Healthcare Market Changes

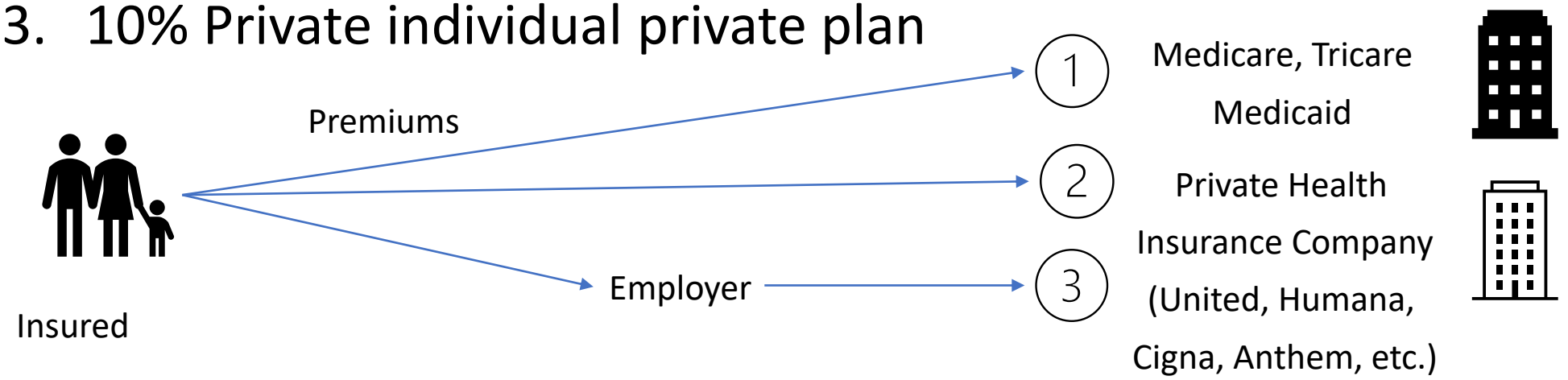
Functional Medicine Energy Center

How People Get Health Insurance

In the US, 10% have no health insurance.

The remaining 90% are in three groups:

1. 30% Public plans (Medicare, Tricare, Medicaid)
2. 50% Private employing-based private plan
3. 10% Private individual private plan



Trends in Healthcare

1. Increased Premiums
2. Decreased Private Plan Viability
3. Increased HealthCare Insurance Diversification

Increased Premiums

- Caused by:
  - Increased scope of healthcare
  - Increased cost of technology (and drugs) in healthcare
  - Increase global competition (decreased US employer dominance)
- Increased costs passed to government/employers → individuals
- Average annual premiums for family coverage have increased 200% over the past two decades and 50% the past decade.
- In 1999, family coverage was $5,791; in 2022, it is $22,463.

Decreased Private Plan Viability

- Remember: The majority of people, (currently 60%), are covered by private plans.
- The increase in premiums priced employers and individuals out of the market, decreasing the demand for private plans.
- As demand decreased and costs rose, plans limited coverage, passed more costs onto patients through copays, deductibles and coinsurance and narrowed networks (meaning patients had fewer doctor choices).
- More people became uninsured (no health insurance) and underinsured (insufficient coverage).

Increased Health Insurance Diversification

- As health costs increased and private plans became less viable, health insurance diversified:
  - Medicare Advantage
  - Pharmacy Benefit Managers
  - Practice Ownership

Medicare Advantage Growth

- Medical Advantage (MA) allows private plans to administer Medicare.
- Today's MA plans began in 1997; the Affordable Care Act of 2010 increased potential reimbursement of MA plans.
- From 2009 to 2017, MA enrollment increased more than 80%, growing to cover 33% of Medicare beneficiaries.
- From 2018 to 2022, MA enrollment grew to cover almost half (48%) of Medicare beneficiaries.
- **Health insurance companies make significantly more money on MA than "straight" Medicare or private plans.**

Pharmacy Benefit Manager Acquisitions

- Pharmacy Benefit Managers (PBMs) have typically been third-party intermediaries that manage the negotiated prices between drug manufacturers, pharmacies and, as a result, insurance companies.
- In vertical integration, insurance companies/pharmacies/PBMs have consolidated through acquisitions and mergers.
- CVS/Aetna and Cigna/Express Scripts are examples.
- By controlling PBMs, insurance companies can leverage pricing for bigger profits.
- PBMs and MA plans now account for the top two revenue streams of companies.

