**A WORKABLE PLAN FOR HEALTH CARE REFORM**
**– REVISED AND UPDATED – It Ain't Over 'til She Sings**

**Stephen L. Bakke – December 24, 2009**

## Background

As I write this it appears the House and Senate, both having passed health reform legislation, will enter conference committee to resolve their differences. That product will then be brought to a vote in both houses. The most likely result is that the final legislation will be very close to the Senate version which rejected both the public option and an expansion of Medicare – both good things. Also apparent is that "the fat lady hasn't sung" – and it ain't over 'til she sings.

It's mostly wishful thinking, but before the vote by both houses, not before late January, there could be important changes. As we enter the election year 2010, no matter what is passed you can count on the Republicans seeking major modification of this legislation. This is made possible because the provisions of the reform don't begin until 2013 (over 3 years away) and probably won't be entirely implemented until sometime in 2015.

As long as the debate continues, I want to hold onto my suggested elements of health care reform, and I want to be on the record as to my most current suggestions for reform. Some of this you have seen before, but I have made several changes.

## Commentary

I believe any reform must deal effectively with those who are chronically uninsured, e.g. two years or more – those that have truly "slipped through the cracks." Most Americans agree that everyone should have ACCESS to affordable health insurance coverage. But the debate really is centered on: How do we expand the number of insured? Who will pay the costs of expanded medical care? And, what is the proper payment arrangement?

I believe the key elements of sound health care reform are competition, consumer control, and free market influences. Many of our problems, some of which are serious, stem from departures from free market principles, tax treatment, costly insurance mandates, and bureaucratic interference. Also problematic is a lack of spending "consciousness" by consumers resulting from 6 of 7 dollars being spent by third party payers.

Consumer-directed health care initiatives, under which individuals manage their own health care dollars through systems such as Health Savings Accounts (HSA), are superior to traditional first dollar coverage. There is considerable evidence that consumer-directed programs reduce costs. When the costs drop, insurance premiums drop, and paying directly for care becomes easier. Paying directly (using HSAs) for some services further reduces costs by eliminating the overhead costs of third-party payment systems.

For all its success at helping people live longer and healthier lives, America's system seems too costly, confusing, inefficient, and uneven in its results, and it leaves too many

people not accessing benefits. Correcting those faults while maintaining the history of innovation and creativity is what we must achieve.

**And there should be no new bureaucracies created by this reform!**

**Summary of Reform Elements**

Here are my ideas of a framework for workable health care reform:

***Changes Affecting the Insurance Industry and Insurance Coverage***

- Individuals should be the key decision makers in a reformed system. Individuals should own their own health policies. Prices for coverage, services, or products should be transparent to the individual. Once consumers actually control the treatments and costs, they will collectively apply pressure to maximize value. This separates coverage from employment and provides portability.
- Coverage must be available for all individuals. "Pre-existing condition" provisions and those of "lifetime limits" in insurance policies must be eliminated. To the extent this is found to be actuarially unwise or burdensome for any single insurance company, something like a "reinsurance cooperative" should be created which would be owned jointly by the many insurance companies in the country.
- Individuals should not be "required" to purchase health insurance. However, significant tax incentives should be made available specifically for the purchase of major medical/catastrophic coverage. The current system is tied to the much more expensive "first dollar coverage." The new emphasis would be on higher deductible policies, e.g. $5,000 or $10,000 (or whatever the consumer chooses), and would be surprisingly inexpensive.
- Eliminating "pre-existing condition" limitations and because individuals would not be "required" to purchase coverage, one big problem is introduced – exploitive individuals would still try to "game" the system by waiting until care is needed to purchase insurance – this in spite of the generous tax treatment which would also be available. I would limit this by not having perpetual access to guaranteed coverage – e.g. a person would have to accept or reject coverage at a point in time, and would not again be eligible for guaranteed coverage for a specified period of time. This could be set at 3 to 5 year intervals, for example. Additionally, after declining to purchase available coverage one time, when such coverage is ultimately obtained, there should be a waiting period before non-emergency treatment would be covered – say 6 months to 1 year.
- Individuals should be allowed to buy insurance across state lines. State borders now act as unnecessary regulatory walls. This would permit shopping among a robust variety of insurers. They all currently exist – we just can't access them outside of our state of residence. Each consumer now has very few options, thereby limiting competition. This would remove that problem.
- State mandates for insurance coverage should be eliminated and we should move closer to a "shopping cart" approach for buying insurance. This would allow insurers to offer a range of plans – from basic/lower cost to comprehensive/higher cost coverage – which would meet a variety of individual needs and preferences

while making access more affordable. Mandates have been estimated to increase the cost of health care for a typical individual by 50%.

