Bridging the Ideological Divide in Health Care Reform:
An Actionable Plan for Oregon

By Stephen A. Gregg

October 2006

Introduction

The subject of health care reform in the United States has become a disturbingly chronic debate for decades. Who can remember when we were satisfied with the costs or functionality of our system? What action-oriented person can bear to read another article providing a restatement of excessive costs and the uninsured? For a problem of this importance to persist for so long with no credible or sustainable strategy must signal important subtleties at work, beyond the deductive reasoning required to construct a new future.

Proposed here is a voluntary health care reform proposal that has the potential to change significantly the way health care and health insurance are provided in America. Oregon should be an early adopter of this proposal; and when proven beneficial here, it then can be implemented elsewhere.

Before considering the substance of the proposal, it is useful to reflect on the universal constraints influencing this debate.

The Ideological Divide

Health policy is divided between those who believe access to quality health care is a fundamental right that government in some form should provide, control and guarantee, and those who believe in the painful requirements of individual responsibility and management of the system by means of free market forces. Facts tend not to matter to either position. Indeed, this contest of ideology could be summarized as "who has the right to decide," "who pays" and "who controls whom." Is the money that pays for care "my money" or "community money"? These polar views have matured to become intractable, impassioned positions assuring that any solution directed at choosing one over the other will not be supported by a significant fraction of the population.

Underestimating Sustainable Economics

The smartest people directing health care policy are underestimating the sophisticated nature of long-term cost control. There are literally hundreds of thousands of economic interests involved in providing goods and services, each of whom expects to make more money than last year. This can be driven by crass greed, or by more benign acts of simply doing more to meet a perceived and perhaps unnecessary need at someone else's expense. Over the years we have tried to constrain these aspirations in almost every way possible by controlling supply, prices, access, prevention and improved coordination. When are we going to recognize that when the health care industry suffers a loss of revenue because of cost containment actions, it reacts with offsetting counter-measures?

> ***"Proposed here is a voluntary health care reform proposal that has the potential to change significantly the way heath care and health insurance are provided in America."***

Furthermore, most urban markets have evolved to be health care oligopolies dominated by two to three major provider and insurance systems with marginal differences in service and cost profile. This provides an atmosphere of shadow pricing, minimizing disruptive competitive behavior, discouraging new market entries and arguably an unhealthy control of the market by the vendors of service.

The Incrementalism Problem

There is considerable agreement that reform cannot be successfully addressed by aimless incremental change, and yet that describes our collective behavior. Incrementalism has become a corrupt pretense, inviting shared enthusiasm for a variety of efforts that have little prospect of threatening the economic benefits of the existing system. Indeed, armies of academics, policy-makers, marketers and administrators mobilize themselves around such

Cascade Policy Institute

813 SW Alder
Suite 450
Portland, Oregon
97205
(503) 242-0900
fax (503) 242-3822
info@cascadepolicy.org
www.cascadepolicy.org

subjects as information technology, prevention, pay-for-performance and evidence-based medicine, with impassioned and highly rationalized advocacy. The very substantial vested interests appreciate the conundrum but have no reason voluntarily to embrace the unpredictable disruption of comprehensive change or its attendant reductions in cash flow.

"Indeed, we do suffer from a 'leadership crisis,' in that it is more difficult to identify the leading agent of change than it ever has been."

The Absence of Leadership

The state of dissatisfaction with our health care system begs the question: If we have great health care and political leaders in positions of authority, why do we have such an unsatisfactory health care system? An interesting exercise is to develop a limited list of a state's top health care leaders, and interview them. What would you discover? Poor problem definition, a desire to blame technology and an aging population, deferral of responsibility to someone else, a "can't do" attitude, uninspiring solutions and an all-consuming goal of maximizing economic performance within the status quo. Government, particularly at the state level, seems unqualified to deal with the complexity of the problem. It is too often a captive of industry lobbyists, a deeply entrenched entitlement culture within its own workforce and a political fear of health care reform. Reform at the federal level is perhaps even more speculative.

Indeed, we do suffer from a "leadership crisis," in that it is more difficult to identify the leading agent of change than it ever has been.

Given the problems of access and costs, and these complicating aforementioned factors, how do we proceed?

