Health Insurance Transparency and Efficiency:

Keys to Controlling Health Care Cost

Testimony to Senate State Affairs Committee • May 21, 2008 • Presented by Susanne Madden

Today we see a growing trend of employers dropping coverage for their employees and the number of uninsured individuals increasing rapidly every year.

Most of us do not understand how insurance companies are managing our health insurance premium dollars and where that money is going.

Good morning. My name is Susanne Madden. I am president and CEO of the Verden Group. I would like to thank the chair and the committee for the opportunity to testify on interim Charge No. 1 — about the factors that contribute to increasing the cost of health care. In addition, I will discuss on how greater transparency and efficiency of the health insurance market could positively affect employers, their employees, and individual purchasers of health insurance.

Point 1: Lack of Transparency in Premiums and Medical Cost Ratio Calculations

The manner in which health insurance companies conduct business is not understood. In fact, health care spending in general is not understood. Why? Because the term "cost" is not defined adequately. Let me explain.

We need first to understand clearly the difference between the cost of health care, and the amount that is actually spent on health care. The two are quite different:

- **Health care spending** is the amount that managed care organizations (MCOs) actually spend on services rendered by health care providers, such as physicians, hospitals, labs, and pharmacies.
- **Health care "cost"** is the amount it "costs" employers and patients for their health care — the largest portion of which is the amount employers and patients spend on their insurance premiums.

Health insurer profits are expressed as part of the industry terms "medical cost ratio" (MCR) or "health benefit expense" (HBE). MCR/HBE is the percentage of premium dollars spent on payments to physicians, hospitals, and other health care providers for health care services rendered. The amount of premium dollars left over after spending on health care constitutes health insurer profits. Simply stated, insurers can maximize their profits by keeping the amount of your premium dollar they spend on the MCR/HBE low.

It is not complicated. We — employers, employees, and individual consumers — pay insurers to assume some risk and administer benefits on our behalf. Employers look to insurers to manage employee benefits and help control costs. As enrollees in the health plan, we assume our insurer will pay for our health care services. Insurance companies are therefore charged with controlling costs actively, and hence, the logic goes, "managing" care with the goal of reducing inefficiencies in the system.

Yet costs are not controlled; instead, costs are simply shifted. As premiums rise, employers cannot afford to pick up the whole tab. So employees end up contributing more to health insurance premiums, and paying higher out-of-pocket costs through higher deductibles, copays, and coinsurance, while at the same time

receiving fewer benefits. Conversely, physicians, hospitals, and other health care providers are paid less and less for their services.

What we have seen over the last decade is that the amount spent on medical care reimbursements has declined, and the largest portion of that decline is a reduction in the amount physicians, hospitals, and other health care providers are paid. Yet the cost associated with purchasing health insurance has continued to climb dramatically.

Point 2: Lack of Transparency in Health Plan Financial Statements

Health insurers release financial results quarterly, usually in the form of a press release accompanied by financial statements. On a standard financial statement for any large, publicly traded MCO, such as UnitedHealth Group, the information on the balance sheet is reported under revenues as premiums, services, products, and investments; and under operating costs as medical costs, operating costs, cost of products sold, and depreciation and amortization. Medical costs payable are listed as a liability.

The press release outlines the "financial highlights" contained in the company's numbers, and explains why financial targets were missed. However, the statements never tell us what activities go into medical costs payable. "Medical costs" seems to suggest that costs are associated with payments for the delivery of health care services. Yet the balance sheet does not mention marketing, administration, and recruitment activities, and there are no line items for these activities. That means all those activities must be captured in the "medical costs." With no information about how much is spent on marketing, administration, and the like, we simply cannot calculate how efficiently our premium dollars are being spent.

"Managed care plans earn higher margins today than they ever have before, and operate at lower medical loss ratios than at any time in their history."

