

Appendix B

Inherent Dysfunctions in Health Insurance

The dysfunctions in using the health insurance industry are not problems caused by ill-intentioned people or the lack of regulation. Although there are some obvious problems with greed and abuse, overall, the problem is that health insurance is an economically dysfunctional way to pay for health care expenses. These dysfunctions have resulted in the U.S. health care system being far more expensive than any other health care system in the world, and bringing U.S. health care expenses down to their expected level will require a model like Balanced Choice that moves away from using traditional health insurance to fund health care.

Two excerpts from *Balanced Choice: A Common Sense Cure for the U.S. Health Care Systems*¹ describe the dysfunctions that are inherent in health insurance. The first excerpt is from Chapter 2—Making sense of health care financing, and the second is from Chapter 10—Health Care Insurance is Obsolete.

from Chapter 2—Making sense of health care financing

The Insurance-Driven Health Care System

In World War II, due to an accident of history, employers began paying for health care insurance.¹ Because of a federally mandated wage freeze, employers could not attract new employees with higher salaries. To compete for desperately needed employees, they began offering fringe benefits, which were exempt from the wage freeze. These fringe benefits included health insurance. America began its tradition of having employers take a primary role in providing health care.

Since its beginning during World War II, insurance-driven health care has become the dominant way of financing health care. In the doctor's office, often the first question following, "What is your name?" is, "What is your insurance company?" Currently, some insurance is provided by employers, some is purchased by individuals, and some is funded by the government. Most people have come to believe that having traditional insurance is the only way they can have health care security. Indeed, until the 1980s, when health care cost escalation forced the movement to managed care, insurance-driven health care was a good option.

In many parts of the economy, insurance functions well. When insurance works, it spreads the risk of a catastrophic event. Take for instance, the possibility that fire could burn someone's home. This might happen to one out of a thousand people. If all thousand people pool a small amount of their money in an insurance company, when the one-in-a-thousand homes burns to the ground, there is money to rebuild the home. This is the legitimate business of insurance—spreading the risk of a large unfortunate event.

In health care, insurance is different than in other areas of the economy. It not only spreads the risk of a catastrophic event, but also is now considered the way to pay for most health care expenses. Doctor's visits, medications, and routine lab tests are paid by insurance as well as the costs of catastrophic illness. Instead of merely spreading the financial risk of catastrophic medical expenses, insurance became a prepayment system that covers all health care.

Because health insurance pays for most care, it has created a major problem in market dynamics. Insurance coverage has caused consumers to lose their cost consciousness. If people have insurance, they often say, "I don't care how much it costs, insurance is paying the bill." When most of the people say cost does not matter, fees escalate unreasonably—no one is comparing prices like they do in a healthy market system. This

¹ Miller, I. J. (2006). *Balanced Choice: A Common Sense Cure for the U.S. Health Care Systems*, Bloomington, ID: Authorhouse.

loss of cost-consciousness is generally considered to be the cause of the price escalation in health care before the advent of managed care.

In insurance-driven health care, patients ask for the highest quality care and readily available care. Thus there are market dynamics that improve quality and accessibility. The consequence of insurance-driven health care is a rapidly growing, high-quality health care system with great accessibility to a patient's chosen provider. But, as mentioned above, the dynamics lead to an excessive rise in costs that is unsustainable.

Insurance-Driven Market Dynamics



Understanding how insurance does *not* work for financing health care is essential to curing the system. When insurance sticks to the business of insurance, spreading the risk of a catastrophic event, prices in the marketplace are not affected. To return to the example of the one-in-a-thousand homes burning down, the cost of new homes in general does not go up just because the family rebuilding the burned home says, “We don’t care how much it costs because insurance is paying the bill.” The cost of homes and repairs, as well as homeowner insurance would increase unreasonably if homeowner insurance paid for all home related expenses the way that health insurance pays for all health related expenses.

This problem can be further clarified by imagining what car insurance would be like if it were used to finance all expenses related to automobiles. Insurance would pay for gasoline, oil changes, new tires, and repairs, in addition to major accidents. Not only would the insurance cost be enormous, but also the cost of routine items—gasoline, tires, oil changes, new tires, and repairs—would rise sharply, as consumers would say, “I don’t care how much it costs because insurance is paying the bill.” Quality would rise and the availability of services would improve, as consumers would want high quality and convenient access. Soon, the cost of automobile insurance would be out of sight. Due to the high cost of automobile-related expenses, many consumers would be unable to afford to operate a car without insurance, and often unable to afford the insurance.

