10 MYTHS ABOUT HEALTHCARE AND HEALTH INSURANCE
Introduction

Healthcare here is expensive. In 2013, U.S. spent 17.1% of its gross domestic product (GDP) on health care. This was almost 50 percent more than the next-highest spender (France, 11.6% of GDP) and almost double what was spent in the U.K. (8.8%). To look at it another way, U.S. spending per person was equivalent to $9,086 while in the UK spending per person was $3,364. And despite spending more on healthcare, Americans on average have fewer hospitalizations and physician visits.

Not only is it expensive, but healthcare costs continue to rise at an unsustainable pace. Over the last 16 years Healthcare premiums have increased by 221%. And yet, most employers stick with the conventional approach of offering insured HMO and PPO products. They expect healthcare costs to go up every year and they’ve accepted that’s just how it is. Why? Perhaps it has to do with the acceptance of some common myths and the marketing major insurance carriers and health systems do to protect the status quo. In this paper, we will seek to challenge some common health care myths that might prevent employers from looking outside of the traditional insured options in the marketplace.

Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2015

Myth #1
Insurance Carriers are motivated to provide the lowest cost possible for an employer

In a post ACA world, insurance carriers must meet Medical Loss Ratios (MLR) of 85% which simply means 85% of premium must be spent on claims. Therefore their underwriting profits are limited to what is left after all admin, ACA fees and broker commission expenses...say 2%-4%. All the insurance carriers are public companies who must report earnings to shareholders on a quarterly basis and shareholders are interested in seeing profits grow. The only way for insurance carriers to increase earnings is to grow market share (which is difficult) or increase premiums such that their 2% or 3% profit margin equates to larger dollar amounts every year. The insurance companies have little incentive to lower healthcare costs (and by extension, premiums) as that would reduce earnings; their primary motivation is to keep premiums competitive enough with the marketplace so they don’t lose business. The insurance products offered, primarily HMO and PPO, have remained virtually unchanged over the last 30 years. A marketplace that rewarded the most effective and lowest cost model would see much more dramatic innovation than the minor deviations from the current products that are available today.

Insurance products offered, primarily HMO and PPO, have remained virtually unchanged over the last 30 years
Myth #2
HMO and PPO Network Discounts are Critical Components in Controlling Costs

Insurance carriers have HMO and PPO provider networks that they market to employers. These networks consist of physicians, professional service providers and inpatient and outpatient facilities. In exchange for being in the insurance carrier’s network, the service provider must agree to a negotiated amount for a given service. Providers generally want to be in network so they can attract patients to their practice. The network discount, then, is the difference between what a provider bills for a medical service and what the provider agrees to receive through the patient’s insurance plan. For example, if your family doctor charges $100 for an office visit and the contracted rate through the insurance network is $60, then the network discount would be 40%. We can refer to this as the “Network Model.”

The Network Discount Fallacy
Network discounts are a common benchmark to measure the effectiveness of an insurance carrier’s negotiating ability with the providers in its network(s). In theory, the bigger discount a carrier negotiates with a health system or provider means lower cost of care. This concept may have begun with the noblest of intentions, but today the discount is off a starting point (the billed charge) that has become completely arbitrary and continues to increase which is why we continue to see increases in unit cost.

The evolution of this focus on network discounts, instead of the actual cost and value per service provided, has led to often huge cost and quality variations within the network for the same exact service. There is generally no price transparency, employees don’t know if the service they are receiving is expensive, cheap or reasonable. The insurance carrier provides little to no guidance for the patient on which providers are more cost effective, so the value of the network is severely diminished when patients end up getting care at the most expensive service providers in the network. For example, a recent study by the American Journal of Managed Care, showed that for individuals with employer-sponsored insurance, prices for common services (office visit, CT Scan, MRI, X-ray, endoscopy and colonoscopy) performed at hospital outpatient departments were higher than prices for the same services at other care settings (i.e., physician offices and/or ambulatory surgical centers). Price variation ranged from 21% more for an office visit to 258% more for chest radiography at hospital outpatient departments1.
The health insurance industry has “attempted” to remedy this through a combination of high deductible health plans and transparency tools that push the responsibility of finding the most cost effective care to the patient. This has had limited success.

