BENEFIT SOLUTIONS®

Managed Health Care! Try it, you might like it.

By Gary V. Cupo, CLU ChFC

The only constant thing in life is change. However, for many of us, change is hard to accept. The inevitable change in our health care delivery system is certain to meet resistance.

As people become informed about innovative alternatives in health care delivery, they will see these new processes as benefit enhancements. In time, they will support the advantages of change.

Managed care, preventive medicine and primary care physician are terms that represent change in our health care delivery system. In a managed care system, the subscriber, the insurer and the provider work together to assure that the most appropriate care is provided. Often a primary care physician monitors the patient's care and emphasizes the value of preventive medicine.

Some would argue that managed care deprives the subscriber of quality and choice when, in reality, it can produce greater efficiency and early detection of medical problems helping to ensure prompt treatment and successful outcomes.

As a child, there was only one doctor that I recall visiting frequently. He was called our "family doctor." Today, he would be called a primary care physician. When we had a problem, we saw him first. If he thought it was necessary, we might be referred to a specialist. But, our treatment was always coordinated by the family physician.

In recent years, more physicians have become specialists, in part, because of the financial incentives. The same financial incentives will now bring physicians back to the role of "family physician," now called "primary care physician."

Traditionally, doctors have been paid a fee for each service they provided. The more services they provided, the more fees they collected. Insurance companies generally paid with few questions asked. When the claims and expenses paid out exceeded the premiums collected in a given year, the cost was passed on to the consumer in the form of higher premiums.

There were no checks and balances, only "blank checks." Those who took advantage of the system—both providers and insured—forced premiums up for the rest. Public outcry convinced insurance companies that they had to bring down the cost of health care.

Insurance companies began to reduce risk by becoming more selective about whom they would insure. This process is called "underwriting." Healthy young employees paid lower premiums while people with less than perfect health or "pre-existing conditions" were charged higher premiums or went without coverage. Government subsidized insurers and companies that did not underwrite became the dumping grounds for those who were left out of the system.

Insurance pools of healthy people charged their group plans lower premiums and paid fewer claims. Other plans raised premiums higher and higher to keep up with increasing claims. This leads a plan to what is known as a "death spiral" where, eventually, the plan ceases to exist.

Another way to reduce the cost of health care coverage is to reduce the amount of health care you cover. Always, read the fine print!

Many states require that insurance companies provide certain benefits. To avoid these state-mandated benefits, Multiple Employer Trusts, located out-of-state, would market benefit plans exempt from the rules of another state. Sometimes these plans would contain severe restrictions and policy limitations.

For instance, an out-of-state trust might offer a small group plan that pays limited or no benefits for organ transplants, maternity care, convalescent care, and treatment of mental/nervous disorders, alcoholism, drug addiction or AIDS. The premiums would be considerably lower than the amount charged by an in-state insurer who is mandated or an out-of-state insurer who voluntarily provides coverage for all of those items.

Low-cost premiums can also be found in hospital-only plans that cover only in-patient care and with hospital indemnity plans that pay a fixed dollar amount for every day the insured spends in the hospital. Policies such as these can give the consumer a false sense of security.

I attended a meeting hosted by an insurance

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company that was introducing its group and individual health products. The company representatives offered a lot of hype, but little substance. When I reviewed the contracts and determined what these plans covered or, more importantly, what they didn't cover, I found that I could not offer them to my clients. Yes, premium was low and commission extremely generous, but the product was clearly inferior.

The state of New Jersey enacted a law for groups of 2-49 eligible employees. The benefit requirements are "extra-territorial," which means that an insured plan must comply with the state mandated benefits, regardless of where the Multiple Employer Trust is located.

What about reimbursement levels? At one time, the insurance industry used a fee schedule that let health care providers know what the reimbursement would be for specific services. Because prices varied according to geographic location, the industry developed a "relative value schedule", with unit values assigned to each procedure and dollar values based on geography. For instance, if an appendectomy had a unit value of 24 and a dollar value for a given geographic area of $20,000, the reimbursement would be $480.

When life was simpler, this straightforward approach worked. Today, however, terms like "reasonable and customary" (R&C) and "Usual, Customary and Reasonable" (UCR) are familiar to people in the industry, but remain a mystery to consumers.

How is R&C calculated? Unfortunately, that depends upon your insurance carrier.

Most insurers use a database maintained by the Health Insurance Association of American (HIAA). The Association solicits information from physicians in a given geographic area to determine their fees for each procedure they perform. HIAA then ranks the charges for each procedure on a percentile basis.

