HEALTHCARE REFORM: A PROVEN SOLUTION

A White Paper by:

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I am proposing the adoption of an already proven healthcare delivery system that actually works for all key healthcare system participants, and that effectively reduces healthcare costs while significantly improving patient health and disease prevention. This proven healthcare delivery system recognizes that patients and their physicians must be the focus of any cost-effective healthcare system, and therefore rewards physicians for adoption of high quality processes such as Electronic Health Records (EHR's), HEDIS compliance, and Pay for Quality (P4Q) criteria and, most importantly, rewards these physicians for better patient outcomes and improved health status. This highly effective healthcare system also recognizes and is based upon the free enterprise and competitive free market system that currently exists in many metropolitan areas of the country.

The net result of this system is that it can be adopted and implemented without a tax increase, and basic preventative and elective healthcare benefits can be available to all American citizens who are currently uninsured or underinsured. The universal adoption of this proven private sector healthcare delivery system by the government for all entitlement programs will improve the longevity of our Social Security system and allow the Baby Boomers to receive the Medicare benefits that they have been paying for their entire working lives; indeed, they will receive more improved Medicare benefits than their predecessors. It will also halt the dangerous annual increase in healthcare costs as a percentage of the GDP, and gradually reduce the percentage of healthcare costs to GDP; thus improving our ability to reduce our national debt over the next 10 years. It will also increase our ability to attract higher numbers of Americans into the healthcare profession so that access improves for all Americans.

PART ONE

As background, although the US Healthcare system does not currently provide preventive and elective healthcare coverage for all Americans, it must be recognized at the outset that our current system does provide for the acute-care and emergency needs of ALL citizens, regardless of their legal status. Our current system is also arguably the best in the world in terms of health outcomes, as documented by the Stanford Study.[1] Although the World Health Organization study places America as 37th in the world in overall ranking, its many ideological assumptions have been rightfully called into question. Interestingly, this WHO study does list America as number one in the world for technological innovation and also for total healthcare expenditures. It also states that America is the "Early Adopter" of technology improvements in healthcare and it extols the virtues of this for the American people. It should be noted that America has a predominantly competitive private market healthcare system and doesn't have

1 Scott W. Atlas, "Medicine and Health: Here's a Second Opinion," http://www.hoover.org/publications/digest/49525427.html (2009)

any significant government rationing or insurance company rationing. This is undoubtedly why America leads the world in total expenditures per capita and in technology innovation.

This Executive Brief shows that the percentage of uninsured working Americans is between 3%-6% at any given time, which is a much smaller percentage of the US population then the Media and the academic elites would have us believe. Indeed, the actual number of uninsured Americans is much less than half of the "16% of Americans" statistic that is bandied about by these ill-informed and/or deceitful elites.

The following is a summary of the existing governmental programs and private insurance system that currently provides this healthcare coverage in the US.

- **ELDERLY (Medicare Program):** Note that our elderly are covered through the Medicare program, which now includes coverage for drugs.

  It should be noted that the Medicare program has significantly improved the care for the elderly over the last 7 years through the privatization of Medicare called the Medicare Replacement or Advantage Program. This Medicare Replacement Program has actually significantly improved the healthcare benefits and lowered the Out of Pocket (OOP) costs for the elderly who have chosen this privatized Medicare Program. The privatization of this government program is actually lowering the costs of treating the elderly and shows incredible promise for reversing the spiraling costs of healthcare in the US.)

- **PHYSICALLY DISABLED and ECONOMICALLY CHALLENGED (Medicare/Medicaid, Dual Eligible Program):** Our physically disabled population and economically challenged elderly population are covered through a combination of the Medicare and Medicaid programs and these Americans enjoy no Out of Pocket (OOP) costs (no deductibles or co-pays), of any kind.

- **SINGLE MOTHERS with DEPENDENT CHILDREN (Medicaid Program):** Our poor, single mothers and their children are covered under the Medicaid program and these Americans also enjoy no OOP costs of any kind.

- **CHILDREN OF THE WORKING POOR (SCHIP Programs)**: Children of working Americans whose parents' income levels are above poverty guidelines, but fall below 200% of poverty guidelines can apply for and receive State Children Health Insurance Plan (SCHIP) benefits for their dependent children and there is generally no OOP cost for these children or their parents.

- **WORKING INSURED (Third Party Insurance Plans)**: Most of our working Americans and their families who are under the age of 65 and who are not disabled are covered through a third party, private insurance plan (202 million Americans in 2007[2]), and

2 U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2007*, Table C-1, "Health Insurance Coverage: 1987 to 2007," http://www.census.gov/prod/2008pubs/p60-235.pdf.

roughly 84% of these working Americans are relatively satisfied with their insurance coverage,[3] although the (OOP) cost can be significant at times, depending on the insurance plan policy provisions. However, the inclusion of reasonable OOP cost is a necessary element of any insurance plan in order to ensure that any healthcare services which are sought by the insured are indeed necessary and are not simply frivolous, duplicative, and unnecessary. In other words, when healthcare is completely free to the insured, there is a much higher incidence of unnecessary and frivolous healthcare testing. Unethical Providers and Providers who are concerned with litigation potential (often referred to as "Defensive Medicine") will often order expensive and unnecessary or duplicate tests simply because the patient isn't responsible for the bill and therefore does not question the necessity of the procedure. The inclusion of reasonable OOP costs is therefore a necessary element of a cost-effective insurance plan in order to involve the patient in healthcare decision-making; thus reducing unnecessary and costly testing and treatment.

