

SecureChoice: A Vision of a Fundamentally Changed Health Care System

Harold S. Luft, Ph.D., Director of PAMF Research Institute

In my recent book, *Total Cure: The Antidote to the Health Care Crisis*, I offer a description of how the health care system can be fundamentally changed to provide higher quality, lower cost, and professionally empowering health care. The program that is designed to accomplish this is called *SecureChoice*.

Q: How does *SecureChoice* work?

A: Under *SecureChoice*, all Americans will be required to have coverage for hospitalizations and chronic illness care. A publicly-chartered Universal Coverage Pool will be established with premiums based on demographic and geographic factors, not health status. Lower-income people will be eligible for public subsidies. People can also meet the mandate with traditional employment-sponsored plans.

Coverage for routine and minor acute care will not be required, but nearly everyone will buy “wrap around” policies for routine and acute care with co-payment levels of their choice. This bundled coverage will also be subsidized based on income.

Q: Why is requiring universal coverage for hospitalizations and chronic care important?

A: Hospitalization and chronic care account for over sixty percent of medical costs. Ensuring universal coverage for these occurrences protects currently uninsured Americans from financially catastrophic events and lowers costs for everyone by spreading the risk. When the uninsured need hospital care, it is usually provided and paid for either by immediate enrollment in publicly supported Medicaid or by shifting costs to those who have insurance. Collectively we are already paying for such care; *SecureChoice* does this more equitably and efficiently.

Q: *SecureChoice* doesn't mandate coverage for everything; why distinguish hospital and chronic care from everything else that is valuable?

A: Nearly everyone agrees about coverage for major medical costs; there is less consensus about coverage for other services. Arguments about exactly what *services* need to be covered, ranging from acupuncture to specific diagnostic tests, relate mostly to services provided in the outpatient environment. *SecureChoice* differs from most other plans in not specifying exactly what services will be covered, focusing instead on the types of problems for which people must have insurance and those for which it is optional, albeit desirable.

Coverage for hospitalization is necessary—we require hospitals to provide emergency care to those who need it, regardless of ability to pay. Insurance often becomes unaffordable after a chronic condition is identified, hence it must be covered in advance. Common minor acute problems and routine checkups don't warrant the administrative costs of insurance; they do need a way to spread such costs over the year and subsidies for lower income people. Many preventive services are beneficial; some however, are not only costly, but can be harmful. *SecureChoice* creates incentives and information for practicing physicians to think about the value of the services they provide.

Q: How does *SecureChoice* pay for inpatient care and why is that payment method better?

A: During a hospital stay, physicians make most treatment choices; other costs are controlled by the hospital. Why hold patients financially responsible for those decisions? Under *SecureChoice*, hospitals and most physicians practicing in the hospital will create Care Delivery Teams accepting a bundled payment covering all the services needed during the episode. The episode includes appropriate pre-admission testing, post-discharge follow-up, and complications. The Care Delivery Team can be a single entity or a collection of independent practitioners and a hospital sharing risk. It will establish its own governance rules and decide how its members are paid, ranging from fee-for service to fee-for-time to salary.

Q: Doesn't Medicare do something like that?

A: Medicare does pay hospitals a bundled amount for inpatient services, but this excludes physician services as well as pre-admission and post-discharge care. More importantly Medicare payments are based on national averages and constrained by Congressional appropriations. The Universal Coverage Pool would pay care delivery teams an amount reflecting the use of services by those teams across the nation achieving *above average* outcomes for their patients. As a national reinsurance pool, rather than a public program, these payments would not be constrained to meet federal budgetary targets.

Q: Care for chronic illness can go on for years, involving many different providers who may not come into contact with one another, so how does *SecureChoice* deal with that? Isn't chronic illness care intertwined with routine and minor acute care?

