Health Economics Program

Issue Brief
October, 2007

Health Insurance Premiums and Cost Drivers in Minnesota, 2006

Rising health care costs create pressure on the budgets of consumers, employers, and the public sector in a variety of ways. For example, increases in the cost of private health insurance reduce the affordability of coverage, and also affect people's access to coverage through employers. With regard to public health care spending, rising costs create pressure on public budgets in two ways: through increased spending per person, and through rising enrollment that results from the erosion of private coverage.

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.[1] Key findings of this analysis for 2006 include the following:

- After slowing to 4.5% growth in 2005, private health insurance premiums grew by 7.6% per person in 2006.
- Growth in health plans' spending per enrollee also increased between 2005 and 2006, from 7.2% per enrollee to 8.9% per enrollee.
- Private health insurance premiums and health plan expenses per enrollee were roughly equal in 2006, at $3,460 and $3,440 per person respectively.
- Enrollee out of pocket costs such as deductibles and copayments accounted for an additional $562 per person in 2006, a 15% increase over 2005. Enrollees' out of pocket cost as a share of total spending was 14.0% in 2006, up from 10.1% in 2000.
- Although the gap between growth in health care costs and other key economic indicators has narrowed over the past few years, growth in health care costs per person that are paid for by private insurance is still two to three times higher than growth in per capita income and wages, and over 5.5 times higher than inflation.
- Most health care spending growth continues to be driven by services that account for the largest share of the health care dollar to start with. Physician services accounted for 43% of spending growth between 2004 and 2006, while inpatient and outpatient services together accounted for 45% of growth. Health plan administrative spending was flat during this period, and prescription drug spending per person declined slightly.

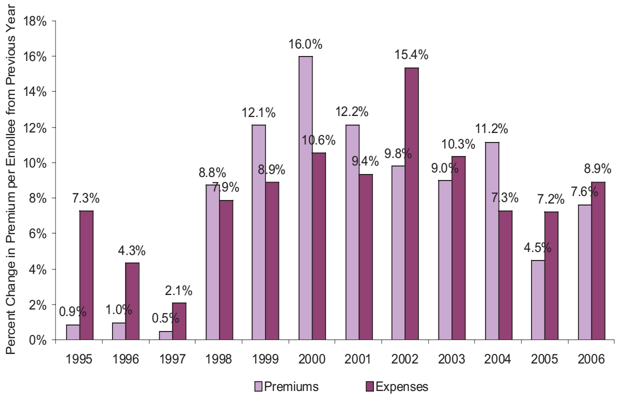
Some results for previous years have been revised in this issue brief, as a result of adjustments to historical data.[2]

Premium and Cost Trends

Figure 1 illustrates the trend in private health insurance premiums and underlying costs per person in Minnesota. As shown in the figure, growth in premiums per enrollee was 7.6% in 2006, up from 4.5% in 2005. Although premium growth may vary from growth in underlying expenses in any given year, over a period of several years we expect to see premium growth that is similar to growth in underlying spending. The higher rate of premium growth experienced in 2006 was similar to recent growth in underlying costs, as expected. However, growth in underlying expenses also accelerated in 2006, from 7.2% to 8.9% per enrollee.[3]

Figure 1

Private Health Insurance Premium and Spending Trends in Minnesota, 1995 to 2006

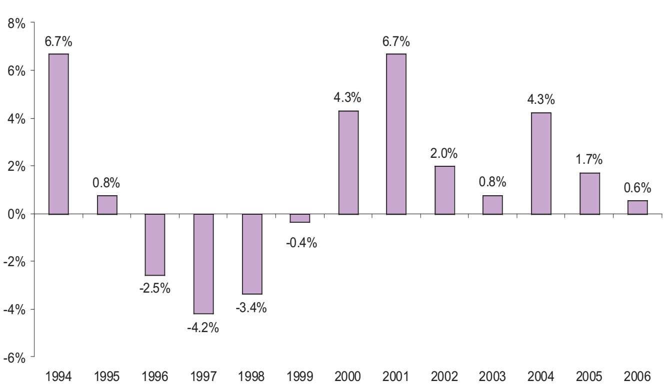


Source: Minnesota Department of Health, Health Economics Program

Because of uncertainty in predicting health care costs, the premiums charged by health plans exceed costs in some years and fall below costs in others. This pattern is illustrated in Figure 2. Because spending growth has exceeded premium growth in each of the last 2 years, the amount by which premiums per enrollee exceeds spending fell from 4.3% to 0.6%. In other words, in 2006 there was only a 0.6% difference between premiums and spending per enrollee.

