Health Care: A Case of Neglected Opportunity?

by Robert O'Connor

Over the last decade, health care has developed into one of the most hotly debated issues in the United States. As costs continue to rise and the population ages, fears are growing that the country's medical system will not be able to meet the pressures it will inevitably face.

These concerns are being felt acutely by American businesses, which, through employee benefits packages, long have been the country's main health care bankroller. Just a few years ago, employers offered lavish health plans without giving the subject much thought. Not only was the coverage relatively cheap, but it was necessary for any company interested in attracting and retaining a skilled workforce.

With rate increases now reaching as high as 40 to 50 percent, recession-hit businesses are determined to reduce their medical costs. Employers are cutting back on coverage and increasing deductibles and employee contributions. This leaves employees with difficult choices: they can accept the new conditions, look for new jobs or move onto their spouses' plans. "Most individuals are at the mercy of their employer," says Bruce Buttle, CFP, CLU, president of Buttle Financial Network in Dyer, Indiana.

This changing health care environment is presenting difficult challenges for financial planners. One measure of success will be their ability to create flexible plans that save employers money while meeting the needs of employees. It will no longer be enough merely to test the market and move carriers. Another gauge will be the ability of planners to deliver affordable products to the retired and the self-employed. And planners, like their small-business clients, will also need to address rising health care costs within their own practices.

Yet there are strong indications that many financial planners do not understand enough about health care or the opportunities that it offers. Planners often are criticized for concentrating too much on devising investment strategies and not devoting enough time to harnessing costs.

"Most planners I work with are investment jockeys," says Chris Cooper, CLU, ChFC, CFP, owner of Chris Cooper & Co., in Toledo, Ohio. "They're stock and bond gurus, mutual fund gurus."

But that focus is changing. George R. Collett, CFP, managing partner at Your Source Financial, a wealth management-oriented financial planning firm in Phoenix, Arizona, says he is paying more attention to health care than he once did. Until 2000, Your Source Financial, which targets both business owners and high net worth individuals, referred most of its health insurance business out. But as clients became more dissatisfied both with their health insurance and the providers of that insurance, he says, "we found it necessary for us to step in and find out what was going on." In every case where his firm has been asked to provide such scrutiny, Collett says, it has been able to make improvements. "We've been able," he says, "to write the business, change it or find something that works better for them. And generally they're pleased."

How Bad Is It?

Some observers believe that rising costs for planners' business and individual clients, and their own practices, will force more and more planners to pay attention like Collett. Gregory P. Seal, CFP, CIMC, president of Seal Financial Services in Denver, Colorado, points to the withdrawal from the market of health maintenance organizations that had been focused on the elderly. The disappearance of senior HMOs, Seal says, means that patients are left to choose between a dwindling number of HMOs or buying costly Medigap supplemental policies. Further, these patients are being forced to make these decisions as they begin to grapple with the issue of long-term care. And he cites the 40 percent rise in 2001 in his own firm's health care costs.

Cooper says that the last ten years have seen "a ratcheting down of dollars being spent on acute care," which he defines as life-saving emergency medical care. "The providers of acute care have basically stripped their product down so it's almost nonexistent," Cooper says. "It's almost worse than a third world country at times, because people are getting medical treatment, but then they're getting no support after their medical treatment."

Adding to individual's woes will be more health coverage cutbacks by employers as the economy gets tighter, believes Bruce Buttle. He notes that employers now pay 50 to 75 percent of the cost of their workers' health care coverage. The situation, Buttle says, is particularly serious for small employers, who make up most of his market. He suggests that public awareness of the issue is lower than it should be, because so much attention has been focused on Fortune 500 companies. Very large employers, Buttle observes, benefit from the "the law of large numbers," which tends to smooth out risk. He says that while the largest companies may be facing annual rate increases of 10 percent to 12 percent, smaller companies are being hit with jumps ranging from 20 percent to 50 percent. These employers, Buttle says, cannot absorb such increases.

Businesses 'Getting Killed'

James E. Robson, Jr., senior associate at SS&G Investment Services, in the Cleveland suburb of Solon, Ohio, couldn't agree more. Businesses "are absolutely getting killed" by rate increases, he says. Robson, whose customer base consists mainly of small to medium-sized companies and their employees, works with business owners on their overall benefits packages, as well as with individual employees.

