The Rolling Hills Group
Health Reform Proposal

Executive Summary

February 2009

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Healthcare Reform

The Need for Healthcare Reform

Many Americans believe the United States has the best medical system in the world, but what we have is the largest, most expensive system. We spend more on health care than any other country, but fall behind most other developed countries on quality and access to care.

Health spending in the U.S. was an estimated $2.4 trillion in 2008, an average of $7,868 per person. The share of the economy (GDP) devoted to national health spending has increased from 7.2 % in 1970 to an estimated 16.6 % in 2008. This level of spending cannot be sustained.

Historically, the focus of reimbursement has been toward acute care encounters with limited resources for wellness, prevention and maintenance for those with chronic diseases, and no incentives for providers to coordinate care and work together to provide the best outcomes for patients. The system forces U.S. citizens to illness before there is reimbursement, resulting in the provision of more intense services and institutional care.

Healthcare costs threaten the international competitiveness of U.S. manufacturers who now spend more than twice as much for healthcare benefits than their foreign trading partners.

Nearly 47 million Americans lack health insurance. Research clearly documents this lack of coverage impacts access to health care and, ultimately, health outcomes. The high number of uninsured also creates a system of cost shifting where those with private insurance subsidize the costs that providers incur caring for those who cannot pay.

The Rolling Hills Group agreed its overall charge was to develop a reform plan for Tennessee that can serve as a structural model for other states and the nation, and established the following goals:

Goals for Healthcare Reform

1. Universal insurance employing a mix of private and public structures and funding.
2. Health system reforms that produce a higher value for the dollars spent on care and increase the use of best practices and evidence-based decision making.
3. Funded through changes to the federal tax code and the better use of existing funding and resources without adding new costs.

Federal Reform

The Rolling Hills Group realized true reform in Tennessee was not possible without national structural reform. Changes to the federal tax code are required to better use funds and provide subsidies for low-income residents, and ERISA plans cannot participate in state-based reforms because they operate under federal law.

Universal Coverage via a Structured Private Insurance System

Coverage would be provided through private insurers that agree to participate in state or regional health pools overseen by a Federal Reserve-like regional regulatory mechanism, hereinafter called the Federal Health Reserve (FHR) system. The FHR, insulated from politics, would organize and negotiate a range of health plans, using the Federal Employees Health Benefits Plan (FEHBP) structure, for individuals and families to purchase in each state or region. The FHR would act as a "connector" to facilitate the selection and purchase of private insurance plans by individuals and businesses.

The way in which the private insurance market currently operates is a disadvantage for small groups, individuals with health problems and older individuals. Participants in the risk pool would operate under the following reforms in order to achieve accessible and affordable insurance:

- Guarantee issue and prohibition on pre-existing condition exclusions.
- Use modified community rating to determine pricing.
- Operate within guidelines for participating payer profits, and make medical loss ratios and other information to characterize payer performance public.
- Provide participating employers annual plan and group utilization reports.
- Accept administrative simplification.

Plans offered through the risk pool must include benefits that provide coverage for inpatient and outpatient services, enhance the management of chronic diseases, and encourage prevention services and the use of evidence-based medicine. The cost of the plans would be based on the actuarial value of a minimum benefit package. Insurers would be allowed to create various copayments, deductibles and other benefit designs to provide consumers a choice of plans best suited to their needs. The group recommended having a standard plan with a deductible rate of $750 for individual policies and a similar deductible for each family member under family plans, indexed to inflation.

Subsidies for Those with Lower Income

- A system of subsidies or "transfer payments" to qualified plans through the tax code (refundable tax credits) will guarantee payment of premiums and coverage under a basic insurance benefit for the lower income uninsured who cannot afford to buy coverage.
- Tax subsidies will be limited to the "actuarial value" of a Blue Cross Standard Option PPO, with a $750 deductible indexed to inflation.
- Tax subsidies would be paid directly from the U.S. Treasury to the plans participating in the risk pool on behalf of the lower income uninsured.
- Individuals eligible for subsidies must have been uninsured and not have had access to employer-subsidized insurance for the 12-month period prior to receiving a subsidy.
- Individuals with income less than 150% poverty would receive full subsides.
- Individuals with income from150 % to 350 % of poverty would receive partial subsidies on a sliding scale.

