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SHEDDING RISK
Insurers see banking future
*** Many have found that managing customers' money is more profitable than underwriting medical coverage.**
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By Michael A. Hiltzik, Hiltzik is a Times staff writer.

WellPoint Inc., the nation's largest health insurance company, ran into a snag last year while pursuing an important new business initiative.

Federal banking regulators insisted on classifying WellPoint as a healthcare company. And that was interfering with its efforts to open a bank.

The Federal Reserve Board eventually agreed that the company's core insurance business could be considered financial services. But what about its mail-order pharmacy and its program for managing chronic diseases, which was overseen by WellPoint doctors and nurses? Wasn't that healthcare?

WellPoint finally convinced the Fed that those activities were merely "complementary" to its main business -- financial services. It pledged to limit them to less than 5% of total revenue.

That a medical insurer would agree to keep a lid on healthcare expenditures so it could get approval to open a bank illustrates a fundamental change in the industry: Insurers are moving away from their traditional role of pooling health risks and are reinventing themselves as money managers -- providers of financial vehicles through which consumers pay for their own healthcare.

Like home and auto insurance, traditional health coverage is based on shared risks within broad populations of customers: a small proportion with big medical expenses and a large majority with few or none. Premiums paid by the latter help pay the costs incurred by the others and provide a margin of profit. In theory, this system serves everyone's interests, because people generally can't know in advance which group they'll fall into.

For several decades, health insurance has been retreating from this paradigm.

A sea change occurred in the 1970s, when large employers began self-insuring medical costs, in part because a new federal law exempted self-insured plans from state regulation.

Insurance companies began remaking themselves as administrators, providing employers with expert help in processing claims and negotiating rates with doctor groups and hospitals. Profit margins on these services are high because the companies can charge fees without assuming the cost of underwriting customers' medical needs.

A similar change is now rippling through the rest of the health insurance market, driven by federal tax breaks for individuals who pay for their own routine medical care.

"This is a turning point," said Jacob Hacker, a professor of political science at UC Berkeley who has written extensively on healthcare reform. "It's a fundamental shift away from the idea of broadly shared risk. It's going to lead to a complete transformation of the health insurer, which will be increasingly focused on providing management of money."

Wealth in health savings accounts

Among the signs of the change is the growth in health savings accounts, which allow individuals and families to pay out-of-pocket medical expenses from tax-exempt savings. As with individual retirement accounts and 401(k) plans, the money in HSAs tends to sit for long periods and can be invested in mutual funds and securities.

HSAs are different from flexible spending accounts, which allow employees to set aside tax-free dollars to pay deductibles and other medical expenses. At the end of the year, any unspent money in a flexible spending account is lost. In contrast, money in an HSA can carry over year after year indefinitely.

Federal tax rules for HSAs were liberalized in 2003, making them very attractive to well-heeled taxpayers. Commercial banks such as Bank of America and Mellon Bank, seeing the opportunity to collect management fees on the accounts, jumped into the business.

"Every bank wants to increase its share of HSAs," said John Casillas, director of the Medical Banking Project, a Franklin, Tenn., organization that helps medical administrators develop financial service systems.

"There's fees for managing the account, transaction fees, fees for investing the funds," Casillas said. "You're going to see many billions of dollars moving from premium payments to professionally managed investment funds under HSA rules. Some people think that banks are going to threaten health plans by replacing them in the marketplace."

Hence the rush by medical insurers to open their own banks.

"This is an offshoot of what's going on in the market," said Kelvin Anderson, chief executive of OptumHealthBank, founded in 2005 by UnitedHealth Group, owner of PacifiCare and other health insurance plans.

"Our choice was either to start a bank or partner with a third party," Anderson said in an interview. UnitedHealth chose to start its own bank, he said, to "provide better service to the customer."

The company also stands to collect fees for maintaining the accounts, handling some disbursements and investing the balances -- and for overdrafts, electronic transfers, even printed checks and monthly statements.

OptumHealthBank has attracted $600 million in health savings account deposits from nearly 400,000 customers. The bank collected more than $34 million in service charges on those deposits in the year that ended June 30, according to its reports to federal banking regulators. Over the same period, it earned $46 million in interest and produced a profit of nearly $33 million for its parent company.

That's a small fraction of UnitedHealth's $4.6 billion in overall profit last year, but it required a capital investment of just $35 million. Moreover, the business is growing fast: Deposits have more than doubled in the last 18 months.

OptumHealthBank was the first bank to be chartered by a medical insurer, but it did not have the field to itself for long. Blue Healthcare Bank, funded by 33 of the 39 member plans of the Chicago-based Blue Cross and Blue Shield Assn., was chartered as a Utah-based thrift last year, and WellPoint's Arcus Bank received approval from the Federal Deposit Insurance Corp. this year.

Arcus is still awaiting formal approval from state regulators in Utah, its home state, but expects to be in operation within six months, said Chief Executive James Rowan.

Utah has been the state of choice for the new charters because state law allows non- financial companies to establish state banks without subjecting the parent company to supervision of federal bank regulators.

Last year, however, the FDIC imposed a moratorium on granting deposit insurance to such banks unless they were owned by a financial services company -- hence WellPoint's attempt to show that its principal business was financial services, not healthcare.

WellPoint had to make that case to the Federal Reserve Board to get a waiver of the FDIC moratorium. In the end, the company reached an agreement that allows it to obtain no more than 15% of its revenue from pharmacy services and disease management, triple the limit initially set by the Fed.

Rowan and Anderson say their banks will benefit customers by offering health savings accounts and healthcare coverage under one roof.

"We want the customer to be empowered," Rowan said.

