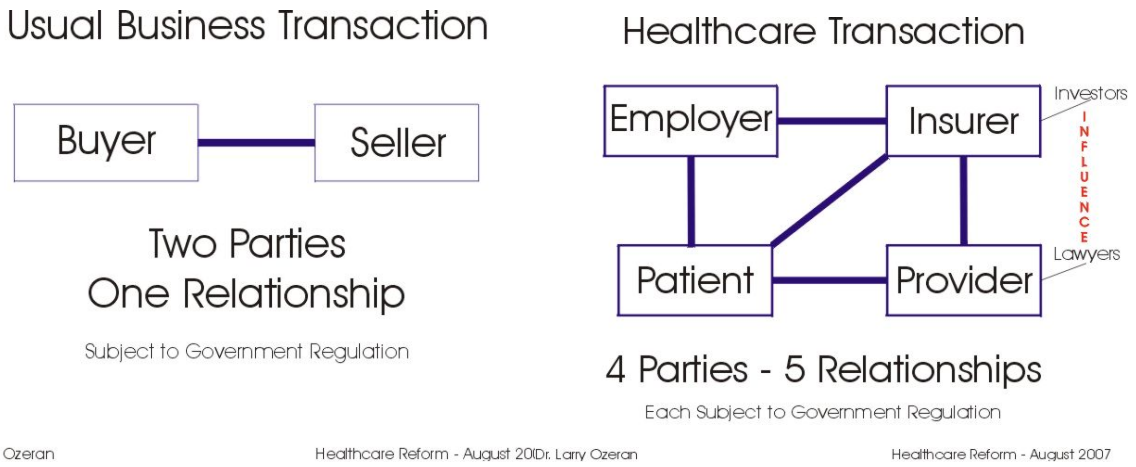
Blueprint for an Effective and Sustainable Healthcare System

America innovates medical devices, procedures and pharmaceuticals for the world. We offer the best medical treatment system in the world, but that is only as good as being the best at putting out house fires after they have started. Fire prevention is cheaper and more effective than fire recovery. The same is true for healthcare. Our healthcare system is broken.[1] Fixing our healthcare system requires addressing the underlying causes. Many of these causes are related to prior action by our government.

Many people do not understand our healthcare system or why it is so complicated. This brief explanation is intended to provide a common frame of reference. In our generally capitalist democracy, buyers and sellers come together to trade. While the specific goals of the buyer and seller are different, their broader goals are aligned. Alignment means that if the seller achieves their goal, to sell a product, the buyer also achieves their goal, to buy a product. Unfortunately, in our healthcare system, there are more parties involved in the transaction than just the buyer (patient) and seller (provider). In addition, in the usual transaction, there is only one relationship subject to government regulation. In the healthcare transaction there are five relationships and each one is subject to government regulation. [2]



While the healthcare provider wants to give the best care and the patient wants to get the best care, the goals of the other parties, employers and insurers, are not aligned with either the patient or the provider. In fact, the goal of the insurer, to spend as little as possible on clinical care, often conflicts directly with the goals of the patient and the provider.

In our current healthcare environment, we cannot negotiate to the center of a table tilted heavily in favor of the health insurers whose goals are counter to the optimal healthcare transaction. That will only continue to promote a dysfunctional healthcare system. At best, it puts off the collapse of our healthcare system for a short time and benefits only a fraction of those it intends to help. At worst, it makes the needed reforms harder to achieve. As a result, we must first recognize where we are and identify what we want our healthcare system to look like in the future. Identifying the difference between the two (a "gap analysis") can help us to map out a plan for effective and sustainable reform of our system.

Below are the core problems which we must resolve to achieve an effective and sustainable healthcare system. The Possible Solutions do not pretend to be the best or only options. They are offered to suggest one possible general direction based upon the principles referenced at the end of this document.

Quality Limitations

Timeliness is reduced by unnecessary insurance company delays

Verification of medical necessity can serve as a useful tool in eliminating unnecessary procedures and costs when used judiciously. The insurance industry's commonly used authorization and referral processes delay patients from receiving timely care, sometimes with life or limb threatening results. Only a tiny fraction of the care requested is not eventually authorized, serving only to increase administrative costs, delay needed care, and increase healthcare costs while reducing clinical outcomes due to these delays.

