

2019 Healthcare That Works for All

This paper is one of a series describing what a decade of successful change in healthcare could look like in 2019. Each paper focuses on one aspect of healthcare. To see the other papers for a comprehensive view of systems change, go to http://www.altfutures.com/2019_Healthcare_That_Works_For_All.

Healthcare Payment Systems in 2019

A Healthcare Payment System That Works for All

Redesign of payment systems requires:

1. Access to high quality, affordable healthcare for all Americans
2. A combination of private and public options cover the population, but with limits on third-party obligations that define a basic tier of care that is constrained by value-based purchasing
3. Government funding of an open source network that assesses the comparative efficacy of treatments, and those assessments shape reimbursement policy
4. A new Independent Health Board proposes annual national health budgets that only are increased by Congress through higher taxes or designated shifts from other parts of the federal budget
5. Fee schedules that constrain excessive profits and salaries in healthcare so that equity is honored.

How Payment Systems Need To Change

The American systems of payment have reinforced standardized procedures and diagnostic categories without explicit designs for outcomes, quality, innovation or individual needs. Over the next ten years payment systems can change incrementally so they gradually increase the percentage of payments that reward healthy outcomes, care coordination, behavior changes and personalization for individual patients. Payments will have to decline for procedures and services that provide less value for the money and grow for prevention and primary care that supports a healthy population.

The government can take the lead by setting policy that defines the responsibility of all third-party payers and the limits beyond which individuals must pay for additional care. The federal government

will need a stronger policy arm, which serves health and protects the economy. This Independent Health Board can incorporate policy functions of the Centers for Medicare and Medicaid Services (CMS) along with additional capabilities from a strengthened Agency for Healthcare Research and Quality AHRQ. This Board can also make coverage decisions based on value assessments from an Open source Network for Comparative Efficacy (ONCE). The Independent Health Board should be responsible for proposing national healthcare budgets and determining third-party payment rates. Citizens can choose either paying for charges above those rates set by the government, or find lower cost options in the U.S. or abroad. Hospitals and specialized providers would be paid through global fee schedules based on the medical conditions of patients they treat, with level of payments determined by co-morbidities, severity of illness, socio-economic factors and outcomes.

Forecasts for Successful Payment System Changes

Payment systems begin to shift in 2009 when a new administration sets a policy course that supports access, quality and affordability for sustainable healthcare delivered to all Americans. This coordinated process moved through phases defined by planning, implementation and evaluation. The phases were defined early on when the new administration proposed broad legislation that authorized formation of the Independent Health Board and funding for an Open source Network for Comparative Efficacy to assess the value of therapies. The decade of healthcare politics that followed was marked by extensive planning and preparation so legacy systems could convert into an integrated payment system. Government programs set the course that private third-party payment systems follow, making payment rules transparent for providers and citizens alike. Continual monitoring by regulators for the Independent Health Board identifies unanticipated rises in cost, typically leading to swift adjustments in policy or recommendations to CMS for regulatory action to enforce budgetary discipline. As spending trends move upward, the Independent Health Board proposes changes in either tax policy to Congress or regulatory change for the CMS.

Most Americans continue to get their healthcare insurance through employers. Others have an option to buy insurance from other organizations using regional risk pools that cover people with pre-existing conditions with transportable coverage. Those at lower income levels receive graded subsidies from the government. By 2019 all individuals are mandated to have healthcare insurance so the basic tier is available to all Americans. The cost of this basic tier is only allowed to increase at the rate of growth of GDP. Those who want more than the basic tier of care can pay out of pocket or buy supplemental insurance, but tax incentives only go to support the basic tier.

The payment system becomes more open and adaptive over the decade through continuous learning around a core set of agreed upon values that are fixed by law as well as public consensus. Health, social justice, compassion and responsibility for and from individuals are core values that legally bind healthcare payment systems. Public and private payment systems must be accountable to these values as they evolve to demonstrate progressive improvement. The challenge that every payer faces is to

honor these values while staying within agreed upon budgets and maintaining sufficient transparency to sustain public trust. Those that meet the challenge learn to account for individual variation among beneficiaries to improve the health outcome derived from every dollar spent on healthcare. In effect they create more flexibility in payments to adjust to the variability in the population.

