Medical Expense Trend Targets: Continued Discussion of Methodology Options

Rhode Island Health Insurance Advisory Council
February 28, 2012

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Presentation Outline

1. Responses to five information requests and questions posed during the 1-17-12 Council meeting
2. Continued discussion of eight medical expense trend target methodology considerations

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Five Information Requests and Questions Posed During the 1-17-12 Council Meeting

1. What does the Producer Price Index (PPI) look like for health care, and how does it compare historically to the common PPI?
2. How do the Medical Care CPI and the All Item CPI less Medical Care compare historically to other CPIs?
3. Why is the medical component of the CPI only 7% if Health Care is 20% of the economy?
4. Is there a Rhode Island CPI?
5. How have Rhode Island health insurer medical expense trend rates compared to national medical expense trend rates?

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Producer Price Indices - Background

- PPI – Finished goods less food and energy, is the most commonly referenced data series. As with the CPI, it removes the more volatile food and energy segments
- PPI - Direct Health and Medical Insurance Carriers
  - The indexes for this industry measure the change in the total premium (employee and employer contribution) paid to the insurer plus the return on the invested portion of the premium.
  - See additional detail on the slide that follows.
- PPI - Selected Health Care Industries
  - This index is a net output aggregate index for all the health care services that are currently priced in the PPI. This index represents the net output of the NAICS 621 (Ambulatory Health Care Services), 622 (Hospitals), and 623 (Nursing Homes) sub-sectors covered by the PPI and was first calculated in 2007..

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PPI - Direct Health and Medical Insurance Carriers - Background

- The indexes for this industry measure the change in the total premium (employee and employer contribution) paid to the insurer plus the return on the invested portion of the premium.
- To track price movement for the selected policy, insurance companies participating in the survey are presented with two options.
  - Option1: Companies are asked to estimate a premium for a "frozen" policy. An actual policy is selected, and the price-determining characteristics are held constant when the policy is priced each year on its anniversary or renewal date. The companies estimate the premium using current charges applied to the characteristics of this policy.
  - Option 2: Companies follow the selected policy over time. They are asked to provide the actual premium charged to the policyholder and to identify any modifications to the policy each year on the anniversary, or renewal, date. Any changes in benefits over time must be factored out so that index movements reflect only changes in price and not any additional benefits. To maintain constant quality, the companies must be able to provide the value of the risk change associated with any change to the policy characteristics.

