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# The Mythology of Insurance: A White Paper on Federal Intervention in Health Insurance Regulation



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THE MYTHOLOGY OF INSURANCE: A White Paper on The Effects of Federal Intervention in Health Insurance Regulation on Consumer Behavior, With A Suggested Outline for Reform

**W**e are all familiar with the complaints that our American system of financing health care is too uncertain, too complicated, and too expensive. There is no doubt that our health care costs are consuming us. For example, data from 2003 shows that total spending on health care was \$1.7 trillion, or about \$5,800 for every person in the country, and accounted for more than 15% of our gross domestic product (an even larger figure than the 14% of GDP in 2002).

Astonishingly, despite this spending, we have a huge *systemic gap in the financing system itself*. The Institute of Medicine reported in June 2003 that the U.S. loses between \$65-130 billion annually as a result of poor health and early death *due to a lack of health insurance*. As more Americans lose their employer-sponsored coverage following disability or retirement [a scenario that will surely accelerate in frequency as the boomers age], and as more employers choose to scale back or eliminate health benefits due to exploding costs, the number of uninsured Americans will similarly grow. In fact, as more Americans age, we will witness an increasing trend of Americans being diverted from private insurance and into substandard Medicare or Medicaid benefit plans that offer inferior health care services and options. Since this occurs when many of those Americans need healthcare the most, we are likely to experience an explosion in health-related costs due to this “system gap.” The Congressional Budget Office in May 2003 estimated that 59 million Americans are uninsured at some point in the course of a year, while 21 million are uninsured for the whole year. *If we want to solve the problem of runaway health costs, we must eliminate in a meaningful way the barriers that prevent uninsured Americans from obtaining health insurance, and especially encourage more Americans to obtain health coverage that includes reasonably certain continuity.*

My experience as a professional planner suggests that the essence of our problem can be traced to a sort of “mythology” of insurance that guides most Americans’ (mis) thinking and (mis)behavior in making health-care spending and insurance choices. In other words, most Americans carry around in their heads a set of fallacious notions about

insurance that guide their decisions and opinions on the subject and encourages faulty decision-making. For example, probably the most common and insidious element of that fallacious mythology is a warped view Americans have developed about the very *purpose* of health insurance. Insurance was originally developed as a means to spread the risk of a catastrophic loss over a large group of individuals so that a single individual would not have to sustain that loss with their own resources alone. For the most part, this remains the way Americans view all of their insurance products *except* health insurance. Health insurance, on the other hand, is judged by how well it is perceived by the purchaser as making *ordinary healthcare expenses* fit within a typical personal monthly budget. In other words, “good” insurance is coverage that closely matches the total “out-of-pocket” expenses in a typical month with an amount the purchaser *wants to spend for everyday health care costs*. “Bad” insurance is coverage that presents a mismatch – either by leaving too many everyday “out-of-pocket” costs to the individual, or by leaving few actual costs to the individual but at a premium level that makes the insurance difficult to afford. Health “insurance” has therefore become little more than a cost-shifting tool whereby Americans expect ordinary health expenses to be paid by an insurer so that such ordinary health care costs have little, if any effect on the typical monthly family budget. Very little attention is ever paid to how well health insurance is likely to perform in the face of a true, prolonged medical catastrophe; in fact, most typical employer-sponsored health insurance plans contain some form of legally-mandated *discontinuity* that ensures that such health insurance plans can be discontinued for a truly prolonged illness if such illness is serious enough to disrupt employment for the primary breadwinner.

