MEDICAL INSURANCE COSTS: WHAT'S NEXT?

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During the 1980s, we saw the advent of what is referred to as medical "managed care.' There were several reasons for the development of managed care. These included:

- limiting the patient's ability to go to any health care provider as often as he or she chose
- directing patients to health care providers who had agreed to percentage discounts off their regular fees or to a preapproved fee schedule
- the idea that patients would visit those doctors who would take responsibility for the overall management of the employee's health care
- the perceived reduction of health care costs per person and the bringing about of health care with better outcomes

To reach these objectives, preferred provider organizations, health maintenance organizations (HMOs), and point-of-service plans were developed over a several-year period.

Insurers developed networks of health care providers charging reduced fees in exchange for the insurance company directing more of its insureds to these providers. What the provider lost in discounts would be offset by a higher volume of patients.

As these networks began to proliferate, we found that nearly all providers were in multiple plans. Thus, everybody under an insured plan was getting discounts, and the ability to provide more patients to a given provider soon disappeared.

Coupled with the lack of effectiveness of a managed care network, we have seen more expensive technology, procedures, and medication arrive in the medical marketplace. The cost of these new goods and services rapidly ate up any prior discounts achieved.

Furthermore, health care providers were not truly managing the care of a patient. Their time and fees did not permit the counseling and wellness services necessary in a true managed care environment. For example, in an HMO where the patient pays only a minimal copayment, the doctor gets paid a monthly fee from the insurance company whether the patient visits the doctor or not. Some doctors saw the patient visit as a liability rather than an asset. They had to spend time to provide treatment to an individual in return for an additional $10 or $15 payment. They were going to get the other income anyway.

In summary, there were a number of forces at play which resulted in the total cost of health care continuing to rise faster than the cost of goods and services in our economy as a whole. Especially hard hit were those individuals who did not have a medical insurance policy that fit into one of the “discount” plans. These people ended up paying full fare, and often a surcharge to enable the health care provider to recover some of the losses incurred from their managed care patients.

Perhaps the biggest detriment to managing health care costs and the associated insurance plan payments is the fact that the benefits provided by most medical plans are so rich that the patient pays only a small fraction of the total bill. In fact, it's unusual in a managed care plan for an employee to ever see a bill or to know what the total costs of the treatment have been. This scenario is a disaster in any type of financial transaction.

HMOs originally started this trend. Employees and employers were initially reluctant to enter a managed care plan that provided treatment only by a limited number of physicians. Thus, the plan was made very rich in order to persuade individuals to join the HMO plan. Deductibles were eliminated and replaced with very small copayments for visits to the doctor or for the purchase of prescriptions. Employees had no claims to file and, in fact, never saw a bill. It made no difference to the employee if the office visit cost $50 or $300.

My personal experience confirms this. Last year, I incurred in excess of $10,000 worth of medical expenses that involved one day in the hospital for surgery. My hospital bill was paid in full and I had a series of small copayments for office and lab visits. There was no reason for me to see the bill since all I was paying were the copays, and I had no claim to file

What's Going to Change?

Any time you have someone purchasing goods or services where someone else pays the bill, there is no responsibility on the part of the purchaser. This applies whether someone is buying health care services, automobiles, televisions, or a meal at a restaurant.

What will no doubt occur over the next two years is a total redesign of health care plans. Patients will pay a much larger percentage of the budgetable bills, and insurance plans will continue to pick up nearly all of the costs associated with higher cost care.

Because of the increased cost exposure to the patient, we should see a rapid increase in the use of flexible spending accounts (FSAs) for health care.

Specifically, plan designs that are evolving may have the following provisions:

- higher plan deductibles of $500, $1,000 or $2,000 per year, per person
- the elimination of copayments or use of much higher copayments
- all prescriptions changing from copayments to coinsurance with the coinsurance percentage increasing to higher levels on brand and nonformulary prescriptions
- coinsurance levels of 50 60 percent for the first $1,000 or $2,000 of expenses

These types of changes will cause employees to look at bills, make decisions based on cost, and to shop for health care services. The result will be reduced premiums. The employer will set some of their savings aside as seed money into a medical FSA plan.

When I was eight years old, I wanted a bicycle. I finally got up enough courage to mention it to my dad, who promptly replied, "You can have any bicycle you want, as long as you pay for one-half of it." At the age of eight, I had no money, but found that for every dollar I would earn doing chores, he would match it. That was my first 401(k)! Needless to say, I ended up getting the bicycle a year late and it was just a basic model. However, because I had a lot of personal money invested, I treasured that bicycle and kept it for many years. My dad did the same thing when it came time for a car and college education. His approach really bothered me as a young person, because some of my friends did not have to share in the costs of such things. However, I am very much indebted to my dad for his sense of financial responsibility.

The same approach will work in the health care area. Employers are willing to draw the line on how much they can spend on benefits. If the American family can spend several hundred dollars per month for each of two cars, they can certainly spend a couple hundred dollars a month for medical care. I wonder what kind of cars we would all be driving if we only had to pay a $25 per month copay regardless of the car's price.

Major insurance companies have already designed and priced these new plans. They are on the street now and they will gain strong momentum over the next two years. If you want to differentiate yourself in the marketplace, bring this to the attention of your clients. It's the only thing left that will work in the health care marketplace.

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