Increase in Corporate Practice

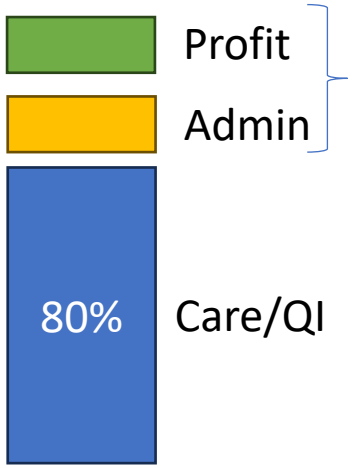
- Another area of vertical integration is the acquisition of provider practices by insurance companies, private equity and hospitals.
- Two popular provider targets are primary care and lucrative specialists.
- By employing primary care, corporations control patient steerage.
- By employing lucrative specialists, corporations control costs.
- While 76% of physicians were practice owners in 1983, estimates today are that 70% of physicians work for a corporate entity.

Impact of Trends

- Health insurance companies now control more than 70% of the MA market.
- Health insurance companies now control more than 89% of the PBM market.
- Corporate entities, including health insurance companies, now control 70% of physicians with an emphasis on primary care.
- **While consolidation in healthcare has always been touted as saving money, consolidation in healthcare has almost always led to INCREASED costs due to increased market leverage.**

Impact on Insurance Companies

- The Accountable Care Act capped health insurance profit at 20%; 80% of premium revenues are required to be spent on clinical care and quality improvements.
- The goal of the 80/20 was to limit price gouging, but insurers found two “solutions” to increasing profits.

