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Fundamental Healthcare Reform Doesn't Require a Government Takeover

By Ken Terry and Stephen Klasko

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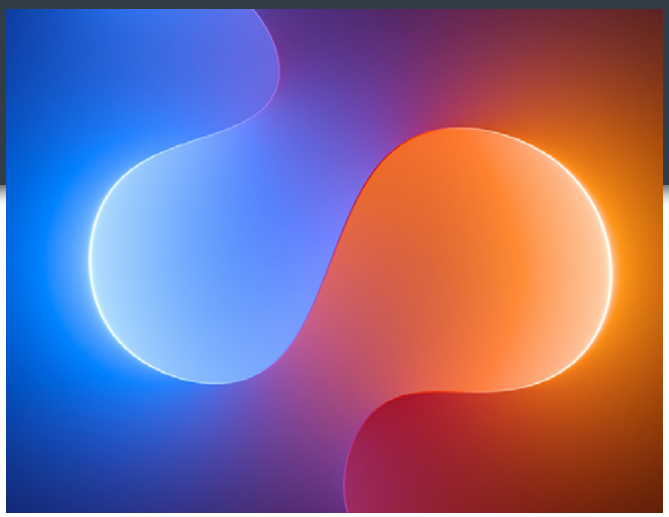


The announcement that annual U.S. health spending is expected to hit $7.2 trillion, or roughly 20% of GDP, in 2031 has elicited a giant yawn. Few people in the healthcare industry seem to be concerned, and it isn't an issue for Congress, which recently tied itself in knots over the partly healthcare-fueled jump in the national debt.

Yet there's no doubt that this is a crisis — even without considering the effect on government spending. For example, the average cost of private family health coverage in an employer-sponsored plan recently passed $30,000. With employers contributing 59%, on average, an employee's payroll deduction plus out-of-pocket expenses for this average plan would be $12,800.

How many workers can afford that today? How many firms will still be offering anything other than a high-deductible plan by 2031, when total healthcare costs are predicted to be 54% higher than they are today (unadjusted for inflation)?

To head off this worst-case scenario, we clearly need to think differently about reforming our healthcare system than we have up to now. A number of alternative scenarios might be considered, but any effective solution would require us to reorganize payment models to deliver higher-value care with more consumer choice. A restructured system would also have to align incentives to deliver the best care outcomes at the lowest cost. Government-funded universal health insurance, aka Medicare for All (M4A), misses the forest for the trees.

THE WRONG AND RIGHT WAYS TO REFORM HEALTHCARE

The key barrier to fundamental reform is often seen as the inability of the left and the right to agree on how — or even whether — to provide adequate health insurance to everyone. As a recent *New York Times* op-ed explains, however, the endless argument over how to achieve universal coverage is misplaced. Other advanced countries have found many different ways to provide healthcare to all. The more difficult questions that need to be answered revolve around healthcare delivery, the real driver of spending growth.

M4A would guarantee universal coverage, but it doesn't address healthcare delivery or the fee-for-service incentives that pump up costs. This draconian solution also requires massive cuts in provider payments that would be anathema to the industry.

There is a better way. As we point out in our new book, "Feelin' Alright: How The Message In The Music Can Make Healthcare Healthier," it is possible to insure every U.S. resident without a government takeover of the system. Moreover, if a new system were designed properly, it could guarantee good healthcare for all at a significantly lower cost than what is currently projected.

Because of the large, well-funded lobbying forces of the healthcare industry, no comprehensive reform proposal can succeed unless the solution leaves the big players mostly whole. Since the pharmaceutical companies spend the most on lobbyists, and their products generate only about 9% of costs, it would be best to leave drugs alone for now — but not forever — and focus on reforming the healthcare provider and insurance sectors. Those portions of the industry would fiercely resist any fundamental change in the system, but it is our belief that they could be persuaded to support reform if it were shaped in ways that could sustain or increase their profits.

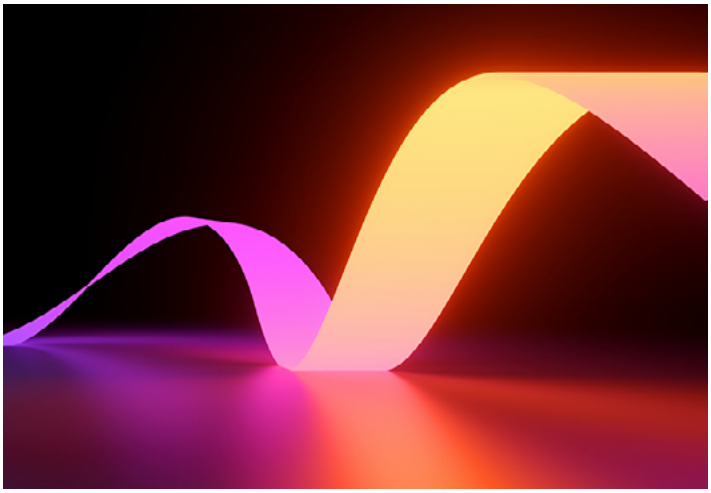
Whatever solutions are adopted, it must move the healthcare industry to value-based care. While there are many definitions of this trend, we regard it as high-quality, efficient care for which providers take financial responsibility. Hospitals and physicians must assume financial risk so that their incentives are aligned with those of payers and so they can be in charge of clinical decisions. Consumer choice must be a central element in the model. And the solution must guarantee health equity for all individuals, regardless of race, ethnicity, gender or geography.

