NH Insurance Department

Report on Patient Contributions to Medical Expenses

May 19, 2008

Summary

This report analyzes patient cost sharing to insured members related to their use of health care services. The primary question addressed by this analysis is whether an increase in cost sharing to the member exceeds the rate of increase in provider payments made by the carrier. If so, the claims will show a higher percentage of the total payments made to the provider as the patient responsibility. If the amounts due from the patient are increasing proportionately to the increase in payments to the providers, there will be no change.

Patient contribution is measured as a percent of the amount due to the provider from the patient. However, due to the failure of some members to pay the full amount, the amount shown as due will not reflect what is actually received by the provider. This table summarizes the percent of total payments to providers from the patient:

Year	All Insurance	PPO	HMO	POS	Indemnity
2005	8.39%	9.75%	7.50%	4.04%	14.03%
2006	8.55%	10.18%	7.61%	4.09%	14.22%
2007	8.91%	11.88%	7.14%	3.91%	15.48%

These data are derived from a data set that included $2 billion paid to providers for medical services. Therefore, each 0.1% represents $2 million. The shift from 8.55% in 2006 to 8.91% in 2007 is equal to a $7.2 million shift in patient responsibility.

Analysis and Methodology

Patient liabilities occur in the form of deductibles, coinsurance and copayments made to providers either at the time of service or after the service is provided. There is a general understanding that the cost of health insurance is increasing due in part to increases in payments to providers. The payment levels to providers are determined by contracts between the insurers and the providers, as well as the number of services delivered. Member costs are reflected in the form of deductibles, coinsurance and copayments, as well as the contribution toward premiums. The member contribution toward premiums is outside of the scope of this analysis.

The NH Insurance Department (NHID) analyzed medical claims data in the NH Comprehensive Healthcare Information System (NHCHIS) to determine whether the observed increases in member liabilities increased proportionately to increases in the cost of medical services. Claims paid for self-insured and fully-insured policyholder accounts are included. Claims processed under the pharmacy benefit are not included in the analysis.

Health insurance benefit design is influenced in part by the type of insurance product. Accordingly, this analysis considers both payments in aggregate when all insurance types are pooled together, as well as separately by product line. Insurance type is classified as one of the following: Indemnity, HMO, POS, and PPO. Exclusive Provider Organization (EPO) type insurance products are included under the PPO insurance type. By measuring patient liability in aggregate, member contributions are averaged across product lines.

