TEXAS PUBLIC POLICY FOUNDATION
PolicyPerspective

July 2009
Center for Health Care Policy

FAQs: President Obama's Health Care Plan vs. Patient-Centered Approach

by Elizabeth Young
Policy Analyst

Introduction

Within the health care debate, there are striking differences between the solutions proposed by the various participants. Everyone agrees there are problems that must be addressed—access, cost, and quality—but then the road splits in opposite directions. One road leads to government-controlled health care, with the other to patient-controlled health care. It is incumbent on the people to carefully but quickly examine the promises versus the reality of the proposal currently being vetted in Congress. People should learn about all options for reform before decisions are forced upon them by politicians.

Both government-run and patient-driven health care concepts have been tried before, but not all aspects of these plans are easy to understand. This paper draws from multiple sources to educate the public about the current health care reform options from a national perspective.

The Government's Plan for Your Health Care

What are individual and employer mandates?

An individual health insurance mandate is a legal requirement that every American obtain adequate health insurance coverage, much the way drivers are required to purchase auto insurance. People who do not receive insurance coverage through their employer or some other group would be required to purchase their own individual coverage. Those who fail to do so would be subject to fines or other penalties. Additionally, the government will require employers to provide what it deems "acceptable insurance" to all employees.

Reality: Congress will use its power to impose penalties that force you to purchase and your employer to provide health plans that serve their interests, not yours.

What is a public option for health insurance?

Under the current plans circulating in Congress, a "public option" similar to Medicare would be set up to compete alongside private insurance plans. Supporters of a public option claim the public plan will keep private insurers honest.

Reality: As we have observed in other insurance markets, the government has the ability to impose regulations that favor itself ahead of competing private services, as well as to subsidize its activities through taxpayer dollars. Because a public option subsidized by tax dollars would be priced at an artificially low price, many employers and individuals will go to the public plan, eventually forcing private plans to fold and making the public plan the only option.

The government-run plan will act as a one-size-fits-all plan that will not take into consideration what you can afford or your individual health care needs. The young and healthy will pay the same as older and sicker Americans, creating another taxpayer-funded entitlement for all income levels. With one-third of Americans already covered by government-run plans (such as Medicare, Medicaid, and benefits for military and veterans), and more than three-fourths of Americans satisfied with their current health plan, is there really a need for another public plan?[1]

900 Congress Avenue
Suite 400
Austin, TX 78701
(512) 472-2700 Phone
(512) 472-2728 Fax
www.TexasPolicy.com

PP22-2009

continued on next page

What is comparative effectiveness research and what are the implications it could have on health care quality and access?

The recent stimulus bill created the Federal Coordinating Council for Comparative Effectiveness Research (FCCCER). Comparative effectiveness research is the direct comparison of existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harms. The core question of comparative effectiveness research is which treatment works best, for whom, and under what circumstances. Current research in this area is focused on identifying best practices so doctors can have the most comprehensive data possible when they make treatment decisions with their patients.

Reality: FCCCER lays the foundation for limiting patient health care options. Once fully in effect, FCCCER would give a committee of appointed policymakers in Washington the power to decide what treatments are (or are not) acceptable, forcing physicians to comply with its decisions and without taking into consideration the patient's ability to pay. Comparative effectiveness research can certainly be valuable to physicians and patients, but it should not be used as a blunt tool to determine whether or not a patient receives a life-enhancing or life-prolonging procedure. Britain's National Institute for Health and Clinical Excellence uses a similar system to FCCCER that now determines which procedures and treatments may be used and for which patients based on life expectancy. Oregon makes similar evaluations for Medicaid enrollees.

What is an insurance exchange?

According to the Obama plan, The National Health Insurance Exchange would act as a watchdog group to create rules and standards for participating insurance companies, and make coverage more accessible and affordable. Insurers would be required to justify above-average premium increases. The exchange would publicize differences between insurance plans.

Reality: As an administrative body, an exchange would provide comparative information on prices, plans, and benefits, facilitate enrollment of individuals and employees, and reduce the administrative costs for small businesses. If the exchange is conceived as more than an administrative body, and is designed as another regulatory agency, it could easily become a mechanism to constrain personal health care choice and discourage competition by limiting the kind and number of suppliers than can enter the market, increasing the cost of coverage.

Patient-Driven Health Care Concepts Explained

What are the consequences of America not having a patient-driven approach to health care?

With the system in place today, health care costs are rarely paid by the patients. A substantial majority of the costs are paid by third parties, such as employers, insurance companies, or the government. Often times, consumers never even see the claim form or the bills. As a result, consumers are not sensitive to price, driving doctors to perform unnecessary tests and procedures—which increases the price of health care for everyone.

Reforms that place patients in control of their health care would eliminate this problem because they put the patient, not the government, in the decision making role for health care. If implemented, these patient-centered reforms would empower patients to harness the free market, resulting in more choices and lowered costs.

What does it mean to have competition in the insurance market?

