Health Reform, American Style

by Hobson Carroll

Today's health care financing mess requires an American fix. We need a rational solution that recognizes where we have come from in paying and providing for health care in this country, as well as our government, history, culture, economic system and all the other things that define us as a nation. The entire world is struggling with health care financing. Solutions need to be locally relevant, and the United States is no exception. My proposal for reforming core elements in the health care system follows.

Everyone Is Charged The Same Amount

Currently, the same service from the same provider costs different parties different amounts depending on who is paying. This is patently ridiculous for something society has effectively stated is a right, or at least a social utility. We must require all-payer, transparent pricing from providers for their products and services. Each provider is free to set prices as they deem appropriate, but those prices must be the same to all purchasers.

I am referring to a price that represents the true, bottom-line net charge that the provider bills and collects. Payers won't be able to negotiate with providers for special discounts or pricing concessions for any reason. If a provider agrees to a particular schedule of fees or prices with a given payer, fine. But it then applies to every other payer as well.

This doesn't mean that insurance benefits must cover whatever the provider charges. Schedules of allowed maximum charges, or networks of providers for which the insurer will cover 100 percent of the provider's fees, will come into play. Applied against these will be the usual cost-sharing devices of copayments, deductibles and coinsurance.

Provider charges that exceed the insurer's allowed charge schedule, however, must be balance-billed to the patient and should be treated the same as other cost sharing under the benefit plan. This will be critical in bringing true competition to the marketplace of health care services.

Providers will be allowed to waive collection of the patient's portion of their bill, as a charity adjustment or for other economic need as perceived by the provider. However, provider flexibility on the patient's balance must not be used as a loophole to effectively discount charges of one group or another by, for example, promising to waive copayments for those in a particular network that has negotiated with the third-party payer for copay forgiveness. No deals will be allowed that essentially change the provider's charge schedule for persons covered by that payer's program.

The same goes for government programs, especially Medicare and Medicaid, except for some possible minor concessions for administrative savings. A full discussion of how important this is and why it is at the core of health care reform is larger than the scope of this essay. But Medicare and Medicaid are among the chief culprits creating the current turmoil and basic tenets of their design need to be corrected. Making these programs pay on the same basis as others is right, fair and necessary. There's no way we can have such a significant portion of medical services being paid for through a price-setting mechanism that dodges responsibility and creates cost-shifting distortions whose effect touches the rest of the economic sector.

Everyone Is Covered

A significant percentage of our population is either not covered by any formal insurance program or is inadequately covered. This flies in the face of effective risk pooling. The only way to reach anything approaching universal coverage is to require it, full stop. Everyone must be in the pool if the principles of social solidarity and individual equity are to be in balance. Details of how to mandate coverage, how it is enforced, how violations are punished, etc., are very solvable (if not simple) issues. Various financing mechanisms to provide necessary subsidies related to income and other measures can be established via tax policy.

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Choice of coverage essentially should be left to an open and revitalized marketplace, which will grow out of new demand and other changes that I discuss herein. However, coverage must provide at least a minimum level of acceptable and reasonable insurance benefits. This can be monitored through a supervising entity that sets a minimum standard and oversees the demonstration of actuarial equivalence for benefit variations.

Everyone Is Eligible For Coverage

The current system not only requires underwriting by both group and individual insurers, but also the resulting inherent discontinuities that arise through actuarial discrimination (classification). This not only generates practical, ethical and economic distortions; it also undercuts the idea of pooling, a critical societal tool for managing health care finance. It also creates significant and unnecessary administrative, legal and marketing costs.

In both the individual and group market arena, we must do away with underwriting based on claim history and medical conditions. This will eliminate the need for so-called high-risk pools. To interweave these elements with universal coverage, there will be a need for risk-adjustment programs, such as reinsurance pools that ensure actuarial balance between insuring entities. With anti-selection eliminated, minimized or made equitable across the entire market through universal coverage, underwriting will no longer be necessary and the societal goals of broad coverage and relative equity can be maintained.

Everyone Receives Fair And Open Insurance Pricing

Pricing transparency must be established within the new insurance marketplace. In particular, mandatory full disclosure of all marketing/sales compensation—in whatever form—should be required for all medical expense insurance. In addition, serious consideration should be given to moving insurance product pricing to some variation of a modified community-rating basis. This can be integrated with changes in the tax system, so as to provide necessary cross-subsidization.

Everyone Is Taxed The Same Way On Health Costs

We must balance tax policy and health care financing costs by allowing qualified medical expenses, whether out-of-pocket claims or insurance premiums, to be deductible no matter who is paying them. The maximum deductible amount could vary based on taxpayer demographics. Tax policy could be integrated with a subsidy program so as to promote affordability of mandated universal coverage.

Maximum benefit levels for deductibility should be established in conjunction with the valuation of benefit plans against a minimum standard. The definitions of "affordability," "qualified," "minimum," "maximum," as well as other tax policy details are subject to practical resolution. (I recognize that deciding exactly who or what entity makes such decisions will prove to be an interesting challenge.)

Of course, a viable, though just as controversial, alternative is to eliminate any deductibility whatsoever. The key is fairness through consistency.

Everyone Has Information

Between "Everyone Is Charged the Same Amount" and "Everyone Receives Fair and Open Insurance Pricing," a foundation is laid for true consumer empowerment in the purchase of health care services and insurance. But there's still a piece missing—rational and efficient management of medical records and measurement of provider quality.

Everyone seems to agree that significant information technology advances are attainable in the health care arena. But writing about it doesn't make it happen and talking is about all that we get from the politicians, academicians and physicians who are active in the current movement for health care reform. Someone with authority needs

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to make a decision on what the universal standards will be—incorporating a dynamic that anticipates continuous improvement—and then require all relevant parties to meet those standards in very short order and with no exceptions.

There are no acceptable excuses for why America can't revamp its health care system to harness the tremendous productivity and quality improvement that is available through the application of appropriate technology. In reality, the solution lies less in technical know-how than in political will.

A Solution That Works

Are these the only things that would contribute to improving the situation in which our country finds itself? What about an emphasis on primary and preventative care, the importance of individual responsibility, or controlling the apparent runaway increases in health care costs that confront us every day?

The first two are matters for benefit design, and the latter is a symptom of the underlying problems, not a cause. By addressing basic issues and allowing the resulting managed—but corrected—marketplace to come into being, primary care and individual responsibility will be emphasized and enhanced through meaningful, creative and cost-effective benefit packages. Innovation in reimbursement and information will follow.

The current system has stymied creativity and entrepreneurship, two of America's greatest strengths. The medical industrial and financial complex needs to be fixed at the core, not patched to death on the periphery. Goals for comprehensive care, a higher quality of care, the proper kind of care, and the most cost-effective care are actually different facets of the same single goal: financing and providing for the best care. This starts with simple and rational changes at the fundamental level, so as to create a health care financing system that's consistent with the history, cultural trajectory and creative powers of the American experience.

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