A: The Care Delivery Team concept is designed for inpatient care. Except in integrated group practice settings, a single team rarely treats a large number of patients for ongoing outpatient management. Multispecialty groups, however, are uncommon in most of the U.S. *SecureChoice* is designed to work everywhere. Patients will select a primary care practitioner (PCP) around whom care is organized. The PCP selects a payment intermediary (in some cases these may be health plans) to handle the billing for all his or her patients. The intermediary gives each patient a health credit card good for services from any provider. As it processes these claims, the intermediary identifies the number of patients with various chronic conditions seeing each PCP. It notifies the Universal Coverage Pool, receiving a monthly payment for the chronic illness management of those patients.

People differ a great deal in how frequently they want to see a doctor and whether they want to manage their own care or have someone else do it. Physicians vary enormously in how much they do in caring for patients; those ordering fewer tests and scans often provide better care.

Plans can set premiums for enrollees in ways that reflect patient preferences for high vs. low copayments and the styles of practice of the physicians the patients choose. This is the “choice” aspect of *SecureChoice*. The Pool doesn’t cover care for minor acute problems because there is little risk involved, but people will want those costs managed by some plan, and health plans will include coverage for such services. Many office visits might be initiated for an acute problem, such as an ankle sprain, but also have chronic illness management, such as blood pressure checks and glucose monitoring. Being paid a fixed monthly amount for all chronic illness management, plans can take responsibility for all outpatient care, but have no need to distinguish why a visit occurred. Plans and clinicians have complete flexibility in how they develop compensation arrangements and set fees. They can stay with traditional fee-for-service, switch to capitation, or use innovations such as monthly payments for serving as a “medical home.”

Q: If employers or individuals were satisfied with their current plan, would they have to switch to *SecureChoice*?

A: No, *SecureChoice* does not eliminate the role of private insurers and can operate side-by-side with the current system. In time, many of those with conventional coverage make the switch, but there is no timeline or pressure for them to do so. *SecureChoice* can also be a reinsurer for existing plans, pooling risk and reducing administrative costs, especially for those with individual and small group coverage.

Q: How would *SecureChoice* work for people without employer-based coverage?

A: People will go on-line to identify the PCPs in their area—most likely finding someone they are already seeing. After entering some information about their age and sex and making a few coverage decisions, such as whether they prefer a \$10, \$25, or \$50 per visit copayment and what proportion of any excess charges for hospital costs they want to have covered, they would then see the monthly premium associated with each practitioner and out-of-pocket costs they would expect. They

will also have access to various quality measures. Some of these will be objective, such as how well patients with diabetes have their blood sugar controlled. Others will be patient assessments about their care. Premiums will vary by PCP, reflecting the fees charged and the efficiency with which they deliver care. Each person in a family can make his or her decisions separately.

Employees of firms not offering insurance coverage, and workers unable to afford their share of the premium of the plan offered, currently have no tax subsidy. With *SecureChoice*, they can have their employer direct part of their wages to a family account used to pay premiums. This makes the tax subsidy available to all while pooling wages from many jobs.

Q: How does *SecureChoice* differ from the other plans being discussed in Washington?

A: Most plans being discussed simply focus on how to get more coverage for people. But people who currently have coverage feel their plans don’t work well, the quality of care is less than optimal and costs are rising every year. *SecureChoice* is designed to ensure coverage *and* transform the delivery system to make it work better for patients and professionals.

SecureChoice is a sound compromise between the single-payer plan favored by the left and the right’s preference for markets. It ensures universal coverage but keeps the government out of detailed decisions about what services to cover and how much to pay for them—the kinds of decisions that usually end up being controlled by special interest groups. It creates a mechanism for private insurers to partner with a public reinsurance plan, eliminating their need to select low risk enrollees while avoiding the sick. It harnesses private creativity for new payment arrangements to make primary care more attractive to physicians and for them to better coordinate care.

Q: What has been the response to *SecureChoice* on Capitol Hill and at the White House?

A: The reactions have been very positive. *SecureChoice* is “outside the box” thinking on an issue that many have come to understand cannot be fixed by tinkering with the current model. It changes the paradigm and realigns incentives to reward quality care, innovation, and efficiency. In the legislative world, however, no proposal is adopted without change. *SecureChoice* is a vision for a comprehensive proposal to illustrate how all its components will work together. I am now adapting key aspects for consideration in the current debate.