Figure 2

Difference Between Commercial Premiums and Spending Per Member, as Percent of Premium 1994 - 2006



Source: MDH, Health Economics Program

In recent years, health insurance benefit sets that require higher enrollee cost sharing have become more common. In addition to the emergence of high-deductible "consumer-driven" health insurance products (which still account for a relatively small share of the market), enrollee cost sharing has risen in more traditional products as well.[4] Figure 3 illustrates the trend in total spending per enrollee, including both the health plan and enrollee out of pocket shares of spending. In 2006, total spending per enrollee was $4,002 per enrollee (an increase of 9.7% over 2005); the amount paid by private health insurance was about $3,440 per enrollee, with enrollee out of pocket spending covering the remaining $562. Enrollee out of pocket spending represented 14.0% of total spending per enrollee in 2006, compared to 10.1% in 2000.

Figure 3

Trend in Total Cost and Health Plan/Enrollee Shares

($ per privately insured person)

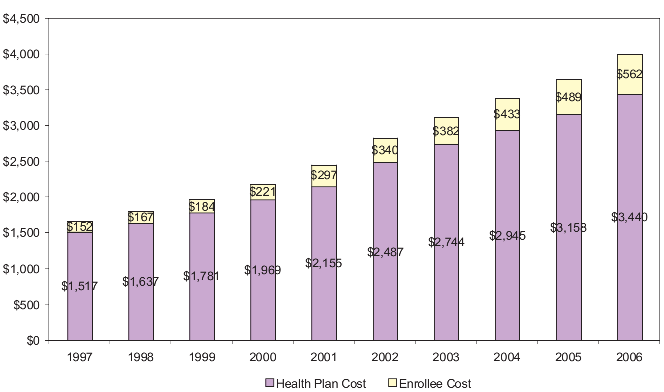
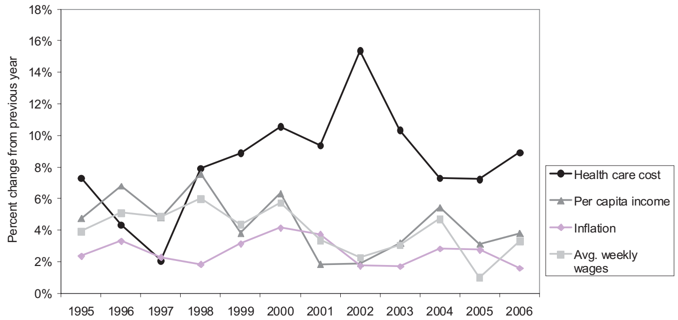


Figure 4 compares the trend in private health insurance cost per enrollee to trends in inflation, per capita income, and average weekly wages. As shown in the figure, the gap between health care spending and these other economic indicators grew in 2006, after having narrowed over the previous few years. In 2006, health plans' spending per enrollee (excluding enrollee out of pocket costs) grew about 2.7 times faster than average wages. 2.3 times faster than per capita income, and 5.6 times faster than inflation.

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 MN Department of Employment and Economic Development

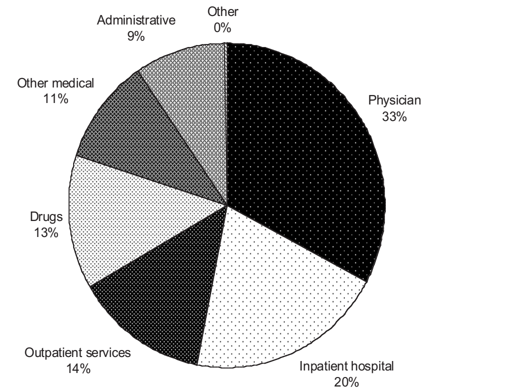
Drivers of Spending Growth

In addition to total spending and premium growth trends, the data used in this analysis are also useful in analyzing which types of health care services are driving overall cost growth. The share of growth accounted for by each type of service depends on two factors: the relative share of total spending accounted for by each service, and the rate of spending growth for each service.

