CHA | California Hospital Association

Key Messages

Insurance Companies Must Prioritize Patients by Doing Their Part to Make Monthly Health Care Costs Lower for Working Families

1. **Hospitals are doing their part to keep costs down for health care consumers. It's time for insurance companies to step up as well.** Hospitals are a pillar of California's health care system, dedicated to caring for those who need them 24/7, and have been working for years to slow the rate of growth in health care spending.
   - Since 1980, the share of national health care spending attributable to hospitals has decreased by 26%, and California hospitals are efficient, caring for state residents with 31% fewer beds per capita than the national average.
   - Since 2010, California hospitals have averaged annual operating margins of 3.4%, and more than 40% of California hospitals operate with negative margins. The average annual operating margin of four of the largest, public insurance companies is 7% — 104% higher than hospitals.
   - Ensuring care is affordable for consumers requires a significant effort from insurance companies to offer broad networks that guarantee adequate access to all types of services and specialists in communities throughout the state, without disruption to care. Relationships between hospitals and insurers must be founded on a shared commitment to ensuring access to high-quality care for all Californians.

2. **Insurance companies have enormous power in California and can use that influence both to keep costs down for consumers and ensure that hospitals and other providers are paid in a timely manner.**
   - In California, 94% of the commercial health insurance market is controlled by just six companies.
   - Since 2015, California hospital revenues have grown an average of 4.4%, while insurance premiums have grown 14% faster during the same time. Insurance companies must work to reduce monthly premiums for all Californians.
   - Health insurance premiums have averaged a more than 5% annual increase every year since 2016, more than double the general pace of inflation over the same period.
   - In California, health plans have 45 working days to pay claims to hospitals, and unnecessarily employ tactics such as asking for the same information to be submitted multiple times to delay the payment process.

3. **The administrative requirements of insurance companies put an undue burden on providers and their patients.**

- Health plans are increasingly shifting administrative burdens to providers, requiring their workforce to spend more and more time on the phone with insurers resubmitting claims, seeking prior authorization, and more.
- The more time that doctors and providers must spend writing appeals and gaining prior authorization takes time away from much-needed patient care and drives up health care costs for every Californian, further contributing to their burnout.
- Requiring providers to file multiple appeals to get reimbursed is not an infrequent process, with the annual value of challenged claims ranging from $11 billion to $54 billion annually.
- Insurance companies often drag out the prior authorization process required to transfer patients to skilled-nursing facilities and rehabilitation facilities, leaving patients in limbo and delaying their transfer to a facility that is best suited to handle their needs.
- At the same time, patients are often left in the middle to wait and wonder, "Is my insurance company going to pay for this?"
- In addition to generating stress for patients, administrative burdens also increase costs: more than one-third of all health care costs in the U.S. are due to insurance company overhead and resources to deal with billing.

4. **Certain pharmaceutical policies are even more directly harmful to patients.**
   - A policy known as "white bagging," in which insurance companies use just a handful of select pharmacies to ship medications for patients, jeopardizes Californians' health, safety, and well-being by restricting access to critical medications. This commercial payer policy requires an alternative method for distribution and payment of certain costly specialty drugs that are administered by a clinician to a patient through an outpatient setting, typically a physicians' office, hospital, or clinic. It upends the traditional approach by moving the drugs to a pharmacy benefit and requiring providers to accept drugs purchased and handled by the payers' owned or affiliated specialty pharmacies.
   - In this attempt to boost their bottom line, insurance companies are creating the following risks:
     - Since the medications are ordered on a case-by-case basis, as opposed to the traditional bulk procurement process that hospitals use now, there is potential for delays, mistaken deliveries, diversions, and lack of appropriate quality control and temperature monitoring.
     - Because a patient's initial treatment plans may be changed, not having the specific medication available at the time of their visit causes delays in treatment and recovery that could lead to disease progression or life-threatening events. Hospitals must have the ability to modify medications immediately to address patients' condition at their scheduled appointment.
   - White bagging negatively affects the most vulnerable patients — those with complex and challenging clinical diagnoses, and in many cases, children with life-threatening illnesses such as cystic fibrosis and cancer.