Where Does Your Health Care Dollar Go?

Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive and improves health care affordability, access and quality for everyone. **Here is where your health care dollar really goes.**

This data represents how commercial health plans spend your premiums. This data includes employer-provided coverage as well as coverage you purchase on your own. Data reflects averages for the 2016-18 benefit years. Percentages do not add up to 100% due to rounding.

AHIP
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CATEGORIES	WHAT THIS INCLUDES	EXAMPLES
Prescription Drugs	Payments for out-patient prescription medications, mostly self-administered drugs; as well as payments for prescription medications administered in the physician's office or clinic. For both of these drug categories the prescription drug spending was calculated net any estimated prescription drug rebates paid by the drug company.	Medications you pick up from your local pharmacist, like antibiotics, blood pressure pills, or creams for rashes. Also, injectable drugs that are administered by a nurse or doctor either at their office or your home.
In-Patient Hospital Costs	Payments for all services during hospitalization, including the administration of prescription drugs provided during a hospital stay, payments to physicians, and facility payments.	The costs for your hospital room and board, including equipment or supplies used during your hospital stay. Salaries of doctors, nursing staff and all other hospital personnel. General overhead costs of running a hospital, such as utilities and land.
Out-Patient Hospital Costs	Physician and facility non-drug related payments for treatment in the out-patient department of hospitals, not including emergency room care.	Going to a hospital to get an MRI or an X-ray. Visiting a primary care doctor or a specialist who are working in the hospital out-patient department.
Emergency Room Costs	Physician and facility non-drug related payments for emergency room visits and ambulance transportation.	Paying doctors for their time and expertise in arriving at a diagnosis and a treatment plan during your hospital emergency room visit; paying for equipment or supplies used during your visit; general overhead necessary to operate the emergency room around the clock. If you stay overnight the payment is included under in-patient hospital costs.
Doctor Visits	Payments to doctors or clinics for all non-drug related out-patient services provided during visits to doctor offices, clinics, and urgent care facilities.	Equipment or supplies used during a doctor or nurse visit; paying doctors for their time and expertise in arriving at a diagnosis and a treatment plan for you; salaries of nursing staff and other ancillary staff; office rent and general overhead costs of running a physician's office or clinic.
Other Out-Patient Care	Payments for all out-patient services incurred outside hospitals, doctor offices and clinics, such as claims from ambulatory surgery centers, labs, dialysis or at home care.	Lab work, treatment in dialysis centers, home health, or surgeries performed in the ambulatory surgery centers.

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Taxes and Fees	All taxes and assessments paid by the health insurance provider.	All the usual federal, state, and local taxes paid by any business, like income taxes, property taxes, payroll taxes. Also includes payments that are unique to a health insurance provider, like taxes paid on insurance premiums and regulatory authority licenses and fees.
Other Fees and Business Expenses	Agent and broker direct sales salaries and benefits, fees and commissions paid to agent and brokers, and insurance rebate payments.	Expenses required to run any insurance business, like costs associated with paying insurance agents and brokers. Also includes money paid back to customers as insurance premium rebates.
Cost Containment	Claims adjustment expenses, detection and prevention of fraud and abuse, case management, expenses for appeals, expenses for developing and managing provider and prescription drugs networks.	Prevention of fraud, waste, and abuse by doctors and patients. Answering questions from doctors and hospitals. Helping providers with best practices. Ensuring proper credentialing for quality care. Programs to better manage chronic conditions and coordinate care between doctors, to ensure that the right treatment is provided to the right patient at the right time.
Quality Improvement	Efforts to improve health quality and increase the likelihood of desired health outcomes such as preventing hospital readmissions, improving patient safety, wellness and health promotion, and health information technology.	Preventive care programs to keep you healthy, like weight management plans or helping people to quit smoking. Patient education and follow-up calls by health plan staff to members discharged from a hospital. Services to improve health in communities, like sponsoring local health fairs and providing free disease screenings and other educational events.
Other Administrative Expenses	General and administrative costs to run the business, including salaries, outsourced services, equipment, accreditation and certification fees, rent, legal fees and expenses, advertising, postage, utilities etc.	Managing employee benefits and retirement plans. Reviewing contracts or conducting legal research. Maintaining office space.
Profit	Net profit of for-profit health insurance providers and the difference between total revenue and total expenses for not-for-profit health plans.	The revenue remaining after all costs are paid. In for-profit companies it is commonly paid to shareholders in the form of dividends.

Methodology

The goal of our analysis is to show how premiums for a typical commercial (employer-provided coverage and individual market) health insurance plan are invested. The analysis shows the inflation-adjusted average annual amounts paid by commercial health insurance plans in 2016-2018 for the medical care of plan members; the average annual amounts paid for general operating expenses; and the average annual reported profit or loss. These data do not account for the potential impact on health plan spending related to COVID-19.

What's New from Prior Updates

For this edition of the premium dollar spending analysis AHIP made several methodological changes compared to its most recent version released in 2018:

1). Changes to categories: AHIP used the new, easier to understand methodology, by dividing medical spending into categories based on the place of service for the medical care received (e.g., emergency room costs, in-patient hospital costs etc.) which are more familiar to the general public vs. the previously used more accounting-centered approach. For example, in past editions the facility and professional costs incurred during hospitalization had been assigned to different categories - hospital costs and doctor services, respectively.