Third-Party Managed Care: An Attempt To Fix Insurance-Driven Health Care

In the 1980s, double-digit inflation in health care caused the nation to realize that insurance-driven health care systems were unsustainable. Consumers had lost cost consciousness, and price escalation of insurance was unbearable for employers. The attempted solution was to add managed care. Because conventional wisdom had abandoned the idea of restoring cost consciousness in consumers, it was incorrectly assumed that managed care was the answer. It has now become the dominant form of health care in the United States. Managed care, unfortunately, continues to undermine cost consciousness by promising consumers that their only financial responsibility is to make small copayments.

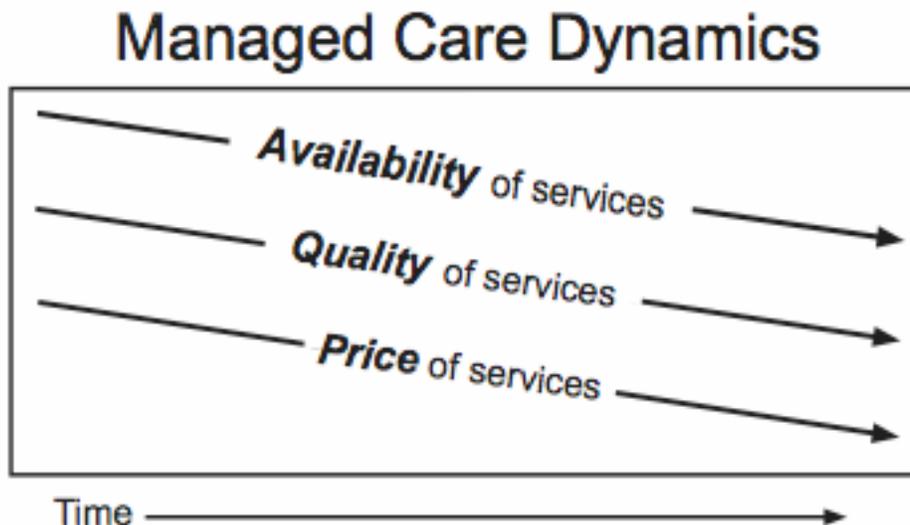
Although managed care temporarily contained price escalation, it created its own set of problems. It is extraordinarily expensive to operate. It requires organizing an extensive network of providers and developing bureaucratic systems to control the providers. Although it has been successful at cutting costs, it has accomplished this by compromising quality and accessibility.

One needs to use imagination to think of an example of an economic system similar to managed care. Imagine having groceries managed. In the managed grocery system, employers would assign their employees to a grocery store that decided how much food and what kind of food each member could consume. The store would use secret proprietary policies to determine which foods were worth the cost. Consumers would make a flat copayment each time that they went to the grocery store.

Undoubtedly, these managed grocery stores could provide nutritious food for all of the members. Indeed, these stores could prevent people from gluttony and poor food choices. Starvation would not be a concern because of government regulation and the public outrage that would result if the managed grocery store did not feed its members. However, it is doubtful that these privately managed grocery stores, each striving to lower costs and increase profits to shareholders, would provide the abundant and plentiful quantities of choices that are available in the current free market grocery stores.

Managed care operates differently than the large group or cooperative, which obtains lower costs with their purchasing power. In a cooperative or group purchase, consumers are free to use the cooperative or to purchase goods and services elsewhere. In order for managed care to have enough power to lower prices to the degree necessary in health care, it also needs control over consumer health care decisions. It tells consumers which providers can be seen and what services will be covered.

While managed care is powerful in cutting medical costs (the added costs of administration, marketing, and profit-taking are discussed elsewhere), it creates unhealthy market dynamics. Once consumer choice is gone, providers are no longer solely responsive to patients and are pressured to serve the managed care company. Managed care companies have earned a reputation for creating barriers, hassles, and frustrations that prevent patients from obtaining high-quality treatment, and that restrict the availability of providers.



