

AMERICA'S AFFORDABLE
HEALTH REFORM PLAN:
A COMMON-SENSE SOLUTION

Council for
Affordable Health
Insurance

In 1992, when the country entered a serious debate about health care reform, the newly formed Council for Affordable Health Insurance (CAHI) drafted its “Eight-Point Plan” for health care reform. The goal was to highlight needed steps that would help create a consumer driven health care system, where every consumer has access to affordable health insurance policies and patients have more control over their own health care decisions. We believed then, and still believe, this approach would inevitably give consumers more health coverage options and encourage them to become value-conscious shoppers in the health care marketplace — and it has done exactly that.

Due in part to the efforts of CAHI and organizations like us, the health care system has moved significantly in the consumer driven direction, giving consumers choices they never had before. But more progress needs to be made.

- There are many Americans who do not have access to timely and quality treatment when needed. While some of this problem may be due to the number of people without insurance, universal coverage will not guarantee access.
- Health insurance can still be expensive, especially in some states and for modest-income families who don't have access to employer-subsidized coverage.

And while there has been an explosion of information about medical-care options and the need for healthier lifestyles and preventive care, providers and consumers don't consistently act on that information as much as they should.

Now we find ourselves at the center of a health care reform debate again. Despite the evidence that consumer driven care has led to more affordable health insurance — e.g., more than 30 percent of those with Health Savings Account (HSA) plans were previously uninsured — and increasing consumer control, many still look to the government to provide solutions, despite the fact that programs like Medicare and Medicaid are unsustainable. We think there is a better way.

The country can address the problems of access, affordability, competition, transparency and wellness promotion by expanding choices, creating tax fairness, reducing certain regulations and giving consumers more control over their health care dollars. The policies discussed below provide a blueprint for achieving those goals.

1. GUARANTEED ACCESS — Ensure everyone has access to affordable health care and health insurance. Both federal and state governments play a large role in determining whether people have access to affordable policies and health care. Some states have created a reasonable regulatory climate that permits lots of choice and competition, while others have virtually destroyed their health insurance markets, leaving people with only one or two very expensive options. In addition, the health care safety net — a system intended to provide care and/or coverage to low-income and struggling families and those with medical conditions — is very expensive, covers many people who have no need of a safety net and excludes many who do.

The key to guaranteeing access is to ensure that there are a wide range of affordable policies available and a viable and sustainable safety net. Those options should include:

- High risk pools, which provide an affordable option for insurance applicants who have a serious preexisting medical condition.
- Consumer driven policies, including high deductible policies and Health Savings Accounts.
- The option for low-income individuals to choose private coverage — perhaps through a system of vouchers — rather than enrolling in a public program such as Medicaid or the State Children's Health Insurance Program (SCHIP).

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- Maintaining coverage in job transition and the insureds' ability to renew policies, both of which are facilitated by the Health Insurance Portability and Accountability Act (HIPAA) and state guaranteed renewability laws. However, both could work better.
 - A restructured health insurance entitlement system that gives people the ability to opt out and use private coverage to the extent possible and relying on social insurance only where private insurance is not viable.
- 2. CREATE MORE AFFORDABLE CHOICES — Promote a regulatory environment that fosters choice.** Some state regulations and legislation, while well intended, drive up the cost of health insurance and often limit choices. What is needed is a regulatory environment that promotes insurer participation and competition rather than destroys it. That goal can be achieved by:
- Encouraging innovative new policies that meet the demands of today's consumers.
 - Allowing individuals to purchase health insurance across state lines, which greatly increases competition.
 - Eliminating guaranteed issue and community rating rules — which run contrary to actuarial principles of risk classification and lead to higher prices and limited access.
 - Creating an environment in which prices paid for care in government-sponsored programs have a reasonable relationship to prices paid for private care, which helps avoid substantial cost shifting to private markets.

3. TAX FAIRNESS — Equalize the tax treatment for individuals purchasing health insurance. Workers with employer-provided health insurance and the self-employed get an unlimited federal tax break for money spent on health coverage, making it much more affordable; workers whose employers do not provide coverage receive no tax break. That problem can be addressed either by:

- Providing employees who do not have employer-provided health insurance with a refundable tax credit. Such a credit would also help subsidize lower-income workers, many of whom are uninsured;
- Or, eliminating the current employee exclusion for health insurance and replacing it with a standard tax deduction or credit.

4. LIMITING MANDATED BENEFITS — Permit access to policies that avoid most or all state mandates. States have imposed more than 1,900 mandates nationwide on health insurance, requiring coverage for countless providers and services. While these mandates make health insurance coverage more comprehensive, they also make it more expensive — increasing the price of a policy by 25 percent to 50 percent, depending on the state.

The federal government has also imposed mandates on the states that have created numerous problems. For example, the guaranteed issue requirement in HIPAA for the small group market combined with rate bands (i.e., a restriction on the prices charged) imposed by states has resulted in a troubled small group market in many states.

The solution is to:

- Allow mandate-lite plans that avoid virtually all state mandates and allow consumers to buy the policy that fits their needs.
- Encourage insurers to offer innovative benefit designs, which may deviate from some state mandate laws such as requirements that insurance provide first-dollar coverage for some conditions or health care services.
- Allow limited-benefit plans — accompanied with the proper disclosures that they are not comprehensive policies — since they are usually more affordable than standard coverage.