Possible Solution: Require the insurance industry to document where authorization actually meets its stated purpose to eliminate unnecessary care. Then restrict the insurers' ability to require this process to those services and procedures which actually warrant it. Ensure that only clinical providers with experience in the service being requested have the authority to determine medical necessity

Patients do not regularly seek prevention or screening services

By delaying or skipping regular medical evaluation, patients do not benefit from screening for high blood pressure and diabetes, counseling for smoking cessation, or receiving flu vaccines. This results in worse overall health status at a greater financial, functional and emotional cost to the nation.

Possible Solution: Provide financial incentives (e.g. premium reductions, copay waivers, health club memberships) for patients who get regular check-ups. Ensure that all Americans have coverage for preventive and screening services. Work with employers to enable patients to take time away from work to see their physician for preventive and screening services without penalty in the workplace or, as some employers have done, bring health professionals into the workplace.

Patients want freedom to choose, but are reluctant to accept the consequences of their choices

Patients who smoke may want their insurance to pay for annual chest CT scans, rather than choosing between paying for the CT themselves or quitting smoking. Not uncommonly, patients who don't wear seat belts, don't wear motorcycle helmets, or are intoxicated from drugs or alcohol are angry about their lingering scars or disabilities after recovering from emergency treatment for an accident. Obese patients increase their risk of many diseases including diabetes, cancer and joint disease. We live in a free country, but that also means that the government should protect its citizens from costs incurred unnecessarily due to the choices made by others. If you wish to engage in behaviors that increase your healthcare costs, you must be responsible for that increase and not force your chosen costs onto others.

Insurance is a little bit of your money and a lot of other people's money, often from American taxpayers.

Possible Solution: Ensure that Americans who engage in risky or self destructive behaviors have access to effective options for making recommended behavioral changes. Those who do not choose to change should choose between a) higher premiums or co-pays to meet their financial responsibility for increased costs, or b) forever opt out of treatment paid by insurance for any disease related to their chosen risky or self destructive behavior. In the event that they opted out and became ill from one of those preventable diseases, they would have the choice of foregoing the treatment of those diseases or paying for treatment from their own funds.

Providers may only give best care about 55% of the time

According to the American Medical Association (AMA), Physicians with paper records do not have a patient's chart when seeing that patient 30% of the time.[3] One study has documented that physicians only provide "best practice" care about 55% of the time. [4] People are unique. There may be good reasons why deviations occur in the provision of best practices to many patients. However, it is unlikely that 45% of patients require care which deviates from best practices. It appears likely that implementation of Electronic Health Records (EHRs) will improve the rate of providing best practice care to above 80% by displaying best practice options to physicians at the point of care. This may be a reasonable target to ensure that the statistical limitations of studies which created best practice guidelines do not create a straightjacket for providers when they treat individual patients that might lead to harm. The main barriers to implementation of EHRs are **costs**: software, hardware, Information Technology (IT) services, process change, staff training, and reduced provider productivity. The American Recovery and Reinvestment Act of 2009 (ARRA) legislation only addresses a small part of these costs. The currently planned "meaningful use" criteria are probably too stringent for the first year of stimulus payments. Several physicians have already stated that after calculating the financial results of each option, it will cost more to implement an EHR, even with stimulus payments, than to accept the Medicare penalties to be implemented in 2015.

Possible Solution: Extend the ARRA stimulus deadlines for expending the **$36 billion** dedicated to Health IT to provide more time to develop an adequate Health IT workforce and improve EHR user interfaces to reduce provider productivity losses. In addition to the initial stimulus payments, supplement Medicare E&M (Evaluation and Management) reimbursement for physicians who use EHRs to compensate for their ongoing productivity cost. Since private health insurers will benefit from the implementation of EHRs and currently only public insurers are paying for the stimulus (via the American taxpayers), work with private insurers to raise additional funds for EHR implementation.

Limited data sharing and duplication of tests

Even with EHRs, there is limited sharing of information. Patients often don't know what medications they are taking or the dosing. The lack of information about medications that patients may be taking poses the risk of a dangerous interaction with a drug prescribed by another provider. It also enables "doctor shopping", searching for a physician who will prescribe medication of the patient's choosing. When lab or test results are unavailable (or "lost"), they are repeated. This unnecessary duplication of tests is both costly and in some cases increases risks to the patient. The ARRA stimulus has directed the Office of the National Coordinator (ONC) to spend **$300 million** on Health Information Exchange (HIE). By one estimate, distributing HIE throughout California alone, depending upon the method, could cost as much as **$2 billion** [5]. The ARRA funds will not go very far. Like the post office, HIE is less effective if it has limited reach. The larger the number of connections, the more valuable the exchange.

