SPENDING FOR PRIVATE HEALTH INSURANCE IN THE UNITED STATES

NIHCM FOUNDATION DATA BRIEF
JANUARY 2013

NIHCM FOUNDATION

KEY POINTS FROM THIS BRIEF:

- Total national spending on premiums for private health insurance was almost $850 billion in 2010, or one-third of all U.S. health spending. Approximately 89 percent of non-elderly people with private health insurance were covered through the employer-based group market, and premiums in this market accounted for 95 percent of all private premium spending. The remaining spending was from people who purchased coverage directly from insurers in the non-group market.
- Nationally, aggregate spending on private premiums increased by about 15 percent between 2006 and 2010 despite declining enrollment. Over the same period, the average premium paid for a policy in the group market increased by around 20 percent.
- Employees have been required to shoulder an increasing portion of rising premiums through their explicit contributions, hitting 27 percent in 2011. They are also increasingly likely to face a deductible, and average deductible levels have been rising quickly. Increases in premiums and out-of-pocket cost sharing have dramatically outpaced general inflation and growth in earnings and median incomes.
- Average premiums in the non-group market are lower than in the employer-based market and have been increasing a little less rapidly. Deductibles, on the other hand, are considerably higher in the non-group market, consistent with a growing prevalence of plans eligible for health savings accounts.
- In 2010 private health insurance companies spent an average of 88 cents of every premium dollar purchasing health care services for their enrollees, with most of this spending paying for inpatient care and for physician and other clinical services. The remaining 12 cents of the premium dollar was used to cover plan administrative expenses, rate credits and dividends, taxes, contributions to reserves, and profits.
- Increases in the amount spent by insurers to purchase inpatient services accounted for 45 percent of the total increase in premium revenue between 2006 and 2010. Another 25 percent of the premium increase was due to higher spending for physician and clinical services. Only 3 percent of the premium increase was attributable to factors such as administrative costs, taxes, additions to reserves and profits.
- Numerous studies have shown that it is the higher prices being paid to providers for a unit of service – rather than an increase in utilization or a shift to a more complex mix of services – that has been the main factor behind the escalating spending for health care services in recent years.

OVERVIEW OF PRIVATE HEALTH INSURANCE

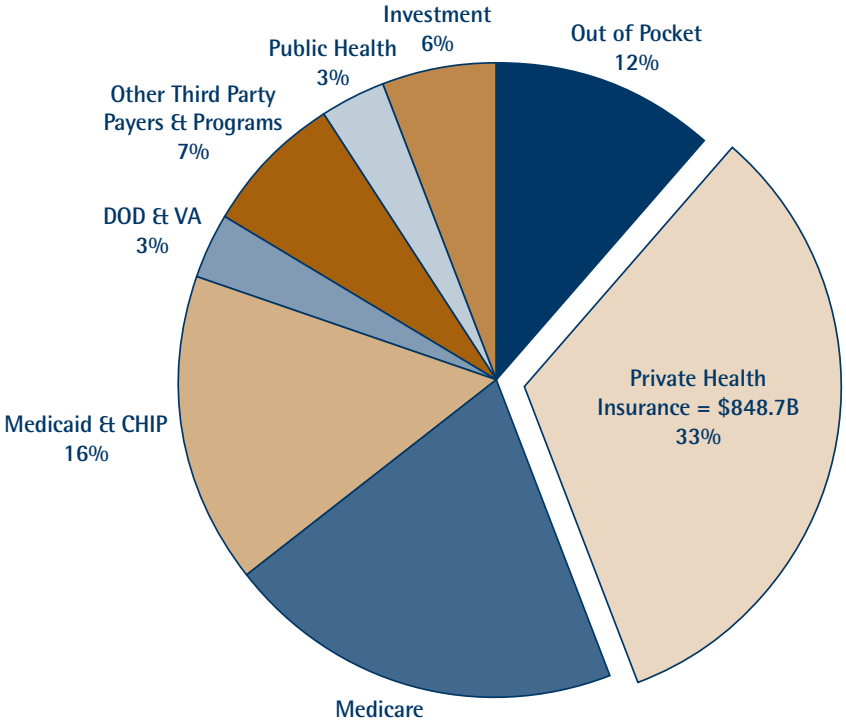
In 2010 one-third of all health-related spending in the United States – totaling nearly $849 billion – was for premiums to purchase private health insurance (Figure 1). Private health insurance in the U.S. is predominantly employer-sponsored, that is, arranged and at least partially financed by employers for their workers, dependents and, in some cases, retirees. Because these policies are obtained for groups of enrollees, employer-sponsored insurance (ESI) is referred to as being part of the group market.

Employers providing health benefits may elect to self-insure, bearing the risk of incurred claims (generally with some protection through separately purchased stop-loss insurance) and contracting with insurers or other third-party administrators only for administrative services. Or they may transfer all risk to the insurer by opting to be fully insured. The percent of workers with employer-based coverage who were in self-insured plans has grown steadily over the past decade, and stood at 60 percent in 2011. Large firms have a much higher likelihood of self-insuring due to their greater ability to bear risk; 82 percent of employees in firms with more than 200 workers were in self-insured health plans in that year, compared to only 13 percent of workers in firms having fewer than 200 employees.[1]

Under the current U.S. tax code, employers can deduct the cost of health insurance as a business expense, and their contributions to premiums are not treated as taxable income for employees.[i] Employee contributions to their premiums are also typically collected on a pre-tax basis so that no income or payroll tax is due on this portion of earnings. These provisions result in a sizeable implicit subsidy that not only strongly encourages the purchase of employment-based insurance but may also fuel demand for richer benefit packages than would otherwise be purchased. The Joint Tax Committee of the U.S. Congress estimates that these tax exclusions cost the federal government some $145 billion in lost revenue in 2011,[2] and recent estimates from the Congressional Budget Office indicate that the exclusions will amount to 1.8 percent of GDP over the next ten years.[3]

In addition to this employer-sponsored coverage, a portion of the population purchases private coverage directly from insurers in what is termed the individual, or non-group, market. The strong tax incentives to purchase employer-based health insurance mean that most people obtaining coverage in the non-group market lack ESI options through their own employment, through a spouse or as a dependent. Many are self-employed, but they might also be working for an employer that either does not offer coverage or offers

FIGURE 1. SPENDING FOR PRIVATE HEALTH INSURANCE PREMIUMS IN THE CONTEXT OF TOTAL NATIONAL HEALTH SPENDING, 2010



2010 Total Spending = $2.594 T

NIHCM Foundation analysis of data from the 2010 National Health Expenditure Accounts.

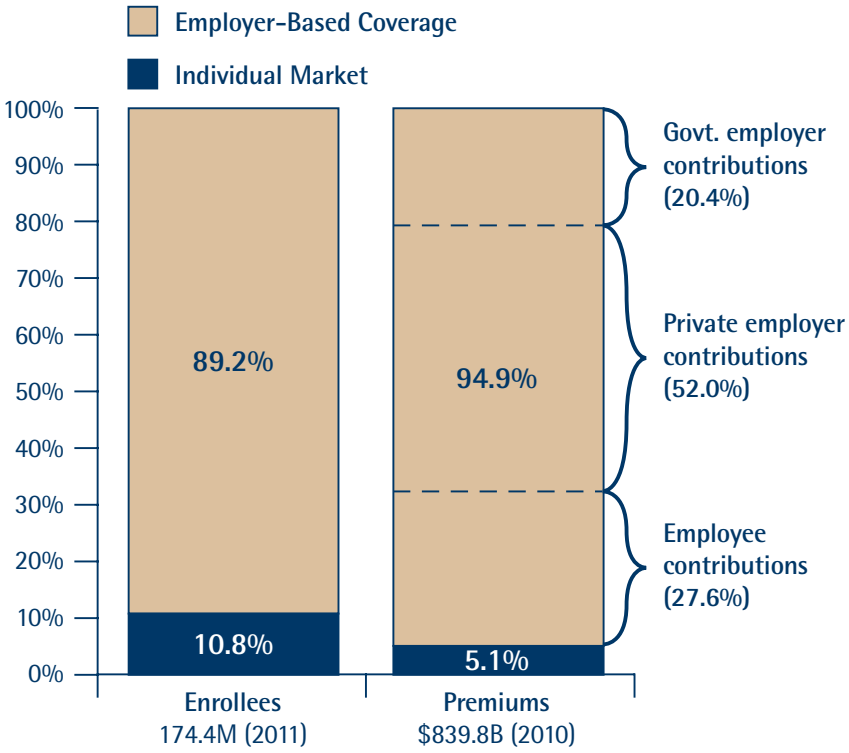
i Likewise, any employer contributions to employees' health savings accounts (HSAs) or health reimbursement arrangements (HRAs) also are excluded from employees' taxable incomes.

coverage that is unaffordable or for which the employee does not qualify. Older students and children who are no longer eligible for coverage on their parents' policies and early retirees who are not yet eligible for Medicare may also be purchasing coverage in the non-group market.[4] While the self-employed are allowed to deduct their premium expenses from income for tax purposes, other people purchasing coverage in the non-group market do not receive a tax subsidy. With no tax subsidy and no employer contribution, those purchasing coverage in the non-group market bear the full cost of the policy they select and would be expected to be more price-sensitive than their counterparts in the employer-based market.

