US health costs spike: insurers put under pressure

For international travel insurers doing business in the US, reports about a spiking of healthcare costs under President Obama's newly imposed Affordable Care Act are not good. If insurers were looking for relief from soaring fees and prices for hospital and doctors' services, they best put their hopes on hold, says Milan Korcok

From all indications, insurers – foreign as well as domestic – need to be prepared for a renewed series of price hikes, a sustained period of health cost inflation, and a serious shifting of the cost spiral to the private insurance sector. They should also be prepared to catch much of the blame for contributing to soaring health costs – a tactic the Obama Administration has pursued relentlessly.

Recent confirmation of the cost inflation trend comes in an exhaustive report from the Kaiser Family Foundation and the Health Research & Educational Trust*, released on 27 September 2011, which shows that the average annual cost of employer-provided health insurance for a family of four increased by nine per cent to an average of $15,073 in 2011 – up sharply from $13,770 last year. That is much faster than both general inflation and rises in workers' wages and, according to Dr Drew Altman, Kaiser president and chief executive officer (CEO), is 'especially painful for workers and employers struggling through a weak economy'. He also noted this was one of the largest premium increases seen since the annual survey has been done, but said: "I don't know if this is a one-term hike or whether it signals a return of sustained increases in premiums."

To put this increase into a broader perspective: since 2001, family premiums have increased 113 per cent compared with 34 per cent for workers' wages and 27 per cent for inflation. The saving grace in this scenario is that employers will pay, on average, $10,944 of those premiums: but that still leaves families with $4,129 to pay – $344 per month on average, not counting the deductibles and co-payments that are part of every visit or service. And these are the most favoured families. Those who rely on individual, non-employer sponsored plans, or the self-employed, must pay the full tariff and their costs are even higher.

[International insurers] benefit from, and some count heavily on, the deep price discounts that the BUCAs and PPOs can deliver to them by cost-savings arrangements they could never hope to achieve on their own

What has caused the report to generate headlines in American media is that the Kaiser Family Foundation – the nation's leading health policy analysis source – is perceived as a supporter of President Obama's Affordable Care Act, and so the revelation that the initial reform provisions in the Act may, in fact, have contributed to a cost spike instead of the expected moderation, caused some agitation in the White House.

International impact

The cost of employer-based health insurance is widely accepted as the most sensitive gauge of the cost, as well as the integrity, of America's healthcare system. It is tangible; more meaningful to the person in the street than are the more abstract references that healthcare

costs the nation 17.6 per cent of GDP.
Employer-based health insurance is responsible for providing cover for nearly 160 million people under age 65. The remainder are covered by government-sponsored Medicare (65 and older), Medicaid (for the poor), government programmes for veterans and some government workers, and private insurance plans for individuals and the self-employed. In addition, approximately 17 per cent of Americans go without health insurance for at least part of the year – depending on whether or not they are employed.
Though the Kaiser report focused primarily on insurance premium increases as indicators of health cost inflation, the insurance industry quickly retaliated by saying that blaming private insurers for the increasing cost of healthcare (which has been a cornerstone of the president's reform initiative) seriously deflects attention from the real core of the problem. In response to the Kaiser report, Karen Ignani, president and CEO of America's Health Insurance Plans (AHIP), said in a statement: "Policymakers in Washington and the states need to focus on all of the factors that are driving premium increases: soaring prices for medical services, changes in the covered population that has resulted in an older and sicker risk pool, and new benefit and coverage mandates that add to the cost of insurance."
For many international insurers and their cost containment representatives, domestic insurers such as Blue Cross/Blue Shield, UnitedHealthcare, Cigna, and Aetna (collectively referred to as BUCA) are important conduits in their relationship with American hospitals and doctors. They benefit from, and some count heavily on, the deep price discounts that the BUCAs and PPOs can deliver to them by cost-savings arrangements they could never hope to achieve on their own. The BUCAs are also the frontline troops in establishing contract trends with hospitals, setting discount benchmarks, and defining usual and customary reimbursements. Without these benchmarks and cost savings, international insurers would have a hard time dealing with the price hikes that seem inevitable – in the short term and into the misty future as well.
Dr Colin Plotkin, medical director at Dr Colin Plotkin & Sons Consulting Inc. (DPC), which specialises in settling medical claims on behalf of insurers, reinsurers and TPAs, asserts that as the US moves to provide health insurance coverage for all its citizens, someone besides government will have to pay the price. "Providers of medical care, with the emphasis on hospitals, will still have to balance their books," he says. "In other words, someone will have to pay for this. Logically, this means an increase in premiums for the insured, be they domestic or international."
He warns that some international insurance payers, who have been enjoying 'unrealistically low rates of reimbursement' designed only for the domestic market, will have to shoulder their share of the burden. In effect, they can't go on forever expecting to receive Medicare-based rates, which are money-losers for hospitals, and which are subsidised by taxpayers for the purpose of supporting elderly Americans and the disabled.
"Even multiples of these base levels of reimbursement, often used as a standard to calculate reimbursement levels, are not being accepted by the vast majority of providers," he adds; especially as the international insurers or their intermediaries can't provide the volumes, the steerage, or the strict payment deadlines that the major domestic insurers are routinely expected to meet.

