April 1, 2022

Dear Speaker Huston and President Pro Tempore Bray,

The members of the Indiana Association of Health Plans (IAHP) appreciate the strong interest the Indiana General Assembly is taking in lowering the cost of the healthcare system in our state. Moreso, it is a welcome development to have a new partner embracing cost containment.

In accordance with the directives of your letter, the IAHP and Indiana Hospital Association have engaged in a series of meetings to discuss how the two industries will collaborate to work towards the objectives you have outlined. The participants in these meetings have been the top decision makers from their respective companies. The result has been consensus that significant progress can be made in the areas of reducing administrative friction, addressing system configuration conflicts, and partnering on public health improvements. It is the belief that this unprecedented level of communication between the two industries on a macro level will help address potentially unnecessary burdens to reducing costs.

While this enhanced level of communication will certainly help to reduce some of the operational and societal costs to the overall system, undoubtedly the most significant efforts to reign in the costs will come in the contract negotiations between health plans and hospitals. Health insurance exists to make the unaffordable affordable by containing costs. Excessive costs are not in the health payers' interests because unaffordable products cannot be sold. Recent contractual developments in reimbursement negotiations with some large hospital systems have demonstrated the commitment of the insurance industry. Less high-profile negotiations have also taken place.

The members of the IAHP are committed to continuing to strategically negotiate responsible reimbursement reductions to at or below the national average by aggressively engaging large hospital systems who control the market. There will also be efforts to strengthen relationships with small and rural hospitals to address their unique needs independent of the large systems.

The most effective means to enhance the bargaining power of the payer side will be to better engage, educate, and partner with Hoosier employers and businesses. The employers who live in the same communities as the medical providers who serve their employees are strategically situated to apply the necessary downward pressure on high hospital costs, a burden they should not have to bear. Meanwhile, innovative products need to be developed to meet the needs for employee assistance programs, behavioral health engagement, and improved wellness programs.

Calling on the insurance and hospital industries to reduce the cost of healthcare in Indiana, while a start, was an incomplete assignment. Without question there are numerous other stakeholders who must be challenged to do their part. Various other medical providers need to be analyzing their own costs. And, of course, pharmaceutical companies play a large role as the price of prescription drugs will have increased by 136 percent between 2010 and 2025.

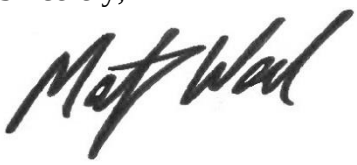
If the goal of the General Assembly is to truly reduce healthcare costs, then it is imperative the legislature re-evaluate its own role as a stakeholder. For more than three decades the insurance industry has seen its cost control policies limited and even prohibited by statute. Unnecessary and inefficient regulatory reporting requirements have been implemented. At the same time, coverages have been mandated and expanded without seriously looking at the levels in which these actions drive up overall costs.

Attached is a document produced by the IAHP that takes a deeper dive into evaluating the overall system and outlines strategies health insurers have at their disposal to help address cost of care in Indiana.

The Indiana Association of Health Plans strongly endorses the Indiana General Assembly's call to action for all stakeholders, including the legislature itself. The political pressure brought by your letter, coupled with activism from various Hoosier employer groups, has been heard loud and clear.

The health insurance industry looks forward to playing a critical role in meeting the healthcare needs of every Hoosier.

Sincerely,



Marty Wood
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INDIANA ASSOCIATION OF HEALTH PLANS

Indiana Health Payers' Hospital and Hospital Sub-Entities Healthcare Cost of Care Reduction Strategy

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Indiana Health Payers' Hospital and Hospital Sub-Entities Healthcare Cost of Care Reduction Strategy

On Friday, December 17, 2021, Speaker Todd M. Huston and President Pro Tempore Rodric D. Bray addressed letters to health payer and hospital executives urging both industries to submit a plan to reduce healthcare costs on or before Friday, April 1, 2022. The strategies herein are representative of the comprehensive plan the health payer industry will continue to implement to lower the cost of health care and reduce hospital reimbursement to at least the national average for reimbursement -- about 260% of Medicare.

Health payers work for the employer, their employees (patients), the individual consumers, and the state and federal taxpayers. The interests of these stakeholders are aligned with those of the health payers: the delivery of high-quality care, at the right time, in the correct clinical sequence, at the proper site of care, and at the best possible price to increase quality and improve health outcomes.

It is in the best interest of health payers to keep Hoosiers healthy, compliant with their appropriate prescription medications, and with the appropriate level of care so that chronic conditions do not worsen. Excessive costs run counter to insurance company principles because we cannot sell unaffordable products. If high costs served the health payers' profit strategy, we would not continually implement cost of care strategies to lower costs that are opposed every year at the Statehouse and attempted to be prohibited in state law time and again. Health payers' profits are capped by federal law and earn approximately three cents on every premium dollar collected[1] (America's Health Insurance Plans: *Where Your Health Care Dollar Goes*, 2021 or see Appendix B). Some of our largest members represent hundreds of millions of Americans across the United States and its territories, and they represent millions of Hoosiers. The health payer industry is not a high margin business, but a high-volume business whereby market share matters and further government intrusion does little but enable large health payers to absorb more membership at the expense of smaller competitors. Finally, the health payer industry is a very competitive market made up of large traditional insurers, large and small third-party administrators (TPAs), and smaller non-profit health payer plans. The market is a natural check on the most affordable premiums as a reflection of the underlying cost of care. Unlike other areas of the healthcare ecosystem, employers shop for health coverage.