The most difficult part of dealing with business owners, Robson says, is not being able to reassure them on costs. "The answer they want to hear," he says, "is we want our rates to go down 20 percent, not up 30 percent." Robson, who started in the business a decade ago selling employee benefit packages for an insurance company, began to see signs of serious trouble about three years ago. Since then, he says, the downturn in the economy has made employers more confident about asking workers to pay more of their health costs.

Robson has found a way to turn discontent over the health care system to his advantage. He begins meetings with employees by letting them "vent a little bit. And everyone has a complaint about health care." This process demonstrates that health care is not an individual problem. And it contributes to the development of a group identity on the issue. It also allows the planner to show that he is on the employees' side. The next step is to begin to move, together, toward some solutions. "It's not a fun conversation in the beginning," Robson says. "But I really think it helps."

Robson tries to educate employees so that they can become active participants in their health care plans. Such awareness can help control costs and improve the employer's bottom line. Robson points to the common example of the employee who might be reluctant to make an $80 doctor's visit to deal with a minor complaint, only to wind up several days later incurring a bill of $1,000 in a hospital emergency room. "The days of just not understanding your benefits and going to see any doctor or running to the emergency room are over," he says.

A big part of Robson's job is explaining to employees how expensive health care is. Often, he says, the message does not hit home until someone is laid off and is presented with a monthly COBRA bill of $600-plus for family coverage. Once a laid-off employee absorbs this shock, Robson says, he or she will have to decide how to make the payments. Would it be a good idea, he may be asked, to take money out of an IRA? "That's where the individual planning side comes in," Robson says.

Restraining Cost-Cutting Instincts

Robson sometimes finds himself trying to restrain the instincts of company managers to cut everything in sight in order to reduce costs. He tells them that this kind of approach can devastate employee morale and make the company less competitive as people either leave or become resentful. Instead, Robson immerses himself in the details of the client's coverage, seeking to make every dollar count. Rather than simply reducing a budget across the board, for instance, Robson might suggest that that $10 co-pay could be raised to $15, or that the conditions applying to the pharmacy card be changed. SS&G Investment Services conducts market-wide benchmarking studies to let clients know where they stand vis-à-vis their competitors. This kind of research helps the companies balance the need to reduce costs against the need to recruit and retain workers. Says Robson: "We say, 'Here's where the market is right now in terms of an average plan. Here's where you're above it. Here's where you're below it.'"

Robson concedes that his arguments for restraint don't always get through. He is encountering some employers who are sufficiently worried about the state of the economy to take drastic steps. He says, "I have found more and more employers saying, 'Look, I'm trying to stay in business right now. And if a few people get upset and leave, that's not

something I can control.'"

Like Robson, Buttle tries to keep companies informed about what other companies in their industries are doing nationally in relation to plan designs, contributions and deductibles. He draws on information from the trade press and statistics issued by the Department of Labor. Some employers, Buttle says, will try to match trends, while others will ignore them. But in either case, the overall push is to extract higher contributions from employees.

Buttle, 75 percent of whose practice is made up of health care, says that the health care market in the Midwest is dominated by about half a dozen insurance companies that may, alternately, be in binge and purge modes. This profile can limit the options of planners. "It's like a merry-go-round," Buttle says. "We jump off of Aetna, go to Blue Cross. Jump off of Blue Cross, go to Cigna. Jump off of Cigna, go to Humana."

Rather than continue this process indefinitely, Buttle says, some employers are choosing to redesign their in-house plans around their desire for big increases in employee contributions. Buttle agrees that the rise in unemployment means that employers no longer feel compelled to absorb rate increases in total. The more a planner knows about a client's benefits package, the easier it is to advise employees on their options. In suggesting that employees might consider going onto spouses' policies, Buttle notes that there could be as many as four plans to choose from—two from each spouse's employer. Buttle says that the employers understand the realities of the new market, but he doubts that consumers understand them.

