SOCIETY OF ACTUARIES

Article from:

Health Section News

October 2004 – Issue No. 48

ple, copayments might be reduced or waived when associated with lab procedures or prescription drugs necessary to control a chronic condition. Plan design considerations in today's insurance programs generally take the opposite approach, increasing cost sharing across the board in the hopes of reducing "unnecessary" utilization. An exception is prescription drug plan design, which has evolved to encourage cost-effective utilization. This approach should be expanded to other service categories, recognizing that incentives and barriers to cost-effective care differ according to the health status of the individual member.

Cindy Miller:

We already see the movement to benefit designs that require more cost sharing by the consumer, and I imagine that this will continue. Given the continued demand for more individual choice, and the desire of many employers to reduce or eliminate their role in purchasing health insurance for their employees, it is likely that we will see more movement to individual products and perhaps a blurring of the distinction between group and individual policies. Benefits and networks will emphasize quality and incent the patient to use providers that meet quality standards. While I'm not sure that this is likely, I would like to see benefit designs that reward individuals who choose healthy lifestyles. That is, provide richer benefits or reduced rates to individuals who don't smoke, who exercise, maintain a healthy weight, consistently take medications required to control chronic conditions, etc.

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Who Is to Blame for Cost Increases?

by Dinkar Koppikar

Almost all respondents blamed "we" for cost increases without defining "we." As many have correctly pointed out, we must expect cost increases as advances in medical technology conquer many illnesses and the population becomes older. If people live longer and healthier lives, the increasing proportion of health care cost in our per-capita income is nothing to complain about. In fact, enlightened public opinion will expect that to happen. However, certain anomalies in the way the costs are assessed aggravate the cost crisis and the appearances thereof. Unfortunately, neither pure market mechanisms nor pure governmental regulations would be sufficient to correct those.

Let me first point out the anomaly in group health insurance pricing that aggravates the crisis in health insurance pricing, as well as appearances thereof. Most elements in an employee benefit plan are of the deferred compensation type, in that the resources set aside are available for use by an employee only in the event of some future contingent event, when an employee has no income from employment. However, the resources earmarked for group health insurance are available while income from employment continues. Thus, group health insurance effectively supplements current income, that too on a pre-tax and partially or fully employer subsidized basis. As soon as he loses his job or retires, he receives a COBRA notice of his "right" to continue health insurance, at a premium rate several times what he used to pay during employment, at a time when he has little or no income, so any tax subsidies are meaningless. While employed, even if the employee and their family use health care services in a profligate manner, they rarely see big bills coming their way. Their health care problems may be minor. With unemployment, dormant health problems may upsurge. With big medical bills in the mailbox the perception of costly and unaffordable health care gets aggravated.

In short, the culprit "we" are the affluent sections of the society getting tax and employment subsidized health care (high income, self-employed can incorporate and get benefits as "employees"), who seduce health care providers to charge big bills for

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minor health care problems. Inevitably, retired, unemployed and poor get comparatively shoddy (or very costly for them) health care services, without any subsidy. Naturally, this creates resentment among those not so privileged who call for public subsidization of their health care services and gives rise to the unending spiral of subsidies and regulations.

Now, suppose health insurance was employer funded and/or tax subsidized only for providing resources when a person was unemployed, retired or otherwise with little or no income, with employed persons expected to pay health care bills out of earned income (with wages and salaries suitably adjusted initially). Since real health problems interfere with normal enjoyment of life, people will have incentive to lead healthier lifestyles to minimize health problems, shop around carefully for treatment when such problems do arise and seek cost-effective quality treatment (just as people may shop around carefully for groceries and other necessities). The health care habits formed thereby can be expected to be continued during unemployment (which is usually of short duration) or on retirement.

Insurance should provide resources during an exceptional situation that the insured has no incentive to cause and/or aggravate. The current practices essentially incite profligate use of health care services while employed and effectively withdraw resources when needed. Therefore, the insurance mechanism operates in a topsy-turvy manner.

In my letter to the January-February 2004 issue of *Contingencies*, under the caption "Health Insurance When You Really Need It," I had proposed that regulation should require that health insurance policies (including group health) continuously accrue minimum mandatory paid-up periods to be determined by a formula with a bias toward increasing the accrued paid-up periods the longer the insurance is in force, ultimately making it paid-up for life. This proposal was really a further evolution of the proposal I had made in my two articles in *Contingencies* in May-June 1998 and November-December 1999 with pricing examples from the 1998 issue of *Actuarial Research Clearing House* (ARCH) published by the Society of Actuaries.

