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# Cost and Benefit Trends Observed in July 1, 2011 Renewals for State Employers

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State employer health plans face complex cost dynamics as they plan for the future. Our article "Cost and Benefit Trends Observed in Jan. 1, 2011 Renewals for State Employers" in the January 2011 issue of *Health Watch* examined these dynamics and the plan changes that the 27 state employers with Jan. 1 anniversary dates implemented as of Jan. 1, 2011.

Of the remaining states, 21 renew their employee health plans on July 1. One state renews on Sept. 1 and one on Oct. 1. The appendix shows the 21 states that renew their employee health plans on July 1. For each state we summarize its plan offerings and its observed premium trends and benefit changes implemented on July 1, 2011.

We observed lower benefit-adjusted premium trends for the July 1, 2011 renewal states than for the Jan. 1, 2011 renewal states. Some of this observed decrease could simply be due to differences between the two groups of states or to random variation. This article addresses several other possible explanations for the differences.

## Comparing July 1 Renewal Trends to Jan. 1 Renewal Trends

Figure 1 summarizes the trend data for the states in the appendix, and estimates the impact of benefit changes on observed trends.

**Figure 1: Premium Trend, State Employee Plans July 1, 2011 Renewals**

| Plan Type | July 1, 2011 Premium Trend | July 1, 2011 Benefit Change | July 1, 2011 Benefit-Adjusted Premium Trend |
|---|---|---|---|
| HMO | 2.4% | -1.2% | 3.6% |
| PPO | 3.5% | 0.2% | 3.3% |
| HDHP | -0.7% | -1.1% | 0.4% |

Includes data for the following states: Alaska, Colorado, Delaware, Idaho, Illinois, Louisiana, Maine, Maryland, Massachusetts, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Rhode Island, South Dakota, Utah, Virginia, West Virginia.
Connecticut was excluded because it delayed this year's start date to October 2011, because of union negotiations.

The same information for the states with Jan. 1, 2011 renewal dates can be found in our earlier article in the January 2011 issue of *Health Watch.*

We looked at trend separately for three plan types: health maintenance organizations (HMOs), preferred provider organizations (PPOs) and high-deductible health plans (HDHPs). Because the differences between HMOs and PPOs are becoming less distinct, and point of service (POS) plans fall somewhere in between, we defined an HMO plan to be a plan with an in-network deductible of $100 or lower and an HDHP plan to be a plan with an in-network deductible of $1,500 or higher. The premiums for HDHP plans with employer-funded spending accounts included the cost of that funding. The Premium Trend values in Figure 1 are averages. We applied equal weight to each state, and did not weight plans within a state by their membership.

The Benefit Change values are the average amounts that the premiums were reduced because of benefit changes such as increases in deductibles and co-pays. For each plan, the percentage premium reduction was estimated by pricing both the prior and new benefits using the Milliman *Health Cost Guidelines*™.

The Benefit-Adjusted Premium Trend values are the estimated average premium trend rates that would have occurred if no benefit changes had occurred. These represent a better estimate of the underlying utilization and cost trends for these plans.

### *Observations on Premium Trends*

Comparing the July 1, 2011 benefit-adjusted premium trends in Figure 1 to the Jan. 1, 2011 values in our earlier article shows a surprising decrease in observed trends. Specifically, the average Benefit-Adjusted Premium Trends for Jan. 1, 2011 renewals were 8.4 percent, 9.7 percent and 9.8 percent for HMO, PPO and HDHP, respectively. Some of this observed decrease could simply be due to differences between the two groups of states or to random variation. The following are additional possible explanations.