The current societal problem with this private system of providing insurance benefits is that many insurance plans exclude certain individuals from receiving coverage if there exists a "Pre-existing Condition" that can be documented. This greatly increases the cost of healthcare for these unfortunate individuals and can bankrupt these people if their pre-existing condition flares up and requires the use of the healthcare system. Their high cost of treatment is also most often borne by hospitals without any meaningful reimbursement for these costs. The good news for many Americans is that, as a result of good old-fashioned competition for customers in certain metropolitan markets, many HMO's have eliminated this problem by eliminating any "No Pre-existing Condition" clause from their Plans. Any legislation that is considered must provide penalties for inclusion of this clause in insurance contracts.

- **WORKING UNINSURED:** There are many estimates of the Working Uninsured and many definitions of this group. The most common estimate promoted by the liberal and conservative media is 47 million people. However, the truth is far different. Note that the total uninsured in 2007, as most recently reported by the US Census Bureau in their August 2008 "Income, Poverty, and Health Insurance Coverage in the US: 2007" edition was 45.7 million people.[4] Please see the Bar Graph below.

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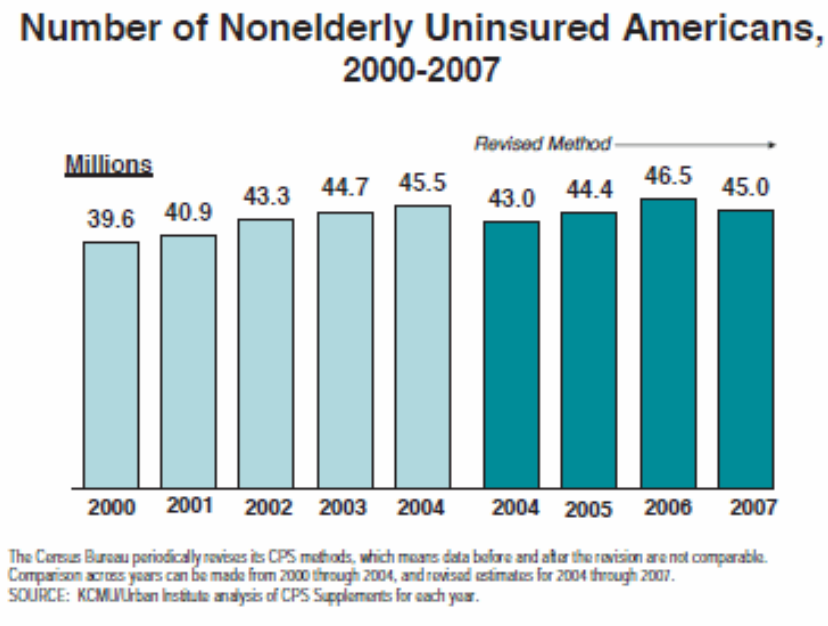
3 Zogby International, "UT Health Science Center at Houston/Zogby Poll reveals Americans wary about U.S. Healthcare reform," http://zogby.com/search/ReadNews.cfm?ID=1722 (July 16, 2009); Zogby International Survey Results, http://www.zogby.com/news/wf-healthcarereform.pdf and http://www.zogby.com/news/x-healthcarereform.pdf.

4 U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2007*, Table 6, "People Without Health Insurance Coverage by Selected Characteristics: 2006 and 2007," http://www.census.gov/hhes/www/hlthins/hlthin07/p60no235_table6.pdf.



Graphic courtesy of The Henry J. Kaiser Family Foundation, "The Uninsured: A Primer – Key Facts About Americans Without Health Insurance," pg. 13

This US Census Bureau report and the Kaiser Foundation report on the Uninsured (dated October 2008) both report that the number of uninsured actually dropped from 2006 to 2007 by 1.5 million people.[5] However, as these reports show, this 45.7 million uninsured statistic is deceptive since it includes illegal aliens, high-income working Americans, and poverty level non-working Americans who have access to insurance plans and Medicaid but simply choose not to apply for this coverage until needed. **Therefore, a more accurate estimate of the actual number of uninsured working American citizens who desire health insurance coverage but cannot afford such coverage is approximately 17 million people or a total of 6% of all Americans at any given time.[6] However, it is important to note that 45% of these 17 million Working Uninsured will actually have private insurance within 4 months of being without insurance because of transitioning between jobs, since most Americans receive insurance through their employers. Therefore, the more accurate number of permanent Working Uninsured is only 8.2**

5 The Henry J. Kaiser Family Foundation, "The Uninsured: A Primer – Key Facts About Americans Without Health Insurance," http://www.kff.org/uninsured/upload/7451-04.pdf (October 2008), pg. 13; U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2007*, Table C-1, "Health Insurance Coverage: 1987 to 2007," http://www.census.gov/prod/2008pubs/p60-235.pdf.

6 The Henry J. Kaiser Family Foundation, "The Uninsured: A Primer – Key Facts About Americans Without Health Insurance," http://www.kff.org/uninsured/upload/7451-04.pdf (October 2008).

million people, or only 3% of the American population, according to the Kaiser Foundation in their October 2008 report.[7]

Again, the specific facts from the authoritative 2008 US Census Bureau and Kaiser Foundation reports are as follows:

1. Approximately 25% of these 45.7 million people (~10-11 million Americans) qualify for Medicaid coverage, but simply choose not to apply for coverage until services are actually needed,

