Now is the time to enact a U.S. health care system

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My editorial published in the Summer 2020 issue of *The Pharos* was about the inadequacies of the United States health care system, made all the more apparent by the current pandemic, and possibilities for the future of health care and medicine in our country.[1] The "federalism" response to the COVID-19 pandemic, medicine, health care, and the profession of medicine is not working well and needs to change. A serious societal and public review and plan of action for change is needed with regard to why and how the U.S. must improve overall health care and create a new health care system for all Americans.

The U.S. is the only developed country in the world that has not determined that health care is a fundamental human right. Universal health care should be considered by all as a social good and a national priority. Medicine and health are obligatory public and social contracts, that must be provided in a health care system that is based on exemplary leadership, and stewardship, along with effective governance, policies, and management, in which competence, caring, and character are imperative. If organized properly, the outcomes will be the most compassionate, competent, and professional services providing high quality care for patients, exceptional service to the community, and superb public health.

In the early 20th century, health care was rudimentary, and patients often avoided hospitalization whenever possible. In the second half of the century, science and medicine began to make significant advances in the diagnosis, treatment, and care of patients. Antibiotics, vaccines, new surgical techniques and technology, and public health research, contact tracing and prevention measures emerged. These advances were effective, could save lives, and often relieved suffering. Patient hospital stays and duration decreased dramatically.

As of 1950, it took about 50 years for knowledge in medicine to double. By 1980, medical knowledge was doubling every seven years. And, by 2010, it was doubling every 3–4 years.[2] However, all of this, along with technological advances of the late 20th century and early 21st century came with a dramatic rise in health care costs, and a shift from a not-for-profit service provider to a profitable commercialized business.

The long-standing federalism approach to health care is associated with a lack of leadership, the absence of a solid plan, setup, or organization to manage our national health care. Also it is slow to respond to national and

international issues. It has not worked well and leaves the country's health care system disjointed, confusing, and expensive. The federalism approach, in which all 50 states and five territories each have their own rules, regulations, and financing, has been a barrier to providing health care for every U.S. citizen, regardless of where they reside. This approach also creates inequities in the treatment of citizens from different states or regions and generates a cumbersome decision-making process with the inability to collaboratively implement processes and achieve outcomes for the greater good.

The American College of Physicians recently made policy recommendations to transition to a system of universal health care coverage in the U. S., providing every individual access to affordable health care.[3] However, even under this plan, the corporatization and businessification of medicine and health care will continue to drive many, if not most, decisions in medicine.

One option that is often discussed is a single payor system in which the government is the only payor through tax and other revenues and manages health care as a public and social good. Currently in the U.S., the Military Health Care System, Indian Health Services, Veterans Health Administration, and Medicare are all government single payor systems. Medicaid and the Child Health Insurance Program (CHIP) are jointly funded by the federal government and state governments. All totaled, these government funded programs provide health care coverage for nearly 50 percent of the U.S. population.[4] In other words, the U.S. already has government run, single payor health insurance for half of the population. However, nearly 30 million people in the U.S. remain uninsured.[5]

The other half of the population is covered under their employer-sponsored health plan; is self-insured; or receives coverage through individual market health plans, including ACA-compliant plans; or completely lack any type of health insurance. Through the private health insurance programs, private insurance companies are responsible for paying claims for their members. Hospitals, physicians, pharmacies, and other health care providers each file claims independently.

There is a way to develop, operate, and manage a health care system that would provide universal coverage while also having multiple payers, including employer-based health insurance; i.e., maintaining the private option for half. Through the development of the quasi-independent, apolitical National Health Reserve System (NHRS) proposed in the Summer 2020 issue of *The Pharos*,[1] the U.S. would have a health care system modeled after the Federal Reserve System, allowing for government funded care for half, and private insurance for half.

The role of the NHRS would be to govern, integrate, coordinate, and manage a nationwide system of health care, both private and governmental. It would be far more extensive operationally than the Federal Reserve and would be governed and managed by experts, including physicians, health professionals, and others using data, experience, evidence, and planning to operate a national health care system independently with transparency and quasi- independence from politics.

Former Senator Tom Daschle, S.S. Greenberger, and J.M. Lambrew published the book, *Critical: What We Can Do About the Health-Care Crisis*, in 2008,[6] in which they describe the history of health reform and propose a Federal Health Board modeled on the Federal Reserve System for universal health care. They point out that health care is incredibly complex and that special interests are especially numerous and influential. The book explains that health care comprises one-sixth of the U.S. economy at that time (it is now 17.7 percent of the U.S. GDP). Daschle, et al., explained that the "current mess" is not sustainable, and that the U.S. health care challenge requires exceptional leadership. That was 13 years ago, and the problem remains and continues to intensify.

