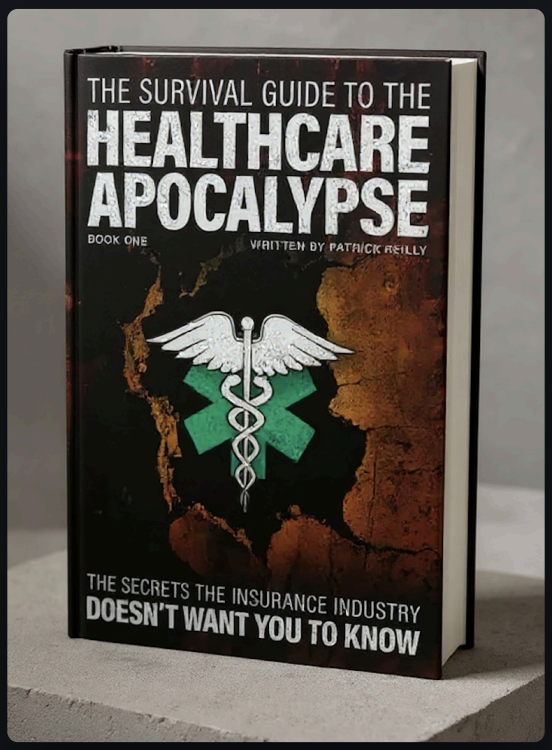


FREE SAMPLE · INTRODUCTION AND FIRST THREE CHAPTERS

The Survival Guide to the Healthcare Apocalypse

What the Insurance Industry Doesn't Want You to Know

Patrick Reilly

A note from Pat

Thanks for asking for this.

Most employers never get shown where the money in their health plan goes. They get a renewal letter with a new number and no reasons. I wrote this book to show the reasons.

These pages cover how the system drifted away from its original purpose, where the hidden costs sit, and what it looks like when an employer pays claims directly instead of buying a bundle. Read them with your own renewal letter next to you. If something doesn’t add up, you’re not crazy.

The last page tells you where to get the whole book.

Pat Reilly

Introduction

I needed a name for a book that would catch your attention—a title that conveyed the urgency and severity of our healthcare crisis yet also resonated with the humanity at stake. My friends thought it was too shocking. But how else can you shake people awake about what is happening to the U.S. healthcare system?

For the past 36 years, I've been immersed in the health insurance industry, running an insurance brokerage and benefits administration firm. I've seen it all—from the optimism of creating innovative solutions to the grim realities of an industry increasingly driven by greed and misaligned incentives. As the Co- Founder of PeopleOne Health and a Partner in Preferred Healthcare Systems, I've worked to build networks of hospitals and providers with direct contracts that prioritize community care over corporate profit. PeopleOne Health is the most advanced Direct Primary Care (DPC) solution on the market today, receiving both recognition and funding from Google Ventures. This revolutionary model integrates cutting-edge technology and personalized care to deliver outcomes that redefine what healthcare can be. Its success and potential have garnered national attention, solidifying its place as a beacon of innovation in a system desperate for change. But despite these efforts, the system has continued its spiral into dysfunction.

Today, the U.S. healthcare system is a battlefield. Patients, employers, and even providers are losing, while insurance companies, Pharmacy Benefit Managers (PBMs), and large hospital systems rake in obscene profits. The numbers are staggering: nearly 60% of Americans fear an unexpected medical bill more than a major illness. Medical debt is the leading cause of bankruptcy in this country. And yet, the healthcare giants thrive, reporting record earnings year after year.

I've witnessed firsthand the billing abuses that leave patients drowning in debt, the claims denials that prioritize profit over care, and the administrative bloat that siphons billions away from actual health outcomes. These systemic failures don't just impact wallets—they create a pervasive atmosphere of fear, stress, and anxiety that debilitates the very people the system is supposed to help. Instead of promoting health and healing, the U.S. healthcare system often exacerbates chronic conditions, feeding into a vicious cycle of physical and emotional harm. Patients feel trapped and powerless, while their well-being becomes collateral damage in the relentless pursuit of profit. These aren't isolated issues—they're systemic problems that threaten the very foundation of our healthcare system.