2. Another 22% (9.737 million in the 2007 Census) are illegal immigrants, and therefore should not be covered anyway. Even Michael Moore agrees that only legal US citizens should be entitled to receive health insurance coverage![8] Sadly, he is one of the greatest perpetrators of the absolute lie that 47 million Americans are uninsured. He actually reported on his website that the US Census Bureau had "underreported" the number of people without health insurance! Regrettably, many reporters such as Katie Couric have unwittingly echoed these lies on widely watched public television.[9] Many of these mainstream reporters have referred to the American healthcare system as deeply flawed, when in fact; it is the envy of the world, and is even reported to be number one in the world in certain quality indicators by the World Health Organization (WHO).[10] Note that the highly esteemed Stanford Study also documents that mortality and morbidity rates in Government Single Payer countries are much higher than in the US. It also documents that Americans have better access to treatment for chronic diseases and preventive care than in other state-run healthcare countries. [11]

3. Another 8.74 million Americans report incomes of greater than $75,000 per year and therefore can afford insurance coverage, but simply choose not to purchase such coverage. Sixty percent (60%), of these people report being very healthy and have simply made the choice to not buy health insurance.

4. The Kaiser Foundation, a liberal non-profit organization, also reports that 45% of the 19 million Working Uninsured (or approximately 8.55 million people), will actually have private insurance within an average of 4 months of being without insurance because of

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7 The Henry J. Kaiser Family Foundation, "The Uninsured: A Primer – Key Facts About Americans Without Health Insurance," http://www.kff.org/uninsured/upload/7451-04.pdf (October 2008).

8 Julia A. Seymour, "Health Care Lie: '47 Million Uninsured Americans'," Business & Media Institute, http://www.businessandmedia.org/printer/2007/20070718153509.aspx (July 18, 2007).

9 *Ibid.*

10 World Health Organization, *The World Health Report 2000,* http://www.who.int/whr/2000/en/whr00_en.pdf, Annex Table 1.

11 Scott W. Atlas, "Medicine and Health: Here's a Second Opinion," http://www.hoover.org/publications/digest/49525427.html (2009)

transitioning between jobs since most Americans receive insurance through their employers.

5. For public policy purposes, only 18 percent of the 45.7 million uninsured people (or 8.2 million people), are properly considered to be in the class of the permanently uninsured Working Uninsured!

Total Uninsured People		**45,657,000**
Less: Qualify for Medicaid Coverage but Choose Not to Apply		10,500,000
Less: Not an American Citizen		9,737,000
Less: Can Afford But Choose Not to Be Insured (>$75k/year)		8,740,000
Net Working Uninsured at any given time	**16,680,000**	
Less: Americans in Transition Between Jobs		8,500,000
Net Uninsured Americans		**8,180,000**

Summary of the Working Uninsured: Therefore, at any given time, there are approximately 17 million Working Uninsured or 6% of the total population, but the permanently uninsured Working Uninsured only total approximately 8.2 million people, or just 3% of the US population. Due to promotion of the SCHIP programs and expansion of private insurance programs, the number of Uninsured actually decreased from 2006 to 2007 by 1.5 million people![12] These 8 million+ working Americans and their families who are gainfully employed at incomes above poverty levels, but earn below $50,000 per year, are truly the ones who are left out of the preventive and elective healthcare system. They work for employers who either cannot afford to offer a private insurance plan, or employers who do offer an insurance plan, but such insurance plan is not affordable to these employees (hence the title, the "Working Uninsured").

Therefore, with the exception of paying cash or borrowing to pay for care, their ONLY access to acute and emergency care is through the EMTALA legislation that requires hospitals to diagnose and treat limb or life threatening diseases or injuries regardless of the ability to pay for such services. The real net effect of this law though is that most of these Working Uninsured also end up receiving their primary care through the nation's Emergency rooms; thus crippling the ability of hospitals to offer timely emergency treatment to everyone else. Emergency Room waiting times have increased dramatically since the implementation of this law.

Although the EMTALA legislation has the positive effect of providing acute and emergency care to the Uninsured when needed through the Emergency Rooms and Hospitals, the problem with this EMTALA system for treating the uninsured is that this population must either pay cash for preventive and elective healthcare services or wait

12 U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2007*, Table 6, "People Without Health Insurance Coverage by Selected Characteristics: 2006 and 2007,**"** http://www.census.gov/hhes/www/hlthins/hlthin07/p60no235_table6.pdf.

until an emergency occurs and then go to the closest Hospital for emergency services. This very helpful legislation unwittingly increases the overall cost of healthcare for the uninsured and the American taxpayer because the provision of emergency services is much more costly then the provision of preventive and elective healthcare services, even for the younger working population.[13] This EMTALA legislation also significantly burdens our nation's hospitals financially at a time when hospital net profit margins have all but disappeared due to price pressures within the Medicare and Medicaid programs and the gradual growth in the number of Americans who qualify for these programs; i.e., the Graying of America and the growth in unwed mothers of children within certain cultures.

There are therefore only two "Healthcare Coverage" problems with the American healthcare system today that need to be reformed. The <u>first</u> problem is the unfair, exclusionary, and costly *"Pre-existing Condition"* clause that must be eliminated from all insurance policies and the <u>second</u> problem is the lack of coverage for the "Working Uninsured". These are both public policy issues that the American people overwhelmingly support reforming through limited legislation that specifically addresses these inequities.[14]

A. The first problem of "Pre-existing Condition Clauses" is being eliminated slowly in certain areas of the country through private sector competition, but a government prohibition of this unfair practice through limited legislation is warranted and is endorsed by the American taxpayers.[15] The insurance industry defends this "Pre-existing Condition Clause" practice because it inhibits the abusive behavior of beneficiaries who wait until they are sick to purchase insurance. Although this is a very sound and reasonable argument for allowing insurance companies to continue this practice, the government can reduce or eliminate this "wait until I am sick" abuse of the insurance industry by either:

1. Levying a special tax equal to the average cost of "A" or better rated Catastrophic (high deductible) health insurance policies available in each state upon all working adults age 25 or higher who choose to not be insured and who make an income of greater than $50,000 - $75,000 per year. However, this is a <u>constitutionally unsound</u> method and is not recommended;

   OR

13 Emergency Medical Treatment and Active Labor Act, 42 U.S. C. 1395dd, http://www.emtala.com

14 Zogby International, "UT Health Science Center at Houston/Zogby Poll reveals Americans wary about U.S. Healthcare reform," http://zogby.com/search/ReadNews.cfm?ID=1722 (July 16, 2009); Zogby International Survey Results, http://www.zogby.com/news/wf-healthcarereform.pdf and http://www.zogby.com/news/x-healthcarereform.pdf.

15 Ibid.

2. The government can offer the same tax break for and on behalf of individuals who purchase insurance that employers currently receive for providing health insurance for their employees. This "tax break" alternative is much preferable because it doesn't violate the basic freedom to choose guaranteed by our Constitution.

This would greatly reduce the current inequity that is presently in our system, and empower the individual to compare and purchase the insurance policy that best suits their needs. This is the same financial incentive psychology that has resulted in millions of employers offering health insurance for their employees and will encourage all Americans to be responsible and purchase third party insurance as soon as their incomes and employment allow them to do so. Encouraging more Americans to purchase insurance via tax incentives, also creates a larger volume of membership in the insurance plans, and thereby reduces adverse selection and minimizes the financial impact on insurance companies from insuring Pre-existing Conditions.

State Insurance Pools (commonly referred to as Health Insurance Exchanges or HIE's) can also be used to help cover working uninsured adults making less than $50,000 per year who have not been insured because of the Pre-existing Condition clause problem. States can incentivize Insurers to cover these Pre-existing Condition individuals during the first year of coverage by subsidizing the premiums through the State Insurance Pools during the first year. The typical one year waiting period that many of these State Insurance Pools have adopted will need to be outlawed in order to eliminate this problem for low income individuals.

B. **Working Uninsured**: Since the size of the Working Uninsured problem is between 3%-6% of the total population of US Citizens, and since America already has effective private and government programs for extensive coverage of the healthcare needs of 94% - 97% of its legal citizens, there is therefore NO NEED for extensive Healthcare Reform legislation. HR 3200 is a sweeping government power-grab disguised as Healthcare Reform, and deceptively packaged through promotion of the lie that 47 million Americans are uninsured. It empowers the federal government to control and ration healthcare and to eliminate the private insurance sector entirely within a few years of its inception. **The "Public Option" provisions in this Bill and the taxation provisions of the Bill will cause the insurance industry to collapse. This will cripple the US healthcare system, and will likely bankrupt America completely; especially because more and more Americans are aging.**

Furthermore, this HR 3200 bill mandates that the existing and very

Remember, in 2007 according to the US Census Bureau, 202 million Americans had extensive private insurance coverage, 83 million had extensive governmental coverage, another 10 million citizens qualified for Medicaid coverage, but only purchase it when they need it, and another 8.74 million report incomes of greater than $75,000 per year and therefore can afford private healthcare insurance but simply choose not to purchase it. Even more revealing from the 2008 US Census Bureau report is the fact that the number of Americans with health insurance actually increased from 2006 to 2007; 249.8 million to 253 million people.

successful privatization of Medicare through the Medicare Advantage Program be included in the regulatory mess created by this bill. This would destroy the shining light of free market competition, (the Medicare Advantage Program), that is responsible for steadily improving the health and welfare of our senior citizens. HR 3200 and similar legislation will do so by unwittingly eliminating the very means by which overall costs per Medicare beneficiary will decrease, thus making it impossible for the Medicare Program to be saved for future generations to enjoy.

America therefore needs, and the American people overwhelmingly endorse, a cost-effective program for providing preventive and elective healthcare for the Working Uninsured and for the Working Insured with Pre-existing Conditions. This Program must provide the same basic healthcare benefits that are enjoyed by the Working Insured, but must also contain similar disincentives for inappropriate use of the healthcare system such as the inclusion of reasonable OOP cost provisions. This Program and all existing government and private healthcare programs should contain proper incentives that align the interests of all healthcare participants towards healthier lifestyles and habits.

The perverse incentives that currently exist must be eliminated if healthcare costs are to be controlled and lowered as a percent of GDP and on a "Per Member per Month" basis. The American people also support the inclusion of higher premium costs for those who smoke and/or refuse vaccines and cancer screening.[16] In other words, the American people now overwhelmingly support higher premium costs for obvious bad health behavior. Employers who offer and pay for supervised wellness/fitness programs, and employees who regularly attend and participate in such programs should receive tax incentives and lower premium cost in order to promote good healthful behavior. All Health Plans should be encouraged by each State to offer lower premiums to employers and individuals who evidence healthful behaviors and who maintain fitness. Gross Obesity should be penalized through higher premiums as well. Obesity and smoking are the number one killers and contributors to our high cost of insuring Americans.

This Working Uninsured Program must also be Federal and State Budget neutral, and be funded through existing tax revenues and without tax increases. Overall government expenditures for healthcare coverage must also be decreased over the next 10 years as a percentage of the US GDP, or tax increases will be absolutely necessary. Total governmental healthcare expenditures have grown as a percent of the GDP from 12% to 16% during the last 10 years.[17] This trend must be stopped and gradually reversed; which is a particularly daunting task in light of the "Graying of America".