Americans have developed this mythology as a direct result of Congressional encouragement to expand *employer-sponsored* coverage. This Congressional encouragement, coupled with the way health insurance is marketed to employees has fostered a completely new paradigm of expectations for health insurance by its purchasers that have little to do with the central purpose of insurance in spreading catastrophic risk. Instead, employer purchasing decisions are based on perceived short-term, immediate needs rather than potential long-term catastrophic health-care risks. Insurers are *very* aware of who their purchasers are, and the health insurance system has been designed to exclude as many people with true catastrophic healthcare costs as possible. Instead, insurance purchasers are *employers* who are considering the expectations of their *well working employees -- and those employees in turn want to meet those employees’ specific monthly budgetary demands with few out-of-pocket expenses – but with an ever-increasing list of demanded covered “ordinary” health services*. For example, few employees ever judge their health coverage

by the quality of durable medical equipment coverage. Nevertheless, a power wheelchair, implanted medication pump, ventilator, or prosthetic leg can be very expensive and would be required only by the most serious or chronically ill person. Unfortunately, as with other expensive items that are typically only needed by truly catastrophically ill persons, an increasing trend in employer-sponsored health insurance coverage is to limit, establish a formulary, or exclude this category of benefits altogether! As critical but not commonly considered benefits are reduced or eliminated, ordinary “working well” insureds are not likely to notice. However, imagine the outcry that would occur were the coverage to change the co-pay for well baby care, chiropractic or massage-therapist care, an ordinary prescription drug, or a counseling session! It is not hyperbole to assert that insurance has increasingly become a tool for financing *well care* and that there is a long-term increasing trend within employer-sponsored health plans toward spending fewer insurance dollars on truly catastrophic care, while “front-loading” health care expenditures for the “working well.” Every single “mandate” that assures benefits for *well* workers [no matter how critical the perceived need for the benefit may be] has the necessary effect of either increasing the overall cost of coverage or causing a further shift in the “insurance expenditures pie” toward well workers and away from catastrophic care. In other words, health plans have simply shifted their claims expenditures away from categories of benefits most likely needed only by the truly seriously or chronically ill (such as rehabilitation care, durable medical equipment, therapy sessions, etc.) and increased the types of benefits that could be utilized by well employees. By doing this, insurers are able to lull employees into a false sense of insurance “effectiveness” when they are working; unfortunately, most employees who believe they have “good” health plans would be shocked to discover how *poorly* their “good” insurance actually performs in the face of a prolonged medical catastrophe, and how *many* of their medical needs are simply no longer covered or – worse yet – that their insurance is *not* designed for long-term continuity at all!

In order to begin the task of re-aligning insurance design with rational insurance needs, it is useful to explore how employees’ misalignment of expectations for health insurance came to exist in the first place. The origins of employer-sponsored health care can be traced to World War II, when employers who were faced with government-imposed wage controls discovered that they could offer benefits in lieu of higher pay as a way to compete for workers. The Internal Revenue Service encouraged this practice in a ruling on October 26, 1943 that held that employers did not have to pay taxes on such benefits. This tax-exempt status of employer-provided health insurance was codified into law by Congress in 1954. This tax-exempt status provided a great incentive for employers to begin offering

insurance benefit packages. Rather than paying workers wages that could be taxed, companies could instead use pre-tax dollars to purchase health or other insurance benefits; thus, instead of paying an employee wages, and having 40% or more of those end up in government coffers, employers would instead pay directly for benefits wherein 100% of the dollars spent buy benefits for their employees with no taxation.

The first element of the misalignment became evident when employees who became used to such benefits began to think of “price” in terms of their own costs. In other words, the “price” of health care – as far as they were concerned, persisting even today – was a combination of the cost of premiums as well as any out-of-pocket expenses. Insurers then perpetuated these notions of “cost” by encouraging or discouraging utilization of specific benefits by attaching co-pays, deductibles or other limitations on disfavored benefits.

The most dramatic advance in the misalignment and the beginning of the development of our American insurance mythology based on that misalignment occurred in 1974 when Congress passed the Employee Retirement Income Security Act (“ERISA”), in which Congress attempted to prevent employer abuses with respect to employee benefits. ERISA was enacted out of Congressional concern about compromised pension security resulting in persistent under funding. As entire American industries faced economic decline – such as railroads in the 1930s and automobiles and steel in the 1960s and 1970s – many companies paid only a small fraction or none of the pensions they had promised. The legislative record was also rife with examples of abusive self-dealing and mismanagement of employee benefit funds – including not only pension plans, but also other programs providing benefits such as health care, disability payments, and legal services.