— CIBC World Markets Analyst Carl McDonald

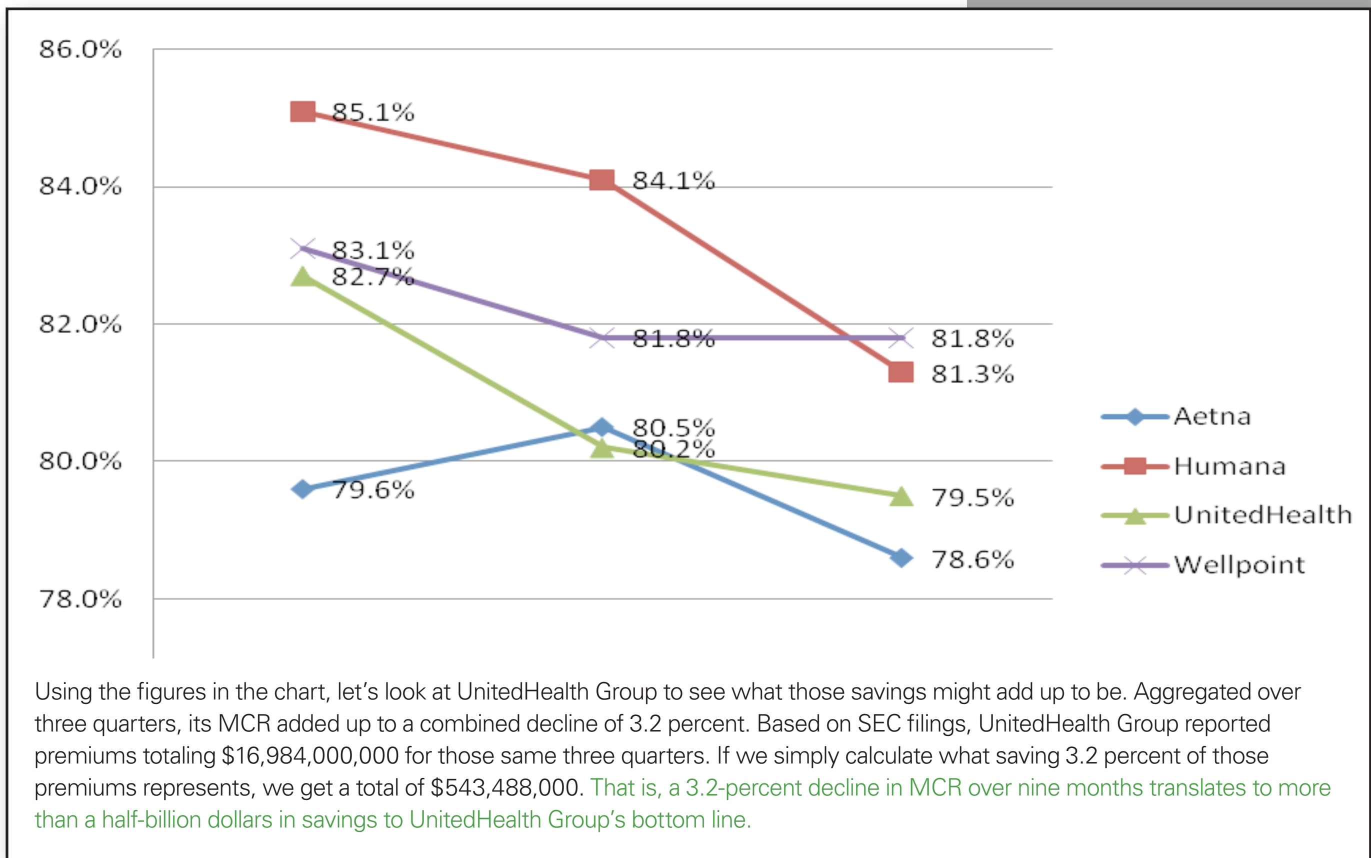
Control Costs or Cut Payments?

If we believe that MCR/HBE is the percentage of premium dollars spent on payments for health care services, then insurers hold onto roughly 15 to 21 percent of premiums as profit.

