What Real Reform Should Do

I believe we should replace all of the various government health care programs with something much simpler, cheaper and more efficient.

From the outset we must assure seniors, the truly disabled, and others in genuine need that their health care needs will still be met even though specific programs will change or be replaced. Second, we must assure individuals and employers who have non-government funded health care that they are perfectly free to keep their existing plans.

With those assurances, and, again, assuring those who already have policies that they can keep those policies, we should phase out and replace all of the current federal and state government need or age based health programs with the following:

1. Basic prepaid health care that covers routine medical, dental, vision and mental health and requires no insurance forms. Such programs could be for profit or not for profit and individuals could choose which basic health programs to participate in, but everyone without employer based or individual insurance would be required to enroll.

2. Catastrophic insurance would then cover low risk but high cost occurrences, expensive pharmaceuticals and devices as medically necessary, plus long term care. Individuals could choose these plans from a range of options that meet specified coverage and financial soundness requirements, including for profit or not for profit plans.
3. To expand risk pools and assure that people will not lose care if they move or change jobs, basic care and insurance plans would be state based, regional or national. A single and simple form would be used by all insurance plans and a Congressionally established national health and insurance commission would assure financial soundness, quality of care, and provide redress for concerns.
4. Individual payments for basic care and catastrophic insurance would be based on financial means. Everyone participating, regardless of age, would pay as their financial resources allow. Those who can afford to, or whose employers choose, would pay for the full costs of basic care and insurance directly. Those who need financial assistance would receive needs adjusted support from the government for their coverage.
5. Discrimination against pre-existing conditions or genetics would be banned, but there would be incentives for positive health choices and illness prevention.
6. Student aid and loan assistance, plus increased compensation rates, would encourage general and family practice and other high need health care providers. A federal licensing process would standardize professional licensing for health care practitioners nationwide.
7. Comprehensive malpractice reforms would preserve patient rights and improve quality of care but provide alternatives to litigation and reduce defensive medicine and abusive lawsuits.
8. Veterans, the Guard, Reserve, and active duty personnel and families would be able to continue existing VA or DOD provided

health care, or have the option of participating in the alternative program with the government funding their costs as the terms of enlistment and personal circumstances allow or require.

9. The program would be paid for by money now spent on all the existing federal and state programs and bureaucracies that would be replaced; through cost savings from malpractice reforms, paperwork reduction, national risk pools and improved preventive care; and through direct payments and premiums from individuals and employers (but no new taxes would be placed on existing insurance).

That's it. Simple, affordable, individual choices with existing insurance and health care plans preserved. There would be no discrimination for pre-existing conditions, basic health would be met through prepaid plans that cover medical, mental dental and vision, and people could choose insurance from state, regional or nationwide private or not for profit insurance choices. Support for those in need would be provide on a sliding scale with everyone required to purchase basic care and insurance. Paperwork would be reduced, malpractice laws reformed, long term care would be included, provider shortages resolved and there would be no addition to the debt or deficit.

More will be said about each of these elements in a moment, but first another word about the tax code as it relates to health care.

Replace the Tax Code and De-link Health Care

While replacing government health programs with something better, we should, as discussed earlier in this book, do the same with the tax code by eliminating all income and payroll taxes along with all of the current health care tax exemptions, deductions, credits, etc. This would "de-link" our health care system from the income tax system and end all of the distorting and unequal tax subsidies that contribute to costs and complexity of health care delivery.

Together, the new health care and tax programs should require just a few hundred pages to describe yet that would replace tens of thousands of pages and massive bureaucracies associated with the existing tax and health care laws.

