

Growing health premiums are big threat-January 1998

For the past several years, employers of all sizes have experienced relative stability with their group health insurance premiums.

Many of the health care insurers, especially HMOs, have been scrambling to gain their market share as well as stay competitive.

Which brings us to 1998 and the resurrection of the old saying “all good things come to an end”, because once you attain market share, it’s time to become profitable.

Small employers may soon be experiencing, if they haven’t already, a double-digit rate increase in their health insurance premiums.

In addition, small employers that have an employee with a “notable” health condition, will find themselves summarily being excluded from changing or obtaining a health plan due to cost.

These issues are, in part, the result of federal and state legislation that is dictating the terms of this insurance.

The Health Insurance Portability and Accountability Act of 1996, that went into effect last July, forced all health plans to underwrite groups of two to 50 lives, to accept and insure all applicants, even those with terminal illnesses.

The Mental Health Parity Act of 1996, which took effect January 1998, requires annual and lifetime benefits for mental illness to be equal to that offered for other physical disorders.

The Newborn and Mothers Health Protection Act of 1996, which also took effect January 1998, ensures a two-day hospital stay for childbirth.

And Arizona’s SB1109, enacted in 1993, allows insurers to increase premiums no more than 15 percent unless there were “demographic” changes in the group, which was the apparent “loophole”. Another contributor to higher health insurance rates is the current trend to include various medical specialists as covered benefits.

There is a disturbing trend to allow legislation, or “government know-how”, to be the final arbitrator of how inclusive our health insurance should be.

The concept of insurance is that the risk of accident or illness is spread over a large population, thus making the cost manageable to all. None of us know who will have that car accident or will contract cancer, so we pay premiums to the insurance company and hope that we never collect.

More and more, however, health insurance has come to mean something different than spreading the risk. Now this system is becoming more like “prepaid” health care.

If through all this legislation we allow our health insurance to cover every shot, every office visit and every diagnostic test, we’re not really spreading the risk because we are paying for services that most people will need.

Logic should tell us that overly inclusive health care means higher costs. If we legislate that certain medical procedures and specialists are covered, there is a natural progression for more of the same to be added to the list.

Should the free market take on the responsibility for deciding the extent of our coverage or should we let the political system force us to pay additional premiums so that your fellow employee can have a back adjusted or get a herbal remedy at no cost? The growing list of mandated providers is based, in part, on the anti-discrimination argument against other forms of healing.

However, these mandates don’t provide more health care freedom, but are actually a way to coerce us into paying for the wants of some. One does not need to be an accountant or an insurance actuary to

figure the impact.

And, finally, this insurance actuary or underwriter is the one who will compute the result of these mandates.

In fact, a group health insurance renewal letter will contain phrases that are designed to placate the consumer with apparent rationale.

Examples of these phrases are “exclusive renewal formula”, or “federal cost-shifting to the private sector”, or the renewal rate being based on the “actual cost of all benefits”, “state-mandated benefits”, “optional benefits”, “attained age calculation”, and in accordance with “state regulations”.

Groups sometimes will see the phrase “rate normalization” with a resulting percentage added to your premium. This is another way of saying “we undercharged you when you first bought our policy, so now we’re making up the difference.” The most common term(s) used for these increases is “trend”, which is another word for medical inflation.

Rate increases are usually only single-digit when “trend” is used, but when other so-called contributors are added, the overall rate increase is elevated to that of “double-digit.”

Such increases will be prevalent in 1998. I already have witnessed premium increases of 20 percent to 50 percent or more.

In controlling health care costs, there are only so many times an employer can change health plans, increase premium sharing on the part of the employee, and/or reduce benefits before coverage simply becomes unaffordable.

Even though our economy is strong and our unemployment rate is one of the lowest in the world, this trend toward higher health premiums will cause a decline in the number of those insured by private health coverage and give “unknowing” fuel to the creation of a national system.