Insurers reduce their risk by controlling costs in a number of ways. In its finest form, cost cutting is achieved through efficient operations; negotiating better contracts with high-volume service management companies, such as labs and diagnostics; and actively promoting well-care programs to achieve healthier members. Some of this happens, but there is a growing trend across the board to simply cut payments to health care providers and erode provider revenues through policy and procedure changes.

By examining the medical cost ratio or health benefit expense of four large, publicly traded national MCOs for the three quarters ending September 2007, we can see how MCRs/HBEs have decreased from period to period. While the percentage points are small, the financial impact is dramatic. See Fig. 1.

Fig. 1. Medical Cost Ratios Q1-Q3 2007



Using the figures in the chart, let's look at UnitedHealth Group to see what those savings might add up to be. Aggregated over three quarters, its MCR added up to a combined decline of 3.2 percent. Based on SEC filings, UnitedHealth Group reported premiums totaling $16,984,000,000 for those same three quarters. If we simply calculate what saving 3.2 percent of those premiums represents, we get a total of $543,488,000. That is, a 3.2-percent decline in MCR over nine months translates to more than a half-billion dollars in savings to UnitedHealth Group's bottom line.

As we can see in Fig. 1, each incremental percentage point decrease is worth millions of dollars in savings to these insurers and provides a telling example of how insurers can manipulate their MCR/HBE to their investors' advantage.

How Do Health Insurers Arrive at Their MCR?

Insurers can manipulate MCR in several ways. The easiest way is simply to reduce the amount paid out for medical services delivered by providers through payment cuts and policy changes. I have never seen those strategies directly discussed in any financial report. Instead, when an MCO figures out a way to hold on to more of the premium dollar, it is called a "favorable development" and is recorded as such. All associated initiatives that result in holding those premium dollars are lumped under that term.

To explain more fully, a "favorable development" is when the actual cost is less than the estimated cost over a given period. Therefore, when an insurer's medical costs go down more than expected, the event is referred to as a "favorable development."

Fig. 2 is an excerpt from an SEC filing that shows how favorable medical cost decreases were for one MCO over the period 2002-06. Note the column titled Increase (Decrease) to Medical Costs. This column is evidence that "spending" decreased year over year. But while that insurer spending is down, health care costs to society are still increasing. This clearly illustrates the disconnect between actual "cost" (premiums) and real "spending."

We can see that the profit margin comes not only from increasing premiums but also by lowering the amount MCOs spend on health care every year.

Fig. 2. SEC Filing

	Favorable Development	Increase (Decrease) to Medical Costs (a)	Medical Costs		Earnings from Operations	
			As Restated (b)	As Adjusted (c)	As Restated (b)	As Adjusted
2002	$ 70	$ (80)	$ 18,938	$ 18,858	$ 1,969	$ 2,049
2003	$ 150	$ (60)	$ 21,482	$ 21,422	$ 2,671	$ 2,731
2004	$ 210	$ (190)	$ 27,858	$ 27,668	$ 3,858	$ 4,048
2005	$ 400	$ (30)	$ 33,669	$ 33,639	$ 5,080	$ 5,110
2006	$ 430	(d)	$ 53,308	(d)	$ 6,984	(d)

(a) The amount of favorable development recorded in the current year pertaining to the prior year less the amount of favorable development recorded in the subsequent year pertaining to the current year.

(b) Restated to include the impact of FAS 123R, which we adopted effective January 1, 2006, as well as impacts associated with the restatement described in Note 3 "Restatement of Consolidated Financial Statements."

(c) Represents reported amounts adjusted to reflect the net impact of medical cost development.

(d) Not yet determinable as the amount of prior period development recorded in 2007 will change as our December 31, 2006 medical costs payable estimate develops throughout 2007.

Note also the restated and adjusted costs listed in Fig. 2. This discrepancy is due to the lag time involved in receiving and processing medical claims. Medical costs have to be estimated at the end of each period and each year. As each calculation is restated, we get a clearer picture of how operations from the prior period(s) show ever-increasing dividends for the insurer and how manipulation of these payments owing will result in better MCRs.