Health and Tax Reform FAQs

1. Why is this proposal better than what we already have or what has been proposed so far in the House and Senate?

Answer: First of all, this is much simpler. The reason the House and Senate bills are so long and complicated is they try to modify multiple programs, each of which was designed to remedy problems left or created by what came before, but each of which created its own new laws, bureaucracy and problems. This complexity adds to the confusion and to the costs but it does not improve health care. Replacing all other government insurance programs with one needs-based federal program and expanding options for private insurance will dramatically reduce costs and complexity. In fact, rather than the thousand plus pages of the House version, the new proposal should require just a few hundred

pages and that would simultaneously replace all the additional thousands of pages that currently describe the Medicare, Medicaid, SCHIP, FSA, DSH and other programs and bureaucracies. The same is true of the tax reform proposal, which would dramatically simplify how taxes are paid and collected and would replace more than twenty thousand pages of current tax law.

A second advantage of this proposal is that it much more clearly and honestly protects those who have existing insurance or basic care and wish to continue with what they already have. Apart from ending pre-existing discrimination and recisions, existing plans would be unchanged. In addition, by allowing nationwide basic care and insurance plans, individuals and employers can participate in much larger risk pools and therefore have lower costs. At the same time, people who change jobs, move, or travel will not have to lose or change their coverage if they are part of a cross state plan.

Another very important difference is that the new proposal includes medical, dental, mental, and vision health care plus long-term care insurance. This is not the case with existing programs or with any of the leading House or Senate proposals, all of which largely neglect dental and vision and none of which adequately address the looming crisis and costs of long-term care.

Finally, this proposal ends the linkage between the income tax code and health care. It replaces the tax code with a much simpler, fairer system that rewards savings and eliminates tens of thousands of pages of complex law and associated paperwork and bureaucracy.

2. What happens to people who are already receiving care through existing federal or state government programs?

Answer: Any citizen or legal resident whose income and assets are such that they are in genuine need will receive government support to purchase basic health care and wraparound insurance, but this will be based on financial means, not age, state of residence, or any other category. This assistance will be provided on a continuum with those in greatest need receiving the greatest help, while those who can afford to pay more on their own bearing that responsibility themselves. This will apply to people of all ages equally. Hence, a two year old child whose family needs assistance to afford health care will receive that assistance as will a 98 year old from the same federal government program. However, if the 98 year old or the family of the two year old can afford to pay the bill themselves, they will do so without government assistance.

3. Why “means test” this program?

Answer: Our national debt exceeds 12 trillion dollars and the deficit for the past year was more than 1.4 trillion. The present value of our 75 year entitlement commitments exceeds 52 trillion dollars, more than the net worth of all the American people combined. Given that we are passing that burden of debt on to our children, who had nothing to do with creating it, we cannot honestly justify having the government borrow more money to pay for the health care of people who can afford to pay for it themselves. If people who don't need the financial help had to literally tear the money from the hands of their children and grandchildren to avoid paying their own way, they would recognize that doing so is immoral and irresponsible.

4. How much would this cost per person and how much would it cost the government?

Answer: To estimate the costs of the proposal, we can look to real world examples already in place. One such example is the Qliance program from Seattle, Washington.

Qliance is a company that offers basic care through what it calls “Direct Primary Care Medical Home” at a per-patient cost of between $39-79 a month. This is not an insurance policy but prepaid basic care through which most routine medical visits are covered for a simple monthly fee with no need for complex insurance paperwork, co-pays, etc. The elimination of insurance and associated paperwork, bureaucracy etc. produces large cost savings while allowing more quality time with health care providers who are salaried rather than paid on a fee-for-service basis. Qliance also negotiates pharmaceutical and other contracts directly on behalf of their patients so these costs are kept to a minimum.

To cover higher expense and specialty services that cannot be offered within their own clinics, Qliance participants purchase separate wraparound insurance. For high deductible policies, Qliance participants typically pay about $250 per month per patient. Combined with basic care, total monthly costs not counting deductibles total around $325, with annual costs at $3,900. Contrast this with estimated annual per capita expenditures of $7,400 in the United States and it is evident that substantial savings can be realized from a different approach to health care.

Because the model I have proposed also includes dental, mental, and vision plus long-term care insurance, I researched a number of existing plans to estimate these additional service costs. If we go beyond the Qliance costs to cover additional services at $125 per month plus wraparound care at $500 per month, on an individual basis, the total monthly cost for this care plus insurance would be $625,

with annual costs of $7,500 per person. In actuality, it is very likely that costs could be substantially lower, but this is a useful upper end estimate.