**The Network Cost Fallacy**
The provider network discount doesn’t always provide the lowest cost. The discounted prices employers pay through Provider Networks are often 200% - 400% times higher than Medicare rates of reimbursement. Additionally, a recent LA Times article discussed how cash prices may often times be less than insurance discounted prices for common procedures. In the example, 4 routine blood tests at Torrance Memorial Medical Center were billed to Blue Shield at a rate of about $80 each, while the cash price was closer to $15 apiece. One problem with paying cash prices for someone with insurance is that it doesn’t accrue to your deductible or out of pocket maximum, so the current system actually penalizes a patient for being a good consumer. The bottom line is that insurers’ negotiated rates have little to do with the actual cost of providing a medical service and employers and employees are not necessarily getting the best deal through their network discounts.

The Network Model is actually part of the problem. We have been conditioned to believe that we can get the best pricing using an “in-network” provider thus we usually seek to find a provider in the network. This Network Model and corresponding belief has allowed providers of all types to raise their prices regularly and led many insurance companies to accept provider increases so they can maintain a large network of providers as that is what is desired by employers. The Network Model and the lack of price transparency actually inhibits the ability of consumers and employers to seek the best value of care (low price and high quality) and protects the current opaque provider reimbursement model that naturally leads to higher prices.
**Myth #3**

**HMO’s are the best option for controlling costs for an employer**

HMO products are based on a reimbursement model called capitation where the provider gets a fixed dollar amount per month, per year (i.e. a budget) to manage the healthcare costs for an individual and/or a specific population. There are a number of payment models in use that employ capitation, but the basic concept is common to all of them. This payment structure shifts risk to the provider(s) and away from the insurance company which changes the set of incentives for each party. The insurance company, by shifting the risk and responsibility to the provider, has reduced some of its responsibility for the patients’ well-being under their insurance program (while still collecting the same profit margin). Providers are generally given a fixed dollar amount per patient regardless of how much care each patient actually needs/uses. Basic economics tells us that the less care a provider must provide to their set of patients, the more profit they stand to reap. Capitation reimbursement rates, negotiated with the insurance carrier, generally go up every year, and so the incentive is for providers to manage costs to a target profit margin within their budget.

Capitation based HMO products in certain markets have proven to be more cost effective than traditional PPO offerings, but the underlying incentives still support higher costs and there isn’t any opportunity for an employer to see the benefit of lower than expected utilization of their employee population, other than a renewal below medical inflation which we have been trained to believe is success.
Myth #4

It’s the Insurance Companies That Are Screwing Everybody and Driving Up the Cost of Healthcare

Politicians and the Media love to label insurance companies and Big Pharma as the villains in our healthcare conundrum. And while insurance companies are certainly complicit, tacitly or actively, in the overall upward trend in healthcare costs, we cannot exclude the healthcare delivery system from the equation. Providers and Hospitals are generally staffed by good people who want to deliver good care and outcomes to their patients. That said, they are a major part of the problem. Unit cost increases from the provider community are a direct contributor to higher medical inflation that drives our insurance costs higher each year.

There is an incredible amount of gamesmanship by providers to manipulate the insurance payment system to their benefit (i.e. charge as much as possible). Providers hire consultants to help them with “upcoding” or strategic billing to maximize what they can bill insurance; examples of “creative coding” are where simple procedures are coded at higher severity levels to generate a higher cost. I’ve listed a few examples below:

- Ex. Injecting a patient’s knee with steroids can be coded as “surgery” and generate $1,200. ³
- Ex. A blood draw in the ER costs $1,137 for the “work” done by the ER doctor and $2,198 for Hospital “services.” ³

Additionally, Hospitals are buying up primary care and specialty practices, in an effort to “drive efficiencies”, but the net effect of those consolidations is higher reimbursement rates as the larger entities leverage their volume to negotiate higher rates of reimbursement with insurance carriers. A recent study published in JAMA Internal Medicine explored what happened to healthcare spending when physicians and hospitals integrated. They discovered that outpatient spending rises as physicians gain market power through their hospital alliance. The spending increases are due almost entirely to price increases⁴. The providers and hospitals are not victims, rather they are players/collaborators in the healthcare continuum all looking to maximize their slice of the pie, much to the detriment of payors (employers and employees).
Myth #5
High Deductible plans are the best ways to reduce costs as employees will know how to spend healthcare dollars more effectively

