Health Care Reform Proposal

By Roberta Casper Watson*

This article is an outline of a health care reform proposal that should have a chance of getting bipartisan support in the not-too-distant future. While it addresses some of the problems in our system that contribute to out-of-control medical costs, the proposal adopts a somewhat outside-the-box structure. It adds enough governmental structure to provide near-universal coverage, while keeping as much private sector involvement as may be consistent with the need for universal coverage and as may be sustainable over time. It is not necessarily a complete structure, and refinements to it could be made based on the input of various experts.

This proposal is based on my more than 40 years as an ERISA lawyer, most of which has been heavily involved with health plans. During this period, I have spent much time and energy thinking about what kind of structure might work to provide universal (or nearly universal) coverage without forsaking the ability of the various provider industries to continue to operate somewhat independently and the US public to have some elements of choice while having a guaranteed health care safety net. There are rumors as to flaws in the health systems of some other countries, and this proposal is designed to avoid those flaws.

I am not an economist or an actuary, and have not attempted to prove any specific cost assumptions. I invite comment on the economics of the various features and the economics of any alternatives.

The Affordable Care Act (ACA) provided much-needed reforms to the pre-ACA system, based on continuing to utilize private sector providers to provide care. Recent Exchange enrollment numbers seem to indicate that it is doing well by many people, particularly those who receive subsidies to help pay for the ever-increasing premiums. But it has proven not to be sustainable in certain respects, particularly in the high prices that must be paid by those not receiving subsidies. One reason for difficulties with the ACA is that it did nothing to utilize the immense bargaining power the government would have if it applied itself in negotiating prices for care, particularly prescription drugs. Meanwhile, news articles about unexplainable logarithmically increased prices for specific drugs demonstrate the need for some kind of control on what the basic health care system will be forced to bear. This proposal starts with the ability of a governing board to determine what will be covered by a basic care system, and to negotiate prices with providers that wish for their products to be covered by the basic system. Although the basic care is available to all, individuals may elect to be treated by providers outside the basic care system, either by paying directly or by purchasing insurance.

Basic Universal Coverage

The core of the program is a bare-bones basic government option that would be guaranteed to everyone, funded by a payroll tax on employers and individuals. All citizens and legal residents would be automatically enrolled in the basic program. Thus, it will provide close to universal coverage of basic needs.

The care covered by the basic program would be preventive care, life-saving care, care needed to prevent or abate pain, and care needed to restore functionality (*e.g.*, to allow the patient to return to work). In addition, care that can be demonstrated as cost-effective

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would be added to the basic care program, and it is hoped that over time more and more providers and manufacturers would structure what they provide to meet cost-effectiveness standards.

Preventive Care Expanded

Preventive care would be required to be covered. At a minimum, preventive care would include that which is currently defined as preventive under the ACA. This would include birth control, prenatal care and well-baby care, and various screening tests as prescribed by the organizations currently setting the standards for such tests under ACA rules.

The current ACA definition of preventive care does not include any care that constitutes treatment for a diagnosed condition, whereas the new program's primary care would not be that restrictive. Rather, preventive care would also include basic primary care for diagnosed conditions, particularly where ongoing treatment prevents more serious episodes. A classic example of a need not met by the ACA's primary care provision is insulin or other blood sugar control drugs, and blood sugar monitoring for diabetics. Those are not currently deemed preventive (and thus not covered without cost to the patient) because the only individuals medically eligible for them are those with a diagnosis of diabetes and the diagnosis automatically takes the treatments out of the ACA's preventive care definition.

Often, low-income diabetics skimp on their diabetes drugs, which can cause their conditions to worsen resulting in the urgent need for various treatments that are more expensive than the cost of the preventive drugs. The agencies issuing ACA regulations have been asked to declare these antidiabetic medications to be preventive care so as to remove the financial burdens on at-risk individuals, but agency officials have felt that they did not have statutory authority to do that. Under the new program, these treatments would be deemed preventative and would be provided without out-of-pocket costs. Similarly, the drugs and tests to prevent repeat strokes and heart attacks could be declared to be preventive care, as could drugs to prevent asthma attacks, epileptic attacks, and other conditions for which careful management is considered to be critical to preventing more serious episodes of a diagnosed condition.

Basic Care Priorities

Care paid for as basic care (in addition to preventive care) would be based on priorities. The expectation would be that care necessary to save life would be covered (there would be NO death panels). Also, care to avoid or alleviate pain and care to keep a patient functional, would be prioritized. (Stories abound of patients in some countries having to wait months or years for a knee replacement when they cannot return to work without one. The new program would place a high priority on treatments needed to restore the ability to work so that such delays would not occur.)

Cost would be an important factor in determining what specific treatments are prioritized based on these guidelines. Where there are multiple possibilities to achieve the same prioritized objective, choices would be made as to which would be covered under the basic care program, and others would be excluded if deemed not to be cost effective. In general, treatments not essential to life, pain avoidance and functionality would be viewed as luxuries and not prioritized, except that such additional treatments could become covered as part of basic care if strict cost-effectiveness standards are met.

