Universal Individual Coverage within a National Risk Pool

Governor Vilsack asked if I supported an individual mandate and I didn't directly respond. I had to think about why I don't support an individual mandate, but I do support individual choice. Let me tell you why.

I don't like the terminology "individual mandate" because it equates to ordering individual consumers around. Not an attractive political picture in a democracy with a libertarian streak that crosses both political parties. Don't choose language that invites defeat.

In shaping a political solution to the current broken health care and health care financing systems, leaders should not automatically adopt academic terms of art or let the academicians put the politicians in a political straight jacket. Labels do matter in politics.

But it's not just a problem with the label. Additionally, I'm not sure "individual mandate" is really the right concept to describe what is required to solve the double problem of inadequacies in health care and in health care financing. Fixing financing without addressing the health care being purchased won't solve the problem with poor results for the money we spend.

Success on both problems will require empowerment of individual choice to assure accountability. The goal is not to burden consumers with a mandate. This might sound like something said by advocates for health savings accounts (HSAs). Market accountability is good, but HSAs are not sufficient reform, partly because they operate within a broken system. HSAs are not working for a variety of reasons, but primarily because the semblance of an insurance market is an illusion. Consumers can't drive the market as it currently exists because they cannot make any rationale judgment balancing cost and quality in a value equation. We don't provide the tools or the information to do so. In a reformed system, both government and the market should be working for citizens. We do what citizens as voters and consumers want, not vice versa. The reformed system would make the system accountable to individuals, but would also empower individuals to strike a value equation in a way that is impossible today.

The terms "market" or "marketplace" carry their own baggage, so maybe it is better to talk about individual choices and incentives. Economic rules operate whether you recognize them or not. Economic motives will exist regardless of whether the political system believes such motives do or should exist. Better to accept them and direct them to achieve socially desirable ends. Pay people to deliver better health care results and manage care over a lifetime. That's a much better result than the current system which predominately pays providers to deliver volume and insurers to avoid risk. We have a for-profit system today and are paying for the wrong results.

Change the rules, change the results. The opportunity to make a profit for the wrong reason does not mean there is a successful market from the viewpoint of consumers.

Consumers as voters are fairly asking whether even "socialized medicine" would necessarily be worse than a profit driven system that pays for the wrong things.

Insurance companies (risk managers more broadly – looking at third-party administrators of ERISA plans and more) are paid to avoid risk rather than to manage care to reduce long-term costs or maximize quality of life and longevity. Health care providers are more often paid for volume rather than coordination and management of health care outcomes. It is important to understand that both the health care delivery side and the risk-bearing health care financing side of the problem are broken or dysfunctional markets or incentive systems.

A solution should address the need for change in both sides of the equation.

Consider something more like universal individual coverage within a national risk pool, common financing rules and sources, and individual choice of providers and administrators.

The political system is incapable of delivering a perfectly reformed system by anyone's definition. It may be much easier to agree upon rules that move the system over time through better incentives and organic change.

Administrators would be paid for the risk they actually receive and not rewarded for the risks they avoid. There could be a prospective risk analysis for initial payments[i], but there would also be a retrospective risk adjustment for risk actually encountered. This is absolutely necessary to avoid rewarding subtle risk avoidance mechanisms (like where you advertise or provide services). Similarly, there would be retrospective performance adjustments penalizing failure to provide adequate preventive services. The goal is best performance over the person's lifetime, not just lower costs this year.

We have to change why and how administrators make money and only pay for results that consumers want, better outcomes at lower cost.

The risk adjustment would not be based upon costs actually expended but health risks (diagnosis) actually experienced.[ii]

There would be a government safety net program, but the market regulator which pays from the common risk pool would be separate from the government administrator of risks within the safety net program. The safety net would be the default choice and would probably end up serving many who cannot or will not choose other options. [iii]

Individuals could choose private administrators but the private administrators would receive no more than the government program would for the same risk (and vice versa). To attract customers, private administrators would have to do it better for less. The private sector has a chance to demonstrate its creativity and managerial expertise but consumers will not choose a private option unless it really does deliver better qualitative outcomes, lower costs or other tangible benefits to the consumer, because consumers will direct health care dollars, empowered by government both by a common financing

system and by government creating a truly accountable market for health care and administrative services.

