Recommendations for National Health Care Reform

Student White Paper

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A successful strategy for achieving comprehensive national health care reform must reflect a balance of principle and practicality. This effort will require political skill and public pressure. As students and practitioners of health professions, we are acutely aware of the challenges facing our health care system and the health of individual Americans. We also acknowledge that health care is both a central economic and a social issue. Therefore, the time has come to address the following facts:

1) The United States is the only major industrial capitalist country that does not guarantee health care to all of its inhabitants.
2) The U.S. spends comparatively more money on health care yet our health care system ranks lower than countries that spend less.
3) Providers and patients are increasingly dissatisfied with the current complicated and insecure system.

The principal goals of our recommendations for health care reform are to achieve universal coverage, control health care costs, and achieve a workable financing mechanism. We believe attaining these goals will facilitate a high quality, well coordinated, high performing health care system that strengthens individuals, communities and the nation.

To achieve these goals we recommend the following:

- Universal publicly financed coverage for individuals below the age of 26.
- The option for individuals to enter Medicare at the age of 55 (and pay the full cost of Medicare insurance to age 65).
- An individual mandate for individuals 26-65 to have health insurance.
- Mandate that all employers provide health insurance to employees aged 26-65.
- Mandate that all private health insurance companies adopt a not-for-profit organization.

- Define a standard minimum benefits package for both private and public insurance.
- Standardization of cost, payment, billing, claims, and enrollment for both private and public insurance.
- Eliminate Medicare utilization of private health insurance.
- Medicare compensation will be linked to high value, high efficiency, and high performing health care delivery benchmarks.
- Mandate Medicare to negotiate bulk discounts with the pharmaceutical industry.
- Providers are to be organized by level of care, i.e. primary, secondary, tertiary…
- Payments to providers will be outcomes-based and tailored to the level of care provided.

Expansion of Coverage

A fundamental value of any health care system is access. Our current system of employer-based health insurance does not meet the needs of large segments of the U.S. population, and unnecessarily places the burden of insurance at the feet of individuals and employers. However we cannot ignore that the elimination of employer-based insurance would cause significant dislocation and interruption for millions of Americans. Our recommendations, therefore, seek to improve current conditions by stipulating universal coverage through two distinct mechanisms. Firstly, the government would cover care for individuals under the age of 26 and above the age of 65. This program would effectively expand Medicare. At the age of 55 individuals would have the option of buying into Medicare at full cost. This option would allow early retirees access to a Medicare system that has the power to provide comprehensive coverage at a lower cost than private insurance. So as to not over burden the Medicare system, these opt-in individuals would contribute the full cost that Medicare would incur to provide coverage until they reached the age of 65.

Individuals 26-54 would receive private coverage through their employer. Employers would be mandated to purchase tax-deductible group insurance for their employees. Private insurers would compete for employer's business by offering attractive insurance products for employee pools. Small businesses and the self-employed would be insured by creating organized buying pools, subsidies, and/or tax incentives.

Unemployed individuals would be covered by government insurance programs. Private and public insurance programs would offer choice of provider and treatment modality, as well as a standard minimum benefit package.

Cost Control

Controlling health care costs is central to achieving a sustainable health care system. We believe several elements of our plan will contribute to cost savings. Mandating universal coverage will facilitate timely treatment, reducing the burden of high cost, high-risk interventions, as well as improve worker productivity. Streamlining administrative procedures associated with reimbursement will significantly reduce overhead costs. Additional savings will be gained by allowing Medicare to negotiate lower drug prices. Optimizing efficiency will lower costs significantly by eliminating redundancy and waste that is currently rampant in the system. Medicare is capable of administering and providing access to health care and payment for services without the intervention of private health insurance. Medicare also has the power to improve the quality of health care delivery by rewarding care that meets the needs of patients, providers, and policy makers. Finally, by expanding the insured population, risk will be further distributed and costs can be met more equitably.

Sizeable costs are incurred because of the for-profit health insurance industry. Resources are devoted to maximizing profit for shareholders by denying coverage, challenging claims, shifting costs to consumers and providers, and maintaining excessive pay for executive officers. These practices are fundamentally inconsistent with the notion that health care is not a commodity but a basic social service for any productive dignified society. A mandate that all private insurance be freed from the constraints of for-profit mechanisms would not only save money but ensure that health care investment returns improvements in actual care.

Private insurance purchased by employers will still be a tax-deductible expense. Costs for employees will be controlled through competition between not-for-profit private insurers competing for employer business, as well as the ability to spread risk over the employee population. Employees will be guaranteed a standard minimum of coverage that will balance comprehensive care to maintain worker productivity and cost-effective care that maximizes investment.

The current payment system is rife with perverse incentives that detract from excellent care and escalate costs. Currently, technical skill is valued above clinical judgment. Payment reforms that reward outcomes rather than volume will reign in costs and improve outcomes overall. Tort reform will eliminate significant waste dedicated to the practice of defensive medicine.

Financing

The expansion of government sponsored health care will be financed by an increase in the Medicare tax for both employers and employees, in the form of payroll deductions as is currently done with the Medicare portion of Social Security tax deductions. All income, both wages and investments would be subject to this tax based on the financing needs of the program. Taxes not collected from payroll deductions would be collected with the individual's tax return. Tax credits could be applied to very low income tax payers. Since insurers would be mandated to adopt not-for-profit organization, the majority of revenue would be reinvested in costs for care and offering competitive programs. Individuals that opt into Medicare before 65 will pay a premium that covers Medicare's cost for providing insurance for this population.

We recognize that one of the barriers to healthcare reform is the challenge of being all things to all people. Different populations will need different things from the system. We propose a payment system that embraces versatility and is tailored to the needs of the individual patient, via an explicit stratification based on health status.

Healthy patients would benefit from a capitated system with rewards for providers and patients who meet screening and prevention goals. Advanced practice nurses or other mid-level practitioners could provide care. Patients with intermediate health would benefit from a system similar to the status quo, with a modified DRG structure. There would still be rewards for meeting screening and prevention goals. Payment for acute or sub-acute problems would be bundled, regardless of inpatient or outpatient, surgical or nonsurgical treatment. The sickest, most complicated patients, or the patients with the highest utilization, would be assigned to a care management system. This would involve a dedicated case manager (likely a registered nurse or licensed social worker) who would coordinate the care longitudinally across clinical sites. The care coordinator would work closely with the primary care provider. A coordination fee would be provided to the medical home team. Payment for chronic disease would be paid

based on care cycles. For example, caring for a class III heart failure patient for 1 year would be expected to cost X dollars, and require X days in the hospital. Each chronic condition would generate another care cycle, with an added complexity multiplier, recognizing that disease processes may be synergistic.

We believe these proposals offer the best opportunity for addressing the major gaps in our system. By ensuring universal coverage, cost control, and responsible financing, we believe achieving a high performing health care system in the United States is possible.