



BUSINESS

New Health-Care Plans May Not Be a Panacea

By KATHY M. KRISTOF

Aug. 25, 2002 12 AM PT

TIMES STAFF WRITER

Companies that are trying to save money on employee health-care benefits increasingly are turning to a new type of plan that may make coverage more affordable--and available--but also could saddle some workers with sharply higher medical bills.

The so-called consumer-driven insurance plans have been embraced by companies such as Lattice Financial, a software firm in Princeton Junction, N.J., where President Adam Berger signed up his 10 employees because traditional insurance had become unaffordable.

“Our insurance carriers came back to us with a 30% increase in premiums last year,” Berger said. “I can’t say what our experience is going to be with this new program, but at least people are given the right incentives.”

American workers probably will hear a lot more about consumer-driven health plans in coming months for much the same reason. Insurers, consultants and business owners are looking for new solutions to rising health insurance costs as the promise of cost containment through managed-care programs is fading.

With corporate health insurance costs up 10% last year and expected to jump 16% in 2002, according to consultant Hewitt Associates, employers are flocking to solutions that at least provide hope of cost containment. A recent survey by Mercer Human Resources Consulting indicates that 29% of large U.S. employers will be offering a consumer-driven plan, or CDP, by next year.

That's already creating some concern among consumer advocates, who fear that the plans will penalize workers who have a lot of health problems.

"Offering these new products is like stepping into a cold lake. You go slowly, with a lot of fear," said Bob Hunter, director of insurance for the Consumer Federation of America in Washington. "It's always a danger to buy these products when they are in the first few years of release because it's unclear how they are going to emerge."

CDPs combine a high-deductible health insurance policy with a health-care spending account that's funded by the employer. The spending account usually can be tapped the moment the consumer has a qualified medical cost, providing the ever-popular "first dollar coverage" that workers have come to expect.

But there's a catch. The spending account usually doesn't amount to as much as the deductible on the insurance policy. The gap between the medical expenses paid by the spending account and those paid by the insurance policy must be filled by the consumer. At some companies, that gap is small--\$100 or \$250, like the deductible on a traditional health plan. At others, it can be a chasm amounting to \$1,000 or more.

For instance, a plan may offer an employee a \$1,000 annual health-care spending account, coupled with an insurance policy that has a \$2,500 deductible. Once the employee runs through the first \$1,000 in medical expenses, the next \$1,500 must come out of his or her own pocket before insurance coverage will kick in. At that point, the insurance will pay 80% of any additional medical costs.

For those with consistently high medical expenses, that can be a problem, consumer advocates note. Paying both the employee's portion of the health insurance premium, plus potentially thousands in uncovered costs each year, could bankrupt an otherwise solvent employee who has a chronic ailment such as diabetes or high blood pressure.

Consumers with chronic ailments who are given a choice of coverage may choose to avoid the plans. So, too, might a couple planning to have a child or someone facing \$3,000 knee surgery. In these cases, an employee's out-of-pocket medical costs probably would be thousands of dollars more than they would be in a health maintenance organization or other type of plan.

Interest in CDPs has mounted since the Internal Revenue Service ruled in June that unspent funds in the spending account portion of these plans can be retained by the employee and rolled over from year to year. That provision could allow healthy workers to create a portable savings account for medical expenses.

Theoretically, a healthy worker could accumulate thousands of dollars in a spending account, using it to bridge the entire gap if the employee became sick while still employed or to pay health insurance premiums in retirement.

"Big companies are looking at this as a way to finance medical benefits into retirement," said Amit Gupta, president of CareGain, a Monroe, N.J., health-care management company.

But in practice, the plans vary widely. Some employers say they'll allow workers to roll over all the money left in their spending accounts each year; some plan to take back a portion of it; some may leave the spending accounts alone but contribute less if their workers build up balances--or if the company's finances get tight. But because the oldest such plans have been in operation for less than two years, the long-term results of any of these models are unknown.

"For people with resources, the strategy of having a large deductible and holding aside some money in an account is a good one," Hunter said. "But there ought to be some guarantees that [funds in the savings account portion of the plan] is your money that the employer can't ever take away from you."

Consumer-driven plans are united by one common theme-- if consumers are given an economic stake in the medical decisions they make, they may spend more prudently, said Tony Kotin, leader of knowledge and service delivery at Mercer Human Resources Consulting in Chicago.

Traditional insurance and managed-care programs give consumers little incentive to watch their usage, said Marc Backon, chief marketing officer at Destiny Health Inc. in Oakbrook, Ill., which also sells CDPs.

In traditional plans and managed care, once the employee pays a relatively modest deductible, all medical bills are paid by insurance. From the consumer's point of view, that made all care appear to cost roughly the same--just the \$5 or \$10 co-payment for an office visit or prescription, Gupta said.

As a result, health-care consumers often are insensitive to such factors as the price disparity between brand-name and generic drugs, Kotin said. The traditional model also doesn't discourage people from rushing to a doctor at the first sign of a sniffle, when the more cost-effective and possibly healthier solution could be to stay in bed.

On the other hand, those who sign up for a CDP are expected to be more cost-conscious because they will see money coming from their accounts. Depending on how the plan is set up, they also may have the promise of an economic reward if money is left over at the end of the year--and the threat of personal cost if they spend more than they're given.

Consumers will be able to see the doctors of their choice and buy brand-name or generic drugs, Gupta said. They also will see--and possibly feel--the economic effects. That could encourage an employee with allergies, for instance, to use a generic medication that costs \$50 for a 90-day supply instead of a well-advertised brand name for \$300, he said.

But it's tough to do comparison shopping for some medical services, Kotin acknowledged. Although several Web sites provide detailed information on differences

in drug prices and even medical outcomes for surgical procedures, doctors generally don't publish fee schedules. Even if they did, the costs might be misleading because you're often getting a la carte prices for services that essentially are sold as a package, Kotin said.

For instance, the doctor's fee is only a small portion of the total cost of knee surgery, Kotin said. There's also anesthesia, physical therapy and recovery time. One doctor may charge more for the surgery but have such good results that the physical therapy requirements are diminished, he noted. That can make looking for a cheaper doctor an inadvisable alternative on both an outcome and an economic basis.

Experts also worry that some consumers might become so cost-conscious that they won't get checkups, immunizations and other preventive care. Many plans are attempting to head off such inadvisable economizing by making checkups and immunizations a "no-cost" benefit, Kotin noted.

"The intent of these plans is not to prevent people from consuming appropriate care," he said. "It's the discretionary piece that they're trying to manage."

No one is claiming that CDPs are the latest health-care panacea, Kotin said. Although they appear to have promise, their flaws probably will become apparent with time--just as was the case with managed care. But experiments such as this are necessary to address prices that are rapidly outpacing the ability of both companies and consumers to pay, he said.

"We know what doesn't work," Kotin said. "We're still working on what does."

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To contact Kathy M. Kristof, write to Personal Finance, Business Section, Los Angeles Times, 202 W. 1st St., Los Angeles, CA 90012, or e-mail kathy.kristof@latimes.com.

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