feature

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# health insurance check-up

## Is your coverage too much, too little, or just right?

EDITORIAL | PAULA WILSON

**Employers and individuals continue to seek the level of medical insurance coverage purchased years ago.** Cradle-to-grave coverage is no longer affordable, yet many employers offer reduced-coverage plans in an effort to remain competitive and attract employees in their particular industry. While some options continue to carry a high level of coverage, often times they are not a responsible option for the employees making the buying decisions.

Many manufacturers' reps seeking coverage in the individual or small group health insurance market often perceive coverage as *unaffordable*. This generally occurs because they are seeking a level of coverage offered through previous employer-based plans. Historically, employers weren't purchasing a level of coverage to merely meet the financial needs of an individual, but rather a package of expensive benefits designed to attract and retain an employee workforce. Employee benefit levels are being reduced as the result of rising insurance costs but are still being presented in a manner that would attract new employees. The self-employed need to change their mindset and purchase insurance just for the reason it was designed — to cover any catastrophic financial burden that may present itself as the result of an unforeseen accident or illness.

The total cost to insure health care is no mystery. In the case of a big claim, you usually end up with similar overall costs whether you have a low deductible plan or a high deductible plan. The total of premium and out-of-pocket costs are very close. So how do you win at this game? It is important to take the time to educate yourself and others on the basic economic concepts of health insurance.

## Striking a Balance

An individual looking for health insurance needs to begin by deciding what their *real tolerance* is for risk. In other words, if you have a million-dollar claim, how much of the cost are you willing to bear before asking the insurance company to step in and pay the rest? All real insurance policies have a stop-loss or out-of-pocket limit in their policy provisions. This limit is the most important factor when purchasing insurance with an eye to risk tolerance. Knowing how each company determines which expenses are credited toward that number is something you need to ask your insurance consultant.

What is *your* risk tolerance? Is it more than your annual new car payment? Is it more than the cost of the vacation you just booked? I am not shocked at all when people tell me their risk tolerance for medical care is lower than their annual cable bill or beer allowance. I'm not suggesting that you need to cut out all vacations, cable and car payments, but I am suggesting that you look at health care risk as it really is. After shelter and food, it should be high on your priority list. You should be willing to plan to incur expense for health care in the bigger picture.

There are two options in the table below — Plan A and Plan B. Regardless of your health, which one would you choose? For purposes of this conversation, we will assume your out-of-pocket costs are made up of your deductible and co-insurance amounts. Co-insurance is the 20 or 30 percent that you are asked to pay on each expense incurred. The quote is for a 35-year old single person purchasing an individual health insurance policy.

| Coverage Options | Plan A | Plan B |
|---|---|---|
| Deductible | $3,000 | $ 500 |
| Out-of-pocket Annual Risk | $3,000 | $4,000 |
| Coverage | 100% after deductible<br>Prescriptions covered<br>100% after deductible | $30 office visit charge<br>75% Hospitalization<br>$10 generic / $20 brand name |
| Monthly Premium | $115<br>($1,380/YR) | $520<br>($6,240/YR) |
| Annual Premium Difference | $4,860 | |

If you have a million-dollar claim, **how much of the cost are you willing to bear** before asking the insurance company to step in and pay the rest?

It may seem obvious to you that the plan with the $3,000 deductible is the better choice, for all reasons. The premium is affordable and the maximum risk in the case of the million-dollar claim is $1,000 less. Additionally, this $3,000 deductible plan happens to be HSA-qualified, allowing you to pay for those deductible costs with pre-tax dollars, resulting in a net savings of at least another $800.

In reality, however, the choice is *not* obvious to most people with which we consult. When I suggest to people that they purchase a plan like this, they balk. Because the majority of the country does **not** spend more than $3,000 per year on health care, they perceive **no benefit** in having this plan. In the case of the younger purchaser, since the "better" plan is out of their price range, they often opt not to have coverage at all. This is where the education is needed.

## Beware of the Mini-Med Plan

A disturbing trend that is gaining popularity is the "mini-med" plan. Mini-med plans look just like Plan B with the premium of Plan A. The difference is that Plan B (above) will pay your bills up to 2 million dollars whereas a mini-med plan usually has a maximum benefit of $10,000 to $20,000 per year. I believe these plans to be counterproductive for two reasons. First, they are designed for the sole purpose of satisfying the irrational need to get *some* type of claim payment, no matter how small, merely to feel like you received a benefit for your money. Second, they really don't provide any solution to the risk of catastrophic coverage. Many bankruptcies are caused by medical debt incurred by those who were eligible to purchase insurance but chose to be uninsured because Plan B was too expensive. I run into people every day who are uninsured because they can't afford Plan B and they think Plan A is a "waste of money."

The truth is *everyone* saves when proper buying decisions are made. Those that feel they cannot afford dependent coverage (for their families) may actually be able to cover all of their dependents when they take responsibility for a larger portion of their risk. With the projected steady health care inflation of 11% per year, this change in mindset is a trend that must take hold. The status quo cannot stand much longer. More and more people will continue to choose not to insure if they can't be convinced that taking on more risk is the future.

## Educate Yourself

So, is it that easy? The answer, unfortunately, is 'no' — it's not *always* that easy. Individual purchasers with pre-existing conditions may find it difficult to qualify for any new individual coverage. Group plan insurers are still working with the changing claims experience from these consumer driven health care plans so that the cost gap between the options continues to close. Financial viability depends upon the rates of the day and the competitive cycle of the insurers. Actuaries are still fine tuning the proper pricing of these plans.

We have seen employers and individuals cut their benefit costs in half. Consumer driven high-deductible plans encourage everyone to strive for good health. People want to learn how to become good health care consumers. The benefits of this education result in healthier, more productive employees, lower absenteeism rates, and better claims experiences. All of these components lead to lower health care expenditures and would slow the increase in costs if more people would jump on board.

Even though the numbers might not be as impressive for you or your company, everyone should take advantage of the expertise of their insurance advisor — getting them to do the homework and review the results. When making changes to employer group plans, it is important that the advisor stand ready to provide the educational tools you need to pass valuable information on to your employees. Make sure you aren't over-insuring at a time when the cost is much too great and the options even greater.

We look forward to the continued fight to change the landscape of the health insurance market and to bring some sort of stability to the ever-rising costs.

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