U.S. Health Care System Proposal: Private And Public Choice

by Kevin Wolf

By offering consumers two additional choices of private and public health insurance plans and a few changes to the current health care system, the United States can create a system that is more accessible, more affordable, and—by covering the now uninsured—more equitable. To achieve this, stakeholders (including individuals, employers, government, health care providers and insurance companies) will share in the solutions and sacrifices that come with the changes.

The current main public insurance alternatives are Medicare and Medicaid for well-defined populations (generally seniors or low income) and are not available to other health care consumers. For private coverage, the U.S. has employer-provided coverage (including government employers) and individuals buying their own insurance.

In addition to the insured, there are over 45 million people in the United States currently uninsured, including those who are financially unable to pay for employer-offered benefits.

The new system will have three components:

- The current U.S. health insurance system with minor changes (called the Current Option).
- A private insurance option that allows consumers to sign up for the Federal Employees Health Benefit Plan (FEHBP). This will include subsidies based on income to make it affordable for everyone. This is called the Private Option.
- A public option which is administered like Medicare but with more benefits, and emphasis on preventive care. This is called the Public Option. [1]

A concern of private insurance companies, and the reason they underwrite (reject persons or exclude benefits), is that consumers may seek insurance only when they anticipate being sick. To prevent this adverse selection the new system will allow consumers to change their Current, Private or Public Options infrequently (e.g., every two years).

These new choices will improve the health of consumers, reduce bankruptcies,[2] provide affordable coverage to consumers, help businesses become more globally competitive, support quality health care, and increase life expectancy.

Changes To The Current Option

Under the Current Option, employer-provided benefits remain the same with the following caveats:

- Waiting periods, exclusions based on pre-existing conditions and other barriers to coverage are prohibited.
- If employers have no coverage, drop coverage or their employees don't take their coverage, then they must pay a payroll tax (based on a sliding scale, depending on their size) for non-covered employees to subsidize the Public and Private Options.

Private Option

Households or individuals can choose any of the FEHBP benefits[3] in their location (like Basic, Standard, HMO, etc.). They will pay the full premium for this benefit. As in the current option, waiting periods, exclusions based on pre-existing conditions and other barriers to coverage are prohibited. The pooling of people selecting the Private Option with federal employees provides administrative efficiencies over persons buying individual insurance in the Current Option. There is a subsidy for low-income households. Households taking the Private Option pay a small progressive tax on income exceeding some minimum to defray the cost of the subsidy to low-income households. This will cover many of the low-income uninsured and those who can afford a significant portion of group premiums.

Public Option

Those not taking the Current or Private Options are put in the Public Option.

Two new independent entities[4] support the Public Option: 1) Health Care Benefits and Financing Administra-

tion (HCBFA) who develop benefits for and the method to pay for the Public Option, using guidelines given below; and 2) Quality of care standards are developed and enforced by the Health Care Quality Commission (HCQC).

The Public Option is funded through a progressive tax[5] on all household income.[6] All households pay the tax whether or not they are insured via the Public Option (just as homeowners pay property taxes to, in part, support public schools even when they don't have children who attend them). The Public Option tax is estimated by a survey to establish who will choose the Public Option. The tax rate rises or falls as more or less households/individuals join the Public Option. But when the tax rate rises, the total cost of Current and Private Options naturally falls (because less people select those Options).

Key Features Of The Public Option Are:

- *Benefits* are comprehensive and set by the HCBFA. Co-pays—through a low progressive tax on household income—apply to non-preventive services. As an incentive no co-pays apply to preventive services, determined by HCBFA, which can include smoking cessation,[7] obesity weight reduction,[8] preventing diabetes and its complications[9] and alcohol and substance abuse cessation.
- *Payments* to health care providers are at the same level as Medicare recipients.[10] The reimbursement levels and methodology for Medicare are well established, which are generally lower than private insurance reimbursement, and are ready to use when the Public Option begins.
- *Provider Incentives:* 1) Public Option-only providers have limits on medical malpractice liability including removing the medical expense portion to significantly decrease malpractice premiums; and 2) Waive federal and state education loans for providers who practice in underserved areas of the United States for a specific period; especially if they become primary care doctors, nurses and other high need professionals.
- *Quality Control:* The HCQC are practicing health care providers, patient advocates, Public Option participants and Health and Human Service career support staff (lobbyists should be discouraged). The HCQC can set minimum standards for:
  - Provider qualifications—with due consideration for state licensing. Evaluating provider practices and quality—consider outcome modeling (i.e., looking at the entire duration of care for each medical type of occurrence by provider).[11]
  - Creating a national quality and qualification database that rates all hospital, clinic, physician, nurse, etc. providers (consider license, malpractice court decisions, multi-patient and multi-peer *confirmed* complaints or compliments) and is available to the public; must meet minimum qualifications to remain licensed. Consider state input.
  - Medical record administration, Health Information Technology and uniform electronic claim/service reporting with the goal to significantly reduce Public and Private Option and health provider administration costs and increase efficiency.
  - Fraud prevention and auditing.