Consumer-driven healthcare

Whether these new services represent a solution to the nation's healthcare crisis is widely debated.

Health savings accounts are "a step backward," said George Halvorson, chief executive of the giant Kaiser health plan system and outgoing chairman of America's Health Insurance Plans, the health insurance industry's Washington-based lobbying arm. He calls the medical banking trend "off the point of where we need to go" to provide medical coverage to all Americans.

That's because HSAs and their related health insurance policies, which carry high deductibles and offer bare-bones coverage, are particularly beneficial to healthier, younger and wealthier customers. If these customers abandon the conventional insurance market, they will trap those with chronic or serious conditions in a shrinking, high-cost insurance pool.

"Eventually it will be harder and harder to find individual policies that aren't high-deductible plans," said Timothy S. Jost, a law professor at Washington and Lee University in Lexington, Va., and a critic of health savings accounts. "Those plans are great if you're healthy. Other people will find that they have access to health insurance but not healthcare."

HSAs are rooted in a conservative principle called "consumer-directed healthcare," the notion that healthcare expenses have been rising in part because most American consumers, who receive health coverage as an employment benefit, don't know how much their care actually costs.

If Americans paid for more healthcare out of their own pockets, the argument goes, they would become more frugal and discriminating. They would avoid seeing doctors for trivial complaints, insist on generic drugs rather than costlier brand names and seek out cost-effective treatments, not fashionable or experimental therapies, even for serious conditions.

To help foster this change, the insurance industry developed a new form of health plan carrying a low premium and a deductible -- the amount a customer must pay out of pocket each year before the insurance kicks in -- of $5,000 or more.

The new plans offer fewer overall benefits than traditional plans. They are designed to cover chiefly catastrophic medical expenses. Routine medical care becomes the responsibility of the consumer. Some of the plans exclude maternity benefits, preventive care and mental health services.

The federal rule changes in 2003 required anyone opening a health savings account to be covered by a qualified high-deductible plan, giving the insurance industry a convenient hook to market the products in tandem. The idea was that the tax break provided by HSAs would give individuals a greater incentive to buy a high-deductible plan.

Among the earliest promoters of HSAs were John Goodman of the National Center for Policy Analysis, a Dallas think tank that was instrumental in pushing President Bush's Social Security privatization plan, and J. Patrick Rooney, a libertarian insurance executive who had promoted a school voucher program in his hometown of Indianapolis.

Their first victory came in 1996, when Congress approved a four-year pilot program providing limited tax relief for what were then known as medical savings accounts. Rooney and his supporters pressed Congress to expand the concept. In 2003 they succeeded. Contribution limits were raised sharply and indexed to inflation. (In 2008, the limits are $2,900 for individuals and $5,800 for couples.)

Under the rules, contributions to HSAs are tax-exempt, as are their investment gains. Withdrawals are also tax-exempt if they are used for qualified medical expenses. Over time, HSA balances could grow to hundreds of thousands of dollars.

Already, HSAs and high-deductible plans have made strong gains in the marketplace. America's Health Insurance Plans, the industry lobbying group, reported that 6.1 million Americans were covered by high-deductible plans by the end of 2007, a 35% gain from a year earlier.

Only a fraction of those customers have also opened an HSA, however. That has led to charges from critics that the savings accounts function more as a tax shelter for wealthy taxpayers than as a tool to manage healthcare costs. A study this year by the Government Accountability Office found that the average taxable income among HSA holders as of 2005 was $139,000, more than double the average for all taxpayers.

The GAO also found that average withdrawals per year were less than half of contributions, suggesting that the account holders were building up retirement savings.

'Nothing is covered, absolutely nothing'

There is evidence that enrollment in high-deductible plans has grown not because the plans offer greater value but because they are often the only plans that customers can afford -- and sometimes the only plans an insurer will offer applicants with chronic conditions such as asthma, diabetes or depression.

That reflects the experience of Alex Kipper, 55, of Campbell, Calif., an engineer who lost his employer-provided health insurance during the dot-com bust when he was laid off by a Silicon Valley company. Since then he has eked out a living translating Russian medical and technical papers on a freelance basis, earning roughly $30,000 a year.

Because he has high blood pressure, Kipper found himself virtually uninsurable. Fearing that he could be financially wiped out in a medical emergency, he signed up for a bare-bones policy that provides no coverage until his medical expenses exceed $8,000 in a year.

His health plan's concession to preventive care was a $25 discount on a physical. Once diagnostic tests were included, the fee for the checkup came to more than $300, Kipper said -- which the health plan declined to pay.

He hasn't returned to a doctor's office in three years. He gets his blood pressure medicine from the discount retailer Costco, which charges him $15 for a month's supply. To renew his prescription, he goes to a local free clinic.

Although the policy costs only $200 a month, "nothing is covered, absolutely nothing," Kipper said. "This plan would be fine if it was really cheap, like $25 a month. But not $200."

A 2006 survey by the Kaiser Family Foundation found that although customers in high-deductible plans did cut back on medical services overall, they tended to avoid arguably beneficial services as well as purportedly wasteful ones.

They were more likely than participants in conventional plans to avoid filling a prescription or to take less than the prescribed dose, to skip a test, treatment or follow-up visit recommended by a doctor, or to skip a checkup.

"The basic premises of consumer-driven healthcare are seriously flawed," said Mark Hall, a professor of law and public health at Wake Forest University Medical School, who contends that people with serious medical conditions have little time or inclination to search for the most cost-effective treatment.

"They're not consumers, they're patients. And when you're a patient, you're not in a shopping mode. You have other things on your mind."

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michael.hiltzik@latimes.com