Health Economics Program

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Health Insurance Premiums and Cost Drivers in Minnesota, 2005

Rapid increases in the cost of private health insurance since the late 1990s have led to rising concern about the affordability of private health insurance. Between 2001 and 2004, the share of Minnesotans covered by employer-based health insurance declined from 68.4 percent of the population to 62.9 percent.[1] The rising cost of health insurance, in combination with other factors such as changes in employment patterns, has contributed to this change.

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.[2] Key findings of this analysis for 2005 include the following:

- Health insurance premium growth slowed to 4.5 percent per enrollee in 2005, the slowest growth rate since 1997. Premium growth for 2005 was less than half the 11.2 percent growth rate experienced in 2004.
- Growth in health plans' spending per enrollee also slowed between 2004 and 2005, from 7.4 percent to 6.8 percent. Growth in spending per enrollee has slowed each year since 2002.
- 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 faster than growth in per capita income, wages, and inflation.
- Including enrollee out of pocket costs such as deductibles and copayments, total spending per enrollee was $3,735 in 2005. The average share paid by health plans was $3,247 per enrollee, with $489 per enrollee in out of pocket costs. Enrollees' out of pocket cost as a share of total spending was just over 13 percent in 2005, up from about 10 percent in 2000.
- The slowdown in health care spending growth has occurred across a broad range of health care services. The largest declines in growth rates took place in spending for prescription drugs and physician services.

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 slowed to 4.5 percent in 2005, the slowest rate of growth since 1997. The decline in expenses per enrollee (expenditures paid for by health plans, including both medical costs and administrative spending) was more modest, from 7.4 percent in 2004 to 6.8 percent in 2005. The growth rate of health plans' spending per enrollee has declined each year since 2002, when it peaked at 15.5 percent.

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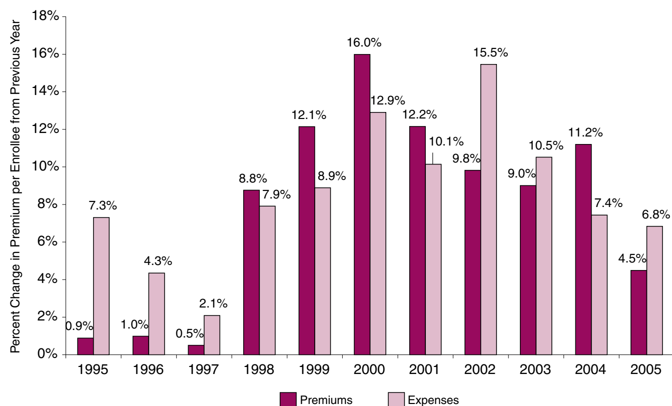
Figure 1

Private Health Insurance Premium and Spending Trends in Minnesota, 1995 to 2005

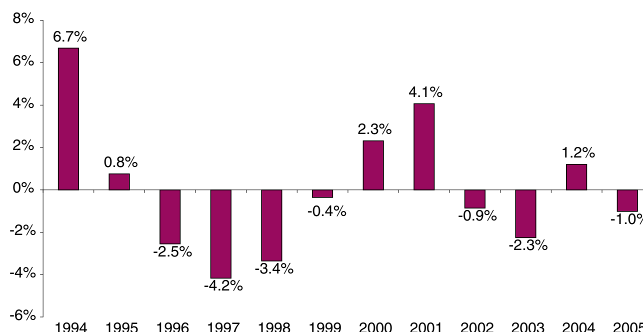


Source: Minnesota Department of Health, Health Economics Program

One likely reason why premiums grew more slowly than underlying costs in 2005 is related to the cyclical pattern of health insurance premiums. 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. In 2004, premiums per enrollee exceeded costs by 1.2 percent, which may have led health plans to increase their premium rates by less than they would have otherwise in 2005. In 2005, however, health plans reported a 1.0 percent shortfall in premiums compared to costs per enrollee.[3] As shown in Figure 2, the difference between premiums and spending per enrollee has been much smaller in the last few years than it has historically been (for example, there were large swings in the difference between premiums and spending per enrollee between 1994 and 2001). If this trend continues, then we would expect to see less volatility in health insurance premium growth rates in the future. In other words, health insurance premium increases in any given year would be a more accurate reflection of growth in underlying costs and would be less influenced by cyclical factors.

