HEALTH CARE IN AMERICA: A NEW WAY FORWARD

In his presidential address at the Society of Actuaries 2011 Annual Meeting in Chicago, Brad Smith called on actuaries to speak out more about "societal problems that have substantial actuarial components." Part of his speech included the following, which is worth repeating here:

> I am reminded of the presentation by Professor Paul Embrechts at last year's annual meeting. Dr. Embrechts is a professor of mathematics and economics. He gave a fascinating presentation on how he used his technical skills to predict the mortgage and financial crisis of 2008 well in advance of its occurrence. He described how he tried to warn regulators and government officials of this impending calamity—how they largely ignored him as being "too academic." …
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> …
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> Think about it. He had the skills and technical ability to predict this coming calamity, but because he lacked the ability to communicate effectively with a non-academic audience, he could not help the world avoid the pain and suffering it eventually caused (and is continuing to cause today)!
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> Have you ever been accused of being "too actuarial"? I certainly have. … [Then] someone pointed out to me that they were not criticizing the necessarily highly complicated and technical nature of the work that actuaries do, but rather, my inability to communicate the issues in a non-technical fashion to non-actuaries.
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> This represented a professional deficiency as critical as not having the technical ability to develop the solution. If you cannot articulate the problem you are trying to solve and the solution you are proposing, you will fail as a professional —or at least fall short of your potential.
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> …
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> We need to recognize that we are not always right. That there are elements to any solution that we may not appreciate. That we are not always "the smartest person in the room." Having said that, we must also recognize that, if this happens too often, clients will eventually stop asking our opinions. We will become irrelevant.

Brad is right about becoming irrelevant. I see it in the management of life insurers, and I expect it's occurring with health insurers. If it hasn't happened with our state and federal policymakers, it soon will. I don't want our profession to become irrelevant. Do you?

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Health care in America is an incredibly complex, and incredibly costly, "system" involving every one of us and greatly affecting our national economy. Even with the eventual full implementation of the Patient Protection and Affordable Care Act of 2010 (PPACA), it's obvious that there's still more that must be done.

It is because of this—and also because I don't want us to become irrelevant—that I would like to share with my fellow actuaries a proposed approach to health care in America and encourage a dialogue with actuaries and others. While I have tried, without real success, to communicate with policymakers about this, I have concluded that starting within my profession may be more

effective. Given PPACA's recent adoption, and subsequent Supreme Court affirmation, it will understandably be difficult to convince policymakers to make changes before the new "system" is fully implemented; but I think we need to try. These changes will take years to implement.

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— BACKGROUND —

It's no secret that health-care costs in this country are increasing at a long-term rate that our economy cannot afford. There have been so many articles published over the last few years establishing this fact that there really is no need to list them here. These costs are only going to increase further under PPACA, which is commonly referred to as Obamacare. In a recent *New York Times* article by Nate Silver,[1] the conclusions from his very informative analysis included the following paragraph:

> The growth in health care expenditures, for better or worse, is not just a government problem: private spending on health care is increasing at broadly the same rates and is eating up a larger and larger share of economic activity. It's an immensely complicated problem, but the arithmetic is simple: if we can't slow the rate of growth in health care expenditures, we'll either have to raise taxes, cut other government spending or continue to run huge deficits. Or we could hope to grow our way out of the problem, but health care expenditures may be impeding private-sector growth as well.

Yet, with all the money being spent on health care in this country, the overall health of our citizens is not as good as in many other countries. According to a recent report released by the panel of experts convened by the National Research Council (NRC) and Institute of Medicine,[2] as of 2011, as many as 27 countries had higher life expectancies at birth than did the United States. Those other countries spend less per person on health care but have healthier citizens.

Why? The report identified a handful of reasons, most of which could be classified as societal and can't easily be addressed by new legislation or programs. But one primary reason identified in the report is our inefficient health-care "system," the main deficiency of which that was cited is the lack of "universal coverage."

In this author's humble opinion, it's also because, in America, health-care providers are compensated for *treating* illnesses, not for *preventing* illnesses. So Americans get illnesses more frequently, and we pay more and more for treatments. This also is why most young medical doctors do not choose primary care as a specialty—they realize that, especially relative to other specialists, they lose out financially.

