

A Novel Proposal for Health Care Financing—An Analysis

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The Institute of Medicine has recognized the specialty of Anesthesiology for its unique contributions as an innovator and leader in patient safety. Motivated by our core philosophy of patient advocacy, we have become increasingly engaged in the areas of efficiency, resource management, negotiation, and political activism. However, we have not yet taken up the charge to lead in restructuring the economic underpinnings of our imploding health care system. To thwart the demise of our profession as we know it, we may be able to do more. In the May issue of Pediatrics, a radical proposal in this regard has been offered by Austin and Burnett.¹ The following intends to summarize these authors' innovative ideas and to stimulate further reflection on the future of our country's health care system.

To Austin and Burnett, the problem with the American system of health care financing is that there are huge numbers of medically uninsured (> 40 million) and underinsured “residents,” despite the United States’ spending a higher percentage of its GNP on health care than any country. To meet the basic medical needs of the entire populace, they propose a new medical financing system that would be efficient, non-inflationary, pro-competitive, stimulating of innovation, and moving toward quality of care in a cost-effective manner. They dismiss the current “market-driven” and federal government quasi-National Health Insurance programs as inadequate, and lament that single payer and nationalized systems in other countries “suffer from under funding, long waiting lines, inadequate facilities, rigid regulations, and frequently lack of patient choice.” They propose to establish a new independent Federal Health Insurance Reserve System (FHIRS), isolated from direct political, legal, and commercial pressures, as is the Federal Reserve System in banking, and which can overthrow ingrained interests and employ the most positive aspects of both the market and government systems. They claim that their proposal is rationally designed, fiscally sound, and uses resources prudently.

The FHIRS, isolated from lobbying, would collect outcome and cost data and develop (using scientific analysis) a package of “health insurance benefits and payment parameters,” to include universal catastrophic insurance and mandatory basic insurance for children and for “citizens” under the 200% poverty level.

The paragraphs in italics are the author's commentary.

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Is the term “payment parameters” a euphemism for fee schedules? The collection of data and its analysis certainly could be accomplished according to generally accepted scientific principals. However, in the application of the science to develop the “package,” moral and economic judgments (social science) are likely to be invoked. It would therefore be disingenuous to characterize the end result as “scientific,” in the sense that science is objective and dispassionate.

Others would be encouraged to participate via the carrot of tax deductions for insurance and health care that conform to the FHIRS mandates. The cost of this package of federal benefits would be borne by direct federal subsidies for the poor and by tax credits for others. An estimate of the budgetary impact would be developed by the Congress, which would in turn direct the FHIRS to limit tax-advantaged treatment to a specific budgeted figure, without itself directing FHIRS how cuts or benefits would be adjusted.

Depending upon how much Congress limits the federal government’s financial exposure, the program could constrict to insure just the poor and/or catastrophic problems, or could extend to a much greater proportion of the populace through tax incentives.

Employers would no longer be permitted tax deductions for the cost of health insurance, but instead would provide employees with a defined contribution, which the individuals themselves could then use toward the purchase of health insurance. The individual employee purchasers then would get a tax credit (inversely related to income) to purchase FHIRS defined policies, and defined contributions not used in this specific manner would become taxable income. Employers would be prohibited from choosing particular insurance companies for their employees. Insurance companies could offer tax-advantaged plans and also taxable supplemental policies from which employees could select the plan best suited to their needs. Purchase of policies by individuals and families, and not by employers, would eliminate the inefficiencies of duplicate insurance coverage by working spouses.

FHIRS would approve disclosure statements from insurance companies to prospective purchasers: identifying eligible providers, how providers are paid, ratios of providers to patients, a clearly delineated benefits package, and co-payment amounts and rules. To nullify the perverse financial incentive for insurers to enhance their economic return by enrolling healthier groups of patients (that is, “cherry picking”), the FHIRS would level the risk by transferring premiums from pools of lower risk to pools of higher risk groups within and between plans. Enrollees would complete a demographic and confidential

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health questionnaire and family history, and an average enrollee risk index would be established. Incentives for the insurers would shift from marketing and capturing a healthier pool of patients to becoming more administratively efficient in delivering care.