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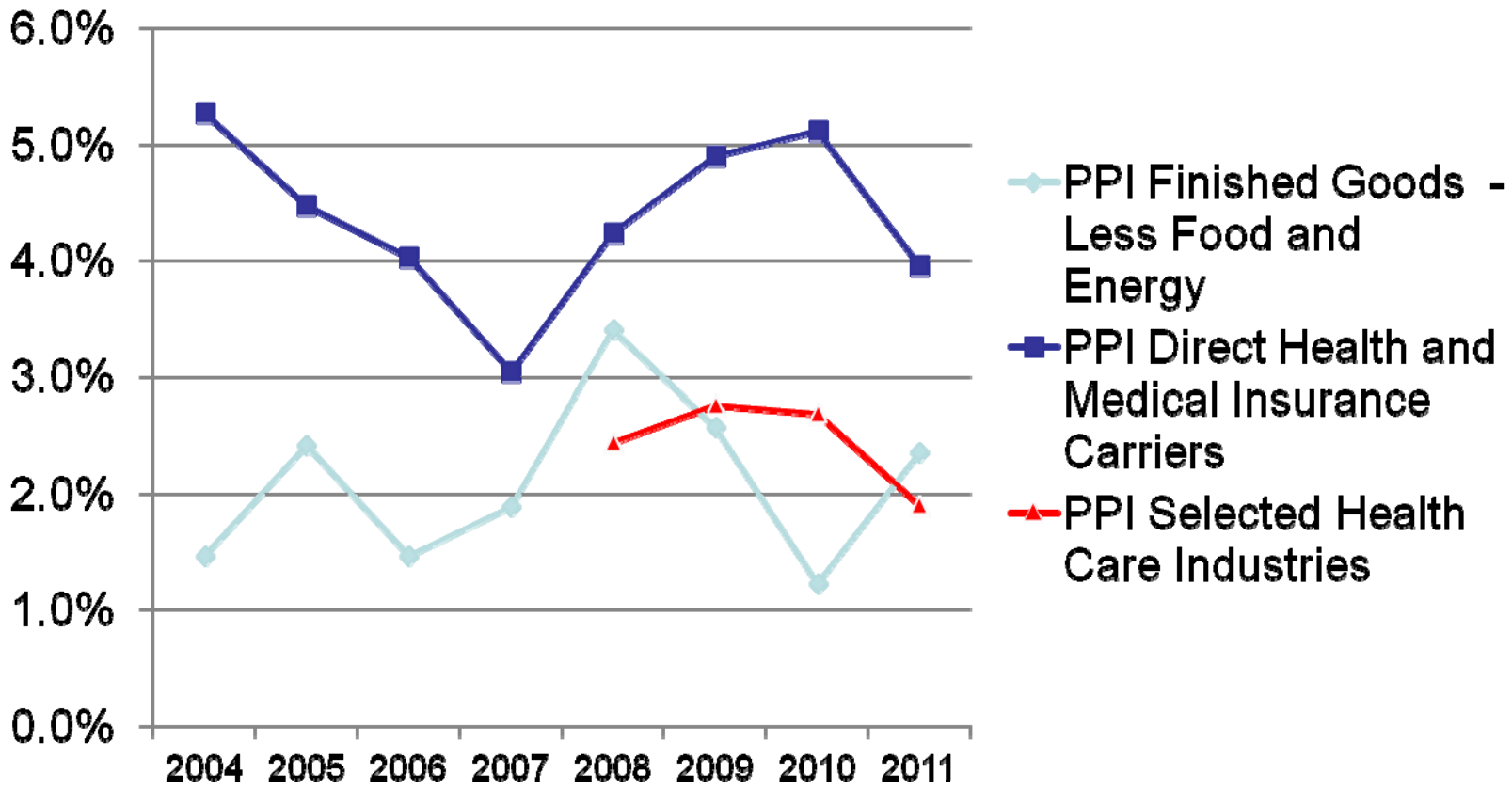
Select PPI Indices Over Time



