

An Innovative Proposal for the Health Care Financing System of the United States

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ABBREVIATIONS. FHIRS, Federal Health Insurance Reserve System; NHI, National Health Insurance.

With >40 million uninsured residents in the United States, we still spend more of our gross national product on health care than any other country in the world.¹ Changes in the various health financing systems must occur if this problem is to be solved.²⁻⁴ A sound medical financing system that will meet the basic needs of the entire population requires efficient use of the medical dollar while ameliorating medical care inflation and encouraging innovation, productive competition, and progress toward quality cost-effective health care. Neither the current market-driven system nor the existing governmental quasi-National Health Insurance (NHI) Medicare and Medicaid programs meet these requirements.⁵⁻⁸ Single payer and nationalized health care in other countries suffer from underfunding, long waiting lines, inadequate facilities, rigid regulations, and frequently lack of patient choice.⁹ We propose new and innovative reforms that require a Federal Health Insurance Reserve System (FHIRS) to reduce ingrained errors and enhance the positive aspects of both the market and government systems. Whatever system develops a FHIRS will be pertinent, be it our new market-driven proposal or a single payer or national health insurance systems.

PROBLEMS REQUIRING SOLUTIONS

1. The uninsured and underinsured.
2. Politically and litigiously mandated benefits.¹⁰⁻¹²
3. Unequal tax treatment for health financing.
4. Lack of individual choice of plans and providers.
5. Perverse financial incentives for the insurance industry.¹³⁻¹⁷
6. Underfunded and confused Medicaid programs.^{7,18}
7. The Ponzi-type Medicare scam of cross-generational financing.¹⁹⁻²²
8. Insufficient national clinical trials and lack of constraint of unnecessary malpractice suits.^{4,23,24}
9. Unfair competition by hospitals charging their own patients different amounts for identical ser-

vices and pharmaceutical companies charging individuals and small organizations more than large organizations, increasing the number of uninsured.

10. Excessive costs threaten the national economy, access to quality medical services, and federal and state budgets partly because of the lack of economic incentives to limit health care expenditures.
11. Lack of a national program to coordinate, analyze, and recommend optimizing medical care and controlling costs.

To correct these deficiencies, we propose that Congress create individual tax incentives, mandate universal catastrophic coverage, and charter an independent FHIRS protected from direct political, commercial, and legal pressures to establish regulatory controls and productive incentives for a competitive market-based system. FHIRS would be charged to encourage efficient use of health care dollars for the public good, increase freedom of individual choice coupled with acceptance of individual responsibility, ameliorate inflation, and stimulate innovative and fair competition. The most unique portion of this proposal is the enactment of FHIRS, which would be useful for either government or market-based systems.

HOW THE FHIRS PROPOSAL WOULD AMELIORATE THESE PROBLEMS

1. The underinsured and uninsured:

Congressional enactment of compulsory catastrophic health insurance for all residents and compulsory additional basic health insurance for all children and citizens under the 200% poverty level would bring all residents into a multifaceted health care system.

2. Politically and litigiously mandated benefits:

FHIRS would be isolated as much as possible from direct political, legal, and commercial pressures, as is the Federal Reserve System for banking, allowing it to collect outcome and cost data and use scientific analysis to develop tax-advantaged health insurance benefits and payment parameters. FHIRS would define the benefit packages for catastrophic insurance required for all and the more comprehensive basic insurance mandated for children and encouraged for the entire population. A federal subsidy would be

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Received for publication Dec 23, 2002; accepted Jan 28, 2003.

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PEDIATRICS (ISSN 0031 4005). Copyright © 2003 by the American Academy of Pediatrics.

used for those under the 200% poverty level and reverse-to-income tax credits for all others.

Congress would estimate the cost to the budget from subsidy, tax credits, and loss of revenue from favorable tax treatment and direct FHIRS to limit tax-advantaged expenditures to a budgeted figure. It would not direct how the cuts should be made or cut or add specific benefits. Those would be developed by FHIRS on a scientific rather than a political basis. Which benefits will be the most beneficial to society remains to be seen and will become an ongoing FHIRS decision.

3. Unequal tax treatment for health financing:

The employer would no longer have deductions for the cost of health insurance but could provide employees with a defined contribution. Individuals could use a defined contribution, their own funds, and would receive a tax credit inversely related to income to purchase tax-free FHIRS defined policies. Any defined contribution not used to purchase approved FHIRS policies would be taxed at the usual rate for that individual.