ERISA responded to that legislative record by creating federal regulation of employee benefits. ERISA does not require employers to provide benefits; however, should an employer choose to do so, then ERISA applies to any employee benefit plan maintained by “any employer engaged in commerce” and any union representing employees so engaged. ERISA thus governs virtually all private employment in the United States, regardless of the size of or number of workers in the firm. But ERISA did not stop there. ERISA contains one of the most sweeping state law preemption provisions ever enacted in a federal statute.

Before ERISA, Congress was specifically prevented from regulating insurance due to the federal McCarren-Ferguson Act (which is still technically in effect) that specifically prohibits Congress from regulating insurance – leaving that subject matter to the states. The Supreme Court subsequently ruled that ERISA does not violate McCarren-Ferguson because it does not constitute a regulation of “insurance;” rather, ERISA constitutes a regulation of “employee benefits” by Congress. The result of the Supreme Court’s decision was that ERISA preempted virtually all of the vast body of existing state insurance, contract, tort, and other remedial law applicable to health plans, but without putting any effective substantive federal standards in their place.

Unfortunately, ERISA itself became the genesis of two essential components of our health insurance mythology. The *most* insidious effect of our current ERISA-based mythology of insurance is that *continuity is never considered an integral part of employer-sponsored health coverage*. Imagine how many people would purchase life insurance if there were no guarantees that the insurance company would be in business or that the policy would be enforceable in 20 years, or even next month? Of *course* that would be ridiculous and intolerable. Nor would a rational person purchase a policy that would only pay if the economy stayed strong throughout the entire time the insurance was in force; nor one that would only pay if the insured was actually working on the day he or she died; nor one that would only pay so long as the insured remained married to the same person throughout the policy term. In fact, these ideas seem *ludicrous* to us and completely *irrelevant* to the bargain we are striking for our life insurance. So, why do Americans find it perfectly acceptable to adopt such limitations in their health coverage? Why are these ideas not also ludicrous for our health insurance decisions? Why is it that Americans do not demand similar continuity in our health coverage as for other coverage? In talking to many of my clients, the issue seems not to have occurred to most of them. Most view the insurance bargain as one that has been struck by the employer over whom they have no control; almost universally those employees do not apply principles of *continuity* to *any* of their health insurance decisions. A fair summary is that as a nation we have willingly “adopted” Congress’ “carrot” of employer-sponsorship for tax advantages, and sacrificed the critical element of continuity in the bargain. When continuity becomes irrelevant, Americans *just assume that there is no continuity in health insurance coverage; their purchase decisions are made strictly for “today” based on their current budget, and are “priced” accordingly.*

The ERISA trade-off was an incredibly bad mistake for American consumers, and has led to most of the major health insurance public policy dilemmas of our times. ERISA specifically exempts employer-sponsored insurers from having to offer the kind of continuity we expect elsewhere, and few Americans ever question the wisdom or fairness of this exemption. ERISA irrationally ties insurability to work continuation, and Americans have adopted the mythological tradition that only working Americans or their dependents are (or should be) eligible for private insurance coverage. Inexplicably, this mythological notion requires individuals to *forego* the best coverage *at their most vulnerable time* – *when health issues are serious enough to interfere with employability, or when advanced age prevents them from working*. The unfortunate individuals who become too sick or old to work have paid dearly for Congress' short-sightedness, but few Americans ever question the fairness of a system that *discontinues coverage as a matter of law precisely when it is needed the most*.

