

## Prepaid Medical Care And Medical Insurance

by John I. Mange

*Note: This essay won first prize in the contest sponsored by the SOA Health Section.*

Ask yourself this: Other than medical (or dental) insurance, is there any insurance product on which you expect to make a claim every year? Undoubtedly, the answer will be, “Of course not.”

Through decades of practice, policymakers and the public have become accustomed to thinking of insurance as how one accesses medical care. The reason one expects to make a claim every year on medical insurance is that much of what is sold as medical insurance today is not insurance. It is prepaid medical care. Covering prepaid medical care drives up the cost of insurance and contributes to the extraordinarily high rate of trend in medical costs from year-to-year.

### An Inefficient System

The medical insurance system is, nevertheless, the means by which most people access the medical care system in the United States. It is remarkably inefficient for that purpose. Why?

Medical insurance today inserts a third party—an administrator—and its attendant costs into virtually every single doctor/patient interaction. The presence of the administrator, whether public or private, weakens the doctor/patient relationship. There is someone else in the room, figuratively speaking, exerting influence over decisions that the doctor and patient should make together.

Moreover, the administrator’s costs are high, much more so than, say, credit card transaction costs, because the administrator has many difficult questions to answer before it can process the transaction:

- Is the patient eligible?
- Are the services covered?
- Were the services medically necessary?
- Were the costs reasonable?

Because these questions are often not answered in advance, the patient may not know his/her net costs (after

insurance) until long after services are delivered. How are doctors and patients supposed to make informed decisions in such an uncertain environment?

### Misaligned Incentives

In addition, today’s medical insurance system distorts incentives in several ways. First: because much of today’s insurance is prepaid medical care, those covered by insurance are incentivized to extract value from their insurance instead of, as with other insurance, hoping that they never make a claim. This contributes to overutilization and causes demand for medical services to be comparatively inelastic contributing to high unit costs.

Second, because reimbursements are often based on the services delivered and not on the outcomes produced, providers are incentivized to deliver as many services as possible. This, too, contributes to overutilization.

Third, reimbursements are often limited to amounts that are usual and customary, so providers are incentivized to determine the maximum reimbursement available, not the economically appropriate price. This contributes to high unit price inflation.

Finally, because prices for medical insurance today rarely reflect lifestyle choices, medical insurance fails to incentivize covered lives to adopt healthier lifestyles. Wellness is, of course, covered by many medical insurance policies today, but there is often no financial incentive to take advantage of such benefits when they are covered.

The issues cited here—interference in the doctor/patient relationship, the costs of administering prepaid medical care, and the design of medical insurance—are but a few of the many issues facing the U.S. medical care system, but they are often overlooked and frequently misunderstood. Failure to correct these issues will perpetuate their effects on the system, and the resulting system will fail to deliver on higher quality, more affordable medical care sought by advocates of reform.

Prepaid Medical Care And Medical Insurance by John I. Mange

**Addressing The Issues**

How can we address these issues? First, educate policy-makers and the public that medical insurance should be like other insurance, a financial service that is frequently bought (perhaps even mandated), rarely used, but critical to the physical and financial well-being of the insureds.

Second, effect legal and regulatory changes that differentiate between prepaid medical care and medical insurance. For example:

- Define medical insurance as coverage for medical care that exceeds an agreed amount per person per year, perhaps expressed as a percentage of income and indexed to inflation.
- Require that prepaid medical care and medical insurance be unbundled from one another.
- Continue the tax deductibility of medical insurance.
- Eliminate the tax deductibility of prepaid medical care.

Third, encourage the pricing of medical insurance based, in part, on known actions of the insureds that demonstrably lower the cost of medical care, including:

- Cholesterol screenings.
- Mammograms and pap smears.
- Immunizations.
- Smoking habits.
- Demonstrated weight management behaviors.

Fourth, require that costs—both of services and of insurance reimbursements—be transparent. That is, providers must post prices for the services they provide so that their patients know what they will be asked to pay, and insurers must schedule benefits so that patients will know how much they will be reimbursed.

Fifth, require that insurance reimbursements be based on episodes of care, adjusted as appropriate for complications. Such a requirement would likely cause providers to adjust their posted prices to an episode-based approach, which would, in turn, focus attention on how to achieve favorable outcomes efficiently instead of on the services that were delivered.

Sixth and finally, encourage, but do not mandate, the purchase of prepaid medical care, and allow prepaid medical care to be offered by providers directly to the public. Concurrently, allow prepaid medical care plans to be designed so that transaction costs can be reduced to the level of a credit or debit card. The costs covered are predictable, and many people would not perceive the need to pre-fund these services. They do not need to be part of an insured medical package.

The perceived but needless connection between insurance and access has clouded our thinking about what medical insurance is and how best to address the issues of access and affordability. If, in our effort to reform the medical care system, we fail to:

- Address these issues,
- Help policymakers and the public make the distinction between medical insurance and prepaid medical care,
- Squeeze administrative expenses from the cost of prepaid medical care,
- Restructure the pricing of medical insurance to encourage healthy behaviors, and
- Restructure medical insurance to correct its distorted incentives, we will likely fail to slow the inexorable rise in the cost of medical care. We can ill afford to fail at this task.

*John I. Mange, FSA, MAAA, is executive director and chief executive officer of Health Reinsurance Management Partnership in Danvers, Massachusetts. He can be reached at [jmange@hrmp.com](mailto:jmange@hrmp.com).*