Health Care Reform: Separating Wheat from Chaff

Insurance reform has three fundamental goals: lowering costs, increasing availability, and maintaining or improving quality. When reviewing the paths to these "end points", the question is, whether they progress toward achieving them (goals) or whether the means to get there are simply different paths with no discernible difference in outcome

ISSUES ON WHICH THERE IS BROAD AGREEMENT

ACCESSIBILITY: Insurance policies should (a) *not* exclude pre-existing conditions; (b) *not* allow cancellation of an existing policy; (c) guarantee issuance and renewals; (d) extend dependent child coverage to 26 years.

AFFORDABILITY: Insurance policies should (a) *not* set lifetime or annual limits on benefits; (b) set reasonable annual limits for deductibles and co-pays; (c) *not* allow price differentials based on sex; (d) set reasonable restraints on age-related differentials; and (e) create a national high risk reinsurance pool to protect insurers from enrollees who incur extremely high cost medical treatments.

QUALITY: Insurance policies should (a) *not* require cost-sharing for *basic*, preventive health care services; (b) require an essential benefits package that covers all *basic* health care needs; (c) standardize forms to reduce inefficiency in processing claims and enrollment; and (d) further computerizing medical information.

ISSUES ON WHICH THERE IS LESS AGREEMENT

PUBLIC OPTION: Arguments in favor are that a government non-profit insurer would provide basic insurance with less overhead. Arguments against are that it adds government insurance into the mix, pulling business and profit margins away from private insurers. Note: private insurers did not object to government Medicare for seniors which took the lion's share from private insurers.

ANTI-TRUST: Removing private insurers' anti-trust exemption increases competition. Exemptions allow insurers to not only collude on setting premium prices, but also to monopolize markets resulting in higher prices.

SALES ACROSS STATE LINES: There are two ways to sell. The first is leveling the playing field with a uniform set of rules similar to what CAFE mileage standards do for car manufacturers when mandating "corporate average fuel economy" that apply in all states. A national exchange is the health equivalent for enforcing uniform standard rules. The other alternative is to use the credit card "model", where different rules apply depending upon the insurer's home state. The question becomes, would the public prefer insurers to act more like credit card companies (banks) with no federal intervention, or to participate on a level playing field with federal enforcement?

TORT REFORM: Many states already have such reform; this would be a federal cap on non-economic damages. The argument in favor is there would be less defensive-medicine and overall health care costs would drop significantly. The argument against is there is minimal relationship between caps and health care costs; that "defensive medicine" has more to do with generating income than avoiding liability.

AFFORDABILITY CREDITS: Affordability credits are a sliding scale subsidy for individuals and families earning less than some multiple of the federal poverty level (FPL). To fund affordability credits (subsidies), a tax could be levied on individuals with adjusted gross income exceeding $250K ($500K for families), and taxing plans with Cadillac benefits. Arguments for and against tend to center on the method of funding.

PURCHASE MANDATE: This mandates that all citizens purchase health insurance. Arguments in favor are that by adding millions of customers, insurers would incur lower average costs. Mandatory insurance would also have the salutary effect of reducing the number of those without insurance who rely on hospital emergency rooms for non-emergency health care---a very inefficient way to render treatment. Arguments against include whether such a requirement is constitutional, though it seems similar to Medicare insurance through withholding work; and whether or not insurers will increase premiums for new insurance reforms, like no pre-existing condition barring coverage.

The only way a mandate works is if affordability credits are extended to millions of financially disadvantaged. Affordability credits will come from government subsidies, and because taxpayers are responsible for these monies, many believe it fair to expect insurers to discount, or reduce, premium charges when setting rates.

MANDATE EXPECTS LOWER PRICES: Insurers are not likely to do this voluntarily. Price controls are one way to restrain premium rates, but are not viewed as a long term solution. The current mix of for-profit and not-for-profit insurers has also not been successful in restraining prices. The best solution remains more competition, and is the impetus behind those advocating a strong public option.

DISCOUNTED DRUGS: Allow Medicare to negotiate drug discounts and cross-border purchases. Arguments against are that margins are needed for research into new drugs and that the quality of imported drugs cannot be assured. Arguments in favor are that the current no discount policy has resulted in U.S. drug prices far above what prescription drugs cost in other industrialized countries. As for quality, many of the drugs purchased here are the very same that buyers in other industrialized countries purchase.