Chapter 1

THE DISADVANTAGES OF EMPLOYER-PROVIDED HEALTH INSURANCE

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Don't despair as you start to read this chapter about the problems with employer-provided health insurance. Beginning with Chapter 2, this book is about a solution that you can take advantage of immediately.

Employer-provided health insurance is insurance provided by employers and offered to employees and dependents of employees. The premium cost is typically split between the employer and employee, with the employee typically paying all or most of the cost to add their dependents to the employer plan. With employer-provided health insurance, the risk is spread over the employees in the company who participate in the employer-provided plan and the premiums typically increase every year based on the previous year's healthcare costs of the group.

Healthcare costs now consume almost one-sixth of America's economy, and, during your lifetime, medical and health insurance costs are likely to be your largest or second-largest expense after housing. Your employer-provided health insurance is arguably the number one threat to your financial future.

Most Americans get health insurance from their employers and never think too much about it until they or a family member develops a serious health problem. That's when they first learn the details of their health insurance benefits, which medical providers they can use, and what their out-of-pocket expenses will be. The term *insurance* in employer-provided health insurance is misleading since the insurance terminates when you lose your job—often the time when you are most financially vulnerable.

Did you know? The number one cause of personal bankruptcy filings in the United States is unpaid medical bills, outpacing bankruptcies due to unpaid credit card bills and unpaid mortgages. Amazingly, three-quarters of affected families had employer-provided health insurance when they first became ill.

Have you ever thought about what would happen if you became ill, lost your job and your health insurance, and couldn't get another job? Every year this happens to millions of Americans with dire consequences—and it doesn't have to be a major heart attack or cancer to lead you to the poorhouse. Have you or a loved one ever had a medical issue requiring multiple doctor visits, laboratory tests, or hospital stays? Then you already know that behind virtually every ill person is a second person needed to transport them to and from medical appointments, get them meals, and/or explain what is happening to their medical providers. Even if you don't become ill yourself, you could still be terminated by your employer while you are performing this service for a spouse, child, or parent.

Approximately 1 million mostly middle- and upper-middle-class families file bankruptcy each year due to medical bills they can't pay—yet amazingly, three-quarters of these families had health insurance from their employer when they first became ill. A family bankruptcy typically affects three individuals and lasts for seven years—meaning up to 21 million people, including children, are living in economic purgatory at any given time due to failed employer-provided health insurance.

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Tip: As discussed in Chapter 2, these financial threats do not exist with individual health insurance because individual plans are portable, meaning you can keep your plan independent of your employment.

Few employers can afford to keep paying absent employees for more than a few weeks after those employees have used up their available sick time and vacation. Such employees are then let go, and their financial problems, which are the leading cause of bankruptcy in the United States, begin.

What are the chances that something like this could happen to you? There are hundreds of circumstances in which you could exceed your allowable sick and vacation leave, and the chances of this happening at some point in your working life are greater than 50 percent.

- **Outdoor activities.** Do you play sports, ski, snowboard, go boating, or ride bicycles? Any one of these outdoor activities could cause an injury that would prevent you from being able to work. Even without a specific injury, many active people will require some type of knee or leg surgery during their working lifetime.
- **Home accidents.** Although most people feel safest at home, the home is actually the place where you are most likely to have an accident requiring medical treatment or one that could prevent you from being able to work. Common causes of home accidents include falls, choking, shootings, poisoning, and improper use of medications.
- **Commuting/driving.** Do you commute to work? More than 3 million people are hurt each year in auto accidents. Common injuries include fractures, broken bones, and spinal damage resulting in short- and long-term disability.
- **High blood pressure.** About 65 million Americans over age 20 have high blood pressure, a chronic disease requiring medication and one that dramatically increases the chances of having heart disease during your working lifetime.
- **The overweight/obese.** Almost two-thirds of Americans are overweight or obese. This has contributed to more than 18 million Americans having diabetes and another 41 million over age 40 having prediabetes. Most people with prediabetes develop type 2 diabetes in 10 years. Diabetes virtually guarantees that you will have health issues requiring time away from work at some point in your life, and 65 percent of people with diabetes die from heart disease or stroke.
- **Cancer, heart attack, or stroke.** One in four men and one in five women will develop one of these debilitating diseases before age 65.