Favorable outcomes result from mergers and acquisitions, higher enrollments, premium increases and various cost-cutting initiatives to network providers. Rather than insurers using premium dollars to reduce costs through disease management, improved preventive medicine, and other initiatives that might **improve** care, "cost-cutting" simply means not paying for and/or reducing the amount of payment for medical services rendered to their members by health care providers.

Meanwhile, as health insurance premiums rise and MCO spending on medical services declines, insurers' profits grow ever wider. Physicians', hospitals', and other health care providers' costs continue to increase due to inflation and the ever-more-complex administrative burdens placed on them by insurers. However, their payments remain flat, and in many instances across the country, their payments actually decreased over time.

WellPoint President and CEO Angela Braly emphasized WellPoint's market power, which she said gives it the ability to lean hard on its network doctors to accept lower reimbursement.

Point 3: Lack of Clarity in Health Insurer Network Contracts

While managed care contracts differ from company to company, most have common overarching themes. Many contracts have provisions that inordinately favor the health insurer, not the health care provider. The terms of these contracts are crucial to how health care providers are paid for the services they render and what they have to do to obtain that payment.

Standard Contract Clauses

The MCO's ability to maneuver at a physician's expense is built right into many MCO contract clauses.

1. **Termination Clauses:** Several contracts have termination language that restricts the physician's ability to leave a plan. Most often, the rules for termination state that the physician must give the MCO 60, 90, or even 120 days' notice. In some cases, the agreement stipulates that in addition, it must be given no later than 60, 90, or 120 days before the contract anniversary date. If a physician misses that window, he or she will have to wait until the following year before being released from the contract, regardless of the economic situation that may be prompting the need to terminate the contract in the first place, such as a cut in rates.

2. **Silent PPO Activity:** Often, without the physician's knowledge or agreement, unregulated "silent PPO" activity occurs where affiliates, leased networks, and acquisitions ensure that MCOs are able to pay for services at the most favorable (lowest) rate. This means that physicians are contractually bound to see patients from other networks at in-network rates as insurance alliances are made, networks are leased, and repricing of claims continue. This removes physicians' ability to control their bottom lines and ensures that they receive the least amount of payment possible.

3. **Recoupments:** Language related to erroneous payments allows insurers to take back or recoup any payments found later to have been made in error. For instance, sometimes insurers overpay claims, pay duplicate claims, or pay for services that should have been denied. After audits reveal these errors, insurers seek back payment. Often, payment is recouped because the patient cancelled his or her policy with the MCO, or the payer thinks another MCO is primary. Many contracts state that the MCO can "take back" or "offset" these amounts against other patient claims. Often this is a hardship for physicians, because it reduces their cash flow and creates an administrative cost to track offset claims against old billing records.

   Further, many of these clauses state that a payer has the right to offset or take back claims payments up to two years after the date of service, but it is nearly impossible for physicians to collect money from the patient or another insurer that long after services have been rendered. Conversely, physicians usually have only have 45-90 days in which to file a claim, or forfeit payment entirely. Fortunately in Texas, at least for the fully insured, state-regulated products, the legislature addressed standardizing filing deadlines (95 days) and this protracted recoupment activity through your prompt pay legislation in 2003. However, ERISA or self-funded plans for which there is no such protection are growing, leaving as much as 50 percent of the business unregulated across the state.

4. **Arbitration:** If an MCO breaches a contract, often the only contractual option is to work through arbitration. Most physicians cannot afford the time and cost involved in arbitration with a deep-pocketed insurer, further ensuring that revenue-eroding practices are likely to go unchallenged.

5. **Bundling/Coding Processes and Medical Policy:** Payment rates are not the actual rates if physicians cannot get paid for these amounts. In many instances, specific codes have designated payment rates, but individual MCOs may not pay for those services depending on the specific coverage criteria and medical policies they employ. We will examine an example of how this works further in to this testimony. Contractual termination strategies keep physicians, hospitals, and other providers of care locked into networks while MCOs continuously chip away at their contracted payment rates or revenue streams. This combination ensures creating economic shortfalls for providers of care.

