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Time To Stop Playing 'Monopoly' With Health Insurance

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Introduction

The primary objectives of healthcare reform are to improve access (providing coverage for the uninsured) and affordability (lowering the cost of health insurance). Now that all the bills are out of their respective committees and the reconciliation process begins in both the Senate and House, it's time to review the provisions and analyze whether they meet the objectives of healthcare reform.

In actuality, the bills being sent to the floor of each chamber will have the opposite effect, resulting in significantly higher costs and putting premiums out of reach for even more Americans. By not addressing the role of large insurers and their respective monopolies, Congress has sold out the American people simply to say they did something!

One simple and inexpensive way to truly fix our healthcare system is to restore competition to the marketplace. In order to do that, our nation needs to do two things: 1) Make the already-existing, anti-trust Robinson-Patman Act apply to healthcare provider services. 2) Set procedure reimbursement rates at a fair cost for providers so that dozens of small health plans, self-funded employers, Taft–Hartley Plans, and other payors, that today are stifled by the big health insurance monopolies can innovate, excel and compete to lower the cost of administering health insurance benefits.

Phone Calls and Razor Blades

The health insurance industry often seems like an impenetrable fortress of arcane terms, complex practices and mysterious arrangements. But at the big-picture level there are two examples from everyday life that most people are very familiar with that can frame the healthcare reform debate: phone calls and razor blades.

Long distance calls used to be special events in many households, a costly occasion that required keeping one eye on the clock to avoid a mammoth bill at the end of the month. Now, most people can call almost anywhere for pennies.

What changed was the 1983 breakup of AT&T, a regulated monopoly that the federal government had encouraged for decades as a way to build a nationwide network of phone lines and service. The court-ordered breakup into seven regional “Baby Bells” was disruptive at first, even painful at times, but eventually consumers had so many options for buying long-distance service that prices plunged dramatically.

Similarly, a few huge companies – For-profit Blue Cross/Blue Shield organizations, United Healthcare, CIGNA and Aetna, more easily referred to as the BUCAs – dominate the health insurance market today. Their size and reach originally had a beneficial purpose. They formed networks of doctors and hospitals by promising to “steer” patients to these preferred providers; in exchange, they received discounted rates that could be passed on to consumers in the form of lower healthcare costs.

But eventually, just like AT&T, they have grown so large that the benefits to consumers have been overtaken by the BUCA’s ability to operate as an oligopoly (a small number of firms that have monopoly-like powers). They are able to hold healthcare providers hostage to lower and lower reimbursement rates, while at the same time generating larger and larger profits for themselves that are not passed on to consumers, and they aggressively protect turf by blocking entry for smaller health plans and other payors.

Why do the BUCA's customers put up with this pattern? Because the razor is cheap and no one pays much attention to the cost of the replacement blades. In a classic business model, the price of a piece of equipment is kept low because the original sale will generate repeat purchases of profitable items over time. Think razors and razor blades, free cell phones and two-year calling plan contracts, low-cost printers and high-cost toner cartridges.

The BUCAs promise customers steep discounts in the cost of health care procedures. But they then charge very high rates for administering their plan. For example, one of the for-profit Blue Cross companies markets the fact that they have a 28 percent discount on health care reimbursement rates. Little attention is paid to the fact that they charge \$28 - \$35 per member per month for administrative services, compared to \$8 per member for smaller, more nimble competitors. The difference mounts up quickly, but it is after the customer has already made a choice based on the promised discounted pricing.

Why don't the smaller companies go out and create their own networks, keep their administrative costs low, and then undercut the BUCAs in pricing? Because without the size of a BUCA company, it is impossible to leverage reimbursement rates low enough to compete. In some states a particular BUCA and/or a combination of two plans control 80 percent of health insurance market.

At one time, consumers may have benefited from the BUCA's purchasing power, when Preferred Provider Organizations held the promise of creating more efficient, less costly health care. But today, through their protectionist policies, BUCA largely stands in the way of lower insurance costs. In fact, the argument can be made that they even block improvements in healthy lifestyles and informed consumer choices. By refusing to share claim experience data with employer groups, they stymie industry-wide efforts to modify behavior, improve health care delivery and adopt innovations in medical care quickly.

Two Solutions

The various bills in Congress today do nothing to break up the monopoly-like hold that the BUCAs have on insurance costs. Indeed, the proposals are enough to make the BUCAs smile with anticipation. As a matter of fact up until this week when the finance committee lessened the mandates on the purchase of insurance (another huge mistake), the larger insurers were actively promoting healthcare reform.

By forcing millions of Americans into the insurance marketplace, the BUCAs ability to deliver patients to providers and negotiate for lower pricing only increases. But as we already have seen, those lower medical care prices never quite make it into the consumers' pocket.

Instead, Congress should consider two steps. The Robinson-Patman should be amended to include service providers. Today, it is a law established to protect small retailers from being forced out of the market by large, vertically integrated chain stores that can demand special pricing from suppliers. Pricing cannot be discriminatory when the cost of delivering goods is the same for similarly situated purchasers. A WalMart may get discounted pricing from a supplier compared to the corner drug store because of volume and extensive warehouse availability, but a hospital that removes an appendix has the exact same costs whether it does so for a BUCA-insured or a small health plan-insured patient.

Second, it is time to move to a system of uniform pricing and transparency in healthcare. The federal government can play a big role in regulating reimbursement rates for healthcare providers. The government

already sets below market rates for more than 50 percent of the marketplace, a major distortion in the supposedly free-market mechanism for setting prices.

By finishing the job of setting rates for the remainder based on Medicare Allowable reimbursements plus a percentage, and by making that percentage a fair deal for health care providers so that the pervasive cost-shifting comes to an end – the government can level the playing field and allow companies to compete on how efficient and innovative they can become in the administration of health care coverage.

Injecting Some Honesty

In the end, health care reform should be about affordability and accessibility. We want health care itself to cost less so that people can get the services they need. But instead of focusing on the rising cost of health care and its causes, politicians have chosen to focus on insurance reforms thus treating the symptoms of the illness and not the cure for the disease.

The problem with today's bills in congress is that they do nothing to address health care costs, only insurance regulation. Premiums will increase. We will still be left with a significant portion of Americans without health insurance. Pricing won't be transparent so that consumers can seek out low-cost options. The high cost of protective medical procedures won't be eliminated because there is no tort reform. Payments to providers will continue to be pegged to procedures instead of outcomes.

So let's be honest about what may be accomplished when and if a bill passes. If we are not going to tackle the cost of medical care, but only the way insurance is provided, then at least we should be making real progress to eliminate monopoly power and the stranglehold a few big companies have on insurance coverage. Amend Robinson-Patman. Set fair reimbursement rates. And then stand back to watch the competitive innovation that results when small health plans have new opportunities to thrive in the health insurance market.