The Employee Benefit Research Institute estimates that 58.4 percent of the non-elderly population had employment-based health insurance benefits in 2011, and 7.1 percent had purchased insurance in the individual market.[5] Thus, about 89 percent of all people with private health insurance received that coverage through an employer (Figure 2). The relative importance of employment-related coverage is even more striking when measured in terms of premium spending. Nationally, 95 percent of all private premiums paid in the U.S. in 2010 went to purchase coverage in the employer market, and the rest was for non-group coverage. Within the group market, employees explicitly covered 28 percent of the premiums, or about 38 cents for every dollar that came from employers [27.6%/(20.4%+52.0%)].[ii] Employer contributions include payments from private-sector employers as well as payments from federal, state and local governments that are purchasing private coverage for public-sector workers.

In this brief we take a closer look at private health insurance spending in both the employer-based and non-group markets, focusing on changes over time in the level of premiums, the sources of premium payments, and required cost sharing by enrollees. We also examine how premium revenue received by private health insurers is spent and delve into what sectors and factors have been most responsible for the rising premiums in recent years. We conclude with a discussion of factors likely to impact the private insurance market in the coming years.

FIGURE 2. ENROLLMENT AND PREMIUM REVENUE IN THE PRIVATE INSURANCE MARKET



Sources: Fronstin P. "Sources of Heath Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey." EBRI Issue Brief 376, Sept. 2012; NIHCM Foundation analysis of data from the 2010 National Health Expenditure Accounts, Sponsor Highlights. Private premium revenue of $839.8B shown here is lower than the $848.7B shown in Figure 1 because Medicare Retiree Subsidy payments and COBRA subsidies are excluded.

THE EMPLOYER-BASED GROUP MARKET

Premiums

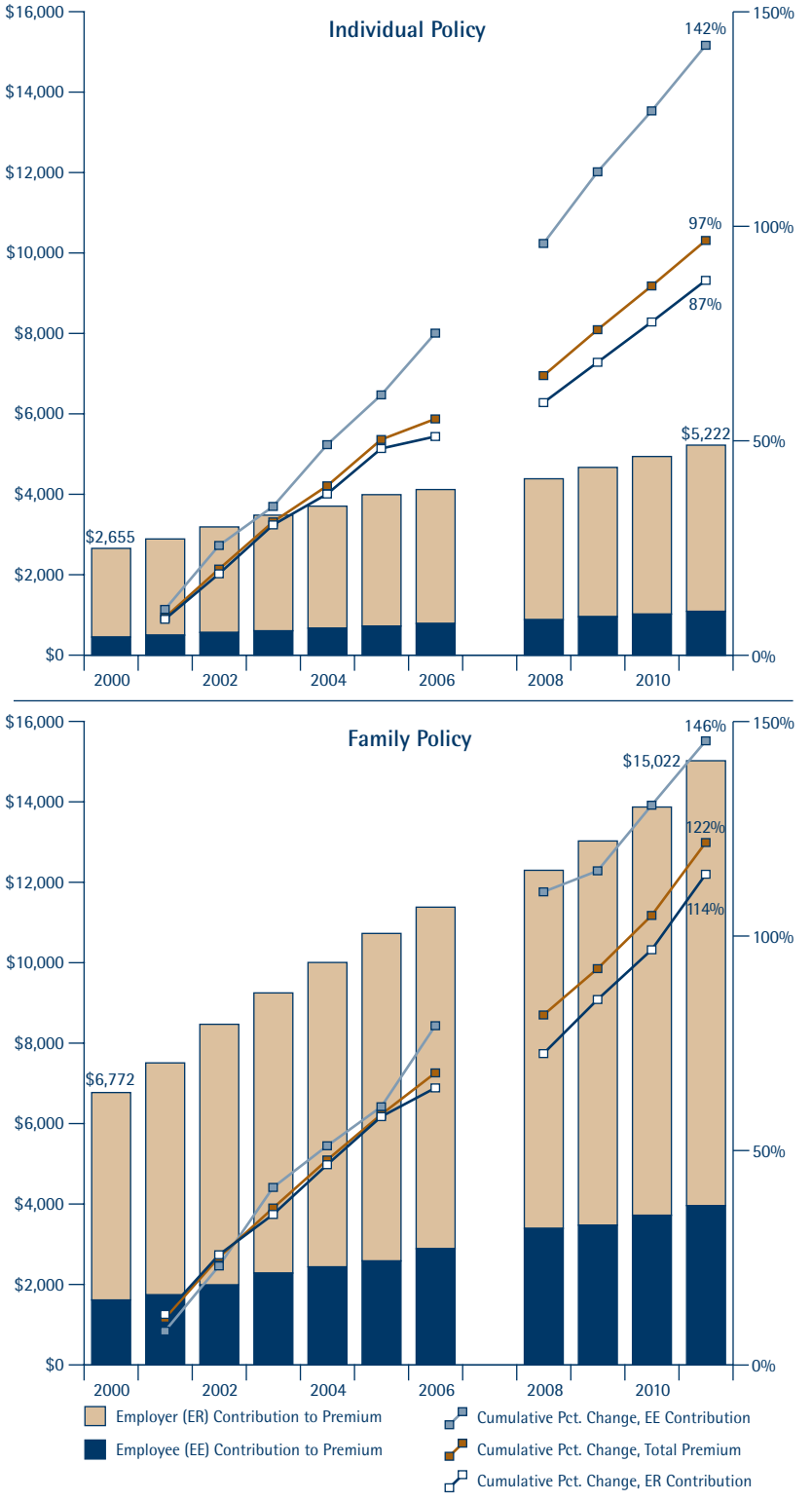
Premiums for employer-sponsored coverage have been increasing steadily (Figure 3, Table 1). Data from the Insurance Component of the Medical Expenditure

ii Most economists make the case that employees also implicitly bear the cost of the employers' contributions through reduced wages. That is, their take-home wages could be higher if employers paid less for health benefits on their behalf.

Panel Survey (MEPS-IC), which collects national data annually from employers about their health insurance offerings, show that private-sector workers enrolling in individual policies (covering only the worker) saw total premiums rise from $2,655 in 2000 to $5,222 in 2011, a cumulative increase of 97 percent. With only one exception during the decade, the year-to-year percentage increase in the employee contribution to premiums for an individual policy was higher than the percentage increase borne by employers. As a result, employee contributions to premiums increased by 142 percent over the period compared to an 87 percent increase for employers, and the share of premiums paid directly by employees rose from 16.9 percent to 20.9 percent. In absolute dollars, employers were paying an average of $1,927 more in premiums by 2011 than they had paid in 2000, and employees were paying $640 more.

Premiums rose even more quickly for family policies, more than doubling from $6,772 to $15,022 over the period. Annual premium increases were sometimes shouldered disproportionately by the employer, and sometimes by the employee, depending on the year. However, over the full period, employees saw their payments for premiums increase by 146 percent (or about $2,350 more than the $1,614 contributed in 2000) while employer contributions rose by 114 percent (up about $5,900 from the 2000 contribution level of $5,158). By 2011, employees were making direct contributions to cover 26.4 percent of the premiums for family policies, a statistically significant increase over the 23.8 percent they had paid in 2000.

FIGURE 3. PREMIUMS FOR EMPLOYER-SPONSORED COVERAGE, PRIVATE-SECTOR WORKERS, 2000-2011



NIHCM Foundation analysis of data from the Medical Expenditure Panel Survey, Insurance Component. Data not available for 2007.