Most insurance carriers pay in the 80th - 90th percentile.

For instance, 100 doctors in a given geographic area charge between $800 and $1,500 for an appendectomy. Eighty per cent charge $1,200 or less for the procedure. Carriers that pay at the 80th percentile would reimburse physicians up to $1,200 for an appendectomy. Physicians who charge more than that amount would have to collect the difference from their patients. This is known as balance billing.

The problem with this system is that there is no universally accepted standard. While most carriers use the HIAA database, some use their own. Many carriers pay at the 80th - 90th percentile, some pay at the 70th.

The State of New Jersey has approved a NJ HIAA Standard at the 80th percentile. This kind of uniformity certainly benefits the consumer by alleviating some of the confusion associated with reimbursements paid by insurance carriers.

Another factor that affects the cost of health care is the cost of processing claims. Carriers and providers spend an inordinate amount of money on paperwork. In a managed care environment, providers are paid a "capitation fee" rather than a "fee for service." Providers paid by capitation are responsible for a specific number of patients and receive payment each month based on that number. The responsibilities associated with billing can be virtually eliminated, allowing the physician to practice medicine instead of business administration.

What about tort reform? Physicians should practice preventive medicine to keep their patients healthy and free of disease. Instead, physicians often feel compelled to practice "defensive" medicine to protect themselves from lawsuits.

Defensive medicine can subject a patient to a battery of unnecessary and costly tests that help to drive up the cost of health care. Even after covering every base, physicians can be slapped with a medical malpractice suit.

Legitimate malpractice claims should be prosecuted to the full extent of the law. No one wants to see incompetent physicians practicing medicine. The frivolous suit, however, cannot be condoned. These actions are often considered a nuisance and are settled out of court. The cost of this unnecessary litigation is passed on to everyone in the form of higher care costs.

Health care reform that ignores tort reform is incomplete.

The insurance company, the insurance agent, the physician, the provider of services, the attorney, the employer, and the employee are all part of the problem. We are also, all part of the solution.

Guaranteed access, portability, and choice have become the buzzwords of health care reform. All are admirable goals, but each has a price tag.

The president has projected the cost of providing health care for every American. Is his projection correct? Probably not. In 1937, the Social Security Employer/Employee contribution rate was 1 percent of $3,000 of income. In 1994, the rate has climbed to 7.65 percent of $57,600 of income and 1.45 percent in excess of $57,600 with no limit for Medicare coverage.

Few would argue that the Social Security Administration is a model of efficiency. And yet, there are reformers in Washington who want to see our health care delivery system run by the government.

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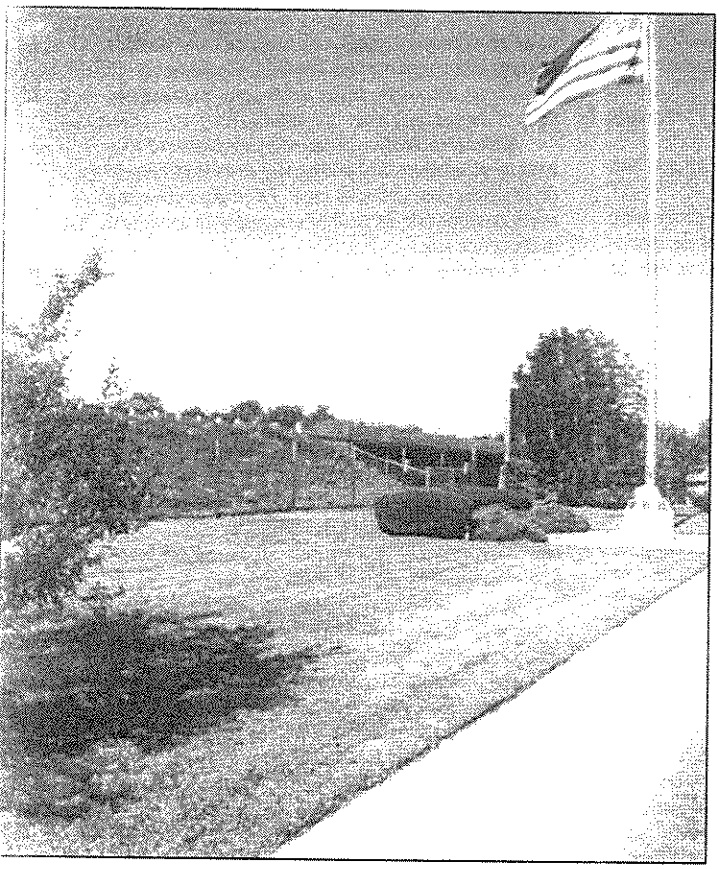

...proximate view of 10,294-foot pie shaped piece of property recently ...chased from New Jersey Turnpike. Walkway in foreground is partially ... "pie" and ends in evergreens. Original plans called for driveway and ...ss-excavation along front of building opposite flag pole and front entrance.