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Did you know? Most Americans will develop some type of major medical condition at least once over a 45-year working life—a condition that could likely lead to job termination and loss of employer-provided health insurance. Are you and your family prepared for this eventuality?

WHAT HAPPENS AFTER YOU LOSE YOUR JOB WITH EMPLOYER-PROVIDED HEALTH INSURANCE

Once you lose your job, you lose your employer-provided health insurance unless you elect to go on COBRA. COBRA is not a snake, although many people who have been on COBRA might disagree. COBRA, which stands for Consolidated Omnibus Budget Reconciliation Act of 1985, is the acronym for the name of the 1985 legislation that requires most employers with 20 or more employees to offer former employees the short-term opportunity to remain on the company's employer-provided health insurance plan at the employee's own cost.

COBRA allows you to continue your employer-provided health insurance for up to 18 months as long as you pay 100 percent of the cost of your former employer's plan plus a 2 percent administration fee (102 percent total).

Before COBRA, when employees are on their employer's health plan, employers typically charge each employee something between 10 and 20 percent of the pro-rata cost—if the employer-provided health plan total cost is $500 per month per person, the employee typically pays between $50 and $100 to include (just) themselves in the plan. When the same employee goes on COBRA, the employee's monthly cost typically rises 200 to 1,000 percent (two to 10 times) to up to $510 ($500 plus a 2 percent administration fee) of what they were paying when they were employed. The average annual cost in 2013 for COBRA was about $6,002 for singles and $16,678 for families (Kaiser Family Foundation, 2013).

If you can afford COBRA, and it is offered by your employer, it's only good for up to 18 months of coverage for you (the employee) and up to 36 months for dependents.

If you cannot afford COBRA, or if your illness requires treatment for more than the 18 to 36 months that COBRA is available, you will be forced to switch health plans. If you are in the middle of a health issue, this could be devastating because:

1. When you switch plans midyear, your deductibles and out-of-pocket maximums will be reset. Depending on your new plan, this could expose you to up to $12,000 in additional healthcare costs per year.
2. Your new plan may not cover your current doctor and hospitals, forcing you to transfer to new medical providers or pay out-of-network for your current providers—which could be almost the same in cost as having no health insurance.
3. Transferring to new medical providers who are not familiar with your recent medical history could be dangerous to your health or the health of a loved one.

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Each year between 1 and 2 million American families file personal bankruptcy. Until recently, the causes of these bankruptcies were unknown, and most people assumed credit card spending, divorce, and loss of employment to be among the major reasons. In February 2005, Harvard University released the results of its study, "Illness and Injury as Contributors to Bankruptcy."

The study interviewed Americans in bankruptcy courts and determined that about half were "medically bankrupt"—driven to bankruptcy by medical bills not covered by health insurance. Equally surprising, the study concluded:

- Three-fourths of the medically bankrupt had health insurance at the beginning of their illness.
- The majority of the medically bankrupt owned their own homes and had attended college.
- Many people filing medical bankruptcy were middle-class workers with health insurance who were unable to pay their copayments, deductibles, and exclusions in the employer-provided health insurance plan.

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This book teaches you how to avoid the insurance gaps that drive millions of Americans into medical bankruptcy.

10 REASONS EMPLOYER-PROVIDED HEALTH INSURANCE IS BAD FOR YOU, YOUR FAMILY, AND YOUR COMPANY

1. It's temporary—You lose your health insurance if you or your loved one gets sick.
2. It's overpriced—You pay $4,000 to $12,000 more than individual health insurance for the same coverage.
3. It's risky—Your coverage may be canceled at any time without notice.

4. It's limited—You don't get to pick your doctors and hospitals.
5. It's one-size-fits-all—You don't get to choose your deductible or copays.
6. It's unfair—You are disqualified from receiving your $2,000 to $12,000 per year share of the trillion-dollar federal subsidy.
7. It's unstable—Your cost could double due to one employee with a million-dollar claim.
8. It's bad for your career—People stay in jobs that don't let them realize their full potential.
9. It's bad for your business—Management spends time on health insurance that should be spent on customers and products.
10. It's bad for America—Employer-provided health insurance is the top reason U.S. healthcare costs are almost $4 trillion, approaching one-fifth the size of the U.S. economy.

