PAUL J. DISSER

is chairman of the board and CEO of Spectrum Vision Systems, Inc., a managed vision care company serving more than 20,000 companies and 4 million subscribers throughout the United States, Puerto Rico and the U.S. Virgin Islands. Disser has served in this capacity since he founded Spectrum in 1987.

Prior to establishing Spectrum, Disser served as executive vice president and board member of First American Health Concepts, Inc., a public company (FAHC, Nasdaq-OTC) doing business as Eye Care Plan of America. Disser was one of the original founders of FAHC in 1983 and was the chief architect of the marketing strategies and tactics for the company.

Before pursuing his entrepreneurial interests in the ophthalmic world, Disser, who is a 1973 graduate of Xavier University in Cincinnati, OH, with degrees in business administration and marketing, spent more than 10 years in the field of employee benefits and mass marketing. Eight of those years were spent with TLA, Inc., a national third party administrator based in Kansas City, MO.

Disser has served on the board of directors of the Mass Marketing Insurance Institute (MI²) and is a past president of MI². He is also a member of the National Association of Health Underwriters, The Greater Kansas City Association of Health underwriters, The American Management Association, and the American Association of Preferred Provider Organizations (AAPPO).

*Disser can be reached at Spectrum Vision Systems, Inc., 7101 College Boulevard, Overland Park, KS 66210. Telephone: 913-451-1672. Email: **pjdisser@preferredvisioncare.com**.*

The Future of Health Savings Accounts...

Whose Ox Is Being Gored?

At a national association annual meeting recently, one of the keynote speakers, who was from a prominent investment banking group, made several remarks regarding the consolidation action that has been occurring within the healthcare industry over the last few years. This consolidation action includes actual providers of healthcare, (i.e., hospitals, clinics, and doctors, as well as the third party funding mechanisms of healthcare, i.e., insurers, HMOs and PPOs).

The most revealing remark to come out of this speaker's mouth was that the banking fraternity was pleased with the consolidation action because it was responsible for "...firming up the pricing models..." among the surviving entities, and the banking fraternity was in favor of "...14, 15 and 20 percent annual price increases...". Consistent with this "stronger pricing is better" ideology was a complete denial that higher pricing was connected to or responsible for the level of uninsured among the U.S. population (estimated to number between 45 and 80 million, depending on whose figures you choose to believe).

An interesting observation is that the level of uninsured as a percentage of the U.S. population remains generally unchanged since 1965, the year that Medicare was enacted. Draw your own conclusions about the correlation between government insurance intervention and the percentage of uninsured.

When asked what effect HSA legislation (part of the Medicare Modernization Act of 2003) would have on the cash flow models of the insurers, HMOs and PPOs surviving this current wave of change in the financing models of healthcare, the speaker's reply was, "I don't believe anyone is studying that." I was astounded. However, after reading the cover story of the September edition of *Managed Care* magazine and its last page "Managed Care Outlook," I'm beginning to think that maybe George W. Bush is the only one who believes that HSAs represent the last best chance for the commercial healthcare financing market to retain its place in this game before abdicating its role to the federal tax lords.

When you consider that our great country has "de-volved" to the point of legislation driven by anecdote, we now have well-organized special interests funding lobbyists to encourage and promote new laws "financed by the many to advantage the few." We do not need redundant legislation and government cost to displace the insurance industry whose very benefit ideology is "many for the few." This concept stands Democracy on its head. No matter how honorable and noble the desired outcome, you cannot force, coerce or extort a democratic process any more than you can "manage" the inexorable force of natural supply and demand economics.

Healthcare, being of a very personal, individual nature, has a tendency to favor an inelastic pricing model in traditional supply and demand economics. In other words, pricing is not solely dependent on

(Continued on page 38)

Disser

(Continued from page 36)

the number of open heart procedures required (demand) spread over a fairly static number of cardiac surgeons (supply). The highly personal nature of a desired successful outcome to this procedure has created a sports-like atmosphere in this field (as well as certain others), wherein the "superstar" surgeons are "drafted" with promises of signing bonuses, performance clauses, stadium improvements (operating theatres with all the latest technological and mechanical support mechanisms), and other cost-sensitive drivers having no bearing on traditional economy of scale pricing formulas.

Unlike a manufacturing process designed to fill a specific product demand evolving in a free-market economy, no one can accurately predict the demand for coronary bypass, nephrectomy, mastectomy or cervical cancer procedures in a given year. At the end of the day—still 24 hours by any reasonable calculation—a single surgeon, or team of surgeons, can only perform so many procedures regardless of the venue and support systems installed. The biggest wild-card variable of all in healthcare, at least in the absence of a totalitarian-imposed queuing/rationing system, is what a given individual is willing and able to pay for access to a desired outcome.

As *Managed Care* Editor John A. Marcille says in his September editor's memo, "Let's face it: Nearly everyone who reads this publication is benefiting from healthcare inflation. Plan or provider, more income is welcome. Cost control is being driven by employers (under the guise of being driven by consumers) and plans are starting to respond with new programs…Some health plans see this situation as a golden opportunity…". That opportunity, so far, seems to have manifested itself as the desire to assuage the investment banking fraternity's wish to see health plan pricing models firm up.

