Premium Hikes: No Cause for Celebration

Lost market share and further erosion of public trust will be the long-term by-products of this short-term solution.

By Frank Diamond
Senior Editor

What's missing in recent reports of HMOs seeking 20- to 22-percent increases in premiums is just how less-than-thrilled health plans are to be asking for that much more money. "Any rate hike will obviously be tough on all insurance products within a given region just because the economy is too slow for employers to accept huge rate hikes," says Thomas Morrow, MD, medical director at One Health Plan of Georgia. Employers, once again, are wondering whether it is worth it.

No industry wants to deal with unhappy consumers, says Jonathan T. Lord, MD, senior vice president and chief clinical strategy and innovation officer at Humana. "Significant increases aren't good for anybody. Employers are facing a significant dilemma about health benefits and how to contend with health benefits increases."

Companies will be inclined to ask health plans to help them solve that dilemma, says Brad Kimler, a health care consultant at Hewitt Associates.

"In the short-term, premium hikes will improve what has been a pretty volatile bottom line across the industry, but they do put more immediate pressure on health plans for innovative new products and they do raise the specter of loss of market share to other traditional solutions, like self-insured PPOs or even self-insured HMOs and POS products," says Kimler. "These numbers represent the initial HMO rates that health plans are requesting based on their underwriting formulas. These numbers will be negotiated by the employer, but this usually includes making plan design changes, such as increasing copays."

It was Hewitt Health Resources that first warned about premium increases in the 20-percent range. On June 4, it released data from a survey that said that HMOs have asked for premium increases of about 22 percent on average for next year. Hewitt collected the information from 140 large employers with a total of more than 1 million workers.

"Health Insurers Are Seeking 20% Rate Rise," warned a headline in the *New York Times* the next day. There followed a story in which employers and employer consortiums expressed dismay and concern.

On June 18, a UCLA Anderson Forecast survey, in which 460 employers were polled, showed that those companies are also bracing for 20-percent increases. The *Los Angeles Times* ran a story in which the owner of a small business — ironically a medical equipment service company — complained that his health care bill jumped 45 percent over last year.

And on June 20, the *Philadelphia Inquirer* reported on a Mercer Human Resource Consulting study that, again, cites the 20-percent mark. "We do not foresee any relief anytime soon in these rising costs," Mercer spokesman Jim DiGuiseppe warned. "The name of the game [for insurers] has switched from building market share … to making a buck."

Making HMOs look bad

Naturally, the escalation of premiums feeds the public's inclination to view HMOs as the bad guys.

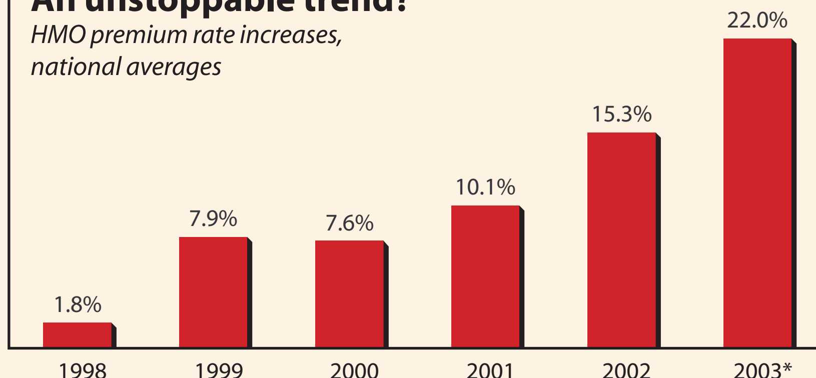
"Sometimes, people look at their health plan and say, 'Why are you charging me more money?'" says Mohit Ghose, a spokesman for the American Association of Health Plans. "But that's a very simplistic viewpoint because HMOs and other types of health plan don't just arbitrarily set rates."

He says that, for the size and importance of the industry, managed care has not made a bundle of money.