Conclusion

Though the United States Health Care System is very complex, a few changes can go a long way toward fixing it. The changes proposed here address the major issues of reform, such as funding, coverage of the uninsured, and the need to equitably distribute benefits and sacrifices among the various stakeholders. By implementing this plan, Americans will enjoy a longer and better quality of life.

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PROS AND CONS BY STAKEHOLDER

Stakeholder	Pros	Cons
Consumer/Households	Will get more choices (every two years) Lower health care costs Cover the uninsured Increase longevity and higher quality of life with preventive care promotion in Public Option	Pay higher taxes Put in Public Option if not selecting Current or Private Options
Health Care Providers	No uncompensated care Support quality providers Reduce malpractice rates & college loan relief for Public Option providers	Subject to greater oversight and competition Quality and qualification database available to public Lower reimbursement for Public Option enrollees
Employers	More competitive in global economy because it's easier to budget costs Control own health plan, like today, or drop it and pay payroll tax	Some employees will select Private and Public Options Pay tax if not covering employees
Insurance Companies	Responsible for Current and Private Options Reduce adverse selection by infrequent allowed changes	Remove underwriting controls Will lose members to Public Option
Government	Public Option has lower administration costs than private insurance Enhance society stability by improving health of consumers and reducing bankrupcy rates	May become bureaucratic Public Option subject to political decision-making (Desire independent HCBFA and HCQC to reduce this)

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[1] *Potential name for the Public Option is MedAmeriCare. The word mixes Medicare and America.*

[2] Health Affairs *February 2005 study by Himmelstein, D. U., E. Warren, D. Thorne, and S. Woolhandler found about half of bankruptcies are from medical causes, which will decrease when the Public or Private Options are selected; study:* http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp_type=&author1=himmelstein&fulltext=&pubdate_year=&volume=&firstpage

[3] *See* http://www.opm.gov/insure/health/planinfo/2009/brochures/71-005.pdf *pages 131-132 for basic benefits summary.*

[4] *In one possible approach, Congress would select HCBFA and HCQC members or delegates member selection to nongovernmental independent organizations; members would periodically rotate, off-election-cycle.*

[5] *For example, this tax could vary by readily available income quintiles (20 percentiles) and upper 5 percentile from* http://www.census.gov/prod/2008pubs/p60-235.pdf *(Income, Poverty, and Health Insurance Coverage in the United States: 2007; table 6)*

[6] *Under this proposal household income would include wages, bonuses, capital gains net of losses, commissions, etc.*

[7] *Tobacco use causes 440,000 annual premature deaths. Direct annual medical costs for smoking related problems are $75 billion annually and $92 billion indirectly. The California Tobacco Control Program led to 33,000 fewer deaths for 1989-1997. The Massachusetts Tobacco Control Program led to significantly reduced smoking during pregnancy (from 25 percent to 13 percent between 1990 and 1996). The Task Force on Community Preventive Services highly recommends cessation programs, decreasing out-of-pocket treatment costs, and smoking bans; from* www.cdc.goc/nccdphp/publications/factsheets/Prevention/tobacco.htm *2/21/2006.*

[8] *Over 60 million adults (age ≥ 20) are obese and 9 million ages 6-19 are overweight. In 2000 total U.S. cost was $117 billion. A 10 percent weight loss that's kept off reduces an adult's lifetime costs by $2,200-$5,300; from* www.cdc.gov/nccdphp/publications/factsheets/Prevention/obesity.htm *2/21/2006.*

[9] *Average annual costs per person are $13,243. Preventing complications includes regular eye exam (treatment could prevent about 90 percent of resulting blindness), foot care exam (treatment could prevent about 85 percent of resulting amputations), and controlling blood pressure could reduce related strokes, heart disease and kidney failure; from* www.cdc.gov/nccdphp/publications/factsheets/Prevention/diabetes.htm *2/21/2006.*

[10] *Under this proposal one exception to Medicare reimbursement: HCBFA can set prescription drug reimbursement levels.*

[11] *For an in depth discussion of outcome modeling, see M. E. Porter and E. Teisberg,* Redefining Health Care, Creating Value-Based Competition on Results, *(Boston: Harvard Business School, 2006).*