As shown in Figure 5, physician and hospital services (inpatient and outpatient combined) each account for about one-third of privately insured health care spending (32.8% and 33.8% respectively), and prescription drugs account for an additional 13.4% of spending. Figure 6 presents data for 2004 to 2006 on growth rates by service, compared to the share of total spending growth that is accounted for by each service. For example, hospital services (inpatient and outpatient combined) represent about one-third of total spending, but accounted for 45% of total spending growth from 2004 to 2006. Spending for physician services accounted for 43% of spending growth during this period, while spending for administrative costs and prescription drugs was either flat or declining.

Figure 5

Distribution of Private Health Insurance Spending by Service, 2006

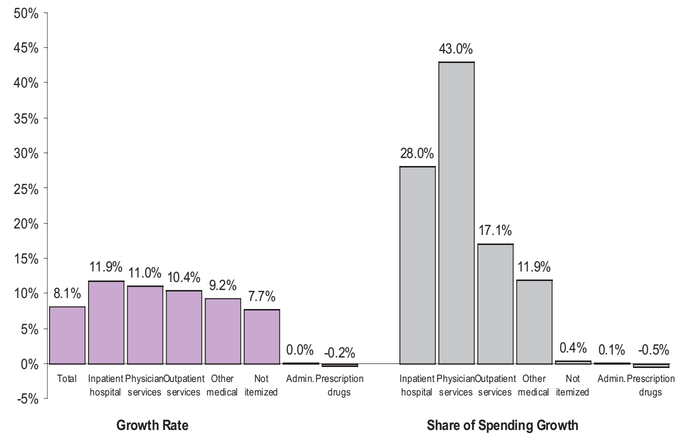


Source: MDH Health Economics Program. Spending excludes dental services. "Other medical" includes skilled nursing facilities, home health care, emergency services, other health professionals, durable medical goods, and chemical dependency/mental health services.

Figure 6

Health Care Cost Drivers:

Growth Rates and Shares of Total Growth by Type of Service, 2004 to 2006



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.

Discussion

While growth in private health insurance premiums and underlying spending has moderated compared to recent years in which double-digit annual growth was common, spending growth over the past few years is still in the range of 7 to 9 percent per person per year. As a result, spending growth is still higher than growth in Minnesotans' wages and incomes, as well as the overall rate of inflation. In addition, the rising share of health care costs paid out of pocket by enrollees is another factor contributing to concern about the sustainability of this trend.

Much public attention is currently focused on strategies to reduce the rate of both public and private health care spending growth in Minnesota. Ultimately, increases in health care spending are the result of a combination of many factors, such as demographics, the overall health of the population, the available treatments for a specific condition, and the cost of these treatments. It is well known that a small percentage of the population accounts for a large share of total health care spending in a given year (for example, the most expensive 10% of the population accounts for nearly 70% of total costs),[5] and so many people believe that focusing on prevention and better management of expensive chronic diseases is one promising strategy to reduce spending growth. Other issues being discussed include a wide range of topics, such as payment reform and reducing administrative costs in the health care system. Continued data collection and monitoring of market trends will be useful in tracking Minnesota's progress toward lowering health care spending growth.

Endnotes

1 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 national surveys show that premium increases for fully-insured and self-insured plans have been similar, we believe that this analysis is a reasonable estimate of trends in the private health insurance market as a whole.

2 Some adjustments were made to spending data from 2000 to 2005, based on revised health plan data that lowered total spending estimates. Because these historical adjustments were only made back to 2000, the per enrollee spending growth rate for 2000 is likely understated by as much as 2 percentage points and the growth rates for 2000 and earlier years are not directly comparable to 2001 and later years.

3 It is important to note that because this analysis does not include other sources of health plan revenue, such as investment income, it is not an analysis of overall health plan profitability.

4 See, for example, Minnesota Department of Health, Health Economics Program, "Benefit Trends in Minnesota's Small Group and Individual Health Insurance Markets," Issue Brief 2001-01, February 2006; The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2005 Annual Survey."

5 Berk and Monheit, "The Concentration of Health Care Expenditures, Revisited," Health Affairs, March/April 2001.

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/healtheconomics.

Minnesota Department of Health
Health Economics Program
85 East Seventh Place, P.O. Box 64882
St. Paul, MN 55164-0882
(651) 201-3550