You Are One Serious Illness Away from Bankruptcy: The Huge Gaps in Your Employer's Health Insurance Plan

Forty-five million Americans lack any form of health insurance and live in fear of a major medical problem. Yet surprisingly, 80 percent of these people are employed and 16 million earn more than $40,000 per family ($20,000 per single).* The good news is millions of these uninsured working Americans can now afford to buy good Health Savings Account (HSA-qualified) health insurance for an average of $92 per month for an individual or $272 per month for a family.† If you or a loved one is in this category, you may want to skip ahead to Chapters 2 and 4 to learn how.

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. In an ideal world, this is how it should be. As a resident of the greatest nation on earth, you should not need a book on health insurance solutions any more than you need a book on life insurance, car insurance, or property insurance. Sadly, this is not the case.

*The poorest 38 million Americans (those who earn less than $20,000 a year) receive free health insurance through Medicaid. See Appendix B.

†Average price in all states for policies offering coverage for 2006. See Appendix A.

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. That's if you're lucky enough to have health insurance. However, as this chapter explains, even if you have health insurance, your traditional employer-sponsored plan is arguably the number one threat to your financial future.

This book describes great new ways you can save thousands of dollars each year while getting better coverage than your employer offers.

The problems with our current health insurance system are deep:

- Up to 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 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 health insurance.[1]
- Tens of millions of Americans are modern-day slaves—unable to retire early, or working in jobs they don't really want, just for the health insurance they need to take care of themselves, a spouse, or a child with a "preexisting condition."
- Health insurance is a crisis for employers as well as individuals. As I write, GM is in serious trouble because health insurance adds $1,550 to the cost of every car it sells. The cost of health benefits now exceeds profits for most of the Fortune 500.
- Small businesses are the backbone of our economy, yet many of them fail because they cannot afford to pay the premiums for their group health insurance plan. Our current employer-based health insurance system is injuring American competitiveness in the world marketplace and costing jobs here at home.
- Millions of self-employed and independent contractors go without health insurance because they don't realize it has recently become affordable and tax deductible.
- American seniors who have fought wars and saved enough money to pay off their home mortgages now live with a new daily physical and economic threat—their monthly prescription drug bill. The largest monthly expense in most senior households is prescription drugs, and many seniors make the terrible choice between buying their food

or their medicine—24 percent of the prescriptions written each year are not filled because of price.*

- Many seniors who have saved up hundreds of thousands of dollars for retirement or for their grandchildren's education sadly live to see their assets completely wiped out by medical or nursing care expenses not covered by Medicare.

None of these situations should exist. Recent changes in law and new health insurance options have made it possible for most Americans to get high-quality, affordable health benefits for themselves, their families, or their employees. This book explains how.

This book also teaches you how to save $5,000 or more each year on your health benefits and create a Health Savings Account nest egg of $200,000 to $500,000 or more for your retirement or future medical expenses.

Let's get started.

What Would Happen If You Became Ill and Could Not Work?

Don't despair as you start to read this chapter about the problems with employer-sponsored health insurance. Beginning with Chapter 2, this book is mostly about solutions that you can take advantage of now.

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.

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. Employees who lose their jobs can get government-mandated health insurance coverage through COBRA for up to 18 to 36 months, but many cannot afford the high cost of COBRA, or their COBRA coverage runs out while they are still sick.

What are the chances that something like this could happen to you? There are hundreds of circumstances in which you could exceed your

*This situation will improve for many seniors with Medicare prescription drug coverage, which begins in 2006 (see Chapter 8).

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 or 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, and common injuries include fractures, broken bones, and spinal damage resulting in short- and long-term disability.[2]

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.[3]

The overweight/obese. Almost two-thirds of Americans are overweight or obese; primarily because of this, 18 million Americans have diabetes and another 41 million over age 40 have 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.[4]

Cancer, heart attack, or stroke. One in four men and one in five women will develop one of these debilitating diseases before age 65.[5]

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 their health benefits. Are you and your family prepared for this eventuality?

The Gaps in Your Coverage When You Lose Your Job or Change Jobs

Once you lose your job, you lose your employer-sponsored health insurance unless you elect to go on COBRA. As explained more thoroughly in

Chapter 3, COBRA is the acronym for the short-term extension of your employer health insurance. Basically, COBRA allows you to continue your employer-sponsored health insurance for 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).

COBRA is unaffordable for most people.