In 2010 the payment system offered sufficient incentives and protections to encourage widespread use of electronic medical records and personal health records. The resulting infrastructure supports a host of incentives for provider teams to coordinate care and improve quality. Many clever programs also provide incentives to beneficiaries that support healthy behavior changes and efficient use of medical resources. Payment systems continuously negotiate value while teaching all parties—patient/consumers, providers and interested parties such as employers—about health and responsibility for outcomes. The payment systems are effectively integrated with learning systems so that current health status and potential improvements are better understood. As people use their payment systems they learn individually and contribute collectively through exchanges with the vast network of users. The result is payment systems serve individuals while staying responsive to the needs, values and desired allocations of society.

Certain principles structure the payment systems so that they sustain healthcare improvements while they support transactions. One is that individual and collective responsibilities are maintained through the combination of private sector healthcare delivery with public sector regulation that enforces civil society expectations. Limits are respected while compassion is expected.

Procedures are clearly communicated so that people can readily navigate payment systems with the help of continuously improving software aids. All coverage decisions are informed by evidence-based medicine that a network of entities organize with coordination of the National Quality Forum. A National Health Board determines the annual expenditure in a budget sent to Congress every year. The National Health Board first conducts a public referendum with randomized surveys so that the priorities represented by healthcare are democratically reinforced when entering the political arena where other priorities vie for support.

A hybrid of public and private systems changes proceeds thanks to enlightened leadership that maintains transparency while continually pressuring competitors to strive to achieve wins that serve the public interest as well as their own. Where the market fails to effectively improve health, equity and value or constrain costs, regulation and taxation quickly shifts incentives. The policy functions that determine who gets paid for what are housed in a CMS that is tasked with assessing value, making payment and policing against fraud. Their work is overseen by the National Health Board, reviewed by Congress and publicly supported through surveys, town hall meetings and elections.

Pragmatic Steps To Take

- A. Hold public dialogues to develop the social contract that defines values, rights and responsibilities that healthcare payments will support. The Oregon experience with Medicaid provides a model that can be studied and modified.
- B. Create a National Health Board that submits budgets to Congress and sets policy for the administration of healthcare payments by public and private third party payers.
- C. Authorize a new public-private entity that utilizes open source research funded with an adequate budget for comparative efficacy studies to support value-based purchasing decisions.
- D. Develop evaluation tools that link healthcare inputs to healthy outcomes. These tools modify payments based on procedures (e.g., CPT codes) and diagnosis (ICD-10 and DRGs) to support prevention and primary care in health homes (see Healthcare Delivery in 2019) moving toward increasing personalization.
- E. Design a global budget process that works at various levels—federal, state, community and family—to align expectations with fiscal plans that place health in balance with other goods and services.
- F. Develop public reports to show the value of health and provide measures that support political discussion of global health budget submissions to Congress by the Health National Health Board.

What Happens If We Fail To Change Payment Systems

Healthcare expenditures will continue rising while access decreases and quality erodes if we do not change the payment system. Healthcare tiers will become more distinct with large barriers keeping the poor and middle class from access to quality providers or innovative medicine. More doctors will refuse to participate in Medicare and more employers will drop healthcare insurance policies. Private insurance will become more expensive and complicated as exclusions, lifetime capitation and co-payments challenge consumers. The overall cost of medical care will drive up taxes and make U.S. business less competitive globally. Trust will diminish, the morale of healthcare professionals will worsen and lawsuits will increase. Many people will opt out of the healthcare system, choosing complementary and alternative medicine, off-shore medicine or home remedies. The health of the population overall will decline relative to other developed countries with more effective payment systems.

Appendix

Healthcare Payment System Principles

1. All Americans will have access to affordable, high quality healthcare

- To meet this mandate within our fractured free market healthcare system a pragmatic combination of private and public options emerged to cover segments of the population
 - About 2/3 of employers still offer healthcare insurance to their employees because costs are constrained and predictable. Those who do not must pay into a government fund to help subsidize coverage of those who buy individual insurance.
 - People without employer provided insurance have two options
 1. Buying insurance from organization or regional risk pooled insurance offerings that covers those with preexisting conditions and is transportable (also must provide at least the basic tier)
 - The government fund provides graded insurance subsidies for those with low incomes
 2. Buying a government sponsored insurance equivalent to Medicare (also graduated subsidies for low income)
 - Medicare, Medicaid and SCHIP programs are available for eligible individuals
 - Americans must have some form of health coverage by law. Hospitals and providers have very limited financial responsibilities for treating those without coverage. It is possible to buy insurance at a time of need, but the coverage has limits and there are additional costs.
- Basically there are options to cover every American. The needs of illegal immigrants will need to be addressed as well.