Revenue Stream

An insurer can alter its revenue stream in several ways within the parameters of its contracts. Any time providers are not paid for services, MCOs make money. Sometimes nonpayment is the fault of physicians, for example, when they use the wrong code or submit an incorrect ID number on the claim. However, insurers along the way manipulate a certain percentage of claims due to initiatives and errors, and through mishandling.

Athena Health and Physician Practice's PayerViewSM has provided insight into how many claims are hung up during the billing (or revenue) cycle. Athena grades payers on seven metrics including "days in accounts receivable" (DAR), "first pass resolve rate" (FPR), denial rate, and percentage of claims requiring medical documentation. These metrics are important because they give us an idea of what it costs physicians to bill these major MCOs for services. Every day claims are outstanding means that physicians, hospitals, and other health care providers are extending credit to insurers. Denied claims need to be resubmitted and/or appealed, costing health care

According to *Physicians Practices*' 2006 Fee Schedule Survey, "average physician reimbursement from commercial payers … collapsed in 2006, with payment levels averaging 17 percent below that of 2002 and a staggering 36 percent below that of 2004."

It doesn't seem like physician payments can go much lower.

providers time and money. Often these entities just forgo the expense, which allows MCOs to "keep the change," futher improving profits and minimizing spending.

To illustrate these points, let's break down some of the information around FPRs and denials, and come up with actual cost estimates associated with these metrics.

- FPR represents the rate at which claims are successfully processed the first time they are submitted.
- Denials are any claims that require further research and/or the preparation of an appeal.

Looking at Athena's national numbers (Fig. 3), here is how five large managed care companies stacked up in these two areas for 2006. (Please note that the metrics are independent of one another, i.e., they do not add up to 100 percent when combined.)

Fig. 3. Athena Report

	Cigna	Aetna	UnitedHealth Care	Wellpoint	Humana
FPR	96.3%	95.9%	95.8%	95.3%	95.1%
Denials	5.9%	6.6%	7.8%	7.4%	7.6%

Source: Athena PayerView[1] 2006 National Rankings

Taking Humana as an example: 95.1 percent of claims are processed on the first pass, meaning 4.9 percent are not and need to be resubmitted. Using $4.40[2] as a rough estimated cost to resubmit each claim, and 2,000 claims as an average monthly volume for a midsize primary care practice, the estimated cost works out as follows

FPR

2000 claims

x 4.9% = 98 non-FPR claims

x $4.40 = $431.20

As you can see, the expense adds up quickly, even with an MCO that ranked well on this metric.

Managing denials is much more expensive. Often it is difficult to determine why a claim has been denied. It requires the rendering health care provider's staff to get on the phone with the insurer, prepare a denial letter, and send it to the designated appeal department. Taking as our denial example Cigna, which has the lowest denial rate nationally according to Athena, and using $40 as our estimated cost (time, plus resources), it works out to be

Denials

2000 claims

x 5.9% = 118 denied claims

x $40 = $4,720

That is a sizable expense for any business!

This may explain why so many physicians simply write off denials. For a primary care physician, each of those claims may be worth $35 to $50 each, making the cost of appeal prohibitive as it costs nearly as much to collect on it as these claims are worth. For every denied claim that should have been paid but goes undisputed, MCOs hold on to those premium dollars, further improving their medical cost ratios.

Policy Changes

Managed care agreements are unlike any other business instrument. The terms that are stipulated in the contract today are unlikely to be the same terms a year from now. That is, the underlying policies related to the agreement change over time, yet contracted entities have to abide by those changes because their contract says so.

Occasionally, these changes can be beneficial for providers, such as UnitedHealth Group's and Cigna's recent changes to allow payment for additional procedures designated by modifiers 25 and 59 (which indicate a procedure or service is distinct or separate from other services performed on the same day). Other times, policies are modified to state that something has become a "noncovered" service, allowing physicians to charge directly for these procedures.

However, changes to policies often are used as a tool for MCO savings initiatives. It may be as simple as deciding to no longer pay separately for a "covered" service

1 Please note that these PayerViewSM metrics are aggregated across all specialties; they will be different for each individual specialty and region.

