NATIONAL CENTER FOR POLICY ANALYSIS

12 Fundamentals of Highly Effective Healthcare

Empowering Patients, Providers and the Private Sector by lowering costs, increasing quality and expanding access.

1. Reform Obamacare to better serve Americans

Congress should:

- Repeal individual and employer mandates in a way that does not increase costs.
- Repeal regulations that prevent insurers and employers from designing affordable health plans, including the "essential benefits" package.
- Allow consumers to choose limited benefit plans and catastrophic coverage.
- Repeal regulations that prevent insurers from fully adjusting individual premium rates to reflect known health risks.
- Restore the right to renew coverage if an applicant has maintained insurance with no gaps of more than 62 days.

Insurers should sell multiyear coverage, allowing individuals to keep their health plans if they change jobs. Health plans should have built in cost-containment tools such as Health Savings Accounts, cost-sharing and pay for performance or value. Insurers and health plans should maintain exclusive provider networks, require competitive bidding and selectively contract for the best prices.

Under federal law states have the authority to regulate all insurance sold within their borders. Thus, the market for health insurance is a 50-state patchwork or differing regulations and mandates. Self-insured employer plans are exempt from state regulations. The only highly regulated insurance market is the health insurance market. Many insurance companies offer products in more than one state, but the process of complying with multiple regulations is inefficient. **Insurers need the flexibility to meet federal guidelines and offer uniform products in multiple states without regard to running afoul of one state's unique regulations.**

2. Make an advanceable and refundable tax credit available to all Americans

Many Americans do not have access to coverage through employment. They are forced to pay for coverage with after-tax wages. **Those who purchase individual insurance should have access to a tax credit that provides the same level of tax relief as employer-provided coverage.** The tax credit should be advanceable (so that it can be used to pay monthly premiums) and refundable (that is, a net subsidy) for those who cannot pay the full cost of premiums because of their income or health status.

The tax credit should replace the cost-sharing subsidies and sliding-scale subsidies of the Obamacare exchanges. The tax credit should be used to purchase private health insurance or pay directly for care. The credit should be adjusted for health status, or age as a proxy for health status. Individuals who prefer should be allowed to keep their employer plans, but the amount of employer-provided health expenditures that is excludable from the taxable incomes of employees should be capped.

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3. Reform hospital care to better serve patients

Nearly one-third of health care spending is on hospital care. Hospitals charge more for almost every service performed in hospitals that can be done in other care settings. Intensive care and major surgeries that can only be provided in hospital settings are inefficient because hospitals do not compete on price with each other.

Hospitals should not be paid more for performing the same service as other providers. The increase in physician employment by hospitals is mostly due to the higher fees hospitals receive compared to independent physician practices, which can provide care more efficiently than in a hospital setting. Moreover, hospital-employed physicians are sometimes pressured by hospital administrators to over-provide services and admit patients who could more efficiently be treated in the community. **Better care coordination by physician-managed medical homes independent of the hospital could save the health care system money.**

Finally, hospitals purchase medical supplies through group purchasing organizations (GPOs). Although well-intended, the antitrust exemption that allows suppliers to provide legal kickbacks to GPOs (and rebates from GPOs to hospitals) creates cartels of large manufacturers. GPOs earn more and pay higher rebates not from sourcing the cheapest suppliers, but by working with the largest, richest suppliers whose high prices provide for high rebates (kickbacks).

4. Encourage price transparency to boost competition in medical services

Market prices set by buyers (demand) and sellers (suppliers) provide essential information for the allocation of resources (capital and labor). When prices are set by a Soviet-style bureaucracy — as with Medicare price controls — markets become inefficient. As a result, it is difficult to ascertain the price of medical care in advance of treatment because there are multiple prices for any given treatment that depend on the payer and the provider's network affiliation. Many health plans treat their negotiated prices as proprietary information. Providers often contractually require price secrecy from their payers. It is especially frustrating for patients when they discover a doctor who treated them is out-of-network even though the patient made sure the hospital was affiliated with their network. Undisclosed out-of-network bills for the balance often result in higher fees and higher out-of-pocket costs.

Public policy should seek to encourage price transparency, where providers disclose fees and declare their network status. Hospital admissions generally require patients to sign a financial responsibility form that is used to enforce all fees charged by affiliated providers inside the hospital regardless of whether those providers are hospital employees or in the patient's network. Payments should be obtained through informed consent rather than consent under duress. **Public policy should encourage a meeting of the minds — the standard for an enforceable contract — and create a safe harbor for a provider to collect fees if he or she is transparent about costs.**

5. Increase Americans' access to primary care

The shortage of primary care providers is expected to get much worse over the next 20 years. The supply of physicians is relatively inelastic — it takes time to train a doctor. **But expanding the number of primary care residencies would help.** In addition, there are many foreign medical graduates who would like to immigrate but find insurmountable barriers to licensure in the United States. Those who can demonstrate comparable experience should have an accelerated route to licensure (at the very least in primary care). **Three-year medical degrees that allow students to begin a primary care residency in their fourth year and shorten the route to primary care would encourage more people to attend medical school and more to go into primary care.**

There are many technological advancements that could increase efficiency, reduce costs and boost convenience for patients and doctors alike. Many states have paved the way for more physicians to use the telephone to consult with their patients. However, some states make it difficult to treat

patients who have not had an in-person visit prior to the telephone consultation. **Patients should be the judge of how they want to interact with their physicians.**

States have different regulations governing the scope of practice of so-called physician extenders — other health professionals supervised by a physician. Some of these require supervision, while others require collaboration with a physician. **Allowing independent practice in areas experiencing a physician shortage would increase the number of nurse practitioners and physicians assistants.**

Public policy should also encourage patient-centered medical homes where people have a routine source of care and someone to help them navigate the health care system.