- We should study the possibility of introducing a system which permits a variety of insurable pools (trade associations, civic organizations, professional associations, business groups, etc.) These pools could choose from a variety of carriers for their members. Each consumer would still own their own policy, and could even choose from a variety of pools for negotiating the best deals.

***Changes Affecting the Tax Code***

- We should change the tax code to allow all medical related expenditures, up to a generous maximum, to be deductible (not severely limited as it is now). We should implement a system of tax credits as part of this tax reform. We should encourage concepts such as health savings accounts (HSAs) through the tax code and permit the consumer/owner of the HSA to accumulate a tax deductible/tax sheltered "next egg" to be used in future years for expenses, or if unemployed.
- The tax provisions should strongly encourage widespread use of HSAs in tandem with a relatively inexpensive, higher deductible insurance policy designed to cover major medical or catastrophic expenses.
- Taking care of children is a "hot button" (witness SCHIP). We should implement tax credits, with generous limits, for expenditures for those under 21 in families below the median U.S. income. This would replace the existing SCHIP program which provides government paid health care to the children of families well above the poverty level, **and even above average income levels**.
- Tax legislation should assist the poorest taxpayers by having a sliding scale of subsidies based on income. **The levels of tax deductibility, tax credits and refundable tax credits would vary with income.**

***Other Changes***

- Tort reform should occur by eliminating abusive and unnecessary lawsuits and settlements. This should include a cap on non-economic damage awards. The result would be more reasonable awards and also a reduction, over time, in defensive medicine and the resulting insurance premiums.
- Health care providers should be encouraged to offer affordable care at convenient locations such as retail clinics at malls, walk-in centers, etc.
- All persons using emergency rooms or walk-in centers should, as part of their treatment, be directed to the parts of our system from which they could benefit.
- I understand there is a shortage of doctors and nurses in our system – particularly for "primary care". This is troublesome because there could be many millions becoming insured as a result of reform. Dealing with this will be very difficult and will take time. If there are artificial barriers to the number of professionals our system develops, they must be eliminated. That would include expanding medical and nursing school enrollment or even encouraging more medical schools in certain areas of the country. This could be done partially through our tax system whereby personal and corporate incentives would be developed. Imaginative planning would come up with many constructive programs.

- There are more elements which should be mentioned here such as streamlining provider administration through "paperless office" practices and administrative technologies. Also, "wellness" programs should be encouraged by using the same tax incentives mentioned above. **But it is becoming ever more apparent that preventive care and wellness programs will make us healthier, but are not likely to reduce health care costs in the long run. But not all costs are bad.**

***Focus on the Uninsured***

How should we deal directly and specifically with the approximately 47 million uninsured? I believe the following would do so in a "smart" way. Some of these are incorporated in what has been discussed above.

- Access to insurance for the transitional uninsured (between jobs or temporarily unemployed) would largely be handled by the change to individual ownership of policies. Payments would be made by the insured with generous refundable tax credit allowances – perhaps some specifically designed for the unemployed.
- Some citizens, for various reasons, choose to "roll the dice" and not spend for health care coverage – even though they could afford it. The approach I suggest should convince many that these provisions make coverage cheaper, more attractive and, I believe, they would buy it. This is where use of HSAs, unbundled major medical coverage, tax deductions and credits, price transparency, etc. would make a difference in the number of uninsured.
- We should aggressively deal with the chronically long-term uninsured (e.g. over two years and "nothing else works") through a system which combines the revised tax credit provisions with the creative use of vouchers for a private insurance pool set up for this purpose. Or we could issue the medical equivalent of food stamps (using restricted debit cards) for their use, thereby subsidizing their catastrophic health insurance premiums – but through private insurance companies, not a government alternative. I believe this would comprehend approximately 10 million people.
- We should limit illegal immigrants to taxpayer paid coverage provided in hospital emergency rooms or at walk-in centers only. Any person residing in the U.S., however, should be free to purchase their own coverage on the open market.

**My suggestions create no new bureaucracies!** I think that is critical if we want to make this an affordable reform.

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We must maintain a free market system of providers, insurers, technology development, pharmaceutical development, manufacturing of equipment and drugs, and marketing of all these products and services. Ours is the system which develops virtually all new medical technologies, new pharmaceuticals, and which has the best treatment outcomes on the planet. We must retain the best of what we have while we fix the problems. Moving in the direction of a government health care system and public insurance option is not the way to do it. We must continue to reject that.