# FINANCIAL PREPAREDNESS

*"One of life's most painful moments comes when we must admit that we didn't do our homework, that we are not prepared." ~ Merlin Olsen*

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## Health Insurance Is a Scam

With the annual Open Enrollment season approaching, it's the perfect time to talk about health insurance. On a free market, insurance is an innovative and useful product that can help protect the policyholder from catastrophic financial losses. Unfortunately, government interference in the marketplace has turned this once-useful product into a scam.

The problem began when the federal government enacted the Stabilization Act of 1942, which imposed wage and price controls (naturally, due to war), but insurance was excluded. Up until then, consumers purchased health insurance on an individual basis, just like all of their other insurance policies. As Wikipedia says, "One consequence of the wage stabilization under the Act was that employers, unable to provide higher salaries to attract or retain employees, began to offer insurance plans, including health care packages, as a fringe benefit, thereby beginning the practice of employer-sponsored health insurance."

Ever since then, health insurance coverage for employees has generally been tied to their employer. This unintended consequence of the Stabilization Act has had a number of unintended consequences of its own. For example, it has reduced consumer choice and health insurer accountability since most employees don't explicitly choose their own

health insurance company and coverage. These plans often change every year due to employers shopping for the cheapest coverage, which usually means covered employees get assigned a new primary care physician who knows nothing about them or their health history. Additionally, if an employee quits or gets laid off or fired, they'll have to find new coverage (and doctors) unless it can be continued under COBRA for 18-36 months.

Historically, there have been three types of health insurance coverage. First, a traditional indemnity plan allowed you to choose your own doctors and refer yourself to specialists. This was the best (and most expensive) type of coverage. I have not heard of such coverage in many years and would be surprised if it still exists.

Second, a PPO (preferred provider organization) allows you to choose your own doctors, but a higher percentage of your medical expenses are covered if you obtain care within the plan's network of health care providers. It's the second best coverage, with lower premiums than traditional indemnity.

Third, an HMO (health maintenance organization) only provides coverage if you obtain care within the plan's network of health care providers. You must have a primary care physician, and only he/she can refer you to a specialist. Providers are paid per capita, so are financially at risk if they provide a patient with "too much" expensive care. Therefore, they have a financial incentive to deny you care.

Health insurance only pays out if you have met you individual and/or family deductible for the year, *and* the charges are "reasonable and customary" for the procedure in that area. Invariably, what the insurance company considers "reasonable and customary" is usually about 20 to 50% of what the provider actually charged. So you have to cover the difference, usually until you meet a stop loss limit.

In the last few decades, health insurance has become exorbitantly expensive due to government interference in the marketplace, the lack of insurer accountability by the consumer, and the much greater involvement of third party payers (insurance companies and the government). Ironically, as health care and insurance become more expensive, the role of third party players becomes more important, which causes the cost to rise even more. It's a doom loop.

Government interference includes Medicare and Medicaid (both totally unfunded), regulations, job-destroying and poverty-producing policies (which results in indigent patients who can't afford health insurance or health care) and (especially in recent years) lax or nonexistent enforcement of immigration policy.

The federal government can't afford to provide all of the health care benefits it has promised under Medicare, so it has become common for it to reduce its reimbursements to health care providers every year, which results in providers spending less time and money on patients and more providers decling to see Medicare patients.

Hospitals still have to provide care to indigents (which increasingly includes illegal immigrants). This has to be done using emergency rooms and ambulances, which is the

most expensive method. So hospitals have to pass on these costs to their non-Medicare patients (who are usually Gen Xers).

Starting in 1994, for years, I tracked the annual increase in my health insurance premiums. They increased at an average annual rate of about 20%. A typical monthly premium for a PPO policy for a small, healthy and relatively young family was about $1,400, and that was with an annual family deductible of about $15,000, but before any "reasonable and customary" disallowances were included. So paying for health insurance was like shoveling piles of cash into the maw of a soulless bureaucracy that never provided any tangible benefit.

Obamacare destroyed the market for health insurance, especially for the self-employed. Which is ironic because the website through which you could shop for health insurance was called "the marketplace." It was like Fidel Castro had taken over all of the grocery stores and set up a website on which you could order groceries, but the shelves were now almost bare.

In the years after Obamacare became law, more and more insurance companies left the health insurance "marketplace" because it became unprofitable, especially due to the unnecessary additional coverages that Obamacare mandated. I'm not sure if this consequence was intended or unintended. Eventually, the only options in my area were an HMO from one insurance company, or my state's Medicaid plan (which provides health care for poor people). So much for "the marketplace."

At that point, I switched to a health care sharing ministry, which is a private group that shares each other's health care expenses. They're a lot like the old mutual aid societies that ensured their members had access to health care, before they were regulated out of existence by the New Deal. Membership is limited to those who profess certain religious or spiritual beliefs, though some are more restrictive than others. This tends to reduce the medical expenses the group has to reimburse that are the result of "sinful" lifestyle choices, as well as the amount of claims fraud.

Members make monthly "gifts" to the ministry, which is not an insurance company, so there is no legal requirement for a ministry to reimburse an expense. (Though I would argue that, due to the "reasonable and customary" clause, there is no de facto requirement for an insurance company to reimburse an expense, either.) Members submit their covered expenses to the ministry for reimbursement, which usually happens within 90 days.

Some ministries have been around since the 1980s, but most began after the advent of Obamacare. While Obamacare's individual mandate (to pay for health insurance) was still in effect, membership in a health care sharing ministry qualified as an exemption from the mandate.

Although ministries are not regulated by the government, they are still regulated by consumers, who talk about their experiences with them on social media. Do your own due diligence, and as with everything else on the market, *caveat emptor*.

Note that if you are self-employed, gifts to a health care sharing ministry are not deductible on your income tax return like premiums for health insurance are. And since you are not covered by a high-deductible health insurance policy, you cannot contribute to a Health Savings Account.

One of the epiphanies I had after my heart attack is that health insurance doesn't get you health care (due to deductibles, copayments and the "reasonable and customary clause"), and health care doesn't get you wellness. Wellness is not a product or service that you can buy. It's something that you have to provide to yourself through education and spending the time, money and energy to do what is necessary to be well.

The best health insurance coverage you can have today is to do the things that are required to *remain healthy*. Health care is so expensive today that you can't afford to get sick anymore. So make a strategic decision to invest up front in healthy food and water and a healthy lifestyle, because the alternative is to incur a lot of medical expenses later, only by then you'll be sick as well. Your greatest wealth is your health. Without good health, you don't have much, because you can't do or enjoy anything else.

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