Independent® Women's Voice

How to Talk About:
HEALTH CARE

Independent® Women's Voice

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What You Need to Know in 60 Seconds

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WHAT'S AT STAKE:

The U.S. doesn't have a health *care* crisis, but we do have a health *costs* crisis and a health *choice* crisis.

Americans have access to the best care in the world, with low wait times and high cancer survival rates.

But Americans lack choice…

- … to shop/plan for healthcare services based on price, because there's no price transparency. This lack of transparency results in *exorbitant* costs.
- …in their health providers, because insurance plans dictate which doctors are in network and which are not.
- …in their insurance plans:
  - Most workers simply accept the plan offered by their employer.
  - Most employers only offer one plan.
  - All plans (employer and non-employer) are standardized to meet federal regulations, limiting customization, variety, and market competition.

This is not a healthy, functional marketplace, and the result is *unaffordable costs*.

Bad Solution

So-called Medicare-for-All is a new name for the same old harmful approach of socialized medicine.

- NO choice in insurance—all employer and private plans would be eliminated, as well as Medicare and Medicaid, leaving only one "option."
- NO or minor choice in care—the only way government can control costs is by paying too little for a service, creating a *shortage* and long wait times.

Right Solution

Health care we can trust where ALL Americans can:

- Trust they won't be surprised and will know in advance what care will cost. Prices should be transparent.
- Trust that they have real choices tailored to their needs that travel with them. Insurance shouldn't depend on where you work.
- Trust that they can afford to get and stay insured, with lower premiums and greater choices in plans. Continuous coverage would especially help those with health conditions to avoid gaps and underwriting.

Pre-existing/Pre-Insured Conditions in 60 Seconds

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WHAT'S AT STAKE:

Chronic conditions are not the same as "pre-existing conditions", which is insurance industry shorthand for any condition that pre-existed insurance covering it. From the patient's perspective, these should be called pre-insured conditions.

Most people with chronic health conditions have health insurance that helps them with their costly bills. This was also true before the Affordable Care Act (or ObamaCare). That's because most people get insurance through:

- an employer (55 percent) or
- Medicare (18 percent) or
- Medicaid (18 percent)*

And these forms of insurance did not (and do not) deny coverage or upcharge anyone due to health status or history. Furthermore, before the ACA, people were permitted to change insurance plans without being "underwritten" for any condition, so long as they didn't have a long coverage gap. And new babies, regardless of any condition, were insured at standard rates, so long as they were enrolled right away.

* Some people are dual eligible for Medicare and Medicaid. In total, public programs cover 34 percent of insured Americans.

The ACA extended these two rules to the individual insurance market:

- **Guaranteed Issue**—requires insurers to issue everyone a policy
- **Community Rating**—requires everyone to pay the same in premium

These rules, while popular and well-intended, are the equivalent of letting your neighbors buy their homeowner's policy after their house burns down at the same rate as you. It ultimately took away the incentive to buy insurance before getting sick. This made insurance pools less healthy, increased premiums dramatically, and drove many insurers out of the market, shrinking choices on policies and prices.

A Better Solution:

We all want people with chronic conditions to live with confidence that they will not lose access to health care or face financial ruin because of their condition.

First, encourage people to become (and stay) insured before getting sick by making insurance more affordable and portable:

- Reduce unnecessary regulations that drive up costs and over-standardize plans, mandating features that patients often don't want or need.
- Make the link between employment and insurance optional. Allow workers to purchase the insurance plan of their choice (with pre-tax dollars) and keep it, even when they change jobs.

Second, strengthen safety nets for those who need them most. As much as we can try to help people avoid it, a small number of people will still end up getting sick while they lack insurance coverage. For them, we should:

- Encourage states to create Guaranteed Coverage Pools that offer subsidized plans. The federal government can fund and oversee these programs.

The ACA Lawsuit Debate in 60 Seconds

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WHAT'S AT STAKE:

The question in *Texas v. United States* is a simple one: is the individual mandate constitutional? More specifically, can Congress justify its requirement that individuals buy a product—here, health insurance—under the taxing power when the purported "tax" raises zero revenue?