Employment-based coverage is also irrational. As long as employer-based insurance forms the core of insurance that is available to members of the public, what guarantee does anybody have that some illness will not make it difficult or impossible for that individual to purchase private health insurance on the private marketplace? Yet, as long as Americans rely on employer-sponsored coverage, that is a risk inherent in their decision – every healthy year that passes while an employee is covered by her employer is one more year in which that employee *assumes* that her health will not change in such a way as to make her *ineligible for private, non-employment based health coverage*. If, in fact her health were to deteriorate while she was covered by an employer, she would find that the private health insurance market would not be so inviting in the future, and all options she might have for either private or continuation coverage (if any) would be completely dependent upon state law mandates.

Unfortunately, our mythology has eviscerated both the *reality* as well as the *expectation* of continuity in health coverage. Why have we allowed such an irrational change? *Because employers have enthusiastically adopted the tax advantages of health benefits and lobbied for their expansion; however, the minority of employees who have suffered the deleterious effect of ERISA discontinuity are seldom present at the workplace to demonstrate the profoundly irrational result of the ERISA policy decision; moreover, there is no organizing cultural core for people who have lost their insurance in this manner, and their political representation – if any – is sporadic, not organized as a group and fairly*

*inconsequential.* Arguably, it is these people who can best demonstrate whether our employer-sponsored insurance system is a success or failure. In fact, despite the lack of organized opposition, the continuity deficiency has forced Congress to add several chapters to ERISA as a veiled attempt to address that issue. Those Chapters have come to be known as “COBRA” and “HIPAA.” Unfortunately, despite the demands of uninsured Americans and the rhetorical claims of Congress, none of these legislative efforts has created effective continuity regulation. The so-called “HIPAA” federal continuation requirement is of no real help because its mandates are illusory: although coverage may be required, the federal law fails to specify what the coverage must be provided or limit the premiums in any meaningful way. Since only people who cannot obtain coverage elsewhere opt for mandated HIPAA continuation or conversion coverage, the HIPAA plans tend to deteriorate rapidly and can quickly become unaffordable or be limited to unreasonably skimpy benefits. Moreover, only the poorest of the poor qualify for Medicaid, and nonelderly individuals who ultimately qualify for Social Security Disability Insurance benefits must wait at least 29 months from the date of application before Medicare coverage becomes available. Even when Medicare provides benefits, neither Congress nor many states mandate that federally-regulated Medigap insurance plans be made available to non-elderly Medicare beneficiaries with disabilities or chronic illnesses. The content of coverage of both Medicaid and Medicare can at best be described as “substandard” and “unpredictable.”

The absence of Medigap plans in some states makes the market reality untenable for nonelderly people who want to plan and provide for their own needs. With the widespread policy of Congress that health insurance should be provided by employers, and the corresponding belief by members of the public and their professional planners that the primary source for health and disability insurance benefits is through an employer sponsor, most individuals covered by such plans never feel compelled to construct a safety net with private benefits not obtained through the employer. Instead, they are lulled through convention into believing that they are secure.

Unfortunately, our mythology has eviscerated both the reality as well as our expectation of continuity in health coverage. Why have we allowed such an irrational change? Because Congress has encouraged—and employers have willingly adopted -- the tax advantages of health benefits, and the minority of employees who suffer the deleterious effect of ERISA noncontinuity are seldom present at the workplace to demonstrate the shortcomings of that choice. The continuity deficiency has forced Congress to add several chapters to ERISA, including COBRA and HIPAA, but none of these legislative efforts have created effective continuity regulation.

I have spent my professional career advising people who are facing limited-term

continuation benefits at precisely the moment when their health needs are the greatest. I have personally witnessed many of them “spiral down” into poverty just to keep some form of reliable health coverage once they have left employment. Had their health coverage not been dependent on employment status to begin with, no such “spiral” into poverty would have been necessary. Because options for non-elderly individuals who cannot work vary widely from state to state, and since government programs are available only to the very poor through Medicaid or to individuals who stay out of work for substantial periods of time through Medicare, the quest for health coverage for many of these people in fact often become the issue that drives their employment decisions, and through cascading downward economic consequences as their lives unravel in the face of government rules and red tape, every other life decision becomes focused on keeping what they perceive to be their only reliable source of “health benefits” through one or more government entitlement programs. This is exactly backwards from what it should be. This strategy is not only incredibly inequitable, it is unsustainable.

