The Real Cost of ObamaCare:

The End of Reforms Promising Personal, Private, Portable, Affordable Health Care

By Linda Gorman • IB-C-2012 • August 2012

Issue Backgrounder

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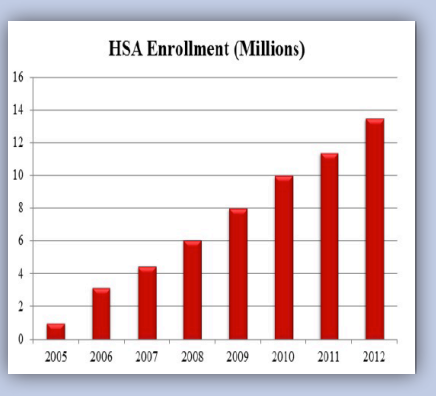
Colorado Health Reform Before ObamaCare

More cash, less third party payment—Having someone else pay for your medical care is the most expensive way to pay for it because it adds insurer overhead costs to the cost of the actual service. Colorado's private sector began switching to consumer directed health policies (CDHPs) when they became more widely available in 2003. CDHPs encourage cash payment for inexpensive and predictable care. Health savings accounts (HSA) qualified plans save excess funds in tax-free accounts that accumulate until retirement. People covered by CDHPs typically enjoy lower premiums and the same or better health. They voluntarily economize on their use of medical care because they are spending their own money. After people switch to a CDHP, expenditures typically fall 4 to 15 percent the first year. Future expenditure growth has been 3 to 5 percent below trend. With no copays or coinsurance once the deductible is reached, CDHPs provide financial certainty, an especially important feature for those with expensive conditions. For some major procedures, cash payment cuts prices by more than half. Cash payment lowers physician costs dramatically. CDHPs work well for some Medicaid patients, too.

Real choice produced real accountability—More people owned their own health insurance policy. People with CDHP policies and cash accounts enjoyed much more choice. They were not limited to local provider networks. Their physicians worked for them, not for an insurer, a hospital, an employer, or the government.

People with pre-existing conditions were already eligible for subsidized, guaranteed, coverage—Federal law has required that states provide coverage for people with pre-existing conditions since 1996. States did such a good job of handling this problem with high-risk pools and insurers of last resort that as of May 31, 2012, just 73,333 people out of a population of 311 million had signed up for the ObamaCare pre-existing condition pools.



Physicians and hospitals were innovating to provide new models of care—Urgent care centers and after hours practices offered new alternatives to emergency rooms. Private outpatient treatment centers for day surgery, diagnostic imaging, and other procedures began competing with hospitals. Concierge physicians provided individualized treatment.

Young people were treated fairly—They used less care so their premiums were up to 1/6th of those paid by older people.

The uninsured received medical care at minimal cost—$85 a year for each insured Coloradan (2007 Lewin Group study). Nationwide, uncompensated care is estimated at about 1.7 percent of insurance premiums.

And yes, 26 year olds could remain on their parents' health insurance policy—Even though it was safer, and often less expensive, to buy individual policies before ObamaCare caused insurers to end inexpensive child-only policies.

How Colorado state government can help reform now:

Stop taxing private health care—Taxes on hospital bills and insurers inflate health care costs. State officials now want to help implement ObamaCare by paying for a health insurance exchange costing millions, even though the law requires the federal government to provide one for free.

Focus on financial accountability for Medicaid and SCHIP—Despite repeated warnings from the state auditor, state officials have preferred fiscally unsustainable Medicaid expansion to responsible Medicaid financial management.

Focus on properly aligning incentives in Medicaid and CHP+—Rather than experimenting with CDHP plan structures, Colorado Medicaid and CHP+ give clients no reason to use health care economically.

Repeal ObamaCare to Protect Patients, Preserve Privacy, Reduce Health Care Cost, and Improve Quality

ObamaCare Health Care Reform

Reckless tax increases—Especially on medical device makers, insurers, and flow-through small businesses that file as individuals, because they are sub-S, sole proprietors, or LLCs.

Higher health care costs and reckless spending—Everyone must purchase the equivalent of a big corporate health insurance policy on steroids. This applies insurer overhead to all purchases, including things such as children's eyeglasses. Households with incomes up to almost $90,000 a year get subsidies.

Higher regulatory costs—More than 150 new oversight groups. Replaces taxpaying insurance brokers with nonprofit, tax-dependent, navigator programs and health benefits exchanges. Heavy compliance reporting costs.

The individual mandate gives government control of household budgets—The government determines the insurance policy you must buy and the fines for not buying it. You may not buy less coverage than the government requires simply because you think it is more important to buy more education, food, housing, or transportation.

You probably will not be able to keep your health plan—The employer penalty is roughly $2,000 per employee. The current employer cost for an individual health policy is roughly $5,500. Does it make economic sense to keep employer plans?

Treatments will be determined by federal committees—Physicians and hospitals will be penalized for deviating from care guidelines and for devoting more than average resources to individual patients. Experience with risk-adjusted Medicare Advantage shows that resources will be diverted from the sickest patients. Many people will be forced into HMOs (renamed Accountable Care Organizations) under incentives that reward pampering those in good health while treating the sick poorly.

Medical privacy is over. Individual income will be tracked and investigated—Every medical contact and resulting record must be reported to a centralized database. Exchanges are required to investigate individual income. HHS will receive IRS data and make it widely available.

Severe Medicare cuts—At least $716 billion from 2013 to 2022 out of a Medicare budget of $549.1 billion in 2012. The 2012 Medicare Trustees report concludes that ObamaCare's lower Medicare payment rates will cause 15 percent of hospitals, skilled nursing facilities, and home health agencies to operate at a loss by 2019. Though ObamaCare increases the Medicare payroll tax from 2.9 percent to 3.8 percent, it funnels the increase away from Medicare.

Forces people into Medicaid—If you are eligible for Medicaid, you will not be allowed to purchase subsidized private insurance. Medicaid is already the most expensive and dysfunctional health program in the country. Ballooning Medicaid costs will force states to cut back on roads and schools.

Physicians and hospitals limited to innovations approved by a central committee—Innovation by committee? Outpatient surgery, assisted living, the ER "golden hour" standard, and H. pylori ulcer cures were not produced by a committee.

Young people forced to subsidize wealthier older people—Older, wealthier people cannot pay more than three times the premium charged younger people even though they use much more medical care, and paid double that before ObamaCare.