1. It's Temporary—You Lose Your Health Insurance If You or Your Loved One Gets Sick

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This is the biggest problem with employer-provided health insurance—it only covers you when you or a loved one is healthy enough for you to remain at work.

Sadly, most people don't realize this until they become too ill to come to work and get terminated, or they can't come to work because they are needed full-time to take care of a sick child or spouse.

Few employees with employer-provided health plans are aware that their health insurance terminates when they lose their job, and that COBRA, if it is offered, only covers them for up to 18 months at an exorbitant cost.

In 1985, when I (Paul Zane Pilzer) was giving a lecture at Moscow State University, a Soviet economist stood up and chastised me for working for "a cruel disheartening nation [the United States]" where "if you lose your job, you and even your children lose your health insurance." I remember denying his accusation and being shocked when I later found out that he was correct.

2. It's Overpriced—You Pay $4,000 to $12,000 More for the Same Coverage

The average cost to cover an employee with employer-provided health insurance has increased from $2,196 per year in 1999 to $5,884 per year in 2013. For family coverage, the cost has increased from $5,791 per year in 1999 to $16,351 per year

in 2013. This is not sustainable for employers or employees. Prior to 2014, the annual cost of individual health insurance was about $2,500 a person—but there was a catch. Everyone medically qualified for employer-provided coverage but, in 45 states, only healthy people and their healthy families medically qualified for individual health insurance.

Did you know? The average cost to cover an employee with employer-provided health insurance has increased from $2,196 per year in 1999 to $5,884 per year in 2013. For family coverage, the cost has increased from $5,791 per year in 1999 to $16,351 per year in 2013. This is not sustainable for employers or employees.

Then, the Affordable Care Act (known as ACA or Obamacare) was passed in 2010. The ACA mandated that the price, benefits, and qualifications for individual health insurance be roughly the same or better than most employer-provided coverage. Starting in 2014, the ACA requires all individual health insurance policies to cover a list of essential health benefits (see Chapter 9) without any monthly, annual, or lifetime limitations.

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Tip: Most Americans think that employer-provided coverage is better and/or cheaper than individual coverage that you purchase on your own. This used to be true; however, the full implementation of the Affordable Care Act in 2014 (Obamacare) has turned this paradigm upside down.

Even if you work for a company that pays 100 percent of the cost for you to participate in the employer-provided health insurance plan, you are probably paying between 50 and 100 percent of the cost to add your spouse and children to your employer-provided plan. Most people don't realize the cost of their family is typically deducted from their net wages via their paychecks.

Back in the 1960s, most employers paid the entire premium for employees and their dependents—with no employee contributions, copays, or other cost-sharing devices. Over the next three decades medical costs dramatically increased, and many spouses began receiving their own benefits by joining the workforce. In response, employers started paying only a portion or none of the premium for the employee's spouse and dependents. Today, employers offering employee health benefits typically pay only 25 to 75 percent of the cost for an employee's spouse and dependents. Only very few employers today still pay 100 percent of the cost for spouses and dependents.

Tip: Many employees are paying 50 to 100 percent of the cost of including their spouse and dependents on their employer's health plan without realizing it since it is automatically deducted from their paycheck.

Employer-provided health insurance has been hit by soaring costs in recent years, making it less affordable for employers and employees. As shown in Figure 1.1, from 1999 to 2013, the annual premium that U.S. health insurance companies charged for employer-provided health benefits plans increased approximately 182 percent to roughly $16,350 per family. For single coverage, the cost has increased about 168 percent to $5,884 per single (Kaiser Family Foundation 2013).

During this period, many employers stopped providing health benefits entirely. The percent of jobs that included health benefits fell to 57 percent—9 percent fewer U.S. jobs provided health benefits in 2013 versus 1999. The average cost of employer-provided health benefits is expected to reach approximately $20,000 per family and $8,000 per single in 2016. On average, employees on employer-provided health insurance will be paying more and getting less in terms of higher deductibles, higher copays, and higher out-of-pocket maximums.