This book isn't just a critique of what's wrong; it's an introduction to understanding how the U.S. healthcare system truly operates—a system so intentionally complex that it takes careful unraveling to expose its flaws. While I provide foundational knowledge and actionable strategies to help you push back against the current system, this is just the beginning. Healthcare is far too intricate and layered to be fully addressed in a single book. Future volumes will delve deeper into these issues, offering expanded insights and solutions to help you navigate and transform this broken system. For now, consider this book your first step—a survival guide to prepare you for what lies ahead.

The healthcare apocalypse is here, but it doesn't have to be your reality. Together, we can rebuild a system that works for everyone—not just the corporations at the top. This book is your survival guide. Let's get started.

Chapter 1: The Fall of the Fee-for-Service Model

Drifting from Original Intent

The introduction of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) plans in the healthcare market fundamentally changed consumer expectations. Unlike the earlier major medical insurance policies, which were designed to cover catastrophic and unforeseen medical events, these newer plans aimed to provide more comprehensive coverage. They promised to cover routine doctor visits, preventive care, and elective procedures, creating the perception that insurance should pay for virtually every healthcare expense.

While this seemed like an improvement, it came with unintended consequences. These plans blurred the line between insurance and prepaid healthcare, driving up costs and embedding inefficiencies into the system. Consumers grew to expect that insurance would foot the bill for everything, from annual checkups to minor treatments, ignoring the economic reality that predictable expenses are not what insurance was originally designed to cover. As insurers adapted to these new expectations, premiums increased to account for the broader scope of coverage, shifting even more of the financial burden onto consumers through higher deductibles and out-of-pocket costs.

Over time, even non-profit insurers have leveraged their financial structures to generate significant profits, challenging the perception that they operate solely for community benefit. Rising premiums, increasing deductibles, and limiting coverage options allow these companies to shift more financial risk onto employers and employees, further straining the very people they are supposed to serve. By passing predictable costs onto consumers, insurers reduce their own exposure while maximizing profits. This strategy, coupled with allowing more expensive treatments to inflate overall spending, creates a financial dynamic where the burden disproportionately falls on policyholders, not the insurance carriers.

Non-profit insurers, such as those in Minnesota and Elevance Health (formerly Anthem), have reported massive earnings while customer premiums continue to climb. For example, Minnesota's four major non- profit insurers collectively earned $625 million from Medicaid in 2022, representing a profit margin of approximately 6.4%. Elevance Health exceeded profit expectations in 2024 by leveraging investment income and reduced medical costs, despite declining Medicaid membership.

These financial successes often fail to translate into improved affordability or benefits for members, raising critical questions about the alignment of their operations with their missions.

While technically non-profit, these insurers often mirror the practices of their for-profit counterparts, delaying payments and prioritizing the accumulation of reserves and investment income over immediate care improvements. This "community benefit" strategy, as it is often euphemistically described, becomes a generous interpretation when rising premiums and reduced access to affordable care continue to burden policyholders.

Here’s how and why the purpose of health insurance began to drift:

From Catastrophic to Routine: Insurance evolved from covering rare, high-cost events to encompassing routine care like checkups, minor illnesses, and prescriptions. This change blurred the line between insurance and prepaid healthcare.

Administrative Complexity: As coverage expanded, so did the complexity. Billing systems, coding requirements, and network contracts created a labyrinth of administrative tasks, driving up costs.

Profit-Driven Motives: The entry of for-profit insurers shifted the focus from community well-being to shareholder returns. Premiums, deductibles, and co-pays increased, while coverage often became more restrictive.

Obscene Profits: Health insurance companies, Pharmacy Benefit Managers (PBMs), and large hospital systems began reporting record profits. CEOs of these organizations earn tens of millions annually, while patients struggle to afford basic care.