This proposal does not call for everyone in the country to be covered under these sorts of plans unless they choose, but if our population of roughly 300 million people were covered by such plans the estimated cost would be approximately $2.25 trillion, which is about what we spent on health care as a nation in 2007. The difference, however, is that the calculations of the new proposal assume coverage of mental, dental, vision and long term care while current expenditures leave more than 40 million with no medical insurance, more than 100 million with no dental insurance and more than 70 percent of adults without long term care insurance. The leading House and Senate bills are insufficient on the issue of dental and vision care or long term care. What is more, in contrast to leading proposals in the House and Senate, the alternative proposed here does not require an additional trillion dollars of expenditures, nor have we factored in the likely savings from malpractice reform, national risk pools and health promotion etc.

The bottom line then is that for what we are already spending as a nation, we can provide comprehensive basic health care including medical, dental, mental, and vision plus wrap-around insurance including long term care for those in need. This would do away with costly and complex bureaucracies, preserve and expand patient choices, and slow the growth of health care costs.

5. How would this be paid for?

Answer: The first source of funds would come from all the existing programs that would be replaced. This includes Medicare A, B, & D, Medicaid, SCHIP, DSH Hospitals, the FSA tax deductions and all of the state run programs. Money would come both from what is now spent on health care through these programs and through savings from eliminating much of the bureaucracy and overhead that goes with these programs. That will cover the bulk of the costs. In addition, because financial assistance is on a sliding scale commensurate with need, premiums paid by participants who can afford to pay a portion of the costs will help hold costs down and provide funding. Further cost savings will be realized by cutting out the costs of insurance paperwork for basic care. Savings on the costs of wraparound insurance will be realized by creating national insurance pools that all Americans can participate in, whether they are purchasing insurance on their own, through their employer, or as part of the government assistance program. Finally, malpractice reforms, cradle to grave wellness and prevention, reduction of costly emergency room visits, and other measures will further lower costs. Remaining expenses, if there are any, will be paid for from general revenues which by law will be set to levels sufficient to pay for the full costs from year to year without passing debt on to the future.

6. What would malpractice reform look like under this proposal?

Answer: Separately in this chapter, discuss legislation which I introduced that sets inflation adjusted caps on non-economic damages, provides mediation alternatives to litigation, improves the quality of health care licensing and review boards, limits "frivolous" lawsuits, and reforms how medical liability insurance is regulated. All of these elements would be included in the reform.

7. How would existing individual or group health insurance policies be affected?

Answer: People would be perfectly free to keep their existing insurance if they or their employers choose to do so. Discrimination against preexisting conditions would be prohibited for all insurance and health care, and the practice of "rescission" that denies people coverage they have already paid for would be eliminated. Replacement of the income tax with a sales tax would do away with the various tax exemptions, deductions etc. that factor into current insurance, but because there would no longer be any income tax there would be no income taxes imposed on insurance either. There would, as for all services, be a modest sales tax applied at the time of purchase of insurance and health services.

8. Where would we get the general practitioners and other providers to treat people?

Answer: Regardless of which health care reform is enacted, be it the one I am proposing or the leading House and Senate versions, we face an imminent shortage of family practice doctors, nurses, general surgeons and medical specialists, along with a looming shortage of gerontologists. We must immediately address this through a combination of educational support and incentives in schools of medicine, dentistry, nursing, psychology and other disciplines. Compensation rates must also reward these professions to sufficiently provide ongoing incentives throughout the professional careers of these practitioners.