Nationally, COBRA premiums average about $700 a month for an individual and about twice that, $1,400 a month, for a family. Since total unemployment benefits average about $1,000 a month, only one in five COBRA-eligible individuals elect to go on COBRA—few people can afford to spend 100 percent or more of their unemployment check on health insurance. Worst of all, after 18 months on COBRA you are out on your own without health insurance. Yet, despite the enormous cost and lack of security, about 5 million people at any given time are on COBRA—mostly because they don't know any better or believe that they will soon get another job with health benefits.

You can get the equivalent of free health insurance for 60 days, saving you $1,000 or more, if you know the "COBRA loophole." Employers are required to offer you COBRA within 14 days of termination, and to keep their COBRA offer open for 60 days. By delaying to choose COBRA until day 59, you can get a free 60-day health insurance option while you shop around for a new employer or new health insurance or both. If, on day 59, you do elect COBRA coverage because you have had a medical issue, you are required to pay for COBRA from day 1. But if you haven't had a medical issue, you just received the equivalent of free health insurance for 60 days. (See Chapter 3 for more details on this strategy, on getting an additional 45 days of free coverage when you change jobs, and on getting 30 days of free coverage when you come off COBRA.)

You should only go on COBRA as a last resort. It is expensive, temporary, and if you should develop a health condition while on COBRA, it could prevent you from getting permanent affordable health insurance. There are much better solutions, which are all explained in this book.

If you have recently lost your health insurance (perhaps because you are accepting a new job), or if you aren't eligible for COBRA, or if your COBRA benefits just expired, you need to pay particular attention to another five-letter acronym, HIPAA, which is explained in Chapters 3 and 7. Most employers today (1) have 30- to 360-day waiting periods before

health benefits begin for new employees and (2) exclude covering employees and their dependents for health conditions that preexisted their date of employment. Yet, under federal HIPAA law, if your new employee benefits begin less than 63 days after your old benefits terminate, your new employer is not allowed to exclude you or your family's preexisting medical conditions from your new health insurance.

In many states, health insurance carriers offering individual/family policies are required to accept HIPAA-eligible applicants without any exclusions for preexisting medical conditions (although typically at a higher premium). However, if you become HIPAA-eligible you will have to act fast—your HIPAA eligibility is limited to just 63 days from the first day you lose your health insurance.

Do not depend on HIPAA eligibility alone if you are changing jobs and need insurance for a family member with a preexisting medical condition—the median length of time between jobs has increased from 56 days in 1996 when HIPAA became law to 70 days today.[6] Once you know you are changing jobs, you should apply for individual/family health insurance immediately. If you get a new job with health benefits quickly and no longer need the individual/family policy, you can cancel your policy without charge before it takes effect.

What Happens When You Lose Your Health Insurance

Once you lose your employer-sponsored health insurance, your nightmare has begun. Not only are you going to have to worry about how to pay for healthcare, you are also going to have to worry about how to get good healthcare. Many medical providers refuse to schedule an appointment for people without health insurance, and those who do agree to see you will typically charge from 150 to 500 percent of what they would have charged you or your insurance carrier had you had health insurance.

Since the 1980s, 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."[7]

The study interviewed 1,771 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 co-payments, deductibles, and exclusions in the employer-sponsored health insurance plan.

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

To protect yourself and your family, you will need to evaluate employer-sponsored health insurance and individual plans that you purchase yourself, paying particular attention to terms like *annual out-of-pocket maximum* (OOP max)—which means the maximum out-of-pocket expense you could incur in a given year from coinsurance, deductibles, and exclusions.

Many employer health insurance plans have annual OOP maximums of tens of thousands or more. You can start to see why 75 percent of medically bankrupt middle- and upper-middle-class Americans mistakenly think their health insurance will cover them.

Chapter 5 reveals how to make sure your employer plan does not have an OOP max that would send you to the poorhouse if you had to pay it and how to get disability insurance to pay your salary if you cannot return to work after an illness. Chapter 6 shows you how to build a Health Savings Account (HSA) nest egg to cover your OOP max plus pay your health insurance premiums tax-free during any period of unemployment or illness, and you learn insider HSA tricks that can add hundreds of thousands to your HSA nest egg.

How to Avoid Losing Your Health Insurance When You Lose Your Job

The best way to avoid losing your health insurance when you lose your job is to purchase your own affordable individual/family policy—just as you purchase your own auto insurance. Unlike traditional health insurance you get from an employer, loss of employment has no effect on an individual/family

health insurance policy. Also, unlike most employer/group policies, premiums on most individual/family policies cannot be increased, nor can the policy be canceled, if you become ill.