TABLE 1. PREMIUMS IN THE EMPLOYER-SPONSORED MARKET, 2000 TO 2011

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
MEDICAL EXPENDITURE PANEL SURVEY – INSURANCE COMPONENT												
Individual Policy												
Employee Contribution to Premium	$450	$498	$565	$606	$671	$723	$788	NA	$882	$957	$1,021	$1,090
Employer Contribution to Premium	$2,205	$2,391	$2,624	$2,875	$3,034	$3,268	$3,330	NA	$3,504	$3,712	$3,919	$4,132
Total Premium	$2,655	$2,889	$3,189	$3,481	$3,705	$3,991	$4,118	NA	$4,386	$4,669	$4,940	$5,222
Percent Change from Prior Year, Employee Contribution		10.7%	13.5%	7.3%	10.7%	7.7%	9.0%		11.9%	8.5%	6.7%	6.8%
Percent Change from Prior Year, Employer Contribution		8.4%	9.7%	9.6%	5.5%	7.7%	1.9%		5.2%	5.9%	5.6%	5.4%
Percent Change from Prior Year, Total Premium		8.8%	10.4%	9.2%	6.4%	7.7%	3.2%		6.5%	6.5%	5.8%	5.7%
Cumulative Percent Change, Employee Contribution		10.7%	25.6%	34.7%	49.1%	60.7%	75.1%		96.0%	112.7%	126.9%	142.2%
Cumulative Percent Change, Employer Contribution		8.4%	19.0%	30.4%	37.6%	48.2%	51.0%		58.9%	68.3%	77.7%	87.4%
Cumulative Percent Change, Total Premium		8.8%	20.1%	31.1%	39.5%	50.3%	55.1%		65.2%	75.9%	86.1%	96.7%
Employee Share of Premium	16.9%	17.2%	17.7%	17.4%	18.1%	18.1%	19.1%		20.1%	20.5%	20.7%	20.9%
Family Policy												
Employee Contribution to Premium	$1,614	$1,741	$1,987	$2,283	$2,438	$2,585	$2,890	NA	$3,394	$3,474	$3,721	$3,962
Employer Contribution to Premium	$5,158	$5,768	$6,482	$6,966	$7,568	$8,143	$8,491	NA	$8,904	$9,553	$10,150	$11,060
Total Premium	$6,772	$7,509	$8,469	$9,249	$10,006	$10,728	$11,381	NA	$12,298	$13,027	$13,871	$15,022
Percent Change from Prior Year, Employee Contribution		7.9%	14.1%	14.9%	6.8%	6.0%	11.8%		17.4%	2.4%	7.1%	6.5%
Percent Change from Prior Year, Employer Contribution		11.8%	12.4%	7.5%	8.6%	7.6%	4.3%		4.9%	7.3%	6.2%	9.0%
Percent Change from Prior Year, Total Premium		10.9%	12.8%	9.2%	8.2%	7.2%	6.1%		8.1%	5.9%	6.5%	8.3%
Cumulative Percent Change, Employee Contribution		7.9%	23.1%	41.4%	51.1%	60.2%	79.1%		110.3%	115.2%	130.5%	145.5%
Cumulative Percent Change, Employer Contribution		11.8%	25.7%	35.1%	46.7%	57.9%	64.6%		72.6%	85.2%	96.8%	114.4%
Cumulative Percent Change, Total Premium		10.9%	25.1%	36.6%	47.8%	58.4%	68.1%		81.6%	92.4%	104.8%	121.8%
Employee Share of Premium	23.8%	23.2%	23.5%	24.7%	24.4%	24.1%	25.4%		27.6%	26.7%	26.8%	26.4%
KAISER FAMILY FOUNDATION/HEALTH RESEARCH AND EDUCATIONAL TRUST												
Individual Policy												
Employee Contribution to Premium	$334	$355	$466	$508	$558	$610	$627	$694	$721	$779	$899	$921
Employer Contribution to Premium	$2,137	$2,334	$2,617	$2,875	$3,137	$3,414	$3,615	$3,785	$3,983	$4,045	$4,150	$4,508
Total Premium	$2,471	$2,689	$3,083	$3,383	$3,695	$4,024	$4,242	$4,479	$4,704	$4,824	$5,049	$5,429
Annual Percent Change, Employee Contribution		6.3%	31.3%	9.0%	9.8%	9.3%	2.8%	10.7%	3.9%	8.0%	15.4%	2.4%
Annual Percent Change, Employer Contribution		9.2%	12.1%	9.9%	9.1%	8.8%	5.9%	4.7%	5.2%	1.6%	2.6%	8.6%
Annual Percent Change, Total Premium		8.8%	14.7%	9.7%	9.2%	8.9%	5.4%	5.6%	5.0%	2.6%	4.7%	7.5%
Cumulative Percent Change, Employee Contribution		6.3%	39.5%	52.1%	67.1%	82.6%	87.7%	107.8%	115.9%	133.2%	169.2%	175.7%
Cumulative Percent Change, Employer Contribution		9.2%	22.5%	34.5%	46.8%	59.8%	69.2%	77.1%	86.4%	89.3%	94.2%	110.9%
Cumulative Percent Change, Total Premium		8.8%	24.8%	36.9%	49.5%	62.8%	71.7%	81.3%	90.4%	95.2%	104.3%	119.7%
Employee Share of Premium	13.5%	13.2%	15.1%	15.0%	15.1%	15.2%	14.8%	15.5%	15.3%	16.1%	17.8%	17.0%
Family Policy												
Employee Contribution to Premium	$1,619	$1,787	$2,137	$2,412	$2,661	$2,713	$2,973	$3,281	$3,354	$3,515	$3,997	$4,129
Employer Contribution to Premium	$4,819	$5,274	$5,866	$6,656	$7,289	$8,167	$8,507	$8,825	$9,326	$9,860	$9,773	$10,944
Total Premium	$6,438	$7,061	$8,003	$9,068	$9,950	$10,880	$11,480	$12,106	$12,680	$13,375	$13,770	$15,073
Annual Percent Change, Employee Contribution		10.4%	19.6%	12.9%	10.3%	2.0%	9.6%	10.4%	2.2%	4.8%	13.7%	3.3%
Annual Percent Change, Employer Contribution		9.4%	11.2%	13.5%	9.5%	12.0%	4.2%	3.7%	5.7%	5.7%	-0.9%	12.0%
Annual Percent Change, Total Premium		9.7%	13.3%	13.3%	9.7%	9.3%	5.5%	5.5%	4.7%	5.5%	3.0%	9.5%
Cumulative Percent Change, Employee Contribution		10.4%	32.0%	49.0%	64.4%	67.6%	83.6%	102.7%	107.2%	117.1%	146.9%	155.0%
Cumulative Percent Change, Employer Contribution		9.4%	21.7%	38.1%	51.3%	69.5%	76.5%	83.1%	93.5%	104.6%	102.8%	127.1%
Cumulative Percent Change, Total Premium		9.7%	24.3%	40.9%	54.6%	69.0%	78.3%	88.0%	97.0%	107.8%	113.9%	134.1%
Employee Share of Premium	25.1%	25.3%	26.7%	26.6%	26.7%	24.9%	25.9%	27.1%	26.5%	26.3%	29.0%	27.4%

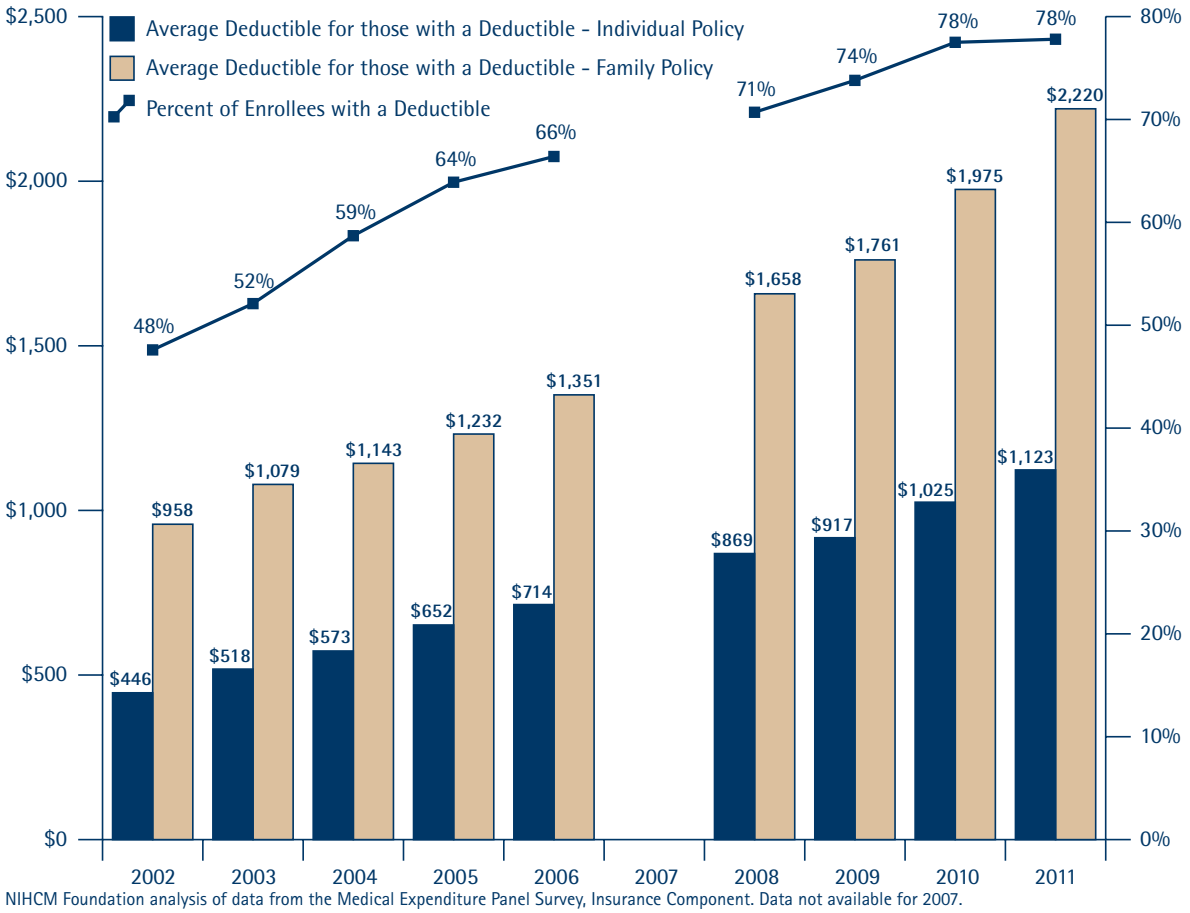
Sources: Data from the MEPS-IC were derived using the MEPSnet Query Tool available at http://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp. Data for 2007 are not available. KFF/HRET data were derived from the annual Employer Health Benefits Surveys available at http://www.kff.org/insurance/ehbs-archives.cfm.