Marcille recognizes the opportunity, but asks, "…is our inaction so pervasive that we cannot respond with the kind of controls that will bring healthcare inflation into balance with the rest of the economy? Will workers stand for rationing? Will employers resist unhappy workers' demands? Can insurers come up with anything truly new, acceptable and effective?" He goes on to quote a beltway research group called The Centers for Studying Health Systems Change (CSHSC) and another organization, the Commonwealth Fund, as suggesting that consumer-directed health plans (CDHPs) could worsen health outcomes by reducing patients' receipt of "…needed preventive care and care for chronic conditions."

To begin with, a CDHP is just a *plan*—an inanimate object that can neither increase nor reduce needed care. Care will be increased or reduced by the appropriate professional presented with such need for care by some *prospective* patient. In a free market economy, neither a "plan" nor a "provider" can dictate "need" (read *demand*), as this is the prerogative of the consumer/patient.

Therein lies the "news" that, up to this point, seems to have escaped the mainstream media. In its desire to sell "news," the mainstream media has chosen to whip a red herring—healthcare—into a frenzied state. Healthcare in the United States is not the problem—the cost of healthcare is the problem!

The reason the cost of healthcare is a problem is that *cost* and *care* have too much insulation between them, so much insulation from third party pay mechanisms that *cost* and *care* bear no direct relationship to each other. What other product, service or commodity has anywhere near the amount of insulation between its use and its cost as healthcare? Whenever you find inelastic pricing models, you can expect to find inordinately extended distribution channels (insulation) between source and use of goods and/or services. Then you are paying for "distribution process," not goods and services.

That is exactly the reason why CDHPs should find a ready market in spite of what the president of the Commonwealth Fund cites as a "…fundamental flaw in their cur-

rent design..." which will attract "...healthier and higher-income individuals," suggesting that not only is it bad to be healthy and to have money, but that such individuals must be stupid to buy a plan that does not "...contain strategies that promote high-quality care...". I would suggest that those people are healthy and have money for the very reason that they do not make stupid decisions.

With the exception of those unexpected shock losses attributable to accidents, cancers and certain premature births, much of healthcare cost overruns can be attributed to manageable lifestyle choices such as overeating, alcohol and drug abuse, unprotected sexual practices, etc. In a culture where 80 percent of healthcare expenditures can be attributed to 20 percent of the healthcare consuming public, it is ill-advised to pay $1,000 to $2,000 a month for a product or service for which you might get $200 to $500 a month worth of use.

According to the CSHSC report, "...70 percent of covered employees had healthcare costs of less than $1,000 a year...". This statistic is consistent with historical utilization data which is, in turn, supported by tax return data including the level of itemized deductions for healthcare expenses in excess of 7.5 percent of adjusted gross income. In other words, for an individual making the real median household income level of $43,318*, household health expenditures would need to be equal to or greater than $3,248.85 (7.5% x $43,318) in order to qualify as an itemized deduction. This is more than three times the level of healthcare costs as reported by the 70 percent of employees studied above. Even a poverty-level family of four would need more than $1,300 in medical expenses in order to itemize.

To use what has morphed into a worn-out cliché, you no more need a health insurance plan to cover your annual physical exam cost than you need automobile insurance to cover a regular lube, oil and filter change, or homeowners coverage to reimburse the lawn service! Major medical coverage is intended to protect against unexpected, catastrophic shock losses! Not low cost, anticipated, budgeted items.

This is exactly what the health savings account language of the MMA'03 is intended to address in a very logical, unemotional fashion. At the risk of appearing "anecdotal" in support of this legislation, consider the following real-life small business scenario:

- The average annual cost of an employee/family $500 deductible major medical benefits plan was $13,800 before MMA'03.
- The average annual benefit reimbursement after three family members out of four max out a $500 individual deductible amount ($1,500) on $3,000 worth of medical expenses ($1,000 each) at 80 percent reimbursement ($1,500 x 80% = $1,200).

With a high deductible healthcare plan, the employer can lower his fixed annual premium expense from $13,800 to $3,000, fully fund the employee's maximum family HSA at $5,000, and still realize a healthcare expense savings of nearly $6,000. Then, assuming the family experiences its average healthcare expenses of $3,000, it uses $3,000 of its $5,000 HSA fund and has $2,000 left over to start the next year. After five years of this scenario, the employer has saved $30,000 and the employee has an HSA with $10,000 in it, at which time he raises his deductible to $10,000, further lowering his employer's cost of coverage. Both the premium expense savings and the net buildup in the HSA can add to the employee's future retirement fund.

So, what is wrong with this picture? *Whose ox is being gored by this process?* Ask the investment bankers, insurers, HMOs and insurance brokers. That historical paradigm cash cow, premium cash flow and sales commissions, so methodically dependable for the last 40 years, is taking a shift in direction. The money is still there; it has not been destroyed. However, it is now with its rightful owner who now has affordable healthcare coverage.

* *U.S. Census Bureau Report on Income Parity and Health Insurance Coverage in the United States in 2003.*