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16 Zogby International, "UT Health Science Center at Houston/Zogby Poll reveals Americans wary about U.S. Healthcare reform," http://zogby.com/search/ReadNews.cfm?ID=1722 (July 16, 2009); Zogby International Survey Results, http://www.zogby.com/news/wf-healthcarereform.pdf and http://www.zogby.com/news/x-healthcarereform.pdf.

17 U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2007*, "People Without Health Insurance Coverage by Selected Characteristics: 2006 and 2007," pgs. 20-21.

Even though there are only 17 million Americans who need such coverage at any given time, this represents an impossible task unless our existing system is improved through realignment of incentives and the establishment of incentives to attract and maintain a significant increase in the supply of healthcare professionals, both in physicians and nurses. Again, our healthcare system contains "perverse incentives" that must be changed if there is any chance of insuring all Americans, improving access to preventive and elective healthcare, and reversing the National Debt so that our children and grandchildren can enjoy the American Dream as we have.

PART TWO

Since Part 1 shows conclusively that all Americans have access to acute and emergency services, the remaining half of this Brief focuses on the necessary elements of a highly functional and affordable healthcare system that affords timely access for all US citizens to quality preventive and elective healthcare. It also compares this ideal free market healthcare system (Competitive Model) to the government-run system that results from the adoption of a healthcare system such as is proposed under HR 3200 (Government Model).

It is important to understand that the overriding premise of this portion of this Brief is that a monopolistic "One-Size Fits All", Single Payer healthcare system will ALWAYS result in corruption and fraud, poor quality, low Provider reimbursement rates, high costs, and denial of timely access to even basic healthcare services. This is due to the fact that under a Single Payer system; innovation, hard work, and creativity are tacitly discouraged, and are not rewarded properly. Also, a centralized, government-run system will cause a flight of medical professionals away from the US, and will cause long waiting lines for even basic care as a result. This is a fact because it has happened in every single country that has adopted a centralized single payer system. Morbidity and mortality rates are also significantly higher in other countries with Single Payer Government managed healthcare, and there is a significant flight of medical professionals into the US from these countries. It is impossible for any centralized large system to operate efficiently and effectively. The Single Payer centralized system, by its very design, cannot reward hard work and innovation. This is true and is also well documented, regardless of whether it is the centralized government or simply a very large centralized public or private company. There is a plethora of factual literature that documents the truth of these statements. *Several of these resources are documented at the end of this Brief, in the "**Notes**" section on page 18.*

HR 3200 calls for a total "Transformation" of our capitalistic healthcare system into a government-controlled system by establishing a "Public Option" Healthcare Plan. Let there be no mistake that HR 3200 calls for a highly centralized, government regulated and managed healthcare system, despite certain elected government officials claiming otherwise. A careful reading of the bill shows conclusively that indeed, it calls for an appointed Health Choices Commissioner and Council to make ALL healthcare benefit and pricing decisions for every qualified healthcare benefit plan (QHBP) throughout the US (See Sections 123 and 141,142).

Even the name of the Commissioner (Health Choices Commissioner) evokes fears about future rationing decisions by the government! Health choices should always be the purview of the Purchaser of healthcare benefits, not the Commissioner. Therefore, if the employee and/or employer are purchasing health insurance, then they have the right to decide which benefit package that they desire, not the government. The primary reason that Medicare Advantage Plans have become so popular among seniors is because private industry has stepped up and provided the additional healthcare benefits that are desired by seniors.

Note also that no insurance company can operate in the US once this Bill is law, unless they meet the minimum standards established by this Commissioner and the Council and adopt the benefit structure mandated by the Commissioner, regardless of differences in opinions relative to the relative efficacy of procedures, drugs, technology, and moral/conscience issues. It will be a "One size fits all" approach to healthcare regardless of the fact that Americans should be able to choose the benefits that are are needed by them, based on hereditary and lifestyle. If the insurance company is grandfathered due to its existence prior to the new law taking effect, they cannot change a single provision in their benefit package, and cannot enroll or disenroll anyone after the law takes effect without inviolating their right to exist outside of the new law. Therefore, all existing insurance plans will be systematically eliminated within one to two years of the inception of HR 3200 – see Section 102, pgs 16-19 for verification of this. As a result of the wording in HR 3200 relative to Grandfathering existing plans, it is preposterous and ridiculous for the President to suggest that this bill will not hurt and eliminate existing insurance plans!

Note that the bill also sets up unfair business practices by mandating that the Commissioner perform an extensive Study of QHBP's and Employers to determine if the Health Reform law provides incentives for small to medium size businesses to self-insure. This effectively allows the Government to interfere in the operations of a QHBP and/or Employer if the Commissioner determines that the potential long term viability of the "Public Option plan" is threatened by the private market!

HR 3200 also unconstitutionally eliminates judicial and administrative review of benefit methodologies and payment rates. This provision violates the constitutional precedent established in the Landmark case of Marbury vs. Madison in 1803. (See Section 223, pg 124.) This means that the government-run monopoly created by HR 3200 is free to arbitrarily and capriciously make decisions that are not in the best interest of the public; especially the old and infirm among us. Power in the hands of a few ALWAYS results in tyranny and corruption.

Again, this centralization of all authority will undoubtedly result in rationing decisions that are not in the best interest of the elderly and the infirm among us. EVERY other country that has centralized healthcare decision-making performs unconscionable rationing of care. This is extremely well documented. Why would we be any different? It is incredibly arrogant and naïve for our President or any elected officials to presuppose that the US government is somehow better at managing healthcare than other smaller, less diverse, and more manageable countries.