Billing Abuse and Claims Denials: Providers charge exorbitant prices for basic procedures, exploiting opaque pricing systems. Insurers routinely deny legitimate claims to pad their profits, leaving patients caught in bureaucratic nightmares.

Misaligned Incentives: The fee-for-service model incentivized providers to maximize billable procedures, leading to unnecessary tests and treatments. Insurers, in turn, prioritized cost containment over patient outcomes.

Erosion of Transparency: Patients lost visibility into the true cost of care. With insurers acting as intermediaries, pricing became opaque, leaving patients unable to make informed decisions.

The Result The original intent of health insurance—protecting against catastrophic financial loss—has been overshadowed by a system that prioritizes profit over care. Today, insurance often feels like a financial burden rather than a safety net. Employers and employees alike struggle under rising premiums, while providers face mounting pressures to balance patient care with economic realities.

The impact of this systemic failure is devastating. Nearly 60% of Americans fear an unexpected medical bill more than a major illness. Over 500,000 families declare bankruptcy annually due to medical debt. Meanwhile, the healthcare giants continue to flourish, amassing billions in profits while patients are forced to choose between life- saving care and financial ruin.

Chapter 2: The Hidden Costs of Insurance

Insurance is supposed to protect us, but it has become a significant driver of financial strain. Behind the scenes, a web of hidden costs and perverse incentives has distorted its purpose, shifting the financial burden onto employers and employees while enriching insurers and brokers. Here's what they don't want you to know:

Administrative Overhead

Up to 30% of every healthcare dollar is consumed by administrative expenses. This includes billing systems, coding requirements, pre-authorization processes, and other bureaucratic tasks that add no direct value to patient care. Unlike industries that strive for efficiency, healthcare administration has grown increasingly bloated, with layers of intermediaries driving up costs.

Employers and employees foot the bill for this inefficiency through higher premiums and reduced benefits.

Premium Increases and Cost Shifting

Small businesses face annual renewal rate hikes of 7-10%, far outpacing inflation. These increases are often coupled with higher deductibles and co- pays, effectively shifting more costs onto employees. Employers, already struggling with rising expenses, are left with few choices but to pass these costs along or reduce coverage options altogether. For employees, the impact is profound: fewer options, higher out-of-pocket expenses, and growing financial insecurity.

Networks That Limit Choice

Patients are often locked into narrow networks, ostensibly to control costs. In reality, these limitations prioritize insurer profit over patient outcomes. Narrow networks restrict access to high-quality providers and force patients to navigate a maze of pre-approved specialists and facilities. The illusion of choice masks a reality where insurers dictate who patients can see and what care they can receive.

Opaque Pricing and Hidden Costs

One of the most egregious failures of the current system is the lack of pricing transparency. Patients rarely know the cost of a procedure or treatment until after it has been performed. Insurers and providers exploit this opacity, charging inflated rates that vary wildly depending on the payer. Employers, too, are kept in the dark, unable to make informed decisions about their healthcare spending, further fueling inefficiency and driving profits at the expense of transparency and fairness.

Moreover, the complexity of the healthcare system is not accidental—it is deliberately designed to be overwhelming. Health systems and insurers benefit immensely from this complexity. By creating a convoluted web of billing codes, pricing structures, and coverage rules, they ensure that employers and consumers feel overwhelmed and dependent. This deliberate obfuscation discourages exploration of alternative models like self-funding or Direct Primary Care, which threaten their revenue streams. As a result, individuals and

businesses remain locked into an unsustainable system, often believing there are no viable alternatives to the traditional insurance model.

Broker Compensation Models

Brokers, who are supposed to represent their clients' best interests, often operate under compensation models that align them more closely with insurers. For example, according to industry reports, over 80% of brokers receive flat-rate commissions tied directly to premium size, creating a clear conflict of interest. These brokers have little incentive to recommend cost- saving measures like self-funding or alternative care models, as these would reduce the premiums driving their income.