NJMTA buys pie-shaped plot to square off headquarters

By Anthony Buccino

Visitors today to New Jersey Motor Truck Association headquarters at 160 Tices Lane in East Brunswick may note when they enter our driveway that a portion of blacktop begins at the right and ends at the grass. Those same visitors will find that when they find what appears to be the front of the building, opposite the flag pole, that the walkway sets out to the north yet ends in a stand of evergreens.

The anomaly of the walkway and driveway to nowhere lies in an approximately 10,294-square-feet pie-shaped piece of property in the northwest corner alongside our flagpole directly in front of NJMTA headquarters. The pie-shaped property belonged to N.J. Turnpike until 1994.

A five-line clause in the Contract for Sale of Property dated July 1965 specifically excluded the triangular area then owned by NJ Turnpike. When the odd slice of property was discovered in 1965 during construction of headquarters, the driveway and walkway, which were to bring visitors to our front door, were halted in their tracks.

Although NJMTA maintained the grounds and until the 1990 widening of the Turnpike enjoyed a woodland wonderland across from the "front entrance", negotiations began in 1985 to purchase the pie-shaped property. Following 8-10 years of negotiations with various Turnpike administrations, in 1994, NJMTA Executive Director Sam Cunninghame and Pike officials agreed on a reasonable price for the land-locked property that could only benefit the current owners of 160 Tices Lane.

NJMTA purchased the bulk of property for headquarters from Sayre & Fisher Company, a well-known New Jersey company that mined clay, sand and other products. Bricks manufactured by the company can still be seen today. If you spot a brick with SF on it, it may have been made with sand that originated on property that is now NJMTA headquarters.

Although no immediate action is being discussed, possible future use for the newly acquired property includes blacktop for parking and release of our present rear parking lot for other uses.

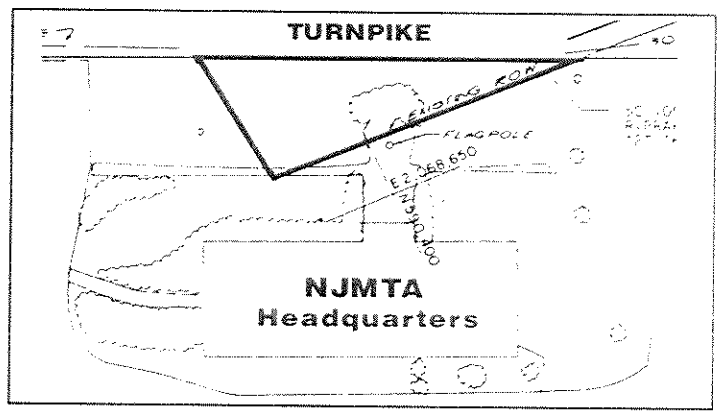

Illustration shows 1988 view of pie-shaped property in relation to NJMTA headquarters and flagpole. NJMTA recently purchased pie-shaped property from NJ Turnpike.

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Does government have a role to play in ensuring that every American has access to affordable, high quality health care. Absolutely!

Should government take over our health care system? I think not!

The issue of health care reform will be revisited later this year by the 104th Congress. All of us must participate in the health care reform debate by contacting our congressional representatives and letting them know what we support. Our office will prepare sample letters to send to your legislators. Please contact our office if you would like to be on our mailing list to contact your legislator at that time.

Together, we can be part of the solution. Together, we can ensure that America continues to offer the best health care in the world!

Gary V. Cupo, CLU, ChFC, president of Benefit Solutions, is one of NJ's leading authorities on small employer health reform and employee benefits. He is president of NJ Assoc. of Health Underwriters representing health agents and consultants committed to health care legislative reforms in Trenton and Washington, DC. Cupo serves as Preferred Broker Consultant to NJMTA Group Insurance Trust. If you have specific questions related to this article, phone Mr. Cupo at 201-805-1050.