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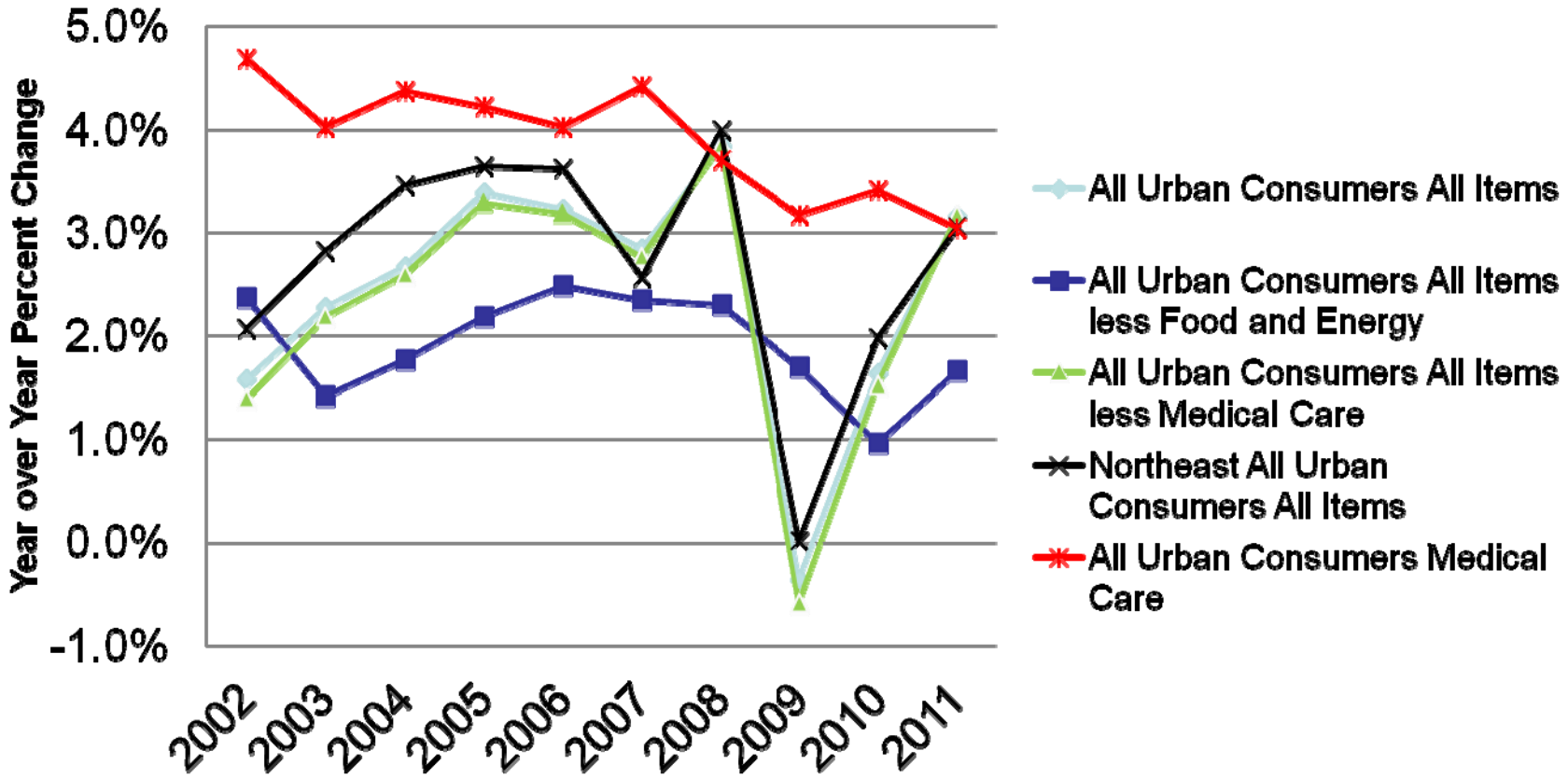
CPI Comparisons:
Excluding Medical Care and Medical Care Only



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CPI Question: Why is the Medical Component of the CPI only 7% if Health Care is 20% of the Economy?

- CPI includes only consumers' out-of-pocket expenditures - and excludes employer-funded expenditures
- BLS reassigns most health care spending to the other medical categories (such as hospitals) that are paid for by insurance.

Source: Bureau of Labor Statistics

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Is There a Rhode Island CPI?

- The US Bureau of Labor Statistics does not calculate a CPI specifically for Rhode Island.
- The BLS puts out a *Northeast Region CPI* that includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
- The BLS also puts out a *Boston-Brockton-Nashua, Mass.-NH-Maine-CT. CPI* comprised of Essex, Middlesex, Norfolk, Plymouth and Suffolk Counties and parts of Bristol, Hampden, and Worcester Counties (MA); parts of Hillsborough, Merrimack, Rockingham, and Strafford Counties (NH); part of York County (ME); and part of Windham County (CT).

RI Medical Expense Trend Compared with National Medical Expense Trend

- The requested and approved large group and small group aggregate medical expense trend in Rhode Island for UHC of New England and BCBSRI are shown on the slides that follow.
- The national medical expense trend displayed in the graphs that follow comes from PriceWaterhouseCoopers (PwC) Health Research Institute reports of May 2010 and May 2011. These data are being used as an estimate of national medical expense trend.
  - This research is based on PwC's employer survey of 1,700 employers from 30 industries as well as interviews with hospital executives and health insurance actuaries

http://www.pwc.com/us/en/health-industries/publications/behind-the-numbers-medical-cost-trends-2012.jhtml
http://pwchealth.com/cgi-local/hregister.cgi?link=reg/Behind_the_numbers_Medical_cost_trends_for_2011.pdf

