Principles For U.S. Health Care Reform

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Introduction

The U.S. health care system, roughly one-sixth of the U.S. economy, is suffering from continued annual cost increases significantly exceeding wage growth. This trend, if continued, will create dramatic pressures on our standard of living. This cost pressure and increasing number of uninsured necessitates comprehensive health care reform.

We see many alternatives advanced to fix the problems. But these attempted solutions regularly do not address the entire health care system. Instead, they focus on one or two issues. Further, many reforms violate economic and actuarial principles while constructing unsustainable safety nets. This lack of vision results in a maze of patches, producing an uncontrollable system that lacks transparency in cost and care.

The objectives of health care system reform should be to improve three primary items: cost, access and quality in aggregate. The complexity of the health care system requires balancing these three variables while taking into account individuals' points of view.

To achieve that balance, health care programs should satisfy economic, actuarial and safety net principles and be appropriately managed. Currently, we see violations of these principles including:

- Economic demand and supply out of sync (price controls, over insurance, little or no transparency in costs or delivery of care).
- Lack of appropriate actuarial risk classification (adverse selection resulting from too much pooling in reforms to date).
- Inappropriate safety net structure.

In addressing these issues, we believe that economic, actuarial and safety net principles should be gradually restored versus the distorted conglomeration existing today. The ideas presented in this paper focus on restoring the use of principles over time, rather than trying to create a system that overcomes certain problems but violates these concepts. We believe any system that seriously violates these concepts will be inefficient and likely unsustainable long term.

This paper provides basic health care reform principles and discussion on incremental solutions. This paper's length limitation prevents further elaboration.

Basic Principles

These basic principles below should be followed in any reform.

Economic Principles

Reforms should strive to encourage the basic economic principle of supply and demand. Price controls, reliance on third party payers, excessive mandated benefits, high malpractice costs, and over insurance are impediments to market driven supply and demand.

Government price controls shift costs to the private markets and cause providers in government programs to increase utilization to maintain income levels. Elimination of price controls relieves the cost shift to the private markets. Restructuring government programs as true safety nets (discussed later) would result in a restructuring of these programs.

The third party payment system desensitizes individuals to the cost of health care. Information must be provided to consumers so they know the cost of the services that they use. Benefit design must result in the consumer having "skin in the game," especially for discretionary health care spending.

Provider incentives should be aligned with value (cost and measurable quality). When providers make more money by providing more care, supply creates its own demand.

Actuarial Principles

Lack of reasonable risk classification will ultimately lead to adverse selection, nonparticipation and increased costs.

Many parts of our current system rely too heavily on pooling to solve problems. While a degree of pooling is necessary, our experience has been that pooling concepts are stressed more than appropriate and risk classification much less than appropriate. Many reforms tried by various states have relied too heavily on pooling, which has caused better risks to opt out or move to leaner coverage, resulting in adverse selection. The cost of pooling—to those who are doing the subsidizing—has to be minimized, which is not often the case today.

Long-term costs should be matched to the population's long-term ability to pay to minimize generational cost shifts.

Appropriate Safety Nets/Government Programs

People should be placed into safety nets based on need only. Safety nets may be funded privately or through government. Safety nets should include a low percentage of the population that receives a substantial subsidy. The subsidy should come from those not in the safety net, with the per person subsidy a low percentage load of their total cost.

Incremental Ideas For Improvement

This section lists alternatives to move the system incrementally toward satisfying the principles presented. The success of some of these ideas is interdependent on others. Testing and monitoring should be established to properly manage the system over time.

1. Increase transparency so individuals understand health care service costs and shop accordingly as if they were using their own money. Price transparency needs to be paired with increased consumer cost sharing in order to maximize the effectiveness of each. Price transparency will help to improve quality because services will become more comparable and local variations in care will slowly be replaced by best practices. Providers should be measured on cost and quality, and that information needs to be made available to consumers. Provider incentives should be structured around those measures.
2. Insurance plan design should encourage more cost sharing. While a high deductible HSA plan may not work well for everyone—likely depending on income—this will reduce over insurance and utilization, and help restore economic and actuarial principles. Increased cost sharing with price transparency will help provide proper incentives to insureds and providers. Benefit designs with payments varying by perceived provider quality or price could be implemented. To encourage lower utilization, payments for bundled services could be used.
3. Reduce or eliminate price controls. Safety nets and government programs should either pay provider rates consistent with private markets or the differences should not be substantial. This will reduce cost shifting, improve transparency and ultimately improve quality.
4. Provide tax equity with respect to health care financing. Tax equity may be achieved through individual tax credits that would vary with certain risk classifications, such as age, income and health status to at least some degree. This needs to be properly integrated with redesigned safety nets. Overall, tax equity will help reduce the number of uninsured individuals.
5. Increase risk classification and use appropriate levels of pooling. Risk classification should be increased in private and government programs, increasing participation and encouraging people to appropriately spend money and receive care as needed. Pooling will not work well if individuals can choose whether or not to participate: high cost individuals with subsidized coverage have no incentive to control costs; and low cost individuals funding excessive subsidies will not want to participate. Pooling created by guaranteed issue, mandated coverage and lean benefit plans might work in the short term. Eventually however, political pressure will likely lead to increased mandated benefits and rate restrictions, which in turn increases the level of subsidies creating improper incentives and pressure for those providing the subsidy to leave the pool, perhaps even illegally.

6. Reform safety nets by restructuring applicable programs such as Medicaid and Medicare. Medicaid could use a tax credit or voucher program, but with higher credits/vouchers as appropriate to a risk class. Medicare needs fundamental restructuring to increase private market involvement and reduce the government role to a safety net. Adjustments are needed to reflect various risk factors such as eligibility age, rich benefit requirements, etc. Oversight of safety nets should involve private and public entities and reflect a sound checks and balances approach. Changes of this magnitude would have to be phased in over time.
7. Reduce mandates to lower costs. Benefit plans are frequently required to cover certain mandated benefits. Many mandates are not essential to a good health insurance plan, but add significantly to the cost of coverage.
8. Implement tort reform. A "loser pays" rule would reduce the problems of high medical malpractice costs significantly. The structure today causes providers to perform many tests despite the cost or likely outcomes.

These types of reforms should gradually create the transparency needed and balancing of objectives over time.

Concluding Remarks

We believe implementation of these ideas—consistent with the underlying objectives and principles noted—will produce a much improved balance of cost, access to treatment and quality over time. Because we have allowed problems to grow over years, bringing our system into a reasonable balance will take some time. The sooner a strategy is created the better; without that, we are headed toward a system with increasing public dissatisfaction.

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