As explained in Chapter 4, the best time to buy your own policy is while you are healthy and still have your employer-sponsored health insurance. If you have a good company plan and wish to keep it, Chapter 5 explains how to choose the best options from your employer-sponsored plan and how to transfer your spouse and children onto their own less-expensive individual/family policy.

No one reading this book should ever go without health insurance. Despite what you read in the newspapers, there are health insurance options available for every American, although it may take you some time, effort, and expense to get them. In most cases, because of recent changes in the insurance industry, you can get good health insurance for an individual or a family for $150 to $300 per month. See Chapter 2 and Appendix A for details.

The Other Huge Gaps in Your Employer's Health Insurance Plan

By now you understand that employer-sponsored health insurance has some serious shortcomings:

- It offers no permanent protection when you lose your job.
- It offers only limited protection when you change jobs.
- It exposes you to serious financial risk even if you keep your job—due to low lifetime maximum benefits, not to mention hidden co-payments, deductibles, and exclusions that you learn about in Chapter 5. Moreover, as you learn in Chapter 3, if your company goes bankrupt or is taken over, federal law (ERISA) protects your pension but not your health insurance—employers may terminate company-provided healthcare at any time.

In addition, your employer-sponsored health insurance plan probably has the following disadvantages:

- It does not provide dollars to spend today on preventive care that can save you thousands of dollars tomorrow.

- It does not provide retiree health benefits if you choose to retire before age 65, and even if it does (as you learn in Chapter 8), many employers today are considering using bankruptcy and reorganization to bail out of their retiree health benefits obligations.
- It does not provide long-term or home care options if you should desire to live out your golden years in your own home versus in a nursing facility.
- It may not provide Health Savings Accounts and other new options that allow you to choose your own medical providers, lower your prescription drug costs, and save what you don't spend on healthcare today for your future healthcare tomorrow.

This book shows you how to get affordable solutions to cover all of these gaps, or to avoid the gaps altogether by buying your own individual/family policy.

How Employer-Sponsored Health Insurance Works

The term *employer-sponsored health insurance* is misleading since, basically, the *insurance* terminates when you lose your job—often the time when you are most financially vulnerable.

Employer-sponsored health insurance is also 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. That's not how employer-sponsored health insurance works. Each time an insured employee in your organization runs up large medical bills, your organization pays these costs the following year with a directly proportional increase in its annual health insurance premium.[8] The "insurance" employers pay for is actually little more than a delayed bill-paying mechanism. Because most very large employers realize this, they are *self-insured,* which means they simply pay for employee medical expenses through a third-party administrator.

In 1985 I testified before the U.S. Congress as follows:

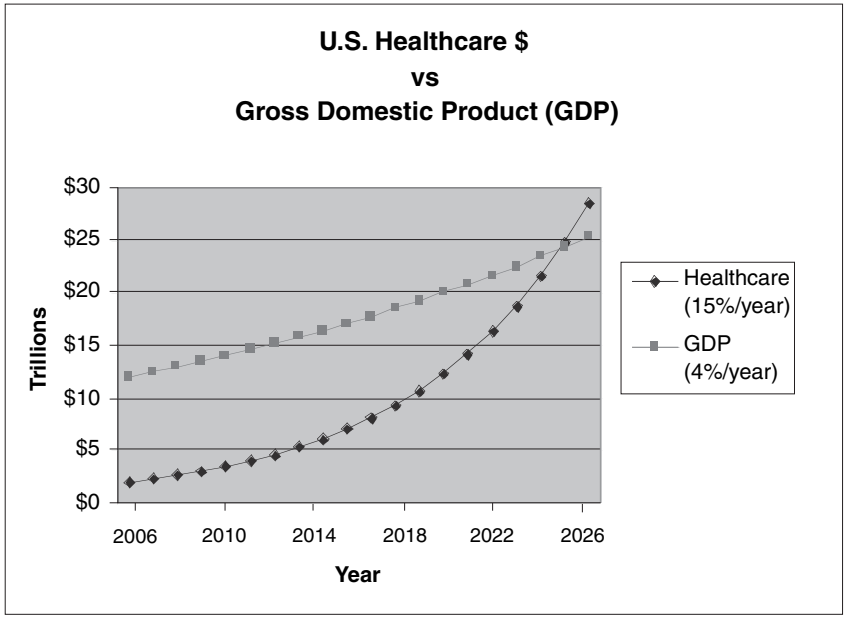
> Show me a person who owns their own 100-employee business, and I'll show you an employer who knows the first name of each child of an employee who has diabetes—even though they are not supposed to know. A small employer with a $35,000-a-year employee should not be burdened with the $75,000-a-year medical 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.