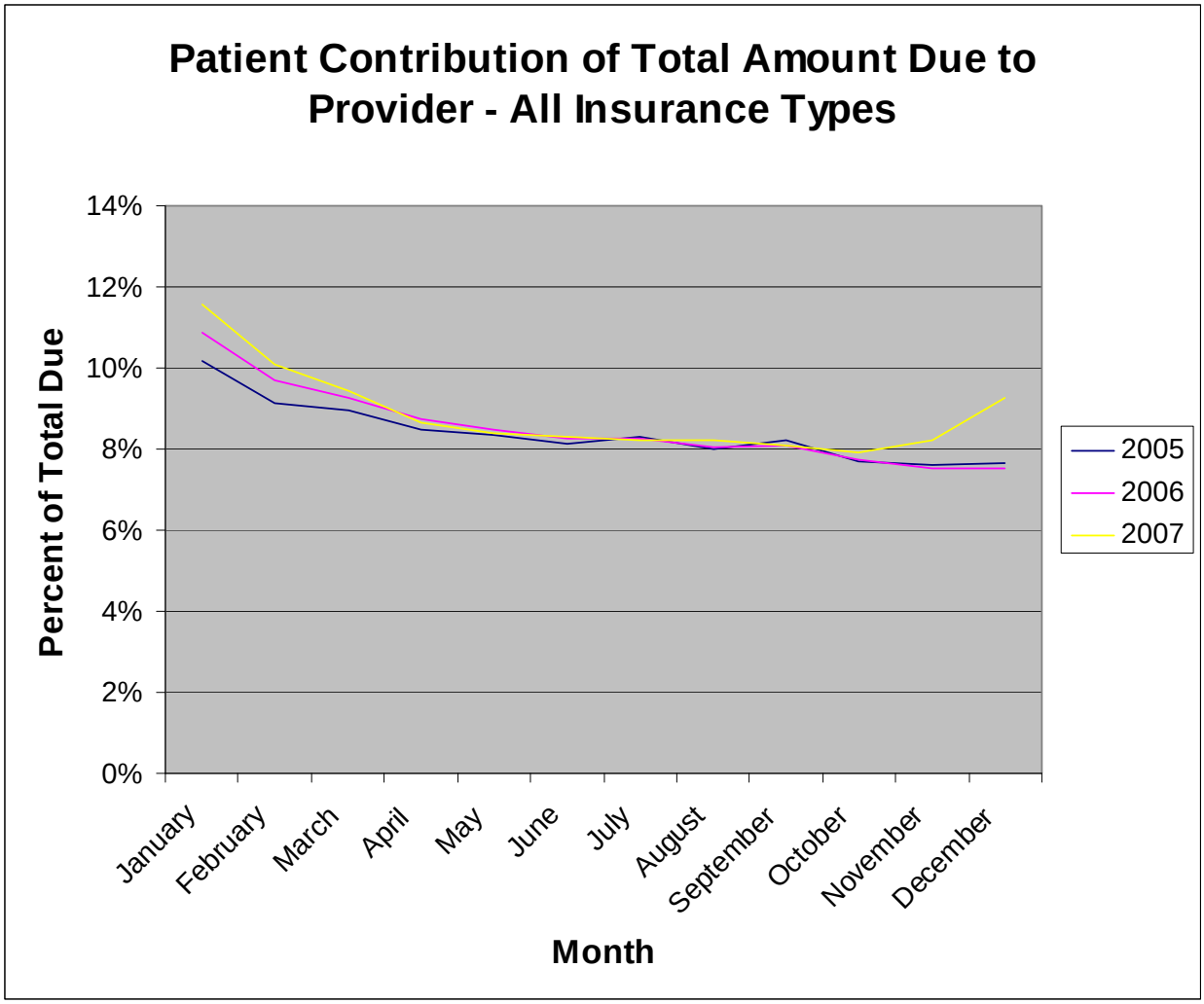
Contributions are analyzed on an incurred per month basis over each of the three calendar years included in the NHCHIS. A limitation with the data at this time is that it does not include all the claims experience through the end of 2007. This is due to the time it takes for claims to be submitted to the insurance company, processed, and included in the database. However, because this analysis focuses on a ratio of the member liability to plan liability, incomplete data is unlikely to be an issue unless there is a bias in the data (for example, there is a disproportionate number of claims from provider types that the patient is subject to a higher or lower level of cost sharing than for most medical services). The degree of incompleteness is reflected between the total amounts paid in 2006 of $2.1 billion and $1.9 billion in 2007.

This analysis does not attempt to assess the actual dollar amounts insured patients pay for health care services or compare those values across years. In order to effectively do this, the analysis would need to consider and potentially adjust for changes in insurance benefit design and the delivery of care, including, but not limited to: benefit coverage (beyond deductible, coinsurance, and copayments), length of enrollment, number of insured, inflation, types of health care services obtained, employee premium contribution, and policy renewal dates.

All Insurance Type Results – Figure 1

The higher percentages of patient contribution that appear earlier in the year reflect the fact that the majority of policies renew on January 1st of each year, and the restart of member liabilities at that time. The figure shows a difference between the calendar years that is more substantial during the first few months followed by similar experience for most of the year. Also noteworthy is the sharp increase during the last several months of the year. This may be due to incomplete data, but this trend is not consistent among all insurance types, which would most likely be the case if the result were due to incomplete data. One possible explanation is that members have reached their benefit limits and are responsible for a greater share of the bill later in the year.