How does managed care hurt quality and accessibility?

Market-based managed care advocates hoped that managed care would merely lower costs reasonably without also lowering quality or undermining accessibility. Managed care has not achieved this ideal, and for several reasons, it does not seem possible that it ever could. First, it is much easier to measure cost than changes in quality or accessibility. Those who operate managed care, even if well intentioned, can always demonstrate a savings in cost even if it is only a penny. They cannot, on the other hand, quantify the impact

of small changes in the intangible aspects of quality or accessibility. Difficulties finding an acceptable or compatible doctor, the subjective feelings of discomfort, or the bedside manner of providers are not as measurable as money. The result is that cost trumps quality and accessibility. Second, the managed care companies do not have interests aligned with patients. The officers of managed care companies care more about pleasing stockholders than maximizing the health of patients. Third, a managed care company needs to make decisions for the typical patient, and as a result, errs in the tendency to select one size to fit all.

Managed care companies are aware of their potential negative impact on health care, and propose complex mechanisms to maintain quality. They suggested that scientific and computer analysis of outcomes would be used to assure that managed care companies compete to have the highest quality services and the best access to services. While computers and science are wonderful, the complex measurement, evaluation and competition system is not enough. Data and outcome systems often can be manipulated to give the illusion of quality care. No matter how managed care companies are measured, their tendency to undermine quality and interfere with accessibility continues. Later in Chapter 11, "Patching-up Insurance Driven Health Care," the many reasons why such systems cannot work will be explained.

Can competition save managed care?

When the managed care scheme was invented, it was promoted as a system in which the managed care companies would compete for quality and accessibility. Competition among managed care companies is supposed to counterbalance the dynamics that lead to declines in quality and accessibility. To make competition work for consumers, consumers need real choices over selecting and changing managed care companies, and they do not have this choice.

Employers, not consumers, usually select the insurance or managed care company, and they have a different agenda than consumers. To switch managed care companies, employees must either change jobs or hope that the employer responds to employee requests for a different managed care company. Changing insurance coverage might require changing providers, thus disrupting important provider-patient relationships. Even when consumers individually purchase their own insurance, pre-existing conditions usually are not covered for a period of a year, and sometimes even excluded. Individuals with pre-existing conditions are often much better off "stuck" with a poorly performing managed care company than with a new company that will exclude coverage for their health needs.

It is so impractical for consumers to change to another managed care company that they are, in effect, trapped with their insurance plan. With captive customers, managed care companies may dictate the cost and conditions of service. Managed care companies also dictate to patients which doctors can be seen and what kind of service is authorized. Because consumers have lost their freedom to choose another managed care company, competition does not prevent a decline in quality and accessibility.

The negative effects of managed care are not merely hypothetical; they are something that many consumers have experienced. Patients already have run into the problems in managed care. Indeed, many consumers and providers have stories to tell about how they had to battle to get needed health care. At times it may take a persistent, well-informed, energetic, and assertive patient or patient advocate hours of struggle with a managed care company to obtain needed care.

Can managed care be fixed so that it does not harm the quality of care?

Can managed care be fixed? The answer is yes, but only partially and at a great expense. A regulatory structure can provide some protection for patients. A complex and expensive appeal system, with professional advocates, could represent patients who are not able to fight the battle themselves. A complicated system of quality controls can be established. The problem is, of course, that if regulation is added to control the excesses of managed care, then managed care becomes increasingly more expensive. As it is more expensive, one has to question whether it adds enough value to make it worth the cost. The most expensive health care system in the world becomes even more expensive.

Chapter 10 Health Care Insurance Is Obsolete

Summary: The health insurance industry is an obstacle to health care reform. In order for meaningful health care reform to occur, the problems with the health insurance industry need to be recognized and confronted. Insurance caused the cost-escalation in health care and created the noxious managed care industry. It has financial incentives to shun the seriously ill patients, makes cost comparisons unwieldy, does not have incentives for good service, and inhibits consumer choices. The inherent dysfunctions in the insurance-driven health care system cannot be fixed in an economical or effective manner. Overall, health care insurance does not add enough value to justify its cost. Since Balanced Choice can overcome the problems in the insurance-driven health care system while costing less money, Balanced Choice can render health care insurance obsolete. Proposals are offered for retraining the health care insurance industry personnel.

