Repositioning fiscal intermediaries in U.S. health care

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Introduction

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Universal health care in the United States is a social good and moral responsibility. It must be a national responsibility and priority, and as such, is gaining support by many organizations—medical, insurance, hospital, business, and governmental.

Medicare, the Military Health Care System, Indian Health Services, and the Veterans Health Administration are already government supported single payor systems. Medicaid and the Child Health Insurance Program are jointly funded by the federal government and state governments and have been expanded as a result of the COVID-19 pandemic. Combined, these programs provide health care to about half of the U.S. population. The other half of the U.S. population is covered primarily under individuals' employer-sponsored health plan, self-insurance coverage, or coverage through individual market health plans, including Affordable Care Act-compliant plans. However, about 30 million people still lack any type of health care coverage.

However, none of this is organized into a national health care system. The U.S. is the only developed country in the world that has not determined that health care is a fundamental human right, and thus does not provide universal health care for its citizens.

The current health care situation, run under a federalist model that allows for 50 disparate health care systems run by the 50 states, is inefficient, ineffective, difficult to navigate for patients, expensive, and lacks oversight and coordination. This approach to national health care has developed with a lack of leadership, the absence of a solid plan, and little to no oversight or responsibility for delivery and outcomes. The system is designed do what is best for business and a profitable bottom line rather than what is best for patients and society.

There are myriad recommendations, ideas, and concepts that have been put forth to develop, operate, and manage a U.S. health care system, including that of a quasi-independent, apolitical National Health Reserve System (NHRS) modeled after the Federal Reserve System.[1,2] A NHRS would allow for government funded care for half of the population and private or employer health insurance for the other half, based on the principle that health care spending provides for the general welfare of all. A NHRS would be far more extensive operationally than the Federal Reserve and would be governed and managed independently and with transparency by experts, including physicians, health professionals, and others using data, experience, evidence, and planning.

In 2008, former Senator Tom Daschle, et. al., published the book, *Critical: What We Can Do About the Health-Care Crisis*, in which the authors proposed a Federal Health Board modeled on the Federal Reserve System for universal health care.[3]

Dr. Fred Sanfilippo (AΩA, Duke University School of Medicine, 1987, Alumnus), and Steven H. Lipstein, a former chair of the St. Louis Federal Reserve Bank, are both members of the Blue Ridge Academic Health Group (BRAHG). The BRAHG has been engaged in discussions on developing a new U.S. health care system. It is composed of 15 to 20 academic health center leaders, health policy experts, and health policy thought leaders, who study and report on issues of improving the U.S. health care system. The group has issued 24 reports, and published *The Academic Health Center: Leadership and Performance*. A National Health Reserve System was proposed more than 10 years ago by BRAHG, followed by a 2008 policy proposal, "A United States Health Board."[4]

In addition to their work with BRAHG, Sanfilippo and Lipstein have continued their studies in health policy. Their proposal that follows reviews the issues of health care affordability, access, and disparities that remain major problems in the U.S. They consider the role, effects, and limitations of the fiscal intermediaries, and recommend that federal and state governments take collective action

to make bold and transformational changes necessary to improve health care affordability, access, and disparities.

Theirs is yet another proposal that deserves consideration as our country grapples with its health care conundrum. While we may have varying ideas as to how to accomplish universal health care in our country, we all agree that the time is now for much needed transformation of the U.S. health care system.

Repositioning fiscal intermediaries in U.S. health care

Steven Lipstein, MHA; Fred Sanfilippo, MD, PhD

Health care affordability, access, and disparities remain major problems in the U.S. Most remedies focus on modifying the behavior of health care consumers and producers employing policy and procedural tactics that are implemented by fiscal intermediaries—those who provide and administer health insurance. These intermediaries influence how, what and where health care is paid for, who does the buying, and at what price. Fiscal intermediaries have attempted to reduce costs and disparities, but these attempts have produced only marginal results leaving the trajectory of rising costs and disparities largely unchanged.