Data from a second commonly used source of information on employer-sponsored health benefits – the Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) annual employer surveys – also show rising premiums and a disproportionate share of premium increases being shifted to employees (Table 1). While the numbers from both surveys are of similar magnitude, the somewhat lower premiums reported by the KFF/HRET survey for 2000 result in higher cumulative premium increases over the period (120 percent for individual policies and 134 percent for family policies) than seen with the MEPS-IC data. The KFF/HRET data also indicate that employees saw a more rapid escalation in premium contributions than did their employers: employee contributions rose 176 percent for individual coverage and 155 percent for family coverage over the decade, while employer contributions rose by 111 and 127 percent, respectively.

Deductibles

At the same time that private-sector employees were being required to contribute an increasing share of the rising premiums for their employer-sponsored coverage, they were also seeing higher out-of-pocket costs due to plan deductibles (Figure 4). In 2002 approximately one of every two private-sector workers enrolled in an employer-sponsored plan faced a deductible. Nine years later, this figure had climbed to more than three of every four enrollees. Furthermore, the deductible levels were escalating rapidly in plans that had them, increasing by 132 percent to $2,220 for family policies and rising by 152 percent to reach more than $1,100 for individual policies. The rising importance of deductibles is confirmed by the KFF/HRET data; by 2012, 34 percent of workers with an

FIGURE 4. DEDUCTIBLES FOR EMPLOYER-SPONSORED COVERAGE, PRIVATE-SECTOR WORKERS, 2002-2011



NIHCM Foundation analysis of data from the Medical Expenditure Panel Survey, Insurance Component. Data not available for 2007.

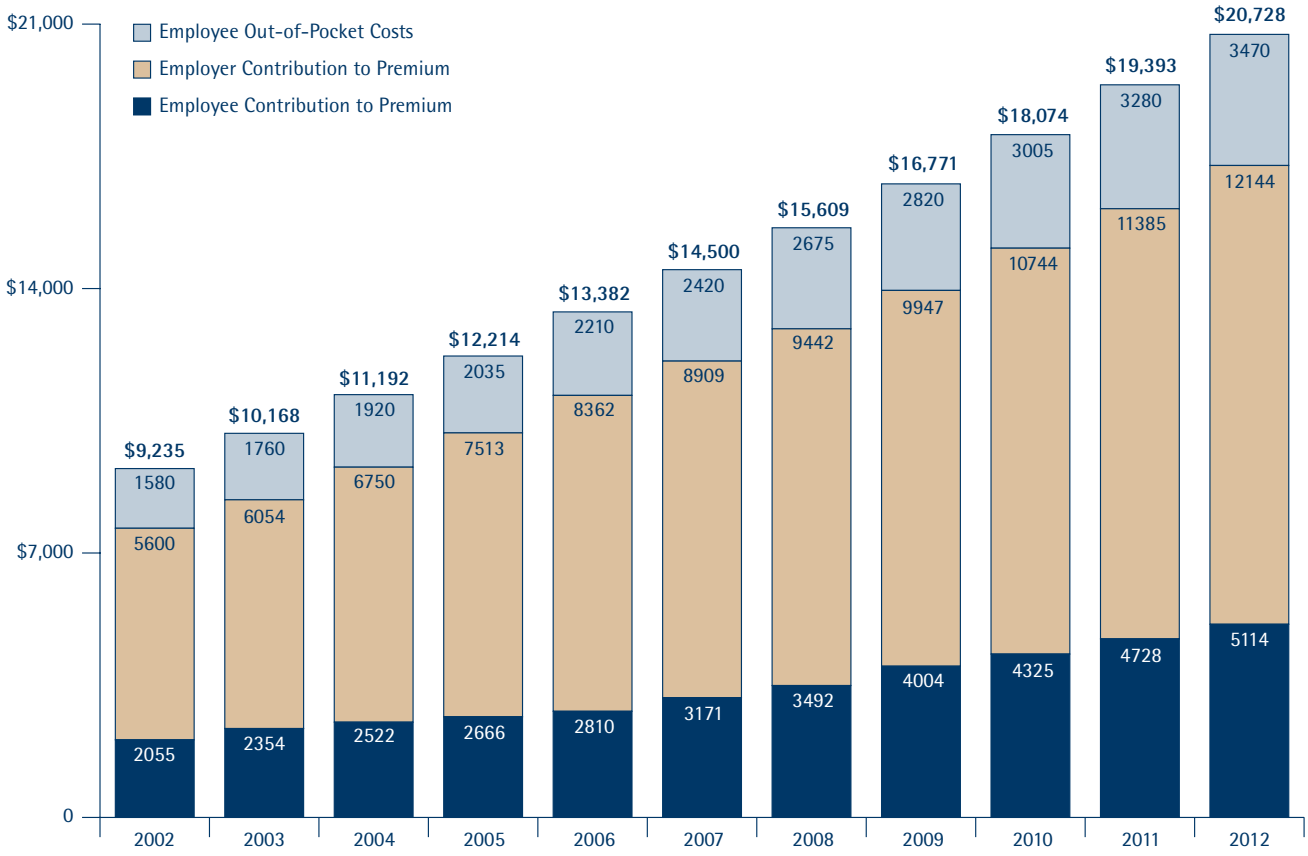
individual policy had a deductible of at least $1,000 and 14 percent faced at least a $2,000 deductible. Just five years earlier, these numbers had stood at 10 and 3 percent, respectively.[6]

Total Cost of Health Care for Enrollees of Employer-Sponsored Plans

Milliman, Inc. annually estimates the total cost of health care for a typical family of four enrolled in an employer-sponsored preferred provider organization (PPO) plan. Their Milliman Medical Index considers both the premium paid explicitly by the employee and the amount contributed by the employer (in lieu of higher wage compensation) to be costs to the employee. They also include all out-of-pocket costs paid by plan enrollees to satisfy deductibles and through coinsurance and copayments beyond deductibles. The total costs included in the index have more than doubled in the past decade, rising 124 percent from $9,235 in 2002 to $20,728 in 2012 (Figure 5). The fastest growing component was the employee contribution to premiums, which rose by 149 percent over the decade.

This rapid increase in the cost of health care for a privately insured family dramatically outpaced the growth in median income for a family of four (up about 20 percent between 2002 and 2010),[7] average hourly earnings for private-sector workers (up about 33 percent between 2002 and 2012),[8] and general inflation (up 25 percent between 2002 and 2011).[9] Thus, maintaining employer-based private health insurance coverage is taking a rising financial toll on American families.

FIGURE 5. ANNUAL MEDICAL COSTS FOR AVERAGE FAMILY OF FOUR IN AN EMPLOYER-SPONSORED PPO PLAN, 2002-2012



NIHCM Foundation analysis of data presented in the annual Milliman Medical Index reports, 2005-2012. Values for component parts for 2002-2005 were estimated using component growth rates reported by Milliman.