The health care insurance industry is the elephant in the room where health care reform needs to take place. Many of the problems in health care financing are a result of funding health care through insurance companies. The health care system cannot be cured unless the problems in the health insurance industry are recognized and confronted.

The health insurance industry is the sixth largest lobby in the country.ⁱⁱ Perhaps because of the industry's power, too many people avoid facing the inherent weaknesses of health care insurance. When Clinton, as a popular President of the United States, tried to reform health care, the insurance industry ran the infamous "Harry and Louise" commercials that killed the Clinton proposal with ridicule within a few weeks. Never mind that Clinton's proposal was a flawed proposal with many other enemies. Having the insurance industry for an enemy was considered the deciding factor. Ever since, politicians and health care advocacy groups have acted as if they are afraid to anger the insurance lobby or as if they are resigned to being in a powerless position.

The question, though, is not whether it is easy to face the insurance lobby. The questions are, what are the real problems and how can they be fixed? Although historically health insurance served a purpose in striving for health care security, it is now becoming obsolete. Health care insurance has fundamental inherent problems that cannot be effectively or efficiently corrected.

Cost-Escalation and Managed Care Are the Result of Insurance-Driven Health Care

Chapter 2, "Making Sense of Health Care Economics," explains how health care insurance undermines consumer cost-consciousness and, consequently, has caused the price of health care to escalate. In an attempt to control cost escalation, the managed care industry was invented. Although managed care has partially controlled medical costs, it has increased administrative costs greatly and harmed the quality and the accessibility of treatment, not to mention aggravating most people who deal with it. Because Balanced Choice does not cause cost escalation and because consumers retain cost-consciousness, there is little need for the expensive and administratively cumbersome managed care system.

Insurance Has Incentives to Shun Seriously Ill Patients

In healthy markets, if people make a better product, they prosper. They attract new customers who want that product, and they make a profit from each customer. In insurance, the incentives are to shun the seriously ill customers, the ones who need insurance the most. A better product, an insurance policy that offers better coverage, can lead to increased losses. This happens because not every customer results in a profit. Healthy people provide the insurance company a profit, while people with expensive illnesses cause a loss instead of a financial gain. If an insurance company offers better products for covering serious illnesses, it attracts people with serious illnesses and high medical expenses. Insurance has invented a term for this phenomenon. It is called adverse selection.

To deal with adverse selection, insurance companies have tried to control who can purchase each insurance product so that few seriously ill patients can enroll. Companies attempt to insure only healthy people who will not need much medical care and attempt *to avoid people who are likely to get sick*.

One way to avoid excessive adverse selection is to insure large groups in which there are mostly healthy people, like groups of employees. In these large groups, people with serious illnesses cannot enroll merely because they want insurance, so the insurance company is protected from adverse selection.

The insurance industry is most vigilant about avoiding people with illnesses when it sells individual plans. If a person has any serious illness, the cost of treatment will exceed the money the individual paid to buy the typical insurance policy. No insurance company wants to sell an insurance policy for \$3,000 to a person with \$6,000 of medical expense. Therefore, individual policies usually have extensive screening or underwriting examinations that are used to identify people with high medical needs. If the applicant is accepted and covered, individual policies often exclude coverage for a patient's preexisting conditions.

Once people have a serious illness, no insurance company wants to cover them. In Colorado, they are called "the uninsurable" and there is a basic-health-care insurance policy that they are allowed to buy. The cost is high enough, however, that many cannot afford it, especially those who have had their income reduced by a serious illness.

The idea that people who are likely to get sick should pay more for their insurance does not make sense in a health care *security* system. Is illness a failure to be responsible? Sometimes behavior leads to illness, but not always. Asking people who are ill to spend more for insurance is not spreading risk—it is avoiding risk. Moreover, the idea of trying to avoid people who are ill is bound to leave some people out—the uninsured and the uninsurable.

Insurance companies will always avoid insuring people with serious illnesses. It would be fiscally irresponsible to insure them. Quite simply, profits increase more by avoiding enrolling people with illness than by spreading the financial risk of illness over all people who want to enroll.