Dr. Fred Sanfilippo (AΩA, Duke University School of Medicine, 1987, Alumnus) and Steve Lipstein, a former chair of the St. Louis Federal Reserve Bank, both members of the Blue Ridge Academic Health Group (BRAHG), are intricately involved with the group's discussions and recommendations on developing a new U.S. health care system.[7] The group is composed of 15–20 academic health center leaders, health policy experts, and health policy thought leaders, who study and report on issues of fundamental importance to improving the U.S. health care system. The group issued 24 reports, and published a book based upon the initial seven reports, *The Academic Health Center: Leadership and Performance.*[4] A National Health Reserve System was promoted more than 10 years ago by BRAHG, followed by a 2008 policy proposal, "A United States Health Board."[2]

Many professional physician organizations have also advocated for universal health care. Recently, a coalition of the American Medical Association (AMA) and six other associations representing physicians, hospitals, insurance companies, and employers have agreed to pursue universal coverage.[8] The approaches vary from single payor health care to market-based solutions building on the Affordable Care Act (ACA) and federal funding.

The American Rescue Plan Act of 2021,[9] an economic stimulus bill passed as a result of the COVID-19 pandemic, includes numerous changes to health care in the U.S., including:

- Subsidizes 100 percent of premiums for COBRA recipients from April 1 to September 30, 2021. Due to these subsidies, at least 2.2 million additional people will enroll in COBRA in 2021.
- Temporary changes to the ACA:
  - » Removing the "welfare cliff" by removing the income limit on health insurance premium subsidies. Anyone can be eligible for health insurance premium subsidies if the cost of their premiums is more than 8.5 percent of their income.
  - » Increasing health insurance subsidies already available to low-income households. An estimated 2.5 million uninsured people will get health insurance coverage due to these changes. Additionally, about 3.4 million of the lowest income health insurance enrollees will see their premiums fall to zero.
  - » Creating a special rule whereby anyone who qualifies for unemployment automatically qualifies for the maximum amount of health care subsidies.
  - » Protecting any ACA subsidy recipient from clawbacks (a contractual provision whereby money already paid to an employee must be returned to an employer or benefactor, sometimes with a penalty) due to income fluctuations in 2020.

The American Rescue Plan Act also implements changes to Medicaid and CHIP, including:

- Requiring coverage of COVID-19 vaccines and treatment and expanding state options for COVID-19 testing for the uninsured.
- Allowing states to provide 12 months of post-partum coverage for new mothers.
- Introducing new incentives for states to expand Medicaid coverage.
- Expanding eligibility for Medicaid to the 12 states without Medicaid for those who earn less than 138 percent of the federal poverty level and offering to pay 100 percent of the additional costs for three years. (The federal government currently covers 90 percent of the costs for states that have expanded coverage.)

Why universal health care?

Health services and medical care should be available where and when needed and include a full range of health services—health promotion, prevention, treatment, rehabilitation, and palliative care. As a developed, industrialized country, we must ensure that all people, regardless of where or how they live, or their socioeconomic status, have access to high-quality health services without undue financial hardship. Balancing health care and/or life-saving medication(s) against bankruptcy should never be required..

Health care for all, or universal health coverage, is a moral issue. As the COVID-19 pandemic has demonstrated, everyone is vulnerable to illness, and injury, which makes health care a social responsibility. Health care should not be dependent and determined by the ability to pay for the needed care. Universal health care should be viewed as a public investment that contributes to a healthy population and our country's national prosperity and well-being.

A better health care system with universal care for all will achieve the goals and vision of the American College of Physicians:[3]

- Everyone has coverage and access to the care they need, when they need it, and at a cost they and the country can afford.
- Health care payment and delivery systems put the interests of the patient first, and support physicians and care teams in delivering high-value and patient-centered care.
  - » Health care spending is redirected from unnecessary administrative costs to funding health care coverage and research, public health, and interventions to address social determinants of health.
  - » Clinicians and hospitals deliver high-value and evidence-based care within available resources, as determined through a process that prioritizes and allocates funding and resources, and with the engagement of the public and physicians.
  - » Incentives are aligned to achieve better patient outcomes, lower costs, and reduce inequities in health care.
  - » Physicians are freed of inefficient administrative and billing tasks; documentation require-

ments are simplified; payments and charges are more transparent and predictable.

