Inspire

The Health Insurance Premium Dollar: Who Gets What?

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Introduction

In today's health care arguments about lowering costs, it is sometimes forgotten that insurance premiums are set based on the underlying cost of health care. Other than the portion (<20%) needed to cover insurance administration, taxes, commissions, and profit, the remaining 80%+ of the cost of healthcare itself goes to the hospitals, physicians, drug manufacturers, and other providers in the health care space.

For a premium reduction to occur, the cost of care either needs to shift away from the insurance premium back to the consumer, or these players that make up the premium dollar – insurers, hospitals, physicians, drug manufactures – need to cost less.

According to the Centers for Disease Control and Prevention (CDC), total U.S. healthcare spend in 2014 exceeded $3 trillion dollars. The portion of this care covered under a typical health insurance policy has remained consistent over the past 50+ years at almost 70%. The major components of health insurance spend – hospitals, physicians, and drug companies – have consistently shared the same proportion of the health care pie, despite significant efforts over the past 30 or so years to move healthcare out of the hospital and into the professional office setting.

Total Healthcare Spend by Service Type: 1960 & Today
cdc.gov data

	1960	2014	Annual Trend
Total Health Care Spend *in billions $*	$27.2	$3, 031.3	
% within typical insurance cost	68.0%	68.9%	
hospital portion	33.1%	32.1%	
professionals, including home/DME	25.0%	27.0%	
prescription drug	9.9%	9.8%	
Census Population	180M	320M	
PMPM	**$8.56**	**$543.54**	**8.0%**

This 8% average annual total health care trend over the past 50+ years has led to the United States spending a higher % of GDP on health care than any other country. Today's health insurance purchasers (i.e., the government, employers, and individual consumers), often need to give up other spending to continue to fund their health care and health insurance needs. The government's reaction has been to use their purchasing power to limit publicly funded trends (i.e., Medicaid and Medicare) to lower levels, but as a result, the commercial market, made up of employers and individual consumers, has experienced trends even greater than this 8% average.

This article looks at the major players whose combined spend makes up the majority of today's health insurance premium. Once we understand all stakeholders are working hard to maintain current revenues and margins, we can understand how difficult it is to reduce insurance premiums. If health care costs continue at high levels it is hard for carriers to reduce premiums. While it is easy for politicians to say they will cut cost by "getting the waste out of the system", these players know that is another way of saying the system is working to find ways to pay providers less to care for their patients.

We will now look at these key players and some of challenges they are dealing with to keep their piece of the health insurance premium dollar.

Hospital Systems

Like any viable institution, hospital systems must manage their finances so they get enough revenue to at least cover their costs, and hopefully provide some margin as well. Hospitals are able to increase their margins through three basic means:

1. Filling hospital beds
2. Maximizing prices
3. Improving efficiency

One challenge that hospitals face is the inadequate reimbursement for Medicaid and other government programs. In many states, Medicaid does not reimburse hospitals enough to even cover their costs, so other products – typically commercial products – require significantly higher rates to cover these losses (i.e., required cost shift). Many hospitals also lose money on Medicare patients as reimbursement rates are controlled. A recent report by the Medicare Advisory group, MedPAC, stated that 64% of hospitals lose money at Medicare levels of reimbursement.[1] The hospital CFO looking at government business that could be as much as 60% of their hospital's revenue is obviously concerned and motivated to achieve as high of margin as possible on the non-government funded commercial business.

Raising commercial pricing is typically the most straightforward way to increase overall revenue, assuming there is no significant unfavorable impact to the hospital's volume of patients. The commercial prices a hospital is able to charge in a market are determined in large part by the market dynamics of the region in which it operates.

Hospitals have a great deal of leverage in negotiating commercial rates with insurers if they are the only facility in their region or if they have developed a reputation as "must-have" for certain services. With this leverage, a hospital can push prices as far as the insurance market will bear. Commercial reimbursement for hospitals can easily be double or triple the level that Medicare reimburses. A hospital's mission to provide reasonably priced care in the community will sometimes come into play, but that is not always the case. There is also the question of what price is reasonable.

In regions that have either competing hospitals or a single dominant insurer, though, commercial reimbursement rates are often much lower. In the first scenario, the hospitals may compete with one another, pushing down prices. In the second, the insurer has the leverage to negotiate with the hospitals and achieve lower rates.

In both of those latter scenarios, hospitals are challenged in achieving margins through higher prices, so they have to take another approach – improve efficiency of providing care. However, improving efficiency is not an easy task – it requires cutting costs (often people's jobs) and taking other difficult operational and clinical steps to offer lower-cost quality care. Where the market allows, it is often easier for a CFO to follow a strategy of demanding higher reimbursements on commercial products than attempting to improve efficiency.

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[1]Roy, A. (2011, September). MedPAC: 64% of Hospitals Lose Money on Medicare Patients. Retrieved from Forbes.com: https://www.forbes.com/sites/aroy/2011/09/21/medpac-64-of-hospitals-lose-money-on-medicare-patients/#3195215921b8

Professional Providers

Professional providers work to earn their profits in various ways, depending on their reimbursement arrangements. Typical reimbursement structures for independent physicians, not employed by a hospital system, pay physicians for every individual service they provide. In these arrangements, doctors have a financial incentive to perform more, and more complex, services even when they may not be necessary or the best option for a patient. Under reimbursement mechanisms often described as "paying for value vs. volume", physicians instead receive a budgeted amount for each patient to perform all necessary care. While these models were once popular during the rise of HMOs and are starting to make a comeback, uptake has been relatively slow and most providers still receive a majority of revenue under the "fee-for-service" model.