9. How is the individual mandate enforced?

Answer: First of all, it is important to explain why there should be an individual mandate. If we are to prohibit discrimination against pre-existing conditions, we cannot let people wait to buy insurance until they discover they are sick. This is unfair to everyone else and distorts the shared risk upon which insurance is based. We require all drivers of automobiles to have insurance because it is not acceptable to let irresponsible people place the burden on everyone else while they pocket savings themselves. The same is true in health care. To meet the mandate, those with existing coverage could keep that coverage as is. Those who lack coverage now, either through personal choice or lack of resources,

would be required to choose a plan and pay for it according to their means with government assistance for those in need. Those who do not enroll in basic health and insurance would be penalized with fines, much as those who do not have auto insurance must pay fines. The level of the fine would be substantial, sufficient to make it unrewarding financially to dodge ones personal and legal responsibility.

10. What holds down costs in this model?

Answer: Cost control is included in virtually every element of this plan. Simplification of government programs and elimination of multiple federal and state bureaucracies will produce substantial savings as will needs testing of benefits at all ages. Providing basic health care without the overhead of insurance paperwork has been proven to dramatically lower costs. Creation of nationwide basic care and insurance programs will expand risk pools and increase competition, thereby lowering the costs of insurance. Requiring that everyone have basic care and insurance will reduce costly ER visits and uncompensated care. Comprehensive malpractice reforms will improve patient care, reduce medical errors and lower the costs of litigation and insurance. Incentives for health behaviors plus cradle-to-grave coverage will help reduce preventable illnesses and promote healthy decisions and treatment compliance. Insurers would have the right to encourage and reward healthy behaviors such as weight reduction, exercise, smoking cessation, medication compliance and other preventive actions. Recent estimates indicate that preventable illnesses alone may be costing our nation more than $100 billion per year. Health care providers would also be required to provide direct information to patients about treatment and diagnostic options along with the empirical evidence of effectiveness and costs of those options. Individuals who insist on choosing more expensive options that do not bring corresponding improvements in proven outcomes would pay higher co-pays.

Proposed reforms in taxes will also produce savings by obviating the billions of hours spent on income taxes each year and eliminate the hundreds of billions of “tax expenditures” that are lost in the current code.

11. Why reform the tax code at the same time?

Answer: It is not absolutely necessary to reform both health care and taxes simultaneously, but the current system that enmeshes health care payments and incentives in the tax code is a mistake that leads to higher costs, inequities and excessive expense. Further, the current tax code itself carries with it huge costs and inefficiencies that hamstring our economy and waste billions of valuable human hours

and dollars. If we are going to grow our economy, we ought to take this opportunity to fix both health care and the tax code.

12. Isn't this just another big bureaucracy?

Answer: No. First of all, this proposal would eliminate multiple existing programs each of which has its own bureaucracy and underlying laws, overhead and inefficiency. Medicare, Medicaid, Flexible Spending Accounts (FSAs), SCHIP, and all state run health care programs would be eliminated. What would take their place is far simpler and more straightforward.

Consider this: Right now we have a Medicare program that sets different compensation rates for thousands of different medical procedures at different levels for different locations across the country. Every year countless interest groups – doctors, patients, insurers, hospitals, etc. descend on Washington DC asking for specific changes to one aspect of this law. We also have Medicaid, which requires negotiations and intergovernmental agreements that can differ from each state and requires both Federal and State agencies to administer. Because many people want more coverage than Medicare provides, there are Medicare supplemental policies, all of which must be regulated and monitored in some way. Then we have SCHIP, that covers children not covered by Medicare and Medicaid but which also can vary from state to state. On top of all that, we have FSAs, which first withdraw money from people's salary so they can avoid taxes but then requires all sorts of paperwork and encourages additional spending if people want to get their own money back. We can and should do away with all of this.

What I have proposed would involve just one agency to administer all government funded need based health and one agency to oversee cross state basic care and insurance plans. This agency would manage the distribution of supplemental funds that go to basic care and insurance plans. The agency would not set compensation rates for doctors or determine payment rates for specific procedures. That would be left up to the basic care and wraparound insurance plans and the marketplace itself to determine as their model of care and financial structure determined.

The second agency would function much as state insurance commissioners do, but on a national scale to regulate and monitor the rates, financial soundness and quality of care provided by cross state plans and to provide an entity to manage claims or grievances filed against a cross state or national plan.

Again, that's it as far as bureaucracy goes.