BLENDED PUBLIC-PRIVATE SYSTEM

Our suggested model blends the public and private sectors into a single system while leaving space for private insurers to thrive. In contrast to other risk-based models, the solution is based on a bipartite division of healthcare financing between ambulatory care and acute and post-acute care. Primary-care-driven physician groups, both employed and independent, take risk for outpatient care (including emergency departments), while hospitals have global budgets for inpatient and post-acute care (but not long-term care).

"Basic care," as we term the nonhospital segment, is financed by subscription fees that are set by the physician groups. Private insurance companies sell "catastrophic" coverage for all care provided to an individual after they are admitted to a hospital or a facility that offers hospital-level care, whether that is an ambulatory surgery center, a cancer center or hospital-at-home. In addition, this insurance covers post-acute care in a facility or at home for a specified period after hospital discharge.

The global budget for each hospital is set through negotiations with the state it is located in. This feature of the model is patterned after the global hospital budgets that proved successful in lowering acute-care costs in Maryland. Because post-acute and ambulatory care costs in the state increased at a rate above the national average during the same period, however, in 2019 Maryland and the Centers for Medicare and Medicaid Services (CMS) switched to a total cost of care (TCOC) model.



This "total cost" approach set a per capita limit on Medicare spending in the state, while allowing hospitals to use CMS' savings to incentivize nonhospital providers to improve the quality of care. But in our model, the basic care groups would already have an incentive to keep people well, and by doing so, to lower preventable hospital admissions. So the earlier global budgeting model in Maryland would suffice to control inpatient costs. If the budget also included post-acute care, hospitals would have no incentive to discharge patients earlier than they should, and they'd work closely with post-acute care providers to minimize readmissions.

KEEPING INSURERS IN THE GAME

Under our model, insurance for basic care would be banned. It would not be necessary if everyone paid subscription fees for all ambulatory care. Yet insurance carriers would still do well, for the following two reasons:

- First, most Medicare and Medicaid beneficiaries would have private insurance for inpatient and post-acute care, so the insurers' revenues in those sectors would be enlarged.
- Second, whereas employers' current self-insured plans pay only administrative fees to insurance companies, all of the catastrophic plans would be fully insured and would therefore have a higher profit margin. These two factors would counterbalance the loss of insurance business for outpatient care to a large extent.

While employers would not be allowed to self-insure, they could still buy catastrophic coverage for their employees. Government subsidies would be available to those whose companies didn't provide this benefit or who couldn't afford the insurance on their own.

Every catastrophic plan would have to provide standard benefits, similar to those in today's Affordable Care Act (ACA) insurance exchanges. The actuarial values of the benefits — which form cost tiers that consumers can choose among — would have to fall into standard ranges such as 66%, 80% or 90% of medical costs.

Like the premiums for catastrophic insurance, the subscription fees paid to basic care groups would come from individuals, employers and the government, depending on a person's income and employment. Medicare and Medicaid would also buy subscriptions for their beneficiaries.

The amount of money available to each individual or family would have to be large enough to provide them with a choice among the groups competing on ACA-like exchanges on the basis of cost and quality. The competing groups would be ranked by their published quality scores, and consumers who chose groups in the highest quality tier would receive discounts on their subscription fees; the government would make up the difference, so the high-quality groups would not be penalized.

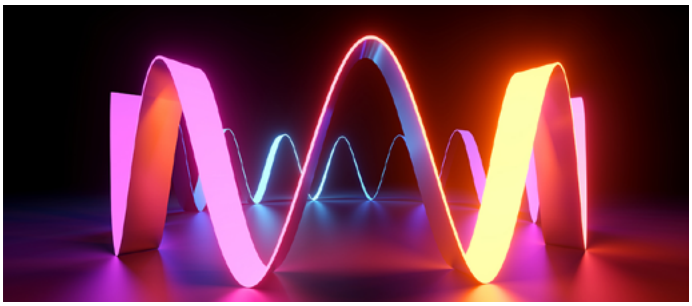
PARAMETERS OF BASIC CARE GROUPS

The physician groups taking risk for basic care could be independent or employed by hospitals, private equity firms or corporations. They would have to be large enough to assume financial risk, but not so big that they'd overpower the competition in their area.

