A Solution, In Theory

by Damian A. Birnstihl

Americans agree that the health care system is in crisis, but there is no agreement on a solution. Proposals range from a single payer system to piecemeal improvements to the existing system.

Key Issues

One key issue in the current system is the fragmented risk pool. Most Americans obtain their health insurance through their employers. Others get coverage through public programs such as Medicare and Medicaid or through the individual insurance market. Many are unable to get coverage because they do not qualify for public programs and cannot find affordable individual policies due to various medical conditions. Still others who can afford individual policies forgo coverage. Making health insurance mandatory would address the issue of those forgoing coverage, but not the issue of those who cannot afford coverage. In a voluntary system, those who choose not to participate are likely to be those who do not perceive the need to participate, i.e., the healthy segment of the population.

Creating a single payer system would be one way to address the fragmented risk pool. However, those who advocate this option should be careful what they wish for: a monumental government bureaucracy and no consumer choice could be the end result.

Another problem with the current system is the lack of portability of coverage. When an employee loses his or her job, any employer-provided health insurance is also lost. Although the employee may be able to continue coverage through COBRA, there are limits on how long coverage can be continued and some people may not be able to afford the premiums.

Further, having employers provide health insurance to their employees is not economically efficient. Money that the employer spends on procuring and administering health insurance is money that cannot then be spent on production, research and development, marketing and other business functions. Also, small businesses are at a disadvantage relative to large business because the latter can negotiate more favorable premium rates or even self insure.

Another economically inefficient aspect of the current system is different payers paying different amounts to providers for the same service. Each private insurer negotiates reimbursement rates with every hospital and physician group in its network. Medicare and Medicaid establish their own fees, which tend to underpay the providers and thereby shift costs to private insurers. The time, effort and cost involved in the negotiation and administration of reimbursement arrangements is vast, and the end result is often frustration and finger-pointing between providers and insurers.

Effective health care reform must address these issues. The fragmented risk pool must be brought back together so that risk can be spread broadly. Coverage should be expanded to reduce the number of uninsured, ideally to zero. Employers should be removed from the business of providing health insurance to employees to improve efficiency across the system as a whole, to level the playing field among employers of different sizes, and to eliminate the problem of lack of portability. Finally, a standardized provider reimbursement methodology should be implemented.

A Proposal

One possible solution (in theory) would be to create a system similar to Medicare Advantage for the entire American population. Coverage would be mandatory, with the federal government subsidizing premiums and out-of-pocket costs on a sliding scale for low-income persons. Employer-provided insurance would be eliminated, as would Medicare and Medicaid.

Private insurers would submit competitive bids to provide coverage in specified geographic areas. The federal government would pay a risk-adjusted capitation rate to the private insurer for each person covered by that insurer.

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Hospitals and other facilities would submit their proposed chargemasters to the federal government for advance approval. For physician services, a standard fee schedule would be established, with geographic factors and perhaps a rural/urban factor as well. A given hospital or physician would receive the same reimbursement from all insurers for the same service.

Private insurers would compete with each other on the basis of price and customer service. A given insurer's price would reflect its ability to control administrative expenses and the effectiveness of its medical management programs.

Consumers would have choice among the insurers selected by the government to provide coverage in their area.

Conclusion

The barriers to reform—whether this proposal or any other—are considerable. If reform were easy, it would have been done years ago and we would all have universal, portable coverage by now. This proposal does not purport to solve all of the problems with the current system, and admittedly has not been fully fleshed out. It is submitted merely as an idea for discussion, with no illusions that it will be or even could be implemented. But the longer we as a society do nothing, the worse the problem gets. It certainly appears that none of the reform proposals on the table provides a workable solution.

Damian A. Birnstihl, FSA, MAAA, is director of Actuarial Services at Aetna in Chandler, Arizona. He can be reached at Damian.Birnstihl@Aetna.com.