A Proposal for the Health Care Crisis

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Where We Are Today

Health insurance in the U. S. today is a mostly unregulated industry consisting of private corporations each funding and managing health care according to their own independent standards. As anyone who has been paying attention knows insurance and health care costs have been rapidly spiraling upward as has the number of uninsured persons. Today medical issues are one of the most significant causes of personal bankruptcy. Additionally Medicaid/Medicare, government-run insurance programs designed for the indigent and the elderly, are becoming larger and larger federal expenditures even as they are criticized as for gross inefficiency and waste.

How have things gotten so bad, especially compared to many other countries? Why has capitalism failed us so badly in this arena when it has worked so well for other things? There are three basic things that have driven this.

1. Insurers have, until recently, shielded consumers from the cost of health care. Without realizing it, consumers have been gradually contributing to the run-up in costs because they are unaware of the costs of their treatments.
2. American society has developed a sense of egalitarianism and entitlement regarding health care: *Everyone is entitled to the very best possible health care regardless of status or income.* Noble as this sentiment may be, it is not realistic.
3. There are little or no financial incentives to guarantee health care to individuals who are already have serious conditions.

The key for us all to recognize is that, while health care in modern society should be considered a basic right, it is not possible to offer cutting-edge health care to every person in the U.S. Put another way, it is possible for everyone to own a car but it is not possible for everyone to own a Lexus.

There have been many proposals for dealing with the current crisis in health care. Most of the proposals that have been put forth for resolving the health insurance crisis suffer from one of three critical flaws. Either 1) they limit competition thereby discouraging innovation (e.g. the *single-payer* systems); 2) they attempt to bandage the symptoms of the crisis without really addressing the where the problems are coming from, or 3) they attempt to address the root causes with complex schemes that ultimately are doomed to fail. In the grand scheme of things the best solutions to a problem are usually simple.

The Proposed Solution for Health Insurance

The following is an outline of how to restructure health insurance.

- *Establish a tiered system of national insurance standards.* A government agency would be charged with defining a set of, say, three "tiers" of insurance standards (it could be more but three is a reasonable number). For each tier, the government would define what types of coverage the insurance would provide. All tiers would cover general preventative care as well as established treatments for illness and injury. The lower tiers would tend to favor lower-cost providers and more tried-and-true treatments whereas the higher tiers would allow more specialists, newer treatments, and perhaps some experimental procedures. The government would not set any standards for insurance premiums for each tier but would require that every insurance plan designate which tier it belongs to and provide at minimum the coverage designated by that tier.
- *Establish a national health assessment agency.* The agency could be a government agency or a private corporation backed by the government. This agency would take on a role similar to the national credit

reporting agencies used by lenders today. The agency would assess the health of all individuals, i.e. insurance clients, and uniformly report the expected health care costs associated with each individual, a "health score" of some form. This would eliminate most of the current redundancies in evaluating client health and establish a more uniform way to compare insurers and, to some extent, health care providers.

- *Establish a national risk pool.* This pool would be a general risk pool to which all health insurance companies are required to belong taking on a role somewhat like Fannie Mae does in enabling home ownership. The pool could be managed by a (non-subsidized) government agency or a private corporation backed by the government. The pool would sell monthly contracts for individual consumers to the insurers. The price of each contract would be based solely on the coverage "tier" which the contract represents. In other words, it would be completely independent of the consumer's health or expected health care costs. Insurers would be required to purchase the appropriate contract for every consumer they enroll. The contract would cover the majority the insurer's payouts for the coverage "tier" (but would not provide payouts for any additional coverages the insurer provides beyond the mandatory coverage for the "tier"). The risk pool payout structure would be such that the insurer would still be responsible for a significant portion of the payouts to consumers (thus providing incentives to reduce costs) but their typical payouts for any consumer would be roughly the same regardless of the consumer's health.
- *Establish a non-profit insurer.* This government-backed insurance company would be a stop-gap to guarantee that anyone who fails to get insurance through a mainstream insurer always has a fall-back plan. This insurer would be intentionally "bargain-basement" providing only the lowest tier of insurance and providing no-frills service. The intention would be that individuals, even low income individuals, would receive adequate coverage but always have a motivation to look for mainstream insurance which would presumably provide more complete service.
- *Provide limited government subsidies for insurance.* All individuals would be required to have insurance and would receive some government incentive (perhaps in the form of tax deductions). Low income and elderly individuals would receive larger subsidies, to the point that they are at least able to afford to pay the non-profit insurer.
- *Require insurers to use health spending accounts (HSAs) or similar programs for some significant portion of health care expenses.* For the lowest insurance tier insurers would be required to fund most of the HSA but for higher tiers the insurer would be required to fund only a portion of it so that the patient would shoulder a significant portion of those costs (i.e. up to some maximum out-of-pocket).