Sadly, until recently Congress has done very little to address this national tragedy. 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 kidney dialysis, can literally 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 $500,000 a year or more. Next year, the health insurance premium paid by your company will go up by $500,000. The cost of your employer-sponsored medical plan would increase more than $900 a month per participant, forcing your employer to cut benefits or possibly terminate the plan. What would happen if two people developed such a condition? Employer-sponsored group health insurance plans are ticking time bombs as their workforce ages.

Company health insurance worked well 45 years ago when most Americans worked for very large companies and for the same employer all of their life. It no longer works for employers or for employees for these reasons:

- Most employee groups today are too small to absorb the risk of a few catastrophic illnesses.
- Most people today change jobs every 1 to 4 years versus every 25 years, and they are often out of work (and thus without health insurance) for months between positions.
- Some employees pick their next job based on near-term medical requirements like pending knee surgery or heart operations. Employers providing good health benefits are under siege from desperate people who have no other place to turn for life-saving treatments.
- U.S. annual healthcare costs have skyrocketed from $27 billion, 5 percent of our economy in 1960, to almost $2,000 billion, 17 percent of our economy today.[9] In 1960 there were no heart transplants, kidney dialyses, and many other treatments that today cost many times the annual salary of an employee.
- For reasons primarily related to employers footing most of the bills, U.S. healthcare costs are rising at 15 percent per annum, almost four



times the 4 percent projected growth rate for the U.S. gross domestic product (GDP). If this trend continues unchecked, U.S. healthcare costs will exceed GDP in 18 years and will cause the collapse of the U.S. economy long before then.

How We Got into This Mess

During the Great Depression, more people began using hospitals and less of them were able to pay. In response, hospitals created Blue Cross nonprofit health insurance entities, which provided guaranteed service in return for a fixed fee—originally paid by either individuals themselves or their employers.

During World War II workers demanded wage increases that were prohibited by wartime wage and price controls. To grant a concession to labor without violating wage and price controls, Congress exempted employer-sponsored health insurance from wage controls and income taxation—in effect allowing off-the-books raises for employees in the form of nontaxable health benefits. This created an enormous tax advantage for employer-sponsored health benefits over health insurance purchased by employees with after-tax dollars (e.g., auto insurance). By the mid-1960s employer-sponsored health benefits were almost universal.

This huge government subsidy, which still exists today, results in the following:

- It allows employers to deduct from their taxable income 100 percent of the cost of employer-sponsored health benefits.
- It allows employees to receive unlimited employer-sponsored health benefits without having to pay wage or income taxes on these benefits.

Originally, employers thought providing health insurance was a great way to compensate employees, with federal and state governments paying about half the bill through a hidden tax subsidy.

With third-party employers and government footing the consumer's medical bill, the medical industry was given free rein to develop thousands of new treatments. Some of these were powerful, but others were not economical or merely preyed upon the hopes of desperately ill people and their families. Another problem that drove up costs was that the pharmaceutical industry began inventing solutions to problems that weren't previously defined as medical issues: prescription drugs to allow people to eat bad foods, Viagra to treat impotence caused by old age, and so forth. By classifying these solutions as "prescription drugs" rather than over-the-counter medicines, the pharmaceutical industry was able to sell them to consumers with a 50 percent tax subsidy through their employer-sponsored health insurance plans. The American taxpayer was thus forced to provide billions of dollars in unintended tax subsidies to the pharmaceutical industry to develop these lifestyle drugs, driving up costs for everyone.

As a result of this and other problems, U.S. healthcare costs, funded mostly through tax-free employer-sponsored health benefits, rose from $27 billion in 1960 to about $2,000 billion today. Today the cost of employer-sponsored health benefits exceeds profits for most large companies and threatens the viability of many of our best employers. In 2004–2005, despite a rising Dow over the same time period, GM's value dropped 50 percent after the company announced a $60 billion healthcare obligation.

Looking back, by making employer-sponsored health benefits tax deductible, Congress created more problems than just escalating medical costs:

- 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 employer health benefits 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.