[1] MLR provisions only apply to fully insured large group plans. Self-funded plans are not subject to MLR requirements but pay a per member per month flat fee to the third-party administrator (industry average of about a $50.00 per member, per month fee); Additional background on the MLR program can be found in AHIP's ACA Commercial Medical Loss Ratio Requirements One-Pager; Data Note: 2021 Medical Loss Ratio Rebates. Kaiser Family Foundation. April 12, 2021; Individual Market: Kaiser Family Foundation Average Marketplace Premiums by Metal Tier, 2018-2021. Small Group and Large Group Market: Kaiser Family Foundation Employer Health Benefit Survey, 2020; Data Note: 2021 Medical Loss Ratio Rebates. Kaiser Family Foundation. April 12, 2021; Individual and small group premiums are finalized before the beginning of the plan year. For example, 2020 premiums were finalized by issuers and approved by state regulators in summer 2019; Additional information on AHIP member's COVID-19 response can be found here: https://www.ahip.org/wp-content/uploads/Answering-the-call-the-COVID-19-Solution.pdf.

Background

In 2017, Rand Corporation published its first study about Indiana's hospital reimbursement using employer cost data.[2] Rand Corporation has since published two additional studies, and is in its fourth iteration as we write[3], all showing that Indiana's hospital prices and reimbursement are at least in the top five in the nation averaging about 340% or more of Medicare reimbursement.[4] These studies and others have all concluded that there are no material differences in the health payers' regulatory environments in these states, such as the absence of so-called administrative burdens like prior authorization. Thus, it points to unit costs at the hospital facility level in Indiana being substantially higher than Illinois, Kentucky, Michigan, and Ohio. In 2017, Hoosier employers drew the line and asserted that they were tired of healthcare costs outpacing inflation and economic growth, in some cases up to four times, making it the second highest labor expenditure next to their payrolls.

We appreciate the Senate Pro Tempore's and the Speaker of the House's leadership and welcome the invitation to partner together to address this important issue.

Culture and Environment

For more than 30 years, at the State and Federal level, there has been a culture to expand coverage and benefits and worry about costs later. Indiana's State Capitol has been no exception. The Indiana General Assembly's (IGA) policy for multiple decades, on a bipartisan basis, has been to expand coverage, mandate benefits, statutorily mandate networks, limit cost controls (if not prohibit them altogether) and worry about costs later. Moreover, if there was recognition that a certain bill would increase costs, the costs were dismissed as de-minimis. Even with this de-minimis approach, when added up collectively over several decades it results in a hefty bill for future generations to pay. This is in addition to the largest healthcare payers: Medicaid and Medicare. Medicaid is one of the largest purchasers of health services in States (reimbursed partially by the federal government), and Medicare is the largest purchaser of health services in the world. Both the U.S. taxpayer and Hoosier taxpayers entirely fund these programs.

The good news is that after the full implementation of the Affordable Care Act (ACA) and former Governor Mike Pence's expansion of Medicaid, with the option under the federal law by and through the Healthy Indiana Plan, the State's uninsured population dropped from over 20% to now 9.9% and continues to decline.[5] In theory, expanding Medicaid should have lessened the cost growth because hospital facilities were engaging with more patients who have coverage and were having to write off fewer services in which they got nothing. Despite these efforts, that has not been the case.

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[2] White, Chapin. *Hospital Prices in Indiana: Findings from an Employer-Led Transparency Initiative.* Rand Corporation. 2017. www.rand.org/pubs/research_reports/RR2106.html.

[3] Rand Corporation. https://www.rand.org/health-care/projects/price-transparency/hospital-pricing/round4.html.

[4] Bray, Rodric D. and Huston, Todd M., Letter to Health Carrier Executive. State of Indiana, 122nd Indiana General Assembly. December 17, 2021.

[5] https://www.kff.org/statedata/election-state-fact-sheets/indiana/.

Part of health payers' long-term strategy is to help change the public policy mindset and continue to engage our employer business clients. These clients pay the healthcare bills while their employees get their wages stifled year after year to offset the disproportionately high costs. The State Capitol should no longer be a place where healthcare facilities go year after year to get what they could not negotiate in a private contract codified into law to either protect their current economic position or seek statutory reimbursement increases in black and white – or worse, seek to overturn something they conceded in a negotiation in exchange for something else. The tenacity in healthcare providers marrying their legislative and contracting strategies is very apparent and a significant contributor to the environment we find ourselves in today.

The days of excessive insurance profit margins are long gone. The ACA settled that on March 23, 2010, when the law capped profits and mandated premium rebates to the policy holder if those metrics were not met. Several of our members are publicly traded, for profit entities, and every penny spent and earned can be traced every year and in real time on the various stock exchanges and on the United States Securities and Exchange Commission website. Additionally, all our members, for profit and non-profit, must file public financial documents with the Indiana Department of Insurance (IDOI). Assertions that the health payer industry is not transparent are false. In fact, it is the only transparent leg of the stool of the American healthcare system. These arguments are merely inserted into the public discourse to deflect, confuse, and buy more time to continue business as usual. They are a throwback to the late 1990s and early 2000s and being asserted by entities who want to take the attention away from themselves. Those claiming a lack of transparency have either not taken the time to learn what laws are currently on the books, the immense amount of regulatory infrastructure in place, or are simply not serious about solving the problem and want to protect the status quo.

