A Better Idea for United States Health Care – The Balanced Choice Proposal

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Editor's Note

The Hawai'i Medical Journal, a Journal of Asia Pacific Medicine, has not generally entertained articles of a political nature for publication. However, on rare occasions, an article addressing a key niche in Hawai'i's healthcare system has been accepted. It is the opinion of the physicians on the Editorial Staff that this article represents a strongly biased opinion, addresses a somewhat controversial insurance scheme, and does not reflect the collective opinion of the Editors. However, we believe that increasing the information to our readers regarding this subject will enhance their ability to understand and judge the evolving healthcare system in Hawai'i.

Abstract

This article introduces a promising new health care financing proposal for physician payment called Balanced Choice. It summarizes the implications of health care economics and current well-publicized health care reform proposals, each of which is problematic for physicians and their patients. The Balanced Choice proposal is for an integrated two-tier national system, which has an economically efficient universal plan similar to single-payer, but with an option for enhanced services using market forces at the doctor-patient level to manage care. The two tiers are linked together and balanced so that each complements and enhances the other. Balanced Choice solves the problems of other proposals in a way that would work well for doctors and for patients, and represents a fresh and uniquely American solution to the problem of health care financing.

The health care reform proposal recently passed by Congress maintains the inefficiencies and perverse incentives of an insurance model that rewards denial of care and imposes intolerable administrative burdens on the practice of medicine. A new universal proposal called Balanced Choice offers economic efficiency, administrative simplicity, and returns care management and control of fees to doctors and patients. To explain, we need to start with a review of basic health economics.

Basic Health Economics

US health care spending rose from 5.2% of GDP in 1960 to 17% in 2008, and is growing rapidly. Rising health care costs are driven by the costs of new medical technologies and by the aging of the baby boomers, compounded by a very fragmented, inefficient, and expensive "system" of health care financing. About 60% of health care in the United States is paid by taxes via government programs, including Medicare, Medicaid, government employees' insurance, Tri-care, and integrated programs such as military health and the VA. About 20% of health care is paid with private insurance, and patients pay about 20% out of pocket.[1] Government and employers are both increasingly reluctant to pay for rising health care costs, and an increasing share is being pushed onto patients. About 17% of the US population had no health insurance in 2008, and many more have policies that don't adequately cover their health care needs. The uninsured and under-insured populations are growing rapidly. Over half of bankruptcies in the United States now are triggered in large part by illness and its financial consequences.[2]

American health care financing is very inefficient. The total administrative costs of health care in the United States in 1999 (adding administrative costs for government, private insurance, physicians, hospitals, and employers) were estimated to consume 31% of the health care dollar. This compared to 16% in Canada, including private insurance administration as well as their national plan. Administrative costs for the Canadian national health plan were only 1.5%, compared to 3.6% for US Medicare. We know that other countries with national plans spend one half to two thirds per capita on health care compared to the United States, provide universal coverage, and achieve better general indicators of public health.[4]

Health care costs are not evenly distributed across the population. About 20% of the population with chronic or serious diseases consumes 80% of the health care dollar. A high percentage of those using the most health care resources have low incomes or are elderly or disabled, and cannot possibly pay for their own health care. Uncompensated care leads to greater costs when patients avoid care until they are seriously ill, and often end up medically bankrupt in Medicaid and Medicare, paid with tax dollars. There are also serious public health risks with a large uninsured population. Therefore, any serious health care financing proposal must include a mechanism for redistributing much of the costs of care for the sick onto the healthy. Nonetheless, most Americans agree that individuals should shoulder some share of their health care costs, according to their ability to pay.

Drivers of United States Administrative "Overhead"

So what are we paying for with those 31% administrative costs? Practicing physicians must pay for basic claims submission, plus submission of claims to multiple insurers for patients with dual coverage, resubmission of denied claims or claims for patients who failed to notify the doctor's office when their insurance changed, responding to prior authorization requests and requests to justify non-formulary drugs, and responding to calls and letters from care managers.

