

SecureChoice

The Long Term Vision

- Everyone has coverage for inpatient and chronic illness care through a Universal Coverage Pool, or UCP
- UCP is a publicly chartered, politically independent, agency pooling risk. It pays directly for inpatient care and covers indirectly chronic illnesses
- Providers such as physicians or hospitals set fees and practice as they choose
- Patients are insulated from the occurrence of significant health problems, but have an economic stake in the value they receive for the care of their problems
- UCP provides bundled payments to new care delivery teams composed of hospitals and independent physicians who collectively agree on governance rules and revenue allocations for episodes of inpatient care
- The payment from the UCP for each episode of care (analogous to Medicare's DRGs) is based on the resources used by those teams achieving *better than average* risk-adjusted outcomes for patients
- Teams may charge more than the UCP payments and can pass such excess charges on to patients or insurers
- People choose a primary care practitioner, or perhaps a specialist, to help coordinate care, but not act as a gatekeeper
- Each practitioner selects one of several competing Payment Intermediaries (PI) to handle his or her billing in a low cost, efficient manner.
- The PI working for each primary care practitioner provides each patient with a health credit card to be used for services from any provider
- In processing bills, the PI identifies a patient's chronic conditions and receives a risk-adjusted monthly chronic illness management payment from the UCP
- Most patients will ask for "wrap around" coverage from the PI to pay for minor acute and other problems, with copayment levels chosen by the patient.
- The net premium for each patient reflects demographic factors, the fees and practice styles of the primary care physician and his patients' regular providers, net of the chronic illness management payments from the UCP.
- All claims and supporting transactional data will be linked by patient and provider number; privacy-protected versions will be made available in a

HIPAA-compliant form for data analysis

- Providers will demand information on their practice patterns and quality to improve the value of services. PIs and independent analysts constantly will try to meet that demand.
- PIs compete for the business of physicians by offering low-cost administration and good information/consulting services. PIs are likely to be new lines of business for existing health insurers as well as transaction experts like VISA

Transitioning to *SecureChoice*

- Care delivery teams (CDTs) could be established *de novo* to receive payments from the UCP—or they could begin under Medicare’s demonstration authority
- Medicare should offer CDTs bundled payments at no less than their current Medicare billings, with commitments not to cut them if there are across-the-board FFS fee cuts, but to increase them with across the board increases.
- Academic medical centers creating CDTs could avoid detailed documentation requirements regarding exactly which faculty member or resident provided services included in the new bundled payments
- The UCP is charged with offering coverage for inpatient and chronic illness to all comers at geographic/demographic-based rates. Eventually it will break-even (after expenses), but some start-up funding will be needed
- Providers of inpatient care wishing to be paid FFS by the UCP will be paid at Medicare rates. Those forming CDTs will be paid based on the costs incurred by the CDTs with above-average outcomes. CDTs are allowed to charge patients or insurers more than the UCP payment.
- Private insurers can buy reinsurance for care needed by their enrollees from the UCP, either just for inpatient episodes or also for chronic illness management.
- The UCP will not pay providers directly for chronic illness management, but instead transfers to health plans (or PIs) on a monthly basis risk-adjusted amounts reflecting the chronic illnesses of their enrollees.
- Insurers buying coverage from the UCP must share claims data with the UCP. Such data, however, should have provider-specific fees masked to reduce anti-trust concerns.
- Employers can continue their current plans, reinsure with the UCP, or convert at any time to a defined contribution model, allowing individuals in a family to pool contributions and buy coverage through PIs.

Facilitating the Transition to *SecureChoice*

- Mandating that every person be covered for at least inpatient and chronic illness care. “Inpatient” includes major interventional procedures in outpatient settings.
- Establishing income-based subsidies, preferably with long-term congressional commitments, operating behind the scenes to ensure affordability and that will consequently subsume much of Medicaid
- Medical liability reforms to ensure fast compensation without the need to prove negligence for patients experiencing preventable adverse events. Corporate negligence suits can be brought against CDTs that pay many such awards without attempting to improve processes to avoid such events
- Private reinsurers offering coverage to CDTs for such “liability claims” and for high cost episodes will seek to identify the “positive deviants”—those CDTs who have learned how to reduce the rate and severity of such problems
- Shifting graduate medical education funding from a hospital reimbursement base to competitive grants provided to training programs, many of which may be entirely focused on ambulatory care and be separate from medical schools.
- Establishing a reinsurance pool that pharmaceutical and other firms can buy into to reduce their risk that their innovative products are overtaken by better ones. This will allow them to reduce marketing efforts intended to sway physicians and build brand loyalty.

Political assumptions leading to the design of *SecureChoice*

- American culture, values, and political system should not be assumed to change
- Current stakeholders will be engaged in the policy debate, so there should be a potential role for each player in the new system
- Even if the relative importance of a stakeholder group will be diminished, there should be opportunities for some members of that group to thrive in the new system
- Although *SecureChoice* is a design with all the components of a fully operational health care system, pieces can be implemented in a thoughtful manner
- During and after the transition, the new system should be able to operate alongside the current system

- Individuals and organizations should be able to choose whether to operate in the new system or the old
- As the advantages of the new system become more apparent, the old may eventually collapse and supplemental funding may be necessary for those too close to retirement to make the transition

Design objectives for *SecureChoice*

- Ensure the long-term viability of adequate coverage for critical health-care needs alongside constantly improving quality and efficiency, i.e., value
- Bring the rate of growth in expenditure on health care more in line with its ability to enhance value for patients
- Empower physicians and other health professionals with more freedom in their practices, more information, and more responsibility for the care of their patients
- In designing a new health care payment system, not everything can be predicted; to the extent possible, the system should have information and feedback loops to be self-adjusting
- Minimize the direct role of government in decision-making around technical issues to facilitate innovation and reduce the power of interest groups
- Use government to ensure the affordability of coverage, the open availability of data and information, and effective competition in the market
- Facilitate the expression of personal values and preferences in how people selection their options for coverage and care, while recognizing that some choices may have economic impacts that should be considered

The appropriate role of coverage, payment, and incentives

- Employment-based coverage is economically inefficient, but deeply embedded in both the tax and compensation system.
- Insurance coverage is necessary for inpatient care (infrequent and very expensive) and chronic illness care (almost impossible to get once one has the problem)
- The rest of medical care (mostly minor acute problems) doesn't really need insurance, but subsidies may be necessary for some people
- Universal coverage for inpatient and chronic illness care can be achieved either

with a fully tax-supported system or by building on existing employer contributions with an individual mandate

- Income-based subsidies are needed to assure affordability of mandated coverage
- Specifying what particular services, devices, or drugs will be covered leads to lobbying by special interest groups; it is better to cover everything been shown to be safe and give clinicians incentive to make wise choices for each patient
- The incentive effects of how payments are made are more important than the size of each payment. Without rationing access, simply constraining fees is ineffective at controlling overall expenditures