Insurers under siege

In pushing healthcare reform, the Obama Administration effectively demonised the insurance industry, blaming it for greedily raising premiums that only served to push up healthcare costs. Health insurers, on the other hand, responded that their average profit margins were far below those of most other sectors of the US economy. America's Health Insurance Plans reported that the health plan industry in 2010 had an average profit margin of only 4.4 per cent and was not a primary driver of rising health costs, a contention supported by Kaiser, which adds that the elimination of insurers' profits and executive compensation would lower healthcare spending by just 0.5 per cent.
Still, as part of the Affordable Care Act, all health insurers seeking to increase their rates by 10 per cent or more in one year are now required to submit their requests to state or federal authorities for a determination of 'reasonableness': a job that insurers say is far beyond the capabilities of most federal or state bureaucrats. The requirement kicked in on 1 September.

that some international insurance payers, who have been enjoying 'unrealistically low rates of reimbursement' designed only for the domestic market, will have to shoulder their share of the burden

Kathleen Sebelius, secretary of health and human services, said of the review programme: "For far too long, families and small employers have been at the mercy of insurance rate increases that often put coverage out of their reach. Rate reviews will shed a bright light on this industry's behaviour and drive market competition to lower costs." (The Act also requires health insurance plans to show medical loss ratios of 80 per cent or better.) She added: "As of today, insurers proposing double-digit increases will have to provide clear information that indicates what factors are causing proposed increases. Experts will closely examine information about the underlying cost trends in healthcare to flag instances when insurance companies are unjustly raising costs. This means consumers will no longer have to take the word of their insurance company; they will have an independent expert reviewing their

proposed rate increases."
The rate review programme has been widely criticised by industry as well as many state government sources as being an overly simplistic approach to a complex problem. Even the federal government's Congressional Research Service (Congress' think tank) has warned: "The complexity of making such a determination (reasonableness) generally requires analysis of multiple factors by actuaries and accountants. Such a review generally does not lend itself to the use of simplistic benchmarks such as merely prohibiting double-digit percentage rate increases." So far, 41 states have established rate review boards that meet federal specifications. The remainder will have to submit their rates to federal authorities until they can pass federal muster.
In the meantime, insurers will have to deal with a healthcare system that continues to grow exponentially, with demands far outstripping funding sources. According to the government's own Centers for Medicare & Medicaid Services, which tracks all health spending, the average annual health spending growth (5.8 per cent) over the next decade is anticipated to outpace average annual growth in the overall economy by 1.1 percentage points (4.7 per cent). And by 2020, national health spending is expected to reach $4.6 trillion and comprise 19.8 per cent of GDP. In effect, one out of every five dollars Americans produce will go to paying for hospitals, doctors, drugs, medical technology, public and private health insurance, and medical research – all the elements of the nation's single, largest industry. Will these costs, in time, become unmanageable for international insurers? Can they be expected to winnow out the number of players in this complex market? J. Ross Quigley, president of Medipac International, travel insurance provider for the

'international insurers that understand the US healthcare system and protocols, and manage their claims, will always do well', and 'the ones that deny too many claims and increase their prices to cover their unsophisticated ways will always do poorly and eventually will exit this complex business'

Where does the money go?