2). Drug costs net of rebates: AHIP subtracted the published estimates of pharmaceutical manufacturers rebates to present the prescription drugs spending net of all rebates received, which are not reflected in the claims data. AHIP used the 2016 estimated manufacturer rebates in the commercial market published by The Pew Charitable Trusts. (2019). *The Prescription Drug Landscape, Explored.* https://www.pewtrusts.org/-/media/assets/2019/03/the_prescription_drug_landscape-explored.pdf

3). Operating expenses: In this update, Oliver Wyman provided AHIP with a granular breakdown of operating expenses using financial statements of health insurance providers as the data source for categorization. A benchmarking model was employed for the 2018 report and graphic. As a result, the names and scope of operating expenses subcategories changed (see more detailed description below).

Overview of Data Used

Medical Services

To determine the annual amounts paid for medical services in 2016-18, the commercial claims data from the IBM® MarketScan® Commercial Database were summarized (Copyright © 2019 International Business Machine Corporation; All Rights Reserved). The Inpatient Services file, the Out-patient Services file, and the Out-patient Drug file of the MarketScan® database were utilized for the study.

Since the analysis used multiple years of data, all expenditure data from 2016 and 2017 were adjusted for inflation and expressed in 2018 dollars. This inflation adjustment was performed using the Medical Care Component of the Consumer Price Index (CPI) reported by the U.S. Bureau of Labor Statistics (www.bls.gov).

Only those patients under the age of 65 on the date of service who had evidence of continuous health plan enrollment for the entire period in each study year (2016, 2017, or 2018) and had prescription drug coverage were included. Claims having missing payment information; missing dates of service; and in the case of the inpatient and out-patient services claims, missing data on whether the claim was submitted by the facility or the physician were excluded from the study. The main variable of interest was the "net payment" variable which is the amount paid by the health insurance provider. The net payment amounts of all included claims for each study year were summed.

Operating Expenses and Profit:

AHIP analyzed financial statements of 30 health insurance providers: five largest publicly traded for-profit commercial health insurance companies and 25 randomly selected not-for-profit health insurance providers that had the majority of their business (i.e., greater than 50% of enrollees) in the commercial market.

To estimate operating expenses and profitability, for the five publicly traded insurance providers, their 2016-2018 10K filings with the Securities and Exchange Commission were examined; while operating expenses and profitability data for private, not-for-profit organizations were extracted from their 2016-2018 Form 990s, filed with the Internal Revenue Service, or, when not available, from the financial

statements published on the health plans' websites. We were unable to obtain a Form 990 or a financial statement from two plans in 2018, thus, their operating expenses and profits are the average of two-years of data (2016 and 2017).

Premium Revenues

Only those revenues attributable to premium payments from health plan members were recorded for each plan for each year (2016-2018). Revenues from sources other than premium payments, such as from other business segments or investment income, for example, were excluded. For each plan, the average revenue across the 3 years was calculated.

For the five publicly traded, for-profit insurers, amounts listed in their 10K filings as "Operating Costs," "General and Administrative Expenses" or "Sales, General and Administrative" were extracted from their 2016-2018 Income Statements. Amounts paid for taxes were also recorded. Amounts shown as "Net Income" or "Net Profit" were also recorded. For each plan, average total operating expenses and an average net profit were calculated across the three years and recorded. During the years of our study, the Health Insurance providers fee was in place for 2016 and 2018. In 2017 there was a moratorium.

For the 25 private, not-for-profit entities their total operating expenses were calculated by subtracting the "Benefits Paid to or For Members" from the "Total Functional Expenses" amounts appearing in their Form 990. Similarly, profitability was determined by subtracting the "Total Expenses" from their "Total Revenues." These calculations were performed for each plan for each year and recorded. For each plan, average total operating expenses and an average net profit were calculated across the 3 years and recorded.

Finally, for those health insurance providers having multiple revenue streams beyond member premiums, some of the plans' total operating expenses and profits could be unrelated to servicing their insured population. To account for that, we apportioned the operating expenses and profits based on the share of health plan's revenue derived from member premiums. For example, if a plan A had 80% of its revenue derived from member premiums, we used 80% of its total operating expenses and profits in our calculations.

For each plan, the average total operating expenses and the average net profit amounts were divided by the average revenues derived from premiums to yield that insurer's operating margin and net profit margin. To account for differences in the sampling of for-profit (n=5 plans) and not-for-profits (n=25 plans), a simple average of the operating margin and an average of the net profit margins were calculated separately for the for-profit and not-for-profit plan subgroups. These two averages were then weighted by these two groups' share of commercial enrollment and combined.

The average total operating expenses calculated across all plans were further subcategorized into the key functional areas. The proportions of the average total operating expenses attributable to each of these core administrative functions were determined by the consulting firm, Oliver Wyman. Oliver Wyman analyzed 2016-2018 Supplemental Health Care Exhibit filings submitted by commercial insurers to the National Association of Insurance Commissioners (NAIC) as part of their statutory filings.

Since the analysis of NAIC filings used multiple years of data, all administrative expenses data from 2016 and 2017 were adjusted for inflation by using the Medical Care Component of the Consumer Price Index (CPI) reported by the U.S. Bureau of Labor Statistics (www.bls.gov) and expressed in 2018 dollars.