6. Reform Medicare Accountable Care Organizations

Accountable Care Organizations (ACOs) seek to reward efficiency by sharing savings among medical service providers as an incentive to better manage and coordinate the care of seniors in traditional Medicare Fee-for-Service (FFS) programs. A problem faced by ACO administrators is that the Centers for Medicare and Medicaid Services (CMS) assigns members retrospectively at year-end. This makes it difficult to develop outreach programs to identify at-risk members with chronic diseases. Moreover, retrospective assignment means costs are borne by one ACO while the benefits may ultimately accrue to another ACO.

Coordinating Medicare patients' care is invaluable after the critical care transition between a hospital and follow up care. A coordinator could advise seniors on lower cost health care settings, evaluate the need for home care and ensure seniors receive post-hospital follow up care and comply with drug therapy. An ACO providing a medical home could also advise seniors on where to find cost-effective services and whether they need a specialist and which specialist to see. Medicare could save billions of dollars if all seniors were given an annual risk assessment and assigned a medical home to coordinate their care.

The ultimate goal is to achieve behavioral change among providers and patients. A primary care provider must have the incentive to keep seniors healthy and out of the hospital. Specialists must have an incentive to communicate with patients care coordinators. Seniors must change the way they interact with the health care system. This means primary care providers (PCP) must be rewarded when they meet benchmarks and metrics that improve the health status of seniors. PCPs must be "at-risk" of losing their quality bonus, but not their fee-for-service reimbursements.

7. Encourage private Medicare Advantage plans

Medicare Advantage (MA) enrollment has increased substantially since 2010. Historically, MA plans cost more than Medicare Fee-for-Service (FFS) programs, but offer additional benefits. Moreover, the Medicare Payment Advisory Commission (MedPAC) believes MA plans offer more potential to coordinate and better manage care for seniors. A Brookings Institution study found MA plans save about 16 percent due to lower acute and post-acute care use. MA plans also had lower readmissions. Although MA plans are currently paid based on a benchmark that is estimated to cost about 2 percent more than traditional Medicare, MA plan administrators can perform the care for less than FFS Medicare — suggesting MA plans may cost less over time, while providing better care.

8. Help seniors better plan for end-of-life with home-based palliative care

About one-quarter of Medicare dollars are spent on seniors within the last 12 months of life. The last year of life is often traumatic, with multiple caregivers providing care in multiple locations. Nearly nine-in-10 seniors say they would rather receive end-of-life care in their homes rather than a hospital. Yet, only one-third that number are able to die in their homes. **Medicare should do more to assist terminally-ill seniors with end-of-life palliative care.** This would improve care and likely save money on unnecessary, ineffective medical treatments.

9. Empower consumers through Personal Health Accounts

Americans are increasingly paying out of pocket for their day-to-day medical needs. Health insurance deductibles have about doubled in the past decade. Moreover, high-deductible plans are the most common both in the individual and the employer health plans. Individuals need more avenues to save for medical bills. Flexible Spending Account (FSA) holders should be allowed to rollover their unused funds into Health Savings Accounts (HSAs). HSAs should be expanded to allow larger contributions. The ACA law prohibiting the use of such accounts for over-the-counter drugs should be repealed. **Workers should be able to use some of their HSA contributions to reimburse themselves for wages lost to sick days. HSAs should be allowed to wrap around any health plans — including Medicare — and individuals should be allowed to use their funds to pay health insurance premiums.**

10. Improve patients' care coordination through medical homes

One-fifth of patients generate 80 percent of medical costs. About half of all medical spending is on only 5 percent of patients, and 22 percent of expenditures are for the sickest 1 percent of patients. **Medical home care coordination managed by a primary care physician in independent practices reduces costs and improves quality.** Coordinated care can reduce the poking, prodding and radiating of patients who are often subjected to redundant medical tests because wasteful expenditures are revenue to uncoordinated providers.

This technique could also be utilized by private health plans for care of nonseniors with ongoing medical needs. Another technique that could be used to improve care for high-cost patients is to establish high-risk insurance pools that require a higher level of patient responsibility for compliance with treatment programs and following the advice of care coordinators.

11. Reforming Medicaid to boost flexibility

Medicaid is an inflexible program in which the federal government sets the rules and states have little ability to tailor the program to their unique needs. States have little reason to boost the efficiency of Medicaid programs since the federal government matches state spending — paying 50 percent to about 80 percent in some cases. **The federal government should convert Medicaid into a block grant that allows states to design their own program to meet the needs of different populations.** States should be responsible for cost overruns.

For able-bodied adults on Medicaid, the program could be designed to transition them to private plans as their incomes rise. This could require enrollees to pay small premiums, to meet work requirements, and to share costs — as is common for most health coverage.

12. Reform prescription drug pricing

Reforming the U.S. Food and Drug Administration and its outdated, slow approval process could unleash greater competition in drug discovery. Today, it takes more than a billion dollars, and sometimes a decade or more, to bring new drugs to market. New advances in information systems and data analysis allows drug makers to track health metrics in ways not possible when clinical trials were enshrined in regulations; such data could be used in lieu of clinical trials. The 21st Century Cures Act signed into law by President Obama in December 2016 aims to speed the drug approval process; however, much more needs to be done to reduce the time to market for new drugs. In addition, beefing up the resources the FDA uses to review and process abbreviated new drug applications would boost competition among generic drugs.

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