To entice insurance companies to insure the ill, there have been proposals to have the government subsidize the insurance of people with specific illnesses so that they can then buy insurance. Does it make sense to subsidize insurance so that they do not need to do their job of spreading financial risk? What is the value of insurance then? Such a system would become one in which insurance companies' success depends on obtaining the most lucrative government subsidies.

Balanced Choice, on the other hand, covers everyone. Because everyone is covered by one system, adverse selection does not occur. Balanced Choice does not waste money developing systems to avoid adverse selection. For less money, it does the job that insurance cannot do; it spreads the financial risk of treating illness and injury over all members of society. It creates health care security.

Insurance Makes Cost Comparison Unwieldy

Balanced Choice can rely on consumers being cost conscious because it makes cost comparison information easily available. Balanced Choice standardizes the cost of health care. Standardizing how to compare costs is important in all areas of the economy. In grocery stores, unit cost (e. g. cost per pound or ounce) is usually the appropriate way to compare the costs of various foods. In Balanced Choice, the pharmacy price list shows the cost of the standard dose of medications and the amount of gap payments required. An Independent Plan provider's fees are a percentage of the Standard Plan fee so one provider can be compared with another. Balanced Choice develops appropriate ways to compare costs.

Insurance companies do not have the same option to standardize costs. Standardization requires that there is one standard pricing system. Different insurance companies, however, negotiate different fee schedules with providers. Providers often work for many insurance companies. Negotiated fee schedules can change at any

time. Providers could not keep accurate gap payment information readily available for consumers in such a system. Such a system would have so much information that consumers would find it unwieldy to track cost comparison information, and their cost consciousness would be undermined.

Insurance has been trying to restore cost consciousness in consumers. Nevertheless, whatever cost sharing or incentive system insurance develops, it is not as direct as having consumers make the gap payment. Balanced Choice, on the other hand, is effective in maintaining consumer cost consciousness and using price comparisons to control health care costs.

Prepayment plans give poor service

Today's health insurance is not just a way of spreading the financial risk of treating serious illness. It has become a way to prepay for health care. A problem with prepayment plans is that marketing promotions tend to exaggerate the policy's benefits. The financial incentive of the insurance company is to minimize the money returned to consumers. It is like buying a warranty. It looks good when it is purchased, but trying to cash in on the warranty can be filled with hassles and restrictions.

Dealing with insurance companies involves numerous hassles. Phone contact with the company requires negotiating a lengthy telephone tree and spending time on hold listening to recordings stating, "Your call is important to us." Accessing information on web sites can be equally frustrating and ineffective.

The rate of errors in processing claims is impressive. It is difficult to imagine that insurance companies could have so many errors unless they had an incentive to mismanage claims. They do. I call this profitable incompetence. Every dollar not paid out to beneficiaries because of incompetence is a dollar that can go to profit the insurance company.

Aside from incompetence, insurance companies have volumes of proprietary rules and procedures that are intended to limit the amount they pay. Insurance policies and policy manuals are too difficult for most consumers to understand. In fact, I have a Ph.D. and am an expert in insurance, and I cannot tell what an insurance company will do by reading their promotional material, policies, and policy manuals. In practice, there are too many ways that the devilish details can restrict payment.

In any prepayment system there will always be a financial incentive for profitable incompetence or fine-print restrictions on payments. To counterbalance these incentives, it will take even more extensive regulation of the managed care industry than we have today. This regulation will be expensive, cumbersome, and, still, there will be cracks in the regulatory system. Once an insurance company has the money, the financial incentive will be to find ways to keep from returning it to consumers. Consumers and providers who deal with insurance have the experience to know this is true.

Balanced Choice does not have hidden proprietary rules. As a public system, information is transparent and the details of the benefits are available. The rules would be available over the Internet and in hard copy. Independent publishers could write manuals clarifying how to understand what is covered and what is not. There would be no surprises hidden in the fine print of individual policies. As a public system, the incentive is for proper administration, not profitable incompetence. Advocacy groups, the media, elected officials, the Consumer Health Advocacy Organization, and ordinary citizens could expose policies and practices that resulted in mismanagement or other problems.

