HEALTH INSURANCE PREMIUM TREND STUDY - BACKGROUND MEMORANDUM

INTRODUCTION

Section 3 of House Bill No. 1106 (2019) (Appendix A) directs a study of ways the state may be able to positively affect the current trend of health insurance premium rates increasing, with a focus on the high-risk and subsidized markets. The study must be solution-based to reduce costs and may include consideration of whether a strict managed-care model might be effective.

LEGISLATIVE HISTORY

House Bill No. 1106 was introduced at the request of the Insurance Department. Sections 1 and 2 of the bill direct the Insurance Commissioner to apply for a federal Affordable Care Act (ACA) Section 1332 Innovation Waiver to establish an invisible reinsurance pool for the individual health insurance market to limit the amount of risk insurance companies assume for the high-risk North Dakotans the companies insure.

The goal of the invisible reinsurance pool is to reduce health insurance premiums in the individual market, making insurance more affordable, while protecting insurers from unpredictable high-cost claims that significantly contribute to the rising cost of health insurance. This is accomplished by using a reinsurance mechanism to help fund high-cost claims. The Insurance Commissioner testified the invisible reinsurance pool should result in double-digit decreases in the cost of health insurance in the individual market, resulting in more individuals staying in the market, some individuals who left the market due to unaffordability of health insurance returning to the market, and more insurers being willing to write policies in North Dakota counties. Ultimately, the invisible reinsurance pool will help to stabilize the individual health insurance market in the state.

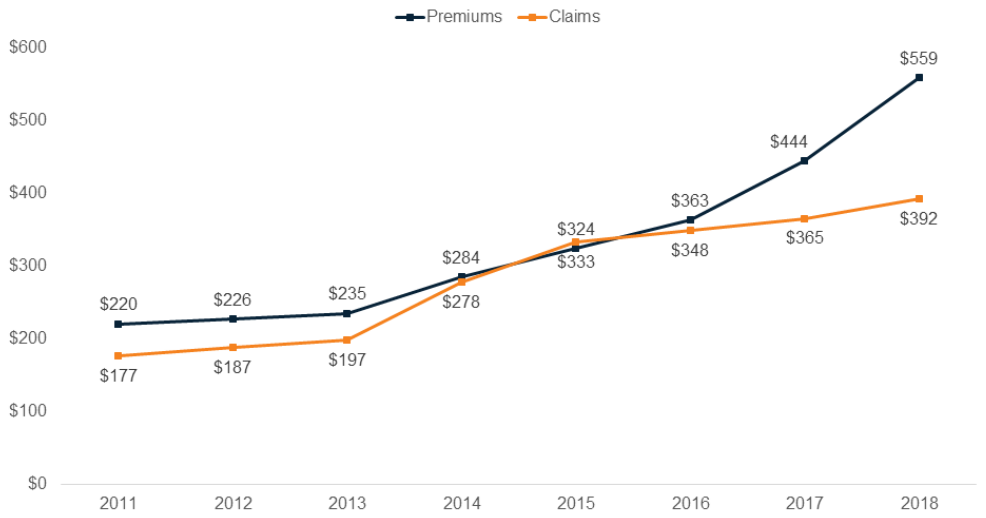
Section 3 of the bill, which provides for this study, was added to the bill by the House, as was Section 4, which provides for an expiration date of December 31, 2021. The legislative history indicates a goal of the study is to look at long-term solutions to the problem of the trend of increasing health insurance premiums. In addition, Section 15 of Senate Bill No. 2010 (2019) (Appendix B), the Insurance Commissioner's appropriation, directs the Insurance Department to assist the committee with the study and to conduct a detailed analysis of health care in the state.

BACKGROUND

Premium rates for the individual health insurance market have continued to increase under the ACA. In May 2019, the Kaiser Family Foundation published the report *Individual Insurance Market Performance in 2018* (Appendix C). The following chart from this report shows the average individual market monthly premiums and claims for 2011 through 2018:

Figure 3

Average Individual Market Monthly Premiums and Claims Per Person, 2011 - 2018



Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates Health Coverage Portal TM

On average, premiums per enrollee grew 26 percent from 2017 to 2018, while per-person claims grew only 7 percent.