We suggest repositioning these intermediaries by reducing the number of public options offered by federal and state governments, and regulating and supervising private health insurance through large multi-state regional districts. Consolidation and streamlining of the existing financing infrastructure would eliminate complexity and non-value-added duplication, and has enough potential benefit for all stakeholders to be worthy of serious consideration. New market dynamics could improve the ability of fiscal intermediaries to favorably influence health care affordability, access, and disparities.

In 2008, when Joe Biden became Vice President of the U.S., the nation's health policy makers were determined to guarantee access to affordable health care and reduce health disparities. The Affordable Care Act (ACA) was a step toward greater access, with protections for people with pre-existing conditions as well as Medicaid expansion and insurance exchanges offering government-subsidized options. Now, a dozen years later, Biden is President and health care affordability, access, and disparities are still major problems.

In U.S. health care, fiscal intermediaries who provide and administer health insurance are brokers between the consumers of health care services (i.e., the taxpayer and/or premium payer) and the producers of health care services (i.e., health care providers and suppliers). They play a key role in the quest for greater affordability and access because they influence how, what, and where health care in America is paid for, who does the buying, and at what price.

Two economic segments

The health insurance marketplace has two large economic segments: a public market and a private market. The public market includes health insurance programs for which government pays the cost of insurance for beneficiaries and serves as the fiscal intermediary between consumers and producers either directly or through private contractors. This market segment includes Medicare, Medicare Advantage, Medicaid, Medicaid Managed Care, Department of Defense Tricare, and Veterans Administration Health. The private market includes those health insurance programs where employers or individuals pay the cost of insurance, and private health insurance companies serve as the fiscal intermediary. Each market insures a population of relatively equal size (approximately 150 million), and accounts for roughly half of the $4 trillion spent on personal health care in 2020.[5,6] It is estimated that approximately 12 percent of people under 65 years of age are not insured, and therefore not counted in either market segment.[7]

When the government serves as the fiscal intermediary prices paid to producers on behalf of consumers are legislated or regulated by the government. When a private insurance company serves as the fiscal intermediary the prices paid on behalf of consumers are negotiated between the intermediary and the producers. Over time, this legislated vs. negotiated distinction has given rise to multiple payment mechanisms, opaque producer pricing, regional variability in health care cost per capita, and an embedded system of cross-subsidies wherein public payers (Medicare and Medicaid) pay prices that are often below the cost of care, while private payers pay prices above cost to cover the public payer shortfall.

Public policy changes are imminent

The federal government is facing two ominous fiscal milestones in the next decade. First, the Medicare Trust Fund is forecast to begin deficit spending during President Biden's first term in office.[8] Second, between 2021 and 2030, the Congressional Budget Office (CBO) is forecasting a cumulative federal budget deficit of $13 trillion (five percent of GDP), culminating in public debt of $33.5 trillion, more than 100 percent of GDP.[9] It is safe to assume there soon will be a flurry of proposals to address these deficits.

President Biden is considering new public options for health insurance. Presumably, any new option would help capture a high percentage of the presently uninsured, and assuming a government subsidy would cap premiums as a percentage of income, would be more affordable for some Americans. Whether or not a new public option can move forward in today's political environment is unknown. Equally unclear is how the addition of yet another health insurance option will lower costs.

Reigning in costs and reducing disparities are not easy as leaders at Amazon, JP Morgan and Berkshire Hathaway learned all too well when Haven Healthcare, their three-year joint venture to transform health care, failed to achieve its stated objectives and shut down earlier this year.[10] As the Biden Administration and Congress consider new policies, it is timely to reassess the potential of current proposals to improve health care quality and access, and lower costs.

