COMMONWEALTH FOUNDATION | FACT SHEET

Health Care Myths and Facts

SUMMARY

- Pennsylvanians want personalized, flexible, accessible, and cost-effective health care.
- Market-based reforms to make price information available, expand telemedicine, and modernize Pennsylvania's Nursing Law can reduce health care costs and expand access to quality care.
- In contrast, recent policy changes to increase government spending and restrict patient options did not reduce health care costs. Medicaid, taxpayer-funded health insurance, is now the largest line item in Pennsylvania's state budget and the largest cost driver of the commonwealth's structural deficit.

MYTH: Markets do not work in health care. Everyone needs health care regardless of their means, and you can't pick your hospital or doctor when your life is in danger.

FACT: Outside emergencies, most trips to the doctor and the hospital require scheduling ahead of time. Market-based reforms to make price information available can reduce health care costs without reducing quality.

- Reference pricing creates a standard price for a drug, procedure, or service. Under this system, the health plan pays up to the standard price, and members pay any allowed costs above the standard price. The national nonprofit Catalyst for Payment Reform (CPR) notes that reference pricing has proved to lower costs in drug plans, and in its application to procedures, CPR cites the California Public Employees' Retirement System (CalPERS) findings that reference pricing reduced joint replacement costs by 26 percent in two years.[1]
- A Cicero Institute study of health care pricing in Nashville, Tennessee, found that cash prices for health care services are often lower than insurance rates.[2] In some cases, paying out of pocket for health care services can lead to significant savings.
- The Direct Primary Care (DPC) model changes the traditional fee-for-service model by allowing patients to pay a primary health care provider a yearly fee for their routine primary and preventative care. DigitalGlobe employees using DPC saw a 25.4 percent drop in per-member per-month costs.[3]

MYTH: Washington, D.C. controls health care. States cannot lower costs or improve the quality of care.

FACT: States can lower prices and improve quality by giving patients access to more pre-paid, insurance, or other service arrangements.

- The DPC model avoids insurance overhead and allows doctors to spend twice as much time with patients.[4] House Bill (HB) 886, introduced by Rep. Seth Grove, would clarify DPC is not insurance and not subject to insurance regulations, giving much-needed certainty to the industry.[5]

- State lawmakers can allow expanded Associated Health Plans (AHPs). AHPs allow small businesses to pool their employees to provide more affordable medical insurance. According to the Foundation for Government Accountability, newly created AHPs provided savings of up to 29 percent.[6] HB 555, introduced by Rep. Valerie Gaydos, codifies a mechanism for small businesses to establish AHPs into state law.[7]
- States can expand telemedicine to drive down costs and expand access to care.[8] Temporary waivers from the pandemic required insurance reimbursement for telemedicine services and allowed out-of-state practitioners to care for Pennsylvania patients via telemedicine.[9] [10]
- Today Pennsylvania is one of seven states that does not require insurance reimbursement for telemedicine services.[11] Senate Bill (SB) 739, introduced by Sen. Elder Vogel, would require insurance coverage for telemedicine services.[12] In addition, in most cases only doctors licensed in the commonwealth can treat Pennsylvanians. Reestablishing telemedicine reciprocity with out-of-state providers would give Pennsylvanians convenient access to specialists across the country.

MYTH: The Affordable Care Act (ACA) lowered the uninsured rate by making health care affordable.

FACT: The ACA lowered the uninsured rate by creating new subsidies that hide rising costs of health care.

- Per capita health care spending in Pennsylvania has grown by 27 percent since the Obama administration fully implemented the ACA in 2014.[13]
- Premium data from Pennie, Pennsylvania's ACA-mandated health care market, shows premiums rose by 3.9 percent on average for 2024.[14]
- The cost of employer-provided insurance is increasing too. A recent study from the Kaiser Family Foundation showed that family premiums rose by 7 percent in 2023, with employee costs for those plans expected to grow in the coming years.[15]
- The Medicaid expansion under the ACA accounted for more than half of the decline in the uninsured rate, according to the Commonwealth Fund.[16] In other words, the law reduced uninsured rates by enrolling more individuals in taxpayer-funded health insurance.
- The rest of the reduction in the uninsured rate came from an avalanche of subsidies in the individual insurance market. The Paragon Health Institute found that the cost for each additional insurance exchange enrollee was $36,798, more than three times the original cost estimate. In fact, 2024's record enrollment is largely due to the availability of insurance plans with a $0 premium.[17]

MYTH: Nurse Practitioners (NPs) provide a lower quality of care compared to physicians. People want health care from a doctor.

FACT: People want choices, including the ability to see the providers they want, and where they want. Current state regulations limit the number of patients advanced providers, like NPs, can see.

- Research shows no statistically significant difference between the quality of care provided by advanced practitioners, like NPs, compared to a primary care physician.[18]

- Polling shows that most voters want personalized, flexible, accessible, and cost-effective health care.[19]
- Currently, state law requires NPs to practice with two collaboration agreements with physicians. SB 25, sponsored by Sen. Camera Bartolotta, would modernize the Professional Nursing Law by eliminating this paperwork requirement,[20] and thereby, increase the number of NPs by 29.5 percent.[21] Full practice authority would also increase the number of patients seen by NPs by 1,792 per week.[22]

MYTH: Medicaid is a benefit to the state, with the federal government paying most of the cost. We should expand the program to help more Pennsylvanians access health care.

FACT: Medicaid consumes one-third of Pennsylvania's state spending and is a major cause of our structural deficit. There is no evidence Medicaid is better than private insurance.

- Medicaid is the largest line item in the budget and the largest cost driver of the structural deficit. Medicaid accounted for one-third of state expenditures in Fiscal Year (FY) 2023–24.[23] According to a recent report from the Independent Fiscal Office (IFO), certain Medicaid costs are growing at over three times the rate of revenue.[24]
- Pennsylvania is one of 40 states that decided to extend Medicaid coverage to healthy, low-income adults.[25] In 2023, expenditures for this population reached $7 billion with the federal government covering about 90 percent.[26] In contrast, the federal government covers about 53 percent of expenditures for seniors, kids, and those with disabilities.[27]
- Empowering patients to make their own choices with a voucher for purchasing insurance or a portable Health Savings Account (HSA) better aligns with the goals of Medicaid providers and patients. Along this line, H.R. 5608, or the ACCESS Act, would let low-income Americans who receive coverage from the ACA marketplace redirect insurance premium subsidies to an HSA account.[28]

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