

CodeBlueNow! Models for Reform

A HEALTHY AMERICA: A PROPOSAL FOR REFORMING THE UNITED STATES HEALTH SYSTEM

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EXECUTIVE SUMMARY (Pages in proposal indicated by a slash followed by a number, ex. "/12").

This system will have a national body that will define and establish basic healthcare coverage. Healthcare will be seen as nothing more than a public utility that is available to all. Individual and families will receive vouchers from the government to purchase healthcare, ranging from \$2000 to \$18,000, depending on health risks, to purchase healthcare coverage. /EXSUMM

The management of the proposed system will be a Health Commissioner at the federal level with appointed state and county Directors of Health Services. Each county will have a regional board comprised of representatives from all healthcare stakeholders, including individuals. The Health Commissioner, state and county Directors of Health Services, and local boards will be responsible for the financial management, establishment of benefits, quality assurance, and other functions. The Health Commissioner will oversee the appointments of Healthcare Directors for each state and county. /EXSUMM

This model is similar to the public education system presently in existence and available to all. /4

A national panel appointed by the President will determine basic benefits and will be review annually. Special interest groups in healthcare, which have a vested interest in maximizing coverage for their services, will not be included in the panel. Explicit legislation will defined a standard definition of medical necessity for all insurance products. /5

With strong government backing, it will take about two-years to put this system in place.

DELIVERY SYSTEM

Individuals and families will receive vouchers to purchase basic healthcare from a private insurer or the government. A national panel appointed by the President will determine basic benefits and will be reviewed annually. Special interest groups in healthcare, which have a vested interest in maximizing coverage for

their services, will not be included in the panel. Explicit legislation will define a standard definition of medical necessity for all insurance products. All insurers must provide medically necessary care available within the limits of the basic or extended benefits purchased. /5 Benefits will include at a minimum, all medical care deemed medically appropriate by the patient's health care provider, including inpatient and outpatient care, diagnostic tests, prescription medications, durable medical equipment, podiatry, dialysis, medical transportation, language interpretation, preventive care, long-term care services, mental health care, and dental and vision benefits. /5

There will not be a minimum charge, and coverage of the basic benefit cannot be sold for more than an age-adjusted price (ceiling price). /5

All licensed providers have the option to participate in the government insurance product and any may construct contractual arrangements with designated health plans. /5

The 20% of patients denied coverage will be contracted under a separate group plan which automatically extends coverage to members of the group (patients with pre-existing conditions such as HIV, diabetes, cancer, heart disease, etc). High-usage patients would be encouraged to attend wellness program through the use of incentives such as discounts on premiums and doctor and hospital co-pays. /8

The government will hold an auction among local healthcare providers interested in coverage for this high-usage group. The local provider will have a monopoly for providing coverage for this group. /8

To trim costs, risks will be shared. For example, if the actual costs were \$900,000 on a bid of \$1,000,000, the government will split the \$100,000 saved. The health care provider would be paid \$50,000 more than their actual \$900,000 costs. If the true costs turned out to be \$1,100,000 then government would equally share the \$100,000 additional expense. /8

If a provider discovers an at-risk member they can simply transfer them to the adversely selected group plan. /8

Those wishing to opt out of the plan will be able to work through the providers directly or purchase additional coverage from local health plans. Individuals that fail to choose a health plan or access their voucher will be defaulted to the government plan. /5