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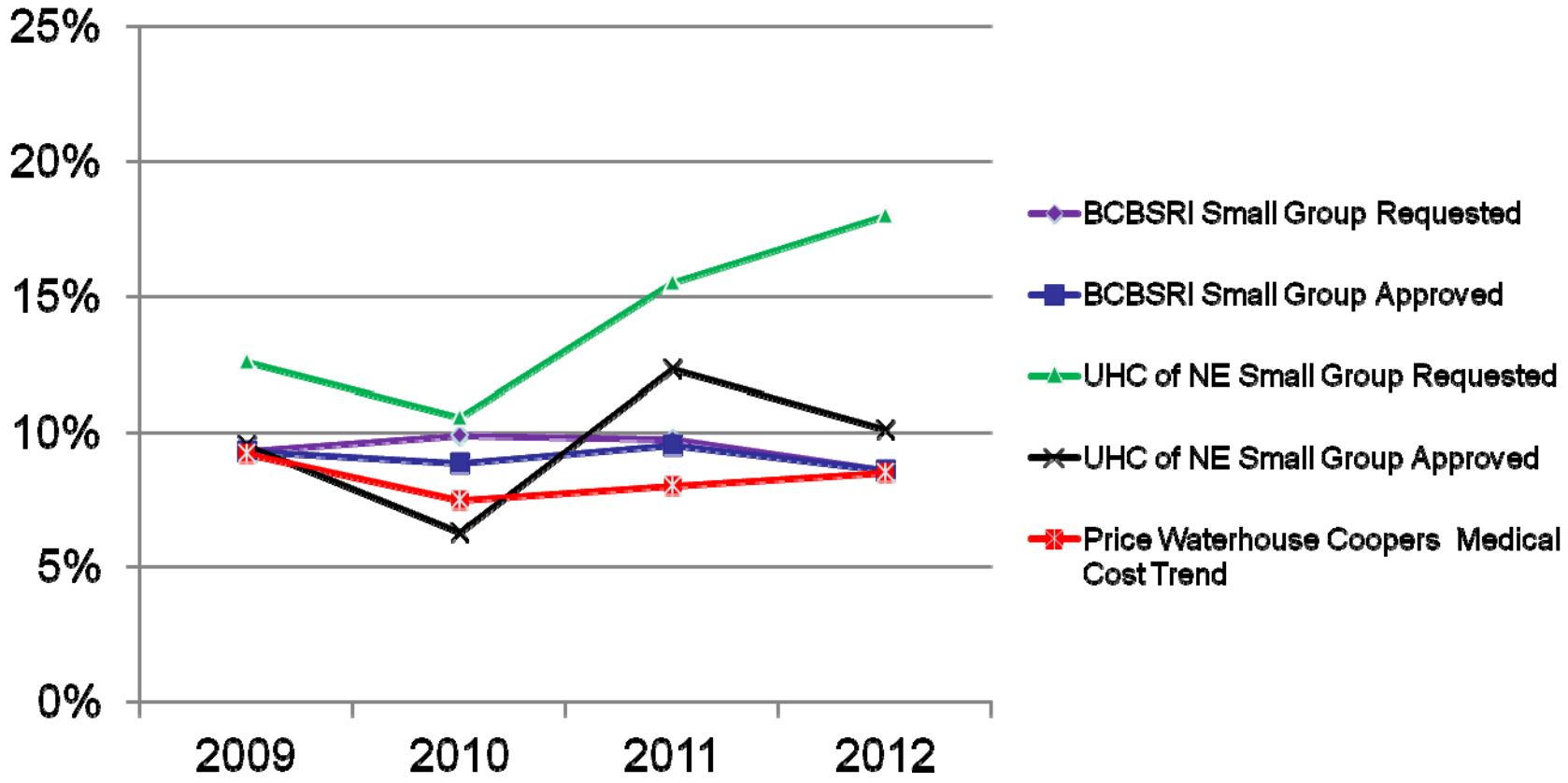
RI Small Group Medical Expense Trend Compared with PWC Medical Cost Trend