2 AdvancedMD Decrease Costs & Increase Revenue, March, 2007

— this means physicians cannot charge the patient for the service directly because they are contractually bound not to, but neither will the insurer pay the physicians. This is because a contracted physician can seek payment outside the contract only on "noncovered" services (e.g., cosmetic procedures); anything considered "covered" stays between the physician and insurer regardless of whether or not the insurer will actually pay for it. It might seem like a lot of trouble to go through, but the economics of such policy changes can be staggering.

One such change occurred when UnitedHealthcare decided that routine pediatric vision screenings would no longer be separately payable. Instead, a policy revision states that the code is now "included" as part of the visit payment. Because the code is still a "covered" service, providers cannot charge their patients for that test, yet the former value of it has not been added to the visit payment rate. Examining this particular policy change shows us just how advantageous this change may have been to that insurer.

By disallowing payment for a previously reimbursed $2.50[3] health care service and combining it into a global payment for the office visit, UnitedHealthcare decreased its spending by an estimated $58 million dollars with this one policy change alone. See Fig. 4.

Fig. 4. UnitedHealthcare — Effect of Policy Change on Pediatricians

There are approximately 60,000 pediatricians in the United States. According to the MCR report, 64.8 percent of physician practices nationally participate in its network. Pediatrician performs, on average, 5,000 visits a year. According to The Physician's Computer Company (PCC), the ratio for sick to well visits is 2.4:1. For this example, let us assume that 40 percent is the average for child well-care visits for 3 to 10 year olds based on that ratio.

A patient mix benchmark from PCC indicates that close to 30 percent of the average practice is composed of 3 to 10 year olds.

The CPT code in this example is 99173, with a realistic average reimbursement rate of $2.50. Therefore:

60,000 pediatricians x 64.8% in-network = **38,880 pediatricians**

5,000 annual visits x 40% well-care visits = **2,000 well-care visits per pediatrician**

2,000 well care visits x 30% (3-10 yrs) = **600 kids per pediatrician**

600 kids x 38,880 pediatricians x $2.50 = **$58,320,000**

Of course, we cannot calculate an exact number without knowing what percentage of physicians actually billed for that code historically, what the actual average payment rate was, or how many times the code was utilized. However, speculatively speaking, these numbers help to illustrate how policy changes such as this contribute to favorable medical cost ratios.

Tiered Schedules

Another way in which MCOs hold onto premium dollars is by tiering payments to physicians, hospitals, and other providers of health care. This can be done by specialty, region, product, and plan so as not to cause too much disruption to the network as a whole.

Each insurer has hundreds of fee schedules. Some are regional, some are by specialty, and some are by product. For example, a cardiologist in New York City will be on a different fee schedule from an internist in New York City, even though they may be billing the same office visit code for the same patient for the same condition. The cardiologist may be paid a higher rate for a level-three post-op visit (referred to as CPT code 99213), and the internist may be paid an entirely different rate for the same code level in the months ensuing after surgery. Further, seeing two patients with the same insurer may result in different rates, too. An Aetna HMO patient visit may be paid at one fee schedule, and an Aetna PPO patient visit for the

3 The actual amount paid for this code is unknown, as payments for any given code vary by region, contract, and product. However, $2.50 is a good approximation based on personally reviewed claims.

same code and diagnosis may be paid at another rate to the same physician. Effectively, the insurer is simply passing along lower revenues brought in by HMO-type plans to its health care providers, even though the service delivered is the same for both patients.

Cutting Payment Rates

This has been another method for holding the line on MCR. Sometimes the cuts are across the board for all specialties, but most of the time insurers will look at their networks to determine in which specialties they can afford to lose participating physicians. For example, if there are plenty of primary care physicians in a given region, that group may be a target for receiving a payment "haircut," which means trimming a few dollars from the payment schedule. If they can afford it, some physicians will drop insurers that lower their payment rates, However, for other physicians, it may be up to a year before they can actually leave, thanks to the contract provisions that lock them in until their anniversary date. In the meantime, the insurer reaps the benefit of the lower rates and gets to hold onto more profit.