4. Lack of individual choice of plans and providers:

Employers would no longer choose so insurance companies would offer the tax-advantaged policies to individuals and families while also offering taxable supplemental policies. FHIRS would approve the insurance companies' disclosure statements to prospective purchasers identifying eligible providers if providers are limited, how they are paid, and the anticipated ratio of providers to patients as well as the clearly delineated benefits package and copayment requirements. Enrollment could take place at the workplace, many public offices, or with the individual's federal income tax payment.

Individuals could hire brokers, but broker fees would not be eligible for tax deductions or credits, whether the fees are included in the insurance premium or the individual pays the broker. Those receiving subsidies for payment could choose their own policies and would be subject to limited copayments.

5. Perverse fiscal incentives for the insurance industry:

The current economic incentive for insurers is to enroll healthy people. FHIRS would level the risk assumed by insurers to encourage fair competition. Each enrollee would submit a simple risk assessment questionnaire to be used to index their individual risk when purchasing a policy. These would be bar-coded and an average enrollee risk index established for each policy to compare with other insurer's policies. FHIRS would transfer some of the premium from plans having lower average risk enrollees to plans with higher risk enrollees. Simple stratification of age/sex data clearly demonstrates risk.²⁵⁻²⁹ With actuarial assistance FHIRS could further refine a simple questionnaire with a few questions on family history or diagnosed conditions, significantly improving its accuracy. Although not exact, such risk adjustment of the money received by the insurer

would help change the present incentive from just enrolling healthy people to an incentive to concentrate on the most efficient way to take care of the sick. Standardized policies and full disclosure could shift the incentive from marketing to administrative efficiency.

Other distorted incentives include more concern about current than about long-term insurance costs as well as an emphasis on full payment for high-cost hospitalization. These lead to high front-end deductibles that do not deter hospitalization but do limit economical coverage of prevention and early illness care, services that could actually reduce hospitalization.^{14,30,41}

6. Underfunded and confused Medicaid programs:

Low-income people on Medicaid are faced with multiple regulations from state programs dictated by 50 different legislatures with hundreds of different pressure groups shaping benefits packages. Parsimonious medical and social funds are mixed, obfuscating the costs of both. Medicaid should be bifurcated leaving the social costs to the states and medical costs to the federal government. FHIRS basic benefit package would be used to bring this group into the mainstream of medical practice with costs subsidized or in some cases paid for with tax credits.

7. The Ponzi-type Medicare scam of cross-generational financing:

When established, ~13 working people were taxed to pay for every Medicare recipient. The ratio is now 3:4 workers per recipient and will become worse, creating a financial disaster for both the elderly and the taxpayers. Medicare as we know it is unsustainable.²² The problem is compounded by political pressure to increase benefits, some for unproven and ineffective services. FHIRS should define the benefits package and the financing mechanism should be changed for future recipients to a forced-savings program as proposed by Senator Gramm.³¹ FHIRS regulations and incentives could replace the current biblical compendium of rigid Medicare regulations.

8. Insufficient national clinical trials and lack of constraint of malpractice lawsuits:

New modalities of treatment are sometimes mandated long before they are proven, increasing costs, frustrations, and suffering.^{11,13} Likewise, obsolete methods of treatment are not excluded from benefit packages because of pressure groups within various provider communities or plaintiff-induced suits fostered by the trial bar. For example, nearly every insurer was forced to cover autologous bone marrow replacement in patients with stage IV breast cancer, although it was later shown to be ineffective.^{32,33} The total problem of the cost of litigation and defensive medicine creates a gigantic drain on the public that ultimately pays through taxes or private insurance.²⁴

Objective national clinical trials encouraged by FHIRS, in cooperation with the NHI, the Institute of Medicine and academia, with a small percentage of insurance premiums for funding, will enable FHIRS

to develop sound benefits packages that could dampen the effects of lawsuits over benefits and some treatment modalities. This, plus required disclosure, could suppress the rising number of class action suits and frivolous litigation. Basic tort reform is essential.