HEALTH CARE REFORM: THE WAY FORWARD

Someone once suggested, "Control the assumptions and you control the solution." Therefore, these assumptions need to be reflected upon carefully. If we disagree here, we will not likely be in alignment when it comes to the solution. In contrast, other solutions most frequently will fail to incorporate one or more of these assumptions.

The Formative Assumptions:

1. One monolithic system serving all is both unrealistic and undesirable, considering the diversity of culture, opinions and needs of the population.

2. We have a three-part problem composed of cost, access and a growing sense of social inequity, which need to be solved contemporaneously and comprehensively.

3. Taming the cost element of this problem is by far the most demanding challenge, requiring humility concerning past failures, skepticism, a willingness to innovate and an insistence on independent measurement of results.

4. Sustainable reform must include all Americans and address both the financing and the delivery aspects of the system to be successful.

5. Any new comprehensive design should be obligated to a "proof of concept" before full-scale rollout.

The New Vision

This reform plan is developed and offered regionally within states, including Oregon, as a voluntary alternative to the status quo. Those who elect to take this option are critical early adopters of comprehensive change, and those who do not may hold onto the status quo until the new way is adequately demonstrated as credible.

This reform (Figure 1) has four key elements:

1. All participants, regardless of age or source of funding, have a personal tax-advantaged medical account referred to as a **"Health Management Fund (HMF),"** governed by regulations similar to health savings accounts.

2. All related sources of funds (Medicare, Medicaid, employers, personal funds, etc.) transform their historical roles as providers of defined benefits into defined contribution. These sources of funds may apply general conditions to their respective contributions, such as the requirement to maintain suitable insurance. Public, private and individual contributions are pooled in the tax-advantaged HMF to enhance personal purchasing power. Government is free to determine how it allocates public dollars to these individual accounts and their broader tax treatment.

3. All contributions to the HMF are assessed a 10 percent fee used to fund a community foundation with the role of reallocating such funds to those needing additional financial support for their health care needs. This new source of funding, in addition to existing public financing of health care, will finance the need-based gaps of the uninsured. For those being assessed this fee, the trade-offs are: These funds are predominately tax-free, this assessment is far less than being taxed at normal income, this structure provides the opportunity to accumulate personal savings, and premiums no longer will incorporate the costs of unfunded care.

4. The delivery and insurance functions are segmented

into three broad categories of choice: **Civic**, **Traditional** and **Self-Directed**, available to all members of the community. Future design innovations that are not adequately bracketed by these choices may be added or incorporated as subsets of these categories. The model welcomes on-going innovation in financing and delivery methods. Individuals have a life-long ability to select the plan that best meets their interests, irrespective of employer alignment or public subsidy. Individuals periodically may change their selections every five years to best meet their perceived needs.