HR 3200 also mandates that any private Qualified Health Benefit Plan (a qualified private insurance company approved by the Commissioner) actually give back a significant portion of its profits to its members! (See Section 116, pg 24). Specifically, this section actually mandates

that QHBP's approved by the Commissioner actually pay profits that accrue to the QHBP back to its policy holders (Members) by mandating that the QHBP's who operate cost effectively and whose Medical Loss Ratio (MLR) is lower than the minimum government established MLR, give back the monetary difference between the actual MLR experienced by this efficient company and the government minimum MLR. This provision is so perverse that it shocks the conscience! It is a direct attack on the privatized Medicare Advantage Program and on the capitalistic system that has made our country the envy of the world. This very effectively eliminates competition in the US healthcare marketplace. There are presently many Medicare Advantage Insurance companies who, through partnership with well managed local Integrated Delivery Networks, have lowered the cost of healthcare delivery to levels that are 10%-25% below the costs of traditional Medicare in the same areas. This HR3200 Bill could actually destroy any profit motive in the hands of the wrong Commissioner and it will most likely eliminate the private insurance industry and the many competitive healthcare benefits that Americans enjoy within 3-5 years of its inception. Access to healthcare providers will assuredly suffer, and long queues will result for lifesaving and life enhancing/longevity procedures.

This elimination of private industry competition and the creation of a monopoly will always result in higher prices and administrative costs. This drastic increase in system-wide costs will result in price fixing and rationing of care and this will drastically reduce the number and quality of healthcare professionals who are willing to work in the US under draconian price controls and rationing measures. "Power corrupts and perfect power corrupts perfectly". This will be the result of a centralized government run system….God-like rationing decisions will become commonplace and will always be framed by the elite individuals in power (the Healthcare Commissioner's Council), as necessary for the general welfare and financial viability of the Plan; as if the Plan is the end goal of the healthcare system.

If the Medicare Advantage Program is subjected to the control of this new Health Choices Commissioner and the HR3200 Council or Committee as is currently the intent of HR3200, then these wonderful Medicare Plans that more than 10 million seniors (25% OF ALL Medicare beneficiaries) now enjoy will be systematically eliminated.[18] This would be a travesty since the Medicare Advantage Program holds great promise for truly lowering the costs of delivering quality healthcare to Medicare beneficiaries. **Note that the Medicare Advantage Program is actually lowering the costs of healthcare while improving the health status of Medicare beneficiaries enrolled in such MA Plans.**[19] This is well documented by comparison studies that have been performed every year since 2002. In fact, a July 2009 Comparison Study performed by AHIP, The Center for Policy and Research, shows conclusively that Medicare Advantage Plans in each of eight different areas of the country that were surveyed in the Comparison Study have significantly lowered costs and improved health status as compared to

18 Matthew DoBias, "Fee or Service Punching Bag," *Modern Healthcare,* April 13, 2009, pg. 6.

19 HHS.gov/CMS Press Release, "Medicare Plans Provide Lower Costs and Substantial Savings," http://www.cms.hhs.gov/apps/media/press/release.asp?counter=1825 (April 3, 2006); AHIP Center for Policy and Research, "Working Paper: A Preliminary Comparison of Utilization Measures Among Diabetes Patients in Eight Regional Medicare Advantage Plans and Medicare Fee-for-Service in the Same Service Areas," July 2009.

the traditional Medicare Program run by the Government through CMS.[20] **It is vitally important to note that these successful Medicare Advantage Plans have partnered with local financially integrated and managed Provider Networks in order to gain these lower costs and health improvements.**

It should be noted here that there are two types of Medicare Advantage Plans: the Managed Care model (HMO's and PPO's) and the "Private Fee for Service" (PFFS) model. In contrast to the successes of the Managed Care models that are evaluated in these Comparison Studies, it is well documented that the Medicare Advantage PFFS Plans, which do not partner or have coordinated and managed Provider Networks, have not fared as well. Their costs have actually been higher than Traditional Medicare FFS systems.[21] These PFFS Medicare Advantage Plans offer no network management and very little coordinated or managed care systems. There is no clinical integration within these PFFS Plans. It is no wonder that they have not had a favorable experience and that they are falling out of favor with healthcare professionals, including physicians.[22] In contrast, physicians who are a part of an Integrated and Managed Delivery Network, which partners with a Medicare Advantage Plan, are generally very happy with the Plan and embrace the benefits that their patients enjoy from these Managed Care Medicare Advantage Plans. These physicians typically spend more time with their Medicare patients and see them in their office more often.[23]

As further proof that Medicare Advantage Plans which partner with Integrated and Managed Delivery Networks are able to reduce the cost of delivering quality healthcare to Medicare beneficiaries, the actual experience of IntegraNet Physician Resource, Inc., (IntegraNet) an Integrated Healthcare Delivery Network based in Houston, Texas, is worthy of mention. IntegraNet is a 14 year-old and highly successful Integrated Delivery Network that has managed a Medicare Advantage network of more than 600 physicians serving over 4000 members for over 4 years in the Houston market. During this time, IntegraNet has experienced a reduction of almost 25% in actual system wide healthcare costs over a three year period with absolutely no rationing of care. These cost savings were the result of Pay for Quality (P4Q) criteria consistently applied across our physician network with the intent of establishing a "Medical Home" for our Medicare beneficiaries in their Primary Care or Specialist physician's office. IntegraNet places its management emphasis upon proactively rendering the highest quality care in the doctor's office and outpatient setting in order to avoid expensive and unnecessary emergency room charges and hospital admissions.

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20 Ibid.

