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Self-Pay All Along

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My opinion

Being an avid reader, I stumbled onto the health insurance practice of ASO [1]. As a healthcare consumer, it is important to know what ASO is. The acronym ASO stands for "Administrative Services Only" [2], a practice that has figuratively evolved the majority of our employers into becoming our health insurance carriers. How (and why) did the evolution of ASO happen? Historically, we all used to pay directly for our healthcare on an as-needed basis. At some point of time, this as-needed self-pay practice became too personally burdensome and subsequently insurance carriers started paying for our healthcare while we (along with our employers) began paying recurring health insurance premiums as our contributions. In time this practice also became too burdensome and currently, instead of contributing their parts towards the employees' premiums, the employers have begun withholding the corresponding funds from the health insurance carriers, supposedly as "cash-in-hand", while their employees continue to pay their parts of premiums [3]. Essentially, majority of our employers have evolved into covert insurance carriers [4] by directly paying for our healthcare bills and our overt insurance carriers' not-so-large ASO fees [5]. The ASO fees primarily serve as compensation for larger insurance carriers' superior negotiating power over healthcare providers that determines healthcare bills' actual/final reimbursable values. Negotiating power is heavily dependent on the number of clients that an entity can bring to the table. For example, our government-owned Medicare & Medicaid, as the largest third-party payer for our healthcare, literally dictates the terms of healthcare payments and fees. Ironically, even the government-owned Medicare & Medicaid cannot currently "negotiate" [6] drug prices with the drug manufacturers although there may be "negotiations" in the future [7].Â

To identify the ultimate payer of our healthcare system, we can illuminate ASO practices by using two scenarios unrelated to healthcare.

- The gratuities [8], that are expected from us as customers being served in restaurants (or for that matter in any server-based industry), are actually the owners' excuse to maintain underpaying jobs for their servers as per the legal subminimum wages [9]. However, if the owners were to start paying their servers appropriately, there would be correspondingly inflated bills which would again be footed by us as customers dining in their restaurants.
- A lifetime total of car insurance premiums [10] paid by an average driver as mandatory fees to drive a car is usually higher in total than what the car insurance carrier would pay out for actual injury claims based on the average driver having three-four car accidents over entire driving-lifetime [11].

With the abovementioned analogies, it appears contrasting that the total Medicare/Medicaid/social security (lifetime) benefits that we recoup, are more than the total Medicare/Medicaid/social security (lifetime) taxes that we pay [12]. However, our government is forced to draw from our lifetime taxes (the non Medicare/Medicaid/social security taxes) to balance its healthcare budget. The lifetime tax bill paid by the average person runs into millions pounds in United Kingdom [13], and the lifetime tax bill of the average person in the United States [14] is probably not far behind. A valid question would be whether our total lifetime healthcare benefits [15] averaging hundreds of thousands dollars (our healthcare costs [16] paid by our third-party payers) are more or less than the total lifetime amount of healthcare insurance premiums [17] paid completely by us or shared between us and our employers over our lifetimes. One thing for certain is that premiums paid by the insured for individual health insurance [18], are considerably less than the total premiums paid when shared by employee-employer, enrolled in group health insurance [19]. Herein, the buffering power of numbers comes into play again. People covered under individual health insurance by the largest insurance carriers with membership in the multimillions [20-22] may expect more stable premiums as compared to the coverage under group health insurance with the largest employers employing couple of millions at best [23] unless the employer's number of employees is larger than the population insured by the regionally available insurance carrier.

We have been long mistaken that employers paying their shares of premiums on our behalves are utilizing somebody else's money, not ours. Hypothetically, how many of us would prefer being insured with individual health insurance over group health insurance [24] if the total (potentially subsidized and/or tax-free) premiums paid under individual health insurance would become a component of our correspondingly improved compensation packages, say on the terms within the legally allowable Health Reimbursement

Arrangement (HRA) [25]? Ironically, the HRA-model may be catastrophically difficult-to-impossible to implement for large employers who are evolving their ASO-model by withholding their shares of employees' healthcare premiums. How (and why) would employers be able to channel their withheld "cash-in-hand" funds into the HRA-model based adjustments in the compensation packages for their large number of salaried employees? Essentially, our employers' lifetime contributions to our healthcare insurance premiums have always been our personal funds hidden as salary-benefits-perks [26], irrespective of whether being paid to our overt insurance carriers or being withheld by our covert insurance carriers. Herein, we could wonder whether the legally allowable variable-graded-tiered compensation packages [27-29] as corresponding to the work responsibilities and productivities can percolate into the healthcare coverage policies within the work environments.

Alternatively, we must NOT wonder about which procedures or prescriptions are covered and what claims or costs will be denied [30]. We will encounter these issues when we directly require medical services. However, when these issues arise, the responsibility lies neither with our insurance carriers who are managing our healthcare costs for minimal administrative fees nor with our employers who have to constantly sustain cash flow and cash in hand for our-and-our peers' soaring healthcare needs. We should realize that everything boils down to our own lifetime healthcare salary-benefits-perks [26], that are overtly visible in the form of premiums paid to insure our healthcare and covertly invisible in the form of the cash-in-hand withheld for the sake of our healthcare.

Summarily, our incomplete understanding of our personal healthcare plans in the constantly evolving healthcare markets may NOT matter as long as we (a) always pay our recurring premiums on-time, (b) never forget that our healthcare system has been and will continue to be a self-pay system, and (c) always try to NOT fall sick. Hopefully, in the due course of time, we as a society will begin to forgive ourselves for our volatile healthcare premiums (similar to our mortgages) that are essentially cloaked ownership of our own health status (similar to our mortgaged homes). An appropriate analogy of this evolution of our healthcare could be an antiquated multi-thousand dollar home (our 20th century healthcare) evolving into a modern multimillion dollar villa (our 21st century healthcare). Embracing the abovementioned understanding, we are welcoming our ushering into a futuristic healthcare consumerism era [31], even though it may NOT be that futuristic after all.Â

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