Possible Solution: Increase available funding for HIE. Because the savings primarily benefit health plans, work with private insurers to create a coordinated approach to blanketing the nation with HIE.

Insurance policy variations make it difficult to select a policy or understand what is covered

Health insurers offer hundreds of different policies with very different coverage rules. As a result, it is difficult for patients to understand what is covered and what is not. Sometimes they receive huge healthcare bills due to a misunderstanding of their complicated coverage. While a public insurance option may not be the only or best way to resolve this, there is a need for every American to have a basic level of coverage at an affordable price. In order for this to occur, there must be overt recognition that affordable insurance means the plan cannot cover everything. We cannot support magical thinking that costs will somehow be paid if the premiums are inadequate for the coverage offered. We can permit people to have both a basic plan and either pay for non-covered services themselves or purchase supplemental plans (like Medicare supplements) which cover the additional services or costs.

Possible Solution: There needs to be a national consensus about what constitutes a basic minimum health plan that ensures that every American has access to quality healthcare. In order to be affordable, the plan will not be comprehensive, might cover preventive services and have a high deductible, and it must be available to everyone regardless of pre-existing conditions. To be able to offer everyone insurance, **everyone** must obtain coverage. Otherwise, adverse selection (where only those who are sick purchase insurance) will make this basic, minimum plan unaffordable. The federal Department of Health and Human Services is developing standard plan language for qualified plans and standard plan documents, with details down to the level of font size, that should have a positive impact on this ongoing problem.

Costs

The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) siphons resources

EMTALA requires that providers care for patients in an emergency regardless of the patient's ability to pay. Often, patients without insurance pay nothing toward their bill, siphoning billions of dollars in unpaid care from the healthcare system. While the intention of EMTALA is noble and even necessary, it is unreasonable that there is no reciprocal **requirement** for payment.

Possible Solution: Require all Americans to have health insurance or to post a sufficient bond to pay for care in an emergency. To be effective, a mandate must have substantial financial and possibly criminal penalties. Financial penalties might include requiring payment of 3 times the accumulated premiums for all the years that the party was uninsured, similar to other legal punitive measures. There can be no exceptions to the coverage requirement (or it is not a requirement). Adequate financial support (public subsidies) for those truly in need should be provided on a sliding scale basis.

Unreasonable expectations

No matter how poorly patients take care of themselves or how many risky behaviors they choose, they still generally expect the healthcare system to make them as good as new. Patients and family members have a difficult time accepting when further treatment is unlikely to improve a patient's outcome, and yet they want treatment anyway. In a payment system where “someone else” pays and there is limited or zero financial cost to those requesting care, it is not so surprising that people ask for futile care.

Possible Solution: Offer better education in all school grades, houses of worship, and throughout the

healthcare system about the limitations of medical care and the responsibility individuals must have for their choices. A coordinated public approach hat strongly supports the outreach efforts of public health departments is needed.

Improved technology

It is not surprising that developers of new technology want to recoup their research and development costs. It is equally understandable that these higher cost options will increase the cost of healthcare. However, not every technology or drug is so much better than the existing options that it warrants widespread replacement of the current technology or drug. We want to continue to innovate, we must continue to do so, but we need to be more rational in how we utilize these new options.

Possible Solution: Cost effectiveness research is needed to learn how much of an improvement a new technology is over an older one and at what cost. Providing this data to physicians and patients may enable them to make better choices together, particularly when combined with a policy requiring patients to pay a portion of the cost difference between the options.

Unreasonable Tort Law

When we discuss the costs of medical liability for all providers, from hospitals to technicians, we know or can reasonably calculate the total cost of annual premiums paid for insurance, plus any additional monies paid. What we cannot calculate is the cost of the unnecessary or questionable biopsies, procedures, labs, or tests done to improve the chance that the provider will not be subjected to a lawsuit. It may help to understand the provider's perspective. Beyond the financial costs of a lawsuit, most providers want to avoid them for the public embarrassment, the courtroom assault by the plaintiff's attorney questioning the provider's intentions, abilities and character, and the time wasted in the process. If you knew that you could marginally improve your chances of avoiding an unpleasant activity and someone else was paying the cost, what would you do? While we have no way to calculate how much is spent in lawsuit avoidance, it is very likely to be on the order of 100 times the direct, calculable cost.