Figure 2

Difference Between Commercial Premiums and Spending Per Member, as Percent of Premium 1994 to 2005

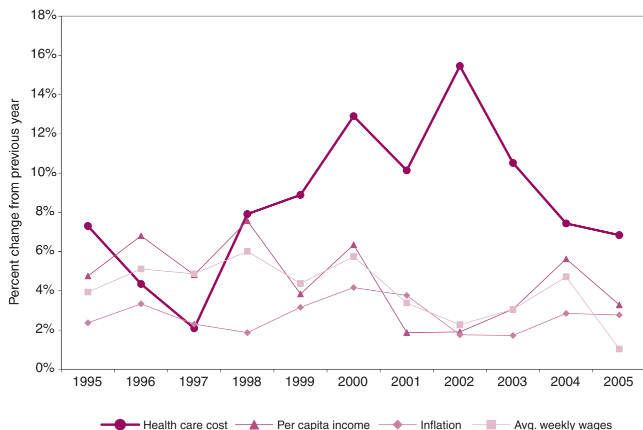


Source: MDH, Health Economics Program

Figure 3 compares the trend in Minnesota health plans' spending 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 has narrowed substantially over the last two years. Still, per enrollee spending of private health insurance grew more than 6 times faster than average wages, and 2.0 to 2.5 times faster than per capita income and inflation in 2005.

Figure 3

Trends in Key Minnesota Health Care Cost and Economic Indicators



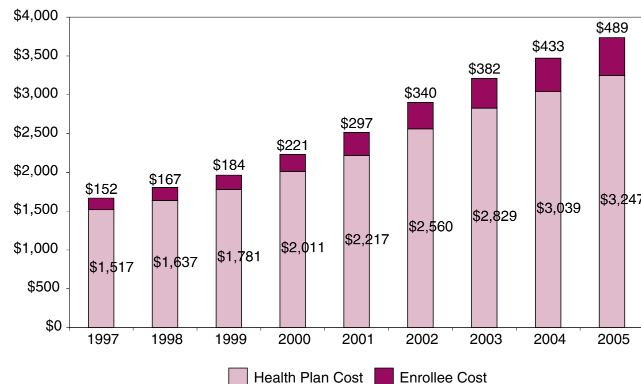
Note: "Helth care cost" is MN privately insured spending on health care services per person. It does not include enrollee out of pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance.

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

As health care costs have risen, one widely used strategy for containing health insurance premium increases has been to shift to benefit structures that require higher enrollee cost sharing. Figure 4 illustrates the trend in total spending per enrollee, including both the health plan and enrollee out of pocket shares of spending. In 2005, total spending per enrollee was $3,735 per enrollee (an increase of 7.6 percent over 2004); the amount paid by private health insurance was about $3,247 per enrollee, with enrollee out of pocket spending covering the remaining $489. Enrollee out of pocket spending represented 13.1 percent of total spending per enrollee in 2005, compared to 9.9 percent in 2000; this finding is consistent with other data about trends in benefit sets.[4]

Figure 4

Trend in Total Cost and Health Plan/Enrollee Shares ($ per privately insured person)



Drivers of Spending Growth

As shown above, growth in overall private health care spending per enrollee has slowed in each of the last three years. Table 1 presents data on the change in growth rates by type of health care service for 2003 to 2005, compared to growth rates for 1999 to 2001 and 2001 to 2003. As shown in the table, growth rates for all of the medical service categories were slower in the 2003 to 2005 period compared to two years earlier. For example, growth in per enrollee spending for physician services slowed from 11.6 percent per year to 3.9 percent. Spending growth for prescription drugs slowed from 18.9 percent per year to 5.9 percent.