Government and private insurers pay to administer all these things on their side. Private insurers also pay for marketing, underwriting (screening out or increasing charges for "high risk" individuals and groups), negotiations with employers, maintaining insurance reserves, duplication of administrative staff for competing insurance plans (including highly paid executives), managed care, lobbying, and profit. This is why the administrative overhead for private insurance is usually about 3-4 times that of government programs. Employers also must pay to manage employees' health benefits.

Malpractice insurance is mostly "administrative cost." Only a small fraction of malpractice premiums pays for health care for injured patients. Malpractice costs are also inflated by the lack of universal health coverage. A large portion of malpractice, automobile insurance, and worker's compensation costs are for estimated future medical expenses, often inflated to "worst case scenario" assump-

tions. Injured patients often feel compelled to sue if they are afraid their future medical costs will not otherwise be covered.

The Hassle Factor

The other big problem with the mix of American health care financing is the hassle factor. Doctors and their office staffs spend un-billable time dealing with eligibility checking, multiple insurance plans with different procedures and forms, crossover claims, denied and lost claims, prior authorization requirements, changing benefits and drug formularies, pharmacy benefits managers requesting a switch to a preferred drug, and writing letters and reports to justify payment. Physicians often provide uncompensated care for patients who were unaware of restrictions in their plan, lost coverage due to loss of a job, or whose coverage excludes pre-existing conditions. These things have a severe negative impact on the practice satisfaction of doctors, especially for primary care specialties.[7]

Third Party Control of Physician Fees

Doctors are angered by these costs and hassles. Insurance plans and government payers control their fees. Medicare's "Sustainable Growth Rate" formula is threatening drastic cuts in physician fees. Doctors are barred from negotiating individually or collectively, and can't raise fees to compensate. "Free market" forces in health care are not at the doctor-patient "point of service" level, but at the level of negotiations between employers and insurance plans. Doctors are finding their fees being frozen or cut, while the costs and un-billable time of providing care are increasing.

Responses of Physicians

Doctors are trying to cope with rising costs and lower fees by scheduling shorter visits to increase the volume of patients seen, spending less time with each patient. Tighter scheduling makes all the "hassle factors" even more frustrating. Physicians are increasingly refusing difficult patients and difficult or low-paying insurance plans, and more patients can't get access to care even if they have insurance. Also, doctors have less time or patience to listen to their patients about new or complex problems, leading to missed diagnoses. Computerized care management systems can help ensure appropriate monitoring for established chronic diseases, but can't compensate for lack of time to listen and think about diagnostic issues when the nature of the problem is not obvious. Both doctors and patients feel frustrated by this, and are increasingly dissatisfied with their respective experiences of the provision of health care. Many established physicians have moved out of primary care practices, out of rural or poorer neighborhoods, and out of high malpractice risk fields. Many are retiring early or getting out of clinical practice.

Reform Proposals

One of the main reasons physicians have not come together on the issue of health care reform is that all of the well-publicized proposals have serious negative implications. There are tremendous pressures from both government and employers to reduce health care spending, and this means reduced payments to physicians and more barriers to care for patients. Most of the administrative costs and "hassle factors" listed above are direct results of the fragmentation and complexity of multiple payers, insurance-based financing with its high administrative overhead, and use of the tort system to deal with adverse medical outcomes. The unraveling of employer-based health insurance is also the major force pushing more Americans into uninsured and under-insured status.

Single-payer

With single-payer, almost all of the administrative costs and "hassle factors" listed above would disappear, and the administrative overhead would drop from around 30% of the health care dollar to around 10-15%, freeing up enough money to fund universal coverage. Savings would come from the 30% administrative costs, instead of from lowered provider fees or restrictions on coverage for patients. However, US physicians have justifiable fears of a government-run single-payer system because they have experienced incompetent administration, frustrating provider services, and inadequate and irrational fees in the Medicare program. There are always pressures to reduce taxes and funding for public systems, leading to compromises in physician reimbursement and patient access to care in countries with universal plans. To varying degrees, these countries have allowed private insurance options for those who can afford them.