Cost-Sharing Reduction Subsidies

On October 12, 2017, President Donald Trump signed an executive order that terminated cost-sharing reduction (CSR) subsidies. The CSR subsidy is the smaller of two subsidies paid under the ACA. The CSR subsidy was paid from 2013 to 2017 to insurance companies on behalf of eligible enrollees in the ACA earning 100 to 250 percent of the federal poverty level to reduce copayments and deductibles. The report attributes this growth in 2018 premiums in part to the loss of the CSR subsidy payments, as insurers are required by law to provide cost-sharing subsidies to eligible enrollees but are no longer being reimbursed by the federal government.

One concern about rising premiums in the individual market is the increased premiums may cause healthy enrollees to drop out of the market instead of paying the high premium rates. Although a majority of ACA exchange enrollees are subsidized and therefore sheltered from paying premium increases, those enrolling off-exchange pay the full increase in premium. However, despite this dynamic, the average number of days individual market enrollees spent in the hospital in 2018 was slightly lower than inpatient days in the previous 3 years.

Health Care Expenditures

Testimony on House Bill No. 1106 stated health care expenditures drive health insurance premiums. The Insurance Commissioner identified the following top five drivers of health care cost increases reported by carriers for 2017:

1. Prescription drugs;
2. Physician services;
3. Outpatient services;
4. Mental health and chemical dependency services; and
5. Diagnostic imaging.

Every 5 years the Centers for Medicare and Medicaid Services gathers and reports data on health care expenditures, breaking down health care expenditures in the following categories:

- Hospital care;
- Physician and other professional services;
- Prescription drugs and other medical nondurables;
- Nursing home care;
- Dental services;
- Home health care;
- Medical durables; and
- Other health, residential, and personal care.

The most recent Centers for Medicare and Medicaid Services report, containing data for years 2010 through 2014, reported North Dakota's expenditures in millions. Hospital care continues to be the state's largest health care expenditure, followed by physician and other professional services and prescription drugs and other medical nondurables.

	2010	2011	2012	2013	2014
Hospital care	$2,514	$2,974	$3,142	$3,528	$3,827
Physician and other professional services	$1,231	$1,266	$1,367	$1,400	$1,461
Prescription drugs and other medical nondurables	$794	$775	$755	$800	$869
Total of all factors	$6,021	$6,454	$6,765	$7,310	$7,841

The American Medical Association reports:

> Health spending in the U.S. increased by 3.9% in 2017 to $3.5 trillion or $10,739 per capita. This growth rate is lower than what was observed in 2016 (4.8 percent) and 2015 (5.8 percent). After a period of relatively fast growth in 2014 and 2015 during the implementation of the Affordable Care Act, 2017 was characterized by slower growth that continued from 2016. In fact, growth in 2017 was similar to the 3.7 percent average

annual rate of the 5-year period ending in 2013. These growth rates are the lowest since the early 1960s when health spending was first tracked in its current format.

Managed-Care Model

Managed care is a health care delivery system organized to reduce the cost of providing health care and providing health insurance while improving the quality of that care. Managed care can take several forms, including integrated delivery systems, exclusive provider organizations, preferred provider organizations, and health maintenance organizations.

During the 2017-18 interim the Health Care Reform Review Committee studied options to operate the state's public benefits programs as managed care. Although the committee studied this topic in depth, the committee did not make any legislative recommendations to direct public benefits be provided through a managed-care model.

STUDY APPROACH

In conducting the study the committee will receive the assistance of and reports from the Insurance Department as the Insurance Department conducts its detailed analysis of health care in the state. In addition, the committee may wish to consult with heath care providers, hospitals, health insurance carriers, the Public Employees Retirement System, the Indian Affairs Commission, and the State Department of Health.

ATTACH:3