***1. Experience-based rating and the impact of economy***

For large groups, such as state employee plans, the new premium as of July 1, 2011 is based on the group's own experience for a recent 12-month period. Assuming the carrier calculates this rate in March 2011, this period might be the 12 months ending June 30, 2010. This historical cost is then adjusted for a variety of factors, most importantly the expected trend from the experience period to the premium period. This can be written as follows, where PY12 indicates the plan year starting July 1, 2011 and ending June 30, 2012:

***PY12 PMPM Premium = (PY10 PMPM Experience) × (Expected Trend from PY10 to PY12)***

The PY11 premium would have been calculated in March 2010 using a similar formula:

***PY11 PMPM Premium = (PY09 PMPM Experience) × (Expected Trend from PY09 to PY11)***

Using these two formulas, and breaking the expected trend factors into one-year factors, we see that the observed premium increase from PY11 to PY12 can be written as the product of three components:

The first component measures how well the carrier estimated PY10 costs, as an intermediate step when calculating the PY11 premium back in March 2010. The second component measures whether the carrier's expected trend from PY10 to PY11 has changed between March 2010 and March 2011. The third component is the carrier's expected trend from PY11 to PY12.

The second component is likely to be fairly close to 1.00, unless the carrier's expectation about provider contract increases from PY10 to PY11 changed significantly between March 2010 and March 2011. The third component, the carrier's expected trend from PY11 to PY12 as viewed in March 2011, is likely to be in the 7 percent to 10 percent range. Most surveys of carrier's future trend expectations are in this range.

Thus, the observed PY12 premium trends in the 4 percent range suggest that the first component would be in the range of -3 percent to -6 percent. In other words, actual PY10 experience was about 3 percent to 6 percent better than carriers expected when setting PY11 premiums. Given the economy during the period leading up to July 1, 2009, a downturn in health spending during the period of July 1, 2009 to June 30, 2010 is not surprising. Based only on our analysis of state plans, it appears that this downturn did not affect actual experience as much from Jan. 1, 2009 to Dec. 31, 2009, which is the experience period carriers probably used when setting Jan. 1, 2011 premiums.

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$$\textit{PY12 Premium Trend} = \frac{\textit{PY12 PMPM Premium}}{\textit{PY11 PMPM Premium}} =$$

$$\frac{\textit{(PY10 PMPM Experience)}}{\textit{(PY09 PMPM Experience)} \times \textit{(Expected trend from PY09 to PY10 from PY11 calculation)}} \times \frac{\textit{(Expected trend from PY10 to PY11 from PY12 calculation)}}{\textit{(Expected trend from PY10 to PY11 from PY11 calculation)}} \times \textit{(Expected trend from PY11 to PY12 from PY12 calculation)}$$

***2. Ability of states to smooth year-to-year premium trends***

Several states mentioned in their employee communication that their July 1, 2011 premium increases were lower than theoretically needed to cover expected costs during the period, with the shortfalls covered by existing surpluses. Given that many state employees have not received salary increases recently, it is apparent that states are trying hard to keep health premiums down. If the above theory about favorable experience in 2009 and 2010 is correct, self-funded plans would have built up some surplus during this period.

Several states had no change in July 1, 2011 premiums for multiple options from different carriers. Because the actual required increase, or decrease, would have been different for each option, this suggests that states made a specific effort to negotiate a 0 percent increase from insured carriers, and made adjustments as needed to produce a 0 percent increase for self-funded options.

***3. States dropping carriers/options with high trends***

Some states dropped carriers and options effective July 1, 2011. To the extent they dropped the options that would have led to the highest premium increases, this may artificially dampen our reported average trends, because we only reflected trends for options that continued on July 1, 2011.

Given the large differences between the observed trends for Jan. 1, 2011 and July 1, 2011 renewals, it will be very interesting to monitor the trends when Jan. 1, 2012 state plan premiums and benefits are announced. In the meantime, a few states have announced future premiums that provide anecdotal guidance.

Texas announced its Sept. 1, 2011 renewal premiums and benefits, with benefit-adjusted premium trends averaging about 6 percent.

Michigan announced its Oct. 1, 2011 renewal premiums, with trends averaging about 4.5 percent.

Among the Jan. 1 states, California is usually the first to announce premiums. The California Public Employees' Retirement System (CalPERS) recently announced that rates in 2012 will rise by 7 percent and 3.5 percent for its two HMO options. It noted that the 3.5 percent increase "includes an offset as a result of favorable claims experience." California's rates for its PPO with highest membership will rise by about 2 percent. None of these premium increases were significantly dampened by benefit changes, because the only major benefit change is a $5 increase in the brand drug co-pay.