THE INDIVIDUAL MARKET

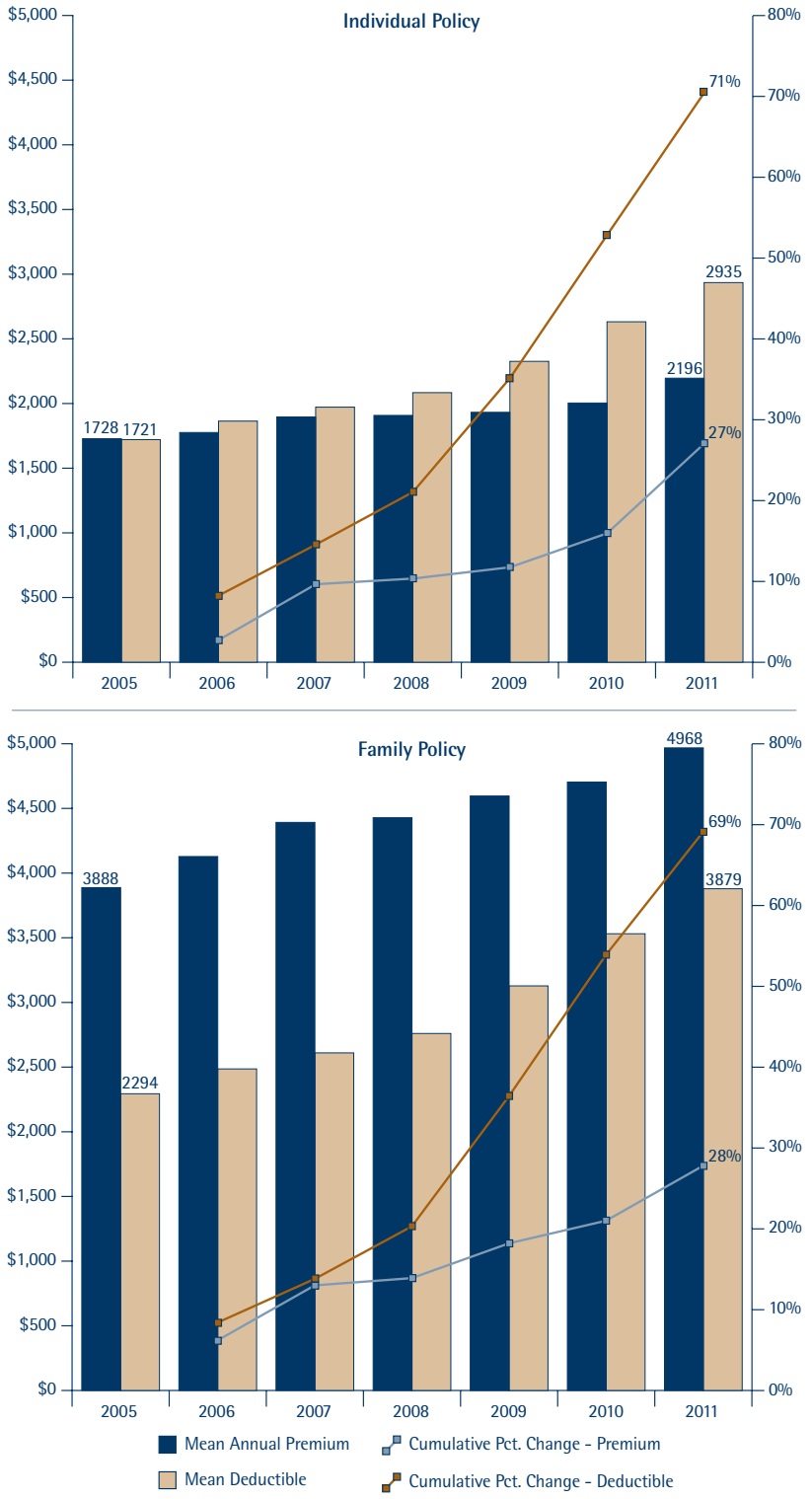
Premiums and Deductibles

Premiums for coverage purchased in the non-group market are considerably lower than for coverage obtained through an employer and are rising at a slightly slower pace. Deductibles, on the other hand, are much higher in the non-group market, reflecting the tradeoffs between premiums and the actuarial value of plan benefits. The higher exposure to the total premium faced by consumers in the individual market likely makes them more willing to accept somewhat less generous benefits in a bid to keep premiums more affordable.

Figure 6 shows trends over the past seven years in the mean premiums paid in the non-group market for individual and family policies and in the mean deductibles associated with these policies. The data reflect major medical policies sold nationwide to non-elderly policyholders through the eHealthInsurance website and represent nearly 120,000 policies in 2005 to 384,000 policies by 2011.

There was a steady progression in mean premiums over the period, with about a 27 percent cumulative increase for both individual and family policies. (By means of comparison, data provided in Table 1 show that premiums in the employer market grew by 31 to 35 percent over this same period for individual policies, depending on the data source used, and by about 40 percent for family policies.) By 2011 the average individual policy sold in the non-group market via

FIGURE 6. PREMIUMS AND DEDUCTIBLES IN THE NON-GROUP MARKET, 2005-2011



NIHCM Foundation analysis of data contained in eHealthInsurance reports *The Costs and Benefits of Individual and Family Health Insurance Plans* (Nov. 2008 and Nov. 2011) and *2009 Summer Cost Report for Individual and Family Policy Holders.*

eHealthInsurance had a yearly premium of $2,196 and family policies had a mean annual premium of $4,968, both well below the comparable levels seen in the employer-based market.

Deductible levels also climbed steadily over this period, beginning a more dramatic upturn around 2009. Over the seven-year period, deductibles in the non-group market climbed by some 70 percent, reaching an average level of $2,935 for individual policies and $3,879 for family policies. These values are well above the deductible levels seen in the employer-based market.

Additional data on the non-group market are available from America's Health Insurance Plans (AHIP) via a 2009 survey of its member companies that were selling products in this market.[10] These data, which reflect some 2.6 million major medical policies with guaranteed renewability and meeting the HIPPA standards for creditable coverage, reveal mean premium levels that are higher than reported from the eHealthInsurance data. Specifically, mean premiums among non-elderly policyholders were reported to be $2,985 for individual policies and $6,328 for family policies in 2009 (again lower than premiums seen in the group market in this year, Table 1). The mean deductible levels in that year can be computed as $2,482 for individual policies and $5,525 for family policies.[iii]

iii These figures were computed as the average deductibles reported for 4 different plan types (PPO/POS, HSA, HMO, and indemnity) weighted by the enrollment in each type of plan.

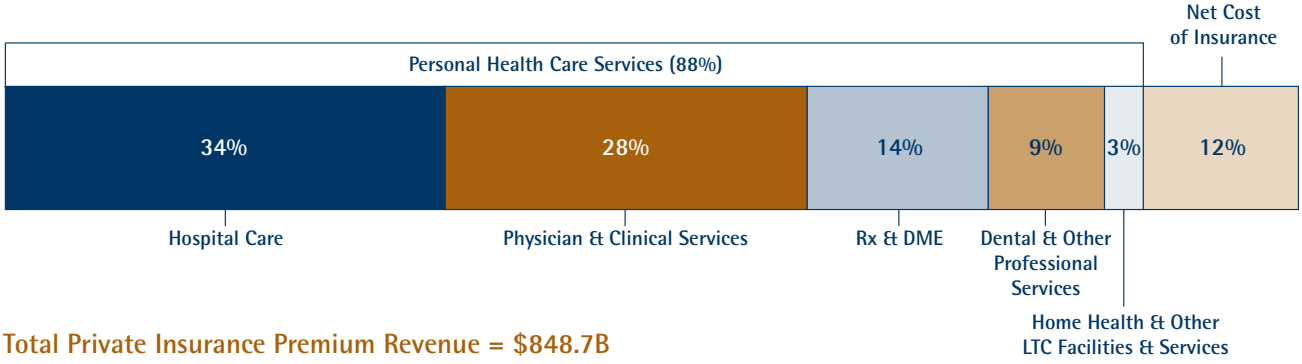
The Influence of Health Savings Accounts

The rapid rise in deductible levels seen in Figure 6 reflects to some extent the shift in enrollment to plans that are eligible for tax-preferred Health Savings Accounts (HSAs) over this period. HSA-eligible plans currently must have deductibles of at least $1,200 for individual policies and $2,400 for family policies. According to the eHealthInsurance data, HSA-eligible plans grew from 7.3 percent of all non-group policies purchased in 2005[11] to 17.3 percent in 2011. Deductibles for individual policies were 27 percent higher for HSA-eligible plans in 2011 than for non-HSA eligible plans ($3,567 vs. $2,810) and deductibles for family policies were 67 percent higher for HSA-eligible plans ($5,685 vs. $3,398).[12]

WHERE THE PREMIUM DOLLAR GOES

Data from the National Health Expenditure Accounts (NHEA) can be used to trace how the nearly $850B spent nationally on private health insurance premiums in 2010 (Figure 1) moved through the health care system. For each dollar taken in by private health insurers in the form of premiums, 88 cents was used to purchase health care services for their policyholders (Figure 7). The largest share of this spending – constituting 34 percent of all premium revenue – went to hospitals to cover expenses related to inpatient stays and hospital-based outpatient, home health, nursing home and hospice care. Another 28 cents of the premium dollar was used to pay for care provided by physicians and independent laboratories. Private insurers spent 14

FIGURE 7. DISPOSITION OF PRIVATE HEALTH INSURANCE PREMIUMS, 2010



Total Private Insurance Premium Revenue = $848.7B

NIHCM Foundation analysis of data from the 2010 National Health Expenditure Accounts.

percent of their 2010 premium revenue to purchase prescription drugs and durable medical equipment (DME) for their enrollees, and another 9 percent was used to pay for care provided by dentists and other non-physician health care providers such as chiropractors, optometrists, podiatrists, private-duty nurses, and various types of therapists. Because most people covered by private insurance are under age 65, only a small share of premium revenue (3 percent) was spent on long-term care services.