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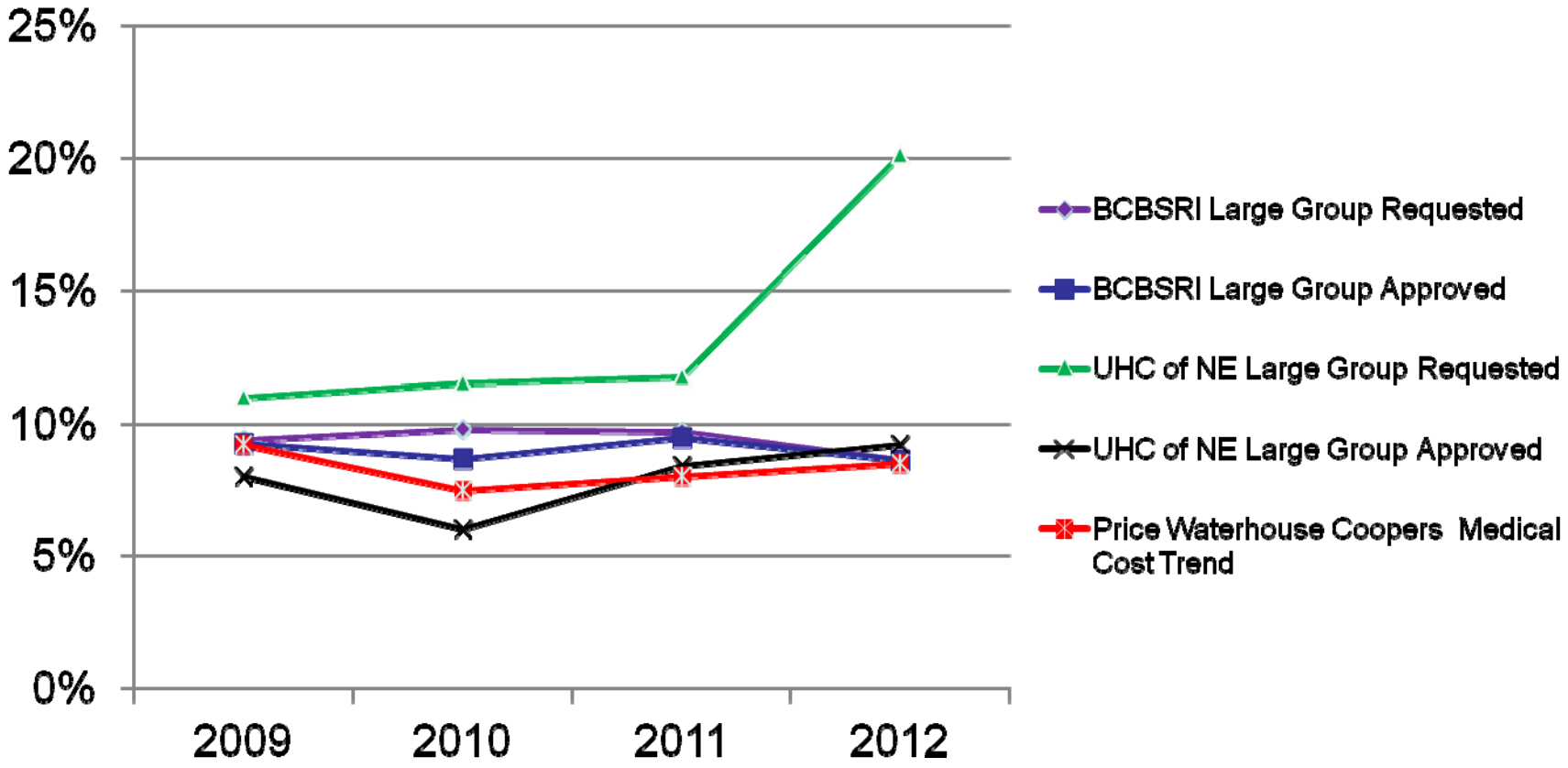
RI Large Group Medical Expense Trend Compared with PWC Medical Cost Trend



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Eight Methodology Considerations

1. What is our objective for the target?
2. What should be the nature of the target?
3. How should the target be set?
4. Is the target a goal or a requirement?
5. What are implications if an insurer proposes a rate that exceeds the target?
6. What state resources (e.g., data, staff) are needed to successfully implement the approach?
7. What help (if any) will insurers need to meet the targets?
8. What are the risks to each approach for setting the target (e.g., medical expense reported as admin expense), and what steps might be taken to mitigate them?