While High Deductible Health Plans (HDHP’s) may provide some visibility into healthcare pricing, there are limited tools available to employees that illustrate price and quality and make it easy to be a good consumer. The concept of ‘shopping’ cannot be applied in the same manner to healthcare as it can be for other goods and services. Healthcare can be extremely complex and even professionals are not always equipped with the information to make educated decisions. The expectation that the average consumer can become their own healthcare expert in relatively short order has not yet, and may never, become reality. Patients tend to rely on their primary care doctor to help steer them to more advanced care as needed. A recent 2015 McKinsey study confirmed that most people’s doctor’s recommendation was the key factor that influenced their decision about where to seek advanced care⁵. A doctor’s primary job is to make sure that you receive the best care and they aren’t generally concerned with cost as they are often not privy to this information outside of their own practice. The notion that people will know how to better spend their healthcare dollars just because they now bear more of the burden of the cost is simply not realistic.

HDHP’s may perform better than traditional plans but further investigation often finds that this is because they attract lower utilizing portions of a population. Medical inflation for HDHPs has not yet proven to be significantly different than that of traditional HMO and PPO plans. What is known is that HDHP’s shift cost from the insurer to the patient in exchange for lower premium. What is beginning to appear in claim studies is that HDHP products may even be discourage people from getting the basic healthcare they need due to the cost of services. This potential barrier to care and delayed utilization could result in higher costs down the road if untreated conditions worsen and require more acute care.
Reconstructing Healthcare

Myth #6
You’re getting a great deal on Prescription Drug pricing through your insurance carrier or PBM

Prescription Drug pricing through insurance is one of the most misunderstood components of the healthcare cost equation. Much like PPO networks, drug pricing is not transparent to the consumer, prices for prescription drugs vary widely between pharmacies and the copay structure of most plan designs removes any incentive for the consumer to worry about the actual cost of the drug.

The cost of the drug at the pharmacy is not what you the employer are being charged. PBM’s and Insurance companies employ a variety of tactics that make it almost impossible to dig down and find out what the bottom dollar cost of a drug is. The most common of these tactics is called spread pricing, where a profit margin (sometimes significant) is added to the price a PBM pays the pharmacy for a specific drug and then charges the employer the higher price for the drug and pockets the difference.

Insurance carriers and PBMs have formularies, or list of preferred and non-preferred drugs. They use their formularies to drive volume to specific drugs. In exchange for volume, they receive rebates from drug manufacturers that are only partially shared, or often not shared at all with the employer and accrue to the insurance carrier or PBM as additional profit margin. Additionally, many PBMs construct elaborate rebating contracts that allow them to reclassify rebate dollars such that they aren’t at all visible, or shared, with the employer. Often drug formularies will be constructed, at least in part, to maximize these revenue streams to the PBM with little or no regard for the actual cost of drugs that the employer and member have to pay.

Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than $100-$200 between two pharmacies across the street from each other! Unfortunately, employees with copay plans aren’t incentivized to seek the pharmacy with the lowest cost for a particular drug, so employers may be paying more than they need.
to for employee’s prescriptions.

Additionally, even If you have insurance with a low copay your copay still might not be the best price. Hundreds of generic medications are available for $4 or even free without insurance. Your $10 or $20 copay doesn't sound so great when you can get the same drug for 60% less. If you have a HDHP, you are likely paying a lot for prescription drugs. However, there are many ways to save 80% or more - coupons, savings tips, pharmacy discounts, manufacturer discounts, cheaper alternative drugs or even just asking for a better price.
Myth #7
Access to the “best” hospitals and medical groups is really important so my employees can get quality care when they need it.

This is the “truth” that we’ve been sold by the insurance carriers and the marketing done by providers labeling themselves as “premier.” In exchange for the “premier” label they have branded themselves with, comes a price tag often times double or triple what is charged at other providers with similar or better quality ratings. The fact is that, while we may want the Porsche SUV, the Honda or Toyota can get us safely from point A to point B at less than half the cost. Similarly, there are many places to get quality care, but without price transparency, the right incentives and a different model to navigate through the healthcare ecosystem, patients will generally opt for the Porsche when there is little to no cost impact to them for choosing it over the Honda….and the employer will pay for it via higher insurance premiums.