Possible Solution: Tort reform legislation modeled after the California Medical Injury Compensation Reform Act of 1975 (*MICRA*) is needed. Education of providers and the public about reasonableness is a needed supplement to necessary tort reform.

Fiscal Crisis

The Medicare Sustainable Growth Rate (*SGR*) is bankrupting healthcare [6]

When Congress created the SGR, they intentionally caused the financial destabilization of the healthcare industry. They explicitly stated that “we cannot afford” the **actual** cost of medical inflation, as measured by the MEI (Medicare Economic Index), so we will intentionally pay less than the actual and increasing cost of healthcare. They were, not surprisingly, afraid of the political fallout from choosing the primary effective alternative, reducing Medicare benefits to only those benefits that taxpayers **could** afford.

When medical costs rise at a rate that is known to be faster than the rise in payments for care, it is only a matter of time before the payments are at and then below the cost to provide care. Worse, because the Medicare Resource-Based Relative Value Scale (RBRVS) fee schedule is used by most private insurers to determine the rates that they pay to physicians, private plan payments have also been rising much less than medical costs. Primary care physicians are having difficulty maintaining solvent practices, so they have been forced to stop adding new Medicare patients and in some cases are progressively withdrawing

from Medicare. As Steven Covey has said, "No margin, no mission." Intentionally underpaying physicians will progressively make physician practices insolvent. Each time our government puts a provider out of business, it means less timely care for every American.

Possible Solution: Eliminate the SGR and return to using the MEI, with a payment update which increases current rates to no less than 20% above real costs.

The Accountable Care Act (ACA) is expanding the healthcare safety net, but there may not be enough funding to meet the expanding need.

Rural and Community Health Centers receive enhanced reimbursement from the federal and state government to act as safety net clinics. They treat all patients regardless of ability to pay. These clinics divert huge numbers of patients from the far more expensive emergency room. Ironically, while ACA expanded the ranks of the Medicaid insured, it seeks to fund the costs by reducing payments to Rural and Community Health Centers.

Possible Solution: Ensure that funding for Rural and Community Health Centers is maintained and even expanded to ensure that the potential savings generated by diverting patients from the emergency room are actually realized.

Insurance companies have antitrust relief while providers do not

While historically both insurers and providers were subject to antitrust restrictions, insurers were given antitrust relief decades ago to the detriment of the financial health of providers and the entire healthcare system. Providers are generally offered "take-it-or-leave-it" contracts with no mechanism for negotiating reasonable payment rates, no way to reduce unreasonable administrative burdens (and expense), and no opportunity to ensure best care for patients by reducing, among other barriers, unnecessary delays. [7] The repeated health insurance company mergers have exacerbated this problem, leaving a small number of payers with huge influence over the provision of healthcare. Consider that the large insurer lobby spent more than **$500 million** of our premiums in their attempt to kill beneficial reform of our dysfunctional system. The new legislation creates the opportunity for providers to align their financial interests in support of better patient care at lower cost through Accountable Care Organizations (ACOs) and potentially compete with the large insurers on both quality and cost.

Possible Solution: Craft appropriate antitrust relief for providers to level the playing field for reasonable negotiation with health insurers. The new ACO model may afford sufficient antitrust relief to enable effective alternatives to traditional large health plans and promote more local control over healthcare.

Insurance companies take too much of the healthcare premium for bonuses and dividends

In California, Knox-Keene health plans are limited to 15% overhead and profit in their operations. However, this law was passed in 1975 when all health plans were non-profit. For-profit health plans have taken their profit from the 85% allocated for current and future healthcare services (e.g. loss reserves), rather than the 15% allowed for overhead. This slick accounting maneuver reduced the amount of premium dollars actually being used for healthcare. Reducing the amount of money insurers are permitted to apply to purposes other than the actual provision of healthcare will increase the amount of care which can be provided without raising premiums or taxes. In California alone, considering only a single health insurer, Anthem, several hundred million dollars would be available annually to provide healthcare if Anthem was required to spend at least 85% of the premiums they collect on healthcare services for every policy they offer.

Possible Solution: Limit health insurer expenses to no more than 15%, including profits and dividends, for every policy they offer. Require every insurer's "Medical Loss Ratio" (MLR) on every policy they offer to be no less 85%.

