Unhealthy Profits

The Three Ways Insurance Companies Make Money from Health Care

Observations and Recommendations

Insurance companies are being criticized by many for their high profits at the expense of the public, many of whom are uninsured or underinsured. While these profits may well be "too high," those who say so should know how an insurance company earns its profits.

Insurance companies provide many specialized services that are necessary in the administration of medical benefit plans, but they are not the only organizations that play this role. Insurance companies also assume risk: they must pay claims even if the total amount is more than what was included in premiums. But, again, insurance companies that manage medical plans are not the only organizations that deal with medical plan risk.

Insurance companies realize profits by setting premium levels that are higher than might be necessary (by including actuarial contingencies) and by betting that actual benefit claims will be lower than the high estimates included in premium calculations. Insurance companies also earn money from short-term investment of the premium money they collect: premiums are received at the beginning of a month, but claims for services often are paid several months later.

Large employers as well as coalitions of employers, union groups, and municipal governmental entities do things differently – they use a "self insurance" approach. If they deal with medical insurance companies at all, it is only to perform administrative tasks, things many of these insurance companies do quite well. Under this approach, the insurance companies are motivated to improve their operating efficiency and effectiveness, but they have no incentive, and no authority, to deny care or hype premium levels.

A "public option" or "co-op" -- open to individuals and employers of any size -- that adopts the same approach is likely to realize significant savings when compared to fully insured medical plans. If they find it economical to do so, the "co-ops" can contract with for-profit insurance companies or other organizations as administrative service providers.

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Background: Medical Insurance Profits

Determining Medical Insurance Premiums

When an insurance company establishes premiums for a medical benefit plan, it takes the following steps, not necessarily in the order shown:

1. Define the medical plan in great detail. Describe what services will and will not be covered and to what extent. For example, physician fees may be covered at 100% up to certain region-specific levels; emergency room visits may be covered except for a deductible of, say, $50.00 that must be paid by the policy holder; and chiropractic treatments may be covered at 80% of an established fee schedule. According to Federal and State laws, those covered by medical plans must be given a detailed description of their plan benefits.

2. Determine the likely annual cost of this benefits plan, the aggregate cost of claims that will be paid. Often the cost estimate is computed by actuaries based upon a group with a standard or common demographic mix of beneficiaries. Costs may be estimated for various age groupings as well as gender. What will the likely cost be for males in their 40s? females in their 30s? and so on. In practice, an actuarial contingency is added to each estimate, to allow for the possibility that actual costs will exceed estimated costs.

3. Analyze the demographic and geographic characteristics of the group to be insured. Make modifications to the estimated plan costs according to the extent to which the group differs from the "standard group." The result will be an estimate of what is called "pure premium," the amount of money the insurance company will collect in order to cover the cost of the claims it agrees to pay. Pure premium is likely to be ten- to twenty percent higher than the insurance company actuaries and underwriters have calculated as the most likely cost. This actuarial contingency is an important part of insurance premiums.

4. To the "pure premium" add claims administration costs, sales costs, and general overhead costs. In addition, add a risk cost – the cost of what is, in effect, an insurance policy that will reimburse the insurance company if a group's claims exceed an agreed-upon percentage of estimated costs; this is called "stop-loss" insurance or "reinsurance."

5. Add all of these annualized costs, including the actuarial contingency, and divide by twelve in order to arrive at monthly premiums. It is common practice to charge premiums based upon family size (single, two-person, and three or more persons). As allowed by state law and regional practice, premiums may vary by employee (beneficiary) age and/or gender.

Types of Profit

With respect to health insurance, there are three major types or sources of profits, each distinct from the others.

Underwriting Profit

What "most Americans" are concerned about when they speak against insurance company profits is what is called Underwriting Profit. If actual claims are less than estimated claims, the insurance company realizes a profit. This can be achieved in two ways: the company might be lucky, and the group as a whole is healthier – and, as a result, spends less than the amount the company's actuaries calculated. But, because the insurance company added an actuarial contingency when determining the "pure premium" (claims costs), there is only a relatively small chance that actual claims costs will exceed the amount used in developing a group's premiums. Therefore, unless the insurance company's actuaries are incompetent or very unlucky, the company almost always is able to realize an Underwriting Profit.

There is a second way the insurance company may be able to generate Underwriting Profits. If the demographics are more favorable than the standard group demographics used in developing "pure premium" – if the group is younger, more male, with fewer sick individuals – actual claims costs are likely to be lower than otherwise would be the case. Therefore, as long as premiums are based upon the demographics of the standard group, the insurance company stands to make an Underwriting Profit resulting from demographics alone. This is why many insurance companies try to insure "good" risks and avoid "bad" risks when they sell group medical insurance.