Recognizing the growing pressure, on our economy, of the growing costs of health care, the Business Roundtable, a lobbying group representing America's blue-chip corporations, recently recommended to President Obama that the minimum age for Medicare be raised from 65 to 67.[3] To adopt this change—one way to reduce spending on federal-government "entitlement programs"—would only shift the responsibility for paying health-care costs at ages

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[1] Titled "What Is Driving Growth in Government Spending?" published online Jan. 16, 2013, at http://fivethirtyeight.blogs.nytimes.com; titled "Health Care Drives Increase in Government Spending," published Jan. 17, 2013, in the *New York Times*, on page A16.

[2] Report titled "U.S. Health in International Perspective: Shorter Lives, Poorer Health," released Jan. 9, 2013, and reported on by Jacque Wilson in the CNN article "Why Americans are dying earlier than their international peers," published online Jan. 9, 2013, at 8:12 p.m. ET.
[3] "Call to raise age for US's Medicare," by James Politi, Financial Times, published online Jan. 16, 2013, 11:04 p.m. ET.

65 and 66 either fully to the individuals themselves if unemployed or, if they are still employed or under an employer's retiree health plan, to both the individuals and their employers. But the costs will continue to grow, no matter who is required to pay them.

By the way, when Silver suggested where these rising costs might lead (in his second sentence above), he apparently overlooked another real possibility. It's possible that, unless our societal attitudes (as expressed in the voting booth) change dramatically, our Congress will eventually succumb to the legislative path of least resistance: universal health care. That could put a lot of health insurers—and their actuaries—out of business. It also might mean re-employing a large number of health-care providers as employees of the federal government.

That would not seem to be an acceptable result—for either the people directly involved or our nation as a whole. Do we really want our federal government to be responsible for our health? As actuaries, we must present a better alternative.

— OVERVIEW —

Rather than simply listing the features of the proposed new health-care system, it may be better to bring the reader through the rationale for the various features. It should be easier to ultimately see how the features fit together and, in whole, should be very effective. (A separate document, written for a more-general audience, provides more background and justification of the plan. It can be provided electronically upon request.)

After a discussion of the features will be a walk-through of how the proposed new system is expected to work. Then there will be discussions of some potential implications of the new system and, last, how we might proceed to advocate its implementation.

— FEATURES OF PROPOSED NEW HEALTH-CARE SYSTEM —

The three issues that seem to need the most attention are:

(1) Improving the overall health of Americans;

(2) Lowering the yearly average cost of health care per patient; and

(3) Providing access to reasonably priced health care for as many Americans as possible (all, if possible), especially including people with pre-existing conditions. (This recognizes that we have answered the philosophical, political, and constitutional questions relating to access. PPACA makes an effort here, but there are millions of people still left behind.)

There is a fourth issue that hasn't attracted quite as much publicity as the first three. It has to do with the employers' part of, as Silver put it (above), the "private spending on health care." The increasing costs of employer-sponsored health-care plans have pressured employers into making unpleasant choices that generally have not been favorable to employees—most frequently either shifting higher portions of these costs to employees or terminating such plans

altogether. In some cases, employers have decided to hire fewer employees because of such high and increasing costs. That also hurts our economy. Relieving this pressure for employers would likely help our employers to compete globally and also lower our unemployment rates.

Improving health and lowering costs. To address Issue (1) and Issue (2), we need a health-care system in America that emphasizes wellness and preventive health care from the date of conception, minimizing unnecessary costs of illnesses that should not occur with intelligent lifestyle choices and effective preventive-care measures. To state the obvious, if we avoid unnecessary illnesses and keep the costs down for wellness, we'll live better (and longer) and also reduce our average annual costs for health care.

We cannot expect everyone to keep up with, understand, and properly use the latest medical information on treatments, nutrition, lifestyle, and other subjects relating to wellness and health. Normally, one's Primary Care Physician (PCP) is the professional best qualified to know what's best for the patient's particular situation. As the commercials rightly say, "Always talk with your doctor before . . . ."

We need to engage each person's PCP more actively in the design and long-term management of the patient's wellness program. This means having a closer and longer-term professional relationship with the patient, in order to develop a strong level of trust and influence with the patient.