Thomas R. Clark, CLU, ChFC, vice president of corporate markets for Successful Resource Management, in Des Moines, Iowa, provides tailored benefits packages to employers. Clark is also a partner with his wife in Compensation Designs, which designs and runs health care programs. Clients normally have 500 or fewer employees.

In assembling health coverage packages, Clark and his wife use a defined contribution approach. The employer begins the process by drawing up a budget for the total cost of labor. Included in this will be a percentage earmarked for benefits. The Clarks will then sketch out up to five levels of health care from which the employees can choose. An older worker with some money in the bank, for instance, might opt for a higher deductible and put the bulk of the benefit into a retirement plan. A younger worker with a family might choose the most expensive health plan.

Changing Workers' Attitudes

Like other financial planners, Clark is working to change the attitudes of workers toward health care. Historically, he says, workers could expect a set of benefits, without regard to whether the mix suited everyone. A defined benefit approach, Clark says, allows employees and planners to focus on particular needs and circumstances. "The employer," Clark says, "then becomes a partner with the employee in designing the health plan, instead of being this 'one-size-fits-all, come on board, here you are.'"

Such a plan, Clark says, requires extensive employee education efforts and the commitment of the employer to set a clear direction and adhere to it. Ideally, Clark would like to go into a client company and spend a year with focus groups drawn from every department. These people would then go back and sell the idea to their colleagues. The need for this kind of groundwork means that installation, over the first year, can be expensive. "But once employees get into it," Clark says, "they will move heaven and earth to avoid losing it."

One objection to allowing employees to choose their benefits is, of course, the specter of self-selection. Bruce Buttle recalls the failure of cafeteria plans in the 1970s. Employees were effectively given a wad of money and told to pick their benefits. "What happened," Buttle says, "was that people who had heart attacks would buy the disability insurance. People with bad teeth bought the dental insurance. And all the people who were perfectly healthy took the money."

Robson says that large employers are showing interest in defined plans. But he sees potential tax problems. Will the Internal Revenue Service, he asks, regard the benefits as income?

Another option has been the mini-group plan, which became popular in the early 1990s. These plans, George Collett says, allowed for a policy to be written on a small group of employers who combined their workforces into one insurance group. Collett says that these plans began to run into trouble around 1998, largely as a result of laws

passed by various state legislatures mandating certain benefits. In response, insurers increased overall premiums and eliminated some non-mandated benefits. In some cases, insurers actually pulled out of states they regarded as especially difficult. Collett says that the premiums for these mini-group plans are now actually higher than premiums for policies purchased by employers for individuals.

The Other Side of the Equation

While the U.S. health insurance system is likely to remain heavily dependent on employers, individual coverage will play an important role. And that role is likely to increase as wealthy baby boomers retire early and as people lose their jobs and find themselves with no coverage.

Take the example of the young widowed client of Ben L. Jennings, CPA/PFS, CFP, manager in the Personal Wealth Management Department of RSM McGladrey's Tacoma, Washington, office, which serves a mostly retired high net worth clientele. Jennings says the woman, widowed in her mid-forties with two children still at home, received three years of COBRA coverage under the terms of her husband's employment. The next step was to find the right permanent health plan. Availability was limited by ongoing regulatory and legislative battles in the woman's home state between the insurance companies on one side and the state authorities on the other. Jennings carried out the research and was able to present the client with three choices. She could decide among such features as ease of referral and maximum lifetime benefits. Jennings says that a $1 million lifetime ceiling on medical claims might seem sufficient. "But if you have transplants or other kinds of things involved," he adds, "that money can add up."

There are suggestions that planners are not taking this market as seriously as they should. Some planners complain that health care insurance demands a lot of work for too small a reward. But individual health coverage also can be seen as an anchor to a client's overall financial plan that can provide the security and generate the trust that will help cement advisor-client relationships. Success in the individual market will require both determination and agility.

When taking on a new client, Jennings begins with six to eight hours of data gathering. He asks about current health insurance coverage, family medical history, and any special requirements that the insured might have. Jennings is attuned to such events as 65th birthdays, which open the door to Medicare. And he tries to get a sense of the client's preferences in terms of the services offered by physician networks. Some clients, for instance, want to be able to see specialists without referrals from primary care doctors. Others are less concerned about this.