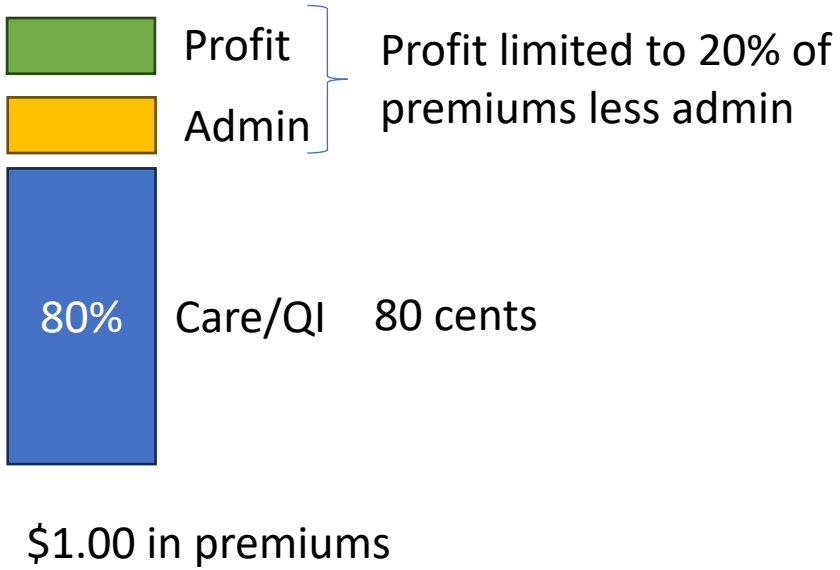


Profit limited to 20% of premiums less admin

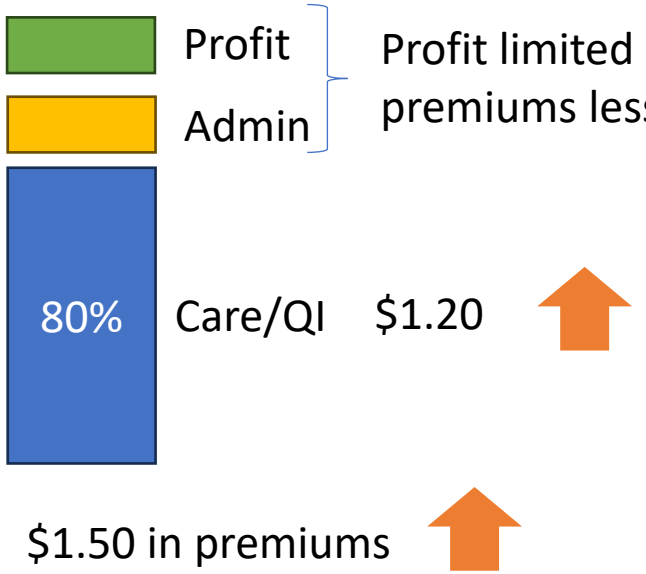
1. Increasing claims expenses and premiums, increased profits.
2. Vertical integration increased profits.

Increasing Claim Expense/Premiums

- Status Quo
  - 15 cents of each dollar → admin
  - 5 cents profit



- Increased Claims/Premiums
  - Keep admin at 15 cents
  - 15 cents profit per (TRIPLES PROFIT)



Vertical Integration

- Status Quo
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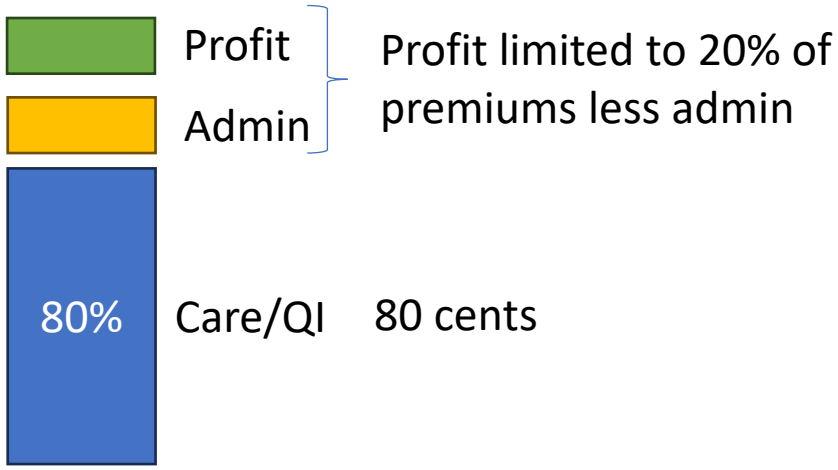
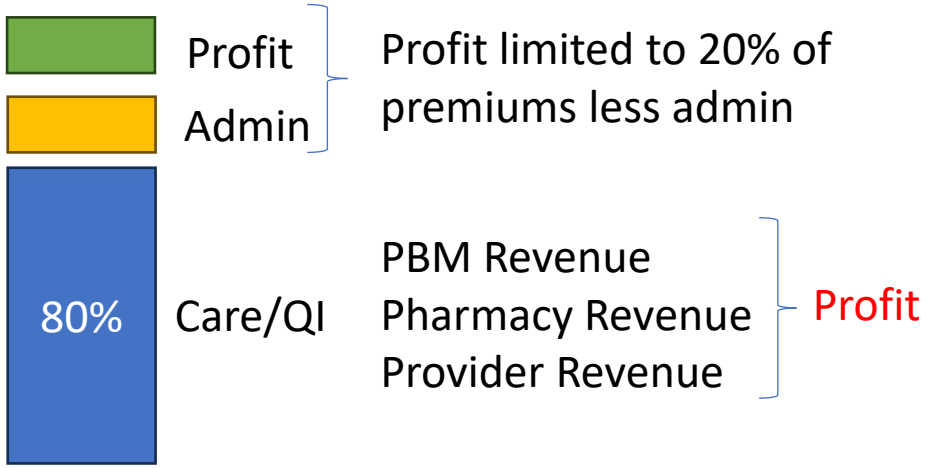


