HEALTH INSURANCE
Discussion Guide

INTRODUCTION: Americans all want everyone—regardless of their health status, financial condition, age, or sex—to be able to obtain health insurance they can afford that gives them access to the health care providers they need. Concern that too many Americans faced a challenge in obtaining insurance was one reason why people supported the Affordable Care Act.

To start this conversation, take the quiz to see what you know about health insurance in the United States.

1: Most people in the United States get their health insurance from?

A. Most people do not have health insurance in the U.S.
B. Buying it on their own from an insurance company
C. A government program, like Medicare or Medicaid
D. An employer-sponsored plan or health benefit at their job

ANSWER: D – Most Americans with health insurance obtained it through their employer. According to Gallup, a plurality of adults in the U.S. (46.8 percent in 2009) got health insurance through their job, or through the job of a spouse or parent. Only about 11 percent of people bought their own insurance. About 15 percent of the adult population was uninsured, and the remainder obtained insurance through government programs.

2: Have employers always paid for health insurance?

A. Yes, always
A. No, only since the Industrial revolution
A. No, only since the early 1900's
A. No, only since the WWII era

ANSWER: D – No – Employers only starting sponsoring health insurance mid-century, during the World War II era. Health insurance used to be bought just the way car insurance or other insurance is bought now: by individuals, directly, to cover their excessive risks. But WWII was expensive, so income taxes got very, very high. Since our tax laws exempted compensation that paid for health insurance, employers could help employees avoid some of that tax by providing health insurance with pre-tax dollars. Employers can use a portion of what they would have used to pay employees for

insurance, and employees don't have to pay taxes on that part of their compensation.

Over time, to shift more and more employee compensation into pre-tax dollars, insurance grew beyond covering the risk of high, unforeseen out-of-pocket expenses, into something that isn't really insurance at all, but a pre-paid system for expected expenses, like checkups and medications. That has made it very expensive. (Imagine if your car insurance paid for gas, windshield wipers, and oil changes.)

3: People who get their insurance through their employer or union pay for it with pre-tax dollars. Do people who buy insurance through the individual market get the same tax benefit?

A. Yes
B. No

ANSWER: B – No. Those buying insurance on their own have to use after-tax dollars, which makes insurance a lot more expensive.

4: Employers paying for insurance sounds like a good thing. But what is the downside?

A. Less competition among insurance companies (because there are fewer buyers, or fewer decision-makers).
B. People lose their insurance when they change jobs. This contributes to the problem of pre-existing conditions now not being covered.
C. Fewer and more expensive choices on the individual insurance market.
D. All of the above.

ANSWER: D – While that may sound like a good thing, employer-centric insurnace actually has caused some real problems. Insurance markets became less competitive—instead of answering to individual insurance holders, insurers focused on pleasing big businesses—and when people changed jobs, they lost their insurance. Those who didn't get insurance through their employer were at a particular disadvantage: They had fewer, more expensive options, and especially if they had pre-existing conditions, insurance could be hard to obtain.

5: Before ObamaCare, most health regulation was left up to states. Often, states decided to mandate that particular treatments or health services be included in everyone's health plan. Which of the following is true of coverage mandates?

A. Average premiums were about the same across states, regardless of the number of coverage mandates

B. States with fewer coverage mandates had higher average premiums
C. States with more coverage mandates had higher average premiums

ANSWER: C – States with more coverage mandates had higher average premiums. This makes sense since covering more services makes health insurance more expensive. Sadly, lawmakers' decisions about which services to mandate for coverage were often politically motivated and had little to do with public health or effectiveness. Just imagine: Any group of specialists has the incentive to lobby that their services be mandated for coverage. This would increase the chance that people use those services and bring them business.

.

6: Some people say the United States should turn health costs over to the government and create a universal "single-payer" insurance system like some other countries have. Often, these people believe that the United States currently has a free-market health system where most of the spending is in the private sector. But what's the truth?

A. America already has a single-payer system, because all of our premiums are paid to the government.
B. America has a free-market in health care, because private insurance companies control health care.
C. America has no government involvement in the payment of health costs.
D. America has a complex web of many payers, including insurance companies and the government.