Medical Savings Accounts

MSA's are intended to make patients more cost conscious in purchasing health care. They consist of tax sheltered accounts and large annual health care deductibles, with insurance for "catastrophic" health costs only. This works well for the relatively healthy and wealthy who can afford to fully fund an MSA, who can use the tax break, and who have low annual medical expenses. However, the 20% of the population that consumes 80% of health care resources are unable to make effective use of MSA's. They will stay in regular insurance plans or end up in government programs, driving up the cost of those programs. Also, a recent Rand study found that when people pay for medical expenses themselves instead of relying on insurance, they cut back on necessary care at least as much as unnecessary care.[5,6]

Individual Health Insurance Plans

Private health insurance has much higher administrative costs than government funded plans. Insurance companies attempt to contain costs by reducing reimbursement, using managed care, and constructing barriers to treatment or reimbursement, none of which make life easier for physicians. Individual insurance plans are also problematic as a means of assuring affordable health care for patients. Insurance companies compete on the basis of how they manage the "risk" of paying for health care. The core idea of insurance is risk pooling, or spreading the cost for the sick across a large, mostly healthy population. However, in health insurance, a high proportion of the population knows their risk because they have pre-existing conditions or health risk factors. Those with pre-existing conditions are highly motivated to purchase insurance, but without a mandate to force everyone to buy insurance, the healthy will often decide to save their money and take their chances. This leaves a sicker than average pool of subscribers, driving the cost of insurance up, and undermining the benefits of risk pooling. To counter adverse selection, insurance companies use underwriting strategies to deny coverage or care, especially for those with serious or chronic illness, which runs counter to the whole purpose of health insurance. Underwriting and competition also carry substantial administrative costs.

Privatizing Medicare and Medicaid

Efforts to privatize Medicare and Medicaid by shifting funds to private Medicaid Managed Care plans, Medicare Advantage plans, and Medicare Part D plans are already turning out to be more expensive than the government programs they replace, not to mention the hassles faced by physicians and patients in dealing with a myriad of plans with complex policies and changing drug formularies.

Consumer Directed Health Care

Surveys show that a majority of Americans believe that individuals with greater means should shoulder part of the burden of financing health care, and that individual responsibility and cost-consciousness should be harnessed to help control and manage health care costs. Neither a universal single-payer program nor insurance-based financing does this effectively, because after paying their fixed co-payment, the patient does not care about the cost. Cost-consciousness is felt by the payer of the "last dollar" much more than "first dollar," so it is insurance companies and government payers, not patients, who have a vested interest in controlling physician fees and managing health care. MSA's also have the patient pay "first dollar," and are subject to the problems mentioned above. By its nature, health care requires some mechanism by which the public at large subsidizes much of the costs of care for the chronically and seriously ill. However, none of the well-publicized proposals finds an effective balance between a cost-effective publicly funded base, and use of "last dollar" market forces at the doctor-patient level to manage health care costs.

A Better Alternative - Balanced Choice

Balanced Choice is a new two-tier proposal for universal health care that combines the administrative simplicity and efficiency of single-payer with the cost containment and flexibility of market-driven controls at the doctor-patient level.[8] Here's how it works:

Balance Choice proposes a single-payer style standard option with a small co-payment ("Standard-of-Care Option", or SO) in which all funding sources are pooled and good health coverage is universal. Fees and covered procedures would be set by a "Balanced Choice Governing Board," analogous to the Federal Reserve Board in the financial markets. The co-payment in the SO could be waived in circumstances of financial hardship. Like single-payer, billing and administration would be vastly simplified.