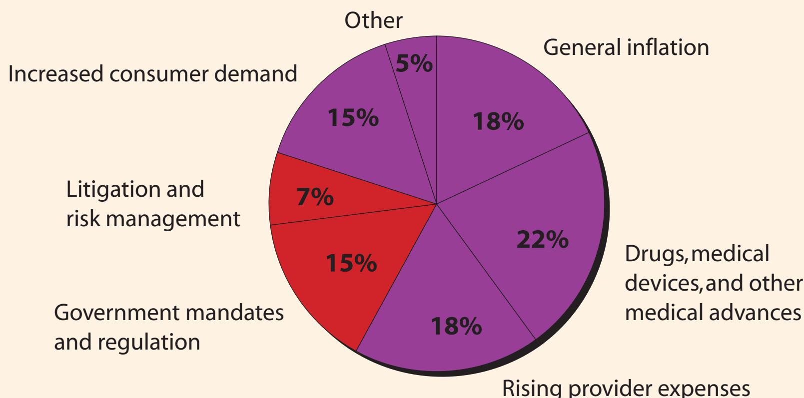
"We're working very diligently toward making sure that people know that there's 27 cents out of

Premium hikes: Short-term balm, long-term headache

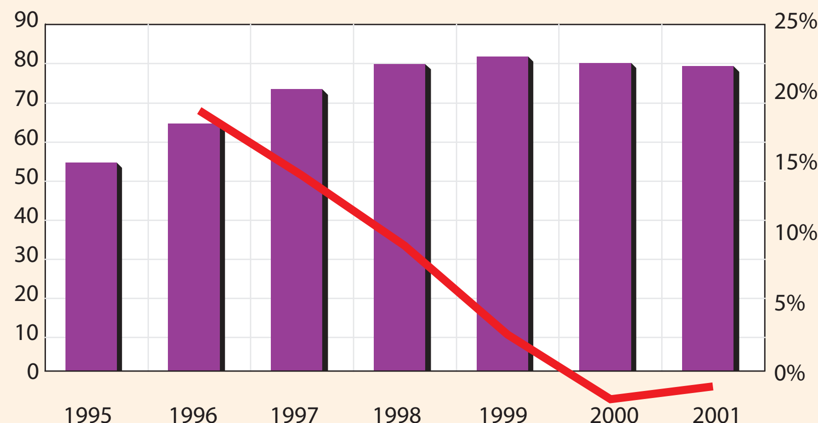
A Hewitt Associates survey of 140 employers with a total of 1 million workers found that HMOs are seeking to raise premium rates by as much as 22 percent in 2003. However, these national averages will most likely be bargained down during contract negotiations: For 2002, the mean initial rate, 19.1 percent, eventually fell to 15.3 percent, according to Hewitt.



Still, it's a safe bet that the increases for 2003 will wind up being even more than last year. The American Association of Health Plans hired Pricewaterhouse Coopers to pinpoint the reasons for the increase. Pricewaterhouse found that premiums rose 13.7 percent in 2002, a little less than Hewitt's 15.3 percent figure. Here's where Pricewaterhouse says the 13.7 percent increase is being spent.



What happens in California cannot necessarily be extrapolated. Still, it may be instructive to recall that when CalPERS was hit with a 25.1-percent premium increase for 2003, that buyer group opted to eliminate contracts with Health Net, PacifiCare, and Health Plan of the Redwoods, narrowing the number of health plans it contracts with from seven to four. Many analysts believe that there is a trade-off between premium rates and market share.



each new health care premium dollar that's going toward things that can be eliminated or controlled."

The 27 cents Ghose cites is the amount of premium dollar that is spent on litigation, government regulation, or fraud, according to a Pricewaterhouse Coopers study funded by the AAHP. (See "Premium Hikes: Short-Term Balm, Long-Term Headache" on page 29.)

A similar study prepared by the Juran Institute and the Severyn Group for the Midwest Business Group on Health found that administrative inefficiencies, underuse, and misuse of medical services wastes 30 cents of every health care dollar.

"There are areas that we can actually control," says Ghose. "We can declare moratoriums on mandates. We can work to reduce fraud and abuse, and we can work to stop frivolous litigation that's not only driving health care costs up but also driving a lot of physicians out of business."

Small-group market

There even exists some doubt in the industry concerning the short-term benefits of significant premium increases.

"HMOs are not going to make any more money just because their costs are higher," says Paul Ginsburg, PhD, president of the Center for Studying Health System Change, a research organization in Washington, D.C. "To the degree that part of the premium increase reflects growth of their margins, that, of course, is good for them. But the part that reflects that the underlying costs are going up, that's not good for them at all and really a negative. Particularly, plans that are in the small-group market have to anticipate that they and their competitors together are going to lose business as some employers will inevitably drop coverage or employees won't take it up."