- » Delivery systems are redesigned to make it easier for patients to navigate and receive care conveniently and effectively.
- » Value-based payment programs incentivize collaboration among clinical care teams.
- » Health information technologies enhance the physician-patient relationship, facilitate communication across the care continuum, and support improvements in patient care.
- » Everyone receives unbiased, equitable, high quality health care and services.

As Daschle, et al., stated in 2008, the U.S. cannot afford to continue down the same path of providing some of the most expensive, ineffective health care in the world. In 2020, U.S. health care spending reached 17.7 percent of the GDP, or $3.8 trillion, which amounts to an average of $11,582 per person, or 17.7 percent of an individual's annual spending.[10,11] This was twice as much per capita as 11 other industrialized nations.[12]

In addition, hospital charges increased 41 percent between 2007 and 2014, and the U.S. spends about 200 percent more per capita on prescription drugs than peer countries.[13] And, the administrative costs of health care account for about 31 percent of the total cost of health care in the U.S., which is more than double peer countries. Administrative costs make up 25 percent of hospital costs and 30 percent of insurance companies' costs. Conversely, Medicare administrative costs are 3 percent-5 percent of plan costs.[14]

Shockingly, these exorbitant expenditures are not associated with better health outcomes. The U.S. has a lower life expectancy and higher mortality rates for most leading causes of death, except for cancer, than other developed countries.[15]

There are numerous hidden costs within the U.S. health care system, including the cost of advertising. The costs for research and development by pharmaceutical companies are included in drug pricing and are justifiable. However, the cost of advertising and marketing of drugs by pharmaceutical companies is passed on to the patient as part of the cost of the drug. In 2018, the pharmaceutical industry spent $3.79 billion on television advertising in the U.S.[16] In 2019, the total marketing and advertising budget for "Big Pharma," the top 10 U.S.-based drug makers was $47 billion.[17]

Hospitals, insurance companies, and other health care entities also spend astronomical amounts of money on advertising. In 2019, a survey of hospitals found that the sector spent $11.8 billion on advertising, and a similar survey of health insurance companies found that they spent $22.3 billion on advertising.[18,19] In 2020, these groups also spent $464 million on lobbying Congressional, state, and local politicians.[20]

The how of universal health care

Health care in the U.S., under the current system, is managed in each of the 50 states and five territories for governance, financing, and management. This is ineffective, inefficient, difficult to navigate for patients, and exacerbates the lack of access to affordable care. For instance, a person living in Mesquite, Nevada, who has Nevada Medicaid, cannot access care in nearby St. George, Utah (35 miles away), but rather will have to commute 80 miles to Las Vegas to access care. This is because Medicaid is state specific and not transferrable across state lines.

A national health care system, such as an NHRS, would provide for national access to care, working within and across regions and states to provide health care for all. A two-phased approach to transition to universal health care based on a NHRS would be optimal for all involved.

The federal guidelines for Medicaid are broad, allowing states great flexibility in designing and administering their programs. As a result, Medicaid eligibility and benefits can and often do vary widely from state to state. Medicaid provided coverage for 97 million low-income Americans in 2018—32 million children, 28 million adults (mostly low income working families), six million seniors, and nine million people with disabilities.[21] About 10 million low-income seniors and people with disabilities are "dual eligible" and are enrolled in both Medicare and Medicaid.[21] Medicaid covers certain "mandatory" services such as hospital and physician care, laboratory and X-ray services, home health services, nursing facility services for adults, and early and periodic screening, diagnostic, and treatment benefits for children. About 75 percent of all Medicaid spending pays for acute-care services (including hospital care), physician services, and prescription drugs.[21]

The federal cost for Medicaid in 2018 was $630 billion.[21] The federal government pays about 60 percent of Medicaid costs with the remainder paid by the states.

Health care providers are not required to participate in Medicaid, and many do not. Medicaid has lower payment rates to providers and has moderate administrative costs of about 5 percent-7 percent.[21] Medicaid is effective in providing health insurance coverage to the most vulnerable people.

Unfortunately, Medicaid is administered by the states, and each state's program is unique. Each state has its own Medicaid eligibility standards. However, in all states, Medicaid plays a key role by providing affordable health coverage for vulnerable populations and is the largest source of federal funds to states.