Each office-based doctor would also have the option of offering an "Independent Option" (IO), in which they would charge higher fees for expanded services (e.g. prime appointment times, longer visits, enhanced access to the physician). Balanced Choice would pay a base payment somewhat less than the SO fee for that service, the doctor would charge whatever they felt the expanded services were worth, and the patient would pay the difference (gap payment = last dollar).

Doctors would be encouraged to offer both options, and patients could choose which option they would use with each doctor. Doctors could also choose how much of their practices would be devoted to each option. Those patients with limited health care needs or limited means could choose the SO, and those who wanted and could afford expanded services would choose the IO. Since the IO patient would be paying "last dollar," cost consciousness would become part of doctor-patient negotiations about choice of treatments, and market forces would manage care at the point of service, with no need for management by insurance or government. Doctors would also have incentives to innovate and focus on patient service to justify IO fees. Some of the resulting improvements, plus the benefits of generally improved physician satisfaction, would likely spill over to the SO patients as well.

In order to avoid inadequate SO fees, the two options would be linked with a balancing mechanism. The Balanced Choice Governing Board would be required to maintain a 70-30 funding split between the SO and IO. If SO fees became too low and too many doctors were refusing SO patients, the Board would have the power to adjust SO fees or vary the IO base payment as a percentage of SO fees, so as to maintain the mandatory 70-30 funding split between the options. The balancing mechanism allows market forces at the doctor-patient level to influence SO fees, limiting central control of fees for the whole system.

Balanced Choice could also be the agency to fund medical training and research, quality improvement programs, peer review, and other functions for the public benefit that need central administration. Hospitals could be paid with global budgets, saving vast amounts of money on billing and administration. Throw in tort reform and expand the National Health Service Corps to encourage primary care in underserved areas, and we would have a system that might really start to solve most of our problems with health care access and affordability.

The Balanced Choice proposal would provide universal coverage, efficient use of the health care dollar for actual health care, and administrative simplicity and transparency, all of which are sorely lacking at present. Unlike single-payer, it limits government control by giving doctors the freedom to set their IO fees higher than the SO rates. It encourages those who can afford it to pay a higher share for health care and get something worthwhile for their money, and it effectively uses point of service market forces to keep fees reasonable and manage care. Instead of private insurance competing with a public system for health care resources, it brings the "Independent" tier into the public system without the excess administrative costs of private insurance. Although it has not yet been implemented anywhere, it shares all of the cost-control elements that have made single-payer health care financing so much more cost-effective in other countries, with the exception of government control of fees for the IO. However, Balanced Choice IO base payments are less than SO fees for the same services, so the public plan would actually pay less for those choosing the IO. Like single-payer, Balanced Choice would take the responsibility for providing health care off the backs of American businesses. It is a plan that could be implemented either nationally or on a state-by-state basis. Of course, it would also make the health insurance industry obsolete, and would likely be opposed by the insurance lobby.

The Future of United States Health Care

So where can we go with health care financing reform? Even with health care reform, the current trend is toward more centralized management by insurers and government, more complexity, and reduced fees for providers of medical care. We are already witnessing a rapid decline in physicians willing to practice primary care medicine.[7] If these trends are not reversed, we will see escalating demoralization and de-professionalization of the physician work

force, increasing barriers to care for the American public, and deterioration in health care quality. The economics of insurance mean that any solution involving competing insurance plans can only "succeed" by squeezing physician payment and patient access to care, which are the very heart of health care. MSA's can work for the healthy and wealthy, but not for the seriously or chronically ill. Single-payer can provide universal coverage for less than we now spend on health care, but involves government control of fees. Single-payer plus private insurance pits the wealthy against the rest for access to health care resources. Balanced Choice, on the other hand, allows single-payer economic efficiency and free market choices between doctor and patient to complement and enhance each other. It returns much of the control of health care costs and management to doctors and patients, where they belong.

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Maka'ala ke kanaka kahea manu:
a man who calls birds should always be alert.