Exhibit 6

Myths And Misconceptions About U.S. Health Insurance

Health care reform is hindered by confusion about how health insurance works.

by Katherine Baicker and Amitabh Chandra

ABSTRACT: Several myths about health insurance interfere with the diagnosis of problems in the current system and impede the development of productive reforms. Although many are built on a kernel of truth, complicated issues are often simplified to the point of being false or misleading. Several stem from the conflation of health, health care, and health insurance, while others attempt to use economic arguments to justify normative preferences. We apply a combination of economic principles and lessons from empirical research to examine the policy problems that underlie the myths and focus attention on addressing these fundamental challenges. [*Health Affairs* 27, no. 6 (2008): w533–w543 (published online 21 October 2008; 10.1377/hlthaff.27.6.w533)]

SEVERAL COMMON MYTHS ABOUT THE BENEFITS and design of health insurance undermine the development of a productive conversation on reform efforts. These misunderstandings both interfere with the diagnosis of problems in the current system and impede the development of a much-needed bipartisan consensus on how to engineer reform. Although many of the myths are built on a kernel of truth, advocacy for addressing real problems often simplifies complicated issues to the point of being false or misleading. In this paper we evaluate these myths using a combination of economic principles and lessons from careful empirical research. The misconceptions often arise from genuine policy concerns, and we hope that stripping them away will promote reforms that focus on the underlying challenges facing the U.S. health system.

Our choice of which misconceptions about health insurance to address is idiosyncratic to our experience. These misconceptions are pervasive enough that pointing to specific instances may be counterproductive. Rather, we prefer to draw attention to the genuine underlying policy challenges. A common feature of several myths is the conflation of health, health care, and health insurance. The three are surely connected, but they are not the same. Others stem from attempts

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to use economic arguments to justify normative preferences. Our discussion is meant to give an economist's point of view, rather than to introduce new analysis or to provide a comprehensive treatment of any of these important topics. We begin by discussing what health insurance is and is not, and then discuss five myths about health insurance in the United States.

What Insurance Is, And Is Not

Insurance, in its simplest form, works by pooling risks: many pay a premium up front, and then those who face a bad outcome (getting sick, being in a car accident, having their home burn down) get paid out of those collected premiums. The premium for health insurance is the expected cost of treatment for everyone in the pool. The key insight is that not everyone will fall sick at the same time, so it is possible to pay for the care of the sick even though it costs more than their premiums. This is also why it is particularly important for people to get insured when they are healthy—to protect against the risk of needing extra resources to devote to health care if they fall ill.

Uncertainty about when we may fall sick and need more health care is the reason that we purchase insurance—not just because health care is expensive (which it is). Lots of other things are expensive, too, including housing and college tuition, but we don't have insurance to help us purchase them because they are not uncertain in the way that potentially needing very expensive medical care is. The more uncertainty there is, the more we value insurance.

Myth 1: The Problem With The Health Insurance System Is That Sick People Without Insurance Can't Find Affordable Policies

■ **Reality.** Insured sick people and uninsured sick people present very different public policy challenges. People who have already purchased insurance and then fall sick pose a particular policy problem: insurance is not just about protecting against unexpected high expenses this year, but is also about protecting against the risk of persistently higher future expenses in the case of chronic illness. With this kind of protection, enrollees' premiums would not rise just because they got sick, but this is not always the case today. In fact, insurers have an incentive to shed their sickest enrollees, which suggests a strong role for regulation in protecting such enrollees. Nor are insurers held responsible when inadequate coverage raises the costs for a future insurer, such as Medicare for those over age sixty-five. These problems highlight the limited availability of true long-run insurance offerings, a reform issue that is often glossed over in the confusion between health care and health insurance.

Uninsured Americans who are sick pose a very different set of problems. They need health care, not health insurance. Insurance is about reducing uncertainty in spending. It is impossible to "insure" against an adverse event that has already happened, for there is no longer any uncertainty about this event. (Insurance

could still cover the uncertainty of other changes to health, but not this pre-existing condition.) Try purchasing insurance to cover your recent destruction of your neighbor's Porsche: the premium would be the cost of a new Porsche. You wouldn't need car insurance—you'd need a car. Similarly, uninsured people with known high health costs do not need health insurance—they need health care. Private health insurers will not charge uninsured sick people a premium lower than their expected costs. The policy problem posed by this group is how to ensure that low-income uninsured sick people have the resources they need to obtain what society deems an acceptable level of care—and ideally, as discussed below, how to minimize the number of people in this situation.

■ **Social insurance versus private insurance.** This highlights one of the many reasons that health insurance is different from car insurance: the underlying good, health care, is viewed by many as a right. Furthermore, we may want to redistribute money from the healthy to the (low-income) sick, in the same way that we redistribute money from the rich to the poor. This kind of redistribution is fundamentally different from private insurance—it is social insurance, and it is hard to achieve through private markets alone.[1] Private markets can pool risk among people starting out with similar health risks, and regulations can ensure that when some members of those risk pools fall ill, insurers cannot deny them care or raise their premiums. Transferring resources from lower-health-risk groups to higher-health-risk groups, however, requires social insurance. There is a distinction between the public provision of a good and the public production of a good: social insurance may or may not be "socialized." For example, providing subsidies for individuals to purchase private insurance or providing the insurance directly (as through Medicare) are both forms of social insurance.

■ **How to provide care for the sick and uninsured?** How then do we provide the sick and uninsured with socially acceptable care? For starters, it would help to understand that unregulated private health insurance markets are unlikely to deliver this goal: no insurer will be willing to charge a premium less than enrollees' likely health costs. Instead, they could be given health care directly or a premium subsidy equal to their expected health care costs. Alternatively, we could force sick people and healthy people to pool their risks, such as through community rating coupled with insurance mandates (to preclude healthy people from opting out of subsidizing sick ones). But such pooling implies a transfer from healthy people to sick people, and consequently is based on normative preferences about redistribution.

The advantage of social insurance programs, including a nationalized health care system, is that they can achieve redistribution that private markets alone cannot. They may also provide benefits with lower administrative costs (although, in the case of moving to a single-payer system, the size of administrative savings relative to overall health care cost growth is likely to be small).[2]

There are, of course, also costs associated with social insurance programs. First,