Here’s a better example: In one geographic area, prices for a standard brain MRI (procedure code 70551) within one 5 digit zip code covering about 0.4 square miles varied from $210 to $1,400. For that same procedure, another zip code just 5 miles away covering 2 square miles, prices varied from $79 to $490. That’s a price variance of 1772% for a commodity procedure, but the current system provides the patient with limited tools or incentives to choose the best value (cost & quality) solution here. Rather the patient chooses with little to no regard to cost which the current HMO/PPO product benefit design enables. No reasonable business owner would allow his/her employees to spend money like this on other business expenses (like business travel, marketing or shipping); employees are generally required to operate within a budget and balance cost vs. quality. Bottom line, access to the “best” providers has very little to do with providing access to quality care for employees. It has even less to do with saving money.
Myth #8
Your provider always recommends the best course of treatment

A substantial amount of the care we receive is not only unnecessary, but arguably not evidence-based medical care. Providers may have undisclosed financial incentives to refer patients to specialists, prescribe certain drugs or suggest complex, expensive procedures. Additionally, many doctors simply cannot keep up with the research and evidence-based medicine practices and continue to do what they’ve always done EVEN when proven not to work or worse, be detrimental to a patient’s wellbeing. Unfortunately, it is increasingly ordinary for patients to get treatments that research has shown are ineffective or even dangerous. Below are a few examples that illustrate this point:

- Musculoskeletal Procedures (ex. knee replacements and spinal fusions) – these procedures are typically 20% of healthcare spending and only 50% of musculoskeletal procedures are evidence based. One hospital in Seattle indicated that at one time 90% of its spinal procedures were of no use.  
- A recent study of more than 1,600 hospitals across the country concluded that about half of all stent placements in stable patients were either definitely or possibly inappropriate.
- Atenolol is a medication to lower blood pressure and reduce risk of stroke/heart attack. Research has proven that it does not work but doctors still prescribe it.
- A procedure known as arthroscopic partial meniscectomy, or APM, accounts for roughly a half-million procedures per year at a cost of around $4 billion. APM is meant to relieve knee pain by cleaning out damaged pieces of a meniscus and shaving the cartilage back to crescent form. A significant amount of research says that it does not work for the most common varieties of knee pain and that most patients would be better off with physical therapy. In other words, a lot of money is being spent on surgeries and a majority of the people who go under the knife are unlikely to get any benefit.
- The following is a list of serious health conditions and the typical misdiagnosis rates:
  - New cancer cases – 20%
  - Spine Surgery – 67%
  - Orthopedic Surgery – 30%
  - Bypass surgery – 60%
  - Stents – 50%
  - Solid organ transplants – 40%
The bottom line is that employers are seeing their claims go up annually with a portion of claim dollars spent on unnecessary care, and most insurance carriers and TPA’s do very little to prevent or curb these wasteful expenses.
Myth #9
Auto-adjudication of claims is beneficial for your plan

In healthcare, "Claims adjudication" is a phrase used in the insurance industry to refer to the process of paying submitted claims or denying them after comparing claims to the benefit or coverage requirements. Auto-adjudication of claims is when the claim is automatically processed and paid without human review based on a set of rules, which improves efficiency and reduces the expenses required for manual claims adjudication. But is that always a good thing?

Insurance carriers and TPA's auto-adjudicate 90% or more of all claims, meaning they pay the claim based on a uniform bill without auditing the details to ensure that the payor is not being overbilled. Studies from the University of Minnesota estimate that 30%-40% of all medical bills contain errors. Additionally, studies by the US government and Equifax indicate that over 90% of Hospital bills contain errors leading to overcharges to the payor. Common billing errors include:

- Services billed, not rendered
- Duplicate billing
- Unbundling (This refers to the separation of charges that should have been billed under the same procedure code.)
- Upcoding (occurs when a medical billing code is improperly changed to one which represents a more severe diagnosis or treatment. This is illegal and can cause your bill to be inflated.)
- Egregious overcharges
- Never events

Here are some examples. In each of these cases, the claim was paid and the error was only discovered when the patient or their advocate challenged the bill.