The remaining 12 cents of each premium dollar is the "net cost of private insurance" – defined by the NHEA as the difference between premiums collected and payments made to providers for the services used by plan enrollees. This residual amount covers all administrative costs, any rate credits given to policyholders and dividends provided to stockholders, all taxes paid to the government, net additions to reserves, and profits (or losses). Health insurers' administrative expenses encompass a diverse range of functions including claims processing, sales and marketing, member enrollment and customer service, actuarial analysis and underwriting, compliance activities, contracting with providers, product development, medical management, quality improvement, and wellness programs.[13] Administrative costs related to operations in the non-group market tend to be higher than in the group market due to economies of scale when selling to groups and the need to pay brokers for marketing to and enrolling individuals.[14]

SECTORS DRIVING THE RISE IN PRIVATE HEALTH INSURANCE PREMIUMS

With premiums rising in both the individual and group markets, aggregate national spending on private health insurance has also been on the increase despite declines in enrollment.[iv] Over the most recent five years for which data are available, total spending via private insurance increased by nearly 15 percent – from $740 billion in 2006 to almost $850 billion in 2010 (Figure 8). Spending for each category comprising private premiums was up without exception, as well.

Figure 9 takes a closer look at the $109 billion increase in total private health insurance premium spending over the period and examines the relative contribution of each component of spending to the increase. The single largest contributor to higher premium spending was the hospital sector, where insurers paid out $48 billion more in 2010 than they had just five years earlier. This sector alone accounts for 45 percent of the overall rise in premium spending, due to both the faster-than-average increase in spending (20.3 percent vs. 14.7 percent growth) and the relative importance of the sector. Higher spending by private insurers to purchase physician and clinical services was responsible for more than 25 percent of the total change in premiums in this five-year span, and higher spending for drugs and DME accounted for another 14 percent of the rise in premiums. All told, 97 percent of the rise in premium spending between 2006 and 2010 was due to growth in insurers' spending for health care services for their enrollees. The $3 billion increase in the net cost of health insurance was responsible for only 3 percent of the growth in premium revenues over this time.

THE ROLE OF PROVIDER PRICES IN FUELING SPENDING INCREASES

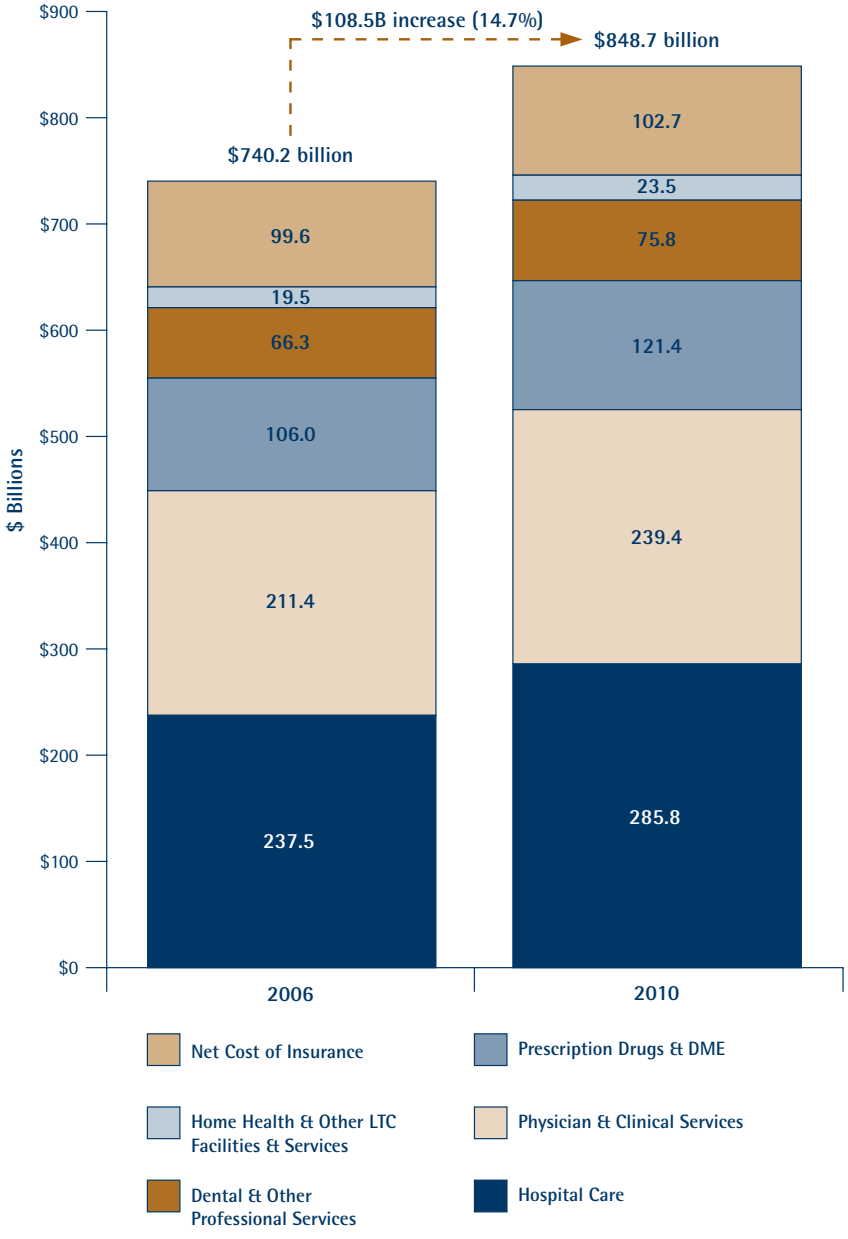
Rising spending for health care may be driven by a number of factors. One such factor is growth in the number of people for whom spending is being tallied (population); this factor can be dismissed as a factor in explaining aggregate private health insurance spending increases since the number of people covered by private insurance actually declined over the period examined.[v] Spending might also increase if enrollees are using more services per capita (referred to as the volume, or utilization, effect) or are using a more costly mix of services (the intensity, or service mix, effect), or if providers are being paid more for each unit of service delivered (the price effect).

iv The NHEA from which these data are taken estimate that the number of people enrolled in private insurance fell by about 10 million over this five-year period. See Table 4 in "National Health Expenditures 2010: Sponsor Highlights" (http://tinyurl.com/6scyo8n) for more information.

v Estimates from the NHEA indicating a decline of 10 million in the number of people enrolled in private insurance between 2006 and 2010 are corroborated by estimates from the Employee Benefit Research Institute (EBRI) showing a fall of 9.2 million in the number of non-elderly persons with employment-based coverage over the same period. See Figure 1 of EBRI's Issue Brief No. 376, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey," for more information.