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1. What is the objective for the target?

- 1-17-12 meeting minutes: "The Council agreed that the target should both define (or at least outline) an affordable rate of increase (does not define affordable and does not necessarily accept all current costs) and force more serious actions by insurers and providers to change price and utilization patterns to achieve that target."
- Is the Council comfortable with this objective statement?
  - Does "affordable" need to be defined, or should this be left to OHIC to define?

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Options for defining “affordable rate of increase”

- Affordable definition options presented during the 1-17-12 meeting:
  - Wages
  - Economic production
  - Prices
    - Medical prices?
    - Non-medical prices?
    - Producer prices?
    - Consumer prices?
- Governor Patrick (MA) as quoted on NPR on 2-14-12:
  - “I think we need legislation [so] that we don't continue to have increases above *the rate of growth in the economy*.”

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2. What should be the nature of the target?

- The Council has recommended that the target be a projected medical expense trend that:
  - is insurer-specific
  - is business line-specific

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3. How should the target be set?

- The Council reviewed several index and forecast options during the 1-17-12 meeting.
- Other options were presented earlier during the 2-28-12 meeting.
- For the purpose of advancing the Council's work, I put forth the following recommendation as a straw proposal for discussion.

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3. How should the target be set?

1. Use an index.
   - Indices are rigorously and independently calculated and reported with regularity. State-based forecasting would be complex, resource-intensive and prone to error.
2. Use the All Urban Consumers All Items less Food and Energy CPI.
   - The CPI represents consumer prices and thus will make more intuitive sense for rate payers than the PPI.
   - This version of the CPI is far less volatile than other versions.
   - While this version includes medical prices, analysis shows that exclusion of medical prices from the CPI has no meaningful impact.

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3. How should the target be set?

3. Allow for possible base and reserve adjustments to the medical expense trend target.
   - The Council has expressed concern that base premium rates be considered, relative to one another and to external benchmarks. Otherwise, high base costs could be "baked in" to future premiums.
   - Particularly high or low reserve levels should inform medical expense targets for individual insurers.
   - Flexibility for OHIC is important because the assessment of base rate levels and of reserves does not lend itself to a simple computation, but rather demands an expert, individual insurer assessment.

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3. How should the target be set?

4. Phase in the target over three years. OHIC would add a diminishing number of percentage points to the index-generated rate until reaching the target rate in Year 3.
   - Reducing medical expense trend to the index level will take considerable insurer effort and provider effort. Insurers are unlikely to be able to renegotiate contracts and make product changes within 12-18 months. So, too, are providers unlikely to be able to make sufficient care delivery changes within that time period.
   - This approach would provide immediate rate relief without creating dangerous disruption to the stability of insurers and providers.

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4 and 5. Is the target a goal or a requirement? What are the consequences for exceeding it?

- The medical expense target could be a goal or a requirement. There are at least three options that can be considered:
  1. Goal - with no specific consequences
  2. Goal - with an automatic hearing at which provider rates and contracts and other cost drivers would be examined.
  3. Requirement - with OHIC's ability to adjust depending on the case made by an insurer

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4 and 5. Is the target a goal or a requirement? What are the consequences for exceeding it?

- Recommendation: Option #2
  - The inherent transparency of the hearings will be highly undesirable for insurers, creating pressure for insurer and delivery system change in order to meet the targets.
  - A mere goal without consequences is unlikely positively influence affordability.
  - Using the target as requirement would prompt a hearing process, so leaving the target as should achieve the same result. If per chance it does not, HIAC could advise OHIC to adopt Option #3.

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Next Meeting

- Continued discussion of the methodology for setting medical expense trend targets.
- Conversation with insurer representatives regarding the approach being discussed.