21 Matthew DoBias, "Fee or Service Punching Bag," *Modern Healthcare,* April 13, 2009, pg. 6.

22 Ibid.

23 AHIP Center for Policy and Research, "Working Paper: A Preliminary Comparison of Utilization Measures Among Diabetes Patients in Eight Regional Medicare Advantage Plans and Medicare Fee-for-Service in the Same Service Areas," July 2009, pg. 2.

The net result is that our Medicare beneficiaries are healthier and consume less expensive resources. Our costs decreased dramatically because for every extra dollar spent in the physician's office, two-three dollars are saved from the reduction in Emergency Room and Hospital/Institutional costs. In other words, the decrease in our Institutional costs has been 2-3 times the increase in our Professional costs (Physician office and testing related costs). It is important to note that these cost savings are shared with the IntegraNet physicians each quarter through a Pay for Quality (P4Q) Bonus system that has been developed and refined by IntegraNet over the years. This has the strong affect of empowering these physicians to render higher quality care, which in turn, creates a healthier Medicare clientele and further lowers costs as a result.

Again, the IntegraNet P4Q criteria are oriented around the concept of establishing a "Patient Centered Medical Home" for our MA members in their favorite PCP or Specialist's office. We are seeing a favorable "Snowball Effect" in our MA membership profits and resultant physician bonuses as a result. Our Professional costs continue to increase on a Per Member Per Member (PMPM) basis as more and more MA members establish a strong "Medical Home" with their PCP or Specialist (when needed) while our Institutional Costs on a PMPM basis continue to decrease quite dramatically since these members are rarely any longer in need of an ER/Hospital.

These are exactly the results that are needed on a national scale! Hospitalization is both risky to the patient due to the risk of nosocomial infections, and is extremely costly to both the patient and/or family and to our healthcare system; especially to the Medicare Program. (Note that total US Medicare Institutional costs in 2007 were half of total Medicare expenditures while Professional expenditures were 40% of total expenditures in 2007.)[24] The net result of more time in the physician office and less hospitalization is that our MA members are steadily becoming healthier despite the aging process, and physician bonus payments are increasing as a result.

This brings me to the most important point of this Brief…the end goal of any healthcare system should be the improved health and vitality of the citizen users of this system. Since we now have ongoing proof that the privatization of Medicare through the Medicare Advantage Program results in significant cost savings, improved benefits, and health status improvement as compared to the government rum system, then we should embrace this system of transferring financial risk to the private sector and apply its concepts to the rest of the government-run Programs, <u>including any new Program to cover the Working Uninsured!</u> Government officials need to recognize that private industry in a competitive environment and with reasonable regulation to inhibit abusive practices will **always** outperform a centralized government-run system. The Medicare Advantage Program has seen a drastic improvement in regulatory oversight from CMS and abuse of beneficiaries has decreased significantly. Again, this favorable experience can be duplicated easily for the Working Uninsured without adding several expensive layers of government, and without a "Public Option" Program that will end up

24 U.S. Social Security Administration, Office of Retirement and Disability Policy, Annual Statistical Supplement (2008), *Data Summary.* http://www.ssa.gov/policy/docs/statcomps/supplement/2008/supplement08.pdf

being a Single Payer system that only empowers a few elite individuals and that fosters corruption.

A summary list of actions needed to expand existing government programs to include the Working Uninsured without additional taxes and without long queues is to:

- Transfer the government's financial risk in providing healthcare benefits to the Working Uninsured to the private sector (self-insured employers and insurance companies) in the same manner as is currently done in the Medicare Advantage Program and empower the private sector (through reasonable funding), to provide competitive health plans that exclude "pre-existing condition" clauses, and regulate these private Plans similar to existing regulation that works in the Medicare Advantage arena in order to curb potential abuse of the Working Uninsured beneficiaries. This would guarantee a minimum benefit package similar to the Medicare Program (especially the existing Medicare Advantage Plans who have experience in working with local Integrated, Managed Delivery Networks), and

- Allow and empower private health plans to cross state lines with their Health insurance plans, and

- Phase out the Medicare Advantage PFFS-type programs and enhance the Managed Care- type Medicare Advantage Managed Care programs. The PFFS type programs lack a managed care network component and have proven to be more expensive than traditional Medicare while the Managed Care type Medicare Advantage Programs have resulted in cost savings that are shared with the healthcare providers. Also, there needs to be a mandate that these private Medicare Advantage Health Plans contract with local Integrated and Managed Delivery Networks that encourage, through measurable Pay For Quality ("P4Q") criteria, a much closer relationship between the physician and the patient (a "Patient Centered Medical Home"). These Managed Deliivery Networks perform Outpatient and Inpatient Case Management so that significant improvements in the health status of patients are accomplished through this privately managed and well regulated system. As the general health of the Medicare and Working Uninsured beneficiaries improves, overall Program cost will decrease on a Per Member per Month (PMPM) basis which will, in turn, extend the life of the existing entitlement Programs; i.e., the Medicare, Medicaid, and SCHIP Programs.

- Mandate that federal capitation funding levels to the HMO's for the Medicare Advantage Managed Care Programs and the Working Uninsured Programs be adjusted downward by a small percentage each year (1%-2% per year as an example) to reflect a small pro-rata percentage of the cost reductions actually experienced by the Health Plans that serve these Medicare and Working Uninsured beneficiaries. In this way, the annual cost per member per month of these entitlement programs will be reduced each year for a number of years, and this reduction will reverse the trend towards insolvency of the Social Security system. To incentivize these Health Plans to proactively manage these beneficiaries and to steadily reduce the MLR each year, the federal government must reward the Health Plans that meet or exceed the federal cost reduction targets or that

experience lower MLR's than the average MLR of the Traditional Medicare Program in the particular market area (these cost effective Health Plans to be called "Effective Health Plans").

