

Voters' Health Care Platform

This *Voters' Health Care Platform* is based on five years of research and dialog with thousands of Americans across the country. It draws on the ideas and wishes of Americans who describe themselves as Democrats, Independents, Republicans, and those who did not wish to declare a party preference. These ideas come from rural, urban and suburban communities. This platform is based on statistically valid quantitative market research as well as qualitative self-selected data.

Part I: Principles and Values

The following elements are essential to any systemic reform:

Equitability: All Americans must be covered and have access to a core set of health care benefits. Without universal coverage, providers will continue to shift the cost of care, and that cost shift causes out of control cost increases.

- Having one set of core benefits for everyone would simplify administration.
- Universal coverage and a core benefit package would reduce the need for all the current eligibility, authorization and referral management. This administrative simplicity would reduce cost and free funds for patient care.
- A standard core benefit package for all would assure greater personal freedom by having complete portability of health coverage, so individuals could move between jobs and income brackets with less red tape and gaps in coverage than is currently the case.
- Individuals, employers and various levels of government will all contribute to insurance costs to varying degrees.
- With everyone having access to the same benefits and premiums based on a sliding fee scale, the need for separate and expensive public programs such as Medicaid could be restructured, thus reducing expenditures of federal and state tax dollars, which can be redirected toward patient care.

Affordability: New financial incentives need to be created to reward providers for health promotion, wellness and chronic disease prevention. Administrative simplicity would lower costs for employers and individuals.

- Premiums will be based on a sliding fee scale for individuals, families and businesses.
- Elimination or reduction of insurance eligibility, authorization, referral rules and regulations, and other fact checking administrative tasks, would reduce administrative costs and waste. This would reduce the cost of providing care, especially in facilities with high-uninsured usage rates, such as emergency rooms.
- Additionally, by having one benefit package for everyone, patients would be able to see a health provider without worrying about costs, and thereby reduce pressure on emergency rooms for the uninsured. It also reduces the paperwork complexity that currently adds cost and no value.
- To reduce malpractice costs, all malpractice claims will go to mediation first. Patients retain the right to go to court should they dispute the mediation findings.

Preventive Medicine and Health Promotion: The health care delivery system will focus on and emphasize health promotion and disease prevention benefits and programs.

- Providers will receive financial incentives for working with patients to keep them healthy and reduce unnecessary surgical interventions.
- Patients may be subject to incentives regarding personal responsibility for their health. Some employers currently have policies that reward people with healthy behaviors, such as not smoking, with lower premiums and they may continue to hold such policies.

Accountability: The health care system needs to be accountable to the payers in terms of patient health outcomes, billing, and precise expenditure of funds received, using methods that are in line with the transparency of information necessary for the market based elements of this platform.

- Health interventions should be based on known medical outcomes and/or follow the care guidelines of professional health care societies.
- The offices of Health Information Technology and the Medicare Coverage Advisory Commission in the Department of Health and Human Services that currently analyze the cost/benefit of new technologies will continue to make recommendations on the efficacy of new technologies and IT infrastructure.

Choice: Individuals and families will have their choice of health care providers as long as the providers are licensed by their profession and by the state.

- Given that nearly one-third of all Americans have non-physician primary care providers, the core benefit package will include access to the Complementary and Alternative Medicine (CAM) professions as well as medical providers.
- Employers and individuals will have the same core set of benefits, but both may add more benefits for their employees and/or for themselves.
- Individuals and families will continue to have their choice of provider.
- Large employers may continue to self-fund their employee health care benefits.

Information: Patients need access to reliable, convenient and easy to understand care guidelines, and treatment cost/benefit options. Many care guidelines already exist, and should be shared widely with patients.

- It will be the responsibility of the provider to present treatment options to the patient. This can be in the form of face to face meetings or referral of the patient to online decision-tree functionalities.
- The guidelines should be readily available and in easy to understand terminology.

Part II. Delivery System, Management and Financing

Introduction/Background

Platform Part II is an attempt to apply the principles from Part I to more complex issues. These issues need further refinement and consensus building among the public, health economists, health care professionals and others with technical expertise. While this platform is not cast in concrete, it has, however, emerged from the values and principles the people have said are important to them. This part of the *Voters' Health Care Platform* is offered as a starting point for further bi-partisan discussion and refinement.

The principles of Part I of the Voters' Health Care Platform of: equitability; affordability; prevention and health promotion; accountability; choice, information and shared responsibility; are the underpinnings which dictate the following consideration for a new system.

The overriding intent is to work as much as possible with existing agencies and programs, and design a complete system that meets the care needs of the poor and vulnerable while simplifying administration and management of the system as a whole.

I. Delivery System

The current delivery system has few rewards for either patients or health care professional to promote the health of patient and rewards procedures which may result in over treatment and/or inappropriate treatments. Given that data show the public values prevention over high tech cures; wants choice of providers; and treatment based on known outcomes and clear care guidelines, we use those ideas to address changes below:

1. Reward Performance/Outcomes

A. Create incentives that reward individual and family health and reward providers for promoting health: Possible rewards could include:

- Assure patient access to reliable screening systems and reward practices for early detection and management of chronic diseases.
- Reward insurance companies and businesses for insurance coverage that focuses on health promotion and disease prevention.