Of course, careful medically-informed decisions would have to be made as to what medications, procedures, and other treatments would be covered under these priorities. These decisions would be made by a critical coverage board that would decide on which treatments would be covered and which could be eliminated or restricted within the bounds of the directive to save lives, prevent or alleviate pain, and restore or maintain functionality. For example, the manufacturers of a new drug that had significant advantages in controlling a condition could not expect the new drug to become covered as basic care just because it had advantages, and the board would not add it just because of its advantages and certainly would not expect to pay a premium price for it just because it had advantages if the older drugs are capable of meeting the priorities. However, if the board is able to negotiate a reasonable price for the new treatment that made it cost-effective in comparison to the older treatments, the board would have the discretion to add it.

In addition to evaluating the cost-effectiveness of various treatments, the board would be authorized to identify standards and limitations needed to prevent overuse of services. Access to expensive imaging equipment in the basic program would be limited to situations when absolutely necessary for life, pain avoidance, and functionality, with cost-effectiveness being a critical factor as to what is approved under what circumstances. The procedures necessary for life, pain avoidance, and functionality would be prioritized,

with cost-effectiveness being a factor. Pharmaceuticals would be limited to those on a formulary designed to prioritize life, pain avoidance, and functionality, and cost-effectiveness would be taken into account in approving drugs for the formulary. The critical coverage board would negotiate with manufacturers of pharmaceuticals for drugs to be placed on the formulary, and with manufacturers of medical equipment for procedures to move up on the priority list. Absolute cost, such as for newly discovered treatments, could keep certain treatments from being provided at all unless and until high standards for cost-effectiveness are met.

Wellness incentives would be aggressively incorporated into the basic care structure, according to current ACA requirements.

The basic program would not be designed to cover everything that current plans consider medically necessary. Only treatments that meet the priority tests of preserving life, relieving pain, maintaining or restoring functionality, and providing preventive care would be covered, in addition to treatments added because they meet excellence and cost-effectiveness standards. Those who wanted everything medically necessary available to them could pay for it out-of-pocket, or could buy supplemental coverage to fill that gap. Over time, if the various drug, medical device, and provider industries adapted to the cost-effectiveness needs of the basic care system, it is possible that the basic care system could end up meeting the needs of, and thus being the sole coverage for, more and more Americans. However, if drug and device manufacturers and providers resisted the basic care system's cost-effectiveness needs, supplemental care and supplemental care insurance would continue to play an important role for many. The free market laws of supply and demand, as regulated by the states according to the wishes of the states, would determine the extent to which a supplemental care market and supplemental care insurance would be necessary, and the extent of the drug, device, and provider networks servicing the supplemental care market.

Structure of Basic Care Coverage

The basic coverage would be funded primarily with a payroll tax. All employers and workers (and self-employed individuals) would pay the tax. Some people have suggested that a payroll tax is regressive and thus not the best structure for such funding. There may well be alternative tax structures that could be used, but the payroll tax seems like something that would be understandable to the employers and individuals making the payments, as it would replace all or part of the insurance premiums that many of them pay now. It could be structured as a new standalone program, as Part E of Medicare, or as Medicaid or a part of Medicaid, and could all be run by the federal government or administered by the states under federal rules. State waivers could be entertained to allow states to experiment within the program guidelines.

The new program would certainly involve government, or a quasi-governmental entity, in the delivery of basic health care, but the program is designed to continue to allow private sector providers to participate so long as they are willing to abide by the program's need for cost-effectiveness. The existence of supplemental insurance will allow for patients and providers to not be limited by the basic care coverage, and federal regulation would not be present for either the supplemental insurance or the operations of the providers being paid by that insurance. However, providers working within the basic care program would have to accept the reimbursement rates of that program.

Anticipating that many providers would wish to work outside the basic care program, a series of public health clinics would be created to provide much of the basic care, with a view to using the clinics to control some of the costs that drive up the overall cost of health care. All US citizens and legal residents would be entitled to receive care at the clinics. Whether the clinics would ultimately be sufficient for most Americans, or whether many would cling to supplemental care insurance and non-clinic providers, would be determined by various market forces as the basic care and supplemental care systems compete for the loyalty of Americans.

Public Health Clinics

Public health clinics would be established so as to provide coverage everywhere in the United States, including in places not adequately served by private sector providers. The staffing for such clinics would be primarily by new medical graduates who would have received heavily subsidized medical education and would have a five-year obligation to serve residencies in the clinics. The basic care residency programs would be affiliated with medical schools, and the residents would be supervised by experienced physicians in a manner similar to existing residency programs. The affiliation of the clinics with the medical school and teaching facility structures would give the clinics access to expert faculty and high-quality young

physicians, while the subsidization of most medical education would allow the basic care system to control the costs of medical education, thus relieving new physicians from the pressure to choose high-paying specialties in order to retire their medical school debt.