Q: How does *SecureChoice* foster cooperation between the public part of the plan and private insurers?

A: The Universal Coverage Pool would be publicly chartered, like the Federal Reserve Board, but not government controlled. Because private insurers can voluntarily reinsure their patients through the Universal Coverage Pool at reasonable rates, they work with – instead of competing against – the public component. *SecureChoice* is also compatible with publicly administered state-based plans that compete on a level playing field with private plans.

(Continued on next page)

On the Bookshelf



The Community Health Resource Centers (CHRC) have many excellent books, videos and DVDs for your perusal.

Boning Up on Osteoporosis: A Guide to Prevention and Treatment

Developed by the National Osteoporosis Foundation in conjunction with the Osteoporosis Center, University of Connecticut Health Center, National Osteoporosis Foundation 2008

This book is a guide to prevention and treatment of osteoporosis. It begins with an explanation of bone basics, how bones change and grow throughout life and factors that affect bone growth. There are practical tips on exercise and nutrition, as well as tools such as a calcium calculator to help determine adequate calcium intake. The book devotes an entire section to the importance of posture, body mechanics and safe movement. Included are instructions and illustrations for bone healthy exercises that promote good posture, movement, strength, flexibility and balance. Another section provides information and resources for those living with osteoporosis. Topics include methods other than medications that can be used to control pain, fall prevention and even information on choices for clothing that looks great and feels comfortable.

(available in the Palo Alto CHRC)

The Denial of Aging

Muriel R. Gillick, M.D.

First Harvard University Press paperback edition, 2007

Through stories of patients and family, the author provides insight into some of the most important areas affecting the aging population: their health care, where they live and how they find meaning in their lives. She explores ways to prepare for and embrace the aging process, rather than spend time and energy focusing on how to avoid getting older and remain forever young. One of several sensitive topics addressed by the author is her belief that care should focus on the quality of life, not on prolonging life at all costs. She explains the need for health care to practice evidence based medicine, which means deciding whether and in whom a test or treatment would be useful based on scientific evidence. The author submits that we as individuals and a society should stop denying aging, and direct our resources to adequately provide for our aging population.

(available in the Palo Alto CHRC)

(Continued from previous page)

Q: What are your concerns with a single-payer system?

A: Single-payer systems may work well in other nations, but will face significant problems functioning in the U.S. Other nations have Parliamentary governments centralizing legislative decision-making and program operations. Our system allows one or two members of Congress to exert enormous control over the “little” decisions made within a payment system, such as removing coverage for an expensive device offering little additional patient benefit. Our health care delivery system is structured in the wrong way, with too many specialists and high-tech equipment and too few PCPs able to spend time with patients and coordinate their care. Any change in that system would require active effort by a single payer; such effort is sure to be stymied by those who fear they will lose income.

Medicare is essentially a single payer system for the elderly. Although it keeps down the costs its beneficiaries pay, it has created an enormous unfunded federal liability for future care dwarfing the current financial bailout. Medicare has not been to slow the overall rate of growth in overall expenditures, although it has shifted some costs to others. If it controlled the whole system, it would have even less ability to make changes.

SecureChoice uses the publicly chartered Universal Coverage Pool to spread risk broadly. It uses government’s taxing ability to raise the funds needed for income-based subsidies to expand coverage for all and government’s rule-enforcing powers to ensure transparency, the free-flow of information, and protections against the exercise of market power. It uses the market to reallocate resources to provide higher quality and more efficient care. Each segment does what it can do best, and in doing, so we can achieve a far better system.

Q: Where can I learn more about *SecureChoice* and how its concepts are being brought to the current policy discussion?

A: I am continuously updating information on my website, <http://www.SecureChoice.info>. This includes shorter versions, commentaries on current issues, and links to other material.

Harold S. Luft, Ph.D., is Director, PAMF’s Research Institute and Caldwell B. Esselstyn Professor of Health Policy and Health Economics Emeritus, University of California San Francisco.

Editor’s note: *This is the first of an occasional article in To Your Health on health care reform.*