Phase I: A single payor for half

As mentioned above, under the current U.S. health care system, nearly 50 percent of the population is receiving their health care through a federally-funded program—Medicaid, VA, Tricare, Indian Health Services, CHIP, and Medicare. An additional 30 million people are uninsured, which often results in the government picking up the majority of the cost of their care. In essence, more than 50 percent of the U.S. population are already part of a single payor system.

A NHRS could centralize Medicaid and CHIP as a national program for all 50 states and five territories, and have it administered by the national Centers for Medicare & Medicaid Services (CMS) with continuation of Medicaid offices in each state. The eligibility rules would be the same for everyone and coverages would be determined on a regional basis. CMS would fund the system, provide continuity, and provide proper health care management and reimbursement for services, as they do with Medicare. All Medicaid and CHIP recipients would be covered by a comprehensive set of health care services for adults and children. Institutional long-term care would be included as part of the benefits package.

All patients in Medicare, Medicaid, and CHIP would have an electronic "smart" card with their electronic health record, that includes their medical record, billing functions, and other data linked to a central repository. Eligibility and reimbursement of Medicare, Medicaid, and CHIP would be separate, but the process would be integrated. All licensed and certified providers would be eligible to participate in the Medicaid program. Medicare and Medicaid would develop and implement a national fee schedule.

The result would be having more than 50 percent of the U.S. population enrolled in a national health care system under the oversight and governance of the NHRS. This would be transparent to those currently covered under the aforementioned government programs, and by adding. the uninsured under this system, 56 percent of Americans would be insured under a single payor system.

The remaining 44 percent of the population would see no change as they would continue to be covered under their employer-based health insurance system or be self-insured. However, should they lose their job and hence their employer-based health insurance, they could easily convert over to the NHRS system and its national coverage plan.

Phase 2: A transparent system of governance and oversight

The creation of a NHRS by the President and Congress, modeled after the Federal Reserve System, will provide a quasi-independent centralized national governance, policy, and regulatory organization for health care and health care delivery that is evidence and data driven for health care and public health in the U.S.

The new NHRS will develop a health care system that is universal and meets the needs of patients and providers alike. It will focus on health outcomes, patient satisfaction, and the efficient use of resources. It will be run by a Board of Governors that provides broad supervisory control over health care and health care organizations to ensure that the system operates responsibly.

The Board of Governors will be a federal agency consisting of nine governors appointed by the President and confirmed by the Senate, each serving a 14-year term with no option for reappointment, thereby maintaining political independence. The chair and vice chair will be appointed by the President from the existing Board of Directors, confirmed by the Senate, serve a four year term, and can be appointed for multiple terms.

The NHRS will have 12 geographic districts with representation of states in the district included in each regional district. It would have a national Board representative of the 12 districts, and a governing board which would include nine members. No member of the board would serve for more than nine years to ensure full national representation while preserving continuity.

The 12 district boards would predominantly be composed of experts in the medical community – physicians, nurses, and other health professionals – representing hospitals, private practices, clinics, government and private insurance carriers, academic health centers, health care finance professionals, state and local representatives, and those who receive health care services in that region.

The NHRS will organize and utilize experts, data, research, and evidence to evaluate all aspects of health care delivery and funding in the 12 geographic regions and collectively determine the best policies, organization, regulations, cost, and reimbursement in support of improving health care in the U.S. The values of the NHRS will be a commitment to the public interest, quality, excellence, independence, and analysis. Its primary objective will be to

improve the health and well-being of patients, communities, and the entire U.S. through professionalism, innovation, and excellence in doing what is best for Americans. It will forge a collaborative, responsible, organized, federal and state health care system.

The NHRS will work to ensure seamless access to services for patients, regardless of their income, socioeconomic status, geographic location, or other factors. It will work to eliminate health inequities, and promote scientific and practice-based research to improve patient health and clinical care. The NHRS will be politically independent and financially sustainable over the long term.

A healthier U.S.

Under a NHRS, Americans would gain the security that comes with stable, high quality and affordable health care coverage. The NHRS will positively affect people's health and lives. It will be developed based on an existing public and private health care system and will fill coverage gaps with affordable group health insurance.

However, to be successful, the NHRS must be transparent and ultimately accountable to elected officials and all Americans. It should make decisions in public and Congress should subject it to strict auditing and reporting requirements.

The time is now for much needed transformation of the U.S. health care system; the COVID-19 pandemic has made this more apparent than ever. We cannot and must not let this current crisis go to waste.

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