5. DISCLOSURE — Provide patients with information about the cost of treatment in advance. The gradual shift to a consumer driven health care system means that more and more people want information about the cost of health care and what they are getting for their money. That trend toward transparency is opening the door to two key issues:

- Access to Prices — Patients need to know how much their treatment options cost. That includes giving patients an estimate of the final cost of all treatments prior to undergoing care.

- Access to Quality Information — Consumers may not want low prices if they lead to poor quality. What they need is access to pricing information and tools in order to make educated decisions.

6. PERSONAL RESPONSIBILITY — Increase consumer participation in health care decisions. There is a growing emphasis on the notion that individuals must take “responsibility” for their own health care costs, which has led a number of policymakers to support requiring people to buy health coverage. The better solution is to create a consumer driven system that provides the right incentives — both economic and health related — that would encourage people to take personal responsibility for their health care and their coverage. That means:

- Insurers should have the freedom to design plans that use a variety of cost-sharing mechanisms that foster personal responsibility, and consumers have the right to choose from among those plans.
- Encouraging insurers and employers to provide wellness benefits that promote a healthy lifestyle to their employees and customers.

7. MEDICAL LIABILITY — Enact sensible malpractice reforms to discourage frivolous lawsuits. Access to affordable care and coverage remains, to some extent, hostage to the country's liability system. Those states that have enacted significant tort reforms are seeing malpractice claims falling, which over time will reduce the cost of malpractice coverage and the practice of defensive medicine and will have a direct affect on health insurance premiums. Options for reform include:

- Limiting non-economic damages.
- Creating a patient compensation fund to pay for economic damages above a specified amount.
- Mandating that all punitive damages supplement the high risk pool fund.
- Encouraging the use of best practices in hospitals and by doctors.
- Absolving patients and insurers of any obligation to pay when it is proven that a medical error occurred.

8. EDUCATION — Promote well-informed consumers because they make better health care decisions. At the heart of the consumer driven movement is an educated health care consumer. That means:

- More interaction between patients and their physicians, as well as more freedom to act on their decisions.
- Greater access to information about health care options and the costs of care.
- Focusing public service announcements on wellness.
- Promoting health and physical education throughout the student years.

The Nonsense Solution

Health care reform will go in either one of two directions: more consumer control or more government control. We have discussed CAHI's "Common-Sense Solution" that increases consumer control. If the country chooses the other option, here's the kind of nonsense we'll get.

1. Lack of Access — Just because you have health insurance doesn't mean you can get health care — as millions living in countries with government-run health care systems know all too well. In Great Britain's National Health Service, breast cancer patients have been denied access to widely used cancer drugs, and lack of access to dentists has led patients to pulling their own teeth. In Canada, 12 percent of the Ontario population can't get a family physician, and Nova Scotia resorted to a lottery so people could get a doctor's appointment. As a Canadian Supreme Court justice recently said, access to a waiting line is not access to care.

2. No Choices — When the government controls the health care system, people get one choice: what the government provides. Don't like that choice? Move someplace else — or try finding someone who cares!

3. Higher Taxes — A massive government expansion of heavily regulated health insurance will cost billions of dollars — Senator Obama estimates his plan will cost between \$50 and \$65 billion a year. That means a significant tax increase to finance the coverage. And to get what? Medicaid for all? The government already covers more than 80 million seniors and low-income Americans in Medicare and Medicaid, and yet both programs are woefully underfunded and increasingly ration care.

4. Government-Designed Policies — Why should the government tell you what kind of health coverage you must have? It doesn't dictate what kind of car or house or food or life insurance you buy. Do older people really

need maternity coverage? Do teetotalers really need drug and alcohol abuse coverage? When the government pays the bills, it includes what the government thinks people need rather than what *they* think they need.

5. Limited Information — In government-run systems, no one knows what health care costs — nor do they care. Why would they when they aren't paying the bill? As a result, consumers don't weigh the costs and the benefits of their decisions; the government does the cost-benefit analysis. And patients only have access to what the government decides is cost-effective care.

6. The Nanny State — Who should take responsibility for encouraging people to make good decisions and live healthier lifestyles? Under a government-run system, bureaucrats make those decisions, and may punish people who don't follow their dictates. Under a consumer driven system, individuals make those choices and, eventually, pay a higher price for making bad choices.

7. Who You Gonna Sue? — Under a government-run system, your chances of receiving bad care go up; however, your ability to seek a remedy for that bad care goes down.

8. Uninformed Consumers — Uninformed consumers are easier to manipulate, whereas information undermines control. That's why every government-run health care system in the world limits consumer information. A well-informed patient demands answers and is less willing to accept substandard, inadequate or rationed care.

Get Involved!

The Council for Affordable Health Insurance (CAHI) was formed in 1992, during the last major national debate over health insurance reform. Insurers active in the individual, small and seniors markets wanted a principled organization standing up for them. In the subsequent 16 years, CAHI has never altered or compromised its mandate to promote market-oriented solutions to the country's health care challenges.

To find out more about how you can be part of the debate and add your voice to CAHI's to ensure a health insurance system that is competitive, affordable and based on free market principles, contact us:

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