Insurance companies are incentivized to violate contracts and systematically underpay providers

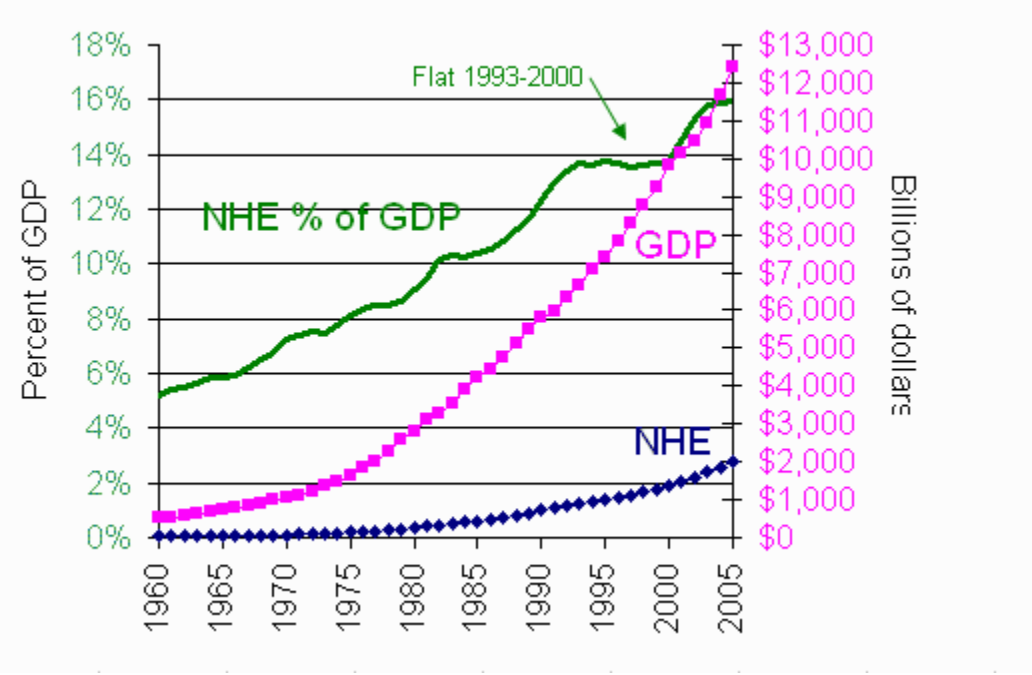
There is a prime example, though certainly not the only example, of health plans underpaying providers millions of dollars and receiving only a small slap on the wrist ($250,000 in this case [8]). In the rare instance where a health insurer is brought to justice, the insurer still pays less than if they paid the claims according to their contract or the law. Any smart businessman would repeatedly violate the law under these circumstances. Violating the law simply becomes a cost of doing business.

Possible Solution: Financial penalties for health insurers who violate the law or their contract must include retribution to those harmed and punitive penalties of three times the amount of funds involved. Jail time for officers and managers who knowingly violate the law should be an option during investigation, prosecution, and sentencing.

Rising healthcare costs will harm the general economy

When the military budget of the former Soviet Union approached 25% of their GDP, their economy collapsed. We are already seeing individual businesses (like GM and Chrysler) declare bankruptcy, in part due to rising healthcare costs. We cannot afford forever rising costs and must learn to utilize our healthcare budget more effectively. Insurance, which has progressively isolated patients from the actual costs of healthcare, has over three generations encouraged the American public to believe that healthcare is free. Whether or not we believe that healthcare is a right doesn't change its cost. Our right to an effective military is not free. Our right to free speech is not free. Healthcare is not and cannot be free.

The graph on the right shows healthcare spending from 1960 to 2005 as a percentage of GDP in green, total GDP in violet, and total healthcare costs in blue.
Graph is attributed to Samuel L. Baker, University of South Carolina, Arnold School of Public Health, Dept. of Health Services Policy and Management.



http://hadm.sph.sc.edu/courses/Econ/Classes/nhe00/

Possible Solution: We must first recognize and then educate Americans that healthcare is not free. There is a cost and it must be paid by someone. There is a limit on how much care we can afford to provide for

the fixed amount of dollars we as a population have chosen to spend together on insurance. We need to start spending more wisely, especially on preventive care and screening, where the return on our investment is highest. Data from the ARRA-supported cost effectiveness research may someday provide data that helps patients and providers to determine which treatment options to pursue.