Innovations would be used as deemed prudent to extend the reach of the clinic physicians. Nurse practitioners and physicians' assistants would have a prominent role, supervised to the extent deemed prudent, but with increased paraprofessional authority where their training and capabilities warrant it. Telemedicine would be used as appropriate. These physician-extender resources would be used as necessary, particularly in rural areas. While the primary staffing would be through the residencies, some doctors (and paraprofessionals) might wish to make careers in the public interest environment and the system would have positions to allow them to do so. Also, to the extent that specialty care was needed to meet the basic care priorities, the clinics would contract with outside providers.

Clinics would be required to provide all basic care that the critical coverage board deemed to constitute basic care. If warranted by the demand for increased basic care (this would likely require that the manufacturers of many products work to meet cost-effectiveness needs rather than remaining in the supplemental care market), clinics would also be allowed to sponsor specialty residencies, and even (if they chose to do so) to provide supplemental care funded by cash payments or supplemental insurance. In short, the clinics would have the flexibility to expand, as appropriate and as warranted by the demand for their services, to meet the United States' changing medical needs.

Medical Education and Medical Research

Medical education would be heavily subsidized, or at least students would have an option to receive subsidies and it would be expected that most, if not all, medical students would have all or part of their education paid through these subsidies. Then, on graduation, five years of service in the new public health clinics would be required of those whose education had been subsidized. Wealthy students who wished to buy out of their obligation could do so, but it would not be expected that students would take loans to avoid the obligation. (There would be no subsidies for such loans.)

Residency programs in primary care would be subsidized and encouraged, with many residency programs in public health clinics. Emergency care and other specialties would also be connected to the clinics to the extent feasible, but interest in a specialty would not be an excuse to avoid the five-year commitment to the clinics.

Medical research would be heavily subsidized in areas deemed likely candidates to produce cost-effective treatments suitable for basic care. The government (or a quasi-governmental agency) would retain a substantial interest in the economic benefits of the resulting discoveries, with a view towards utilizing them to provide cost-effective care under the basic care program.

New medical schools could be established in areas of urban decay and rural, underserved areas, so as to help to infuse medical resources into areas that are now difficult to cover adequately.

Supplemental Care and Supplemental Insurance

It would be expected that those with sufficient resources could and would (if they chose) buy care that the basic program did not cover. Private insurance could be sold to cover supplemental care, or as alternative coverage to cover both basic and supplemental care, but those purchasing alternative arrangements would still have to pay the payroll taxes to fund the basic system. Over time, it is possible that alternative arrangements covering both basic and supplemental care might evolve in which providers of supplemental care might interact with the providers of basic care to more efficiently meet the needs of all.

Employers could offer supplemental insurance or alternative coverage. Employer plans would be subject to pre-ACA HIPAA rules and could even remain subject to ACA's market reform rules. But, if everyone is paying into the basic care system, it should not be necessary for the federal government to regulate the supplemental or alternative policies; that can be left to the states.

Optional Miscellaneous Changes

Certain changes to the rules for health savings accounts (HSAs) and high deductible health plans (HDHPs) could be made if these vehicles fit with the redesigned program. If it is desired to add consumer incentives, HSA limits could be increased (perhaps to the level of 401(k) plan limits), and spouses could be allowed to contribute fully to a single HSA to add family flexibility. Over-the-counter drugs could be allowed to be purchased through HSAs. If desired, HSAs could be subsidized for those with low (or very

low) incomes. Preventive care already can be provided under HDHPs without regard to any deductible, but the preventive care definition would be expanded to include primary care that is needed to prevent episodes of a diagnosed condition, similar to the preventive care changes described above as part of basic care.

If desired, medical malpractice recoveries could be limited to economic damages, possibly with a capped allowance for noneconomic damages. Different triggers for economic versus noneconomic damage thresholds could possibly be adopted. For example, noneconomic damages might only be allowed in egregious cases (measured either in terms of culpability or extreme damage to the patient). Some people think that malpractice awards, or the fear of them, drive up medical costs. If that concern becomes the policy, such awards can be prohibited or limited in a manner consistent with the policy. Of course, most of the additional medical care arising from instances of malpractice would be provided by the basic care system, so it might make sense to restructure malpractice recoveries to account for that change.

Consideration could be given to the elimination of or cap on the tax exemption of medical hospitals and facilities, or the requirements for a facility to be tax exempt could be tightened. Some think that facilities abuse their tax-exempt status in various ways, such that medical providers should all be taxpayers. Others think that tax-exempt status provides a more cost-effective structure for providing medical care, such that certain types of providers should be required to be tax exempt. Changes to the current system could be made in accordance with whatever policy decision is made. ■