Figure 1

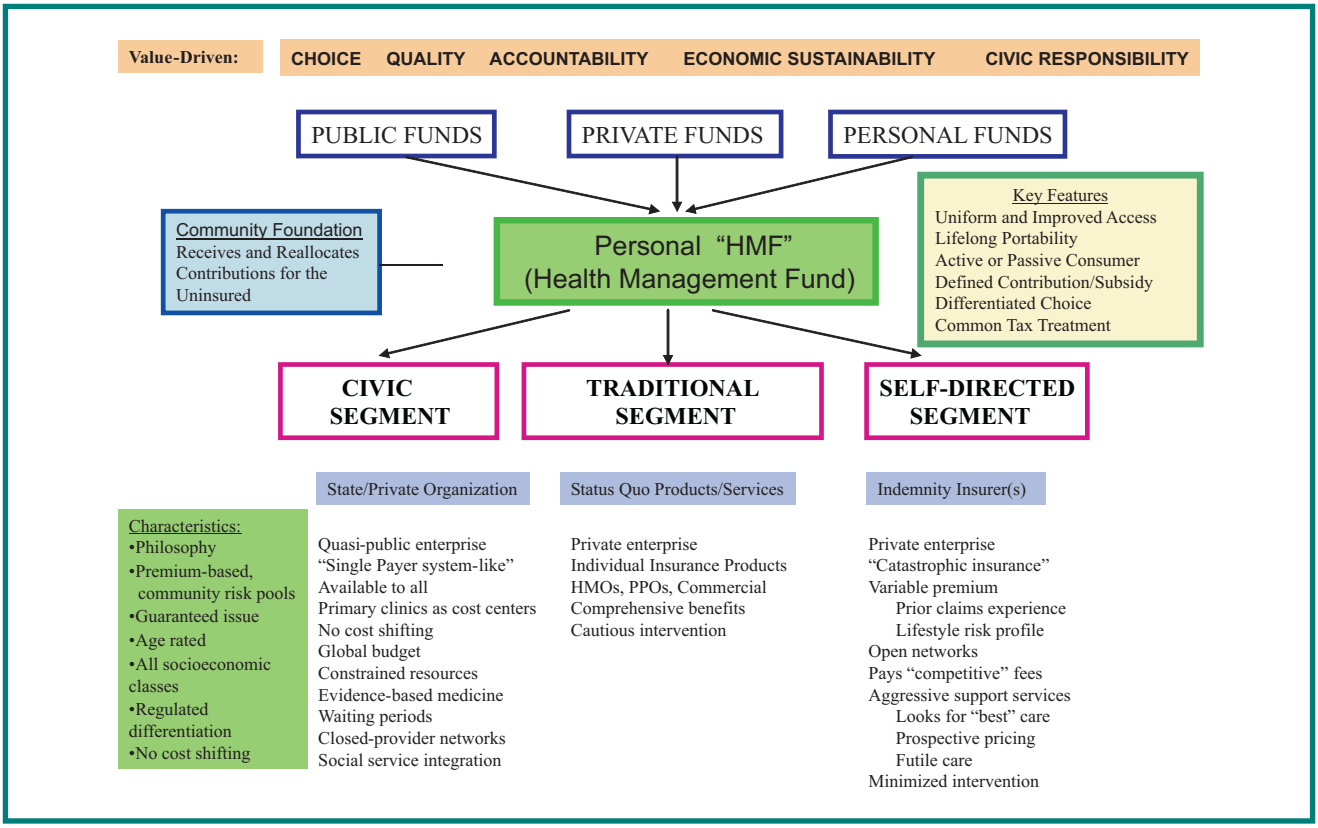
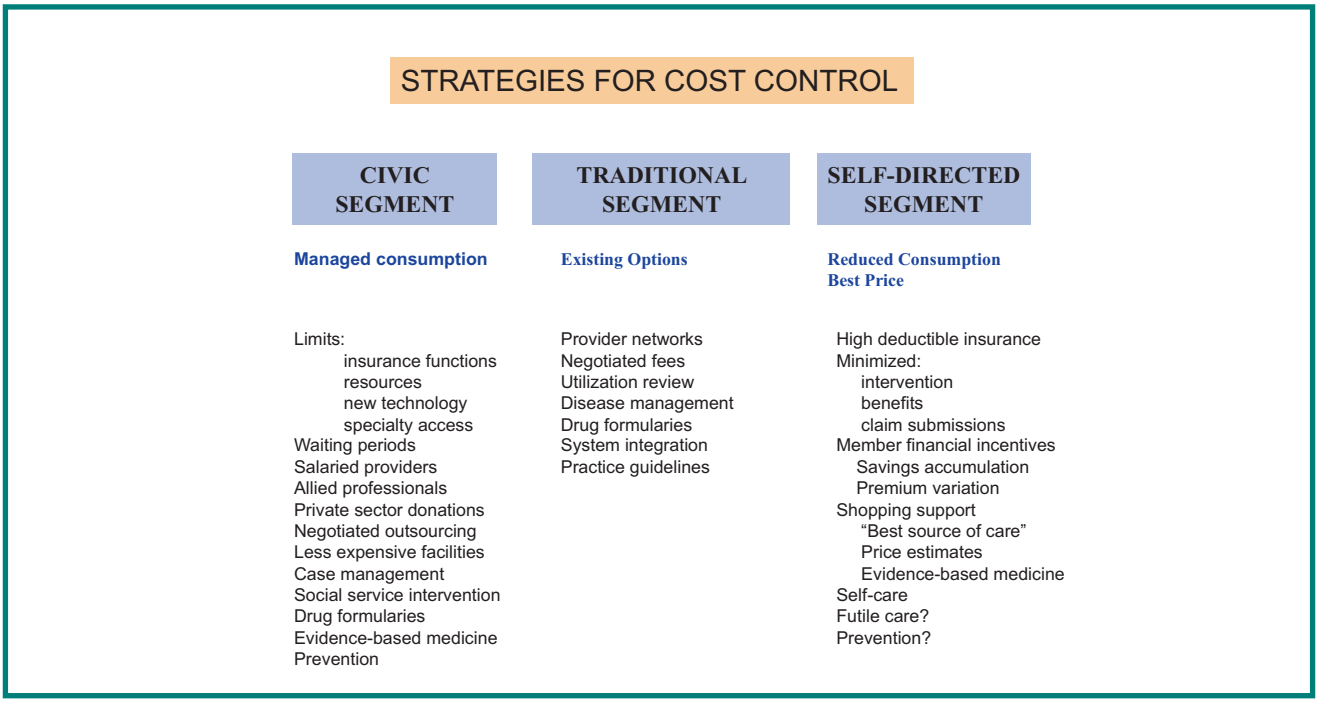