The Marsh & McLennan scandal of the early 2000s exposed how these perverse incentives could lead to systemic abuse. New York Attorney General Eliot Spitzer's investigation revealed that Marsh & McLennan, one of the largest insurance brokers in the world, had been steering clients toward insurers that provided the most lucrative kickbacks and bonuses, rather than offering the best coverage options for clients. This practice, known as bid-rigging, ensured that insurers favored by Marsh & McLennan were consistently awarded contracts, regardless of whether they were the most cost-effective or suitable for the client.

In the case, Marsh & McLennan not only failed to disclose these conflicts of interest to their clients but also actively misrepresented the value of the plans they were recommending. The investigation resulted in an $850 million settlement and significant reputational damage to the firm. While reforms followed, the underlying compensation structures for brokers have largely remained intact, perpetuating the same conflicts of interest that prioritize insurer profitability over client needs.

Furthermore, a majority of brokers are reluctant to explore innovative options like self-funding, Direct Primary Care (DPC), or Reference-Based Pricing (RBP) for their clients. These models remove claims from the fully insured premiums upon which brokers' 3-4% commissions are based. This creates a perverse incentive for brokers to stick with traditional insurance plans that benefit insurers, rather than advocating for solutions that could dramatically reduce costs for employers and employees. As a result, many clients remain locked into high-cost plans without realizing that more cost-effective and transparent options are available.

Over-Utilization and Insurer Incentives

Insurers also profit from encouraging overutilization. By covering predictable expenses like routine checkups and minor procedures, they embed inefficiencies into the system that drive up overall spending. For example, insurers often incentivize providers to order additional tests or procedures to increase billable events. This is particularly evident in scenarios where insurers reimburse providers on a fee-for-service basis, encouraging quantity over quality. These inefficiencies inflate overall healthcare costs and, in turn, justify higher premiums for consumers and employers, perpetuating a vicious cycle of rising expenses without meaningful improvements in care quality.

Pharmacy Benefit Managers (PBMs) and the Pharmaceutical Industry

Pharmacy Benefit Managers (PBMs) are another key player exacerbating the inefficiencies and costs in the healthcare system. PBMs position themselves as intermediaries who negotiate drug prices and manage formularies for insurers and employers. However, their practices often exploit the pharmaceutical supply chain, prioritizing profits over patient affordability. PBMs frequently favor high-rebate drugs on formularies, inflating costs for patients and employers while benefiting from the rebates they negotiate.

This practice often forces patients to use more expensive medications, even when equally effective, lower-cost alternatives are available. For employers, this means higher pharmacy benefit costs and fewer savings opportunities. Patients, in turn, experience reduced access to affordable prescriptions, creating financial and health burdens. The incentives created by PBMs prioritize their profits over patient outcomes, further compounding inequities in the healthcare system.

The lack of transparency in PBM contracts makes it nearly impossible for employers to understand the true costs of the drugs they are paying for. These practices further entrench the unsustainable financial model of the U.S. healthcare system, leaving employers and patients with skyrocketing drug costs. While a deeper dive into the role of PBMs will be covered in the next book, their impact cannot be ignored as a driver of inefficiency and inequity in the current system.

The Result

The hidden costs of insurance are not just financial—they are deeply personal. For instance, a recent survey found that over 40% of Americans delayed or avoided medical treatment due to cost concerns. Families often face agonizing choices between paying for essential medications and covering basic living expenses. These are not isolated stories—they represent a systemic issue where the complexity and inefficiency of the healthcare system place a crushing burden on the very people it is supposed to serve.

This chapter has pulled back the curtain on the hidden costs of insurance. The next step is understanding how to break free from this cycle and build a system that works for everyone. Let’s move forward together.

Chapter 3: Self-Funding as an Alternative Solution

Self-funding represents a powerful and transformative alternative to the traditional insurance model. By directly assuming the financial risk of their employees' healthcare, employers gain greater control, cost savings, and transparency. While self-funding is often perceived as a strategy for large corporations, innovative approaches have made it accessible and beneficial for small and mid-sized businesses as well. Here's how self-funding works and why it matters.

