

Lowering Texas Health Insurance Premiums



The problem is that health insurance premiums and drug costs continue to rise in double digits each year. Here in Central Texas, we saw insurance premiums rise 9 to 18% in 2007 and we can expect similar increases in 2008. What can we do about it?

You should also know that health insurance is regulated by the state. In places like New York, New Jersey and Vermont, insurers must offer coverage to every applicant, regardless of age or health status. Since the health plans have to cover chronic illness, the premiums are very expensive.

In an effort to keep insurance affordable for healthy individuals, Texas legislators have created the Texas Risk Pool. This means that insurers only accept applicants that are generally healthy. If the applicant has on-going tests or treatments, insurers generally decline the applicant until the tests or treatments have been concluded and the applicant is stable.

Still, Texas leads the country in the number of uninsured. Certainly, some of these uninsured meet financial guidelines for government assistance, but the vast majority have elected to do without insurance.

The purpose of this document is to outline suggestions for lowering health insurance premiums for *Individuals and Families*. These health plans are different from Group Health Insurance you might get through your employment. For information on lowering your overall health costs, see "How to Lower Texas Health Costs", which focuses on Health Savings Accounts. The suggestions for lowering Texas health insurance premiums begins with understanding the history and purpose of health insurance.

Brief History of U.S. Health Insurance

For decades, the United States health care system was the envy of the entire world. America had the finest doctors and hospitals, patients enjoyed high-quality, affordable medical care, and thousands of private charities provided health services for the poor. Doctors focused on treating patients, without the red tape or threat of lawsuits that plague the profession today. Most Americans paid cash for basic services, and had insurance only for major illnesses and accidents. This meant both doctors and patients had incentive to keep costs down, but it also meant

that patients were directly responsible for payment for the services they received.

In 1945, Harry Truman asked Congress for a national insurance plan. In 1965, Johnson signed into law Medicare and Medicaid. The HMO Act of 1973 required all but the smallest employers to provide HMO coverage to their employees, permitting the employers to deduct the cost of premiums as a business expense.

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996, giving employees the right to continue insurance coverage when leaving a job with Group Insurance.

The overall result has been the acceleration of premium rates and an increase in government participation in health care. The federal government now accounts for two-thirds of all health insurance spending, through Medicare, Medicaid, and other programs. In 2000, Medicare Part B premium was \$45.40 per month, but in 2008, it is \$96.40.

Purpose of Individual Health Insurance

Thus, the purpose of insurance is to transfer some financial risk to a third party, the insurer.

In 2007, the average health plan was about \$214 per month or \$2573.28 per year, depending on where you lived in Texas.

Let's pretend that you went to the doctor a couple of times over the year and bought prescription medications, so that your annual health care expense was just over \$3000.



Let's say that in 2008, when you saw the rates go up, you decide you'd rather put that \$2500 in savings, instead of paying an insurance bill. When you hear the rates go up, you smile to yourself. However, you should know that if you go to the hospital over the 45 years (19-years old to 65-years old), you can easily go through all of your savings, plus thousands!

That's why the biggest reason for filing bankruptcy in the United States is medical bills. So, how do insurance companies do it? They aren't hurt because they have a large number of subscribers, so the loss is a relatively small portion of the whole risk.

You'll find that cosmetic surgery and obstetrics are rarely covered. This is because of the huge exposure the insurer could take on through complications. For example, a premature baby can spend months in the hospital, costing hundreds of thousands of dollars.

HMO vs. PPO



A Health Maintenance Organization provides a wide range of comprehensive health care services for its members, who pay reasonable monthly premiums for the services of participating physicians and hospitals. HMOs emphasize preventive medicine, while providing service to a limited geographic area and offering a limited choice of health care providers. They are a great insurance value for families, offering the best maternity coverage. However, that limited choice in health care providers, the optional prescription coverage, and the need for authorization to see a specialist, make HMOs unpalatable for some.

For those who don't mind who your doctor is, there are strict eligibility requirements. The applicant must provide evidence of good health. Tobacco usage, current pregnancy, exceeding height/weight guidelines, heart disease, cancer, stroke, diabetes, kidney disease, AIDs, and other conditions that would be expected to require above average utilization of medical services will disqualify the applicant.

Don't expect your Health Insurance Broker to show you HMOs, because you can only buy them through the health service organizations. You can find a complete list of HMO on the Texas Department of Insurance website.

Unlike HMOs, the member of a Preferred Provider Organization (PPO) is not locked into a specific panel of providers. You will pay one price for **in-network** providers and a higher price for **out-of-network** providers, but you can go to any doctor you want.