Single payer: Some believe the solution is to do away with the private market altogether and move to a single payer "Medicare for All" financing system that drives costs to government-set price points. Medicare is popular with the American public, and many Americans can see the advantages of national health insurance. However, too many others, including health care providers, insurers, and suppliers, are opposed to total government control of the health care system. They worry that the absence of widely available private options would reduce quality, choice, and access, and increase overall costs. Doing away with the private market would be a formidable undertaking as almost half of the U.S. population already has private insurance. Moreover, a number of U.S. citizens are shareholders of these companies, the largest of which have a combined market capitalization of more than half a trillion dollars.[11]

Capitation and pay-for-performance (e.g., value-based purchasing): Some believe the solution is to change the payment mechanism within both public and private markets from fee-for-service to capitation and pay-for-performance, thereby creating financial incentives for providers to reduce utilization of unnecessary services and increase utilization of value-added services. Health maintenance organizations (HMOs), the original model for health care capitation, have been around for more than 50 years. HMOs currently enroll about 70 million Americans, including almost 40 percent of all Medicare beneficiaries through Medicare Advantage.[12] And while HMOs have positive attributes, especially an emphasis on wellness and prevention, many Americans are wary of a financing system that serves as gatekeeper and pays their health care providers a per capita amount of money regardless of what the patient's health care needs may cost.

After years of growth in capitation and pay-for-performance financing systems, health care expenditures continue to outpace inflation and economic growth, nearing 18 percent of the nation's GDP.[5]

Financial penalties: Some believe that financial penalties, such as Medicare's Hospital Readmission Reduction Program, would eliminate regional variation in health care costs and utilization. However, simply comparing providers that serve different populations can be misleading and applied inappropriately. It has been well documented that socio-economic factors such as household income, high school graduation rates, crime and substance abuse rates, and the availability of neighborhood resources such as transportation, housing, and grocery stores have an impact on health care costs and health disparities.[13]

Price transparency: Some believe that if prices are visible to consumers, they will redirect purchases to lower priced options. Price transparency can only bring down costs if all payers in both markets pay the transparent price. To illustrate the unintended consequences of price transparency, consider the impact on two X-ray providers. Both X-ray providers sell only four X-rays, and both have identical costs of $100 per X-ray, or $400 total cost. Medicaid legislates to pay both providers $70 per X-ray. Medicare legislates to pay each of them $100, and they each get to negotiate private payor rates independently with commercial insurers.

Provider A serves Medicare, Medicaid, and uninsured patients and sells one X-ray to each. Before selling the fourth and final X-ray, Provider A has collected $170 to cover the $400 total cost; therefore, it needs to charge $230 to one commercially insured patient to break even.

Provider B chooses not to serve Medicaid or uninsured patients and sells two X-rays to Medicare patients receiving $200. To break even, it need only charge $100 to two commercially insured patients to collect a total of $400.

Because X-ray prices are increasingly transparent in this market, Provider B knows that Provider A has a commercial price of $230. To be competitive, Provider B charges two commercial patients only $200 each. That makes Provider B's net collections $600 on a cost base of $400 for an operating margin of 50 percent.

Provider A is left with two choices: lower commercial price to be competitive, fail to cover total cost, and ultimately go out of business, or lower commercial price and stop caring for uninsured and/or Medicaid patients. The net result is that either health care costs rise with commercial prices or disparities increase with reduced access

for Medicaid and uninsured patients. Providers that limit access to uninsured and Medicaid patients have a strong financial incentive to push for greater price transparency.

So long as Medicare and Medicaid pay legislated prices that are not determined by supply and demand, or by the cost of goods sold, price transparency will result in reduced access for populations whose payer is associated with economic loss.

Repositioning the fiscal intermediaries

While the strategies described above are well-intended, they are targeted at modifying behavior of consumers and producers of health care services. They ignore the costs of operating and regulating the public and private insurance markets (the fiscal intermediaries) and sidestep the question of whether intermediaries are well positioned within the health care financing system to modify consumer and producer behavior.