The subscription fees the groups set would roll up to an annual budget, making them financially accountable for all the professional services, tests and prescription drugs their providers delivered, ordered or subcontracted. (The medications included would be common, low-cost drugs, so they wouldn't pose an undue financial risk to the groups or a threat to pharma companies.)

The physicians taking risk for basic care would not include hospital-based physicians such as radiologists, anesthesiologists, pathologists and hospitalists. Emergency-department specialists would continue to work for hospitals (or large groups contracted by hospitals), but their salaries would be part of basic care budgets to discourage groups from sending patients to emergency departments (EDs) unnecessarily. Surgeons who work in hospitals or ambulatory surgery centers would also be excluded from group budgets, although some of their outpatient services (such as gynecological care) would be included.

Around 70% of doctors already work for hospital- or corporation-owned groups that have the resources for taking



professional risk. However, not all independent primary care physicians would want to join a basic care group. Because there would no longer be any private insurance for basic care, and they couldn't get reimbursed by Medicare or Medicaid, their practices would have to be cash-only. Judging by the fairly small number of practices that operate this way today, it's a fair bet that most primary care physicians would join the basic care groups.

The groups wouldn't include all kinds of specialists, and some wouldn't have any. So they'd have to contract out for the specialties they lacked. They would try to make deals with high-quality, efficient specialty practices, providing business to these groups in return for moderate fees. If a specialty were in short supply in a particular market, those doctors' rates would be specified by law. No doctor in an underrepresented specialty in a given region could turn away patients, regardless of which group they were with.

CLINICAL AUTONOMY FOR PHYSICIANS

A major benefit of this model to physicians would be the guarantee that physicians could manage their own utilization of services. No longer would they have to petition health plans for permission to perform a procedure or order an expensive test or drug. Instead, each basic care group would establish its own clinical guidelines, based on the best evidence available and the judgment of its doctors.

Group medical directors would make decisions about the appropriateness of care when it was in dispute. In addition, they'd pay close attention to the data on the cost and quality of individual physicians and would discuss this with them when necessary. In an era when so many employed doctors are discouraged by their lack of clinical autonomy, many physicians would find this feature of our model very appealing. The reduction in administrative work and the fragmentation of care would also help address the current epidemic of clinical burnout.

Beyond that, the widescale adoption of value-based care, including the use of care teams, between-visit care, telehealth and remote monitoring, and the full utilization of primary care, would help the basic care groups greatly reduce the amount of waste in the system. It has been estimated that a third or more of health costs are unnecessary.

Efficient basic care groups could set subscription fees at a level that would allow them to deliver high-quality care at a moderate cost and still pay themselves well by cutting waste. While they might not earn much more than they do today, being able to sustain their incomes while restoring their control of how they practice would be another selling point of this model.

STATE ACTION WOULD BE REQUIRED

Even if Congress could overcome its own divisions and the opposition of the industry to adopt a model like this, the states would have to embrace global budgeting mechanisms like that of Maryland. Some health policy experts have argued that this could be done and would lead to substantial savings. But considerable political opposition could be expected in some states.

Another challenge to implementation of the model would be how to introduce it in rural areas where there aren't enough providers to form competing basic care groups. In these areas, full-service hospitals could have global budgets that covered all care delivery in the area, including ambulatory care.

If this approach led to reduced admissions and ED visits, the rural hospitals might do better financially than they have under the current system. Rural hospitals could also form consortia to take advantage of digital and fourth industrial revolution technologies, making healthcare more accessible when it is physically out of reach.

CONCLUSION: REAL REFORM IS POSSIBLE

This brief description of our model merely scratches the surface of all the creative reengineering that would have to be done to achieve success. But one thing is clear: We could have fundamental health reform, including universal coverage, without the government taking over healthcare and without doing financial harm to key healthcare players. It is time to consider alternative solutions like this one, which might gain political support as the plight of our broken system grows steadily worse.

The cost, inequity and fragmentation of American healthcare are unsustainable from a social and financial point of view. "Healthcare is too complicated" is not a solution or an answer. What we have presented is one option for the prevention of a financial and social health apocalypse for one of the world's richest and most innovative countries.

AUTHORS

Ken Terry is a healthcare journalist and author who has written several books on healthcare reform and value-based care, including a new book coauthored with Stephen Klasko, MD.

Stephen Klasko, MD, MBA, is the former president of Thomas Jefferson University and CEO of Jefferson Health, based in Philadelphia, and has held several other healthcare leadership positions. He currently serves as executive in residence at General Catalyst, an investment firm specializing in digital health, as North American ambassador for Sheba Medical Center in Israel, and as chief medical officer of Abundant Partners.