$1.00 in premiums

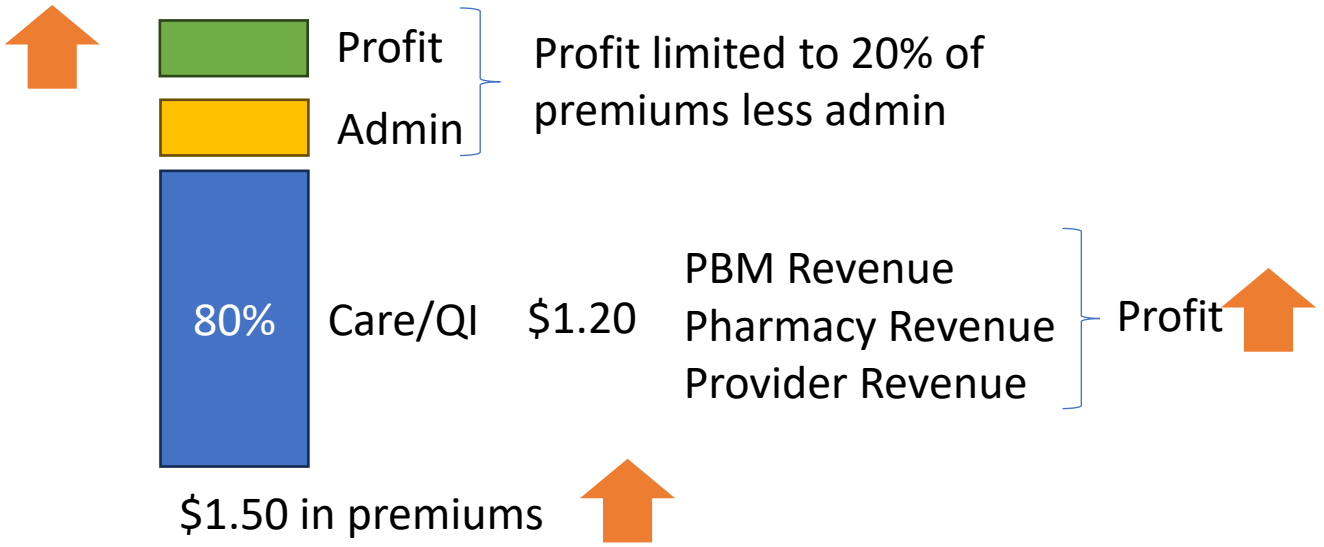
- Vertical Integration
  - 5 cents profit
  - PLUS profit from acquired units