And if we can use compensation as an incentive, we can compensate health-care providers—especially PCPs—to *prevent* illnesses as well as *treat* them. There *is* a way to do this; but in order to do it in an effective way, we need to have electronic access to complete and up-to-date patient medical records regarding not only doctor visits but also hospital visits, tests, scans, labs, specialist treatments, and prescription-medication usage—all including associated cost data.

Electronic Medical Records. The PPACA does include some useful provisions, and mandating the development and maintenance of Electronic Medical Records (EMRs) is one of them. While the idea of EMRs certainly is not new, we need to make them commonplace. Executives in the private sector are better equipped to track sales, manufacturing, and competitor data about their businesses than to track their own personal medical data. Since the private sector is not getting it done, we need to make it mandatory. PPACA does that, and it's a good idea.

No Copayments or Deductibles. Copayments and deductibles were designed explicitly to discourage patients from going to their doctors excessively (as well as to manage plan costs). If the PCP is going to be more engaged in the goals of long-term health and wellness management for the patient, the PCP will decide when to see the patient, and copayments and deductibles will work against these efforts. And the attendant administrative expenses also can be avoided.

Risk-Adjusted Capitation Payments. Compensating PCPs for preventing illnesses means not only compensating them for seeing and treating patients but also rewarding them financially for actually *improving* the health of their patients. This new approach to compensation has to attract a sufficient number of medical doctors to supply enough PCPs to care for all of us.

The health-insurance industry has developed a credible risk-adjustment capability for health-care costs. Using that capability, a process can be developed for calculating patient-specific risk-adjusted capitation amounts to be paid, by the health insurer to the PCP, for each patient under the PCP's care. (It also can be used to calculate risk-adjusted health-insurance premiums to be

paid *to* the health insurer.) Without EMRs, performing this task for everyone would be impossible.

Basically, the health insurer would say to the PCP, "In your local area, for this particular patient, it should cost (on average) $X for one year of quality medical care. Here is $X (or $X + Y%). If it costs you less than that, you keep the difference. If it costs you more, then you cover the difference."

Such revenues are used by the PCP to operate the practice, pay for treatments, tests, supplies, medications (brand-name or generic) prescribed by the PCP, specialists, and hospital costs. The remainder, if any, is retained as PCP profit. This requires the PCP to find the most cost-effective means locally for providing quality health care for his/her patients. The less spent on health care, the more retained as profit. In effect, the PCP becomes the patient's "general contractor" for all medical services not performed directly by the PCP. After all, who is better situated to do this?

Full Coverage. This means that the PCP is managing and coordinating *all* the medical care for the patient that is covered under the new health-care plan. But what's covered? The PPACA uses a notion of "actuarial equivalence" to define minimum coverage requirements, but that's not directly correlated with optimal long-term health. And it also assumes that patients are paying premiums, deductibles, and copayments out of pocket.

Basically everything, with the probable exceptions of dental and vision care, is covered—"cradle to grave." Also, it's expected that not-medically-necessary or -approved treatments (like elective, cosmetic, and experimental treatments or surgeries) and accommodations (such as private and semi-private hospital rooms) would not be part of the new plan. Of course, as is currently the case, a patient always could choose to have a not-covered treatment and pay for it out of pocket.

This "full coverage" part of the proposal may seem controversial—even irresponsible. But let's think about it. What health-care services should be excluded beyond the examples just mentioned? OK, perhaps the knee replacement for the 94-year-old patient with severe Alzheimer's that Brad talked about in his 2011 speech. Any other arbitrary restrictions on coverage will undoubtedly be subject to strong public criticism.

This is where a blue-ribbon panel, representing all major stakeholders, can be used to identify the kinds of medical treatments that should, and should not, be part of this plan. There should be situations where common sense dictates that we draw the line on "full coverage."

Of course, there also needs to be a real insurance component for this new system, to cover the risk of truly unforeseeable health-care issues such as accidental injuries, emergency treatments, and beginning treatments for newly diagnosed cancer. If a patient does need such treatments, the PCP still should coordinate and monitor them for medical efficacy and cost-effectiveness.

While the PCP should always be involved in the patient's health care, the plan should be designed so that the PCP is not financially responsible for such unforeseen medical care. Such an event could unfairly put a PCP out of business. With the PCP monitoring the treatments, there should be no real need for the health insurer to be concerned about patient anti-selection. Of course, health insurers should be able to reinsure for such risks.

