Health Reform—A Proposal

by Timothy J. Luedtke

Today, few argue that change is inevitable for the U.S. health care financing and care management systems. I believe progress happens fastest and most effectively when participants have a vested interest in reaching the best answer. Advancements will occur across the entire health care spectrum from consumer education to health care delivery to financing, and ultimately to cost.

The U.S. health care financing system over time has so distanced the health care service provider from the patient user that medical costs have become increasingly opaque and outpaced general inflation over long periods. As these costs are pushed—at an accelerating pace—through the financing system from insurer to employer to employee/patient, we see employers and young or healthy employees/policyholders revolting and dropping coverage, further accelerating the cost pressures for those remaining in the financing system.

I believe we need to realign our health financing, care delivery and incentive systems to return appropriate checks and balances and make patients and providers more accountable. I believe this realignment can be achieved through:

1. Personal Health Care Savings

Every employer and employee would pay a flat 7.65 percent of maximum savings level as a payroll tax into the OASDHI. The maximum savings level is established such that the employer and employee contributions eliminate the actuarial deficit that exists under Social Security. I estimate the limit to be $40,000 to $45,000 using the most recent long-range Social Security actuarial deficit.[1] Each employer and employee may offset this required payment if they contribute an actuarially equivalent amount to an employer-sponsored benefit plan.

Such a program might look something like:

a. Employers establish a retirement savings plan having a health account on behalf of their employees.

b. Any employee contribution (up to the maximum savings level) goes toward paying retiree income benefits and is made on a before-tax basis.

c. The employer's contribution is allocated to employees' health accounts in proportion to an actuarially determined health risk adjuster; such risk adjuster will allocate more dollars to those having the greatest medical need—such risk adjuster to be calculated assuming the employee is fully compliant with preventive screening, chronic condition standards of care or healthy living standards.

d. Employer contributions are not taxable to the employee.

e. Health accounts may only be used to pay medical expenses such as paying insurance deductibles, purchasing individual insurance, or paying the retiree's share of Medicare premiums. Such payments would not be taxable.

f. Funds held in the health account are available to purchase a whole life insurance policy. Such life policy provides a hedge against a worsening health status and can be monetized as accelerated benefits or through the life settlement market if necessary.

g. Any residual amounts remaining in the health fund at death reverts to the plan to offset future employer contributions.

h. Savings plan is to be fully portable.

i. Each employer plan is required to have an actuarial compliance certification annually.

2. Catastrophic Coverage For Every Citizen

This would be true catastrophic coverage with a significant deductible and would not provide first dollar services as most plans offer today. The plan could be offered by private payers using guarantee issue and the government

providing a risk adjustment based upon the risk characteristics of the accepted individuals. The coverage's deductible will be set at the greater of the asset value of the above health care account or an amount for every citizen that is either a flat amount (e.g., $100,000) or a percentage of the individual's health care taxable wage base (say 100 percent of the wage base). Additionally, rather than resetting to zero every year, the deductible is condition specific, such that should insurance benefits become payable due to a specified condition e.g., breast cancer, leukemia, etc., such conditions will be covered immediately should a recurrence occur.

The insurance protects the individual when they need high cost health care services. These services are often associated with hospitalizations, a generally high-stress setting where consumers have little influence on the services provided and the charges incurred. I believe that offering such catastrophic coverage represents an evolutionary, rather than a revolutionary change, as nearly two-thirds of employers already offer such catastrophic coverage as a part of their benefit programs.

3. Preventative Screening Coverage Provided For Every Citizen (Including Coverage For Chronic Condition Standards Of Care)

Every citizen receives insurance coverage which provides approved preventative screening treatments and chronic condition standards of care free of charge. Such standards of care shall have been shown to be comparatively effective through rigorous research evidence and approved by a standards board of professional clinicians, researchers and statisticians. Such standards could initially include those set by the American Diabetes Association, Merck Manual or the U.S. Preventative Task Force. Where appropriate, such standards will recognize the individual's unique physiology, when being determined as comparatively effective. Being free, all citizens are encouraged to pursue those treatments that will improve their quality of life consistent with value-based insurance design standards both improving an individual's healthy life expectancy and likely productivity. Some employers offer elements of such preventative coverage today as they implement value-based insurance design concepts, yet have been reluctant to expand these programs as the returns on investment, though real, are too long term during these difficult economic times.

Funding for catastrophic and preventative plans is provided through a to be determined tax/premium, yet employers providing equivalent coverage, and employees purchasing such coverage, would receive a tax credit based upon the risk-adjusted premiums for the employer's covered population or for the employee, as applicable, that would have been payable otherwise by the government. Individuals may receive an additional tax credit for those having a bona fide living will.

4. Create A Federal Charter For Individual Health Insurers

Federally chartered health insurers would be exempt from state specific health insurance requirements and able to offer the same contracts nationwide. Such insurers will offer both catastrophic coverage and preventative coverage. Additionally, federally chartered insurers are able to sell supplemental insurance policies on whatever terms deemed appropriate including full medical underwriting, adjustments for living wills, etc.

5. Electronic Medical Records

Encourage every individual to have an electronic medical record. The personal medical record should include not only medical information, but also exercise, biometric and health assessment information. Employees wishing to receive any additional risk-adjustment contribution to their savings plan will wish to provide an electronic medical

record, so that their personalized health conditions are recognized.

6. Provider Reimbursements

Every provider—who accepts government reimbursements—will have to offer a freely self-determined cash price for their services. This price will be available to: cash paying individuals, including patients who use a debit card tied to any Personal Health Care Savings Account at the time of service; third parties paying in advance or electronically in real time; or Medicare/Medicaid for timely made payments. Such price and service schedules will be auditable by CMS or the third party. CMS will provide audit support for services provided to cash paying individuals.

7. Comparative Effectiveness

The United States should continue to expand research into what medical procedures and technology are best in class. Like government efforts to enhance national defense technology, pharmaceutical companies, academic institutions and contract research organizations may apply for grants to perform health care quality comparative effectiveness research.

8. ERISA-like Liability Protections For Medical Providers

Medical providers who do not violate comparative effectiveness guidelines and deliver services without gross negligence shall be protected from punitive damages.

9. End Of Life Care

Services covered by government-sponsored catastrophic coverage are reviewed and approved by a medical care steering committee when the patient has an actuarial healthy life expectancy of less than X months assuming that all available medical treatments are performed. Such a medical care steering committee shall determine whether the services should be provided based upon the prospect for improving the patient's remaining quality of life. Any nonapproved services may still be provided, yet must be covered by personal assets, private insurance or accelerated benefits under a life insurance policy.

I believe this approach will lead to greater alignment of health care resources to empower patients where they have control, protect patients where they don't have control, incent medical research and development that offers improved quality and comparative effectiveness, provide broad coverage, and promote fairness, healthy habits and improved productivity.

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[1] *Summary of the 2008 Annual Reports, Social Security and Medicare Boards of Trustees.* http://www.ssa.gov/OACT/TRSUM/trsummary.html