In fact, the increasing cost of employer-sponsored health coverage creates a substantial disincentive for employers to hire or retain people with health issues *ab initio*. Thus, regardless of laws protecting people with disabilities at the workplace, individuals who experience performance-altering health issues typically have an employment experience dotted with hostility and land mines; *the increasing cost of employee health benefits exacerbates the already-tense relationship between an employer and employee who has health issues. As these costs increase, workplace tensions and complications for affected employees similarly expand.*

In fact, insurers have also done an amazing job – with the help of the federal government – of “creaming out” (i.e., eliminating) most high-risk people from private insurance groups. People who become too sick to work eventually lose their coverage because of limited continuation coverage built into employer-sponsored coverage by law. Moreover, even though Medicare is typically an inferior alternative to former employer benefits for most Americans, many such Americans will nevertheless find themselves forced into Medicare coverage as they age – even if they were previously privately insured, and even if they had been lead to believe that they would receive continuous employee benefits. The U.S. Department of Labor ruled in 2004 that employers may even discontinue retiree health benefits that had been specifically promised through retirement; this is true even if employees relied on a representation that they would continue to receive such benefits throughout their entire retirement.

It is not hyperbole to suggest that Congressional *policy* has been to encourage private health insurance *only* for individuals of working age who are healthy enough to work -- that Congress *planned* for individuals who could no longer work to subsist on second-rate, government health programs. *Our national plan is to move the oldest and sickest individuals out of private coverage and into government programs. In effect, Congress has chosen to make private insurance available only to the young, healthy, and employed, and only so long as they remain that way. Thus, Congress has specifically designed a two-tiered system of health benefits for American consisting of private insurance for the working well, and substandard government programs for the rest of us.*

ERISA has allowed us to create cultural mythologies about health insurance. Yet another aspect of that mythology is the belief that insurance companies are all the same – impossible – and there is no way to make them behave rationally or fairly. In reality, insurer recalcitrance is inversely proportional to the strength of legal remedies that may be used to enforce an insurance contract. Insurance is worthless if it can't be relied on to perform when a catastrophe occurs. Therefore, one of the most important evaluations for quality of coverage should be how reliable the stated coverage will be. This reliability is a direct result of how legally enforceable the insurance policy is; in turn, this is dependent upon the nature and relative strength of the legal remedies available to enforce the contract. The more likely an insurer will suffer deleterious consequences from failure to enforce policy provisions, the more likely the insurer will abide by contract terms. Conversely, if there are few penalties for questioning claims or reading the policy in extraordinarily narrow ways, the more likely an insured will attempt to reduce claims losses through such behavior. *Employer-sponsored coverage governed by federal ERISA law has the least effective set of legal remedies available, and is therefore the **most** likely to result in recalcitrant insurer behavior – and significantly more so than for any other type of private health insurance contracts available in America.* Coverage that is not employer-sponsored is governed by state law, which can include remedies for breach of contract or consumer protection and in some cases bad faith.

For that reason, the likelihood of recalcitrant insurer behavior is *greatest* among employer-sponsored health insurance plans. Again, this can be traced to Congressional policy. Through ERISA, Congress pre-empted state remedies that might otherwise apply to insurance disputes involving employer benefits. In other words, Congress effectively created a *ban* against using any effective state legal remedies such as consumer protection

complaints or lawsuits or bad faith claims – but only if your insurance is sponsored by your employer. In its inestimable wisdom, Congress pre-empted state law remedies for employer-sponsored benefits such as health insurance. It is this lack of consumer protection or bad faith law applying to ERISA claims that makes employer-sponsored coverage legally inferior to other private coverage. Yet, few people are ever educated about this crucial difference; because of the intense marketing by insurers and adoption by employers, most Americans are plunged into the legal abyss of ERISA coverage with the tantalizing incentive of tax breaks.