Currently, not enough competition exists in the health insurance market because of too much government regulation. The over-regulation of health insurance providers limits the coverage options that insurers may provide to patients. The ability of companies to compete for consumers is thus limited, resulting in higher costs for less coverage. In other words, it is hard to compete when each private company is being forced to offer the same product.

There are health care markets where this problem does not exist because third-party payers do not negotiate prices or pay the bills—the transaction occurs directly and completely between the patient and the medical provider. In the market for cosmetic surgery, for example, patients are offered package prices covering all aspects of care—physician fees, ancillary services, facility costs, and so forth. The listing of these prices creates competition within the market. This price competition has reduced the cost of cosmetic surgery over the past 15 years despite a huge increase in demand.[2]

What are Health Savings Accounts and how do they empower patients?

Persons choosing a high deductible health plan (HDHP) are entitled under the law to create a Health Savings Account (HSA), which allows them to pay for health care with pre-tax dollars. A HDHP requires participants to meet their deductible by paying medical bills out-of-pocket (with the HSA) rather than with co-payments or co-insurance. Under this structure, premiums are often lower than traditional health plans. Overall, HSAs provide individuals with greater control over both health care decisions and the way in which health care services are paid. Since contributions are made with pre-tax dollars, this actually represents a cost savings to those who use HSAs.

Just more than half (51 percent) of companies in the United States now offer workers a choice of a Consumer Driven Health Plan, such as an HSA. This is expected to climb to 60 percent by 2010. According to a recent industry census, 8 million people already have an HSA.[3]

What is interstate competition in health care?

Currently, states prohibit insurance companies from selling insurance across state lines, so although most insurers operate in multiple states, their plans must be tailored to each state's specific requirements and mandates. As a result, there is no competitive national market for individual health insurance. Instead, there are fragmented markets and large price differences.

For example, according to a 2007 analysis by the National Center for Policy Analysis, the cost of a standard health insurance policy for a healthy 25-year-old man averaged $5,580 in Texas. A standard policy in Kentucky, which has far fewer mandates, would cost the same man only $960 per year.

If this regulation were eliminated, consumers would be able to purchase out-of-state plans that may fit better with their lifestyle, and all other providers would have to adapt to survive.

What are mandates, and how will reducing or eliminating them make insurance more affordable?

Mandates are regulations and required benefits placed on private insurance companies by either the federal or state governments. The majority of health insurance mandates fall into one of three categories: those that force health plans to cover specific services or benefits; those that require access to specific health care providers; and those that guarantee coverage to particular individuals. These mandates ultimately result in increased health care costs because insurers are forced to charge consumers for certain benefits they may never use.

Reducing or eliminating these mandates would immediately result in lower insurance costs. The uninsured would be better able to afford quality health care plans because they would gain the power to choose only benefit options they need and not be forced to pay for mandated options. A deregulated health insurance market would be much like the auto insurance market, where a consumer has the choice of whether to include car rental coverage.

Why is it important for patients to have adequate choices in health care?

The freedom to choose health care plans, doctors, and hospitals that best fit personal needs is a valuable privilege patients must maintain. No entity knows what health care options work best better than the individual consumer. Health care should never be dictated by government.

Should health care be the responsibility of the individual or the government?

If government foots the bill, individuals will lose the incentive to engage in healthy lifestyles that would keep health care costs manageable for everyone. Most importantly, health care decisions should be personal, not made by any third-party group, even if they claim to have your best interests in mind. Remember: when others control your health, they control both your life *and* quality of life. ✯

---

[1] DeNavas-Walt, Proctor, and Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, United States Department of Commerce Economics and Statistics Administration (Aug. 2008).

[2] Herrick, Devon M. and John C. Goodman, *The Market for Medical Care: Why You Don't Know the Price; Why You Don't Know about Quality; And What Can Be Done about It*, National Center for Policy Analysis (Feb. 2007) http://www.ncpa.org/pdfs/st296.pdf.

[3] Scandlen, Greg, *FYI: Half the Employers Offer Consumer Directed Health Care Plan*, National Center for Policy Analysis (Mar. 2009) http://www.john-goodman-blog.com/half-the-employers-offer-consumer-directed-health-care-plan/.

About the Texas Public Policy Foundation

The Texas Public Policy Foundation is a 501(c)3 non-profit, non-partisan research institute guided by the core principles of individual liberty, personal responsibility, private property rights, free markets, and limited government.

The Foundation's mission is to lead the nation in public policy issues by using Texas as a model for reform. We seek to improve Texas by generating academically sound research and data on state issues, and recommending the findings to policymakers, opinion leaders, the media, and general public.

The work of the Foundation is primarily conducted by staff analysts under the auspices of issue-based policy centers. Their work is supplemented by academics from across Texas and the nation.

Funded by hundreds of individuals, foundations, and corporations, the Foundation does not accept government funds or contributions to influence the outcomes of its research.

The public is demanding a different direction for their government, and the Texas Public Policy Foundation is providing the ideas that enable policymakers to chart that new course.

900 Congress Ave., Suite 400 | Austin, Texas 78701 | (512) 472-2700 phone | (512) 472-2728 fax | www.TexasPolicy.com