A Proposal to Reroute and Reform the Healthcare Money Trail – an Update

A Possible Replacement for Obamacare
or equivalently
A Possible Replacement for the Affordable Care Act

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Summary
The national healthcare debates over the last century continue and center on access, quality, and cost. While the problems are widely acknowledged there is an underappreciated defect driving the disagreements. The essence of that defect is that the major portion of the money is outside the control of the patients and competitive pricing is outside the control of the providers. To correct this defect, we propose that the patients have virtual, dynamically allocated, evidence-based budgets grounded on their medical conditions. From a patient perspective this would keep all the positive aspects of health insurance while eliminating the headaches since it would be the patients who control the authorization and the transfer of money to the providers. The providers, on the other hand, instead of having pricing controlled by a central committee would compete on quality and price. Furthermore, we propose all funding of healthcare be via taxes linked to expenditures to replace and reduce the total healthcare ''premiums'' and decouple health care from employment as it is archaic and hinders employment. This proposal reassigns the control of money from the government and special interest groups and returns it to the control of the patients.

Example 1: Elective Cholecystectomy
The money is collected through taxes and each patient has a virtual healthcare budget based upon their medical conditions. In this case the problem list consists of symptomatic gallstones. The doctors and hospitals publish their competitive bundled fees and nationally determined quality metrics for a cholecystectomy in a uniform manner at a single site. The patient selects a provider and has the procedure. The patient later authorizes the payment transfer. That payment transfer is limited by the median (not mean) fee of the providers in that region. If the fee is less than the median, the patient for that time period has a budget surplus for which they receive a percent as a bonus. There are no patient penalties for exceeding budgets except increasing taxes if most exceed their budgets. If patients do not follow medical advice or medical evidence, they would not be eligible for a bonus. In this model, insurance companies become brokers of care but do not collect (other than fees) or distribute money.

Example 2: Chronic Disease with Diabetes, Hypertension, Obesity
A likely scenario would be the selection of a provider for one year at a given published and predicted cost. There would be one budget expense for the year with performance incentives for the patient. In addition, population health incentives could be either positive or negative.

Example 3: Motor Vehicle Crash
The patient would be taken to an appropriate emergency room, perhaps admitted, and be charged for the care of the initial injuries which would include anticipated rehabilitation and long term care (not possible initially and this needs modification). Of course, the patient could not compare prices prior to receiving care. However the costs would be publically available for scrutiny and the costs applied as a budget expense with a limiting mean cost.

Maximize Access and Quality while simultaneously Minimizing Cost and Complexity:
This is the objective of healthcare and determines the model of the subsequent healthcare system. A different objective constructs a different model. The objective acts as a filter to weigh the many competing proposals. In general, a process which enhances the objective is kept while a process which detracts from that objective is rejected.

Virtual, Dynamically Allocated, Evidence-based Budgets
Imagine that everyone is the president of their own insurance company. Let's call you the CEO (chief executive officer). As CEO you may choose any of the present day methods of paying for healthcare you now have available or you may go along with this proposal. This plan is flexible and will accommodate any payment methodology. You may also change your mind on a yearly basis. In addition, there should be competition between all proposals to see which is preferable.

In this scenario, all the money comes from taxes as it already does for a good portion in the present system. This potentially replaces all co-pays, deductibles, premiums, private insurance, supplemental insurance, Medicaid, the Medicare alphabet, Workman's Compensation, State Children's Health Insurance Program, Department of Defense, Veterans Health Administration, the Indian Health Service, and Government Employees Health Plans with a single payment system directed by you for you and your dependents' healthcare if you so desire. Tools will be available to assist you or if you prefer you may choose to employ a healthcare broker as part of your budget.

Your budget is dynamic. That is it changes with your medical conditions and is a prediction of what it would cost to take care of your medical problems. When a payment is due, you authorize the transfer of funds from the single payment system to your provider. If at the end of the year there is a profit, that is there is money remaining, as any CEO, you receive a bonus. If there is a deficit, that is you spent too much, like the present system, there is no penalty except taxes might rise to cover the expenses. However avoiding preventive care as in recommended mammograms and colonoscopy would void a bonus.

The doctors, hospital, and other providers would publish their bundled (one total price) or episodic fees and quality indicators for treatment intervals in a uniform manner. After receiving treatment for that period, you would authorize the transfer of funds to the providers. However, that transfer of money would be limited by the mean (not median) price for that service in that region. If the provider wishes to charge a higher price and the patient agrees ahead of time to pay the extra out of pocket, that would be allowable.

Not surprisingly many in the healthcare industry feel patients are not capable of acting as their own CEO. However that is precisely what everyone does every time any purchase is made. Further, brokers may be hired and paid with fees in a similar manner. These brokers may also negotiate fees on your behalf.

Note: a voucher system would be similar but more complicated and the doctors and hospitals would still need to compete on quality and price.

Provider Pricing
Presently, prices are essentially set by Medicare and modified as a percentage by insurances. Setting the optimum price is a complex play of give and take between the seller and buyer. This is missing in healthcare with its price fixing in a political environment. It is likely there would be a good deal of innovation and price decreases if prices were allowed to float as they do in other transactions.

Health Insurance is not a Typical Insurance
Insurance is the payment for an event based on risk such that both the premium paid to the insurance company and the payout is determined by that risk. Although there may be deductibles, neither applies in

healthcare. It is as if once you totaled your car it would be replaced by any new car you choose regardless of the price your old or new car. Thus health insurance is not insurance but rather a method to pay for healthcare. It is prudent to search for the best method.

