



PARTICULARS

A Proposal for National Healthcare

A "Medicare For All" plan could fix our present flawed system.

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HR 676, the United States National Health Insurance Act (or the Expanded and Improved Medicare for All Act or the Conyers-Kucinich Bill), uniquely stands out as an action plan for healthcare reform. While presidential candidates in the vaguest of vision talk about how they, if given a chance, would reform the healthcare system, only Congressman Dennis Kucinich has detailed the "whys and how" he plans on fixing what he correctly sees as a healthcare system that is broken. The essence of his reform proposal provides:

- Universal coverage for all residents of the United States;
- A single not-for-profit payer;
- Coverage for all medically necessary procedures;
- Complete coverage of prescription drugs;
- Preventive care, dental care, vision care, long-term care, mental health care;
- Freedom of choice of providers - physicians and institutions;
- Prohibition of private health insurers (yes, there can still be private payers out there) from selling any insurance coverage that duplicates the benefits provided under the Act;
- Price negotiations for approved prescription drugs;
- Eventual integration of all healthcare programs (including the Department of Veterans' Affairs and Indian Health Service) into a single program for all residents;
- Establishment of a National Board of Universal Quality and Access to ensure quality, access, and affordability; and
- Methods to pay hospitals and health professionals for services, prohibiting financial incentives for physicians based on utilization.

Much of what you see above makes absolute sense. Healthcare coverage should be a right. We are one of the wealthiest countries in the world, yet we have 47 million Americans who have no health insurance coverage, either because they can't afford it, can't get coverage for their pre-existing conditions, or simply feel they don't need it. Ensuring universal healthcare coverage is the best investment a country can make in its people.

Every physician should love the idea of a single payer; unfortunately, many don't. I am willing to bet that those against a single payer system haven't really thought it through. They think it is the first step to changing forever the American way of life. Nothing could be further from the truth. Wouldn't it be great to have a single payer with a single (and openly published) set of guidelines, policies, and definitions? Although doctors may, on occasion, grumble about Medicare, it is one of the few payers out there that publishes its guidelines, and that goes out of its way to try to be fair about coverage/clinic/utilization issues. In some states, it is the highest payer. It is among the most efficient of all payers. There are very few who would argue that Medicare doesn't produce the highest bang for its administrative costs. As a practice, you would only have to jump through a single payer's hoop, rather than go through the expense and time to try to understand 50 different payers' policies and demands. Simplifying reimbursement saves practices significant dollars. A single payer system would do that.

Single Payer System Not Enough

But a single payer system is not enough in and of itself. Like Medicare, the payer would have to be not-for-profit. A majority of health plans across the country are for-profit. As a result, they need to meet shareholder expectations. Additionally, their administrative costs can range from 15% to 30% of every premium dollar - right off the top. The leftovers are what providers get to split. Next time you read that the CEO of some for-profit insurance company just received a \$15 million bonus, you will be able to better appreciate why there is no money in the system to improve your reimbursements. Medicare Administrative Contractors (MACs) must work for less than a 3% administrative cost. Is the service provided by those contractors less, the same, or better than, say, United HealthCare or Aetna or for-profit Blue Cross? Is Medicare's hassle factor more or less than the for-profit payers your practice is dealing with? Are their reimbursements, in general, significantly better than Medicare's? Do you really like having to deal with 25, 50, 100, or more payers? Honestly, don't you think that your practice would run smoother if you only had to deal with one payer? Ah, suddenly, a not-for-profit single payer system doesn't sound so bad.

Under my not-for-profit single payer system (we'll call it "Medicare-for-All"), healthcare providers should have the option to either participate or not participate under the plan. If a doctor chooses to participate, then he/she would agree to accept the plan's annually-adjusted fee schedule allowances as maximum payment. There would be no annual deductible. Patients, depending on their adjusted income, would be required to pay a 0-20% copayment at the time of service. Participating providers would not be permitted to bill the patient more than their copayment.

Non-participating providers would not be bound by the Medicare-for-All fee schedule. Non-par providers can establish their own fees, but must post those fees where patients or potential patients can view them prior to treatment (e.g., in a brochure available in the office; on the office website; on the Medicare-for-All website). Non-participating providers' fees would have to be displayed adjacent to their corresponding Medicare-for-All fees, allowing patients to see what their potential costs are if they decide to go outside the system. Of course, patients (or doctors, if they accept assignment) would be reimbursed the Medicare-for-All fee schedule allowance (minus copayment amount). Non-par doctors would be able to balance bill their patients up to their published fees.