2. There is a limit to third party payment for healthcare

- There will be a limited, but comprehensive basic tier of effective health services for treating a full range of diseases and conditions – some form of beneficial treatment will be offered (if available). This is the basic building block of the health benefit made available for Americans.
- However, the basic tier benefit is designed to be of moderate cost to third party payers. The starting point was the cost of a basic health policy in 2008.
- The cost of the basic tier will only increase in step with the growth of GDP [See *Health Economics in 2019*]

- Basic tier benefits will be determined in a systematic way by rating the value to society for all beneficial preventions and therapies, and with the list in rank order determining what can be afforded within the allotted basic tier benefit dollar cap (similar to the previous Medicaid scheme in Oregon). Lower priority therapies that don't make the cutoff are not part of the basic tier. The National Health Board will determine basic tier benefits and annual cost in a transparent way.
- All insurance plans must make available a package including the basic tier at the target price (or less) employee coverage or individual purchase. Insurers can also offer enhanced plans that employers or individuals can choose to buy. In addition there can be supplemental insurance offerings to augment the basic tier plan.
- All employers offering health insurance for their employees must at a minimum provide this basic tier benefit. Employers can offer more if they choose. However, employers receive business tax deductions only for the basic tier benefit.
- Medicare and Medicaid will have long-term budgets (ideally a 30 year budgets) that must be reviewed and adjusted by Congress at least every 5 years. There is a trigger if projected spending exceeds budgeted amounts which will involve automatic benefit cuts or a revenue increase until Congress addresses the problem. Increasing federal debt to fund Medicare is forbidden. The only solutions are shifting expenditures from other programs or raising taxes. [Ideas from *Taking Back Our Fiscal Future*, April 2008 by Brookings Institution and The Heritage Foundation]
- Citizens can buy supplemental insurance and purchase additional health services, but must pay out of pocket for them. The only way to raise the basic tier annual spending cap is through a political process. The net result is that citizens would have to pay higher taxes for Medicare and sacrifice salary increases for employer based insurance.

3. The new goal is to get the most health for the allotted resources through efficient use of effective, high quality healthcare services

- America is spending about twice as much per capita as most other industrialized countries – more than enough to provide high quality healthcare for all citizens if it is spent wisely for appropriate (truly indicated), evidence-based, high quality and safe services at competitive prices. It is just an issue of spending resources differently.
- There is an entity that assesses the effectiveness and cost effectiveness of preventive measures, therapies and therapeutics in a rational and open process that is protected from business and political influences.

- Now the purchasers and providers of care know what works and is most cost effective.
- The payment system is designed to incentivize providers to get the most health benefit for the available money.

4. *The delivery system is designed for competition and innovation* [see Healthcare Delivery 2019]

- The “Health Home” comprehensive primary care clinic
 - It is provided a monthly comprehensive fee for each enrollee based upon the anticipated cost for the comprehensive management that person’s risks and health conditions. The fee has built in support for information technology, education, care coordination, and ongoing quality improvement processes. There are also financial incentives for both the medical team and the patient if milestones of health improvement are achieved. The fee supports an appropriate mix of healthcare staff members for the health home office practice such as advanced practice primary care physicians, advanced practice nurses, a dietitian and maybe a nurse educator.
 - The health home provides all the necessary primary care services including laboratory, imaging and prescription drugs within this global fee. Therefore there is strong incentive to use evidence-based medicine to provide the most cost-effective services to achieve the desired outcome. Because of public performance report cards and financial incentives for improved outcomes, the practice is not rewarded for skimping on care.
 - The health home has flexibility to be innovative and competes with other health homes for patients on the basis of transparent quality, outcomes and range of services offered. They can also compete on price.
- Hospitalizations and surgical procedures are also paid for with a single comprehensive fee for an entire period of care.
 - For a surgical procedure this means a single fee covers all providers such as anesthesiologists, surgeons, nurses and technicians, all associated laboratory tests, drugs and hospital or clinic services – in other words, everything.
 - For specialty care such as management of a breast cancer, the comprehensive fee is for a specified period like 6 months, based on the type and stage of malignancy to determine the realistic resource needs for care. It must cover all health services such as hospitalizations, lab, therapies, medications and involved specialists. There is an objective appeal process for a supplemental payment in outlier cases.

5. Healthcare system reorganization

- Providers and hospitals formed collaborations to manage within a fixed fee and in most cases have become parts of integrated health systems. They have carefully looked at care processes and improved standardization and quality to assure that care is very efficient with low rates of complications. Many systems are so good at this that they offer extra features or compete by offering a reduced comprehensive for some diagnosis-treatment combinations.