Untimely Notification

Most of the time, providers are unaware of payment and policy changes until well after they have gone in to effect. When MCOs change medical policies, procedures, or payment rates, they communicate these changes to their network of physicians by e-mailing newsletters, sending mailings, and/or posting the information on their Web sites. Although insurers are getting better at providing notification and communicating with their networks, all too often by the time a newsletter comes out, the information is already dated. Communications to network physicians are sometimes confusing, using terms with which physicians may be unfamiliar. Often the letters do not state clearly what the actual outcome is likely to be for a physician. In addition, in response to calls about claims where procedures have been denied or new rules have not been adhered to, most physicians have heard the typical MCO refrain, "We posted it on our Web site."

However, the average physician practice participates with 11 to 14 MCO networks[4], making it nearly impossible to keep up with all those changes. Even when medical policies are marked "revised," there is often no indication of what actually changed. Many MCOs simply note a revision date somewhere on the policy with no explanation of what has changed or how it affects the physician. If a physician does not have the last version of a policy to compare with the new version, and very few would, he or she may never know. In addition, due to the huge number of medical policies that each MCO publishes, storing versions is an impossible task for these practices. More often than not, providers of care find out that something has changed 45-60 days after services were rendered and denial for payment shows up on MCO remittances.

"We will not sacrifice profitability for membership."

— WellPoint President and CEO Angela Braly during a conference call to analysts regarding first quarter 2008 performance.

Point 4: Lack of Clarity About Who is Spending What Where

The Robert Wood Johnson Foundation has put out a report saying "The number of private-sector establishments offering health insurance declined to 56.3 percent in 2005 from 58.3 percent in 2001 because the cost of those benefits went up nearly 29.6 percent in the same period."

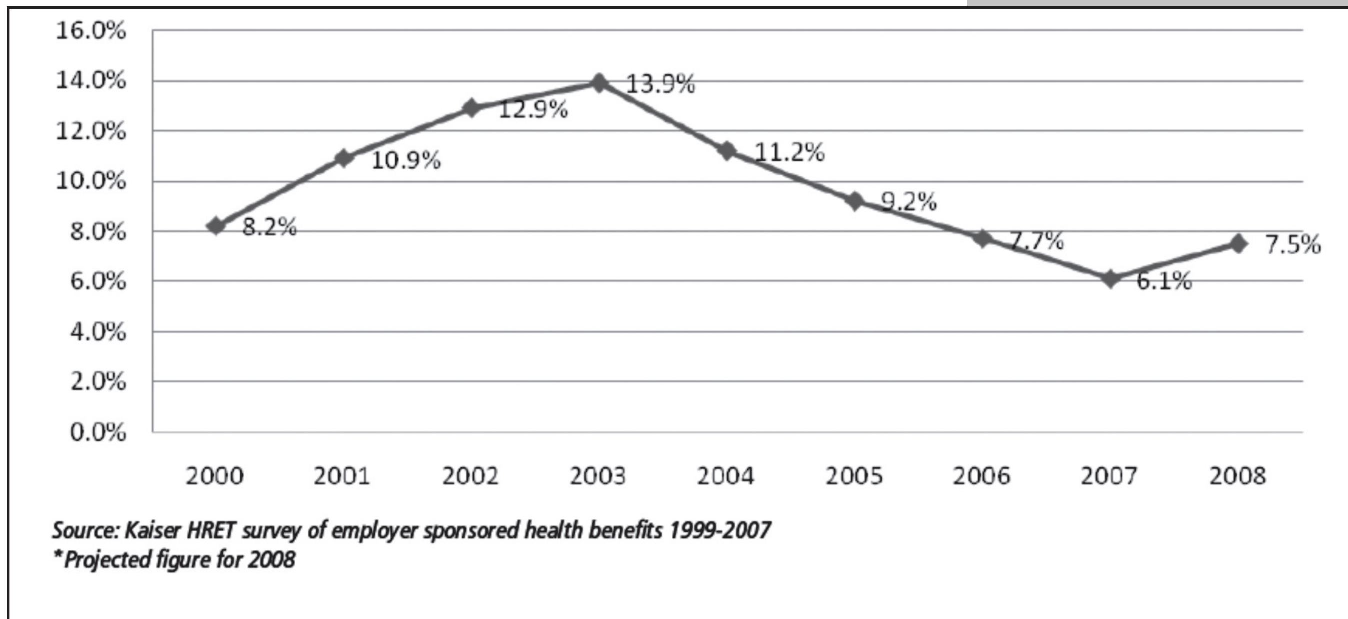
In a recent story by *American Medical News*, foundation spokesperson Michael Berman is quoted as saying, "Increasing premiums have been a big driver in the rise of the uninsured. According to the U.S. Census, the number of uninsured in the U.S. rose from less than 45 million in 2005 to 47 million in 2006, the most recent estimate available, and 61 percent of businesses with 10-199 employees offered health benefits in 2007, down from 69 percent in 2001."