Table 1

Growth Rates by Type of Service, 1999 to 2005

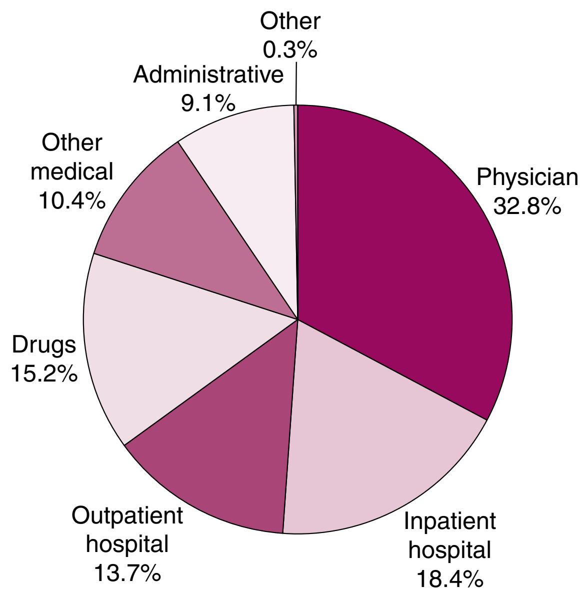
	1999 to 2001	2001 to 2003	2003 to 2005
Average annual growth, per enrollee:			
Physician	10.4%	11.6%	3.9%
Hospital	7.8%	15.5%	10.5%
Inpatient	8.8%	14.2%	8.2%
Outpatient	6.4%	17.6%	13.8%
Drugs	18.9%	18.9%	5.9%
Other medical	14.9%	16.4%	9.2%
Administrative	12.5%	-0.9%	8.5%
Total	**11.5%**	**13.0%**	**7.1%**

Note: Growth rates displayed in this table represent average annual growth over a 2 -year period in spending paid for by private insurance.

As shown in Figure 5, physician and hospital services each account for about one-third of privately insured health care spending, and prescription drugs account for about one-sixth. The share of growth accounted for by each type of service depends on two factors: the rate of growth of spending for that service, and the share of total spending that service represents to begin with. Figure 6 presents data for 2003 to 2005 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 nearly half of total spending growth from 2003 to 2005. Spending for physician services grew slowly compared to overall spending, but because physician services are a large share of spending to start with, this category accounted for about one-fifth of total spending growth.

Figure 5

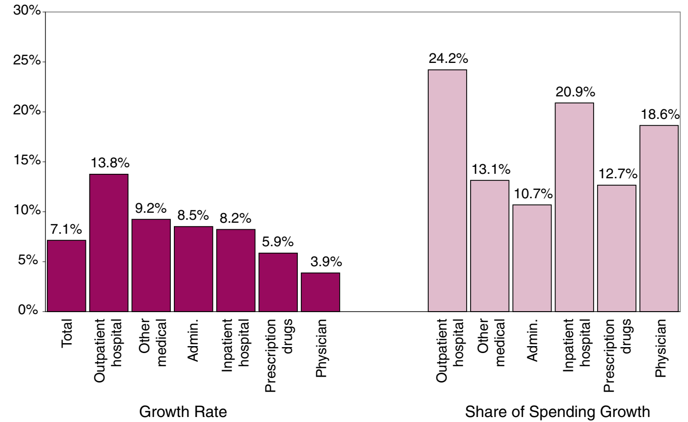
Distribution of Private Health Insurance Spending by Service, 2005



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, 2003 to 2005



Note: growth rates calculated as annual growth per enrollee over the 2-year period.

Discussion

The continued slowing of private health insurance spending growth represents some good news for Minnesota consumers. Affordability of health care coverage will continue to be a matter of concern, however, due to the fact that health care expenses are still growing more quickly than incomes and inflation. In addition to continuing concerns about the affordability of health insurance premiums, the rising share of costs that is borne by enrollees also has implications for affordability of health care, particularly for low-income groups and people with chronic illness.

There are many factors that have likely played a role in the recent deceleration of spending growth. For example, higher enrollee cost sharing requirements have shifted some spending from health plans to enrollee out of pocket spending; however, higher enrollee cost sharing has also likely affected the overall level of health care spending through its impact on consumer decisions about the health care services they use. In addition, the past few years have seen a substantial increase in other efforts to contain costs,

such as disease management for high-cost chronic conditions, and an emphasis on health care quality, evidence-based medicine, and pay for performance. Because the data used in this analysis are highly aggregated financial data reported by health plans, it is not possible to examine in detail the relative importance of the various factors (such as changes in price, changes in quantity, or both) that determine the growth of health care spending.

Endnotes

[1] Minnesota Department of Health and University of Minnesota School of Public Health, "Health Insurance Coverage in Minnesota: Trends from 2001 to 2004," February 2006.

[2] The analysis in this issue brief is based on nonpublic data reported to the Minnesota Department of Health by health plans representing an estimated 86 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.

[3] 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. Minnesota HMOs reported a profit margin of 0.1% on their commercial business in 2005, compared to a 1.4% profit margin for all products combined. (For more information, see: Minnesota Department of Health, Health Economics Program, "Health Care Markets Chartbook," http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html)

[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."

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/divs/hpsc/hep/index.html

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