

Simple Market Changes That Will Change Healthcare for the Better

*By
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Re-inventing the “healthcare wheel” is doomed to economic and bureaucratic failure. There are much simpler options in the competitive marketplace. Let me give you a couple of ideas that build on the Safeway Stores, Inc. model of personal responsibility and adds a few features that are easy to do in the marketplace of competition.

1. Remove the tax deductibility for group insurance
2. Add tax deductibility or tax credit for individual insurance
3. Allow “Broker Portals” that contain *one health underwriting application* for all the insurance companies to underwrite from, and the portal allows access to all the insurance companies the broker represents. It will allow employees to choose a plan that suites them. (The broker’s function is to educate employees on the plans and to coordinate all the other employee benefits with the health plans).
4. Employers fund a flat amount for insurance into an HSA or HRA type arrangement if they choose to subsidize premiums.
5. Employees’ premiums (or contributions from salary) are deducted from this HSA or HRA arrangement whether or not it is funded by employer (allows for an easy payroll deduction for the employee).
6. Employees own their policy; it becomes truly portable. (Can’t you imagine employers advertising they “subsidize \$400 per month for employee only coverage,” while another advertises “\$425 per month,” etc.
7. Require doctors and hospitals to “post” their true charges for services, e.g., the actual amount they have negotiated with the particular insurance carriers—not the charges before the negotiated discounts.
8. Encourage all insurance carriers to change their underwriting rating if one improves his/her health—similar to the Safeway Stores plan.

Comments:

We currently use the tax code to change or encourage economic behavior; that’s why group insurance is a deductible expense for most, mortgage interest is deductible, etc. But, for those who do not have insurance coverage due to a true lack of sufficient income, a tax credit-either in the form of an immediate deduction on payroll taxes or annual income tax filing-could solve coverage for most of the un-insureds due to a true lack of income.

We must remember, however, that lack of a first dollar insurance policy does not translate into not having healthcare. One friend of mine has had the highest deductible the carrier offered, \$10,000 the last time I spoke with him. He has health insurance, but self-funds that first \$10,000 and transfers the rest of the risk of claims to the insurance company via an insurance policy. Since my friend takes good care of himself, probably has his first dollar he earned, he has saved a great deal of money on his insurance premiums over the years. But, should he have some major medical expense, say by-pass surgery, he would be covered. Here is what one organization reports as the cost of a heart bypass procedure (from the VHHA PricePoint website (www.vapricpoint.org), “Heart Bypass Surgeries Without Insertion of Cardiac Catheter With Angioplasty” at Henrico Doctors Hospital (HCA), the median “charges” there were reported to be \$218,229. So, my friend with his \$10,000 deductible policy would be covered for 95% of the charges. Of course, we all know that what the hospital charges and what is negotiated with the insurance company is far different. See below on a discussion of “Transparency.” In any event, he would not be bankrupt due to not having “healthcare, aka insurance.”

Transparency in the pricing of services will go a long way to force out in the open the true cost of services. I just got stung—I went to a new doctor (actually, he had given me my FAA flight exam a few months before) but I still got charged as a “new patient.” So, my office visit was \$180 and Anthem allowed the charge. I failed

to ask the question before I went to the doctor. If I was running his office and wanted new patients, I would give new patients a “deal” to use me as their primary care physician.

As I write these comments, I called Patient First in Richmond, VA, a healthcare facility that advertises itself as “Urgent Care for Injury & Illness; Primary Care,” for some of their services. However, when I called them to ask what they charge for an office visit, the billing clerk was quite clear: “We do not quote pricing on the phone.” However, she would share that an office visit would “probably not be more than \$300.” I asked her why so high and she said that they were “open 365 days a year and that they were primarily an Urgent Care Center. That’s why our prices are higher than a regular doctor’s office but lower than the hospital urgent care/emergency room.” So much for trying to get to the real cost of healthcare costs!

Changing our lifestyles is also the key to reducing claims’ costs. When a person goes to fill a prescription and the co-payment is “only \$10,” then why worry about it? Well, the cost of the drug may have been \$120 to the insurance company, who is really paying for it out of the premiums. So, what if the cost of the prescription to the policyholder was 30% or 50%? Would the policy holder think, “Gee, is there a less expensive alternative that does the same thing?” Why pay \$36 (30%) or \$60 (50%) when something else will work? “Why not change my lifestyle and eliminate the drugs altogether?” For those things that one cannot control or are already permanent diseases and cannot be changed by lifestyle changes, insurance carriers in dire competition will come up with a solution. When the market cannot find a solution, which is rare, then that’s when government may have to step in.

Remember, whether or not a company is a non-profit or a for-profit company, they still have to find a market for their products, someone to represent their products, someone to use them, and they do have to make a “profit.” If they can’t break even, they will have to cut services, cut payroll expenses, cut employees, cut new plant and equipment expenditures, and the list goes on and on. It becomes a ripple effect in the marketplace. If Medicare re-imburement is below market prices and below cost, and they are, how do you think providers will be able to meet payroll, build new buildings, order new equipment, etc. if that is how they are paid under the schemes now being proposed in Congress?

And, lastly, if Congress would be able to solve all the “waste and fraud” in Medicare first, then we may have something to talk about. Show me, first! I know they can’t do it without placing draconian regulations on the industry (providers) and by putting in wage and price controls. While they may “fix” on one side of the dam, water will always find a way to seep out somewhere. Then the “law of unintended consequences” takes over.

Best regards,
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