Multiple studies have indicated that unit price increases have been the most important factor in explaining ever-higher levels of spending in recent years, both for the U.S. health care system overall as well as among those with private health insurance. Analysis of the NHEA data by staff from the Office of the Actuary shows, for instance, that changes in medical prices explained almost 75 percent of the change in total personal health care spending in the U.S. between 2009 and 2010, up from about 45 percent of the total change between 2000 and 2006 and from about 55 percent over the 2007 to 2009 period. At the same time, consistent with the slowdown in utilization growth that began prior to the recession and accelerated during the economic downturn, utilization and intensity changes have been declining in importance as a driver of spending growth, accounting for 43 percent of the change in spending between 2000 and 2006 but explaining only 3 percent of health spending growth between 2009 and 2010.[15]

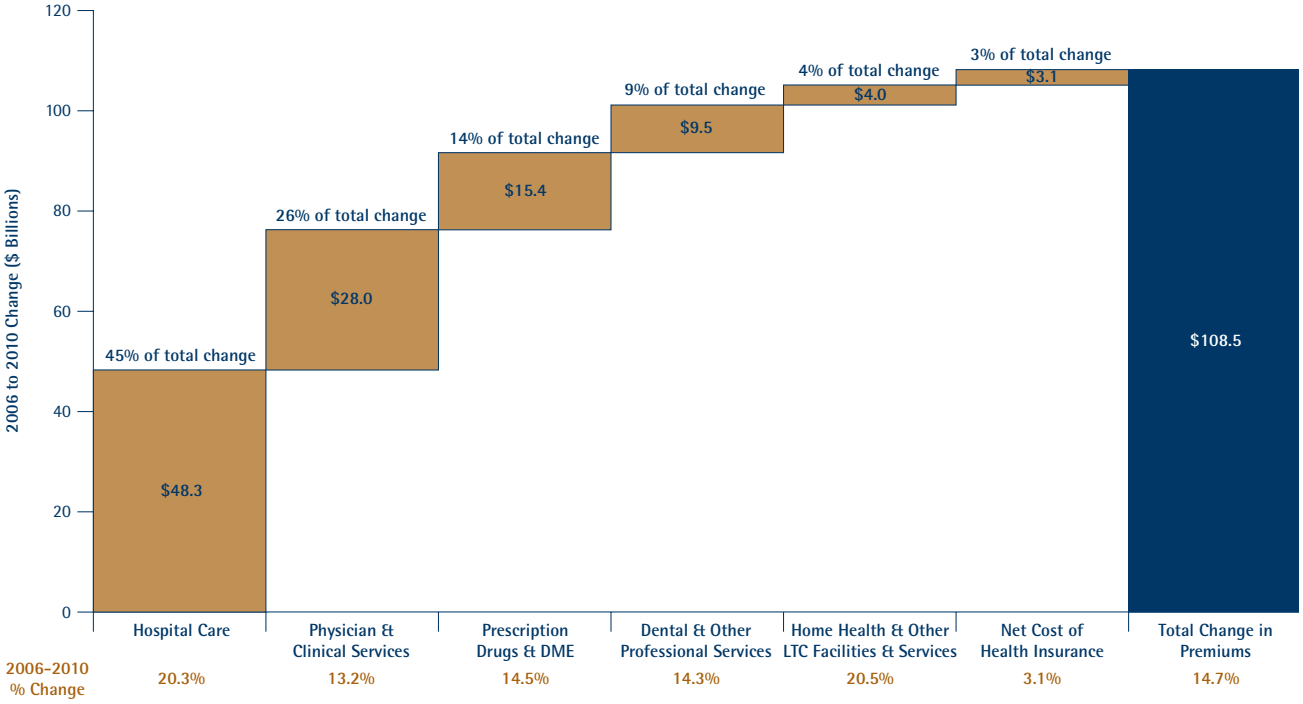
FIGURE 8. AGGREGATE NATIONAL SPENDING ON PRIVATE HEALTH INSURANCE, 2006-2010



NIHCM Foundation analysis of data from the National Health Expenditure Accounts.

Rising unit prices have been similarly important in explaining the recent growth in spending for private health insurance. For example, a PricewaterhouseCoopers analysis estimated that 75 percent of the growth in private health insurance premiums between 2006 and 2007 was due to price factors.[16] Based on an examination of its own claims history, UnitedHealth Group concluded that more than two-thirds of its higher spending between 2009 and 2010 was due to upward pressure on unit prices, particularly in the inpatient and outpatient sectors, rather than higher utilization.[17] Milliman's analysis of data for their 2011 medical index found that unit price increases in the inpatient, outpatient, pharmacy and physician sectors accounted for most of the growth in spending between 2010 and 2011,[18] while their 2012 report noted ongoing increases in the cost of an inpatient day but no growth in utilization.[19] And Aon Hewitt's analysis of data from 26 private health plans found that more than 70 percent

FIGURE 9. RELATIVE CONTRIBUTION OF INDIVIDUAL SECTORS TO RISE IN PRIVATE PREMIUMS, 2006-2010



NIHCM Foundation analysis of data from the National Health Expenditure Accounts.

of the "core trend"[vi] for employer-based and individually purchased coverage over the 2007 to 2010 period was driven by price increases.[20]

Several other recent detailed analyses that have used claims from multiple private payers also demonstrate the importance of price increases as the main driver of overall spending growth for private insurance.[21,22,23] In the first study, the Massachusetts Division of Health Care Finance and Policy used data from the five major carriers responsible for the vast majority of private coverage obtained by state residents to examine the relative contribution of volume, service mix and unit price changes to annual spending increases for inpatient, outpatient, and physician services between 2007 and 2009.[vii] In the other analyses, the Health Care Cost Institute (HCCI) drew upon data from several large national insurers to conduct a similar investigation covering the 2009 to 2011 period.[viii]

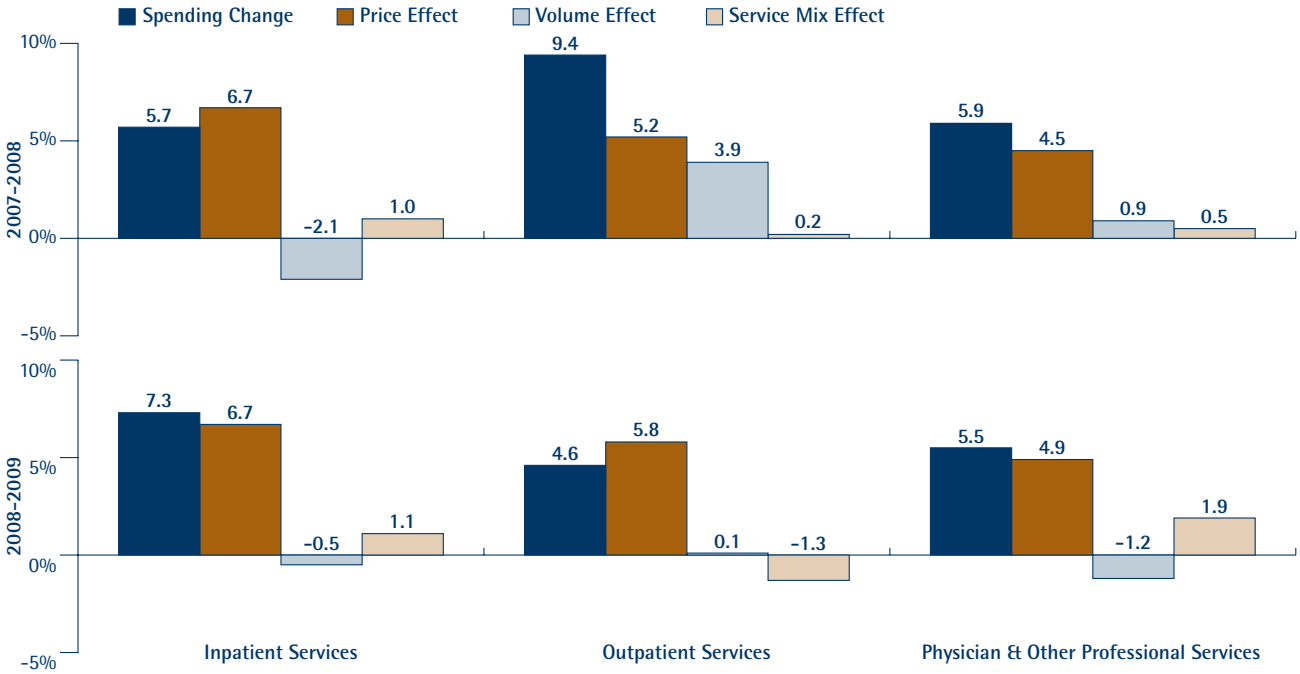
Results shown in Figures 10 and 11 demonstrate the clear importance of price changes. Across all types of services considered, across all four annual periods, and across a variety of private payers, rising prices accounted for the majority of the higher spending. In a number of

vi Core trend, defined as the annual rate of change in the use and cost of health care services, is a key determinant of premium changes. Other factors that might cause premiums to change from year to year, such as changes in the demographic composition of the covered population or changes in benefits, are not included in the core trend.

vii The Massachusetts work used data from Blue Cross Blue Shield of Massachusetts, ConnectiCare, Harvard Pilgrim Health Care, Health New England, and Tufts Health Plan. For inpatient and outpatient services, total spending increases were decomposed into the portions attributable to changes in the volume of services, changes in the mix of services, changes in unit prices, and changes in the mix of providers used (designed to capture possible shifts to use of higher-priced providers). Because it was not possible to separate the unit price changes from the shift in the provider mix for physician services, these two factors have been combined into a single price effect in Figure 10 for inpatient and outpatient services in order to facilitate comparisons across service types. The shift to a more expensive set of providers was responsible for only a very small portion of the reported price impacts for inpatient and outpatient care, adding only 0.1 to 0.3 percentage points to unit price impacts that ranged from 5.1 to 6.5 percent.