Figure 2



The Three Segments (Civic, Traditional, Self-Directed)

The three segments capture the differing ideological approaches proposed by reform advocates for the past many years: a government-operated system, managed care and other present forms of insurance, and a new self-directed system. Each approaches cost containment and increasing value to their customers in a different way (Figure 2). All segments and underlying choices are priced and available to participants on a guaranteed-issue basis during a defined open-enrollment period. Individuals or their representatives select from the full array of prices, benefits and plan characteristics offered. Community employers and providers may decide to participate or not, with implications for feasibility in any given community. Perhaps the most powerful realization is that no one segment will fit or attract the support of an entire population, irrespective of underlying arguments.

In the interests of maintaining system equilibrium, health policy should seek mixed representation of all socioeconomic population categories among the segments. A *Civic Segment* serving only the poor or a *Self-Directed Segment* solely for the healthy and wealthy are undesirable outcomes. This is a plan that embraces constructive competition among the segments, where high quality and value must be achieved to maintain survival.

Each segment and associated participants should be encouraged to innovate aggressively, consistent with the philosophy and values of its segment. *Traditional* HMOs and PPOs should pursue the leverage of system integration, closed provider panels and patient care intervention. *Self-Directed* options should offer high deductible, catastrophic insurance with financial incentives favoring personal management of risks. The *Civic Segment* will emphasize access to basic services, public clinics organized as cost centers for primary care, salaried providers and rationing of selective services.

"Sustainable reform must include all Americans and address both the financing and the delivery aspects of the system to be successful."

Implementation

At some point, a state or community must decide on action over endless talking, complaining and deferral. Indeed, establishing the will and perseverance to act presents its own challenges, irrespective of the solution or vision to be pursued. States, counties and, indeed, individuals will vary greatly in their tolerance for change. The initial stages of comprehensive reform should seek to **exclude** those who are not early adopters and participate with reluctance or, worse, sabotage in mind. What is feasible to initiate in one community may not be possible in another until a later time. Being a proven public policy innovator, Oregon is the perfect state to begin this experiment.

If we were to presume that a limited number of counties in a state wanted to pursue this model of reform, the respective state must stand ready to enable the cause in five ways: 1) scanning all existing legislative and regulatory barriers, making appropriate accommodations; 2) assume the point in acquiring federal support and waivers; 3) partial funding for the effort; 4) enable access to the model by public employees and Medicaid recipients; and 5) providing the necessary encouragement to existing statewide insurers to participate. Again, Oregon has done such things before with its waivers for the Oregon Health Plan and welfare-to-work programs.

"Individuals have a life-long ability to select the plan that best meets their interests, irrespective of employer alignment or public subsidy."

A community with tentative interest must have the enthusiasm of its providers and community leadership for an initiative to proceed. An even more limited number of local "statesman-advocates" must be on the front lines. Considerable review and planning must be engaged in preparing a functioning *Civic Segment*. The model likely will require phasing within a region by initial introduction to the private market, followed by the public sector within a couple years of successful regulatory enablement. An available population of fifty to one hundred thousand people is necessary to achieve critical mass.

