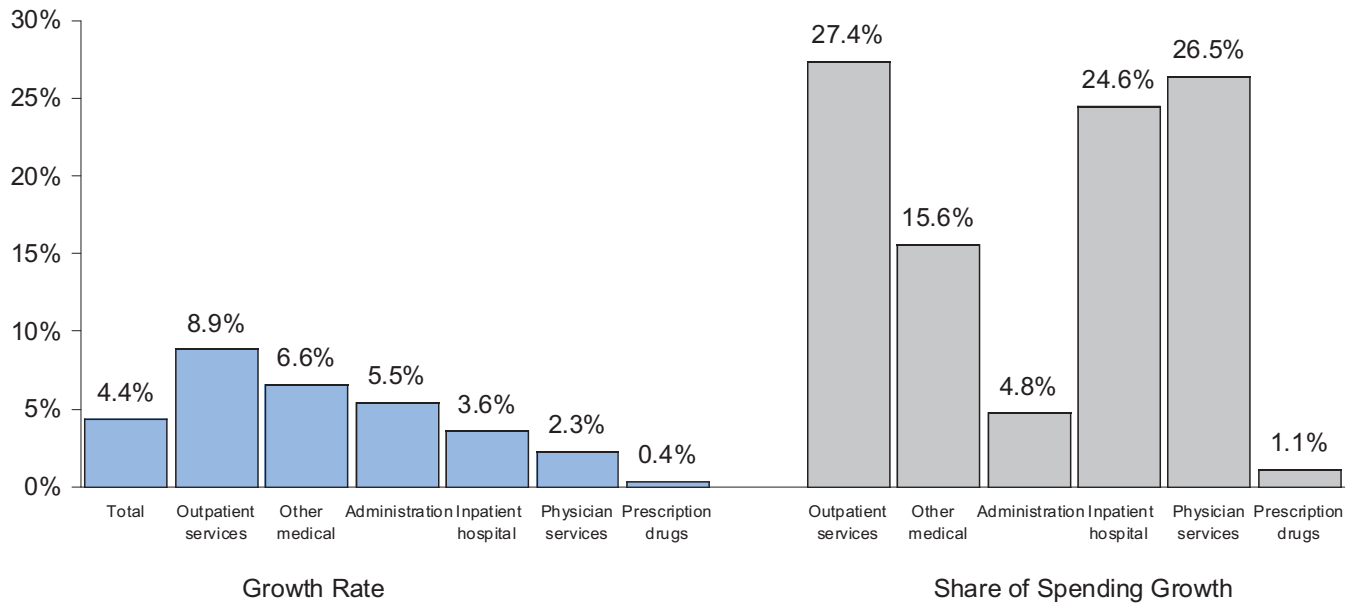


Source: Minnesota Department of Health, Health Economics Program.  
Spending excludes dental services. "Other medical" includes skilled nursing facilities, home health care, emergency services, other health professionals, durable medical goods, and chemical dependency/mental health services.

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Figure 6 illustrates both the growth in spending by type of service and each service's contribution to overall spending growth. For instance, hospital spending (inpatient and outpatient) grew by 6.9 percent per year between 2006 and 2008 (3.6 percent for inpatient spending and 8.9 percent for outpatient), which was faster than the total growth of 4.4 percent per year. Because hospital spending represents about one-third of total spending, hospital spending growth accounted for 52.0 percent of total spending growth during this period. Spending for physician services also represents approximately one-third of total spending, but accounted for only 26.5 percent of spending growth between 2006 and 2008, because it grew more slowly than total spending. Together, hospital and physician services account for more than three-quarters of total spending growth from 2006 to 2008.

Figure 6  
Health Care Cost Drivers:  
Growth Rates and Shares of Total Growth by Type of Service,  
2006 to 2008



Note: growth rates calculated as annual growth per enrollee over the 2-year period. "Other medical" includes skilled nursing facilities, home health care, emergency services, services of health professionals other than physicians and dentists, durable medical goods, and chemical dependency/mental health.

Source: Minnesota Department of Health, Health Economics Program

## Discussion

Health insurance premiums in Minnesota grew modestly in 2008 and underlying health care costs also continued to grow slowly in comparison to recent trends. A number of factors have likely contributed to this modest cost growth.

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For example, there have been a variety of efforts by purchasers, health plans, and health care providers to contain costs through a greater emphasis on prevention, evidence-based medicine, health care quality, and better management of chronic health conditions. In addition, higher enrollee cost sharing requirements have also likely contributed to slower spending growth. It is unclear to what degree the economic downturn played a role in the slower private insurance spending growth in 2008. However, it is likely that the continued downturn in 2009 is affecting utilization of care among people with private health insurance.<sup>4</sup>

Although growth in premiums and underlying costs in 2008 was modest by historic standards and was more in line with other economic indicators than in the recent past, a longer-term perspective shows that there is still cause for concern about the sustainability of cost growth. Cumulatively, wages and incomes in Minnesota have risen by 42 percent and 47 percent, respectively, since 1998; inflation grew by a cumulative 47 percent over that period and the state's economy grew by 54 percent. Over the same period, health care cost grew by more than 90 percent, outstripping these other indicators of economic growth by between 30 and 60 percentage points.

To address the affordability of health care and the sustainability of cost growth, Minnesota is currently implementing a health care reform law passed in 2008, which aims to reduce health care spending growth by investing in community efforts to reduce obesity and tobacco use, and therefore reduce the burden of preventable chronic disease; reforming the way that health care services are paid for in ways that improve health care outcomes and contain long-run costs; and making information on cost and quality more widely available for use by consumers, employers, health plans, and health care providers.

## Endnotes

<sup>1</sup>Minnesota Department of Health, Health Economics Program, "Health Insurance Coverage in Minnesota, Results for 2007," Fact Sheet, April 2008.

<sup>2</sup>The analysis in this issue brief is based on nonpublic data reported to the Minnesota Department of Health by health plans representing an estimated 89 percent of the fully-insured private health insurance market in Minnesota. Because premium increases for fully-insured and self-insured plans have shown similar trends, we believe this analysis is a reasonable estimate of trends in the private health insurance market as a whole. (See, for example, The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2009 Annual Survey." September 2009, for data on premium increases for fully-insured versus self-insured plans.)

<sup>3</sup>The Kaiser Family Foundation and Health Research and Educational Trust, "Employer-Sponsored Health Benefits, 2009 Annual Survey," September 2009. The analysis of national premium growth is based on trends in the cost of family coverage.

<sup>4</sup>Minnesota Management and Budget, "July 2009 Economic Update," July 2009 and Jill Bernstein, "Impact of the Economy on Health Care," Issue Brief, Changes in Health Care Financing and Organization (HCFO), August 2009.

**The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy.**

For more information, contact the Health Economics Program at (651) 201-3550. This issue brief, as well as other Health Economics Program publications, can be found on our website at: <http://www.health.state.mn.us/healthconomics>.

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