Periodic Capitation Payments. Each year (assuming an annual capitation payment schedule), the patient's health factors are re-assessed by inspection of the EMR, and a new risk-adjusted capitation payment is received by the PCP. If the patient's risk assessment is

unchanged, the payment might change only due to factors associated with the increased age (and possibly, changes to the average local cost of treatments) of the patient.

If the patient's risk assessment improves, the capitation amount for the next year might actually decrease with the lower expected costs for treatment. As a way for the PCP to profit from helping the patient's health to improve, however, the capitation calculation can be modified to not fully reflect the improvement in risk assessment in the capitation-amount calculation. This way, the PCP shares financially in the benefits of improving patient health.

Obviously, the risk-assessment mechanism needs to be objective and not subject to PCP manipulation. This is why it's important to have electronic access to the patient EMRs. The calculations of both risk assessment and capitation payment are done electronically, using an algorithm based on EMR information.

If, instead, the patient's risk assessment worsens—for example, blood pressure rises to a new risk range or a diagnosis of diabetes—then the risk-adjusted capitation-payment amount may rise to reflect the additional expected costs for treatment over the next year. However, just as there is incentive in not fully reflecting risk-assessment improvements, there also is logic to the notion of not passing along the entire increase in capitation amount due to the worsening of risk assessment.

In any situation where a patient changes to a new PCP, the initial capitation payment to the new PCP would fully reflect the patient's then-current risk assessment—similar to starting off with a "clean slate," since the new PCP really has no responsibility for the patient's current risk assessment. This raises the question of how a person chooses a PCP and a health insurer . . . .

Health-Insurance Exchanges. Having the PCP–patient relationship terminated by a change in employer (and a resulting change to a health-care plan with which the PCP may not be affiliated)—especially in an era when people are more and more frequently changing employers (voluntarily or not)—only inhibits the effectiveness of the new plan. This would affect the employee's dependents as well. While it certainly made sense many years ago for the employer to sponsor employee health plans, it no longer seems as important. So the nexus of the health-care plan should move away from the employer.

The development and maintenance of state-by-state Health-Insurance Exchanges (HIEs) is another provision in PPACA that makes sense. And if the goal is to provide access to everyone, then use of the Internet seems to be the most efficient platform. And, speaking of access . . . .

Access, for All, to Reasonably Priced Health Care. For Issue (3) above, we really must consider other options for pooling of risks. We all know that there are options in addition to the ways provided in PPACA. Pooling of risks should be both effective and reasonably equitable, to avoid public protest. Asking a patient with very high expected health-care costs to pay an equitable premium for the coverage might politically be a tough sell. (Brad's anecdotal story about the AARP in his 2011 speech comes to mind.)

Well, if we want to cover *all* Americans (and even permanent-resident aliens), then there *is* a way to pool all the risks and yet allow the health insurers to be paid risk-adjusted premiums per patient (at rates that are approved, as they are now, by the state insurance departments) and also, in turn, pay risk-adjusted capitation payments to the PCPs. (Just think "Medicare.")

Federal Tax Collector and Premium Payer. We enlist the existing capabilities of employers and the federal government *only as facilitators*, to collect a flat-percent payroll tax just like the

Medicare payroll tax. The mechanism is already in place. It's only a matter of changing the tax rate.

The federal government, in turn, redistributes the revenue from that payroll tax to pay every health insurer the aggregate amount of all risk-adjusted premiums to be charged for all patients, nationwide, covered under their plans. Each health insurer, in turn, uses that premium revenue to pay each affiliated PCP the aggregated risk-adjusted capitation payments for all patients with that health insurer.

How high might that payroll-tax rate be? That's what the health insurers need to estimate. My guess is between 10% and 15%. That may sound way too high to sell politically, but we must realize that all we're doing here is gathering up all the costs that are going to be paid anyway, from all sources combined, and paying them all with one flat-rate payroll tax. (Think "transparency.")