3. It's Risky—Your Coverage May Be Canceled at Any Time without Notice

One of the scariest things about employer-provided health insurance is that you do not control the policy. Your employer may cancel the entire plan or change the benefits at any time with little or no notice to you, and there is no COBRA available when the entire plan is canceled.

Once your current plan is canceled, you lose access to it—there is no COBRA available on a canceled plan.

	1999	2013	Increase
Total annual family premium	$5,791	$16,351	+182%
Total annual single premium	$2,196	$5,884	+168%
Average monthly employee contribution (family)	$1,548	$4,560	+195%

Figure 1.1 Employer-Provided Health Insurance (1999 to 2013)

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There are numerous reasons your employer may cancel your coverage:

- **Switching to a new health insurance company.** Every year (and sometimes in the middle of the year), thousands of employers switch health insurance companies (and cancel the current coverage) due to the savings it presents to the business, or because the insurance company refused to renew the policy.
- **Failing to meet insurance company requirements.** If the health insurance provider audits your plan and finds that your company is out of compliance with the plan terms, such as a 75 percent minimum participation requirement, the insurance company can cancel coverage for the entire company.
- **Failing to make payment.** Retroactive termination for nonpayment of premium is permissible, and there is no requirement that a premium be accepted after the original due date.
- **Going out of business.** 10 to 12 percent of employers close each year—that's almost 1 million business closures per year.

Your employer-provided health insurance plan could be modified or canceled at any time without your consent.

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Once your current plan is canceled, you lose access to it—there is no COBRA available on a canceled plan. Note also that if you are no longer employed and already on COBRA, and your former employer cancels their entire plan, you also lose your health insurance.

Fortunately, as explained in Chapter 7, having an employer or former employer cancel your plan is a *qualifying event* that makes you instantly eligible to purchase individual coverage on your state's Health Insurance Marketplace at any time, even outside the traditional annual *open enrollment* period. However, should this happen to you, you will still have to switch to a new health insurance policy and possibly even a new insurance company.

When you have to switch health insurance companies, as explained earlier, if you are in the middle of a health issue, it could be financially devastating and/or you could lose contact with your existing medical providers. Your new plan may not cover your current doctor and hospitals. If your new plan does not cover your current medical providers, you will be required to make a choice between (A) transferring to a new provider whom you may not trust or (B) paying out-of-network for your current provider which could be as expensive as having no health insurance at all.

Tip: As discussed in Chapter 2, these financial threats do not exist with individual health insurance because individual plans are controlled by you and not your employer.

4. It's Limited—You Don't Get to Pick Your Doctors and Hospitals

Did you know? Most medical providers charge patients who don't belong to their health insurance network much higher prices (sometimes 10 times higher) than they charge to those in their network for the exact same service.

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A major limitation of employer-provided health insurance is that you and your family do not get to pick the provider network. The provider network refers to the medical providers (e.g., doctors and hospitals) covered by the plan. See Chapter 10 for more on provider networks.

With provider networks, health insurance companies contract with medical providers in local areas to provide service to their policyholders or members for either a flat monthly fee or a discounted rate. Employer-provided health insurance plans will typically provide access to a provider network. If you seek care outside of this network of providers, your insurance may not pay for the services or pay a lower amount. Today, most medical providers, from local pediatricians to big-city hospitals, charge patients who don't belong to their health insurance network much higher prices (sometimes 10 times higher) than they charge those in their network for the exact same service.

If your preferred doctor or hospital providers are not in your employer plan's network, the plan may not cover you if you continue to receive services from those doctors. Even worse, the only way to manage this problem is to either (1) switch medical providers or (2) switch employers.

Tip: As discussed in Chapter 2, individual health insurance allows you to choose your doctor and hospital network when you choose your policy.

5. It's One-Size-Fits-All—You Don't Get to Choose Your Deductible, Copays, or Coinsurance

When it comes to health insurance, employees have very different needs. However, your employer-provided health insurance plan takes a one-size-fits-all approach. With employer-provided health insurance, most employees do not get to choose from a wide range of deductibles or copays. As result, most employees are paired with coverage that does not fit their family's needs.