This Proposal's Merits:

1. Provides the best opportunity for the alignment of patient, provider and insurance cultures and interests.

2. Places all Americans in a similar framework with the same opportunities for choice. It eliminates the indefensible silos of categorical aide and favoritism pervading the status quo design. Invites government to review the distribution of its current funds to achieve improved social equity.

3. There is no more public cost shifting to the private sector, as all participants, irrespective of funding source, are purchasing from among the same health plan options.

4. The model invites on-going, value-enhancing innovation as a requirement for health plan survival.

5. The requirement for hands-on engineering of benefits, control of access and other interventions by employers or the government is minimized.

6. The 10% assessment applied to all contributions to the HMF easily can be understood as a "give-take" arrangement in exchange for a larger personal tax advantage and the opportunity to accumulate personal savings.

7. Transparency, individual responsibility and choice are greatly enhanced.

8. Those policy architects who believe in a particular philosophy, program or policy as rendering the "best value" are challenged to prove the "talk" in a healthy, competitive environment.

9. The government may treat all Americans in a common manner as it applies to the taxable status of HMF contributions and future mandates it wishes to impose on employers or individuals.

10. It is possible to be born, employed by multiple employers, qualified for public assistance, and be eligible for retirement support, remaining aligned with the same insurance plan and providers throughout one's lifetime. This will greatly reduce costly health plan turnover and mitigate the undesirable gaming associated with underwriting selection practices.

11. This model can be executed with a minimum of legislative and regulatory change in almost any regional community with the will to implement.

12. This model is consistent with many of the changes already underway (personal accounts, public delivery systems, closed provider networks, catastrophic insurance, etc.). It is also inherently flexible for future policy and program adaptations.

13. The model has the potential of resolving the budgetary and provider conflicts of each state's Medicaid program because the unfavorable underwriting risk of this population is mainstreamed and there is no more public cost shifting as we know it today.

14. The investment capital needed to activate the model is comparatively very small.

"It is possible to be born, employed by multiple employers, qualified for public assistance, and be eligible for retirement support, remaining aligned with the same insurance plan and providers throughout one's lifetime."

Conclusion

Oregonians and Americans are becoming tired of the chronic nature of the problems associated with our health care system. Indeed, these problems are complex; and we have a long history of attempting to solve them, for the most part unsuccessfully. This plan offers an actionable alternative to how health care is financed and delivered and, if embraced, offers us the united ability to act in a way that aligns the participants with what best meets their needs.

About the author: *Stephen A. Gregg was the founder and CEO of the Ethix Corporation, a Portland-based national managed care company, which was sold to a national health insurer in 1994. In addition to his extensive managed care background, Mr. Gregg has been a senior vice president of a hospital management company and an administrator of a 400-bed acute care hospital in Minneapolis, Minnesota.*

Mr. Gregg is the co-founder of the Oregon Health Assessment Project (OHAP), a community-based initiative concerned with the development of an actionable and comprehensive redesign of Oregon's health care system. OHAP produced its first suggested plan for actionable reform in 2003.

Mr. Gregg has a Master's degree in Health Care Administration from the University of Minnesota and a Bachelor of Science degree from Cornell University. He has lived in the Portland area for approximately twenty-five years and has been an active participant in the health policy debate locally and nationally. He can be reached by email at sgregg1@earthlink.net.

About Cascade Policy Institute: *Founded in 1991, Cascade Policy Institute is Oregon's premier policy research center. Cascade's mission is to explore and promote public policy alternatives that foster individual liberty, personal responsibility and economic opportunity. To that end, the Institute publishes policy studies, provides public speakers, organizes community forums and sponsors educational programs.*

Cascade Policy Institute is a tax-exempt educational organization as defined under IRS code 501(c)(3). Cascade neither solicits nor accepts government funding and is supported by individual, foundation and business contributions. Nothing appearing in this document is to be construed as necessarily representing the views of Cascade or its donors, or as an attempt to aid or hinder the passage of any bill before any legislative body. The views expressed herein are the author's own.