Similarly, allegations that health payers' prior authorization process are the reason health care costs are so expensive continues to be a distraction and deflection as well. HEA 1143 (2018) recently overhauled the process when hospitals and health payers came together to require electronic systems to speed up the process, tighten turnaround times and set other minimum standards to make the process more uniform. The very same health payers operate in Illinois, Kentucky, Michigan, and Ohio where prior authorization is alive and well, but reimbursement in those states averages 50% less than Indiana.

Ironically, decades ago hospitals and healthcare providers approached health payers to set up prior authorization processes to engage the managed care entity early to ensure payment for their own cash flow purposes, and to confirm that they will indeed be paid for the services medically necessary that were rendered. Prior authorization is one of the key tools health payers use to ensure the right services are performed in the right sequence, at the right time, and at the right care site. Prior authorization controls utilization (costs) while not limiting access to services, and it is also a vital data gathering tool for both public health payer programs and private health payers. The IGA should let HEA 1143 (2018) play out before considering another massive overhaul and/or attempting to prohibit the main tool saving employers and employees money and ensuring safety and confirming the appropriate clinical criteria is being applied.

Indiana Department of Insurance's Existing Authority

The IDOI does not regulate healthcare providers or health facilities (medical doctors, nurse practitioners, nurses, et al) or employers. Generally, they have no jurisdiction over self-funded health plans.[6] Although self-funded plans may contract with an insurer or third-party administrator to administer claims, the U.S. Department of Labor's (DOL) Pension and Welfare Benefits Administration regulates self-funded plans. More than 70% of individuals who are privately insured have a self-funded health plan through their employer.[7] Currently, the IDOI refers these complaints to the DOL.

Rulemaking

The Indiana General Assembly granted the IDOI authority to promulgate administrative rules and regulations and issue bulletins.[8] Before administrative rules have the full force and effect of law, they are subject to a comprehensive review process. This review process requires the IDOI to publish the proposed rule, hold public hearings and receive public comments. Only after completion of this review process can a proposed rule become enforceable. Unlike administrative regulations, bulletins are documents that provide clarification about the law. The IDOI issues bulletins regarding certain policies or laws and are effective upon the Commissioner's signature. Current bulletin information can be viewed at http://www.in.gov/idoi/2591.htm.

Financial / Solvency Review

The IDOI's financial division reviews the financial solvency of domestic and non-domestic health insurance carriers receiving premiums from Indiana consumers. A domestic health insurance company is based in Indiana. By contrast, a non-domestic, foreign, or alien health insurance company is headquartered outside of Indiana. All companies receive a certificate of authority from the financial division to sell products in Indiana. Domestic companies submit quarterly, and annual filings monitored by financial analysts. The companies are examined once every five years.[9] HMOs and Limited Service HMOs are examined once every three years.[10]

For non-domestic companies, the IDOI relies on domiciliary regulators to monitor and examine carriers, as states can be accredited by the National Association of Insurance Commissioners (NAIC). This accreditation enables a state to perform financial regulatory exams for solvency, among other things, allowing the state's domestic companies' financial examinations to be recognized by other states. Thus, Indiana's domiciled insurance carriers do not have to go through multiple costly financial exams in other states.

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[6] A self-funded health plan is one in which the employer pays employee health care claims rather than an insurance company. An exception is that State law does apply to self-funded Multiple Employer Welfare Arrangements (MEWAs) to the extent that it is not inconsistent with federal law (Section 514(b)(6)(A)(ii) of ERISA.

[7] This statistic was derived from the market share of the fully insured group employers' (large and small) market share, which is nearly 30%. Therefore, the remainder of the employer-based health insurance market is roughly 70% self-insured. The 30% fully insured employer-based health insurance statistic is derived from the federal Supplemental Health Care Exhibit that Noble Consulting produced for the IDOI in 2010.

[8] I.C. 27-1-3-7

[9] See generally Ind. Code § 27-1-3.1.

[10] Ind. Code § 27-13-23-1.

The regulators examine the companies once every five years and provide their reports to the IDOI. Indiana has the authority to examine a non-domestic company at any time. The IDOI can join an examination among other stakeholders if there is concern that the carrier, for example, might be imposing significant premiums in Indiana. HMOs receive additional scrutiny because health care is paid for in advance according to a fee schedule. As a result, the IDOI monitors foreign HMOs like domestic HMOs since some states do not regulate or have as stringent laws as Indiana.

To maintain financial solvency, the financial conditions of both domestic and non-domestic health insurance carriers must be monitored to protect consumers. The IDOI responds to consumers regarding the financial condition of domestic health insurance carriers and publicly provides information about whether the company is licensed, in good standing, and what line of business a company can write or is able to provide to consumers. Information is also available at the NAIC's website for non-domestic companies.

