

# Comprehensive Healthcare Reform

## *Executive Summary*

*South Metro Denver Chamber of Commerce March 2009*

1. Background of this 4+ year effort:
  - a. Contributions from broad base of well over 100 stakeholders and subject-matter experts, including business owners, health care consumers, payers, providers and hospitals, plus experts in insurance, technology, preventive/alternative medicine and public policy
  - b. In 2007 this effort resulted in a formal proposal submittal to the 208 Commission. It became one of 11 semi-finalists, but not one of the four plans that were modeled financially.
  - c. This proposal has received considerable interest from many business and consumer groups
2. Relevance and context of this proposal:
  - a. We focus on improving what every healthcare consumer receives, not just on who pays
  - b. Represents a blend of private enterprise and appropriate government involvement
  - c. The complexity of – and frustration with – the existing system has resulted in several Single-Payer plans being considered.
  - d. Our approach sets up a privately-funded Colorado Health Care Authority, which will have two years to design a reform plan for Legislative approval
  - e. The Authority will consist of a representative – but manageable – cross section of stakeholders and subject matter experts, and chartered by specific priorities and guiding principles
  - f. We seek federal waivers so comprehensive reform can proceed at the State level
3. Key priorities to be followed by the Authority:
  - a. Access to healthcare must be achieved for all Colorado residents
  - b. There is already enough money being spent within the healthcare system
  - c. Comprehensive reform – not mere tweaking of the existing system – is required
  - d. There should be no automatic connection between employment and healthcare. (or, Health Care should not be tied to, nor dependent upon employment).
  - e. Individuals must be accountable for lifestyle choices, treatment and cost decisions
  - f. Free Market principles are the best means to reduce cost and improve quality
  - g. Increased and rational use of technology will improve cost, quality and transparency
4. Six guiding principles – foundational principles of healthcare reform:
  - a. The fundamental participant in healthcare is the individual
  - b. The fundamental relationship is between the individual and his/her provider
  - c. Healthcare services should be provided to an individual with limited outside intervention
  - d. The goal should be increased value for all participants
  - e. There should be no automatic connection between healthcare and employment
  - f. Movement towards an individual-based system will reduce dependency on third parties such as employers, government and payors, and increase personal responsibility.
5. Cost/value initiatives that need to be addressed:
  - a. Inherent efficiencies such as confusing exchanges of information between/across episodes of care. There needs to be more adoption of information technology and automation.
  - b. Increase the use of evidence-based medicine, best practices and quality measures. Set up and use data clearinghouses that aggregate treatment, diagnostic data and clinical outcomes.
  - c. The consumer does not currently manage the process. Need to promote the proliferation of processes, institutions and entities that help healthcare consumers evaluate quality measures.

The 3-tier coverage system described below will restore free market functionality to healthcare. Using the term “free market” does not mean being even remotely similar to the current system. The current healthcare system is commonly mistaken for a “free market” system but, in fact, it has been manipulated to where it defeats virtually all free market principles. This proposal will lower costs, restore transparency, improve quality, and restore buyer choice, competition, and free market principles.

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## Notes on the Three Tier approach

1. Tier 1 – Preventive Coverage. Universal; Administered by the Government or independent third party. Examples include immunizations, screening, age-/gender-appropriate medically necessary testing, etc. This tier recognizes the proven concept that preventive care results in a lowering of overall healthcare expenditures.
2. Tier 2 – Maintenance Coverage. Individual insurance policies purchased directly by consumers. Covers most medical transactions for most individuals. Maintenance Coverage/Indemnity against major financial loss due to illness/accident. Incorporates concepts of a “Medical Home.”
  - a. Private medical insurance policies, purchased by individuals/families, and not tied to employment. Changing jobs or being laid off will not expose that individual to risk of loss of healthcare coverage.
  - b. Employers will no longer have to be experts in the details of health insurance or claims processing. Neither will they need to risk displeasing their employees by picking the wrong plan. This should result in great time and expense savings for employers.
  - c. Employers will be still be allowed – and encouraged – to provide competitive compensation packages to reflect this new approach, but will not be involved in the buying decision.
  - d. Tax-advantaged vehicles such as HSAs will be preserved and expanded.
  - e. Vouchers will be provided for those who meet means-based testing to purchase private insurance. This eliminates a “lower class” of coverages, where lower-income participants have access only to a government-offered plan, while others have private insurance.
  - f. Mandatory issue without regard to age, health history, heredity or pre-existing conditions. This will end “cherry picking” and will require insurers to mitigate risk by creating the largest pool of customers possible. Without exposure to the expense of preventive and catastrophic care, insurers will have to compete in the open market for the individual’s business based on price, quality and other features.
  - g. Unlike today’s individual health insurance policies, these policies will have affordable premiums. Once individuals become responsible for selecting their own coverage, and armed with the protection of mandatory issue, neither the individual nor the employer will be burdened with unaffordable premiums for so-called high risk individuals.
  - h. Rates allowed to reflect adverse life-style choices – individual choice and accountability. Pricing reflective of life-style choices (smoking, addiction, etc.) will encourage more personal responsibility in patients.
  - i. All insurers in the State will be required to offer at least the basic plan, with coverage for the most basic healthcare transactions, as defined by the Authority.
3. Tier 3 – Catastrophic Coverage. Universal coverage; Administered by the Government or an independent 3<sup>rd</sup> party. Covering conditions exceeding some pre-determined dollar limit (like \$100K-\$150K). In removing the risk of major losses from insurers offering policies in the middle tier, the justification for expensive premiums is dramatically reduced. There should also be dramatic administrative cost savings.