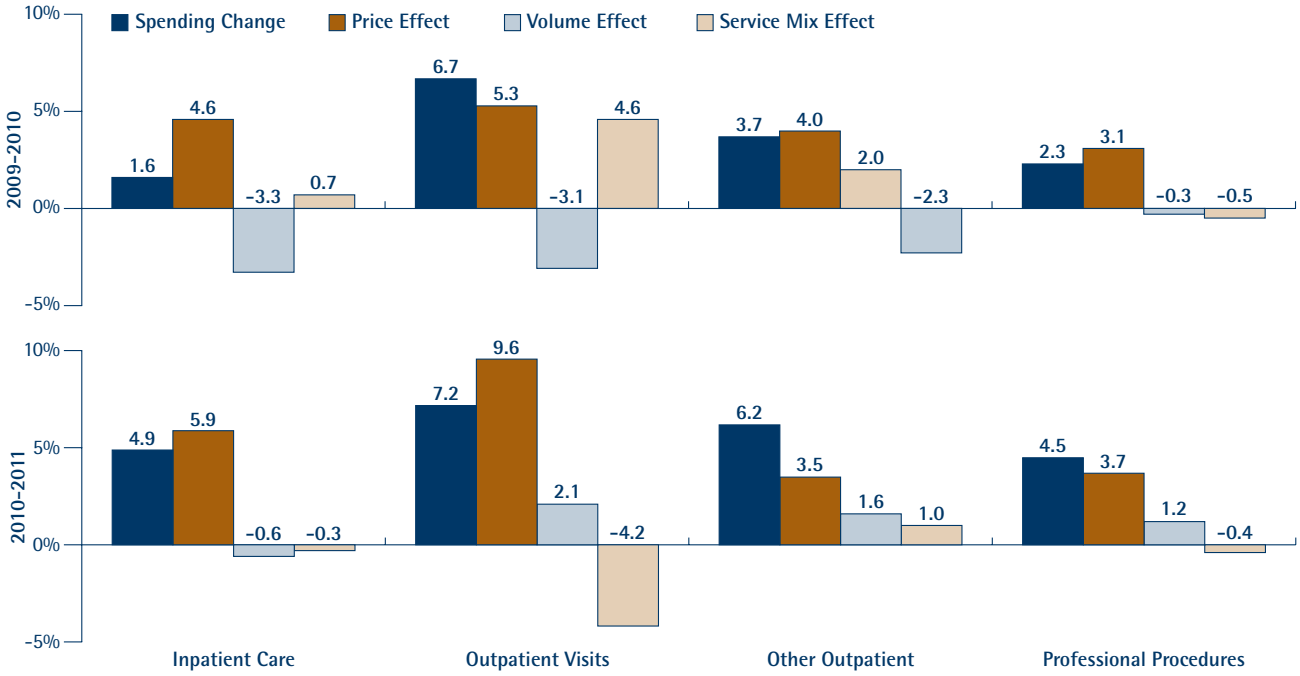
viii The HCCI work decomposed overall spending growth into the portions due to utilization changes, intensity or service mix changes, and an "intensity-adjusted" price factor representing changes in unit prices.

FIGURE 10. RELATIVE IMPACT OF UNIT PRICE CHANGES, MASSACHUSETTS, 2007-2009



Source: Massachusetts Division of Health Care Finance and Policy. " Massachusetts Health Care Cost Trends: Trends in Health Expenditures." June 2011.

FIGURE 11. RELATIVE IMPACT OF UNIT PRICE CHANGES, SEVERAL NATIONAL PAYERS, 2009-2011



Source: Health Care Cost Institute, "Health Care Cost and Utilization Reports: 2010 and 2011," May and September 2012.

instances, rising prices would have driven spending even higher than it actually was had there not been significant offsetting reductions in utilization or intensity of use.

CONCLUSION

Premiums for private health insurance continue to rise, driven principally by rapid increases in the prices that private insurers pay to health care providers for services delivered to their enrollees. Indeed, rising aggregate payments to providers were responsible for 97 percent of the increase in national spending on private premiums over the past five years, with burgeoning payments to hospitals, physicians and laboratories accounting for more than 70 percent of the higher spending. As premiums rise, those who receive health insurance through an employer are being called upon to shoulder an increasing share of the premium explicitly, and they also face rising out-of-pocket costs through ever-more-prevalent and rising deductibles. Those who purchase their coverage directly in the non-group market are also experiencing premium increases, tempered in part by a very quick increase in deductible levels and an on-going shift into high-deductible plans that qualify for tax-advantaged health savings accounts. When the full cost of the premiums and all out-of-pocket spending is considered, an average family of four with employer-based coverage now spends nearly $21,000 per year on medical care. The fact that this amount has been rising much more quickly than their earnings and general inflation adds urgency to the elusive task of finding ways to curb the growth in health care spending.

Numerous provisions contained in the Affordable Care Act (ACA) are expected to affect how Americans obtain private health insurance and how much money is spent for it. Most notably, the establishment of health insurance exchanges and the availability of premium subsidies will transform the individual and small group markets starting in 2014 and could begin to affect the provision of health benefits by larger employers if states opt to open their exchanges more broadly in 2017 as permitted by law. Although there are currently significant differences of opinion about the extent to which employers will decide to move their workers into exchanges, some transitioning of lower income workers into the subsidized exchanges seems likely despite the penalties employers will have to pay if they stop providing coverage to these workers. Insurance reforms requiring guaranteed issue and limiting rate variation by health status are intended to make coverage more accessible, while new rules about essential benefits and actuarial value will change the nature of insurance products offered. The individual mandate should further encourage people to obtain coverage, but the small starting value for the penalty coupled with considerable popular resistance to a government mandate may limit the effectiveness of this provision, at least initially. The Supreme Court's decision permitting states to opt out of the ACA's planned expansion of Medicaid means that many adults with incomes between 100 percent and 138 percent of the federal poverty level may now be seeking subsidized private insurance in the exchanges instead of relying on new Medicaid coverage. The excise tax on high-premium "Cadillac" health plans that will begin in 2018 should temper the incentives to provide excessively generous benefit packages and inject more cost sensitivity into the market, as should the stepped up rate reviews and requirements to meet minimum thresholds for medical loss ratios. Finally, the law contains many features intended to improve the value of our health care spending by transforming delivery and payment systems. If successful, initiatives such as accountable care organizations, bundled payments and patient centered medical homes will moderate the rate of health care spending growth and ease inflationary pressures on private premiums.

These ACA changes will be implemented in the context of – and interact with – other dynamics that are already evolving quickly in the private health insurance market as employers and employees seek to curtail rising premium costs. For instance, new data from AHIP's annual census of HSA-eligible high deductible plans indicate rapid growth in these products, with enrollment tripling over the past five years and now standing at more than 13.5 million Americans. Strikingly, although these products were initially popular in the individual and small group markets, most of the recent enrollment growth has been in the large group market.[24]

At the same time, employers also are beginning to shift from defined benefit health insurance to defined contribution plans, in which they provide employees with a fixed amount of money that can be used

to purchase health insurance. In conjunction with this shift, we are seeing rapid development of new private exchanges, arising as the marketplaces where employees use their defined contributions to shop for the health plan best suited to their needs. Whether and how these private exchanges interact with the public exchanges coming on line in 2014, and what this might mean for the provision and cost of private health insurance, remains to be seen.

There is also a growing interest among mid-size and even smaller employers in self-insuring. This impetus is due partly to improvements in the market for stop-loss insurance that make self-insurance less risky and partly to the fact that self-insured plans are exempt from several important provisions of the ACA and most state insurance regulations. Recent research has pointed out that if a growing number of smaller firms with younger and healthier workforces respond to the incentives and opportunities to self-insure, the resulting adverse selection is likely to disrupt the small-group risk pool, raise premiums and lead to spiraling market destabilization.[25,26]

Lastly, the market for private health insurance might be changed dramatically if the current premium tax exclusions are reduced or eliminated or if the ACA's Cadillac tax is accelerated in a broad overhaul of the federal tax code as part of deficit reduction efforts. Developments on all of these fast-moving and interrelated fronts will bear watching carefully in the coming years.

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ABOUT THIS BRIEF

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Part of the Foundation's larger research focus on health care spending, this document is the fourth in a series of briefs presenting current data and analysis on selected topics relevant to discussions of our nation's high and rising health care spending. Three earlier briefs provided an overview of health care spending in the United States (May 2012), examined government spending for health entitlement programs (June 2012), and explored the concentration of health care spending within a small portion of the population (July 2012).

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