Beginning in 2012, the Patient Protections and Affordable Care Act requires an annual medical loss ratio (MLR) of no less than 80% for individual and small group and 85% for large group insurers or else the policyholder is owed a rebate.[11] This rebate determination is for the previous calendar plan year. For example, any rebate given in 2012 will be for the 2011 plan year. Insurance carriers are required to submit their supplemental health care exhibits (SHCE) by April 1 of each year, which is a projection of the MLR used to determine estimated rebates, if any, owed to policyholders. This does not include long-tail claims[12] and other "run off[13] claims" for that year, which is why it is considered a projection. In June, the actual filing of rebates, if any, is required to be filed with the U.S. Department of Health and Human Services (HHS). The June form will include any long tail or run off claims settled during the prior year that may have been reported to the carrier during the first quarter of the current year. Finally, any policyholder receiving a rebate will be remitted their rebate in August. The IDOI is generally involved in receiving these filings, processing them, and conducting desk audits to ensure rebates, if any, are remitted to the employer and/or the member.

Premium Rate Review

Indiana Code 27, et seq, grants the IDOI authority to review all rate and form (policy/contract language) filings. The IDOI's Company Compliance division oversees all rate and form review. Pursuant to Indiana law, premiums must be reasonable in relation to the benefits provided by the policy.[14] All fully insured insurers operating within Indiana must file rates and forms[15] with the IDOI before insurance products are marketed or sold to the public. All subsequent rate and form adjustments, including premium rate decreases, must be approved thereafter before implementation. For the rate review process to begin, the carrier must complete a filing and provide the required data as outlined at

[11] 42 USC § 300gg-18(b)

[12] The liability for claims that do not proceed to final settlement until a length of time beyond the policy year. High incurred but not reported (IBNR) claims contribute to this "tail" effect, since these losses are usually not settled until several years after the expiration of the policy in question.

[13] Liabilities that result from occurrences taking place after the termination date of the policy.

[14] Ind. Code § 27-8-5-1.5(l)(1).

[15] Rates refer to the premiums charged to policy holders. Forms refer to the contract language of the policy.

http://www.in.gov/idoi/2592.htm. For example, if a carrier requests a premium increase, it must file electronically and provide an actuarial memorandum that includes, at a minimum:[16]

- the health products affected,
- benefits provided,
- implementation date,
- the overall percent rate impact to be requested,
- historical, projected and lifetime loss ratio for each product,
- incurred claims paid each year from inception,
- earned premiums each year from inception, and
- projected medical cost trends

Insurers must also certify that the information is accurate. The IDOI has the right to request additional information as needed to evaluate the request. To prove the validity of the requests, the loss ratio of the product must be equal to or greater than the percentage required. Before the ACA, a loss ratio was simply the amount of premium spent for claims payments divided by the premium collected. Indiana previously required a lifetime minimum loss ratio of 50% to 75% depending upon the type of product involved.[17] The annual minimum loss ratios [18] as mandated in the ACA are 80% for individual/small and 85% for large group.[19]

The IDOI's state employed actuaries review all documentation to determine if the insurance company submitted reasonable actuarial assumptions and trends, if the data is accurate and complete, and identifies any filing or actuarial concerns. This part of the review process can involve many conversations between the actuary and the insurance company. Following the actuarial review, the IDOI's compliance review team meets as needed for discussions regarding the insurer's rate request, at which time additional information may be requested to clarify any concerns the team may have. In addition to the actuarial recommendation, the compliance team considers: (1) the history of premium increases, (2) the number of affected insureds, (3) whether the product is open or closed (receiving new members or not), and (4) the annual Indiana and national medical loss ratios. Once this process is complete, the IDOI approves, disapproves, or offers approval of an increase lower than what was originally filed. If the insurer accepts the recommended increase, the modified increase is approved. If not, the filing is denied, and the insurer may

[16] This varies somewhat by type of product. See the link above for the appropriate checklist.
[17] Although this was never statutorily adopted, it was a department policy that was based on an NAIC model act that was used for rate review purposes.
[18] The ACA's annual minimum loss ratio for rebate purposes differs from the lifetime minimum loss ratio reviewed as part of rate review process. The ACA's MLR allows for the combination of all individual, small group or large group products together and also removes taxes from the premium denominator and adds health quality costs to the claims numerator. Before the ACA, the MLR reviewed by the IDOI as part of the rate review process is simply claims divided by premium. The IDOI considers both lifetime MLR, which considers the entire lifespan of the insurance product from initial sale to closing of the product, and annual MLR which is the experience from the previous annual cycles.
[19] ACA § 2718.

seek an administrative hearing before the Commissioner. All approved rates can be found at IDOI Rate Watch.[20]

Rate Review and the Affordable Care Act

The IDOI has maintained the authority to review rate and form filings for nearly 30 years. Per additions to the IDOI's already codified rate review process, HHS deemed Indiana to have an "Effective Rate Review Program" in all markets on July 1, 2011.[21] The advantage of this recognition to Indiana's health insurance market is that it mitigates the need for carriers to file rate increase requests with two different entities for actuarial review—the State and federal government—which is required in states without an effective rate review recognition if the rate increase is at or above 10%.

The ACA provides no authority to the federal government to implement, approve, deny, or negotiate rates except for the federal multi-state plans.[22] The only leverage the federal government preempted was a national publication of an "unreasonable rate increase" defined at or above 10%. Regardless, if the domestic state approved the increase based on the insurance carrier's actuarial justification, HHS requires national publication and additional reporting requirements for a rate increase at or above 10%.

