

# Health Plans: Maximizing Care, Minimizing Costs

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It is no surprise that the health care industry has historically been one of the most important segments of our society. The services and care that it provides are critical to maintaining the public's health and are oftentimes lifesaving. Over the last century, the delivery of healthcare has evolved dramatically from family practitioners making house calls to care being sought at sprawling medical centers with elaborate diagnostic and treatment facilities.

Due to the growing expenses and complexity associated with the evolution of the health care model, medical consumers are demanding more solutions from the industry to help them manage their care and ensure that the cost of that care is reasonable. In response, health plans are working hard to ensure medical consumers become informed patients who receive quality care at fair prices.

Since their inception, health plans have protected individuals and their families from the financial risk associated with a catastrophic health issue. However, throughout the years they have expanded their services to better serve their members. The functions they perform for the medical consumer include:

- **Developing a Network of Providers** – Members of a health plan are guaranteed a network of providers they can utilize should they require care. This network includes primary care physicians, specialty physicians, and hospital services. The health plan's network, as well as their experts, assist members in navigating through the complicated "maze" of providers whose services they seek.
- **Negotiating Rates with Providers** – A critical benefit to health plan members is the negotiated rates they are guaranteed should they require care from a certain physician within their network. Without these negotiated rates the cost of health care would be prohibitive for many consumers depriving them of essential treatments they need to maintain their quality of life and, in some instances, survive. Additionally, the negotiated rates help reduce total health care costs for employers who provide insurance for their employees. According to the Kaiser Family Foundation's 2005 Annual Employer Health Benefits Survey, the percentage of workers covered by employer-offered health insurance was 60%.
- **Ensuring Quality through Credentialing** – Health plan members are assured of the quality of care they will receive within their network due to the credentialing of providers conducted by the health plan. This ensures that providers within the network will provide the highest quality services.
- **Ensuring Access to Primary Care** – Health plan members have become accustomed to the minimal co-pay required to visit a primary care physician. By making these visits financially feasible for patients, health plans facilitate the utilization of needed health care as conditions warrant while also providing affordable access to preventive measures before illnesses occur.

## Increased Health Care Costs = Increased Premiums

According to a 2006 report by PriceWaterhouseCoopers (PWC), from 1993-2003 the cost of health care benefits grew at an annual rate of 7.2 percent. During the same period health care premiums grew at a comparable 7.3 percent. The correlation between the growth in the costs of benefits and the increase in health care premiums underscores the linkage between direct medical costs and the premiums used to pay for health insurance.

According to the same study, 2005 premiums grew 8.8 percent over 2004 levels, 36 percent lower than the 13.7 percent increase PWC reported in 2002. In analyzing the 2005 increase, PWC attributes the growth to three key areas:

- General inflation
- Health care prices in excess of general inflation
- Increased utilization

Among the factors contributing to health care prices in excess of inflation is cost shifting resulting from providing health care to the uninsured. A 2005 study by Families USA indicated that providing care to the uninsured could add as much as 8.5 percent to the cost of premiums.

Reduced competition from provider consolidation within the health care industry as well as the use of new technology and prescription drugs are also driving up the pricing of health care in excess of annual inflation. From 1994 to 2004, the number of prescriptions purchased increased 68% from \$2.1 billion to \$3.5 billion.<sup>1</sup>

One health plan association reports that U.S. medical costs are rising as much as five times the rate of inflation with the fastest growth in hospital inpatient and prescription drug costs. The report states that more than half (51 percent) of the growth in health care spending goes to hospital inpatient and outpatient costs.<sup>2</sup>

According to PWC, increased utilization is also a key driver of the increase in health care costs. Factors influencing increased utilization include an aging population, complications from unhealthy lifestyles, new treatments and drugs, defensive medicine, and increased consumer demand.