So, Congress effectively curtailed all state legal remedies that could apply to disputes involving employee welfare benefits, creating a dramatic legal windfall for insurers. In fact, a series of rulings has completely exempted “self-insured” employers from state insurance regulation altogether, and created blanket exemptions from state legal remedies for insurers of employer benefits. As a consequence of these legal developments, the insurance industry understandably concentrates its health insurance marketing almost exclusively on employer groups, and employer groups have encouraged the marketing by virtue of their own tax benefits.

Another destructive element of our current mythology of health insurance is that many people falsely believe either that they *must obtain coverage through an employer, and/or that they are only entitled to what their employer provides them*. Insurer marketing and employer adoption of ERISA-based employer-sponsored health coverage has become so prevalent that most policy-makers simply *assume* that employer-sponsorship necessarily forms the core of our health insurance system. Employees – especially younger employees – have adopted this inference as an assignment of rights and duties; *employers are thought to have the responsibility to choose and provide health coverage; employees are mere passive recipients of whatever beneficial arrangements that the employer might provide*. If an employee’s particular need is not met by an employer plan, then the *employer* is blamed. To the extent that no insurance benefits are provided at all by the employer, the employee is deemed to be part of a group of “uninsured” Americans. The mythology often extends the idea that these *uninsured* Americans also *have no access to insurance*. Similarly, when an employer closes a place of employment and lays off workers, the number of “uninsured” Americans is thought to rise. *This can only happen in a world where individuals do not harbor the right and responsibility to create their own insurance portfolios! And – **none** of those things are true. So why do we accept these notions at face value?*

The insurance companies like the lack of continuity; they *love* the lack of reasonable remedies in ERISA, and won't give that immunity up lightly in the halls of Congress. And, Congress holds on tightly to ERISA, because by regulating employee health benefits, *Congress has jurisdiction over about 12% of the American economy that they would otherwise lack.* This is a matter of power, plain and simple. Without ERISA, Congress would be barred under McCarran-Ferguson from regulating, and therefore would stand to lose *enormous power.*

Nevertheless, as individual American citizens, we do not have to “bite” the Congressional poisoned apple. We still have the option of purchasing our own insurance through non-employer groups that are completely regulated by state law. In fact, non-employer groups can provide continuity and remedies that are simply *not available as a matter of law* through employer groups. If for no other reason than to shore up available legal remedies and continuity, *every American should have some form of health coverage that is not employer-sponsored.*

Nor need such coverage – even as an add-on to employer coverage – be expensive. One large inefficiency in employer-sponsored benefits arises from *overuse* by working well employees of generous employer-sponsored health benefit packages. Insurers who successfully market their health insurance products to employers by providing generous benefits for “working well” people should not be surprised to find those benefits being utilized regularly by people who in a more rational system otherwise might not need to file health claims at all. It is no surprise that such overuse has inflated the cost of “first-dollar” coverage – the coverage that is primarily responsible for paying bills after a designated deductible is met. Most people would be astonished to see the change in premiums and improvements in true catastrophic health benefits that would occur by returning to core insurance principles by – for example – implementing a substantial deductible to ensure that utilization is truly “extraordinary.”.. For non “extraordinary” costs, the most efficient measure is for the consumer to pay a fairly priced service individually, rather than adding on the administrative overhead of a behemothe insurance company (assuming that the consumer would pay the same discounted price for a cash payment that the insurer would be offered). The higher the deductible becomes, the more dramatic is the change. In fact, a *very good* catastrophic major medical policy can be obtained from non-employer groups for a person in their twenties or thirties for as little as \$10/month, *if* the deductible is raised to

\$25,000.00. Even though such a policy would not pay first-dollar expenses of any kind outside of a serious health event, such a policy would nevertheless create a stop-loss that could prevent medical bankruptcy from *ever occurring* for mere pennies a day, and provide good, comprehensive coverage in the event a truly significant health event arises. In fact, this is likely a wiser choice for a young and healthy person than more expensive, first-dollar coverage in any event. If every uninsured person knew about these large-deductible catastrophic policies, we might be able to make dramatic inroads into the number of so-called “uninsured” Americans who believe that insurance is too expensive, and reduce the attendant social problems that accompanies an uninsured significant illness.