The Proposed Solution for Health Care

Restructuring health insurance as outlined above will gradually encourage positive changes in health care overall. However, a few additional changes to the health care industry and the law can make important differences.

- *Restructure health care education to create a spectrum of professionals.* Education for different health care fields has traditionally been separated between highly paid physicians requiring many years of education and internship, and low-paid nurses and technicians. The continued perception that a highly-educated physician must supervise even the simplest treatments has helped to push health care costs ever higher. And the fact that nursing schools and medical schools are preserved as entirely distinct programs helps to perpetuate this perception. The development of nurse practitioner and physician's assistant programs is helping to bridge the gap but the system needs to be more fundamentally reworked.
- *Require that, for major procedures (and other major health expenses), insurers must definitively confirm or deny coverage in advance of the procedure.* It is a common problem today that insurers attempt to delay decisions about coverage until after procedures are performed and/or change their decisions. Besides creating grossly unfair situations for consumers and health care providers, these practices can substantially increase administrative costs for health care providers and insurers. Legislation which requires the national risk pool and individual insurers to make timely decisions about coverage would eliminate many of these administrative costs.
- *Provide substantial tax advantages for health care providers who work in underserved communities.* It is no secret that inner cities and rural communities frequently suffer from a lack of quality health care simply

because professionals commonly avoid these areas. Rather than continually trying to raise funding for these communities the government should simply give fixed benefits in the form of major tax deductions to make serving these communities attractive.

- *Redirect punitive damages.* Because of frivolous lawsuits, physicians and hospitals today must pay huge malpractice premiums and often perform unnecessary tests simply as defensive measures against litigation. The key motivation for most of these lawsuits is punitive damages awards. Unlike compensatory damages, punitive damages, by definition, are monies to which the plaintiff is not morally entitled. Yet they are frequently the bulk of the award in a lawsuit. The laws should be altered so that only a very small fraction of punitive damages are paid to the plaintiff's attorneys and none of it is paid to the plaintiff. The bulk of the awards can be donated to charities (but not to the government). This would eliminate most of the incentive for frivolous torts.

Why Is This Better?

These proposals have several important benefits. The most important is *transparency*. By providing uniform methods for assessing patient health and uniform standards for health coverage the decision processes for insurers become much simpler and more obvious. This both reduces the ability of patients to defraud insurers and the ability of insurers to unfairly deny coverage. More importantly it substantial reduces administrative costs on all fronts.

By establishing a national risk pool the effective cost to the insurer for each patient is essentially equalized. This means that there is no cost benefit to rejecting clients with poor health or pre-existing conditions. To the contrary, the insurer simply loses potential revenue.

Above all this system encourages competition through the free market. Insurers still differentiate themselves based on the quality of service and extra items covered beyond the government mandates. And they maintain an inherent motivation to improve their processes to lower cost so as to lower prices and increase profit margins.

Mandating universal coverage and defining minimum standards for coverage reduces much of the administrative overhead for routine treatments since there is less need for health care providers to establish coverage.

Frequently Asked Questions

- *Isn't this just socialized medicine?* Not at all. This system still has private insurers operating in mostly the same manner as today with the important caveat that they pool a lot of their financial resources to spread risk. Arguably this reduces some of the potential for profits for these insurers but it hardly eliminates it. And although minimum standards are set for the insurers, beyond this they are still free to do as they wish in terms of choosing clients, offering extra services, and managing costs (but the proposed changes give them more incentives to the right things).
- *But still doesn't the fact that everybody gets money from the government for insurance mean that it is really closet socialism?* First, the proposal is that most individuals only get a small incentive. This would essentially be a political gesture so that nobody feels left out (i.e. it is not actually necessary but in American politics if the government mandates something on them the public wants to see at least a tax break for it). This incentive would be tiny, though, for most individuals. The only individuals that would be fully subsidized would be low-income individuals who otherwise could not obtain insurance.
- *This sounds like just expanding Medicaid, a system that is notoriously bad at containing costs while providing bad service. Is it?* Because the government manages it directly, Medicaid indeed has poor incentives for cost-cutting and lots of incentives to let costs spiral upward. The proposed system, however, ties all the insurers together by establishing minimum premiums using the risk pool. There is always, therefore, a feedback mechanism highlighting when any insurer is spending too much. And because the proposed system enables one insurer to underbid another there is an inherent competition to reduces costs. Medicaid essentially covers those individuals whom nobody else would want to cover. In the proposed system any insurer can make a profit from any client because the government ensures that the client has money to pay. Also any inefficient insurer, even the non-profit, is automatically weeded out by competition.