Medicaid programs would be bifurcated: the basic medical costs would be standardized and borne by the federal government as part of the package to those under the 200% poverty level, and the social costs would be left to the individual states.

The Ponzi-like Medicare scam of cross-generational financing (initially the ratio of workers to Medicare enrollees was 13:1, but currently it is estimated to be 0.75:1, and worsening) would be replaced by a fiscally sound forced savings program (a la Senator Gramm's proposal).

Phil Gramm, the former Senator from Texas, proposed in 1998 a permanent solution for refinancing Medicare.² He argued that the "transfer-payment financing system in which current workers pay for benefits for current retirees, and no real investments are made to fund medical expenses for future retirees," is unsustainable. He suggested "an investment-based system, in which people build up assets during their working years to fund their medical costs in retirement—each age group, defined as all the people born in any given year, would cooperatively insure itself against retirement medical expenses." He proposed keeping the Medicare tax at the then current rate of 4.39 percent during a 50-year transition. All workers 43 or younger would move immediately into this investment-based system which, with 22 years of conservative investment return, would fund their retirement health care. Those 44 and older would remain in the current system, their retirement health care paid as it is now. The Medicare tax from younger workers, when invested, would help to pay for those in the old system, as well as their own retirement health care. The cost to the government of the transition would be about half that of maintaining the current system.

FHIRS would clearly define a standard benefits package, independent of political obfuscation and pressure to increase benefits, and exclude unproven and ineffective therapies. The plaintiff bar has sometimes compelled insurance coverage for unproven new therapies and obsolete older methods. In the proposed new system, objective national clinical trials, funded by a small percentage of insurance premiums and encouraged by FHIRS, could reduce class action suits and frivolous litigation, and might synergize with basic tort reform to suppress the out-of-control explosion in medical liability litigation.

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The practice of differential pricing by hospitals, long ago justified so that those who could pay subsidized the care of those who could not, now seeks to play one insurance company against another. Under the guise of trade secrets, it obscures the actual cost of services from individual patients. This is anti-competitive in that it does not allow the ultimate consumer (the patient) to choose based upon cost or perceived quality. Under the FHIRS, a fair trade system would evolve and force competition that would be more relevant for patients and small group purchasers. Similar issues concerning pricing differentials also apply to pharmaceuticals, wherein steep discounts are granted to large purchasers in order to “get the business.” However, FHIRS could, using analysis of outcome and cost data, enhance competition in this area as well.

In the article’s last paragraph, the authors suggest that radical reform is not only possible, but also necessary:

The current system is hemorrhaging funds ... making it rational to anticipate that a sweeping reform can be achieved, even in the face of the powerful entrenched players involved. ... The temptation will be to temporarily patch the current system rather than do what is really required—basically reform the system from the ground up. America does respond to crisis so we anticipate that by calling attention to some of the underlying causes crippling the medical care system, articles such as this will increase awareness that reasonable reform is possible.

Austin and Burnett’s radical proposal has many intriguing details and appealing incentives. However, the notion of a single czar or even a small independent group of right-thinking “czarettes” empowered to adjudicate and govern all the disparate powerful interest groups in a sector which accounts for 23% of our GNP is almost breathtaking in its scope. Just consider, for a moment, the tremendous influence wielded by the 12 members of the Federal Open Market Committee³ over the functioning of the entire United States’ economy with such a simple power as setting the federal funds rate.

¹ Austin GE and Burnett RD: An Innovative Proposal for the Health Care Financing System of the United States. *Pediatrics* 2003; 111:1093-1097.

² Gramm P, Rettenmaier AJ, Saving TR: Medicare Policy for Future Generations: A Search for a Permanent Solution. *N Engl J Med* 1998; 338:1307-1310.

³ The Federal Reserve Board. (2003). Frequently Asked Questions (FAQs). Retrieved July 28, 2003 from <http://www.federalreserve.gov/faq.htm#fomcq5>

[Editor’s Note: Dr. Robert Burnett is a practicing emergency medicine and pediatric physician, and a former president of the California Medical Association.]