- During a visit for congestive heart failure, the hospital had double-billed for a ventilator during each day of the weeklong stay, adding $2,416 to the bill.
- During a visit to treat dehydration, a woman was charged 41 times for a single intravenous drip, sending her bill to $5,832. Once bill was corrected, total charge was $420.05.
- Blood draw in the ER is billed at $3,383. The blood draw was coded as a level 5 visit which should have included “a detailed history, extensive management or lab results, and examination of multiple body systems”; none of this transpired.
• Overcharging examples: $1,050 for an oral cleansing device (aka toothbrush), $513.23 for an Acetaminophen tablet (aka Tylenol), $75 for a mucus recovering system (aka Kleenex).

• Anesthesiologist billed plan twice for the same patient on the same day under slightly different CPT codes resulting in double payment.

• Patient arrives at the emergency room on Tuesday at 10 p.m. and the doctor writes an order to admit patient as inpatient to the ICU at 11:35 p.m., but patient doesn’t move into it until 2 a.m. Wednesday. The hospital charges the patient $3,000 for the ICU on Tuesday. Their reason for the full-day charge on Tuesday: The doctor wrote the order before midnight. But if the patient never saw the inside of the ICU until Wednesday, the hospital shouldn’t be able to charge for it.10

Inpatient Facility claims drive a large portion of healthcare spend for most employers. Insurance Carriers and TPA’s aren’t requesting itemized bills or auditing to find these errors, which means employers are likely overpaying for a good portion of their inpatient claims. Furthermore, even when an employer does their due diligence to conduct a claims audit of their TPA, the traditional methods employed for these audits rely on samples of data to audit which are retrospective and allow fraud, waste and abuse to fall through the cracks.

Insurance companies and most TPA’s have little financial incentive to hunt down mistakes on your behalf (see Myth #1). The result is that most employers are unwittingly paying more than they should be.
Myth #10
Employers with less than 200 employees are too small to self-insure and the only safe option is to buy fully insured products

The longstanding perception has been that the smaller the company, the smaller the risk pool across which to dilute any catastrophic or unforeseen claims. Therefore, self-funding was not appropriate for smaller employers who couldn’t tolerate the financial risk of a large catastrophic claims. As a result, less than 20% of employers with 51-199 employees self-funded their benefit plans.

But “safe” is a relative concept and the “safety” of annual high single digit and/or double digit increases from fully insured markets is growing wearisome for many employers. The truth is that employers with under 200 employees are not too small and there are many ways to self-insure and partially self-insure health benefits that can lead to significantly better performance than traditional insured products.

Some of the benefits on self-insuring include: lower taxes and fees, no need to provide all state and federal mandated benefits applicable to fully insured products, ability to get better Rx discounts, control drug formulary, implement benefit design incentives to lower costs and access to your data. Given the large risk charge most insured carriers charge to smaller employers, savings can range from 10%-25%. Most importantly, when costs are below budget, the surplus accrues to the employer and NOT the insurance carrier.

There are, of course, risks to self-insuring benefits and other factors to consider. A few common concerns are 1) managing corporate cash flow when monthly claims bounce up and down dramatically and 2) managing the impact of a few catastrophic large claims. Stop Loss insurance can be purchased to minimize the employer’s risk to an acceptable level as well as alleviate cash flow concerns.
REFERENCES:

American Journal of Managed Care
1 “National Estimates of Price Variation by Site of Care”, American Journal of Managed Care, Vol. 22, #3

LA Times


Forbes
4 “Here’s What Happens To Your Medical Bills When Your Doctor Joins Forces with A Hospital”, Forbes, 6/30/2011
JAMA Internal Medicine

2015 McKinsey study

Health Rosetta Media

The Atlantic

The Wall Street Journal
The Huffington Post
About the Author

Michael Menerey is a Senior Vice President and Benefits Consultant with one of the largest Employee Benefits Brokerage & Consulting firms in the country. He is a partner in the Employee Benefits Practice and works in the Los Angeles office. Michael enjoys collaborating with his clients to challenge the status quo approach to benefits and is constantly evaluating new products, vendors and strategies that can drive lower costs and create value for employers, employees, and their dependents.

To learn more about creative strategies to control your health insurance costs, Michael can be reached at: www.reconstructinghealthcare.com/contact