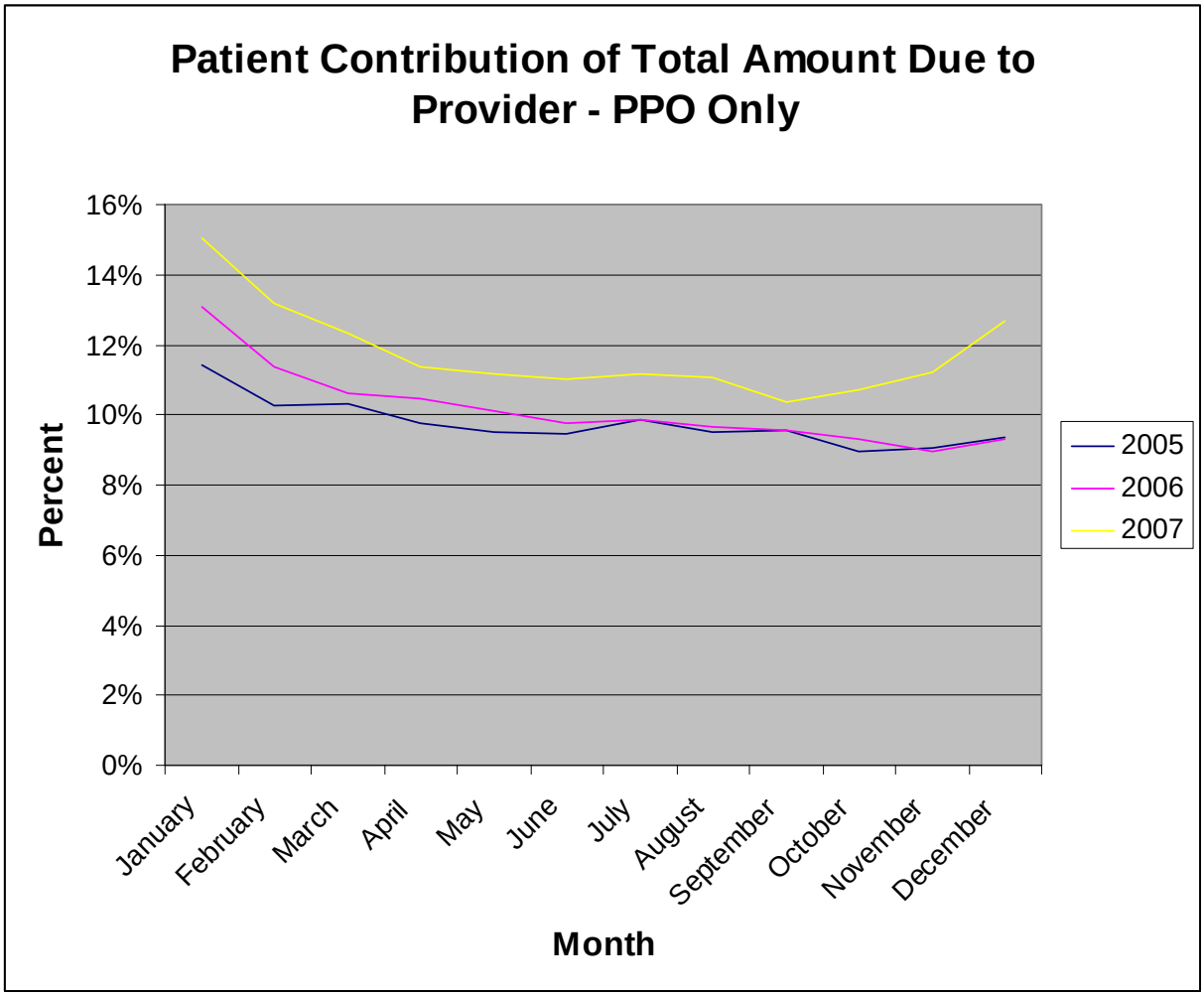
Figure 1



PPO

Figure 2 shows the experience for PPO insurance, one of the most popular insurance types. This graph shows a shift in 2007 toward increased member contribution that is substantially greater than the previous rate of increase from 2005 and 2006.