This proposed plan for health care would replace all existing private health insurance (providing the same benefits and services) *and all the health-care benefits of Medicaid and Medicare*. When one adds up all the costs currently incurred for health care (excluding dental and possibly vision care), and then adds in the expected costs for all the persons currently not receiving health-care services that would now be receiving them, the total could actually translate to a payroll-tax rate that high.

On the other hand, when one considers what the average taxpayer pays now for health care—including premiums, copayments and deductibles, employer's share of the premiums for personal health care; and also Medicare payroll tax and other state and federal taxes diverted to Medicaid, Medicare, and other government-provided health care—a 10% or even 15% payroll tax for middle- and lower-income taxpayers won't seem too unreasonable.

In addition (and this probably is optimistic), one could even justify reducing current federal (and possibly state) income-tax rates somewhat, since such revenues will no longer be needed for Medicaid, Medicare, and other health-care benefits paid for by our various governments (not to mention the revenue gained from the terminated tax deductions currently claimed for health-care expenditures).

Employer Costs. For the fourth issue mentioned earlier, one option would be to no longer require that employers pay for such costs. If employers are no longer the nexus for employees' health plans, there's no need for them to participate (other than to facilitate payroll-tax collection). Although this solution may be difficult to fully justify in today's economy, it is an option to consider. More on this later.

Medical-Malpractice Insurance. One feature that didn't seem to have another logical place in the list is medical-malpractice (med-mal) insurance. So it's discussed last.

First, some states have decided to set maximum limits on med-mal awards. While the purpose of such laws—to control health-care costs—may be noble, the limits are essentially arbitrary and some plaintiffs injured by severe med-mal will be undercompensated because of them. Such limits will not, in this author's view, be necessary if the new health-care system is implemented.

Currently, each health-care provider (HCP) is responsible for its own med-mal liability and hence purchases its own insurance coverage, since health insurers usually are not deemed directly responsible in most med-mal claims. For various reasons, med-mal insurance rates recently have increased significantly (especially in specialties such as OB/GYN), HCPs have had less income with which to pay the med-mal premiums, and more-restrictive health-insurance

benefits (such as approving fewer tests and prescriptions) have increased HCP concerns about med-mal exposure.

This creates a question of indirect accountability for the quality of health care. A way to align the interests of both the HCP and the health insurer—and to improve cost efficiency (med-mal carriers deal only with, and only send bills to, a relatively few health insurers)—is to make the health insurer accountable to the patient for the quality of health care, which requires the health insurer to bear the med-mal risk directly.

Now, this wouldn't relieve the PCP (or any other HCP) of all med-mal risk. As envisioned, any med-mal insurer would look at the combined risk in any insurer/PCP relationship and assess a premium accordingly. And the health insurer would know the relative adjustments of med-mal premium rates on a PCP-specific basis and factor such adjustments into the PCP capitation payments. (It is not yet resolved how this would work for other HCPs.)

This way, the ultimate PCP-specific med-mal premium rates for a given PCP actually could vary by health insurer with which the PCP is affiliated.

— PUTTING IT ALL TOGETHER: HOW IT WILL WORK —

To provide some perspective, PPACA was enacted in 2010 and is designed to be fully implemented in 2014. One reason has to do with funding and taxes (and politics), but the other has to do with the time needed to implement the HIEs and EMRs and to increase the number of PCPs available to take on all the new patients (the additional millions that now will be covered under Obamacare).

Implementing this proposed new health-care system will have similar, if not greater, challenges. Of course, development of the HIEs and EMRs is the same here as with Obamacare. But the three special challenges will be:

1. Preparing enough primary-care physicians (PCPs) to—

    a. Treat the additional population that will be covered (more than with Obamacare), and

    b. Be sufficiently knowledgeable about wellness, nutrition, and prevention to help their patients in more proactive ways;

2. Politically settling on a payroll-tax rate to charge for the new health-care system; and

3. Developing and implementing the administrative system to collect and redistribute the payroll taxes to the health insurers as premiums.

Once the new system (including all HIEs and EMRs) is in place, it is envisioned that:

A. All Americans (and permanent-resident aliens), probably excluding full-time active military personnel, will need to go to their state's HIE to select a health insurer and a PCP.

    (1) Note that this requirement to choose applies to everyone individually.

(2) If a person has not made a valid choice by a certain cutoff date, a default option (approved by the state) must be used.