The regulator would enforce market data collection on risk, outcomes and qualitative service measures so there would be a basis for choice. The market regulator would be like Bill France of NASCAR, changing and enforcing the rules to benefit the fans (consumers) and not to give advantage to one team or another. In NASCAR, the regulator is not a lap dog of the teams, and both the teams and fans are better off for it. A strong federal risk pool regulator would regulate not just individual participants but the system.

Because risk would be pooled at the national level not the administrator level, avoiding risk is no longer rewarded.

We're all in this together as Americans with no guarantee that our family won't be the one to encounter the unpleasant surprises of health challenges. Since we're all in this together call it a national risk or health pool. All Americans participate in the universal risk sharing system because you can't allow healthy people to wait until they are sick before they ask to join the pool. Keeping costs affordable requires that everyone participate and contribute.

Universal or national risk pool

Common or shared financing focuses on two ends of two different spectrums:

- **Risk spectrum** – catastrophic care exceeds the ability of the current system because too many people avoid participating in financing until the risk is realized. Because the catastrophic risk hits so few, high cost exposures fall on government or are redirected by providers through cost shifting. Both options break the rules for a successful market or incentive system by obscuring accountability. A reformed system must better address high cost cases, partly be rewarding better management of such cases over the person's lifetime (preventive care) and partly by better involving the person in balancing cost and quality of life. Those patients subject to early intervention or prevention must be brought into the risk pool as an incentive for prevention.

- **Wealth spectrum** – while premiums paid to administrators are equal for all regardless of wealth the pocket from which premiums and deductibles are to be paid must be primarily tax-financed for those on the lower end of the financial spectrum. I would use government to collect the "premiums" to assure uniformity of administration and low marginal costs of collection. I would also use the tax system to fund the deductibles for lower income participants in the national pool. That said, flexibility is always an advantage in any system. One potential advantage of this system is that it doesn't have to collect all the premium dollars. The federal tax collection portion could be limited to two purposes, first funding low income deductibles, and second raising enough money to make the risk adjustments at the end of the year. Both purposes can have concrete limits so they are not open checkbooks.

Individual service options for providers and administrators

Individuals can opt for private administrators but the default choice is a government agency or safety net program that must meet the same rules as a private administrative services provider.[iv]

All the players are regulated by a single, federal health finance regulator like the Bill France of NASCAR. (Stock car racing fans will understand the role of a regulator that adjusts the rules to deliver better results.) The regulatory arm will not favor either the government service agency or the private administrators but run the incentives and competition to benefit consumers, providing strict and fair service rules so that consumers receive what they are promised.

This system is neither a continuation of the current private insurance system nor a purely government single-payer system.

Why an apparent hybrid?

Why not single-payer? A single-payer system requires no change on the part of providers to better manage the continuum of care, either among providers or across the lifetime of the patient. Single payer runs the risk of freezing in place a fee-for-service system with its own problems. It's easy to have low administrative costs if you pay every bill submitted for payment. It's hard to control costs or to motivate improvements in quality with such a system. Costs are an issue. We cannot spend 100% of our common wealth on health care. Calling it a right doesn't change the need to strike a balance among other competing societal and individual priorities. Just as patients are reluctant to bankrupt their family for a chance at a few extra weeks, voters are reluctant to bankrupt the country fighting an ultimate reality of life. We all die. We can extend life and improve quality of life and should do so, but we can't ultimately avoid the reality of death. Voters are more realistic than many advocates and politicians. Any solution must ultimately demonstrate that it can strike a balance and recognize limits, both financial and technical.

The safety net program is likely to continue (at least initially) as a fee-for-service system that pays for volume not results. By providing the option of privately administered systems that my use more managed and coordinated care options, we provide for the option of organic change and incremental improvement. In engineering terms this also provides redundancy. If fee-for-service absolutely breaks down you've given consumers an option to choose that delivers better results. With multiple choices you minimize the risk of a big mistake and minimized the consequences should a mistake arise in any part of the overall system.