From a demographic perspective, higher health care costs are seemingly hard-wired into our future. The U.S. population is increasing and aging, forecast to be 360 million by 2030, with one in five Americans projected to be 65 years of age and older.[14] The same can be said of health disparities, which are hard-wired to social and economic disparities that are also on the rise. The gap in life expectancy between the richest one percent and the poorest one percent is almost 15 years for men and 10 years for women.[15] A transformational repositioning of the public and private fiscal intermediaries may strengthen their role in reducing costs and disparities, and change the trend lines from the current trajectory.

Fiscal intermediaries in the public market broker more than 50 options. For seniors, there is Medicare. For active military and their families, there is Tricare. For veterans, there is VA Health. And for a high percentage of the nation's low-income population, there is Medicaid, funded roughly two-thirds by the federal government and one-third by the states. Because Medicaid is administered by the states, 50 state legislatures (with their diverse political composition and ideology) are involved in determining state-specific eligibility criteria, designing state-specific benefit plans for those who are eligible, and deciding state-specific payment rates for the health professionals and hospitals who take care of the beneficiaries. Such a fragmented and decentralized system of health insurance for low-income Americans, immersed in the politics and bureaucracies of state government, contributes to higher costs and health disparities.

Fiscal intermediaries in the public market (federal and state governments) could migrate to provide fewer options beginning with consolidation of Medicaid into an expanded Medicare program to eliminate the inefficiency and inequity of administering more than 50 state/territorial health insurance programs. Standards for eligibility, benefit design and payment programs could be established, and nothing would need to change for current Medicare beneficiaries. For others, including children, eligibility could be limited to those with household incomes below a certain percentage of the national median, guaranteed for 12 months, and automatically determined by the prior year's federal income tax return.

The benefit design and payment systems of this expanded Medicare program would need to include the full spectrum of age cohorts and address the special needs of added beneficiaries. If this strategy proves to be effective at reducing the number of uninsured, eliminating gaps in insurance coverage, improving benefit design, and lowering costs and disparities, the migration could continue with consolidation of other public market programs (e.g., VA Health).

Fiscal intermediaries in the private market broker numerous health insurance options offered to individuals directly or through employer-sponsored plans, all regulated by the states. This state-based framework is outdated and no longer responsive to the size and geographic reach of the nation's private health insurance companies and employers. The largest of these insurers and employers have grown to be multi-billion-dollar, multi-state, even multi-national companies, and would benefit from greater consistency across state boundaries.

Federal and state government working together could establish large multi-state regional private health insurance districts chartered to regulate and supervise the private health insurance sector. Districts could be sized to encompass populations sufficient for private insurance companies to strengthen actuarial integrity and stability. States could realize economies of scale and reduce the cost of regulatory burden characterized by 50 jurisdictions. Offering insurance products at the regional level would also stimulate more choices and greater competition. Some states may be large enough to be districts unto themselves. Smaller states could work together to create larger districts, creating more inclusive and sustainable risk pools. District boundaries need not conform to state boundaries if other geographic aggregations are compelling.

Each district could have its own governing body with delegated authority that is consistent across districts. These governing bodies could be appointed by the states that make up each district, with representatives of the

public, employers, health care providers, and insurers. A national coordinating group comprised of representatives of the regional boards and national representatives appointed by the federal government could provide guidance, alignment, and oversight of interactions among the regional districts.

The federal government previously has chartered such public-private multi-state governing bodies to regulate the private banking sector, i.e., the Federal Reserve System in 1913, and the private health care delivery sector, i.e., the National Organ Procurement and Transplantation Network in 1984.[16]

Dividing the country into regional districts is not a new concept. The Federal Reserve has 12 district banks and the VA has 18 Veterans Integrated Service Networks. The creation of regional districts as a model for health care delivery has been previously suggested in a 2008 report by the Blue Ridge Academic Health Group,[4] and Dr. Richard Byyny in recent editorials in *The Pharos*.[1,2]

Costs and benefits

Repositioning fiscal intermediaries in the public market by consolidating Medicaid into Medicare would require an increase in Medicare payroll taxes of $225 billion to $250 billion to cover the state's one-third share of Medicaid expenditures, and assuming a 15 percent differential, an allowance of $90 billion to $100 billion to raise Medicaid payment rates to Medicare levels. In context, such a proposal would cost less than the Medicare Modernization Act of 2004, and less than the ACA of 2010. While still unknown, this repositioning of the fiscal intermediaries could cost less than new public options being considered by President Biden. If budget neutrality becomes a political necessity, $350 billion is approximately six percent of the federal government's fiscal year 2021 $5.1 trillion budget,[9] and budget offsets would need to be identified much as they were for the ACA.

