Health System Reform Proposal – 4/29/2015

The United States has a unique health system in a number of respects. We have the most sophisticated but the most expensive health care per capita. This is largely a legacy of World War II and the post-war period when the USA was by far the richest country in the world with the best medical schools and health research institutions. That legacy includes widespread health insurance through employer sponsored health plans; reimbursement until relatively recently of health care providers generally based on "reasonable costs" and "allowed charges" on a fee-for-service basis[i]; shifting of costs from Medicaid and Medicare to private health insurance; and poorly coordinated electronic medical record systems, health information exchanges and immunization registries.[ii]

In previous articles, we have documented that health care costs in the USA are projected to increase gradually over the next decade so that they consume more than one fifth of the nation entire productive output (GDP) and cost per capita about half of the median wage.[iii] We have also documented that about 30% of all health care is unnecessary, which results in adverse health effects (e.g., radiation from unnecessary imaging causes some amount of unnecessary cancer).[iv]

If we continue to rely principally on employer-sponsored health insurance, this will make many US products and services uncompetitive, which will force many businesses into bankruptcy. In addition, since government pays for more than half of all health care costs in the USA, without fundamental health system reform our nation will incur such huge obligations for health care costs in the next decade that the national debt and/or federal taxes will soar – either of which will reduce our standard of living. To avoid this situation, we recommend the following:

1. **Health insurance should be provided by private health insurers, and all health insurance should include core benefits** (i.e., similar to "essential benefits" in the Affordable Care Act or "ACA"). This should include Medicare, Medicaid and other government health insurance plans, most of which are now provided by private insurance companies but with a wide variety of benefits and often less than market reimbursement to health care providers. Private health insurance plans should compete to get individuals to select them for their health insurance coverage, with the federal government providing an advanceable premium tax credit to subsidize coverage for lower income individuals and families, as is done for coverage provided through health exchanges under the ACA. A supplemental benefit package, as is done with Medicaid premium assistance programs and wrap-around supplements to commercial health insurance, should be provided to individuals with exceptional health problems or needs to assure that these individuals receive adequate care, to provide coverage, such as treatment for drug and alcohol addiction, that is often relatively limited in commercial health insurance, and to avoid future health care expenses.[v] However, health insurers may charge consumers extra premiums for any coverage consumers select beyond the core benefits and supplements provided to them based upon need. The replacement of employer-sponsored health insurance will also eliminate the so-called "family glitch" in the ACA that resulted from efforts to preserve employer-sponsored health insurance.[vi]
2. **Medicaid should be replaced with private, commercial health insurance with necessary wrap-around supplements because it is now often second-class care due to access limitations** resulting from Medicaid reimbursement rates being substantially lower than commercial insurance and Medicare reimbursement rates. A principal rationale for the federal "doc fix" legislation to eliminate the SGR was that Medicare enrollees would have limited access to health care if Medicare reimbursement rates were reduced by 21 percent.[vii]

3. **Cost shifting from private health insurance to cover below market reimbursement to health care providers by public health insurance/benefit programs should be eliminated** because it distorts incentives and supports inefficiency. In the short-term, below-market rates paid by government programs, and the corresponding extra reimbursement paid by private insurers to offset this, should be phased out, as has been done in Maryland for hospital services[viii] and nationally for primary care physician services.[ix] This will assure that poor, middle class and rich Americans have reasonable access to quality health insurance and eliminate the current two-tier system of health care based in which people with government health plans often have relatively limited access to health care.[x] Health insurers should be required to accept all applicants in the insurers' market area regardless of health history or health needs, and the federal government will pay acuity adjustment bonuses to health insurers for each insurer's covered members with high needs, as is provided in the ACA. In addition, the government's subsidies to insurers should be adjusted with a "pay-for-performance" program based upon the quality of the care provided to each insurer's covered population, including both process measures, such as timely immunizations for children and timely lab tests for diabetics, and outcome measures such as hospital readmissions after cardiac surgery.
4. **All health insurance plans must have the insured accept some financial responsibility** (i.e., "cost sharing") for the cost of health care. Cost sharing has repeatedly been shown to reduce unnecessary health care and costs with little or no adverse impact on health outcomes.[xi] Cost sharing for premiums, deductibles and coinsurance should be reduced for low income households, as in the ACA and in Medicare. Further, preventive care should not be subject to deductibles and coinsurance, as provided in the ACA.
5. **One component of the core benefits will be case management** in which individuals with unmet health needs are identified by their health insurers and connected to appropriate health care providers for appropriate health care. This will be done based upon both insurers' claims data and an initial assessment by insurers of each covered member's health status and care needs. Health insurers should be strongly incented to reach out to each insured member within the first month of coverage to assess the member's health status and health care needs. This will both assure that significant care deficits (e.g., unstable diabetics and individuals who have not been immunized) are identified for possible resolution through case management and that a supplemental benefit package may be provided to individuals with exceptional health needs (e.g., fragile elderly people living at home, special needs children and super-utilizers[xii]).
6. **All health insurer and health providers must participate in regional health information exchanges (HIX) and immunization registries**. These exchanges and indexes will be operated by contractors, which may be private or government entities. The federal Department of Health & Human Services, after consultation with relevant health care provider organizations, state health departments and consumer organizations, will determine the health services for which prompts should be issued by the HIX and/or immunization registries to health care providers and to covered individuals, such as when the available data indicates individuals are not current with their recommended immunizations or periodic lab testing for individuals with a prior diagnosis of diabetes.
7. **The Early Periodic Screening, Diagnosis and Treatment program (EPSDT) should be made an opt-in choice for both low income and non-low-income parents** since adults and parents with private health insurance now have some choice about whether to obtain recommended health services for themselves and their children. It is wrong to assume that all parents of children covered now by Medicaid and CHIP are less capable or interested in obtaining appropriate health care for their children. Further, it is known that many children with EPSDT coverage do not receive timely health care, including preventive services. Accordingly, in addition to providing EPSDT as an option to all parents as a supplement to HIX and immunization registry prompts/reminders, insurers and health

care providers each should be obligated unambiguously to report to child protective services when children appear to not be receiving recommended preventive and other needed health services.

8. **The federal Department of Health & Human Services should develop an educational program to encourage the public to obtain their health insurance from the health insurers and integrated health delivery systems that achieve significantly lower than expected per capita health care costs** (adjusted for acuity) and/or better health process measures and outcomes) after consultation with relevant health care provider organizations, state health departments and consumer organizations. This promotional activity should be more extensive than the "five star rating" system used for Medicare and displayed in the Medicare plan finder and other Medicare materials.

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