ANSWER: D – America has a complex web of many payers, including insurance companies and the government. In describing our health care system, it's important not to confuse the terms "private" and "free-market." While private insurance companies exist in the United States, they do not freely compete; they are tightly regulated (and subsidized) by the government. Even before ObamaCare, the government controlled about one out of every two health care dollars spent in the U.S. The U.S. government already spends more than $4,000 per year per person on health care, through a complex maze of entitlements and subsidies. This is more than most other OECD countries, even countries with socialized health care and little private expenditures. Health care represents a growing share of our national economy – approaching 20 percent – and much of this is due to growing public expenditures. Some people blame the problems in our health care system on the free market, but we hardly had a free market even before ObamaCare.

7: In a free-market, how would insurance companies determine how much your premium should be?

A. Insurance companies would look at how much money they spent on claims last year, divide this evenly among plan participants, and charge them all equal premiums.

B. Insurance companies charge customers a rate that they agree upon within a group of companies, government agencies, and nonprofits.
C. Insurance companies would charge more for certain customers or groups of customer just for spite, because they don't want to serve certain groups of people, like women, the elderly, or people with health conditions.
D. Insurance companies would determine your individual risk level, which is a product of the probability you will make a claim times the size of the claim you might make.

ANSWER: D – In a free-market, insurance companies would determine your individual risk level, which is a product of the probability you will need to make a claim, times the size of the claim you might make. This is called actuarial science, and insurance companies have used elements of this in the past to offer each customer a price appropriate for his or her health care needs. It is simple math: Insurers consider how likely it is that you will make a claim and for how much, and the price is set based on that expected cost. That's why teenage boys tend to pay more for car insurance: They tend to get into more accidents and therefore cost more to insure.

8: How many people already participated in some form of government-managed insurance plan before ObamaCare?

A. About 5 percent of the population, or 15 million people
B. About 10 percent of the population, or 31 million people
C. About 20 percent of the population, or 62 million people
D. About 30 percent of the population, or 95 million people

ANSWER: D – In 2010, before the implementation of ObamaCare, already about 30 percent of the U.S. population obtained health insurance through a government program. This included 49 million people in Medicaid, the government insurance program for low-income people, and 13 million military members who were insured by Tricare or other veteran's health programs. Another significant group were in Medicare, where approximately 44.3 million seniors are insured. Among these groups, there is significant overlap – people called "dual-eligible" – but we cannot count them twice, meaning the total is about 95 million people. These programs perform an important function, but they are sadly inefficient and costly. While Medicare beneficiaries often paid into the program during their working years, the average Medicare recipient will spend three times as many dollars in claims as they paid in through Medicare taxes. Enrollment in Medicare and Medicaid are set to grow substantially as Baby Boomers reach retirement and as many states expand eligibility for Medicaid.

9: In what types of situations would you expect to use your health insurance?

A. A routine doctor's visit
B. A trip to the emergency room after a car accident

C. Picking up a refill on a prescription
D. All of the above

ANSWER: D – While individual insurance policies vary, most Americans expect to use their health insurance upon every interaction with the health care system. This is problematic because it creates an outsized role for insurance companies as a middleman. Other forms of insurance work very differently than health insurance. Americans purchase car, home, and life insurance in a marketplace, and expect to make use of those policies only in case of an emergency. Our car insurance doesn't cover oil changes, and our home insurance doesn't pay to paint the house. Yet increasingly, because of government mandates, health insurance has come to pay for routine medical expenses, rather than emergencies.

10: How does the health system of the United States compare to the rest of the world?

A. We rank poorly when it comes to health outcomes, about 40th worldwide.
B. We rank poorly when it comes to responsiveness to the needs of patients.
C. We have one of the most efficient payment systems in the world.
D. We have the best (highest) cancer survival rates in the world

ANSWER: D – The American health system cannot be beat when it comes to quality of care. We are home to some of the best, most innovative medical professionals in the world. We also rank #1 in "Responsiveness to the individual needs of the patient." Unfortunately, many Americans exhibit unhealthy lifestyle behaviors, like smoking, unhealthy diets, and a lack of exercise. This contributes to some bad health outcomes, but it's hard to blame this on our health care system. The biggest failure of the American health system is the inefficiency of our payment structure. Because of over-regulation, our dollars are passed around through a pipeline of employers, lawyers, insurers, government agencies and hospitals before they go to the doctor who earned them. This means we spend much more money on health care than is necessary. But this doesn't mean we do a poor job treating sickness or disease. It's true: We continue to help more patients survive cancer in the U.S. than anywhere in the world, and that's something to celebrate!

