Why is healthcare so expensive and how can we continue to afford it? (Part 4)

This is part of a multi-part series on healthcare by Prospettiva Financial in San Francisco, CA. The rest of this series can be found on our website:  http://www.prospettivafinancial.com/?page_id=187

We are researching this topic because we are concerned about this area of your spending and are interested in proactive measures we can all take to maintain some control over this escalating expense.

PART 4: HOW ADMINISTRATIVE COSTS IMPACT HEALTHCARE EXPENSES

Conflicting studies performed between 2010 and 2012 spotlight the political divide over government-sponsored healthcare. Some studies lowball the administrative portion of healthcare costs while others offer dire predictions about future expenses related to administration of care. It’s useful to track the cost of healthcare administration, yet in comparing the United States with other countries it’s relevant to note that not all healthcare systems define “administration” the same way.

Further, since regulation of the cost of care is a relatively recent development, not all U.S. hospitals used the same statistics to measure this aspect of cost. All studies, regardless of their data source or implied political leanings, appear to arrive at a similar conclusion: healthcare administration is an important and significant expense, but there’s much waste in its current form.

A concise definition of waste is offered by the Commonwealth Fund, which proffers that waste is best defined as money spent on the administration of care that does not translate into improved service or quality. The Commonwealth study suggests that 25% of all healthcare dollars spent in the United State were supporting the administration of healthcare.¹

A large portion of the Affordable Care Act (ACA) sought to simplify coverage by forcing health insurance companies to devise uniform health insurance policies. This should have been helpful to consumers as comparing prices would be much easier if all plans maintained the same basic rules of coverage. It should have been helpful to hospitals because they could eliminate money spent trying to determine whether claims would be covered and to what extent they could collect.

Consider that before the ACA, each hospital negotiated prices for services directly with each health insurance plan. Each insurance company might have up to 10 different health plans, and each plan may have a different negotiated rate for essentially the same procedure at the same hospital. If, for

example, a group plan would direct 100 patients to a hospital, the rate might be lower for, as an example, diabetes treatment. Whereas, an individual health plan by the same insurance company might pay the same hospital a higher rate for the same diabetes treatment because of the smaller size of the risk pool. A voluminous summary of benefits, typically shared only with the hospital’s billing department, would detail special billing codes called CPT codes for each service rendered by the hospital. Each hospital would in turn have the task of deciphering the codes and sending the correct bill to the insurance company for collection. This level of complexity and detail requires most hospitals to hire insurance experts to facilitate billing – essentially duplicating the competency and expertise of employees already working for the insurance companies. This is a key example of waste which the ACA marketplace sought to reduce. The more similar the health plans, the easier it should be to bill and collect.

There have been several improvements in administrative costs following the ACA, but many of them benefit insurance companies more so than providers, and so far none have demonstrated a reduction in the overall cost of care. Robert Book, writing for the American Action Forum, reports that administrative costs have increased in total and cites several examples which appear as reductions in administrative expense, but fail to reduce overall healthcare costs.²

24-hour-on-call nurse phone services are one example that Book reports were previously categorized as administrative expenses because they did not result in insurance claims. Book says that part of the patient protection legislation in the ACA required insurers to report a ratio of premiums collected versus medical losses spent (Section 2718). The government provides an incentive for insurers to maintain a low ratio, a measure intended to reign in health insurance premiums. This, Book reports, prompted insurers to demand a clearer definition of what constitutes a medical loss. The US Department of Health and Human Services provided this clarity. On-call nurse phone services are a medical loss and they are now more accurately categorized as such – reducing the statistical recording of total administrative costs but failing to result in more affordable healthcare.³

Both Federal and State governments spent substantial money on the implementation of a health insurance marketplace, one of the main tools in standardizing insurance plans. The price tag for developing and maintaining this marketplace ended up costing more than it has thus far saved in lower administrative costs. Arguably, the ACA is still being reformed and implemented. Many of the complications in the electronic marketplace have been corrected since its implementation, and this should eventually lead to less expensive information infrastructure in the future. Training and education is also improving so that employees at the state level and employees of insurance companies are better equipped to give advice and assist patients and providers. But cost savings are not coming quickly enough and the ACA seems to be in a state of constant peril.