The Constitution provides for a limited federal government—one of specified, enumerated powers. Those powers not expressly given to the Federal Government are reserved for the states or the people. In order to enact legislation, therefore, Congress must point to a specific power granted by the Constitution. If Congress cannot identify constitutional authority for legislation, that legislation is unconstitutional.

For the Fifth Circuit to uphold the individual mandate now would allow the federal government to require individuals to purchase products even when the "tax" for not doing so raises zero federal revenue. That sort of "tax" is not a tax at all and cannot be justified by the taxing power.

Texas v. United States

Background

In *NFIB v. Sebelius*, a bare majority of the Court concluded that the individual mandate could be saved by reinterpreting the penalty for not having health insurance as a "tax" under the taxing power, in part because the penalty raised government revenue—the "essential feature" of a tax.

The TCJA of 2017

Congress zeroed out that penalty as part of the Tax Cuts and Jobs Act of 2017. Congress did not make any other changes to 26 U.S.C. § 5000A (the individual mandate), and the ACA still requires individuals to "ensure" that they are covered by "minimum essential coverage."

The Current Lawsuit

The States argue that the individual mandate can no longer be upheld as an exercise of Congress's taxing power because the penalty no longer raises any government revenue.

Misperceptions v. Facts

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MISPERCEPTION: If the courts side with states in the lawsuit *Texas v. Azar*, 24 million Americans will lose access to the health coverage they enjoy under the Affordable Care Act (ACA).

FACT: *Texas v. Azar* deals with the question of the ACA's individual mandate penalty, which is now zero dollars, and whether this can be a constitutional exercise of Congress's taxing power, as the Supreme Court held in 2012

The case has a few possible outcomes:

- Uphold the entire law: no changes
- Strike down the individual mandate/ penalty: change the law on paper from "a penalty of zero" to "no penalty," effecting no real-world change.
- Strike down the entire law: effectively repeal the ACA. In this case, the Court would "stay" or pause its decision for some time, during which the Administration would continue implementing the law.

In none of these possible outcomes would Americans experience an immediate disruption to their insurance coverage or related subsidies. Even in the long run, the number of people who would lose coverage in the absence of the ACA is nowhere near 24 million. This disputed figure dates back to a Congressional Budget Office estimate that said most coverage loss would be due to the elimination of the law's individual mandate, which has now already been effectively repealed (and did not result in millions losing coverage).

Instead, if the law were struck down entirely, this would force Congress to revisit health reform and create a new policy that better serves all patients and honors the constitutional limits of government power.

MISPERCEPTION: U.S. medical care is sub-par compared to other countries.

FACT: The United States has some of the best medical care in the world.

International comparisons that rank the U.S. poorly are flawed and deceiving:

- They rely heavily on infant mortality and life expectancy.
- The U.S. counts more babies as born alive, which skews our infant mortality data.
- Other factors like demographics, lifestyle choices, accidents and violent crime, affect these metrics. These are not related to the quality of medical care available.

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When it comes to patient care, the U.S. is world class:

- Best cancer survival rates.
- Consistently ranks #1 for "responsiveness to the needs and choices of the individual patient." (WHO)
- World leader in medical innovation.
- Very short waiting times.
- Americans more likely to get preventive care than Canadians.

The U.S. may have a health costs crisis, but we do not have a health care crisis.

MISPERCEPTION: Universal insurance coverage is the best way to pay all health expenditures.

FACT: Every other kind of insurance is to protect us from very high or unexpected costs. Think how auto insurance costs would soar if you paid for new windsheild wipers and oil changes with insurance.

Funneling ALL health spending through insurance:

- Encourages overconsumption. Think about a group lunch.
- Allows medical providers to build in higher and higher hidden prices.
- Restricts patient choice in providers, because we are stuck with those in our insurance network.

Instead, the answer is greater transparency, competition and choice.

We should think of insurance as a financial protection for very high or emergency costs. Paying directly for non-emergency medical care actually costs significantly less and is the best way to lower costs and restore strong relationships between patients and doctors (by eliminating the middleman).