Beginning in the 2014 health plan year, the rate review process was enhanced to include the following: (1) network adequacy,[23] (2) form review to ensure minimum essential health benefits, (3) form review to ensure non-discriminatory benefit design, (4) quality accreditation confirmation, and (5) quality measures confirmation.

Consumer Services

Consumer Services reviews and investigates all complaints filed by consumers against insurers, agents, and other industry related entities. This division also educates and informs consumers regarding regulations, limitations of the IDOI and current market concerns. Complaints are referred to the IDOI's Enforcement division as necessary. The Consumer Services division is the initial contact for consumers to express concerns related to accident and health, property and casualty, and life insurance policies and practices. Consumer Services responds effectively to consumer issues and is comprised of a knowledgeable team of experts capable of responding to a wide array of insurance related issues.

Complaints can be received by telephone at 1-800-622-4461, facsimile, regular mail, email, or online at http://www.in.gov/idoi/2526.htm. Regardless of how the complaint is received the process is the same. The most common type usually involves consumer disputes about both providers and insurance companies. The complaint process begins with requiring the

[20] The IDOI implemented this transparency tool with grant dollars from the U.S. Department of Health and Human Services in 2012 and has maintained it ever since.

[21] Criteria for an "effective rate review program" are listed in 45 C.F.R. 154.301. Indiana was further deemed by HHS to have an effective rate review program for Association products on October 19, 2011.

[22] 42 USC § 18054, et al.

[23] Network Adequacy refers to a set of standards that are designed to make sure that health plans have an adequate network of providers to care for their enrollees. These standards often focus on the types and number of primary care and specialty providers, the distance which enrollees have to travel to see their providers, and hours of operation.

consumer to submit all claims in writing via paper or electronic means. An acknowledgement letter is sent to the complainant stating the consultant's name and problem report number. In addition, an instruction letter is sent to the company within 24 hours of filing. A company has 20 business days upon receipt of the letter to respond. If a company does not respond within the allowable timeframe, it is contacted again by letter and assessed a minimum $500 fine. If the IDOI does receive a response, the file is pulled and given to the assigned consultant. The consultant reviews the file, and an additional review is completed by a senior consultant. The purpose of the second review is to ensure known details were not overlooked to maintain accuracy in the review process.

If the two consultants agree that the company has not violated Indiana insurance laws, then a letter is sent to the complainant along with copies of the insurer's response. The file is then put in a closed status. The consumer does have the right to appeal. The appeal or rebuttal is sent to the insurance company and the process is repeated within a 20-day window. If at any time the consultants believe a violation has occurred, the file is transferred to enforcement.

Enforcement

Once a file is transferred to the IDOI's Enforcement division, a correspondence letter is sent to the company. Enforcement has the authority to investigate and indict if a violation has been deemed to have occurred. Enforcement may either settle the case with the respondent or file a statement of charges. If an indictment is sought, enforcement proceeds to an administrative hearing in front of the administrative law judge who issues a recommended order, followed by a final order from the Commissioner. Either side can object to the recommended order and seek judicial review of the final order. The enforcement division is not a court of law; therefore, complainants are allowed to pursue a claim in small claims court or another court of law as appropriate with or without the advice from an outside attorney.

Cost Reduction Strategies

Our health plan association members are competitors and employ cost reduction strategies differently and at varying degrees. Some may be applying these currently, while others are determining their individual timing and business approach. This is not an exhaustive list because the market does not move uniformly. The following are high level tactics our members are implementing at various levels:

- Continue to strategically negotiate responsible reimbursement reductions for hospital facilities, from instances in excess of 350% of Medicare, to at or below the national average, by engaging large hospital systems who control the market and make macro differences in hospital reimbursement.
- Engage, educate, and partner with our employer and business clients to form strategic coalitions to achieve the abovementioned.
- Create innovative products to meet employers' needs for employee assistance programs, behavioral health engagement, improved wellness programs, and personal responsibility.

- Strengthen partnerships and address unique needs of rural hospitals, independent rural healthcare providers and independent rural pharmacies.
- Measure all costs and reimbursement as a percentage of Medicare and away from discounts based on a percentage of billed charges and volume.
- Combat, through contract, site of service gamesmanship. Including but not limited to the following:
    - Transparency and honesty in billing,
    - Bill on appropriate form and transaction type,
    - Require off-campus, hospital-owned providers to obtain a separate national provider identifier (NPI), and
    - Establish uniform national requirements on billing.
- Increase network enrollment in health care arrangements for site neutral reimbursement, pay for performance, bundled payments and shared savings to responsibly move the healthcare system from the unsustainable fee-for service to value-based healthcare arrangements.
- Support appropriate healthcare provider licensure expansion to increase access, lower costs and expand opportunities for network flexibility to increase choice and support a healthcare workforce for a technologically driven 21st Century healthcare experience.
- Lead with digital healthcare platforms, telehealth expansion and network opportunities and invest in electronic medical records to alleviate inefficiencies for both healthcare providers and payers to optimize digital capability for real time engagement and payment remittance.
- Support transition to managed care programs and initiatives for all remaining Medicaid fee-for-service, saving direct taxpayer dollars.
- Realign governmental affairs strategies to:
    - Defeat legislation adverse to controlling costs of care, attempts to codify current economic and reimbursement positions, and further restrictions on networking and contracting freedom.
    - Defend cost of care initiatives where there are attempts to prohibit said initiatives by law or thwarted and made impractical.
    - Work with lawmakers willing to repeal and deregulate laws that limit freedom, stifle innovation, and protect the status quo.
    - Continue seeking ways to reduce overutilization of health care services in a fashion that also reduces administrative costs associated with those management tools and advocate against initiatives that hamper the ability to manage those costs.
- Invest in social drivers of health to engage members and patients from cradle through major life events.
- Expand and invest in behavioral health as part of our total cost of care and wellness strategy to improve worker productivity, total health, and physical health outcomes.