Annual deductible—This is the annual amount of your medical expenses that you must pay before your health insurance company begins paying providers or reimbursing you for claims. Traditional plans have deductibles of up to $1,500, as well as copays for doctor visits and prescriptions. High deductible plans have deductibles from $1,000 to $10,000, but much lower premiums.

Copay—This is the amount that you pay each time you visit the doctor, pharmacy, or other medical provider. If you have children and visit the doctor often, you are typically better off with a higher premium plan that charges you a fixed amount (copay) for each doctor visit regardless of what is done during the visit.

Coinsurance—This is the amount, typically about 20 to 30 percent, that most insurance companies expect you to pay on your annual medical expenses after you have met your deductible. Fortunately, most coinsurance clauses have an upper limit of about $4,000 to $10,000. Your maximum coinsurance obligation plus your annual deductible is called your *out-of-pocket maximums*—referring to the maximum out-of-pocket annual expense you could incur under the policy. Some newer high-deductible plans, including many HSA plans, do not charge you coinsurance; they pay 100 percent of your medical expenses once you have met the deductible (see Chapter 9 for more on out-of-pocket maximums).

A mismatch of coverage with your needs can cost you thousands of dollars per year unnecessarily. How? Health insurance plans that cover more of your medical expenses (i.e., health plans with lower deductibles) usually have a higher monthly payment. As a result, you pay more up front in the form of higher premiums in exchange for getting to pay less when you receive medical care.

For example, a plan with a low deductible would probably work best for a family expecting to visit the doctor and pharmacy regularly. However, the same plan might be a poor choice for a young, single adult male who only expects to go the doctor once per year for his annual physical. Since the young, single employee will not use the coverage he is paying up front for, he is being charged up to 100 percent more than he actually needs. By contrast, if he were able to select a high deductible HSA plan (see Chapter 12 for more on HSAs), he could be saving thousands of dollars in an account for future medical expenses.

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	Bronze	Silver	Gold	Platinum
Monthly premium (with subsidies applied)	$0	$164	$321	$402
Deductible (family)	$10,000	$4,000	$0	$0
Coinsurance	30%	20%	20%	10%
Doctor copay	$60	$45	$30	$20
Out-of-pocket maximum (family)	$12,700	$12,700	$12,700	$8,000

Figure 1.2 Example Rates for an Employee Earning $40,000/Year (Family of Four, Adults Age 40)

Source: Covered California 2014.

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Tip: The majority of employees only go the doctor one to two times per year. Most employees with employer-provided health insurance are overpaying up front in the form of higher insurance premiums for coverage they will probably never use.

In contrast, the Affordable Care Act mandates that individual plans sold on the marketplaces be offered at five levels—Bronze, Silver, Gold, Platinum, and Catastrophic. These levels have nothing to do with the care you get, just the deductible, copays, and coverage you receive from the insurance company. (See Figure 1.2.)

Tip: Individual health insurance allows you to choose your health insurance plan deductibles and copays.

6. It's Unfair—You Are Disqualified from Receiving Your $2,000 to $12,000 Per Year Share of the Trillion-Dollar Federal Subsidy

As crazy as it might sound at first, you should be asking your employer, "Could you please cancel our employer-provided health insurance plan?" Why? Because if you are offered qualified affordable employer-provided health insurance by your employer, you and your family are disqualified from receiving the federal subsidy, even if you are eligible based on your income.

Let's say you live in Dallas, Texas, earn $60,000 per year, and have a family of five. Your employer may offer you an employer-provided plan where

your employer pays the full $500 per month cost per person for you, and you pay for your four family members at a monthly cost of $1,200 a month. That's $14,400 per year out of your pocket to have your entire family of five covered by the employer-provided health insurance plan.

Alternatively, on the Texas Health Insurance Marketplace (available via www.healthcare.gov), you could purchase better coverage with an individual Blue Cross Blue Shield Silver plan for all five family members including you without any government subsidy for $899 per month—that's for permanent health insurance, $30 copays for doctor visits, and $0 for generic prescriptions. That's $10,788 ($899 × 12) a year before the federal subsidy for better coverage than the $14,400 per year you would pay just to add your family to the employer-provided group plan.