³ Ibid.
A 2017 study by the international group, The Organization for Economic Cooperation and Development (OECD) titled “Tackling Wasteful Spending on Health” cites several inefficiencies in healthcare spending that could be improved to the benefit of government, providers, insurers, and patients alike.\(^4\)

For example:

- Physicians spend on average 4 hours per week on administrative tasks that could be handled by a non-medical professional.\(^5\)
- Coordination of care is an area in dire need of improvement. The report shows that patients are often kept in hospitals longer because of an inability to coordinate a destination for them when they leave. For example, a patient entering a rehabilitation facility after an operation may spend 2-3 unnecessary days in the hospital while awaiting placement at a rehabilitation facility. The OECD study found that between 20 and 30 days per 1,000 patients per year were unnecessary stays resulting from poor coordination of care.\(^6\)
- Inappropriate Emergency Room admittance accounts for 12% of all hospital visits in the United States. This is actually low compared to other countries. Possibly this is due to the fact that patients typically pay more for emergency room visits even when insurance is available. But the study encourages the use of outpatient facilities instead of emergency rooms, and makes quite clear that the United States needs more outpatient centers.\(^7\)

Clearly our healthcare system could learn a great deal from some of the findings resulting from this study, but despite complications with the ACA the conclusions made by the study advocate a single payer system -- which seems an unlikely outcome for our country’s health care and therefore shouldn’t be part of a financial plan.

**WHAT CAN YOU DO ABOUT THE COST OF HEALTHCARE ADMINISTRATION?**

When you receive a bill for medical care, beware of a common billing error called “balance billing.” Medical providers bill at one rate, but are typically paid at a lower negotiated rate that is deliberated between the provider and the insurance company. In some cases, once a medical provider has been paid the negotiated rate they will ask for the balance from the insured. The practice, which is most often a mistake resulting from the convoluted process of medical billing, can represent a violation of your health insurance contract and, if so, you are not obligated to pay it. Check with your insurance company or your health insurance broker before paying the bill you receive from the provider and confirm that the claim was processed correctly.

If you opt for high-deductible health insurance coverage, you may also be eligible to save for the future cost of healthcare through an HSA plan. This type of savings account allows for tax-free growth and contributions may be eligible for an above-the-line income tax deduction on your Federal tax


\(^5\) Ibid.

\(^6\) Ibid.

\(^7\) Ibid.
return. Money contributed to an HSA plan can be invested in mutual funds through some HSA providers to help protect this part of your savings from inflation risk. And distributions from an HSA plan are tax-free so long as they are paired with a qualifying medical expense.

An example of spending through an HMO vs. a High Deductible Health Plan (PPO) with a Health Savings Account:

<table>
<thead>
<tr>
<th></th>
<th>High-Deductible PPO (HDHP)</th>
<th>Health Savings Account (HSA) can be paired with an High Deductible Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HMO</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium:</td>
<td>$602.42</td>
<td>Contribute $5,500/yr</td>
</tr>
<tr>
<td>Office Visit Co-pay:</td>
<td>$30</td>
<td>Reduces income for AGI. May reduce federal income tax</td>
</tr>
<tr>
<td>Your maximum out-of-pocket per calendar year is $6,750</td>
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<tr>
<td><strong>YEAR 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Doctor visits at $500 each</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO insured paid $90 that year, plus $2,449.32 in additional annual premiums.</td>
<td>YEAR 1</td>
<td>3 Doctors visits at $500 each</td>
</tr>
<tr>
<td>HD PPO insured paid $1,500 that year and did not fully meet deductible.</td>
<td><strong>YEAR 1</strong></td>
<td>If the HD PPO patient did not use their HSA to pay expenses, the account would have $5,665</td>
</tr>
<tr>
<td><strong>YEAR 2</strong></td>
<td></td>
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<tr>
<td>3 Doctor visits at $500 each and an Emergency Room visit at $12,000</td>
<td><strong>YEAR 2</strong></td>
<td>3 Doctors visits at $500 each and an Emergency Room visit at $12,000</td>
</tr>
<tr>
<td>HMO insured paid $390 that year, plus $2,449.32 in additional annual premiums</td>
<td><strong>YEAR 2</strong></td>
<td>If the HD PPO patient did not use their HSA to pay expenses, the account would have $5,835</td>
</tr>
<tr>
<td><strong>TOTAL: $2,839.32</strong></td>
<td><strong>TOTAL: $6,550</strong></td>
<td></td>
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</tbody>
</table>

High Deductible Health Plans are not the right choice for everyone. This illustration is based premiums for a 40 year old insured living in San Francisco’s Financial District where premium rates and benefit summaries were provided by Blue Shield of California.

**A financial planner can help you review whether an HSA plan might be right for you**, and can direct you to resources where your HSA savings can be invested.

**A financial planner can also connect you with a health insurance broker** who is mandated by the government to work for you (and not the insurance company). We can review your spending and your

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income tax return to determine whether a high deductible plan might save you money. We can also review your existing health insurance plan summary and help you understand your coverages and benefits.

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