### Breaking Down Your Health Care Premiums

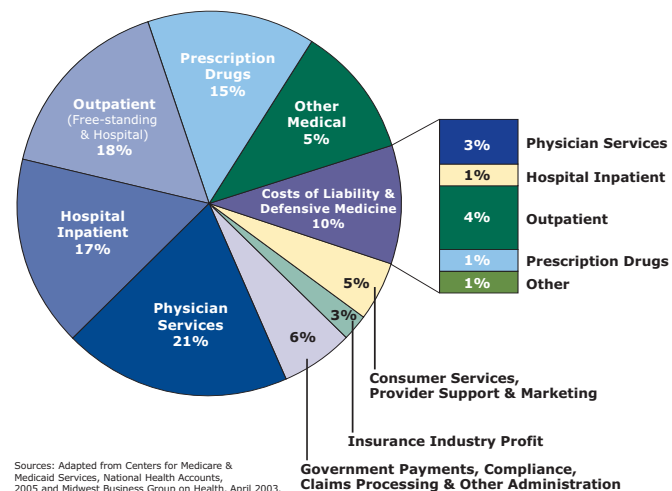
Understanding where healthcare premium dollars go provides a glimpse into the intricacies of today's burgeoning health care system. While the majority of premium dollars are used to pay medical claims, health plans face a number of other costs associated with the delivery of care.

As the chart reflects, approximately 76 percent of premium dollars goes to pay for the cost of health benefits, 10 percent to medical liability and defensive medicine, 11 percent toward administrative and customer related costs and 3 percent to health plan profits.

**Health Benefits.** The bulk of premium dollars is used to pay for claims associated with physician services, outpatient costs (includes free-standing facilities and outpatient departments of hospitals), inpatient hospital costs, prescription drugs and other medical services such as durable medical equipment, nondurable medical equipment, home health care, and other health professionals and personal care. Excluding medical liability, the percentage of each premium dollar used to pay for the following services is:

- Physician services: 21%
- Outpatient costs: 18%
- Hospital inpatient costs: 17%
- Prescription drugs: 15%
- Other medical services: 5%

**Estimated Breakdown of Insurance Premiums With Medical Liability and Defensive Medicine Extracted, 2005**



Sources: Adapted from Centers for Medicare & Medicaid Services, National Health Accounts, 2005 and Midwest Business Group on Health, April 2003.

It is important to note that there are hidden factors within the system that impact the rise in costs but few are aware of the impact they have. For example, a 2002 study by the Juran Institute, in conjunction with the Midwest Business Group on Health, estimates that misuse, overuse, and medical waste contribute to the “cost of poor quality” in health care and account for as much as 30 percent of all direct health care spending.

**Medical Liability and Defensive Medicine.** In order to limit medical liability exposure, many providers have started practicing defensive medicine, that is ordering tests and procedures they do not believe are medically necessary in order to reduce the likelihood of lawsuits. The practice of defensive medicine can expose patients to unnecessary medical risks and drive up healthcare costs.

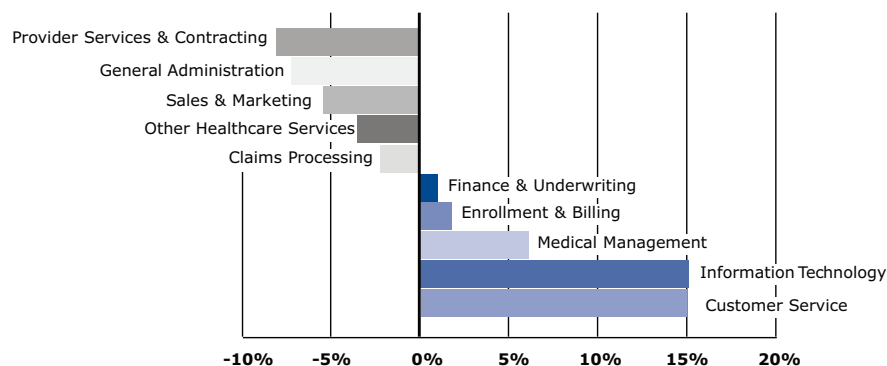
In 2003, the Texas Legislature passed major changes to medical liability insurance laws. The Texas Hospital Association reported that in 2004, a year after the new law took affect, hospitals across the state saw insurance rates drop 17 percent. The reforms are believed to be playing a major role in the reduction in medical liability rates for most providers.