## Observations on July 1, 2011 Benefit Changes

Delaware added a high-deductible option, and Nevada replaced its statewide PPO plan with a high-deductible option. Both feature a state-funded spending account. Other states have introduced high-deductible options in the past, although frequently without a state-funded spending account.

North Carolina moved a large portion of its members to the 70/30 Basic Plan by requiring that members who enroll in the 80/20 Standard Plan attest that they do not use tobacco and have a body mass index (BMI) less than 40, or are actively pursuing these targets.

There appears to be a trend toward states reducing the number of available options, and in making the benefits provisions more similar between options. For example, Ohio moved from five options to two options with the same plan design. Massachusetts modified benefits for several options so that all now have the same basic in-network cost-sharing structure.

Finally, states continue to make modest increases in co-pays, although many of the states made no changes to their cost-sharing provisions in 2011.

## Summary

The forces affecting large public sector plans are similar to those facing all large employers. Analyzing the premium and benefit trends reported by states provides useful data for carriers and large employers.

In combination with our previous article, this article provides an overview of the premium trends observed by almost all 50 states during 2011, and provides details on the benefit-design changes they are making to manage health costs. This view into the details of public employer health plans has only recently become available, with the compilation of data from all states, but will become more useful to public and private employers as a market-based resource for ideas of how to manage their own health care costs.

*Author's note: The information on plan designs and premiums summarized in these articles was obtained from public sources. All data is believed to be accurate, but we suggest that specific details be confirmed by the reader before acting on this information. This article is intended to be illustrative of the medical trend increases facing large employers, both public and nonpublic, around the United States, and the ways in which large public employers are responding to these trends.*

## Appendix: Details on State Health Plans Renewing July 1

These states represent a variety of plan types and geographic areas. They all share difficult budget situations and the need to minimize the growth of health costs. The premiums they negotiated and the program changes they initiated may be indicators of what to expect for the large group market in general.

The premium trends in the table in Figure A-1 are based on the total premiums as reported by the states, not just the portion of the premium paid by the employee. Also, these trends are based on the reported premiums, and are not adjusted to remove the impact of benefit changes. Earlier in this article we estimated the impact of benefit changes on the average reported trends for all of these states.

In Figure A-1 we do not identify changes in preventive services cost sharing. Most states removed this cost sharing this year, although some grandfathered plans did not. Also, some states already had $0 co-pays for preventive services. ■