(3) Using a risk-assessment algorithm developed by the health insurer, the HIE will automatically access the individual's EMR and compute the risk-adjusted premium the health insurer will be charging for that individual.

(4) Similarly, the HIE also can compute the capitation amount the health insurer will pay to the PCP chosen by the individual.

(5) At this stage, the individual also may select supplemental health-care benefits not included with the standard plan, such as dental coverage, a semi-private hospital-room benefit, or any other "Cadillac plan" options.

(a) In some cases, the health insurer for supplemental benefits need not be the same insurer as for the basic plan.

(b) In some cases, underwriting may be needed, and premium calculations and billing must be done "off line."

(c) Otherwise, the HIE can compute the additional insurance premium that may be charged by the health insurer for the supplemental benefits.

(d) Payment arrangements directly to the health insurer for any premiums for such supplemental benefits must also be made at this point.

B. Payroll taxes are automatically deducted from employer payrolls and paid by the self-employed just as they currently pay Medicare payroll taxes. For basic-plan benefits, this is the only means for paying for health care. (Any supplemental benefits chosen are paid for under separate arrangement with insurer.)

C. The federal government receives the payroll-tax revenue and, in turn, redistributes that revenue to health insurers as aggregated risk-adjusted premium payments for each person in the nation covered by the health insurer.

D. The health insurers receive the aggregated premium payments from the federal government and, in turn, make risk-adjusted capitation payments to each PCP for the patients with that affiliated insurer.

E. As each patient visits the PCP or another HCP, or has a medical scan, laboratory, or other test, or picks up a prescription at the local pharmacy (or places an order through a mail-order pharmacy), the patient's EMR is updated to record the pertinent medical information and all cost information.

F. If patients incur health-care costs for medical events covered by "real insurance" through the health insurer, that insurer reimburses either the PCP or the direct provider (not yet resolved) for such expenses. Of course, these are recorded in the EMR as well.

G. Periodically, the health insurers access the EMRs for their covered patients (using insurer-specific approved data security access) for analysis and for development of rate filings to the various state insurance departments for approval.

H. State insurance departments, using state-specific approved data security access, can survey EMRs for all state residents (presumably without having access to personally identifying information) to perform state-level analyses of medical records and treatments, health and disease data, and health-care-expense data.

I. Likewise, federal agencies—*e.g.*, Centers for Disease Control and Prevention, Dept. of Health and Human Services—using federal-level approved data security access, can survey EMRs for all U.S. residents (again, presumably without having access to personally identifying information) to perform nationwide analyses of medical records and treatments, health and disease data, and health-care-expense data.

J. As time progresses, it is expected that the initial payroll-tax rate will need to be adjusted in order to keep pace with changes in demographic and employment trends, and mostly (we hope) with reductions in the average per-person cost of health care. This would likely require occasional Congressional action.

— POTENTIAL IMPLICATIONS OF THE NEW HEALTH-CARE SYSTEM —

The PPACA is a 1,000-page bill that contains several health-care mandates and other initiatives for many distinct segments of our society. It is clearly an example of micro-managing health care in an effort to achieve a noble goal. It also is a collection of bureaucratic complications that add a huge administrative burden to taxpayers. While it attempts to cover the Americans who currently do not have access to adequate health care, it is successful only with about half of those without access today. Last, most would agree that Obamacare really does nothing significant to improve the health of Americans who already have access to a health-care plan.

The design of the proposed new system attempts to address all the inadequacies of Obamacare—and, in addition, actually lower the average per-person cost of health care—by seeking the most cost-effective, and *health*-effective, health-care system possible for all of us, in this democratic society with an economy that is proudly based on capitalism.

As an added "bonus," the proposed new system is designed to run entirely *outside* the government (except for its role as facilitator), removing the costs of health care from the state and federal budgets so that our Congress finally can address our growing national debt.

While the author openly admits that not all details of this proposed new health-care system have been considered and resolved, there are some additional issues and questions that can be discussed here.

Winners and losers. Whenever a new program of paying for services is introduced, some people will pay more than they used to pay and others will pay less. In this case, with everyone paying tax at a constant percentage of income and individuals getting their risk-adjusted health-insurance premiums paid for them, the lower-income taxpayers (and those with no taxable income) gain the most. People previously denied health insurance due to pre-existing conditions also are big winners.