As Albert Einstein has said, “We can't solve problems by using the same kind of thinking we used when we created them.” Finding the solutions needed to ensure an effective and sustainable healthcare system will require a new way of thinking about healthcare and a new process for reform, ones we have not tried before. We recommend that this new thinking involve first identifying our core principles through consensus and only then trying to define the policies which promote and support the principles. This is why the Yuba-Sutter Healthcare Council has identified our key principles for effective and sustainable healthcare.

A government led consensus process might lead to a core set of principles that are different than ours, but they must be equally actionable to drive rational policies in support of the principles selected. How we solve the healthcare crisis will depend upon whether we agree to start with basic principles or whether each party simply continues to lob demands at the others. Once we identify our core principles, some of the policy choices will be clear and others will require lengthy discussion. Despite the passage of ACA, there remains much to improve in our dysfunctional healthcare system. We encourage everyone to ask Congress to consider this new approach to healthcare reform. Please contact us with any thoughts you wish to share or any questions you wish to ask.

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1 - “Why Not the Best? Results from a National Scorecard on U.S. Health System Performance"
http://www.cmwf.org/publications/publications_show.htm?doc_id=401577
2 – “Healthcare Reform: from Problem to Crisis to Solution”
http://www.DrOzeran.com/presentations/reform1-20070815.php
3 - “Computerized patient records improve practice efficiency and patient care”
http://findarticles.com/p/articles/mi_m3257/is_n4_v52/ai_20628502/
4 - “Bringing evidence-based best practices into practice: more than 600 Minnesota physicians put EBM to work”
http://www.encyclopedia.com/doc/1G1-138538818.html
5 – personal communication, California eHealth Collaborative
http://www.CaeHC.org
6 – Comparing the SGR and MEI
http://www.ama-assn.org/ama1/pub/upload/mm/15/cola_medicare_pres.pdf
7 - “AMA meeting: Delegates renew efforts for antitrust relief”
http://www.ama-assn.org/amednews/2009/06/29/prsk0629.htm
“Antitrust Laws a Hurdle to Health Care Overhaul”
http://www.nytimes.com/2009/05/27/health/policy/27health.html
8 - “Failing to Correctly and Accurately Pay Claims to Health Care Providers”
http://www.contractormisconduct.org/index.cfm/1,73,221,html?ContractorID=67&ranking=25

Healthcare Principles of the Yuba-Sutter Healthcare Council

1. Everyone now living will die someday
2. Regardless of how much money we spend, we cannot change the first principle
3. The goals of healthcare should be:
   - promote positive lifestyle choices
   - prevent preventable illness
   - screen for early treatable disease
   - promote effective therapy
   - provide comfort when treatment is not an option
   - allow people to die in a dignified and comfortable manner
4. There is a fixed amount of money that can be spent upon healthcare, even if we choose for it to be 100% of GDP
5. We must optimize our healthcare budget in support of the goals of healthcare
6. Money collected for healthcare should maximally be spent on provision of effective healthcare services
7. Every Californian should be able to access a minimum level of healthcare services
8. No one should be precluded from paying for healthcare services that they choose to obtain in California
9. Patients should have some responsibility for their healthcare choices, so long as they are legally competent
10. Allocation of limited healthcare resources should be done in the most rational fashion that supports our goals
11. No party may dictate to another party what they may charge for their services
12. Sellers of services shall be paid by buyers (or payers) at the agreed upon rate or the seller's price when no agreement exists
13. Buyers (or payers) who were forced to obtain services in an emergency which limited their ability to investigate other options may seek a neutral third party to negotiate a reduction in a seller's price at the Buyer's expense.
14. Provider pricing should be transparent
15. In recognition of the critical need for trained healthcare workers, some resources of the healthcare industry (insurers and providers) should be directed to support education and training for the development of the next generation workforce.
16. To ensure that a healthcare system endures in perpetuity, there must be:
    - adequate financial resources to support education and training of the healthcare workforce
    - enough clinical positions open to enable trainees to complete their practical training
    - strong incentives to encourage those capable of becoming healthcare workers to apply to do so

Individual principles taken out of the context of the whole, may not adequately represent the view of the Council. It is the Council's intention that all the principles be considered together as a unit in any healthcare policy discussion