Tip: Most U.S. families will find themselves thousands of dollars per year better off if their employer canceled their employer-provided health insurance coverage, and that's before asking their employer to reimburse them for part of the cost of an individual health insurance policy.

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But, if your employer didn't offer you qualified affordable employer-provided coverage, you would receive a $580 per month federal subsidy towards paying the $899 per month cost, reducing your monthly premium to $319 per month for all five members of your family. This $580 per month subsidy is effectively a $6,960 tax-free cash gift for you and your family from the federal government.

As explained in Chapter 3, if your employer has less than 50 employees, there is no charge or penalty to your employer for you to receive this subsidy. But, if your employer has more than 50 employees, the employer would have to pay a penalty of up to $3,000 per year for each employee that receives subsidized coverage (up to a maximum penalty of $2,000/year for all employees after a 30 employee credit). When debating the Affordable Care Act in 2010, the Senate originally wanted this $2,000 per employee maximum penalty to be $20,000 per employee. However, Congress reduced it to $2,000 per employee when many employers threatened to close their doors entirely rather than pay $20,000 per year in penalties for an $8 per hour employee earning as little as $16,000 per year.

As shown in Figure 1.3, it gets even better if you earn $38,000 per year and your employer doesn't offer an employer-provided plan—you would get free coverage for your entire family under Medicaid.

If you earned $80,000 per year versus $60,000 per year, your federal subsidy would fall from $580 per month to $312 per month, causing your $899 per month premium before subsidy to fall to $587 per month. Even if you earned $80,000 per

	Annual Income		
	$38,000	$60,000	$80,000
Monthly premium	Free	$899/month	$899/month
Federal subsidy	Medicaid	$580/month	$312/month
Net cost	Free	$319/month	$587/month

Figure 1.3 Dallas, Texas, Couple, Age 35, Three Children—Blue Advantage Silver HMO

year, your annual cost for much better, permanent individual coverage would be $7,044 per year ($587 × 12) for all five members of your family versus your employer charging you $14,400 per year just to add your family members to their employer-provided group plan.

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A massive tax subsidy is now available to help individuals buy individual health insurance coverage through the new state-based Health Insurance Marketplaces. The subsidy caps the cost of an individual's health insurance at 2 to 9.5 percent of their household income if their household income is less than 400 percent above the federal poverty line (that's about $100,000 per year for a family of four in 2014).

7. It's Unstable—Your Cost Could Double Due to One Employee with a Million-Dollar Claim

If you work for a small or medium-sized employer with employer-provided health insurance, if one employee has a baby, a surgery, or is diagnosed with a chronic illness, you are likely to see a large premium rate increase at renewal time. That's because the insurance company needs to recover their losses from a relatively small group of people.

Employer-provided health insurance is misleading because insurance means spreading the risk among a large group of people or organizations so that no single entity bears the cost of a catastrophic illness. However, that's not how employer-provided health insurance works. Each time an insured employee in your organization runs up large medical bills, your organization ends up paying these costs the following year via an increase in its annual health insurance premium. The insurance employers pay for is actually little more than a delayed bill-paying mechanism.

Tip: As discussed in Chapter 2, individual health insurance pools diversify the risk across a much larger population.

In 1985, I (Paul Zane Pilzer) testified to the U.S. Congress about the problems facing small businesses with employer-provided health insurance. I explained:

> *A typical owner of a small business probably knows the first name of each child of an employee who has diabetes—even though they are not supposed to know. A small employer with a $35,000-a-year employee should not be burdened with the $75,000-a-year medical cost for a child of that employee who has diabetes—or have to face the terrible choice between staying in business versus taking care of the sick child of an employee.*
>
> Paul Zane Pilzer testifying before the Committee on Government Operations, U.S. Congress, October 1985

Many employers wish all they had to worry about was paying $75,000 a year for the medical costs of a diabetic child. Some medical situations today, from preterm births to cancer, can cost hundreds of thousands or millions of dollars—making the entire employee health plan unaffordable, or potentially even driving the employer out of business.