With a payroll-tax rate of 10%, a higher-income single person making $250,000 annually would pay $25,000 for one year of health care for himself/herself. At the same tax rate, a lower-income head of household with a spouse and three children, making $25,000 yearly, would be paying $2,500 to insure five people—an average of $500 per person.

The same apparent inequities occur across ages and risk assessments, but this is to be expected from a pooling approach where everyone is automatically in the pool and everyone pays at a constant percentage of taxable income.

On the other hand, everyone can see that flat tax rate of, say, 10%, and work to get it down. As the average health of Americans improves (and all other cost factors remain unchanged), that rate will inch downward over time. Then, everyone wins.

Capitation was not successful in the past—why should it work now? In the past, under the label of "managed care," capitation had two weaknesses:

1. The health insurer, not the PCP, was viewed as deciding where the patient could go for specialist and hospital care. Patients decided that the distant and faceless insurers were only concerned about profits and were not qualified to be responsible for their health.

2. There were other options available in the free and open market that did not require "insurer pre-authorization to see a specialist of your choice."

Under the proposed new health-care system, the decision for care beyond the PCP is made jointly by the PCP and the patient. If the patient doesn't like the choices offered by the PCP, the PCP can explain the reasons to the patient face to face. If the patient still is not satisfied, the patient can ultimately decide to find another PCP. The insurer is not involved. And there will be no other health-plan options available to patients, unless health insurers design new ones.

Why should health insurers continue to be involved in health care? Actually, for several reasons:

1. To administer and coordinate all the cash flows among all the other parties involved;

2. To provide coverage for additional and supplemental health-care benefits;

3. To actually insure against the risk of unforeseen patient events that incur health-care expenses that the PCP should not be directly responsible for covering;

4. To negotiate quantity discounts for hospital expenses, pharmaceuticals, medical supplies, med-mal insurance coverage, and other items that can either allow insurers to offer patients no-cost additional benefits or reduce ultimate costs to patients through lower premium rates, in turn leading to lower payroll-tax rates;

5. To help fund research into new pharmaceuticals and other medical advances;

6. To conduct nationwide health, treatment, and wellness studies for the benefit of all HCPs and patients; and

7. To compete with other insurers in a free and open market to keep costs for patients low.

State-mandated additional health-care benefits. While the proposed new standard plan is expected to be fairly complete in coverage, it's always possible that some states will want to mandate additional features to the standard plan offered nationwide. This could be accommodated by identifying an explicit additional premium payable by state residents and not included in the premium payments distributed to insurers by the federal government. The

states would need to make separate arrangements for payment of these premium amounts to insurers.

Employers contributing part of their employees' new health-care payroll tax. This new health-care system may help to get employers out from under the weight of the current requirements with employer-sponsored health plans. The flat-X%-per-taxpayer cost for everyone is so transparent that any employer sharing of the X% payroll deductions also will be transparent to employees. On the one hand, letting employers decide how much of it they want to (or can) contribute for their employees would let the free and open market decide. On the other hand, our policymakers in Washington might have other ideas.

— NEXT STEPS TO SEEK IMPLEMENTATION OF THE NEW HEALTH-CARE SYSTEM —

This is an opportunity for actuaries, as a profession, to make a difference in our society that the public really notices—to be *relevant*. But to get anything changed in Washington, we'll need the help of another kind of professional. Health actuaries that work—or consult—for health insurers need to convince the health insurers that this is in their best interests. Also, the medical community needs to actively support this new approach.

The health-insurance industry and the medical community each have a lot of influence in Washington. If these two bodies were to combine their efforts for this cause, we might bring about the needed changes.

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President Obama deserves considerable credit for having the courage to address the health-care crisis, not only as a candidate but also as president. In reflecting on his proposal during his first presidential campaign, he once indicated that he would have preferred not to have to start with our current system.

Our forefathers started from scratch and forged a new government without having to start with an existing one. Fortunately, they were not burdened with the public attitudes and expectations borne of an existing monarchy or dictatorship. Instead, they based it only on what they felt was best for the people it was to serve. Starting from scratch seems to have worked out pretty well for America.

Perhaps now is the time to start from scratch with health care in America.

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