***Figure A-1: Premium and Benefit Trends***

| STATE | PLAN OFFERINGS | PREMIUM TRENDS FOR 2012 PLAN YEAR | BENEFIT CHANGES FOR 2012 PLAN YEAR |
|---|---|---|---|
| Alaska | Alaska offers four PPO options through the same carrier: one with a deductible of $500, and three with deductibles of $250. | Premium increases ranged from 9% to 16%. | There were no material changes to any of the plan provisions. |
| Colorado | Colorado offers an HMO plan and three HDHP plans. | Premium increases for the plans ranged from 4% to 8%. | There were no material changes to any of the plan provisions. |
| Connecticut | Although Connecticut traditionally has a July 1 effective date, delays in union negotiations have pushed back its effective date to Oct. 1, 2011. | | |
| Delaware | In the 2011 plan year Delaware offered four options from two carriers: three $0 deductible plans and one $500 deductible plan. For 2012, two HDHP plans were added. | Premiums for the four existing plans were unchanged. | There were no material changes to the existing plans. The new HDHPs feature an employer- funded Health Reimbursement Arrangement (HRA). |
| Idaho | Idaho offers an HDHP, and two PPO plans with low deductibles. The plans are all offered through the same carrier. | Premiums were unchanged for all three options. | There were no material changes to any of the plan provisions. |
| Illinois | In the 2011 plan year Illinois offered seven HMOs and one PPO. Illinois went out to bid for FY2012 plans. It dropped two carriers, but retained one of them through Sept. 30, 2011, which is due to protest timing. There used to be a total of eight plans. Two existing carriers added new options. | Premiums decreased by 7% for the PPO and increased by 0% to 5% for the HMOs. | There were no material changes to any of the plan provisions. |
| Louisiana | In the 2011 plan year Louisiana offered one PPO, two HMOs and one HDHP. As of July 1, 2011, Louisiana added a new regional HMO. | Premiums increased about 6% for all plans. The new premiums, effective July 1, 2011, are for a short plan year, ending Dec. 31, 2011. | There were no material changes to any of the plan provisions. |
| Maine | Maine offers one plan with a $0 deductible. | Premiums were unchanged. | Maine raised specialist and emergency room co-pays, and introduced a 5% coinsurance rate for most other services. |
| Maryland | Maryland offers two PPO options, three exclusive provider organization (EPO) options and three POS options. The eight options are split between three carriers, but all have $0 deductibles, the same medical, and drug co-pays. | Premiums for the EPO options were unchanged. Premiums for the POS and PPO options increased 1% to 3%. | Drug co-pays increased from $5 to $10 for generics, from $15 to $25 for brands, and from $25 to $40 for non-preferred brands. |
| Massachusetts | Massachusetts offers 12 plans with a combination of low deductibles and co-pays. Only one plan also has coinsurance. | Premium increases ranged from 1% to 10%. | Plans with $400 deductibles reduced their deductibles so that now all plans offer a $250 deductible. |
| Nebraska | Nebraska offers one POS and three PPOs. | The PPO with the highest deductible, $1,000, had a 9% decrease in premiums. The other premium increases ranged from 0% to 6%. | The POS deductible and co-pays increased. Emergency room co-pays increased for some options so that all have the same $100 co-pay. One PPO decreased its generic drug co-pay. |
| Nevada | Previously, Nevada offered two regional HMOs and one statewide PPO. This year, it converted the PPO into an HDHP with a state-funded Health Savings Account (HSA) or HRA. | Premiums for the HDHP are similar overall to the 2011 PPO rates, although the rates for specific dependent tiers had large changes. For 2012, Nevada is using a composite premium for the two regional HMOs. | The PPO, formerly with an $800 deductible, 20% coinsurance and selected co-pays, moved to an HDHP with a $1,900 deductible and 25% coinsurance. The HDHP also has an annual state contribution to an HSA/HRA of $700 for the employee and $200 per dependent, with a maximum of $1,300. One of the HMOs previously had a deductible, which was dropped. |
| New Mexico | New Mexico offers four HMO options, with two different benefit designs. | Premiums were unchanged. | There were no material changes to any of the plan provisions. |
| North Carolina | North Carolina offers two PPO options from the same carrier. | Premiums were unchanged for both options. | There were no material changes to any of the plan provisions. A new restriction is in place for the 80/20 plan: members who enroll are required to attest that they do not use tobacco and have a BMI less than 40, or are actively pursuing these targets. |
| North Dakota | North Dakota offers one PPO. | Premiums for the PPO increased 16% (annualized) from its plan year 2010 rates. | There were no material changes to any of the plan provisions. |
| Ohio | Previously, Ohio had five plans with the same network benefits but differing provisions for non-network services. This year, it only offers one plan design, with two different carriers, based on region. | Because of the significant change in plans offered, it is difficult to determine a single trend increase. | The single plan design is a PPO, with no material changes to the in-network plan provisions. |
| Rhode Island | Rhode Island offers one HMO. | Premiums increased by 3%. | There were no material changes to any of the plan provisions. |
| South Dakota | South Dakota offers two PPOs and one HDHP. | Single premiums increased by 5%. | South Dakota dropped coverage for non-preferred prescription drugs for the two PPOs. |
| Utah | As of late June 2011, options for July 1, 2011, were not available. | | |
| Virginia | Virginia offers two PPOs, one HDHP and one HMO. | The HMO premium increased by about 4%. All other premiums were unchanged. | The HMO specialist office visit co-pay increased from $10 to $20. |
| West Virginia | West Virginia offers five PPO options. | Premium increases ranged from 1% to 3%. | There were no material changes to any of the plan provisions. |