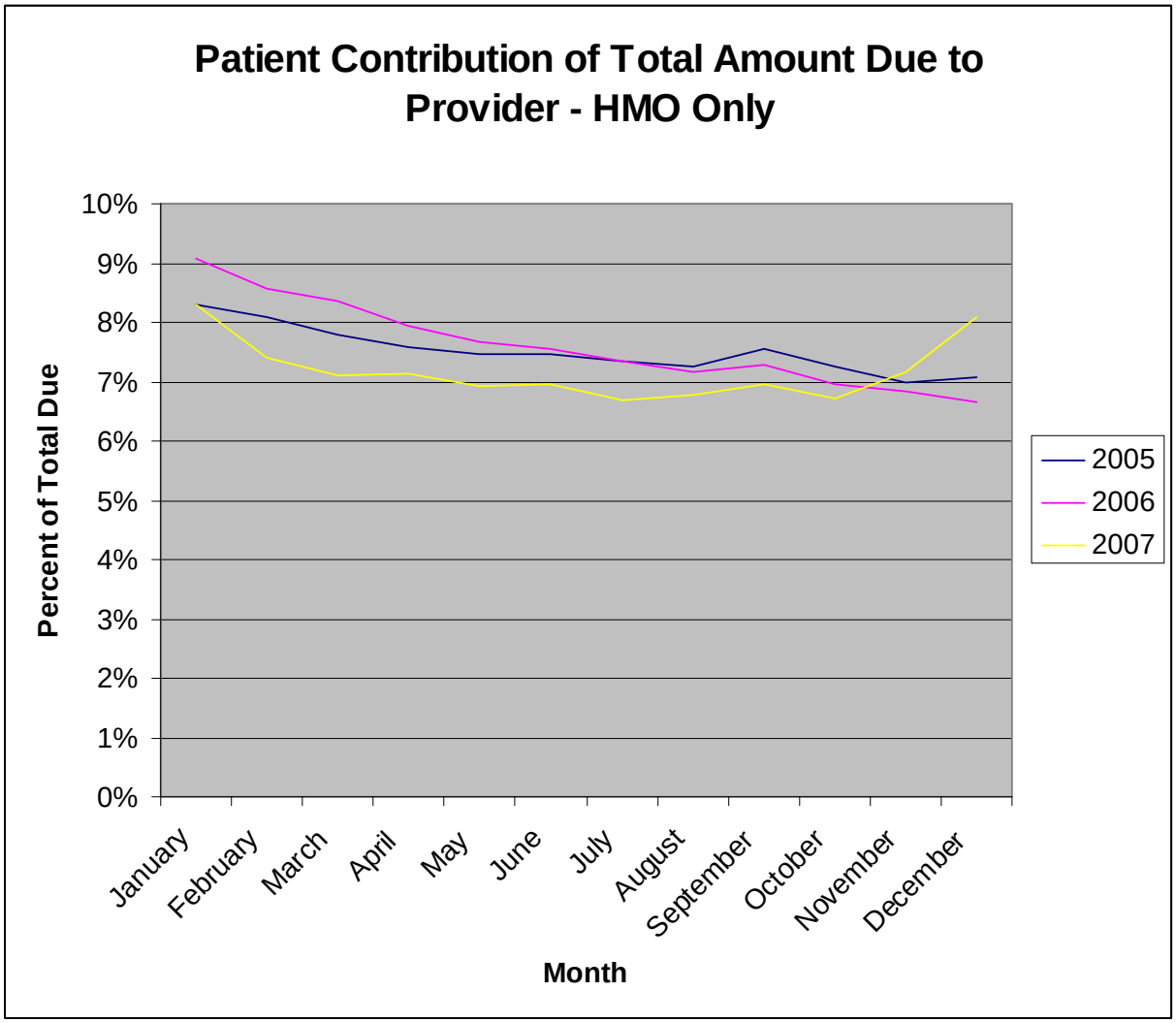
Figure 2



HMO

Given the aggregate trends and the PPO results, the trends shown in Figure 3 for the HMO product line are surprising. Between 2005 and 2006, an increase in patient contribution occurs early in the year, but shifts as the year continues. The trend starting half-way through 2006 continues in 2007 and shows reduced cost sharing for HMO products until late in the year. This does not necessarily show that members are paying less, just that members are paying a smaller percentage of the total payments to providers during the middle portion of the benefit year.