9. Unfair competition by hospitals charging their own patients different amounts for identical services and pharmaceutical companies charging individuals and small organizations more than large organizations, increasing the number of uninsured:

In the past hospitals charged the affluent more than others so they could afford to treat the poor. Overcharging of some is now used commercially to take advantage of insurance payment and discounting, so one neighbor with insurance X pays a far greater amount than neighbor with insurance Y for the same service. This practice, obscured as a trade secret in competitive bidding, is actually anticompetitive in that it does not provide the individual a choice based on cost or perceived quality, but instead gives the insurer of large groups the biggest discounts. This increases costs to small groups and individuals contributing to the rise in the uninsured. A fair trade system for FHIRS tax-advantaged insurance would allow hospitals to compete against each other on the basis of quality and cost so patients can decide whether it is worthwhile to pay more to go to a more expensive hospital for perceived quality benefits.

A similar type of problem inequitably increases the costs for individuals and small organizations purchasing pharmaceuticals. To “get the business,” steep discounts are given to medical groups and insurers to encourage use of a particular brand of medication. Aside from the lack of an overall assessment of the medical and cost-effectiveness of one brand versus another, an issue that also requires correction, this unfair variety of competition is in reality also anticompetitive. The use of a particular medication should depend on its basic value and competitive cost rather than unfair discounting.

10. Excessive costs threaten the national economy, access to quality medical services, and federal and state budgets partly because of the lack of economic incentives to limit health care expenditures:

Under the FHIRS proposal, to cover subsidy, tax credits, and loss of income from tax-free insurance, Congress would establish a budget. FHIRS would have several options including altering the benefits packages, increasing copayments, and/or reducing the upper limits of tax-advantaged fees to stay within that budget without Congressional interference. The first priority of the FHIRS would be to protect basic health financing for the entire population. A high percentage of medical costs result from often heroic and unproven treatment of basically terminal illnesses, followed by a limited poor quality

life. Priorities will ultimately need to be set by an impartial body such as the FHIRS.

Other steps to control costs would be ongoing, regardless of budgetary constraints. The FHIRS would use many tools:

- A. Altering the benefits packages to drop minimally effective services could reduce ultimate costs.
- B. Objectively developed adjustments of copayment can be a valuable tool to encourage proven preventive services and discourage less valuable services, reducing ultimate costs.^{14,34–37}
- C. The FHIRS would have the power to establish geographic upper limits of tax advantage to keep within the budgetary constraints of Congress but would not be able to limit providers from charging more if the individual purchaser was clearly notified when buying the policy of provider charges that would be above the tax-advantaged limits. Competition between providers for patients could tend to suppress escalating costs.
- D. As information develops, the FHIRS could track administrative costs and profits of insurers, and publish them if warranted. However, competition will keep administrative expenses down, and under FHIRS incentives will replace many costly regulations. Marketing costs will be significantly reduced by FHIRS standard policies with fully informed purchasers aware of benefits and premiums. Policies will be available through employers and public facilities so brokers and their nearly 5% fees will be unneeded.²⁰
- E. Working spouses under employer-purchased insurance often have duplicate insurance coverage, creating the expense of coordination of benefits that would be eliminated by individual and family purchase of policies.
- F. Automatic premium collection through the existing quarterly federal income tax mechanism will reduce some administrative costs.
- G. Insurers could contract with providers to offer lower-priced policies to the public by various innovative methods of delivery of care.
- H. The FHIRS and insurers could track and analyze utilization patterns, charges and costs of physicians, hospitals, and individuals and use the confidential findings educationally to improve cost-effectiveness and prudent utilization.
- I. Encouraging personal patient/physician continuity of care by reducing employer-forced changes of physicians will:
 - i. Reduce the costs of transfer of medical records and the increased cost of new patient services versus established patient services.
 - ii. Reduce fragmentation and duplication of care by establishing a medical home that can also reduce expensive emergency department use and hospitalization.^{38–42}
 - iii. Increase the personal physician’s knowledge of the patient with resulting greater efficiency in care, patient satisfaction, and compliance.⁴³
- J. Reducing defensive medicine and malpractice lawsuits:

- i. FHIRS-designed tax-advantaged coverage would be protected from lawsuits about coverage.
 - ii. Full patient previous knowledge of physician accessibility in a plan would reduce suits about choice of physicians.
 - iii. Data collection and analysis can result in more realistic community standards of practice and outcome, reducing defensive medicine.
 - iv. Full tort reform should accompany any finance reform.
11. Lack of a national program to coordinate, analyze, and recommend optimizing medical care and controlling costs:

Even under the present crippled financial systems, medical progress continues. However, some of these efforts receive more attention for their newness than how they affect cost, access, and ultimate outcome. An organized approach to coordinate, encourage, and finance efforts to carefully assess the overall effects of both new and traditional medical modalities can be quite helpful.