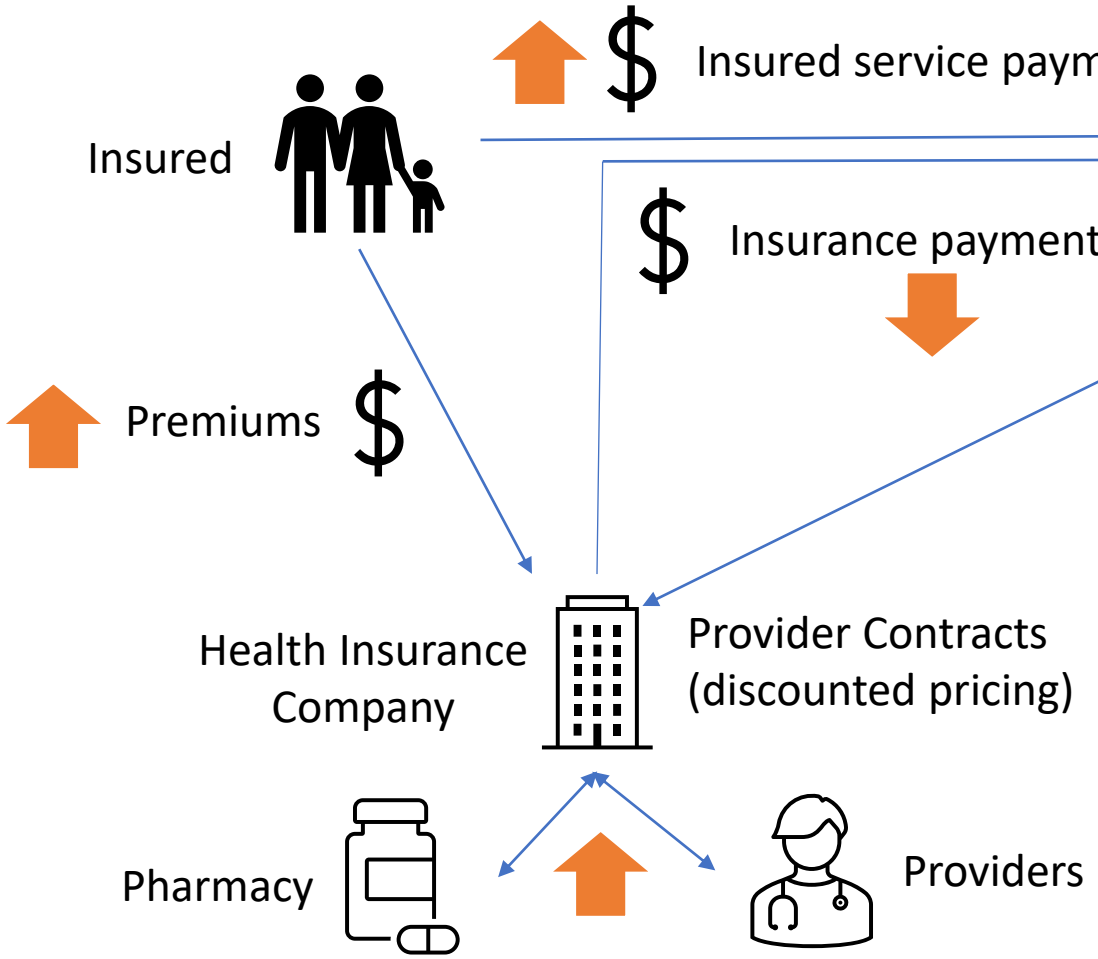
$1.00 in premiums

Increasing Claims/Premiums + Integration

- Increased Claims/Premiums
  - 15 cents profit *PLUS increased profit from acquired units*
- The massive increase in health cost and premiums coupled with consolidation has led to massive insurance company revenue.



Problems in the Market



1. For Consumers: Insureds (plus employers and the government) are have seen their costs skyrocket, forcing many individuals and employers to either go without insurance or choose high deductible plans, which can result in underinsurance.
2. For Providers: Insurance companies are now often in direct competition with providers, as they employ/control their own providers, who get more favorable contracts with higher reimbursement as independent providers see a reduction in reimbursement.

The BIG, BIG Problem

- The current system is unsustainable.
- All funds come from individuals, employers or the government.
- Private plans are being subsidized by the government through tax credits and HealthCare.gov plans.
- Private plans are still not profitable enough for insurance companies, as more pursue the larger profits from Medicare Advantage.
  - In March 2023, Humana announced it would no longer offer employer-based plans, which cover 50% of the market.
- The government is cracking down on MA abuse.

Impact on Providers

- For decades, providers have been tethered to insurance plans for patients and revenue.
- Insurance plans are still the best source of patients, as roughly 70% of patients have private insurance or traditional Medicare.
- *But*…insurance reimbursement is stagnant and is unlikely to increase so long as insurance companies own/control provider groups.
- Independent private practices clearly need to be preparing for the loss of the health insurance relationship.

Market Predictions

- The healthcare market won’t experience a dramatic shift unless health insurance companies begin failing.
- The government will do everything in its power to subsidize health insurance companies due to their economic impact.
- Private plan insureds will continue to be financially squeezed, especially those insureds who don’t qualify for subsidies.
- Private providers will continue to be financially squeezed, complicating provider shortages and resulting in practice models reliant on mid-levels and nurses.

Provider Options

- Practice Structure
  - Concierge Practice: Charge a retainer for services not covered by health plans.
  - Direct Primary Care: Typically a cash-based approach with monthly subscription fees.
- Practice Offerings
  - Ancillary Services: Develop cash-pay ancillary services, (e.g. cosmetic laser hair removal).
  - Adjunct Services: Develop cash-pay adjunct services, (e.g., massage services).
- The challenge is to maximize patient steerage from insurance plans while building a practice model that is viable *without insurance.*

Take Home Message

Every private practice needs to be preparing for health care without health insurance.

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