Real World Examples

Mary – Age 26

Mary had good health insurance through a job, but she lost her job when her company was downsizing. She had just met her deductible when –surprise – she lost her health insurance along with her job. In the meantime, she is working part-time, but her new job doesn't provide benefits. Mary is healthy and doesn't see a doctor too often, but she worries about the unexpected. When Mary goes online and tries to buy insurance, she

finds out that it is very expensive. It includes coverage for a lot of things she doesn't want, like behavioral health and pediatric dentistry, but her new network doesn't include her favorite doctor. On her part-time salary, she can hardly afford to pay $250 each month for a premium. She earns just too much to qualify for a subsidy. She's frustrated that she can't keep one plan as she changes from job to job, and that she has to buy her new plan with after-tax dollars. She's not sure what to do, but wishes she could find a cheaper plan. Millions of people, like Mary, have to change insurance when they change jobs. If they can't find employer-sponsored plans, they are at a disadvantage, especially if they are young and healthy.

The Peters Family

Bill and Maria Peters have a family of three boys. They support their family by running a small business, and they have to navigate buying insurance on their own. Running a business requires a lot of administrative work, and they don't have time to memorize all of the book-length details of their insurance plan, and they don't understand the negotiating that goes on between their insurer and their local hospital. They are a happy family, but their boys are a little rambunctious. Occasionally, one of the boys will have an accident: Last summer it was John's jet-ski accident. This spring Kyle got a concussion during recess. Each of these trips to the ER are scary – not just because of the blood or bruising, but because Bill and Maria don't know what to expect their bill to be. These unpredictable out-of-pocket costs are taking away from their ability to save for their boys' college funds. Bill and Maria don't feel like insurance companies have to compete for their business or provide good customer service because insurance companies are more interested in answering to large group plans, which are favored by government tax policy.

Christina – age 34

Christina is expecting her second child. She is excited about the new baby, but money is tight. She qualifies for Medicaid, the government insurance program for low-income people. Christina knows she needs to find a good gynecologist for her pre-natal care. But she gets very frustrated when she calls a local practice and finds out the providers there have stopped seeing Medicaid patients. She calls another group of doctors in her neighborhood, and gets rejected again! Finally, Christina is forced to see whichever doctor is available at a large hospital across town. She has to take two buses just to get there. The reason for Christina's trouble? Medicaid reimburses doctors too low, meaning many (about one third) of primary care doctors have stopped seeing new Medicaid patients.

Discussion Questions

- What kind of health insurance do you have? Do you buy it on your own, or is it a benefit offered as part of your compensation at work? Do you know where your friends or family members get their insurance? Medicare? An ObamaCare plan?

- Are you happy with the insurance you have? Are you covered for enough treatments and services? Are you covered for some treatments and services you don't want or need?

- Do you think the price you pay for your health insurance is fair? Why do you think health insurance in the United States has become so expensive?

- We are undergoing big reforms currently. What would you say were the biggest problems in our health system before the reform? What problems persist?

- Do you think insurance companies should price policies according to individual risk? This means people with higher risks would pay more, while lower-risk people would pay less. What are the benefits or consequences of this approach?

Articles to Read

How Employer-Sponsored Insurance Drives Up Costs – Forbes: http://www.forbes.com/sites/aroy/2012/05/12/how-employer-sponsored-insurance-drives-up-health-costs/

The Broken State of American Health Insurance – Ayn Rand Institute: http://www.pacificresearch.org/fileadmin/templates/pri/images/Studies/PDFs/2013-2015/BasuF2.pdf

State Mandates on Private Health Insurance – Cato: http://www.cato.org/sites/cato.org/files/serials/files/regulation/1992/10/reg15n4g.html

Action Items

- Find someone in your community who works in the health care system. Ask them what they believe to be the problems in our health care system. Ask them if they have considered the effects of employer-linked insurance and insurance coverage mandates.

- Write a letter to the editor of your local paper about the American health system, what you believe to be the real problems, and whether current policies are addressing the problems.

- Call your U.S. Congressman or U.S. Senator and tell them you don't believe the

Affordable Care Act (or ObamaCare) really fixes the problems in our health system. Tell them to oppose the implementation of this law and to pursue better solutions instead, that focus on the needs of individual patients and consumers..

Further Study

Visit HealthReformQuestions.com. Continue to test your knowledge of health reform and read about American Health Care: Facts vs. Myths.

Read "A Better Direction for Health Reform," a policy focus from IWF that highlights how to solve our problems in health care.