In fact, in my practice, we advise *every person including those with employer-sponsored coverage to obtain non-employer-sponsored high-deductible catastrophic policies of this sort*. We advise this for a number of reasons, including that such a policy would continue according to its own terms regardless whether health issues were to preclude future employment. Similarly, for individuals who are covered as spouses, their current coverage is contingent on *both the health of the spouse as well as the health of the marital relationship!* That situation is too tenuous, and in need of independent continuity. Good catastrophic excess major medical coverage also tends to fill “gaps” in employer policies that have resulted from such plans “skewing” benefits in favor of the working well and to the detriment of coverage needs for the truly sick. More important, however, is that such plans have better legal remedies than employer plans, and are therefore more reliable, so that when an employer plan might irrationally deny a claim, the catastrophic plan would not.

And, for individuals who are either retired or on disability, the private catastrophic excess major medical marketplace may still offer coverage through large groups that offer guarantee issue benefits. Individuals with disabilities may find that such plans could ultimately enable them to re-enter the private insurance marketplace and thereby leave government subsistence benefits and *return to work!*

If as Americans we want to *truly and completely* resolve our health insurance financing system problems with a private but fair marketplace (and therefore avoid the ravages of a brutal socialized health financing system), the best and first step we *must* take is to understand our current mythology for what it is. Having done so, Americans would

then be free to expressly reject our popular and common mythology in favor of a more rational view of health financing that can serve as the basis for a more comprehensive and affordable plan of insurance for the long term. That improved planning will better meet the catastrophic health financing needs of American families in the long run. To encourage the revisionist thinking among the general public that will be required to overcome the current mythology, the most important logical first step for each individual is to veer completely away from the course that has been charted for us by Congress thus far. Yet, ironically, even today most people seek out federal Congressional legislative “solutions” for the dilemmas we experience in our health insurance system, and every federal legislative effort constitutes an expansion of ERISA – the very law that is largely to blame for our current systemic failures. So, as a corollary, we must also begin to return to our states to solve these problems through improvements in state law.

At bottom, the resulting fundamental public policy tension is between Americans who suffer from the lack of continuity in employer-sponsored health benefits, and those pecuniary interests who are willing to sacrifice continuity of benefits for what they deem to be a larger goal of keeping health insurance premiums low by excluding all high risk individuals. The latter approach essentially places the entire burden of illness on sick, uninsurable individuals — even those who have followed social conventions to behave responsibly — and arguably undermines the very reason insurance was created in the first place. Our current approach exposes all Americans insured under employer-sponsored plans to a completely unpredictable and potentially financially devastating health lottery. In all fairness, a just society would at least require representatives who knowingly choose to pursue the latter policy to explicitly acknowledge and educate the public about the erroneous nature of any expectations of continuity during a serious employment-interrupting illness. This would then enable individuals to devise private, non-employment-based strategies to provide security when their employer benefits inevitably cease. Unfortunately, neither our policy makers nor, it seems, our professional financial planners (who, it seems, are not really financial planners at all, but rather merely wealth planners) have undertaken to provide or foster this education.

Our new nonprofit, Pathwise, has been formed to foster precisely that public education. We hope that you will support our efforts in this mission; the success of Pathwise could have a profound effect in reducing the number of uninsured Americans, as well as help to bring the health insurance marketplace from its current ERISA-induced skew back to serving its fundamental purpose. By educating Americans about the Congressionally-perpetuated mythologies and equipping individuals to resist that inducement, we may bring rationality, continuity, and enforceability back to our private health insurance system.

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# *PATHWISE*



*Rethinking  
Disability  
& Economics*



*Providing Advocacy Through  
Health, Work, Insurance  
Strategies & Education*