Patients do not have real choice in selecting health insurance

In a functional market, consumers need to have the option of changing policies when they are dissatisfied; however, this is not the case with health care insurance. If the insurance company does not perform as promised or desired, there is often little a consumer can do to change insurance plans.

When the insurance policy is through an employer, the employee must often change jobs to change insurance. A few companies allow annual choices of different insurance plans, but within the year an

employee is stuck. If the company has only one policy, employees need to wait until the company receives so many complaints that it will go through the long and difficult process of finding a new insurance policy and educating all employees about the change. In the end, the new plan is likely to perform as badly as the old plan.

Individuals who have serious illnesses or injuries are most likely to experience problems with insurance, and they also have the most difficulty changing plans. Because of adverse selection, a new company would want to exclude covering the illness because it was preexisting. This exclusion is sometimes for one year and is sometimes permanent. The people who most need health care are the most trapped by the insurance system. What incentive does an insurance company have to make sure that its captive customers receive the best service? The incentive is actually the opposite; it is to the advantage of the insurance company to get rid of patients with multiple claims rather than provide the expensive treatment coverage.

Some people believe that the solution is to get into a good policy when healthy and keep the policy so they have coverage if illness strikes. Unfortunately, the future is hard to predict. Today's good insurance company may run into financial problems or change management at any time. When people believe that they discovered an insurance company that is really above average in performance, experience warns that the situation may change in a few of years. Often, these high-performing companies have a change in management that results in more restrictive payment policies. The financial incentives are powerful and continuously operate to restrict payments.

In Balanced Choice, both consumers and providers always have the choice to switch plans. This choice keeps Balanced Choice responsive to the market and to the experiences of consumers. In contrast, insurance companies must be responsive to their stockholders.

Insurance Does Not Have a True Incentive for Prevention

Managed care has promoted itself as the type of health care that promotes prevention of health problems. This is only true in the most limited sense. Managed care has some high profile ways to emphasize prevention. These showcase services such as mammograms, screenings, and vaccinations have been used to give the illusion of a total philosophy of prevention. The reality is that the financial incentives work against prevention.

Managed care has claimed that prevention actually saves them money, and therefore, it has a financial incentive for prevention. This was the mantra of Kaiser in its early years. It was based on the belief that Kaiser would be responsible for its members for their lifetime, so Kaiser would be interested in reducing the life-long costs of providing health care. The current reality is that consumers often change employers and employers often change insurance companies. If a prevention effort does not reap financial rewards within four or five years, there is no incentive—another company would receive the financial benefits of illness prevention.

This lack of incentive for prevention services is apparent even in Kaiser Permanente, a leader in promoting prevention services. Mental health services have been shown to have tremendous value in preventing disability, decreasing unnecessary visits to medical services, decreasing the need for hospitalization, and in preventing the need for future mental health and physical health services.ⁱⁱⁱ Mental health treatment's value prevention of physical health problems outweighs its cost. Yet Kaiser has limited mental health services because it requires its staff to maintain such high caseloads that they must limit patients for a few sessions.^{iv} Meaningful outpatient psychotherapy is almost impossible to receive in their program. If Kaiser had an incentive to pursue the extended benefits of prevention, it is doubtful that they would put so little value on mental health services.

Balanced Choice has an incentive for both short-term and long-term prevention. Because everyone is in the system from birth to death, the system will receive the financial benefits of all prevention services, without the concern that patients could switch to a different insurance plan.

The Enormous Insurance Bureaucracy Does Not Add Value

The real question in a market is whether a product or service adds enough value to justify the cost. The insurance-driven health care system has created, by far, the most expensive health care system in the world. It is also far from the best. Where is the value?

Although some argue that insurance adds some value, is it enough value to justify the time and money costs of administrative expense, indirect provider expense, frustration, consumer time, and employer time? If it does not add enough value to justify the cost and there is a better system, insurance is obsolete.

Can There Be a Mix of Insurance and Balanced Choice?

What if there were a mix of health insurance and Balanced Choice? For example, what about Balanced Choice replacing government programs and providing health insurance for the uninsured, while employers continue to provide insurance? Such a system would avoid confronting the health insurance industry.