- The U.S. insurance industry has been preempted from developing affordable health insurance policies that could be sold direct to all consumers—just as it did with automobile insurance, homeowner's insurance, and life insurance.
- Employers and insurance companies 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.
- As the average length of employment fell from 25 years to only 1 to 4 years, employers and their insurance carriers shifted to paying for short-term fixes versus long-term cures—treating the symptoms of disease instead of curing disease. Most of the major illnesses on which you can spend $1 today to save $100 in the future (e.g., 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 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-sponsored health insurance and individual/family health insurance policies that you purchase yourself.

The New Health Insurance Solution: How We Are Getting Out of This Mess

Millions of working Americans believe that the only way they can get health insurance is from their employer. Until recently, their belief was accurate. But in the past few years, a quiet revolution has changed the health insurance options available to employees, self-employeds, and small businesses:

- *Individual/family health insurance has become cheaper and safer than traditional employer health insurance*. When my employer-sponsored

policy (described in the preface) was canceled, I purchased an individual/family health insurance policy directly from the Blue Cross Blue Shield carrier in my state. This policy saved my family more than $4,000 each year in annual premiums and was much safer than my previous employer policy. Other than normal cost-of-living increases, our premium could not be raised, nor could our policy be canceled, because of job loss or a catastrophic illness.

- *Health Savings Accounts are now available.* The individual/family policy I bought qualified me to contribute up to $4,500 a year tax-free to a Health Savings Account (HSA) for preventive care and for future medical expenses. However, at that time very few people qualified for Health Savings Accounts (at that time they were called "Medical Savings Accounts").

  In 2004, Congress made Health Savings Accounts (HSAs) available to all Americans with high-deductible employer-sponsored health insurance or their own high-deductible individual/family policy.[10] Despite the higher deductible, HSAs save most consumers thousands of dollars each year. They also provide funds for preventive medicine, and allow you to save tax-free for your future medical expenses or even retirement. Individual/family policies that qualify for an HSA are now offered in almost every state, and 70 percent of the largest U.S. employers have announced plans to offer them to their employees.

- *Premiums for self-employeds are now tax deductible.* In 1999, when I purchased my individual/family policy, the annual premium was not fully tax deductible even though I was self-employed. It seemed terribly unfair that health insurance premiums were 100 percent tax deductible for businesses offering group health insurance, but not for self-employed individuals. But, beginning 2003, Congress authorized a 100 percent income tax deduction for health insurance premiums for self-employed people.

- *New Health Reimbursement Arrangements (HRAs) are now available for individual/family health insurance.* Prior to 2005, government and insurance regulations prohibited employers from reimbursing employees for individual/family premiums. But the IRS now allows Health Reimbursement Arrangements (HRAs) whereby employers can reimburse their employees tax-free for amounts spent on individual or family health insurance premiums.[11] As you will learn in Part II, these types of changes mean that businesses can now get out of their health insurance nightmare while still enabling their employees to obtain high-quality health benefits.

Three Trends behind the Changes

These and other changes are part of three major trends that are reforming U.S. health insurance. These trends are not dependent on Congress passing any new legislation or public policy—the legislation and regulations for them are already in place. The three trends are:

1. *Consumer-directed healthcare is making increasing inroads.* Health Savings Accounts are part of a much larger movement called *consumer-directed healthcare* (CDH), whereby individual patients choose their medical provider or service, and patients get to keep what they don't spend, tax-free, for future medical or retirement expenses. CDH also means that employers are shifting a larger percent of the healthcare burden to employees, especially employees with an unhealthy family member. CDH products and services are already incorporated into most employer-sponsored healthcare plans and individual and family policies. All types of health insurance will have CDH features within five years except for some existing union-type plans that have fixed contractual obligations.
2. *Individual/family insurance is replacing employer-sponsored health insurance.* Employer-sponsored group health insurance will decline over the next 10 years and be mostly eliminated within 20 years. Instead, employees will be given tax-free money to purchase their own individual or family health insurance policies. Government programs to protect the unhealthy and the indigent, and to provide limited coverage for the uninsured, will be expanded as health insurance responsibility is shifted from employers to individuals and government.
3. *Defined contribution plans are replacing defined benefit plans.* To accelerate the first two trends and to keep from going bankrupt, employers are shifting from paying the direct cost of employee health insurance (*defined benefit plans*) to giving each employee a fixed annual healthcare allowance (*defined contribution plans*)—and requiring that every employee obtain private or government-sponsored health insurance in order to receive this tax-free benefit.

The objective of this book is to teach you how best to take advantage of these trends to enable you to better protect your family and save money.