Rewards can be in the form of member incentives to join the Effective Health Plan, or special considerations relative to promotional methods so that the Effective Health Plan experiences stronger growth in membership than the lesser effective Health Plans. This membership growth will compensate the Effective Health Plans for the slightly lower profit margins each year that may result from the small decreases each year in the capitation revenue from the federal government. Since the decreases each year in Capitation revenue should be only a percentage of the actual MLR decreases, the Health Plan profit margins each year can actually continue to grow up to a certain point when health status improvement levels out in the senior population. It should be noted that as the US population continues to age, overall health status improvement will level out and may even begin to erode unless strong preventive measures are promoted by the Health Plans. The government's role should take the form of incentivizing the Health Plans to offer Wellness, Dietary, and Fitness Programs to their beneficiaries. Americans overwhelmingly support such programs. [25]

- Mandate that all health plans, who receive government program contracts, reward Working Uninsured beneficiaries who stay healthy and comply with wellness and disease prevention criteria such as annual physicals, regular fitness activities, nonsmoking, recognized dietary guidelines, and well recognized screening tests such as Mammography Testing at the age of 35 for women and Colonoscopy testing for men at the age of 50. Again, rewards should be "chronic disease specific" and be designed for beneficiaries who are compliant. These rewards can take the form of reduced OOP costs and reduced premium costs for compliant beneficiaries in subsequent years.

- The government should promote, through tax incentives to Employers, the adoption of Health Savings Account (HSA) insurance plans by HMO's and Employers in order to promote personal responsibility in healthcare decision making by employee consumers and existing HSA legislation should be enhanced to actually promote personal responsibility within the Working Uninsured population once they are insured.

In conclusion, this then is the basic formula that is needed to cure the current two Healthcare *coverage* challenges facing our healthcare system in America today. Part Three, which is not included in this Brief, is a prescription for true Healthcare reform that would simplify our overall system, significantly reduce costs, and eliminate the perverse incentives in our current system so that the supply of healthcare professionals increases to satisfy the increased demand for timely and compassionate healthcare that will result from the cure of our current two coverage

25 Zogby International, "UT Health Science Center at Houston/Zogby Poll reveals Americans wary about U.S. Healthcare reform," http://zogby.com/search/ReadNews.cfm?ID=1722 (July 16, 2009); Zogby International Survey Results, http://www.zogby.com/news/wf-healthcarereform.pdf and http://www.zogby.com/news/x-healthcarereform.pdf.

challenges and the Graying of America. Part Three will be included in a book that I am writing for publication.

It should be quite obvious that there is absolutely NO NEED for HR 3200 or any other comprehensive health reform legislation that results in a "Public Option Program" or a Single Payer Government-run system. Furthermore, there is absolutely NO NEED to reduce Medicare benefits to pay for such a system since the scope of the problem is much smaller than advertized by liberal policy makers. The experience of other socialized healthcare countries show us that these government controlled systems ALWAYS result in significant rationing of care to the elderly and the infirm, along with significantly increasing taxes to pay for the Government-run bureaucracy. These socialized, government-run healthcare systems also result in unfavorable healthcare outcomes compared to the US and its private enterprise system.

However, it is true that our current system needs some minor surgery to ensure that the Working Uninsured are covered through a privatized Government risk transfer program to private insurance industry similar to the Medicare Advantage Program. We must also eliminate the inequity of the Pre-existing Condition clause through the implementation of tax incentives as described above and we must eliminate state line restrictions which inhibit private sector competition. Tax incentives to encourage the purchase of health insurance by individuals must be adopted so that greater numbers of Americans can access preventive and elective healthcare benefits. Eliminating state line restrictions in the purchase of healthcare insurance will also lower the relative cost of these Catastrophic insurance policies. Promotion of HSA's within the fabric of these privatized entitlement programs is also essential in promoting personal responsibility relative to healthcare purchasing decisions.

Thank you for your review and attention to this important healthcare Executive Brief. Please feel free to pass this information on to other fellow Americans, and especially to our political and healthcare/other industry leaders. I am available to answer any questions or for further discussion with reasonable notice.

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NOTES

Referencing Single Payer Government Rationing and Long Waiting Times:

- "Cancer doctors do not tell patients about drugs which could prolong lives"
- "Patients forced to live in agony after NHS refuses to pay for painkilling injections"
- "A million failed asylum seekers (illegal immigrants) will get free NHS care in human rights U-turn"
- "Ruling 'denies treatment to 100,000 Alzheimer's patients'"
- "Transsexuals win right to sex swap on NHS"
- "Patients risk going blind as NHS refuses treatment"
- "NHS targets 'may have lead to 1,200 deaths' in Mid-Staffordshire"
- "Patients with suspected cancer forced to wait so NHS targets can be hit"
- "Hospital chairman quits over dangerous targets"
- "Patients forced to wait hours in ambulances parked outside A&E departments"
- "NICE could deny drugs to stomach patients"
- "NHS staff face the sack if they discuss religion with patients"
- "11 serious errors a day in NHS surgery"
- "War hero refused treatment by NHS"
- "Cancer patient Linda O'Boyle dies after NHS ends free care over 'top up'"
- "Drug addicts get priority access to swine flu vaccine"
- "Row as terminally ill woman given bed in hospital bathroom"
- "NHS staff 'no longer asked if they would be treated in own hospital'"
- "Beat the NHS queue with a medical trip to Malaysia"