4 Strunk, B., Reschovsky, J. Kinder and Gentler: Physicians and Managed Care, 1997-2001, Tracking Report No. 5, November 2002, Center for Studying Health System Change

With most publicly-traded MCOs reporting that "medical spending" is up sharply in the first quarter of 2008 — which equals higher MCRs — physicians, hospitals, and other health care providers may get hit hard over the next few quarters to redress MCOs' profit margins. However, the biggest effect on Q1-2008 MCR is not the actual payment of medical care. Many insurers have lost membership ("covered lives"), thereby reducing the denominator upon which MCRs are calculated. With fewer covered lives and premiums, the ratio shifts give the impression actual spending is up. Currently we have no way of pinpointing MCOs' actual spending on health care services in order to track those trends accurately, due to the lack of transparency in MCOs' financial reporting.

As MCOs' stock value takes a dip, employers will be asked to pay higher premiums next year to compensate. Insurance premiums have increased steadily over the last decade, peaking in 2003 (Fig. 5), and employers have responded by shifting much of the cost to employees (Fig. 6).

Fig. 5. Cost of Premiums 2000-08*



Source: Kaiser HRET survey of employer sponsored health benefits 1999-2007
**Projected figure for 2008*

Fig. 6. Total Employee/Employer Health Care Costs: 2003 vs. 2008

	2003	2008
Employee	$1,284	$2,040
Employer	$5,100	$7,272
Total Cost	$6,384	$9,312

Source: Towers Perrin 2008 Health Care Cost Survey.

The annual premium charged to an employer for a health plan covering a family of four averaged $11,500 in 2006. Workers contributed nearly $3,000 of the premium, or 10 percent more than they did in 2005[5]. The average employee contribution to company-provided health insurance has increased more than 143 percent since 2000. The average out-of-pocket costs for deductibles, copayments for medications, and coinsurance for physician and hospital visits rose 115 percent during the same period[6].

5 The Henry J. Kaiser Family Foundation. Employee Health Benefits: 2006 Annual Survey. 26 September 2006.

6 Hewitt Associates LLC. Health Care Expectations: Future Strategy and Direction 2005. 17 November 2004.

However, while premiums go up and costs are shifted to individuals, premiums never come down in correlation to payment cuts to providers of care. In this way, the management of care equates only to the management of MCO profit.

In closing, Mr. Chair and committee members, I want to thank you for your time. I also appreciate the fact that you are taking the time to truly study and analyze health insurers' business practices. I had no idea when I wrote my paper, *Cost vs. Profit in Managed Care*, that so many people from across the country would be interested in this issue. What you are doing here today is so important. We must start to implement measures that make insurers' business practices more transparent to employers, patients, physicians, hospitals, and other health care providers. We also must start to hold insurers accountable for how they manage our health care dollars to ensure that the money that we entrust them with is actually spent on providing health care rather than garnering profit. Without that accountability, insurers will continue to maintain pricing practices that lead to higher premiums and greater numbers of employers, employees, and individuals unable to purchase affordable coverage.

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