Chris Cooper, who provides individual coverage to the self-employed, discerns various market segments. Owners of bars and restaurants, for instance, might be tempted to purchase relatively cheap plans and to flit from insurer to insurer. Affluent professionals, such as lawyers, often buy their coverage through associations. "Those plans tend to be a little better," Cooper says. "But then as soon as those premiums start jumping, they're trying to shop it. And they find themselves with nowhere to go."

Cooper says that a 50-year-old self-employed client with a wife and two children and making $100,000 a year might expect to pay almost $1,000 a month for health coverage. That monthly figure, he says, is likely to rise by as much $400 to $500 this year. In response to this increase, Cooper says, planners should be prepared to suggest that clients accept higher deductibles. Clients should also be made aware that they might not be able to get some care, such as speech therapy and physical therapy.

The most poignant individual cases are often those of retirees whose circumstances have suddenly changed. Such clients require sensitive treatment. Buttle tells of the 70-year-old widow of a retired steelworker who suddenly lost her health care coverage when the company went bankrupt. Not only did the cost of the woman's health coverage more than triple, but she now had to start paying for her prescription drugs. "She was devastated," says Buttle, who advises people who have been in the military to contact the Veterans Administration for possible help in paying for drugs.

Buttle, whose firm serves the Chicago area, sells individual health insurance to people who, for one reason or another, are not covered by group plans. This category includes students, the self-employed, those between jobs, and people who work for employers that don't offer group health insurance.

Susan Hodges Strasbaugh, CFP, EA, owner of Strasbaugh Financial Advisory in Monument, Colorado, is a financial planner who mainly serves middle- and upper-middle-income clients. Many are self-employed. "For these clients,"

Strasbaugh says, "health insurance is very important." The planner, she adds, should try to keep costs reasonable while ensuring that the right kind of coverage is in place should anything happen to the client.

Strasbaugh, who goes over all of a new client's insurance policies, mentions health insurance to the client during the first year of the association. Many are surprised to hear about health coverage from a financial planner. "For a lot of people," she says, "the only ones who have ever talked to them about insurance are people trying to sell them insurance. I'm really looking at it to see what is the best thing in their situation."

Planners have a number of options when serving the self-employed, Strasbaugh says. They can, for instance, point out that, by employing a spouse, a client can write off the cost of the spouse's health insurance. The self-employed also can earn tax-free reimbursement for money spent on eyeglasses and such service providers as chiropractors and dentists. Strasbaugh spends a lot of time combing the market for her self-employed clients. "I've seen some policies that clients have had through associations that really aren't covering them for very much." she says. "So we review what the coverage is."

Planners as Employers

Perhaps nothing will make financial planners more acutely aware of the changing world of health care than the fact that most planners are employers themselves. George Collett offers his own experience to illustrate the problems facing small businesses. Until a couple of years ago, he says, his firm operated a small group plan. After a premium increase of about 50 percent, the firm switched to individual policies. These were cheaper because of the opportunity they offered for customization. But in 2000, the firm got hit with a 40 percent increase. And in 2000, the insurer pulled out of the market entirely. The firm then went to a medical savings account (MSA). Collett regards MSAs, with their high deductibles, as well-suited to small businesses. But he complains of very stringent underwriting for major medical risks. He tells of one small-business client who was denied coverage because of asthma. Not only was the condition being controlled by drugs, but the applicant had not even had an attack for more than ten years. And the insurer would have been protected by the high deductible.

Greg Seal also has experienced the frustration of trying to provide coverage for his employees. He currently pays all of the insurance costs. But he is looking at a co-pay arrangement under which the firm would pay 60 percent and the employees would pay 40 percent. He hopes that such a change would not lead to higher staff turnover. "More and more," Seal observes, "companies are saying, 'We can't afford to pay all the costs.'"

Health care is a subject that is more discussed than understood. It has evolved, like America itself, in a climate of private enterprise. Few would doubt that the system is in line for major change. The exact nature of that change is unclear. But expertise will be needed. Financial planners should be preparing themselves for the challenge.

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