How does this save the businesses in my community or individuals money? Are the savings passed along?

1. Yes.

2. The overwhelming majority of Indiana employers have engaged in self-funded healthcare arrangements with third party administrators (TPAs). That means the TPA charges a per member, per month fee (or flat fee) ~$50.00 PMPM. Employers capitalize accounts to pay for projected claims for the plan year, and they collect premiums from employees that are also deposited into these accounts. TPAs provide prior authorization services, managed care services, utilization management, utilization review, medical necessity review and pay the actual submitted claim on behalf of the employer. Thus, if reimbursement levels are lowered contractually and cost of care initiatives implemented and sustained, those monies will never leave the employers' accounts to begin with and remains with the employer for their choosing and individual human capital needs. (See Appendix A)

3. If it is a fully insured plan, whereby the health payer bears 100% of the risk each plan year above and beyond the premiums collected, reimbursement reductions steady the premium growth and flattens it or makes it more predictable, which is paramount for business planning. As mentioned, federal law requires rebates to the employer or individual to occur when the medical loss ratio is less than 80% for small group and individual plans and 85% for large group plans. The profits of health payers are capped, and after administrative costs are two to three cents of every premium dollar the healthcare payer collects. Smaller plans run a greater administrative expense load as a percentage of revenue and therefore will typically fall on the lower end. This is all verifiable and heavily monitored by regulators of insurance departments and Centers for Medicare and Medicaid.

4. The State of Indiana adopted a policy circa 2004 to encourage and proliferate high deductible healthcare plans as an option for employers to lessen their healthcare expenditures and encourage consumerism (shopping at the individual level for best price for the same or better-quality healthcare services). At one point, it was estimated that approximately 60% of Hoosiers had a high deductible healthcare plan as defined by the Internal Revenue Code. Some plans have a deductible requirement as high as $10,000, meaning the individual is on the hook for the first $10,000 of health services each year, even if covered by an employer-based plan. As such, lower reimbursement directly saves these individuals money in real time, at the point of sale for healthcare services.

Appendix A

Motivated by a responsibility to the members served by the health payers and the communities in which they live, insurers are meeting the challenge of driving more affordable and accessible care through collaboration with healthcare partners. Strategies to slow the increase in health expenses must address the cost of hospital services since it is the largest component of healthcare today. Our members continue to demonstrate that successful negotiations with hospital partners can lower costs. Highlighted below is an example of a recent contract negotiation with a large Indiana hospital to show how lower reimbursement rates led to a decline in the cost of healthcare for two large self-funded groups.

For instance, an average 12% *decrease* in commercial reimbursement rates in the first year of the contract, a 0% average rate increase in the second year, and a 1-2% average annual increase in subsequent years, is the start of a significant decrease in reimbursement rates for said hospital facility. Drilling down further on hospital claim costs for two of the large self-funded employer groups, they see an immediate and significant decrease in hospital costs beginning August 2020.

For outpatient and inpatient hospital services combined, both employer groups experienced an almost 17% decline in average hospital rates for the 11 months ending June 2021 (the most recent data available) compared to the 12 months ending July 2020. Table 1 below shows the decrease in reimbursement rates as a percentage of Medicare rates for the two employers.

Table 1. Negotiation Impact on Total Hospital Costs

	Hospital Reimbursement Rates as Percentage of Medicare Rates	
	Employer 1	Employer 2
Aug 2019 – July 2020	424%	435%
August 2020 – June 2021	354%	364%
Negotiation % Impact	**-16.5%**	**-16.3%**
Negotiation $ Impact	**$2.7M**	**$2.5M**

There is also a significant impact from successful contract negotiations with the reimbursement rates for one of the large service category components of hospital costs – specialty outpatient drugs. Claims under this service category account for just over 7% of total hospital costs for the two employers combined. Table 2 below shows the tremendous savings for this service category due to successful contract negotiations. The two employers included in the analysis realized estimated savings of $1.5 million from August 2020 to June 2021. There are similar substantial impacts for these two employers when other service categories are analyzed.

Table 2. Negotiation Impact on Specialty Outpatient Drug Costs

	Hospital Reimbursement Rates as Percentage of Medicare Rates
Aug 2019 – July 2020	402%
August 2020 – June 2021	186%
Negotiation % Impact	**-54%**
Negotiation $ Impact	**-$1.3M**

Lower negotiated reimbursement rates not only lead to lower premiums for fully insured businesses, but also translate to direct savings for self-funded employer groups that account for 80% of commercial business. Healthcare savings through successful contract negotiations are significant, immediate, and a crucial step in increasing healthcare access and affordability.

Where Does Your Health Care Dollar Go?

Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive and improves health care affordability, access and quality for everyone. **Here is where your health care dollar really goes.**

This data represents how commercial health plans spend your premiums. This data includes employer-provided coverage as well as coverage you purchase on your own. Data reflects averages for the 2016-18 benefit years. Percentages do not add up to 100% due to rounding.

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CATEGORIES	WHAT THIS INCLUDES	EXAMPLES
Prescription Drugs	Payments for out-patient prescription medications, mostly self-administered drugs; as well as payments for prescription medications administered in the physician's office or clinic. For both of these drug categories the prescription drug spending was calculated net any estimated prescription drug rebates paid by the drug company.	Medications you pick up from your local pharmacist, like antibiotics, blood pressure pills, or creams for rashes. Also, injectable drugs that are administered by a nurse or doctor either at their office or your home.
In-Patient Hospital Costs	Payments for all services during hospitalization, including the administration of prescription drugs provided during a hospital stay, payments to physicians, and facility payments.	The costs for your hospital room and board, including equipment or supplies used during your hospital stay. Salaries of doctors, nursing staff and all other hospital personnel. General overhead costs of running a hospital, such as utilities and land.
Out-Patient Hospital Costs	Physician and facility non-drug related payments for treatment in the out-patient department of hospitals, not including emergency room care.	Going to a hospital to get an MRI or an X-ray. Visiting a primary care doctor or a specialist who are working in the hospital out-patient department.
Emergency Room Costs	Physician and facility non-drug related payments for emergency room visits and ambulance transportation.	Paying doctors for their time and expertise in arriving at a diagnosis and a treatment plan during your hospital emergency room visit; paying for equipment or supplies used during your visit; general overhead necessary to operate the emergency room around the clock. If you stay overnight the payment is included under in-patient hospital costs.
Doctor Visits	Payments to doctors or clinics for all non-drug related out-patient services provided during visits to doctor offices, clinics, and urgent care facilities.	Equipment or supplies used during a doctor or nurse visit; paying doctors for their time and expertise in arriving at a diagnosis and a treatment plan for you; salaries of nursing staff and other ancillary staff; office rent and general overhead costs of running a physician's office or clinic.
Other Out-Patient Care	Payments for all out-patient services incurred outside hospitals, doctor offices and clinics, such as claims from ambulatory surgery centers, labs, dialysis or at home care.	Lab work, treatment in dialysis centers, home health, or surgeries performed in the ambulatory surgery centers.

CATEGORIES	WHAT THIS INCLUDES	EXAMPLES
Taxes and Fees	All taxes and assessments paid by the health insurance provider.	All the usual federal, state, and local taxes paid by any business, like income taxes, property taxes, payroll taxes. Also includes payments that are unique to a health insurance provider, like taxes paid on insurance premiums and regulatory authority licenses and fees.
Other Fees and Business Expenses	Agent and broker direct sales salaries and benefits, fees and commissions paid to agent and brokers, and insurance rebate payments.	Expenses required to run any insurance business, like costs associated with paying insurance agents and brokers. Also includes money paid back to customers as insurance premium rebates.
Cost Containment	Claims adjustment expenses, detection and prevention of fraud and abuse, case management, expenses for appeals, expenses for developing and managing provider and prescription drugs networks.	Prevention of fraud, waste, and abuse by doctors and patients. Answering questions from doctors and hospitals. Helping providers with best practices. Ensuring proper credentialing for quality care. Programs to better manage chronic conditions and coordinate care between doctors, to ensure that the right treatment is provided to the right patient at the right time.
Quality Improvement	Efforts to improve health quality and increase the likelihood of desired health outcomes such as preventing hospital readmissions, improving patient safety, wellness and health promotion, and health information technology.	Preventive care programs to keep you healthy, like weight management plans or helping people to quit smoking. Patient education and follow-up calls by health plan staff to members discharged from a hospital. Services to improve health in communities, like sponsoring local health fairs and providing free disease screenings and other educational events.
Other Administrative Expenses	General and administrative costs to run the business, including salaries, outsourced services, equipment, accreditation and certification fees, rent, legal fees and expenses, advertising, postage, utilities etc.	Managing employee benefits and retirement plans. Reviewing contracts or conducting legal research. Maintaining office space.
Profit	Net profit of for-profit health insurance providers and the difference between total revenue and total expenses for not-for-profit health plans.	The revenue remaining after all costs are paid. In for-profit companies it is commonly paid to shareholders in the form of dividends.

Methodology

The goal of our analysis is to show how premiums for a typical commercial (employer-provided coverage and individual market) health insurance plan are invested. The analysis shows the inflation-adjusted average annual amounts paid by commercial health insurance plans in 2016-2018 for the medical care of plan members; the average annual amounts paid for general operating expenses; and the average annual reported profit or loss. These data do not account for the potential impact on health plan spending related to COVID-19.

What's New from Prior Updates

For this edition of the premium dollar spending analysis AHIP made several methodological changes compared to its most recent version released in 2018:

1). Changes to categories: AHIP used the new, easier to understand methodology, by dividing medical spending into categories based on the place of service for the medical care received (e.g., emergency room costs, in-patient hospital costs etc.) which are more familiar to the general public vs. the previously used more accounting-centered approach. For example, in past editions the facility and professional costs incurred during hospitalization had been assigned to different categories - hospital costs and doctor services, respectively.