MISPERCEPTION: Health insurance should cover and cost the same for every person.

FACT: Every person and family has a unique set of needs and preferences in health insurance. Rather than standardizing insurance, we should welcome a wide variety of options and then let Americans choose what's best for them.

Rather than offering everyone the same price, insurance prices should reflect the risk that someone will file a claim. Otherwise, if insurance premiums are the same for everyone, younger/healthier people will leave the market altogether, driving up premiums for everyone who stays in the pool. This is exactly what happened after the Affordable Care Act restricted how insurers could price health premiums.

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MISPERCEPTION: Without the Affordable Care Act, insurers would deny coverage to anyone with any health condition.

FACT: While millions of Americans have chronic health conditions, less than 1 percent, or about 500,000 people, actually benefitted from the ACA's rule requiring insurers to offer plans to anyone, regardless of health status.

- A "pre-existing condition" is simply a condition that pre-existed or developed before someone sought new health insurance coverage. Pre-existing, or more accurately, pre-insured conditions affect only about 500,000 people. (Source: *Wall Street Journal*)
- **133 million** people with chronic health conditions are covered by employer-based insurance plans or Medicare or Medicaid. These plans offered coverage to anyone, regardless of health status, even before the ACA.
- Many others maintained continuous coverage in the private individual market or found coverage in a state-based safety-net program.

The ACA rule on pre-existing/pre-insured conditions, although well-intentioned, took away the good incentive for people to obtain and maintain insurance before becoming sick.

MISPERCEPTION: Public programs like Medicare and Medicaid work best and should be expanded.

FACT: We shouldn't judge a health program's success by how many people enroll but rather by the quality of services provided. Most who gained insurance under the ACA were added to Medicaid. But this program offers no health benefit and worse access to health services:

- **A study in the New England Journal of Medicine** found "Medicaid coverage generated no significant improvements in measured physical health outcomes in the first two years."
- **CDC data confirm** that physicians are far less likely to see new Medicaid enrollees than other patients.

Furthermore, adding millions of enrollees to targeted programs like Medicare and Medicaid, originally intended for seniors and low-income people, overburdens the safety net, making it weaker for the vulnerable groups it was meant to serve.

MISPERCEPTION: The Affordable Care Act is the only way to protect Americans with medical conditions.

FACT: There are better ways to protect Americans with medical conditions. All

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Americans should be able to purchase and maintain affordable insurance before they become sick, and parents should be able to purchase insurance for new babies without surcharge for any congenital conditions. To make this a reality, we must:

- Reduce unnecessary regulation on health insurance to reduce premiums.
- Weaken the link between insurance and employment, so that coverage can follow us from job to job and so that coverage is more accessible for those without on-the-job health benefits.
- Reserve safety-net programs for those who truly need them.

MISPERCEPTION: Health care should not be subject to market forces because it's a life or death matter.

FACT: When someone needs urgent treatment, the priority should be to get that treatment. Period. But the vast majority of medical care doesn't happen as a part of an emergency. People should have the ability to shop for care and pay for it directly and also buy affordable health insurance that works like other forms of insurance (to protect us from high bills).

MISPERCEPTION: "Medicare for All" would allow every American to get the health care they need because everyone would be "covered."

FACT: Health coverage and health care are not the same thing. While Medicare for All might insure all Americans, it would not guarantee access to medical services.

The only way government can control costs is by paying too little for a service, which creates a shortage and long wait times. This is backdoor rationing, and it is sadly very common in countries with socialized medical systems.

MISPERCEPTION: "Medicare for All" would actually save money, because it would eliminate profit from our medical system.

FACT: There are plenty of other functional industries and markets where competing firms offer goods and services and turn a profit. Why is health care dysfunctional? Healthcare markets actually do function well and lower costs when fair and transparent competition is allowed, such as when drugs are offered over the counter or when cash-only health centers share price information up front. Medicare for All would cost American taxpayers approximately $32 trillion total, which would necessitate tax increases even for middle-class families (earning $50,000 to $75,000), who would pay $7,773 to $9,171 more in new taxes each year on average to fund the program (Heartland Institute).