Suppose you work for a 51-person company where one participant develops a health condition costing $200,000 a year or more. Next year, the health insurance premium paid by your company will go up by $200,000. The cost of your employer-provided medical plan would increase more than $500 a month per employee, forcing your employer to cut benefits or possibly terminate the plan. What would happen if two people developed such a condition? Employer-provided group health insurance plans are ticking time bombs as their workforce ages.

These annual benefit reductions and/or increased outlays by employees inevitably lead to an ongoing version of adverse selection—a perpetual process referred to as the "employer health insurance death spiral."

The death spiral starts when an employee's cost to participate in the employer-provided plan exceeds the employee's willingness to pay. When this happens, the healthiest employees begin to drop off the employer plan in favor of individual policies. This causes the remaining employer risk pool to become proportionately sicker, resulting in even higher insurance premiums on renewal the following year. Then, the process repeats itself—the employer reduces benefits to maintain costs, more healthy employees drop off, and the rate goes up even more the following year.

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This employer-provided health insurance death spiral perpetuates until the business either: (1) cancels the plan itself or (2) is unable to get enough employees to stay in the employer pool and the plan is cancelled by the insurance company for low participation. Virtually all small employer policies require participation of 75 percent or more of eligible employees in order to be renewed.

8. It's Bad for Careers—People Stay in Jobs That Don't Let Them Realize Their Full Potential

Millions of Americans today are modern-day slaves either unable to retire early, working in jobs they don't really want, or working in jobs that don't actualize their full potential—all because they need their employer-provided health insurance to take care of themselves, a spouse, or a child with a chronic medical condition.

Patients with chronic medical conditions like depression, cancer, or diabetes typically require care by the same medical provider over a long period of time, and changing doctors can be very detrimental to their care as well as to their wallet.

While the Affordable Care Act (ACA) has made affordable individual health insurance accessible to millions of Americans, when employees switch from employer-provided coverage to an individual policy, it is unlikely that their new health insurance company has a network that covers all of their existing providers.

Even if an employee finds an individual health insurance company network that covers their existing medical providers or equivalent substitutes, it will typically be very expensive to switch their insurance company and network of providers as previously described.

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Although the ACA has helped millions of Americans get individual health insurance, millions more Americans still remain virtual slaves to their employer's health insurance plan because they don't know that cheaper, better individual health insurance is available in the federally-mandated Health Insurance Marketplaces.

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9. It's Bad for Business—Management Spends Time on Health Insurance That Should Be Spent on Customers and Products

In our specialized economy today, success in business requires that managers and owners focus on better ways to serve their customers. This ranges from continually improving your products and services to finding better ways for your customers to obtain and pay for your products and services. No stone can be left unturned when it comes to improving the customer experience.

Health insurance is an economic crisis for employers as well as individuals. The cost of health benefits now exceeds profits for most of the Fortune 500 companies. GM is in trouble because health insurance adds $1,550 to the cost of every car it sells.

Unless your company is large enough to have dedicated, full-time employees managing your employer-provided health insurance program, the money and time you and your managers spend getting your employees covered is one of the greatest threats to your business. That's because every hour you spend managing your employer-provided health insurance is another hour you are not spending managing and improving your product or service. Even if your company is large enough to justify having dedicated full-time managers of your employer-provided health insurance plan, with health insurance costs today exceeding profits for many companies, it's rare that the CEO and CFO of a Fortune 500 company doesn't spend many hours managing their health benefits program.

Although they don't know it, many employers are not competent at managing their employer-provided health insurance benefits. Just as you see some of your customers are relatively uneducated about how to properly buy and save money on your product or service, you and your managers are similarly uneducated when it comes to knowing how much employer-provided health insurance coverage to purchase and how to pay for it. This is because there is virtually no transparency for employers when it comes to managing their employer health benefits program. Everything is disguised—from how much their health insurance broker makes in commissions and overrides on the different policies they recommend, to the performance and efficiency of each medical provider in the plans' networks.