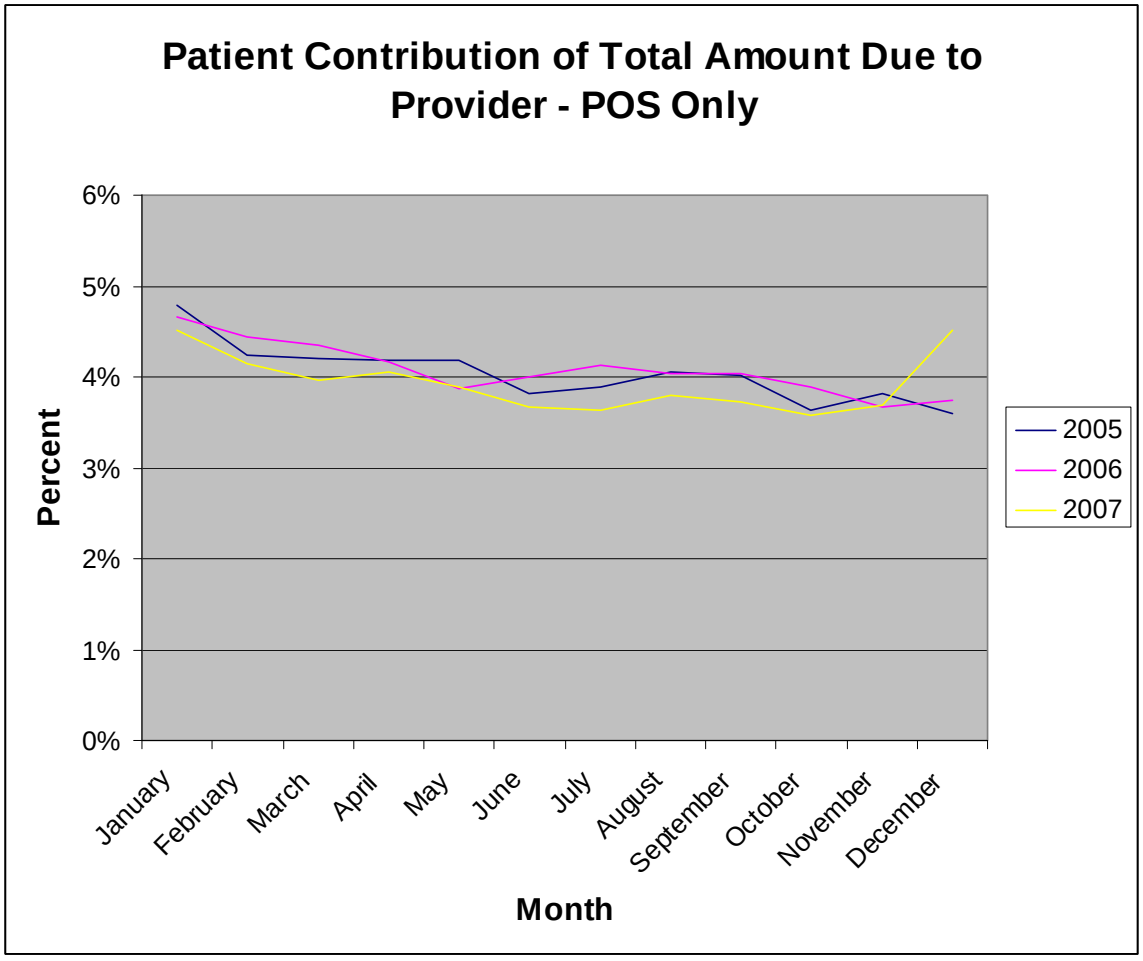
Figure 3



POS

Figure 4 for the POS shows a trend similar to that of the HMO product line.