International travel insurers with heavy exposure in the US market often find the prices charged for medical services in the US are hugely different from those charged in their own countries – or any other country, for that matter. Much of this higher cost is attributed to higher fees by doctors and other health professionals, more intensive use of high-tech equipment and specialised staff per case, more diagnostic tests, higher pharmaceutical prices (which in most other countries are regulated by governments), higher administration costs, and a host of other factors.

According to data collected by the International Federation of Health Plans, an association comprising 100 of the largest health insurance plans in 31 countries, US hospitals and doctors charge insurers and their patients multiples more for given health procedures in the US than hospitals and doctors in other countries.

Examples: (All prices quoted are in US dollars)

The estimated average price charged to an insurer or patient for a routine office visit in the US in 2009 ranged from $59 to $151: in Canada it was $30, Germany $22, and the Netherlands $32.

(The 'average' range in the US accounts for different types of hospitals in different parts of the country.)

A CT head scan in the US was priced at between $950 and $1,800; in France $212, Canada $530, Spain $161, the UK $179.

A one-month dose of Lipitor in the US ranged from $125 to $334; in Germany $48, UK $40, Netherlands $63.

An appendectomy in the US was charged between $629 to $1,803; in France $114, Spain $285, Netherlands $494, Canada $313.

Total hospital and physician charges for an appendectomy in the US were between $11,997 and $40,680; in Canada, France Germany, Netherlands and the UK they ranged from $2,436 to $2,595.

The average charge for a hospital day in the US was between $3,818 to $12,708; in Canada $837, France $1,050, Germany $550.

Canadian Snowbird Association, says 'international insurers that understand the US healthcare system and protocols, and manage their claims, will always do well', and 'the ones that deny too many claims and increase their prices to cover their unsophisticated ways will always do poorly and eventually will exit this complex business'.

He adds that travel insurers' bottom lines depend on many complex issues: "First responder (assistance) … competence, critical mass of business to keep costs low, international currency exchange rates, flu and pneumonia patterns, and removal of fraud are all bottom-line drivers, and a little luck never hurts. You must be able to shrug off several $500,000 claims in a year and survive the 'million dollar babies'. Most insurers are not up to the task with their ever increasing focus on narrow business lines and profitability."

As for the likelihood that accelerating US healthcare costs will seriously impact international travel insurance premiums, Quigley says: "The only way to avoid significant Canadian premium increases is to have a much lower US dollar," a reference to the frequent fluctuations between US and Canadian currencies, which, when favorable to Canadians, can offset the higher US medical costs.

Certainly, the prospect of high US health costs is a concern, says Quigley, but he adds that a 10-per-cent currency shift in one month is significant compared to the prospect of US healthcare costs increasing to 20 per cent of GDP over eight years. Nonetheless, premium prices do matter, even to staunch, uncompromising snowbirds who see winter-long vacations as a rite of elderly passage. Says Quigley: "We do see a decline in participation every time prices (premiums) increase and there are certainly declines as the significantly higher prices arise when the older age bands are reached. Moving from an 80-84 age band to an 85+ age band is a very expensive proposition: people cease to be snowbirds due to insurance costs, and the US dollar decline will not cushion them enough to (allow them to) continue travelling."

Juliann Martyniuk, affinity markets, Manulife Financial – one of Canada's largest providers and underwriters of international travel insurance – believes that trying to predict what will happen to healthcare costs in the US and how they may affect international travel insurance costs in coming years is 'a difficult question'. "It is not at all easy to predict – without the help of a crystal ball – how such a dynamic system will change," she said, adding it is clear that travel insurers 'may have to increase their focus on risk management of claims; that is, managing their medical cases to control or reduce healthcare charges'. "As the US healthcare system evolves, the answers will hopefully become much clearer," Martyniuk concluded.

Certainly, clarity is one of the missing elements right now in trying to see where American health costs are headed. Perhaps a more probitive question is 'how high' are they headed? ■

**The Kaiser Family Foundation is an independent, non-profit organisation. The Health Research & Educational Trust is a private, not-for-profit research organisation affiliated with the American Hospital Association.*