**Administrative Costs.** Administrative costs represent expenses and outside direct medical costs health plans incur to provide for and enhance the delivery of health care. Thirty years ago, administrative costs primarily covered claims processing but today they have become an integral part of the health care delivery system utilizing technological advances to improve access to information for patients and providers; offering efficient and streamlined processing of claims for providers; enhancing customer service; providing for the implementation of disease management programs; and ensuring access to 24-hour medical help lines. While they also cover such functions as claims processing, financing, and marketing, administrative costs are also used to fund government mandates such as prompt pay requirements, HIPPA regulations, and premium tax assessments.

According to a study by Milliman USA, health plan administrative costs grew 4.6 percent between 1998 and 2002 compared to the approximately 7.4 percent growth of premiums for the same period. The report indicated that the greatest growth (80 percent) in administrative costs for this period was a result of an increase in information technology to enhance customer service. Industry trends confirm that significant investments continue to be made in this area. The Milliman report also indicated for the period studied general administrative costs declined by more than 8 percent; costs for provider services and contracting decreased by 9 percent; and costs associated with claims processing dropped an average of more than 2 percent. Overall, as a percentage of premiums, administrative costs have remained relatively constant for the last 40 years.

**Health Plan Profits.** Comprising the smallest portion of each premium dollar is health insurance company profits. Profits for health insurance companies consist of retained earnings, money allocated to reserves, and dividend payments to shareholders. According to a 2003 report by Milliman USA, profits for the U.S. health insurance industry averaged 2.7 percent in 2001. In comparison, profits for hospitals average 4.2 percent<sup>3</sup> and those for pharmaceutical companies 16.4 percent<sup>4</sup>.

**Health Plan Administrative Costs: Average Annual Change (1998-2002)**



Source: Milliman USA, *Health Plan Administrative Cost Trends*, 2003

## A Prescription For Change

There is little doubt about the cost of health care continuing to increase. In fact, by 2011, Americans are expected to spend almost \$2.9 trillion on healthcare, about a \$1 trillion increase from 2004.<sup>5</sup> Medical, pharmaceutical, and technological advances, new treatments, consumer driven health care, an aging and growing uninsured population and treatment of chronic diseases will all be important factors that will contribute to rising demand and costs of medical care.

Solutions that may help to address the rising cost of health care while ensuring quality care is delivered may include:

- *Pay-for-performance for providers* – There is growing evidence that current payment systems not only fail to reward or encourage quality care, but sometimes actually penalize providers for exceptional care. A pay-for-performance system would give health care providers an incentive to provide better quality at a lower cost.
- *Engaging medical consumers* – By making consumers more aware of their health care options and the preventive steps they can take to reduce the likelihood of disease or illness, we can reduce the demands placed on our health care system.
- *Ensuring transparency* – By increasing transparency of the pricing and quality of the health care system, we can ensure competition will remain high resulting in better care at lower prices for consumers.
- *Encouraging healthy lifestyles* – Poor diet, lack of exercise, use of tobacco products and other lifestyle choices are a significant factor in rising healthcare costs. By advocating healthy lifestyles, we can reduce the prevalence of potentially preventable diseases such as diabetes and cardiovascular disease.
- *Investing in new technology*. Investments in new technology will help streamline administrative processes, enhance customer service, empower medical consumers, and improve medical care.
- *Establishing benchmark reporting*. Creating a reporting system for the health care industry that measures efficiency, quality, effectiveness, and safety will lead to higher quality, lower cost medical care.

## The Future of Health Care

Creating a health care system for the future that will balance the dynamic developments in medical research and discovery with the ever-changing health needs and economics of the society it serves is a daunting challenge. Such a task will only be accomplished through the combined commitment and vision of our health care officials, providers, insurers, the business leaders, and our elected representatives.

From stem cell research and discovery of life-saving vaccinations to robotic surgeries and genetic coding, no other industry developments have a greater impact on our quality of life. As the health care industry continues to evolve to meet the ever-changing demands of medical consumers, health plans will continue to play an integral role in our nation's rapidly changing and expanding health care system.

<sup>1</sup>Kaiser Family Foundation, November 2005.

<sup>2</sup>BlueCross Blue Shield Association, "Understanding Health Plan Administrative Costs," 2003.

<sup>3</sup>American Hospital Association, Hospital Statistics, 2003.

<sup>4</sup>Forbes.com, The 2002 Global 500.

<sup>5</sup>Centers for Medicare and Medicaid Services.