How Self-Funding Works

In a self-funded plan, employers set aside funds to pay for their employees' medical claims rather than paying fixed premiums to an insurer. Typically, employers work with third-party administrators (TPAs) to manage claims, provider networks, and compliance. Stop-loss insurance is purchased to protect against catastrophic claims, capping the employer's financial risk. This model shifts the employer from being a passive participant in the healthcare system to an active manager of healthcare costs.

The Benefits of Self-Funding

Cost Transparency: Unlike traditional insurance plans, where premiums often include opaque administrative fees and profit margins, self-funded plans provide employers with full visibility into where their healthcare dollars are going. Employers receive detailed claims data, enabling them to understand exactly how their money is spent. This transparency allows businesses to identify cost drivers, such as high pharmaceutical expenses or chronic disease claims, and implement targeted strategies to manage and reduce these costs.

Customizable Benefits: Self-funded plans allow employers to design benefit structures tailored to the specific needs of their workforce. This flexibility can lead to improved employee satisfaction and better health outcomes.

Savings Opportunities: By eliminating insurer profit margins and leveraging data to manage costs, self-funded employers often achieve significant savings compared to fully insured plans.

Incentivizing Healthier Behaviors: Self-funded employers can invest in wellness programs, preventive care, and chronic disease management initiatives, reducing long-term costs while improving employee well-being.

Enhanced Employer Creativity: With access to granular claims data, employers can develop innovative programs to address the specific health needs of their workforce. For example, they can implement disease management initiatives for conditions like diabetes or offer incentives for employees to use cost-effective generic medications over expensive brand-name drugs. This level of detail and control is simply not possible under fully insured plans, where carriers hide data behind a wall of opacity.

Challenges and Misconceptions

One of the primary concerns employers have about self-funding is the perceived financial risk. However, protective measures like stop-loss and aggregate coverage significantly mitigate these risks by capping liabilities for both individual and total claims, providing employers with a predictable and manageable financial framework. Stop-loss insurance, also known as specific stop-loss, is designed to limit an employer's liability on high-cost individual claims by capping the amount payable for any single claim. This ensures that even the most expensive medical cases, such as catastrophic injuries or chronic conditions, don't derail a company's financial stability.

Aggregate coverage, on the other hand, sets a ceiling on the total claims payable by the employer across all employees in a given plan year. This provides protection against an unexpected surge in overall claims, ensuring that the employer's healthcare costs remain predictable and manageable.

Together, these insurance layers create a safety net that allows employers to confidently transition to self-funding without excessive exposure to financial risk.

For employers seeking even greater stability and cost predictability, Captive Stop Loss plans offer an innovative solution. These plans pool risk among a group of employers, spreading out the financial impact of large claims across the collective pool. By participating in a Captive, employers benefit from greater purchasing power and enhanced rate stability, as the shared risk model reduces volatility. Additionally, Captive Stop Loss plans encourage proactive health management across the group, as all participants have a vested interest in keeping claims low. This collaborative approach makes stop-loss coverage more attractive and ensures a more sustainable healthcare funding strategy for all involved.

Real-Life Example

A mid-sized manufacturing company transitioned from a fully insured plan to a self-funded model. Within the first year, they reduced their healthcare costs by 25% by analyzing claims data to identify cost drivers, such as high pharmaceutical expenses and chronic disease treatments. They reinvested the savings into targeted employee wellness programs, including preventive care initiatives and chronic disease management, and reported higher satisfaction among their workforce as a result. Stop-loss insurance protected them from high-cost claims, ensuring financial stability while reaping the benefits of greater control and transparency.

Self-funding is not just an alternative—it's a solution that empowers employers to take back control of their healthcare spending. By breaking free from the inefficiencies of traditional insurance, businesses can create a more sustainable and equitable system for their employees.

Where to go from here

Read the whole book

The Survival Guide to the Healthcare Apocalypse is on Amazon.
https://www.amazon.com/dp/B0FTGVGMTC

Got a renewal coming up?

We'll look inside your plan with you, piece by piece.

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