Health Insurance versus Virtual Budgets
Insurance has a risk based premium and payout. For example, car insurance increases for poor divers and the repair or replacement of the crashed vehicle is restricted by the insurance. Health insurance is different in that the premiums increase based on wealth, not health, and the payments are essentially unlimited. If car insurance was like health insurance and you crashed your car, you would be entitled to replace your car with the most expensive car available. Further, to continue the car insurance analogy, everyone is going to crash and some of us are going to crash many times. The point is health insurance is not a classic insurance; it is a method to pay for healthcare which everyone will utilize.

Once an understanding of the true definition of health insurance is achieved, many possibilities become available. Its complexity and cost should be minimized while its value maximized. For example, a single payer for everyone such as Medicare would reduce total costs while increasing value. Unfortunately, Medicare for all does not reduce costs enough. The reason is that Medicare has a central committee which fixes prices and experts are incapable of optimizing costs within the complexities of healthcare.

There is also a sinister aspect to the concept of insurance. Once the premium is paid, the maximum return on the investment is made by consuming as much of the distribution as possible. This drives utilization and coupled with unlimited healthcare (see "Rights versus Responsibility" below) is unsustainable.

Optimizing costs requires a distributed processing system such as the hospitals and doctors competing on price and quality while the patients distribute the money. The reason this obvious solution is not in place is the inertia imposed by the concept of and institutions of insurance that have the most to lose from our proposal. Of course the winners in our proposal are everyone.

Health Savings Accounts versus Virtual Budgets
The idea behind Health Savings Accounts is to have the providers compete on quality and price while the patients distribute the money. The biggest problem with Health Savings Accounts is that they pay for only a very small percentage of the total cost of healthcare so that the prices would never be maximally competitive and there is an incentive not to receive necessary care. In addition, the poor do not have access to these accounts. Virtual budgets correct these deficiencies.

Funding:
The present healthcare system is supplied by a menagerie of funding types of which taxes play a large part yet all funding (premiums, co-pays, deductibles, etc.) is in essence a tax. Keeping with the above objective would be to simply call it what it is and collect the money as a tax at the state or federal level.

Healthcare as a Right versus Responsibility:
In Franklin D. Roosevelt's 1944 State of the Union Message he described the first Bill of Rights as political rights which are "…rights to life and liberty…". He then introduced a second Bill of Rights as economic rights which included "The right to adequate medical care and the opportunity to achieve and enjoy good health". The term "adequate" was not defined. This changed in 2010 with the "Patient Protection and Affordable Care Act" in section 2711 to "no lifetime or annual limits". Thus it is now the law of the land that every citizen is entitled to unlimited healthcare.

At a more fundamental level "political rights" are those everyone already possesses whereas "economic rights" are those which must be given to individuals. In other words, "political rights" do not entail the removal of something from anyone whereas "economic rights" can only be supplied if something is taken

from someone and given to another. As it stands now, everyone is entitled to receive unlimited resources from everyone else. This is not logical.

We deal with this problem in the following manner. While our proposal does not directly limit care, the expenses of healthcare are linked to taxes which everyone needs to pay at some level. This provides, along with competitive pricing and incentivized budgets, a feed-back mechanism to restrain costs. In this view as opposed to a right, healthcare is the responsibility of everyone.

Medicare Payment Reform Initiatives MIPS and APM
With the repeal of the SGR (Sustainable Growth Rate) formula two Medicare models of reimbursement have been implemented. The purpose is to increase quality and perhaps decrease overall costs. It is informative to compare these models with ours. These initiatives are top down methods to control costs and increase quality. It is as if Medicare were both the referee leveling the playing field and the coach picking the players. In our proposal, Medicare would remain as referee but each health care system would have their own coaches and compete against other healthcare systems. As it is now, physicians have two choices, MIPS or APM. Most physicians will be within MIPS.

MIPS (The Merit-Based Incentive Payment System)
Here providers will be viewed, at the provider's expense, through a series of check-boxes and given a score in comparison with other providers. While there may be a slight increase in overall payments it is a version of a zero-sum game. In other words, the winners win at the loser's expense or the "bad" pay the "good". Besides the fact that check-boxes are known to be inadequate to optimize complex systems which are not well defined, if this warfare between providers is allowed to persist, the mounting casualties will diminish care.

APM (Advanced Alternative Payment Models)
This is another version of the accountable care model which has yet to achieve a lasting success because it puts physicians at risk to treat patients. The idea is to improve quality with some of the MIPS check-boxes and decrease costs by increasing efficacies. There is nothing intrinsically wrong with that approach but the bottom line is that what MIPS and APM are trying to do is to create a complex system which approximates a market. It is far simpler and less costly just to create the market as we propose.

Where the Money Resides until Used
The money gathered via taxes would be placed in the banking accounts to collect interest. This money would be dedicated for healthcare and outside the purview of state or federal government.

This is not a Medicare Replacement
Initially there would be a competition between this proposal and the present Medicare. If this increases quality while reducing costs, it would become a Medicare option, perhaps Medicare Part E. Most important Medicare would remain the overseer of healthcare.

The Role of Health Insurance Companies
Health Insurance Companies would not collect or distribute money. However, for a fee paid through the patient's budget, they would negotiate prices and act as brokers.

Employment
Healthcare would no longer be linked to employment as it would increase employment and decrease the cost of business and thus products.

Future Items:
History of this Proposal
History of Healthcare Reform
Solving Complex Problems – Central versus Distributed Processing (Optimization)