FHIRS, as an apolitical agency free from commercial pressures, would be in an ideal position to lead and encourage such efforts. The large computer capability necessary for other aspects of FHIRS operations could be used to collect insurer's data, hospital outcome data, and longitudinal data on chronic conditions and costs. Used with assured patient confidentiality, they could be shared with various private and government research institutions, academia, and organized medicine.

DISCUSSION

The number of uninsured demonstrates a partial failure of our medical system. Many recognize the necessity for compulsory catastrophic coverage for all residents. In addition, a more comprehensive basic coverage is justified for children who cannot make economic choices for themselves. The problem is how to achieve this in a system that can maintain economic viability while meeting the basic health needs of both individuals and society. Among the basic flaws in the current system that reduce viability is limited individual freedom of choice of care with lack of perceived individual responsibility for the cost of that care. Neither the current market-driven nor the single-payer government systems have managed to solve these problems. Our proposed FHIRS is the linchpin necessary to correct these problems by reforming the current market-driven system and avoiding the difficulties of single-payer government programs.

Eliminating employer selection of health insurance for their employees enhances individual freedom and responsibility. Insurers would clearly disclose all aspects of their offerings and the percent that qualifies for favorable tax treatment to enable choice based on benefits, provider availability (including how the providers are paid), and the tax consequences to the individual. Providing individuals

with reverse-to-income tax credits and allowing those without employer-defined contributions the same tax advantage improves tax system fairness.

Ultimately, in the proposed system, its fiscal integrity would rest on the amount Congress is willing to subsidize directly and forgo in tax-related income, buttressed by the freedom of individuals to purchase taxable services as most do now, for example, when paying for unproven alternative medicine.⁵ A FHIRS is essential to objectively decide, on a scientific basis, which benefits under the Congressional fiscal limits are included in subsidies or tax-advantaged policies. If fiscal integrity is to be maintained, with medical science poised as it is to take quantum steps forward, it is essential that a body such as the FHIRS decide on the advantaged benefits rather than lobbyists or the trial bar with their threats of huge class action lawsuits. Also, it is essential to protect Medicare from the fiscal quicksand it stands on. The FHIRS, by being able to adjust coverage, maximum tax-advantaged charges, and copayments can modulate utilization and costs to keep within the Congressional tax budget. Allowing providers to charge above the tax-advantaged limits, with prior patient knowledge, enables patients and providers to agree or compromise on the personal value of services.

A risk adjustment index for each policy based on the risks of individual enrollees can shift the incentives of insurers away from just seeking healthy enrollees to one with more emphasis on prevention and effective efficient care of the sick. Requiring an all-payer system for hospitals and pharmaceuticals would further enhance fair and innovative competition. FHIRS stimulation of national clinical trials can lead to improved community standards of practice, medical efficiency, and better patient outcomes. Protecting FHIRS-designed policies from lawsuits over coverage, and the development of scientifically-based community standards of care could reduce expensive litigation. FHIRS also has tremendous potential for tracking longitudinal outcome data, sharing it with medical organizations, academia, and the Institute of Medicine to develop improved practice procedures and outcomes.

Because FHIRS would develop the benefit packages, including those of Medicare and Medicaid, they would be designed to be compatible with funding. This would be a marked contrast to the present situation in which political bodies mandate benefits but underfund them, thus requiring administrators to squeeze benefits into inadequate funding. The resulting biblical-sized regulations requiring provider compliance create significant administrative expense and may occasionally limit care inappropriately.

The FHIRS would pragmatically merge the independent free market of health care financing with necessary oversight under a policy that will allow flexibility, innovation, and productive competition progressing toward efficient health care while increasing individual freedom of choice and reducing provider shackles. It would correct the market system's transgressions, establishing a basis for fair competition. Regardless of the system adopted,

whether it is some form of NHI, single-payer or our proposed market-driven system, a FHIRS organization will be needed to rationally design and prioritize benefits, leading to fiscally sound systems and prudent use of resources.

Can we get there from here? The current system is hemorrhaging funds and a tourniquet is needed, making it rational to anticipate that a sweeping reform can be achieved, even in the face of the powerful entrenched players involved. Band-Aids won't work. 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. There may be a FHIRS in our future!

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Pediatrics 2003;111;1093

DOI: 10.1542/peds.111.5.1093

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