Would repositioning fiscal intermediaries, offering fewer options in the public market, and a streamlined regulatory framework in the private market be effective at modifying consumer and provider behaviors to improve health care delivery? It seems likely that reducing overhead and variation in the public market, and increasing market size and competition in the private market would each have a favorable influence on cost, access, and quality of health care services.

Consider that Medicare would cover half of all Americans, including those who by virtue of age and/or income are most likely to utilize health care services and are most likely to benefit from improvements in access, quality, and cost of care. If the eligibility threshold for added Medicare participation was set at 75 percent of median household income, approximately 60 percent of the uninsured (17.5 million) would be covered.[17] While that might seem to be another incremental expense, the cost of caring for the uninsured is already built into producer pricing. Recalibrating prices should neutralize the impact on Medicare.

If Medicare pricing were adopted for all its beneficiaries, the financial burden of subsidizing below-cost prices in the public market with above-cost prices in the private market could be lessened, if not eliminated. Eliminating that cost-shift, and adding to the purchasing power of private market fiscal intermediaries by enlarging risk pools, should reduce producer pricing and private insurance premiums. Policy variation across the national network of regional districts would provide a means to identify best practices while new private market dynamics should reward innovation, quality, and efficiency.

Impact on stakeholders

The federal government would fund the increased costs of consolidating Medicaid with Medicare, but would have greater fiscal control over Medicaid spending (for which it already pays two-thirds of the cost), and would have greater influence over health care benefit design and administration for all taxpayer supported health care.

The states and territories would no longer have financial obligations for Medicaid and could eliminate the state-level bureaucracies that administer Medicaid programs. The savings of $225 billion to 250 billion would alleviate some of the financial strain on states' budgets and allow for other state and local priorities. Some states may have unfunded spending priorities while others may favor a state tax reduction to offset the increase in the Medicare payroll tax.

Private insurers would be able to develop multi-state (within district) health insurance products to enlarge and stabilize insurance risk pools and realize economies of scale and geography. Through the lens of private insurers, regional district regulation and supervision is preferable to either a single payer or new public option.

Health care providers would be able to work with one public insurance plan instead of two (or more), bringing consistency and parity to payment rates, data requirements, and coverage for low-income Americans. In most parts of the country, health care providers receive better reimbursement from Medicare than from Medicaid, making this an opportunity to reduce the financial burden of the public to private payor cost shift.

The public would receive a more rational system of health insurance. Seniors who rely on Medicaid for long-term care coverage and Medicare for health care coverage get one plan for both types of care. Children living in low-income households would have access to the services necessary for optimal health. Most working age adults have employer-sponsored private health insurance and would be able to keep what they already have. Half of the population would be covered by one public option (Medicare) that insures everyone over age 65 years of age and everyone with low household incomes, and the other half by employer-sponsored private health insurance with guaranteed and affordable choices.

Altering the trajectory

Change management is not a core competency of either federal or state government. Altering the trajectory of health care affordability, access, and disparities will demand transformational change. The current COVID-19 pandemic, and its impact on the health and economy of the U.S., has caused political leaders to act boldly. Hopefully, policy-makers have learned that the health of all citizens can be improved when we act collectively as a nation. Repositioning the fiscal intermediaries in American health care requires that federal and state governments again take collective action as a nation to make the bold and transformational changes necessary to improve health care affordability, access and disparities.

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