2). Drug costs net of rebates: AHIP subtracted the published estimates of pharmaceutical manufacturers rebates to present the prescription drugs spending net of all rebates received, which are not reflected in the claims data. AHIP used the 2016 estimated manufacturer rebates in the commercial market published by The Pew Charitable Trusts. (2019). *The Prescription Drug Landscape, Explored.* https://www.pewtrusts.org/-/media/assets/2019/03/the_prescription_drug_landscape-explored.pdf

3). Operating expenses: In this update, Oliver Wyman provided AHIP with a granular breakdown of operating expenses using financial statements of health insurance providers as the data source for categorization. A benchmarking model was employed for the 2018 report and graphic. As a result, the names and scope of operating expenses subcategories changed (see more detailed description below).

Overview of Data Used

Medical Services

To determine the annual amounts paid for medical services in 2016-18, the commercial claims data from the IBM® MarketScan® Commercial Database were summarized (Copyright © 2019 International Business Machine Corporation; All Rights Reserved). The Inpatient Services file, the Out-patient Services file, and the Out-patient Drug file of the MarketScan® database were utilized for the study.

Since the analysis used multiple years of data, all expenditure data from 2016 and 2017 were adjusted for inflation and expressed in 2018 dollars. This inflation adjustment was performed using the Medical Care Component of the Consumer Price Index (CPI) reported by the U.S. Bureau of Labor Statistics (www.bls.gov).

Only those patients under the age of 65 on the date of service who had evidence of continuous health plan enrollment for the entire period in each study year (2016, 2017, or 2018) and had prescription drug coverage were included. Claims having missing payment information; missing dates of service; and in the case of the inpatient and out-patient services claims, missing data on whether the claim was submitted by the facility or the physician were excluded from the study. The main variable of interest was the "net payment" variable which is the amount paid by the health insurance provider. The net payment amounts of all included claims for each study year were summed.

Operating Expenses and Profit:

AHIP analyzed financial statements of 30 health insurance providers: five largest publicly traded for-profit commercial health insurance companies and 25 randomly selected not-for-profit health insurance providers that had the majority of their business (i.e., greater than 50% of enrollees) in the commercial market.

To estimate operating expenses and profitability, for the five publicly traded insurance providers, their 2016-2018 10K filings with the Securities and Exchange Commission were examined; while operating expenses and profitability data for private, not-for-profit organizations were extracted from their 2016-2018 Form 990s, filed with the Internal Revenue Service, or, when not available, from the financial

statements published on the health plans' websites. We were unable to obtain a Form 990 or a financial statement from two plans in 2018, thus, their operating expenses and profits are the average of two-years of data (2016 and 2017).

Premium Revenues

Only those revenues attributable to premium payments from health plan members were recorded for each plan for each year (2016-2018). Revenues from sources other than premium payments, such as from other business segments or investment income, for example, were excluded. For each plan, the average revenue across the 3 years was calculated.

For the five publicly traded, for-profit insurers, amounts listed in their 10K filings as "Operating Costs," "General and Administrative Expenses" or "Sales, General and Administrative" were extracted from their 2016-2018 Income Statements. Amounts paid for taxes were also recorded. Amounts shown as "Net Income" or "Net Profit" were also recorded. For each plan, average total operating expenses and an average net profit were calculated across the three years and recorded. During the years of our study, the Health Insurance providers fee was in place for 2016 and 2018. In 2017 there was a moratorium.

For the 25 private, not-for-profit entities their total operating expenses were calculated by subtracting the "Benefits Paid to or For Members" from the "Total Functional Expenses" amounts appearing in their Form 990. Similarly, profitability was determined by subtracting the "Total Expenses" from their "Total Revenues." These calculations were performed for each plan for each year and recorded. For each plan, average total operating expenses and an average net profit were calculated across the 3 years and recorded.

Finally, for those health insurance providers having multiple revenue streams beyond member premiums, some of the plans' total operating expenses and profits could be unrelated to servicing their insured population. To account for that, we apportioned the operating expenses and profits based on the share of health plan's revenue derived from member premiums. For example, if a plan A had 80% of its revenue derived from member premiums, we used 80% of its total operating expenses and profits in our calculations.

For each plan, the average total operating expenses and the average net profit amounts were divided by the average revenues derived from premiums to yield that insurer's operating margin and net profit margin. To account for differences in the sampling of for-profit (n=5 plans) and not-for-profits (n=25 plans), a simple average of the operating margin and an average of the net profit margins were calculated separately for the for-profit and not-for-profit plan subgroups. These two averages were then weighted by these two groups' share of commercial enrollment and combined.

The average total operating expenses calculated across all plans were further subcategorized into the key functional areas. The proportions of the average total operating expenses attributable to each of these core administrative functions were determined by the consulting firm, Oliver Wyman. Oliver Wyman analyzed 2016-2018 Supplemental Health Care Exhibit filings submitted by commercial insurers to the National Association of Insurance Commissioners (NAIC) as part of their statutory filings.

Since the analysis of NAIC filings used multiple years of data, all administrative expenses data from 2016 and 2017 were adjusted for inflation by using the Medical Care Component of the Consumer Price Index (CPI) reported by the U.S. Bureau of Labor Statistics (www.bls.gov) and expressed in 2018 dollars.