For the record, based on what he's heard from some prominent health care experts, Ghose expects premiums to rise from 12 to 15 percent in 2003.

Ginsburg, however, believes that much can be deduced from the opening bids: "Even if HMOs will eventually settle for less, employers wouldn't have expected these opening quotes to be up to 20 percent. They may expect them to be up 10 percent, maybe. After bargaining, employers could well pay a higher increase in 2003 than they did in 2002 and given how that compares to growth in wages or general inflation, that's a huge gap."

But Ginsburg says that HMOs, for the most part, just can't relieve the financial pressure any other way.

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> **— Paul Ginsburg, PhD, Center for Studying Health System Change**

"With the loosening of restrictions on care, those plans that had the most restrictive policies are being affected the most," says Ginsburg.

Kimler points to the pressure that HMOs are under to be profitable, and their years of underwriting costs to gain market share.

"There's clear evidence that their costs are increasing more rapidly than ever before," he says. "On top of that, they have also been squeezed in terms of their margins over the last three or four years. So, certainly, they're trying to recover and get back to a reasonable return on their investors' equity."

What will employers do?

Employers aren't convinced that they'll get more for the extra they'll have to pay, says Morrow, the medical director. "That's the big issue. How can we show value for the premium hikes? If we can turn a 15- or 13.7-percent rate hike into a 20-percent productivity increase, they're all for it. But all they see are rate hikes."

Not that HMOs aren't struggling to prove their value.

"We're certainly putting more resources into disease management and outcomes measurement," says Morrow. "We're putting more effort into trying to design benefit packages that maximize the efficacy of care for those people who would otherwise end up with higher costs and minimizing the impact on the employers of lifestyle issues."

How CalPERS reacted to rate increases

When the California Public Employees' Retirement System (CalPERS) was forced to swallow a premium-rate hike of 25.1 percent for basic HMO plans for 2003, the broker for 1,400 public agencies warned of a crisis nationwide for companies that will not be able to drive so hard a bargain. However, it is specifically CalPERS's historical ability to drive hard bargains that diminishes it as a bellwether, many experts believe. In other words, CalPERS was due.

"They were ripe for a big increase because of their having had so much success as negotiators in the past," says Paul Ginsburg, PhD, president of the Center for Studying Health System Change.

CalPERS spokesman Clark McKinley has another explanation, describing CalPERS as the "loss leader" in the '90s. "HMOs signed with us to beef up their enrollments, sometimes for below their actual costs. Some HMOs said during negotiations for 2003 that they had lost money on CalPERS. Market experts like Mark V. Smith of the California Healthcare Foundation tell us that the game changed from getting numbers to getting better profit margins."

Thomas Morrow, MD, medical director at One Health Plan of Georgia, is inclined to agree with Ginsburg, while also alluding to "really strange market dynamics" in the Golden State. "You can't really compare what happened with HMOs in California and what may happen in the rest of the country."

Still, just to be on the safe side, it may be instructive to review how CalPERS reacted. In 2002, CalPERS reduced the number of insurers it contracts with from 10 to 7. For 2003, the number is being further reduced to four, with Health Net and PacifiCare being dropped. Also, on June 19, CalPERS's board of administration voted to drop Health Plan of the Redwoods because of that plan's bankruptcy filing.

In addition, CalPERS is considering a new type of benefit that would entail contracting with just two or three insurers that would offer an HMO option and another benefit plan in each county.

The public employer group is also considering switching to a self-funded pool that would be managed by a third-party administrator.

One of the two models could be phased in as early as 2004.

Kimler agrees that employers will want to see some innovative approaches.

"Employers are asking health plans, 'What kinds of new solutions can you deliver to me, because with the double-digit increases, I'm back to paying 100 percent benefit for something that I'm no longer receiving discounts from."

Prescription drugs are a major reason for the increases, but hospital costs are also a huge contributor.

Hospitals, Kimler contends, are saying something like: "I don't know why I'm giving Health Plan A a better discount than Health Plan B, since nobody's providing me any additional market share. So, I'm just going to give everybody a common rate, and it's going to be higher than what anybody's paying me today."

Does choice really cost more?

Humana answered the question about what employers will do by asking it of itself. "We realize that we are a large employer, too," says Lord. "We have about 14,000 associates who work for the company and we face the same pressure that every other employer does, which is double-digit increases in our health care costs."