It would not work. A double system would undermine many of the benefits of Balanced Choice. It would change Balanced Choice from a health care security system to another insurance company. Balanced Choice would lose its ability to reduce costs. Employers would continue to carry the major burden of health care expenses. The system would not achieve any savings, and the most expensive health care system in the world would become even more expensive.

It does not fix the problems in health care financing to keep insurance along with Balanced Choice. Balanced Choice works because it replaces the hodgepodge of systems with one system. *Balanced Choice is not just another insurance company. It is a national health care security system.*

Can There Be Gap Insurance in Balanced Choice?

In the short-term, gap insurance may seem appealing to those who want the best health care without any out-of-pocket expense. It may also appeal to providers who imagine that it will allow them to charge whatever they wish without discussing costs with consumers. However, to maintain consumer cost consciousness, gap payments need to come from the consumer, not a third party. If there were gap payment insurance, the Independent Plan prices could escalate beyond what consumers could afford without insurance. It would restore insurance-driven cost escalation. This defeats the purpose of making the Independent Plan affordable, and undermines the market forces that come from consumers comparing cost versus value.

Whoever pays the piper calls the tune. If a third party, an insurance company, is paying for the gap, all of the dysfunctional health insurance dynamics would be restored. Gap insurers would divide the risk pool and seek out healthy beneficiaries while avoiding people with illnesses. The size of gap payments would be determined by insurers, not patients, and providers would again need to negotiate with insurance companies. Patients would be trapped once they became ill because no other insurance company would want an ill beneficiary. Insurance companies would have an incentive to avoid gap payments and develop complex procedures and regulations regarding payment. Managed care might be imposed to control cost escalation.

Balanced Choice makes health insurance obsolete only by completely replacing it. This is an either-or choice, either the health insurance mess or Balanced Choice.

Is Any Health Insurance Possible with Balanced Choice?

There is a possible form of insurance that could be purchased by consumers who want additional security if they become ill. It could be designed in a similar manner to disability or life insurance. If a consumer were diagnosed with a serious illness, the consumer could be paid either a monthly stipend during the illness or a lump sum payment as in life insurance. This money could be used at the consumer's discretion for any expenses including loss of income, gap payments, or any other purchase. The consumer would be in charge of how this money is spent. This kind of insurance could be offered with a Balance Choice system because it would not undermine cost consciousness.

Another type of insurance could pay for non-covered services. This might include experimental treatments or non-traditional treatments. This type of insurance would not undermine Balanced Choice.

How Can Health Care Insurance Be Eliminated?

It may be unconstitutional or at least un-American to outlaw health care insurance. It would be more appropriate to legislate that health care insurance plans should be primary payers, and that Balanced Choice would be secondary, only paying after health care plans paid their full amount. This would make health care insurance financially unreasonable. In essence, health care insurance would no longer lower the consumer's portion of health care expense, but it would only lower the portion paid by Balanced Choice.

Employee retraining and an insurance buyout might be necessary

Eliminating health care insurance would benefit many people but it would cause unemployment for many workers in the health care insurance industry. Some of the insurance employees could be retrained to provide jobs delivering health care to the millions who were previously uninsured or to providing prevention and educational services. The lowered health care expenses would be an economic stimulus for American businesses, and this would provide additional jobs. Establishment of a safety net for unemployed insurance industry workers would be appropriate.

It is difficult to decide what to do with the stockholders of insurance companies. They might redirect their resources with a creative business plan that allows them to thrive in another area. In a capitalist society, some industries become obsolete and this is part of the risk investors take. Typewriter companies and horse buggy companies have faded or retooled when technology has made them obsolete.

On the other hand, the insurance industry has great power and influence, and it may be necessary for the government to give it financial compensation. A buyout would be less expensive than the continued government subsidies and wasted consumer dollars that are used to support this obsolete industry. A buy out, however, is a political question, and ultimately, the American people need to decide if and how much they will pay to remove the elephant from health care reform.

Conclusion

The insurance industry is huge. It could be considered the owner of health care. However, it does not effectively accomplish the goal of health care security and does not add enough value to justify its financial burden on the American people and employers. It is obsolete, and in any real health care reform proposal, it needs to go. Programs can be developed to address the needs of the employees and owners of the insurance industry.

Chapter 2. Making Sense of Health Care Economics

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