2. Revise Provider Compensation

- Reward and promote primary care
- Reward provider groups for maintaining healthy patients

3. Promote Care Coordination

- Encourage systematic improvements based on care coordination and continuity of care.
- Assure a neutral place for second opinions on major care decisions, such as surgery. Use something like 'decision-tree technology' or other neutral approaches.
- Include CAM professionals in new compensation guidelines.

II. Benefit Management: Central Standards, Private, state-based management

Assuming that the reform package will have one core set of benefits for all Americans, this could lead to a new benefit management structure. Our data indicate compellingly that the public does not want a government, tax-based health care system; nor a system based completely on personal responsibility. Thus the health care system will remain a shared responsibility of employers, employees and government, using private insurers, but with greater nonpartisan oversight, similar to the Federal Reserve Board and the Federal Employees Health Benefit Plan (FEHBP). This assures accountability will be built into the system.

A. Use the Federal Employee Health Benefit Plan (FEHBP) as a management model

- Benefits would be specified nationally, but managed at the State level.
- Self-insured companies and labor unions would continue to self-fund, as long as they offer the minimum core set of benefits.
- The FEHBP is offered as the management model because of its years of proven experience in providing benefits and in using the administration and profit analysis factor criteria. Recognizing the complexity of the care needs of our Veterans, the Veterans Administration shall continue to remain a separate care system.

B. Provider Rates

- Provider rates would be negotiated at the state level, because salaries and prices vary significantly between states and within states. These rates would be determined by a formula at the federal level to be applied at the state level.
- The rate structure would be decided in conjunction with Office of the Insurance Commissioner; state health care professional associations; state health insurance association; and consumer representatives.

C. Regulatory Oversight and Appeals

- These functions would remain at the state level because those structures are already in place in Insurance Commissioners offices.

D. Insurance Pools and Benefit Design

- Develop a series of benefit packages for individuals and employers to select from, much like Medicare Part B options to assure choice and reduce administrative complexity.
- Assure one core benefit package to offer administrative simplicity and reduce waste and save costs.
- Expand the functions of SHIBA (Senior Health Insurance Benefit Advisor) and/or work with state insurance broker association to advise individuals and employers on their respective choices.

E. Medicaid

- With a core benefit package guaranteed for everyone, the need for totally separate public care systems would be significantly reduced, with the exception of long term care, and care for the disabled and chronically mentally ill.
- Those needing financial assistance can apply through the state, as is currently the case, and the state and federal government will subsidize insurance on a sliding fee scale, much like the current Medicaid program.
- This eliminates the need for a separate rate structures for low income patients
- Groups that specialize in providing care for low income patients, such as neighborhood clinics and community and migrant health centers, would continue to provide that care and their providers would be reimbursed at the state designated rates.

III. Financing

Extensive research findings indicate the public wants the financing of health care to remain a shared responsibility of individuals, government, and employers. They also want standards, intelligible information and choices.

1. Retain Private Market and Add Performance Accountability

- Employers and individuals will continue to purchase health insurance from private insurers.
- Benefit packages will be sent out to bid to state insurers, who will be subject to the same administrative and profit analysis factors of the FEHBP. This assures the continuation of a private health insurance market, but regulates the market and sets performance standards, much like the Federal Reserve Board regulates the banking and investment industries.

2. Subsidize Low Income Individuals and Small Employers

- Low income individuals and small employers will have their premiums subsidized based on a sliding fee scale.
- The GAO will conduct research and make recommendations on the most equitable approach, such as tax credits; tax deductions; premium subsidies, etc.

3. Promote Personal Responsibility and Long-term Care Savings: Health Savings Accounts

- Individuals and families will retain the option of having a health savings account for each individual or family, much like the current 401(k) retirement plans.
- These plans would be used for both health care and long-term care. These benefits could also be transferred as part of an estate.
- The funds would be taxed heavily if they are used for anything other than health care or long-term care.

4. Promote Equity: Tax Reform

- The tax code must be changed so that everyone—individual and employers—have the same ability to deduct their health care premiums and costs.

Conclusion

Many of these elements need further work and refinement. It is important to remember that the elements of this Platform are derived from the people. These ideas emerged from a national contest in 2003, have been tested in a pilot project, and validated with market research. We have worked with numerous organizations across the country. No matter whom we approach or who answers the questions, we keep finding the same solid conclusions reflected in this Platform. While this Platform is not cast in concrete, it does however, chart a clear course of what could be possible for a new health care system if we listen to the views of the public. We offer this Platform not as an iron clad solution, but rather as a ray of light and an invitation to collaborate with others to refine a more complete solution.

Kathleen O'Connor and CodeBlueNow! Board of Directors
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