The answer, Humana officials hope, is that a novel approach to benefit design can not only provide more choice, but can cut costs and keep premiums in check. (See "Humana Uses Its Employees As 'Test' Population" on page 33.) One of the programs that the plan tested on its employees has since been launched in the marketplace; data showing how it has fared will not be available until the fall. Still, even in the preliminary stages, the health plan has learned some interesting things, Lord says.

For instance, Humana took on the maxim that choice costs more.

"One of the paradoxes that exists in the business is that while we see increasing numbers of uninsured, the people with insurance probably have too much insurance," says Lord. "For our company, which is pretty consistent with most large companies, about 70 percent of our employees spend $500 or less on health care. So, we've built plans that allow people to tailor benefits that probably cost them less than they did last year. Part of the reason for this sort of unending march of large double-digit premium increases is because people haven't been engaged."

In mentioning the uninsured, Lord touches on

the problem that Morrow says will be most exacerbated by significant premium increases.

"Every increase in premiums causes an increase in the uninsured and that's a bigger problem," says Morrow. "What's happening is that employers are starting to shift some of those dollars to the patient. When that happens we're going to see a lot of people say, 'I'll take my chances with my health and keep the money.' That's scary because at that point, those patients still have medical care; they just don't pay for it. Somebody has to pay for it. It's endured by society in other ways and it's a hidden tax on the system."

Educate the consumer

Every expert contacted says that much of the response to premium rate increases must come at the utilization end of health care. In other words, to dredge up a term that's already become somewhat hoary: the educated consumer. Whether this ideal can actually be attained is the subject of much debate.

After all, Humana's in-house success with its innovations may have much to do with the fact that its captive audience, by the nature of the business it does, needs to be an educated consumer. One would assume that people working at a chocolate factory know more about chocolate than those working at the software manufacturer down the street.

However, Kimler believes that HMOs may be getting an unexpected ally in this attempt to educate consumers: employers. He sees a subtle shift in the "blame game."

"What more and more employers are saying is that these premium hikes are not necessarily the HMO's fault," he says. "It's a function of how expensive health care is. Health care is produced by the pharmaceutical manufacturers, the hospitals, and the physicians. And that's where we've got to get transparency of costs out there for employees." MC

Humana uses its employees as "test" population

Humana realizes that it has a ready-made large employer at hand upon which the health plan can test benefit designs whenever it wants — namely itself, says Jonathan T. Lord, MD, senior vice president and chief clinical strategy and innovation officer at the health plan.

Humana faces the same pressure that every other employer does — double-digit increases in health care costs.

Lord believes that one of the problems with rising premium rates has been the uncreative and boring manner in which health plans have reacted in trying to control underlying costs.

"Most of the adjustments have been to tweak the copays or the coinsurance," says Lord. "Simply taking benefits away is not a good strategy to deal with these increases in costs."

Two years ago, the health plan introduced a new approach.

"We went from a model where we gave our employees a choice between an HMO and PPO to one that gave them more choices, which we called SmartSuite," says Lord. "That's a product for the commercial market today."

In May 2002, Humana also introduced SmartSelect for its employees. This innovation, says Lord, allows for a customizable benefit design at the individual level.

"SmartSuite was going from two options — an HMO and a PPO — to six options," says Lord. "SmartSelect is going from those six options to being completely customizable." SmartSelect has not yet been put on the market.

These sorts of designs, Lord hopes, will be breakthroughs. "Essentially, this means that there are 42 possible plan designs that people can have, but they don't have to make one choice out of 42," says Lord. "Each one of us has different families, and different family types, and different needs. The old system of there being just one HMO, or one PPO, or one choice, which is sort of an oxymoron, didn't fit anyone's needs."

The premise is to create a system where engaged consumers make choices that are right for them, says Lord.

Humana launched SmartSuite in May 2001 and has tracked the savings. "What we saw in the marketplace was about a 19-percent increase in medical expense," he says. "With about eight months of claims experience, since July 2001, that is down to the single digits."

Can something that works at a health plan also work at a textile mill? That remains to be seen.

Lord says that Humana doesn't have numbers for its outside clients yet, since SmartSuite has been in the marketplace only since January.

"That means they really only have about five months of claims experience thus far — not enough to really give a definite and accurate response to that question," says Lord. "We should have a better idea of success by August or September."