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10. It's Bad for America—Employer-Provided Health Insurance Is the Top Reason U.S. Healthcare Costs Are Almost $4 Trillion, Approaching One-Fifth the Size of the U.S. Economy

When you drive to work today look around at the people, cars, and buildings you pass by. Between one-sixth and one-fifth of the people you pass on their way to work, representing 17.5 percent of our gross domestic product, work producing a product or service nobody really wants to buy—healthcare, or more accurately sickness care, since what most Americans call healthcare has very little to do with health.

Despite the fact that the U.S. spends two-and-a-half to three times per person what other developed nations spend on healthcare, the United States is the

unhealthiest developed nation on earth. There are many reasons proposed for why this is so.

For example, 95 percent of the pharmaceutical prescriptions filled each year in the United States are for drugs you are expected to take for the rest of your life—because drug companies find it much more profitable to create customers for life by producing maintenance drugs that treat the symptoms of diseases versus drugs that cure diseases.

Medical providers from the individual doctor to the largest hospital are paid for their procedures and time spent versus their outcomes or health of their patients.

However, the major reason that the U.S. healthcare industry costs so much is because the employers who pay for most U.S. healthcare do not have a financial stake in the long-term health of their employees.

Employees used to stay with one company for 25 years or more. Today, the average employee is projected to change jobs more than 10 times over his or her 45-year working life. Most of the major illnesses on which you can spend $1 today to save $100 tomorrow (like heart disease from obesity or cancer from poor nutrition) will not show up until an employee is long gone or retired, at which time the $100 cost is picked up by another employer or by taxpayers through Medicare.

As medical costs have escalated, employers have, in effect, told their medical providers to pay for only those expenses related to keeping or getting the insured back to work—and this does not include paying for the prevention of a disease that will not manifest itself during the expected tenure of the employee with the company.

Despite a new federal mandate in the ACA that employers must cover preventive care, the federal definition of preventive care includes tests like mammograms and prostrate exams that merely screen for diseases rather than help prevent them (see Chapter 9). Significant weight reduction, nutritional advice, vitamins, minerals, smoking cessation, and hundreds of other wellness-related treatments are excluded from most employer-provided and most individual health insurance plans. Although at least with individual health insurance plans you can choose to apply the savings to your wellness care.

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Did you know? More than one-sixth of the U.S. economy is devoted to healthcare spending and that percentage continues to rise every year. Our employer-based health insurance system is not delivering value equal to the roughly $3.5 trillion we spend annually on healthcare. Experts agree that an estimated 20 to 30 percent of that spending—up to $1 trillion a year—goes to care that is wasteful, redundant, or inefficient.

We could go on and on about why healthcare costs so much in the United States. But this is not a book about healthcare; it's a book about health insurance

and how to finance healthcare—the number one financial challenge facing America, American employers, and American families. The exorbitant cost of U.S. healthcare is one of the major reasons the United States has so large a federal deficit and federal debt.

The number one reason U.S. healthcare costs so much is because the overwhelming majority of U.S. nongeriatric care is paid for indirectly through third-party employers versus directly by consumers themselves.

The U.S. healthcare marketplace has been discouraged from developing innovative healthcare solutions for consumers at affordable prices because it has focused only on solutions that could be sold to employers' human resource and insurance company executives. This is in contrast to the dramatic innovation in every other part of the U.S. economy such as automobiles, restaurants, personal computers, telecommunications, and so forth, which are focused on solutions sold directly to consumers.

America's employers have become the nation's healthcare gatekeepers, deciding, in advance, what type of medical care employees should receive—which by definition often means yesterday's treatments versus today's treatments. This also prevents entrepreneurial medical providers and alternative medical providers from developing better treatments, since they cannot get paid for them.

In summary, rising healthcare costs, driven mostly by employer-provided health insurance, punish our nation on multiple fronts:

- For you and your family, rising healthcare costs mean less money in your pockets and force hard choices about balancing your children's education, food, rent, and needed care.
- For your company, rising healthcare costs make it more expensive to add new employees and reduce budgets available for marketing, customer service, and product development.
- For the government, rising healthcare costs lead to reduced funding on other priorities such as infrastructure, education, and security.

As you will see throughout this book, all of this has recently changed thanks to new federal legislation and regulations that have leveled the playing field between employer-provided health insurance and individual health insurance policies that you purchase yourself.

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