The nomenclature "employer-subsidized" aggravates the problem because the "employer subsidy" is really part of compensation set aside for a dedicated use. I believe tax deductibility of employer "subsidy" without corresponding taxable income to employee has a lot to do with this. (One may note that this is exactly opposite of the tax treatment of employer-paid group life insurance in excess of $50,000, which generates taxable income to employees far exceeding actual premium cost to employers.) One actuary has blamed late President Roosevelt for this. Stringent wage and price controls had to be imposed during World War II for successful pursuit of war against totalitarian states who committed unspeakable crimes against people. Employers and their tax advisors discovered loopholes in tax codes to defeat wage controls. It is impossible for tax writers to divine the loopholes determined tax payers may discover in order to minimize taxation. In any case, in the 60 years since Roosevelt, Congress still hasn't dared to plug the loophole. It does not behoove an actuary to blame a president from 60 years ago for abuse committed by powerful taxpayers in defying his tax code, abuse which has been condoned by law ever since.

What should be the government's role in ensuring health care coverage and keeping costs down? By "government," I mean both federal and state governments. I am only proposing here what may be novel ideas. There is no point in repeating many other ideas that are already promoted or practiced with varying degrees of success.

If health insurance (group or individual) is required to accrue a paid-up period depending on the number of annual premiums paid, as proposed in the foregoing, it will enable people to remain covered while unemployed, as well as provide incentive to people to minimize temporary use of a paid-up period, so as to earn lifetime paid-up coverage sooner. It may be noted that while a life insurance paid-up period is a byproduct of all other actuarial elements, what is proposed here is a paid-up period to be prescribed by a regulatory formula with a premium schedule (revised from time to time depending on the deviation of actual experience from what is expected) as a resultant product.

Tax subsidization of health insurance premiums should be abolished (except for the element that builds up the paid-up period). It should be replaced by tax credits graded by age, sex and income groups. Such tax credits should be partly cumulative and partly non-cumulative for a limited period. Every year the average health care cost per person, graded by age group, income group and sex, should be determined. Tax credit should be a varying percentage of the health care cost depending on the income group (higher for lower income groups, reducing as income increases). A person may or may not fully claim credit in a given year. Unused tax credit should be accumulated in that person's account (and adjusted for changing age and average health care costs from year to year) available for use in later years. At younger ages people should be encouraged to accumulate health care credits. Non-cumulative (and cumulative for a limited period) health care credits should be made available at later ages to be used for preventive health care.

Apart from that, government should encourage a lifestyle of a healthy diet and exercise. All products and services should be subjected to graded health care excise tax or subsidy, depending on whether and/or how they promote or jeopardize health. Where moderate consumption of a product is healthy (or at least not unhealthy), but excessive consumption is not, a graded excise tax depending on the size of the packet sold or portion served might be a useful idea. The revenues from health care excise tax can be used to finance health care tax credits, with surplus revenues used to set up reserves for unused tax credits and invested in projects to promote healthy lifestyles.

To encourage couch potatoes to exercise, TV stations could be required to display pictures of people exercising from time to time (say 15 minutes every three hours) and encourage couch potatoes to do the same.

Patent regimes should be strengthened to prevent abuses. Research and development in drugs should be made truly international to minimize R&D and production costs with the federal government having the right to acquire patents if new drugs and treatments are proven to be breakthroughs.

To discourage excessive use of medical tests, laws should permit reimbursement of expenses incurred for such tests, based to some extent, on end results. The more negative the results of tests and/or less serious the problems, the lesser the percentage of reimbursement. This will provide incentive to insureds (and health care providers) not to go in for expensive tests unless they strongly suspect the presence of serious problems.

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CONGRATULATIONS!

The following are newly-elected members of the Health Section Council. They will serve a three-year term, beginning in October, 2004.

Damian A. Birnstihl
MVP Health Care
Schenectady, NY

William R. Lane
Heartland Actuarial Consulting, LLC
Omaha, NE

Lisa F. Tourville
Reden & Anders, Ltd.
Eden Prairie, MN