The insurers have negotiated with the in-network providers for discounted rates, which are independent of the deductible. For example, you might go to an in-network doctor, who wants to do a bunch of tests. After the tests, when you go to the account manager, who says you haven't met your deductible, you simply tell her (or him) to run it through. Your insurance statement will show the cost of the tests and the discounted price. You've received a discount for having insurance!

Strategies for reducing premiums

In this section, we'll address several strategies for saving money on your health insurance premium.



Get higher deductibles

There are several advantages to getting a plan with a \$2500 Deductible, instead of a \$1000 Deductible. The first reason is the savings on premiums. The second reason is that higher deductible plans tend to get lower rate increases. For example, for one insurer in my county, the plans with \$500 Deductible went up 18% over 2007 rates, while the \$2500 Deductible plans went up only 12%.

Buy only what you need

The people who study insurance trends report that there is a trend to either buy the top insurance product or nothing. Of course, there is another approach and that is to buy only what you need.

If you only go to the doctor once or twice a year, and the premiums for copays is more than \$240, don't get a plan with unlimited doctor visits. Most insurers offer "saver" plans, which either offer few office visits or none.

If you don't need prescription drug coverage, then consider a prescription discount card.

Texas Insurance rules suggest Adult Preventive Care, mammograms and pap smear screenings for women over 35 or prostate screenings for men, as well as "well child" care for inoculations. Don't buy a comprehensive plan, when you don't have to.

Reduce the frills

Most Major Medical plans offer comprehensive medical care, along with some physical therapy coverage, skilled nursing, home health care, and mental health coverage.

Insurers offer a range of lifetime maximums, from \$1,000,000 to \$8,000,000. It generally costs very little for more coverage, but if you are watching pennies, you should know you have an option.

Insurers offer rate guarantees, which says that the insurer won't increase rates for a given period, usually 12 months. You can sometimes save money by increasing the period of your locked-in rate.

Insurers have different networks. Some networks are worldwide, while others are local. You can reduce your premium by picking a network that meets your needs.

Insurers sometimes have deductibles for hospital visits. It is an effort to encourage you to visit a doctor's office, rather than the emergency room. You can save money on your premium by increasing your facility fees.

Why pay for coverage that you don't need?

Pay higher coinsurance



Assurant, Imerica, and other insurers offer several rates of coinsurance, as well as different out of pocket maximums. For example, with Assurant, you can have a 50% coinsurance with \$2000, \$3500, \$5000, or \$7500 out of pocket, 70% with \$7500 out of pocket, 80% with \$7500 out

of pocket, or no coinsurance. Which of these would you think might be the most expensive?

The cheapest is the 50% with \$7500. However, if you have a high deductible, your total out of pocket can be quite high.

The 50% with \$2000 is close in price to the 80% with \$7500 out of pocket. However, your financial exposure is your deductible, plus the coinsurance. With a \$5000 deductible plan, the insurance company pays everything above \$9000, while with the popular 80% plan, the insurer doesn't start paying 100% until \$22,500.

Similarly, though the 0% coinsurance is the most expensive, it can be a quite reasonable decision. A client went skiing and broke his arm. Bad things happen. However, he was surprised by the emergency room fees, the doctor fees, the facility fees, etc. "I thought I had insurance!"

Another strategy for saving money on your premium is combine a high deductible health plan with no coinsurance, along with a health saving account. As you increase your savings to cover your deductible, plus anticipated expenses, you can increase your deductible.

For example, you might purchase an HSA with \$1100 deductible. In the second year, you might increase the deductible to \$2850, and so forth.

For more information on HSAs see my website.

Split the family

While purchasing Individual Health Insurance can be difficult, buying health insurance for a family can be painful, especially when there are small children in the house. That's because we may not know how often small children may need health services. Is this a child that develops asthma? Will the child get chronic ear aches? Could it be something worse. Thus, we tend to want comprehensive coverage on the small children. However, purchasing comprehensive coverage for the entire family can be very expensive.



Similarly, a woman might have a family history of cancer, where she might want comprehensive coverage.

One solution is to put the male parent and older children on a "saver" plans, which has limited doctor visits, and the female parent and younger children on a comprehensive plan.

Depending on the size of the family, the carrier, and the age of the children (children up to two-years of age have higher premiums than three-year olds) your family can save hundred of dollars a year.

Conclusion

We may never be able to totally go back to the days of paying cash for basic health services. The threat of lawsuits means that health care providers will perform extensive, expensive tests to legally protect themselves. However, there are numerous ways that individuals and families can protect themselves from financial disaster. You can choose an HMO, pick a higher deductible, buy only what you need, reduce the frills, pay higher coinsurance, or buy different plans for different members of the family.