- *Isn't this just a single-payer insurance system?* Not really but it sort of depends on how you define "single-payer". The classic definition of a single-payer system is one in which there is a single insurer with a single fund paying all of the medical costs. The proposal above does not mandate a single fund and, indeed, certainly allows for multiple funds although, obviously it does establish one fund which incurs the brunt of the expenses. More importantly, though, although this proposal does establish important standards, the system still involves multiple independent insurers all competing and each managing its own operations independently. So this cannot really be described as "single-payer" in any real sense.
- *Doesn't the tier system simply codify denying important coverages to low-income individuals?* It is understandable why some people might have this knee-jerk reaction but this is not the case. The fact is that today health care is unevenly distributed and frequently in grossly unfair ways. Unless you want to adopt fully socialized medicine you have to accept that there will be inequities. What this proposal does, though, is prevent abuses by specifically stipulating minimum requirements and making the whole system more transparent. Yes, low-income individuals may have less coverage than high-income individuals but they will be firmly guaranteed adequate coverage.
- *Doesn't using HSAs with low-income individuals effectively deny them coverage?* The proposal is that, for the lowest tier, the HSAs are mostly funded by the insurer. If the tier definition is structured properly this would mean that, provided they used the HSA responsibly, low-income individuals would have most or all of their routine care paid for by the insurer through the HSA and any more serious treatments paid directly by the insurer. It would also, though, give them an incentive to look for lower cost health care providers and treatments since doing so might save them enough money to have access to non-essential but beneficial treatments.
- *Doesn't a national risk pool just mean a money pit for the government to dump taxpayer dollars into?* No, the national risk pool, whether government or private, would operate much like the postal service. Virtually all of its operating capital comes from its clients, not the taxpayers (excluding aide for low-income consumers). If the pool starts to run low on capital it simply has to charge the insurers more in premiums. In that way, the process is self-correcting. Additionally, because any "cheating of the system" by the insurers simply means that they all pay more in premiums, they are not only motivated to be more honest but they are motivated to report on abuses by other insurers.
- *But this risk pool can't just start from scratch can it? Won't the government have to use a lot of taxpayer money to get this started?* Yes, the national risk pool will need substantial capital to even get started and could not realistically fully support the entire insurance industry from the outset. A transition plan would be necessary both for Medicaid/Medicare and for the private insurance industry that would grow the risk pool from funding only a small portion of national insurance payouts to funding the larger portion of them. The funds provided by the government, however, could be made as a loan to the risk pool which could then repay the government out of the premiums charged to the insurers. As such, there should be no net cost to the government for the risk pool, although it might take some time for the loan to be repayed.
- *Isn't the national risk pool just the same thing as the re-insurers that exist for insurance companies today?* No, it is a different animal altogether. At a high level a re-insurer exists to provide insurance against catastrophic expenses. That is, it is not there to balance costs but rather to keep the original insurer from going bankrupt if something horribly unexpected happens. The proposed risk pool, by contrast, is involved in most payouts and is there explicitly to balance expenses so that no insurer, regardless of how big or small it is, has more risk than any other even if they take on high-risk clients. One of the most important aspects of this is that it gives insurers an incentive to want to take on all clients instead of only those who are expected to have lower medical expenses.
- *This plan does not actually cap expenses. Why not at least provide caps on costs?* History has shown that legislated caps on costs for anything normally accomplish nothing more than create shortages (which would mean making the existing problems in health insurance worse). One of the fundamental problems right now is that the free market does not have sufficient incentives to lower costs. One of the most important aspects of the proposed framework is the enforcement of using HSAs or similar mechanisms to incentivize consumers to help cut costs. Beyond this, by streamlining the decision-making processes for all parties and making decisions more transparent, misuse of funds becomes more obvious and competition tends work more efficiently to drive costs down.

- *Aren't the payouts from the risk pool simply subjective judgements about how much things should cost? Why wouldn't the natural tendency be for the risk pool contracts to simply spiral upward in cost?* An important aspect of this is that legislation must obligate the risk pool to determine its future payouts based on strict formulae related to the previous payouts by insurers. In other words, if the insurers are paying less to the doctors, the premiums and payouts for the risk pool must be lowered accordingly. Because the insurers are motivated to lower their own costs their own frugality will put downward pressure on payouts by the risk pool.

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