Investment Profit

Medical premiums usually are billed and are payable monthly in advance. Claims, however, are received by the insurance company throughout the month. In fact, claims incurred in a particular month may well be received many months in the future. This "claims lag" allows the insurance company to pay claims well after the company has received premiums. By investing these reserve amounts (in safe financial instruments) the insurance company is able to generate additional profit.

An additional source of investment profit is the "extra" cash that accumulates because the insurance company usually includes in premiums an amount that is ten- to twenty percent more than it expects to actually pay out in claims. This "extra" cash is invested, and the returns are collected by the insurance company as additional profit.

Administrative Profit

Insurance companies incur costs associated with actuarial determinations, negotiating with provider organizations for "discounts" on fees charged to its beneficiaries (*providers routinely accept payments from insurance companies that are less than half of amounts charged; about the only patients that pay must pay <u>all</u> of the amounts billed are those without insurance*), marketing, and, of course, claims processing. These administrative costs are included in what the insurance companies refer to as "retention." To the extent that these administrative costs are lower than amounts included in premiums, the insurance company realizes a profit, in effect, a profit from operations.

A Reasonable Approach to a "Public Option"

What Large Groups Do Now

Many large employers, union trusts, and aggregations of public sector entities such as school districts "self insure" their medical plans. They hire an insurance company or third party administrator to provide administrative services, but these self insured plans assume responsibility for risk – the plans, not an insurance company, have to cover claims that are in excess of budgeted amounts. The plans usually purchase what is called Stop Loss insurance (from specialized insurance carriers) as a hedge against the possibility that actual claims costs will exceed a certain level. Often these Stop Loss policies will reimburse the self insured medical plans if claims for an individual are more than, say, $50,000 and if claims paid for the entire group during a year are more than 125% of actuarial estimates. Self insuring is not feasible for all groups, but it can be appropriate for groups with a thousand or more individuals.

For a number of reasons large employers and others have found that they don't need insurance companies to run <u>all</u> aspects of their medical plans. They retain insurance companies or third party administrators on an administrative services only (ASO) basis. The ASO contractor does most of the things an insurance company would do if the plan were fully insured, but the insurance company doesn't assume risk, nor does the insurance company manage the premium funds. Instead of being funded at the beginning of a month, at a level that is higher than anyone expects, claims are funded by the plan only as claims are paid by the ASO contractor.

With an ASO arrangement the insurance company or administrator is not able to earn an underwriting profit because all of the risk associated with the amount of claims actually paid for medical services incurred is borne by the plan (sponsored by the large employer, union trust, or group of public sector entities). Nor is the insurance company or administrator able to earn an investment profit, because the plan -- and not the ASO contractor -- holds the funds.

The only profit that can be earned by the insurance company or administrator is related to how effectively the ASO contract is administered.

Third party administrators and insurance companies that have ASO arrangements with large groups have an incentive – and, under ERISA an obligation – to pay claims in exact accordance with the Plan Document, the contract between the group and the member that details what services will be covered and under what conditions. With most ASO arrangements, certainly those that are subject to ERISA, it is illegal for the administrator to pay less than the beneficiary is entitled to, and it also is illegal for the administrator to squander plan assets by paying too much. Not too hot, and not too cold, but just right. Those ASO administrators that do an effective job on behalf of the plans they manage will have their contracts extended; those that don't, won't.

What might be Possible?

Given that many (most? all?) of the large insurance companies already manage medical plans on an ASO basis, earning profits only as relating to how well they perform their administrative functions, it would seem reasonable that under a "public option" a few insurance companies could be retained to do the very same things that they are already doing. An "exchange" or "co-op" board would be in charge of a regional plan. This board, with professional assistance, would establish the plan criteria – what the benefit structure will be, who is to be eligible, what the premiums should be, etc. Then the board, through a competitive bidding process, would hire one or more insurance companies or third party administrators to perform the several administrative functions.

This isn't a novel concept. It is pretty much what large employers do now. And the approach works very well. The major difference is that eligibility for the plan(s) would be open to individuals and to groups not large enough to enter into an ASO arrangement on their own. Currently small employers are precluded from joining together in this way, but this would change under such an approach.

A "public option" that is administered (not managed) by insurance companies (for profit as well as not-for-profit organizations) and not by a governmental body, would be reasonable. It may well be widely accepted. *After all, this is how Medicare operates.* Such an approach would remove incentives for an insurance company to deny coverage in order to boost its profits. It would remove incentives for an insurance company to hype premiums in order to earn investment profit – there would be none! Physicians and other medical providers would be encouraged to participate in plan management and oversight by serving on the regional boards as members or as advisors.

Would there be a role for the federal government? Yes, but not much different from the government's current role with respect to medical benefit plans: ERISA, HIPPA Privacy and Security, HIPAA electronic data interchange mandates, IRS regulations, and so forth.

The key point is: existing and accepted mechanisms can be put in place in order to accomplish much, probably all, of what is necessary to provide medical benefits to all Americans in an economical and responsible manner. Doing so need not be scary!

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