From a hospital's perspective, the value of a physician relationship is often tied to their ability to refer patients or steer them to their hospital. For example, physicians in specialties that fill hospital beds with high-profit procedures (e.g., neuro-surgery, cardio-thoracic surgery, etc.), especially those with the best reputations, are very attractive to hospitals. Hospitals want these surgeries to be done in their facilities so they can reap the profits from them. Stark laws (laws against self-referrals) create a challenging dynamic for these surgeons, though – it is illegal to receive compensation for a referral. Hospitals have gotten around these laws by buying the physician practices. By employing these physicians, often at escalated salaries, the hospital needs to make up for this cost elsewhere. As we saw in the previous section, these costs are often covered by increasing commercial prices for the types of surgeries noted above. Further escalation of costs occurs because employed physicians are now performing services for their patients in the higher-cost hospital setting vs. previously when much of their care could be performed in the office, or in low-cost ancillary sites. Where you receive your care has a direct and significant impact on how much that service costs. For example, you can have a colonoscopy done in a physician's office, in an ambulatory surgical center, or in an outpatient (hospital) setting – the procedure is the same, but the cost can be two or three times as much if it is performed in the hospital.

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Insurance Distribution Channels

The health insurance distribution channel includes health insurers themselves and those involved in the sales of their products (primarily insurance brokers and employee-benefit consultants). These payers and sellers often make their earnings as a percent of the healthcare premiums being charged. So as these health insurance premiums have increased at an 8% clip over the last 50+ years, so has the revenue and income of many of those involved in the distribution of health insurance. Without market pressures from other insurance companies or pushback from regulators or large employers, there is no inherent incentive for insurers to lower their prices or manage cost trends.

In a region with multiple insurers but little or no hospital competition, I often see a pattern where the hospital has normalized their insurance contracts to a point where every insurer pays a similar rate. Insurers are satisfied with this, because even though the rates may be relatively high compared to those in competitive hospital markets, at least the insurer is not at a disadvantage to their insurance competitors. And hospitals are satisfied, because as government payers continue to ratchet down reimbursement, they can go to their commercial insurers to help make up the difference, promising similar rate increases for all insurance competitors to keep the playing field level. But health insurance consumers are hurt, because insurance prices in these regions are often the highest in the country.

Large Employers

So how do purchasers in the commercial market continue to pay these increased prices each year? Increasingly, the answer for the individual consumer is that they can't. Without the government assistance through today's health care reform, many would not be able to afford their insurance coverage. But what about employers? While some small businesses have discontinued coverage for their employees and sent them off to the individual exchanges, most large employers continue to provide their employees with health insurance coverage. And many of these employers still demand robust benefits for their employees along with a wide choice of providers in the network – there is a general unwillingness to burden their employees with the inconvenience of a limited network for the sake of saving money on insurance premiums.

> "Without the government assistance through today's health care reform, many would not be able to afford their insurance coverage."

This unwillingness or perceived inability by large employers to demand lower health care trends has put them in a position of being bystanders to the rest of the market forces in play. The various market environments described in the previous sections show that costs and prices are absolutely influenced by the negotiating leverage various players have. Large employers could insert themselves into that dynamic by using their purchasing power to demand lower-cost benefit structures or narrow network products that achieve a pricing advantage. Particularly in markets with robust hospital and insurer competition, if employers were willing to burden their employees with a narrow network product, we could see greater movement towards optimal efficiency in hospitals and their network of physicians and ancillary providers. Those systems that can achieve the highest efficiency will receive a greater percentage of the available patients and their health care spend, and maintain a greater percentage of their margins.

In markets without hospital competition, unfortunately, things are more complicated. Regional employers would need to demand the premiums that exist in the highly efficient markets, or move their operations to one of the more efficient regions. This, of course, is more complicated and will only occur over a longer timeframe.

Conclusion

This article describes the key players that make up the health care, and health insurance premium, dollar. In today's environment of health care reform and debate over prices, it can often get lost that premiums are made up of the revenues and margins that many different players in the health care space rely on. For health insurance premiums to go down, either the consumer needs to pick up a greater percentage of the overall tab, or one of these players needs to take less. And these players are not likely in a position where they want to take less, so they look for all ways possible to protect their revenues and margins.

We see in today's regulated worlds of Medicaid and Medicare that the government has set prices at a level where hospitals and other providers are unable to achieve positive margins, so they look to the less regulated commercial market to make up the difference. This pushes up commercial premiums. One of the key commercial insurance consumers is large employers. Especially in regions with competing health systems, large employers could create benefit designs that narrow networks and encourage lower cost care. While these changes may lead to an inconvenience to some of their employees, the resulting market dynamic can lead to hospitals systems improving their efficiency and providing lower costs in the region, and ultimately lead to lower premiums.

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