Why not private insurance? Private insurance today spends enormous effort avoiding risk in underwriting rules and subtle marketing ploys that filter who can buy insurance. It spends additional resources deferring or avoiding risk or liability for risk with procedural barriers and arcane rules that benefit the insurer and not the consumer. Merely continuing a private insurance option as it exists today cures none of the obvious market ills of the financing system. Those market failures are driving consumers as voters to conclude that even a government system might not be as bad as the current dysfunctional system that poses as a market, but which provides consumers none of the power and control consumers have by definition in a real market.

Things that could be done or enabled by such a reformed system

Budget for the system. No blank check is necessary for this overall system of care and finance. The current runaway system is an open pocketbook. That can't last forever. A common risk pool with retrospective adjustments allows government to potentially fix a national health care budget. The dollars get some adjustment at the end of the year among the administrators.[v]

Prevention. Well care and prevention become as important as sick care. Done correctly, the system provides incentives for and pays for well care and prevention, not just sick care. The incentive grows over time allowing the system to learn and change.

Incentives for innovation. We could allow some health care to stay in a private market. Just like elective cosmetic surgery is largely an unregulated private market today, the reformed system might leave some services outside the regulated system or defined risk pool, available to those who can afford it, but also subject to consumer accountability. This might be an effective way to maintain a dynamic market for procedures, drugs or treatments that do it better for more. The budget constrained national risk pool system will naturally reward those that can do it better for less. Improvements in care that improve outcomes, but at significantly higher cost would become a luxury market with the potential to attract consumer dollars if the advantages are significant enough. Once proven and developed to the point of meeting the standard of care requirement, these innovations would have to be incorporated into the system by the NASCAR-like administrator, but preserving a totally consumer driven market for innovations protects America's advantages in new and novel care.

Conclusion

Empower individuals with a national risk pool featuring individual choice of providers and administrators. Pay for better care, not just more care. Reward well care and prevention. Create an incentive system truly accountable to consumers for quality. Don't accept the current semblance of a market for a system truly responsive to consumers. Also don't create an inflexible single-payer system that doesn't address the problems of health care while trying to solve the health care financing problem.

Daniel Pitts Winegarden
1240 18th St
West Des Moines, IA 50265-2321
515.771.3416
Daniel.winegarden@gmail.com

---

[i] Think of this prospective risk adjustment as a best guess to distribute the cash to keep the system running. This is conceptually similar to what Blue Cross & Blue Shield does with provider payments to hospitals. But there is also an adjustment at the end of the year to make sure that payments reflect real services and not just gaming the prospective risk adjustment formula.

[ii] There is the risk that providers and administrators will game diagnosis codes. Rules to assure uniform reporting are already in place and are enforced in Medicare and Medicaid. At some point misrepresenting diagnosis codes becomes fraud. We have experience assuring uniformity and fairness in reporting. This doesn't require reinventing the wheel.

[iii] At some point in time in the future, with an established track record, it might be possible for the market regulator to assign those not able to choose on their own to a specific administrator with a demonstrated track record of excellence in a particular health risk. Another option would be assigning people at random to a menu of all privately administered plans, but with many low income Americans already in Medicaid, a government safety net system seems a less disruptive change for this group of vulnerable consumers. The decision-making process for allocating dollars to the safety net would change, but this alone would not necessarily be immediately obvious to the patient.

[iv] I use "administrator" rather than "insurer" because the risk pool is national, with a large share of financing through the tax system. An insurer is paid to bear risk (accept a transfer of risk). The administrator is paid to manage risk not bear risk. One of the problems with the current dysfunctional insurance system is that insurers are bearing comparative little risk. They shift risk, often after the fact. We don't mean to, but de facto we are paying insurers to avoid risk, kind of the opposite of the theoretical definition of insurance.

[v] What if administrators have already paid dollars out? How do you take them back? The private sector relies on a variety of escrow and holdback mechanisms that could be used here. The administrator could hold back a certain percentage within the anticipated margin of adjustment. The administrator might also employ a holdback with provider payments during the year to accommodate the potential for a year-end adjustment. Or adjustments might be made in future year payments. Regardless, there are systems out there today that deal with similar prospective payments and retrospective adjustments.