Under my Medicare-for-All plan, "private" insurance plans would exist, but could only cover treatments that were not covered under Medicare-for-All (i.e., non-covered items/services, cosmetic surgery), just like under the Conyers-Kucinich Bill. Also, a "National Board of Universal Quality and Access" would exist that would set - with

major input from medical societies, academic medical centers, and research centers - evidence-based medicine guidelines on treatment and utilization, assess outcomes, and provide continuous quality measures. There would be no “pay-for-performance” bonuses, and no “Physician Quality Reporting Incentives” (PQRI). Good medicine is expected – one does not get (or deserve) a bonus for providing excellent care. Delivering consistently poor or below expected standards-of-care, overutilization of services, billing abuse, and, of course, fraud would be grounds for termination of provider status under Medicare-for-All.

In addition to the above, under my healthcare reform plan, tort reform would happen (and on a nationwide basis). Healthcare education would once again be partially subsidized by the federal government based on provider need. Post-residency graduates would be able have the federal and state governments pay all or part of their education debt by signing up to serve as healthcare providers in “under-served” regions of the United States, government-run health centers, or in the armed forces. All healthcare providers who aim to practice medicine - regardless of specialty – would receive the MD degree - the only such degree - from a four-year medical school.

Specialization would be determined by the residency program chosen (e.g., orthopedics, psychiatry, osteopathy, podiatric surgery, urology, nurse practitioner, GI, etc.). The training and use of physician assistants and other extenders would be significantly increased. Non-profit or government-run urgent care centers or walk-in clinics would be created to improve patient access, and healthcare delivery. Physicians and other healthcare providers would be salaried in these facilities (not fee-for-service).

How can we pay for it all? Simple...

- Use existing sources of federal government revenues for healthcare.
- Increase individual federal and state taxes based on income [individuals use healthcare services; individuals already contribute toward their health insurance; individuals should contribute to the cost of their healthcare present and future]
- Employers contribute through a payroll tax (part of which would be tax deductible) for their employees. This not only contributes to the overall healthcare financial pool, but since there is a single payer, there would no longer be a need for “Workers' Comp” and - employers would instead pay into the healthcare financial pool].
- The tax cuts put in place would be eliminated for high-end earners.
- The gasoline tax would increase. After all, cars/trucks contribute to the cost of healthcare - accidents, disability, respiratory problems, etc. - the more you drive, proportionally, the more you pay.
- The tobacco tax would increase. Since there are direct correlations between smoking/chewing and illness, the more you smoke, proportionally, the more you pay.
- The alcohol tax would increase so that alcohol (and care for the diseases associated with it) would be subsidized by those who imbibe, proportionally.

How does my idea of healthcare reform save money if all residents of the United States have access to it?

- With the elimination of for-profit payers, the immediate saving is on the order of 10-20% that was previously wasted on administrative/non-clinical costs.
- The cost of prescription drugs would be reduced since my plan requires a negotiation with the drug companies, just as the Veterans Administration currently does.
- Under a single payer, additional administrative overlap and waste is eliminated;

harnessing the Internet, benefit verification, copayments, guidelines, policies, electronic records, etc. can provide instantaneous transfer of information, eliminating “human” effort on both sides, payer and provider, and

vastly improving administrative efficiencies...and reducing the cost of business.

- Patients needing healthcare, who previously avoided the care to save money or because of access difficulties, would have access to physicians and healthcare facilities everywhere. Money would no longer be a barrier to preventive care, and ongoing care and treatment. The result would reduce costs by reducing the most expensive healthcare costs – chronic diseases and progressively worsening health scenarios.
- Evidence-based medicine implementation would eliminate those services, tests, treatments, procedures, and health-related devices/supplies that fail to meet a reasonable effectiveness threshold – they just would not be reimbursed.
- With a single universal set of billing/coding/payment guidelines, policies, clarified definitions, healthcare fraud and abuse can finally be addressed and reduced.

Healthcare reform can occur. Politicians talk about healthcare reform, but refuse to address the pros and cons of leaving the for-profit payers in place. Maintaining a system that includes hundreds of for-profit payers administrating healthcare costs guarantees 1) nothing substantive will change in healthcare delivery. Tremendous monies will continue to be sucked from the system for non-medical services and bonuses, 2) healthcare providers will continue to face fee controls and loss of service value, 3) minimal change will occur in the uninsured and underinsured numbers. The minimal threshold for access into the “reformed” system may still be too high for the people who can least afford to obtain healthcare coverage, and 4) without true reform of this nation’s healthcare system, the cost of providing healthcare (as evidenced in its percentage of GNP) will bankrupt the country.

Our healthcare deliver and payment system are broke. It won’t be fixed with more Band-Aids. The system needs a complete overhaul – tear it down, and build it from the bottom up.