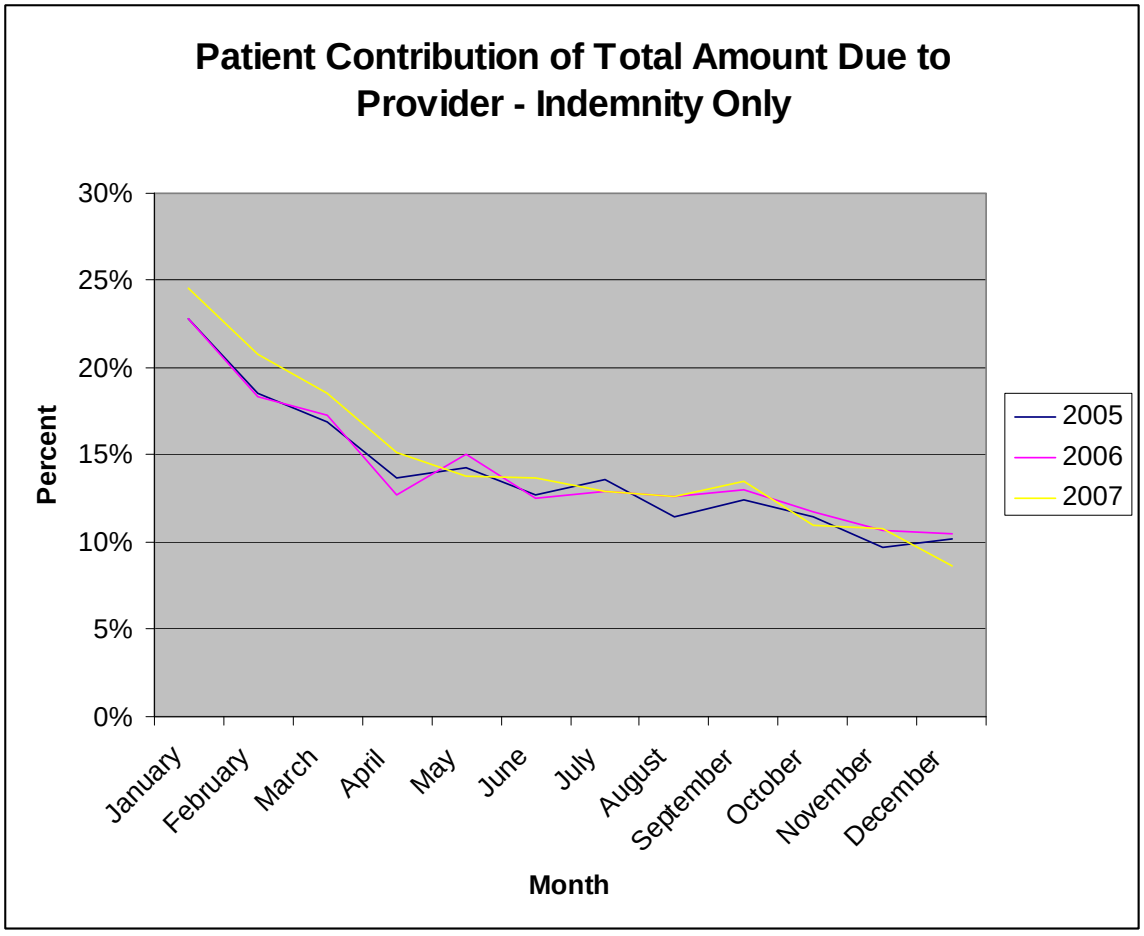
Figure 4



Indemnity

Figure 5 shows that the patient contribution with indemnity insurance reflects the characteristics of this type of insurance, including relatively steep cost sharing until out-of-pocket maximums have been met. Out-of-pocket maximums are particularly meaningful when the insurance coverage has a coinsurance which the patient must pay until the maximum patient responsibility has been satisfied. As seen with other insurance types, cost sharing during the first few months has increased in recent years, most likely due to higher deductibles. Also noteworthy is the decreasing trend during the final months of the year. This is the evidence that suggests the steep increase seen in the later months of the other insurance types is unlikely due to data issues, but rather is reflective of product characteristics.

Figure 5



Summary

Overall there is evidence that insured patients are paying a greater portion of the reimbursement to providers versus what the health insurance company pays. However, the trend is not consistent for HMO and POS health insurance types between 2006 and 2007. Also noteworthy is the substantial increase in the patient responsibility observed toward the end of the year. The increases in patient liabilities may be a sign of erosion in insurance coverage over the benefit year for people who are insured. An increase in deductible, coinsurance, or copay amounts may be anticipated early in the year, but a reduction of coverage late in the year may not be expected until those financial liabilities are incurred.