Funding the Subsidies and Cost of Administering the Federal Program
Funding will be generated through changes to the federal tax code that would increase taxable income for individuals and reduce deductible business expenses for employers by the value of health insurance benefits that exceed the actuarial value of the FHR standard benefit plan beginning in 2010. For example, if a business provides health insurance benefits to their employees that cost $6,000 per year per employee and the actuarial value of the FHR standard plan is $5,000 per year, the employee would be taxed on the additional $1,000 and the employer could only deduct $5,000 as a business expense.

From 2010 to 2019, the deduction to employers would be further phased down to 50 % of the actuarial value of the FHR base plan ($2,500 in the example above) to discourage employers from over-subsidizing health costs--and encourage purchasing insurance via the FHR plans.

As uninsured levels fall, public spending on existing provider subsidies for indigent care also should fall and be recaptured to buy insurance for low-income beneficiaries. At least $50 billion per year in 2010 dollars is spent on these costs for uncompensated care today.

The federal tax code change is estimated to increase federal tax revenues by $70 billion a year in 2010 dollars when fully phased in, and in a system with far fewer uninsured, $30 billion a year could be recaptured for financing coverage for the uninsured.

Phasing in the Plan
The plan first would require coverage in 2012 for higher income individuals who are above 350 % of poverty and can afford to purchase health insurance and for the most vulnerable, lower income individuals with income less than 100 % of poverty who would have fully subsidized insurance. By 2019, all Americans would be required to have coverage. Full subsidies would be available for those with income less than 150% of poverty and sliding scale subsidies would be available for those with income from 150 % to 350 % of poverty.

Enforcement of the Coverage Requirement
Enforcement of the insurance requirement should be through an individual's or family's normal interaction with government, without creating a new bureaucracy. For example, enrolling a child in school, applying for a driver's license or other services could be denied to those without coverage. Individuals without coverage could then be referred to the risk pool to obtain coverage or be randomly assigned to a participating plan. Individuals encountering the health system (hospitals, etc.) without credible health insurance coverage would be randomly assigned to a qualifying FHR plan. The cost of their premiums would become IRS tax liabilities if they did not pay. For lower income individuals who qualify for subsidies, the subsidy amount would be paid by the U.S. Treasury directly to the qualifying plan and any remaining balance would become an Internal Revenue Service (IRS) tax liability.

Impact on the Current Insurance System
Individuals who lack access to health insurance would have choices of affordable private plans through the FHR system. Employers that currently provide fully insured products to their employees and self-insured ERISA plans could move their employees into the more affordable FHR system. These employer-sponsored plans could continue to operate outside of the federal health insurance system, but would participate in risk pools via "risk adjustment" methodologies to avoid systemic medical underwriting. Plans with higher risk patients, including ERISA plans, would receive payments from the pool to lower premiums. Those plans with relatively lower risk would make additional payments to the pool.

Resulting System: "Everyone in the Pool"
This reform would result in an insurance system, covering all Americans not eligible for Medicare, Medicaid, or the state children's health insurance program (SCHIP) with private, well-structured insurance products, in a modified community-rated system.

- Uncompensated care rates would be expected to fall below 2 % (some aliens and unpaid deductibles) and providers would be compensated for the bulk of care.
- Expensive tax subsidies that create incentives for excessive insurance for high income workers will be reduced, and redistributed as subsidies to lower income Americans.
- Coverage and utilization decisions will be depoliticized via the federal health insurance boards, resulting in a better allocation of resources.
- Universal private insurance would be provided to all who are not eligible for Medicaid, Medicare or SCHIP, with a rational level of public oversight.
- The estimated cost of universal insurance for a basic plan in 2010 dollars is $100 billion and that cost could be covered with the funding mechanism established in the plan. *(IOM report adjusted for inflation; also see Moran estimate.)*

Additional Federal Reforms

- Return to the original rules concerning direct to consumer advertising for prescription drugs, which effectively limited television and other electronic media advertising.
- The Federal Health Reserve system should make drug coverage recommendations that would guide plan formularies for cost and effectiveness. States and the federal government should make comparative effectiveness research a priority, and assist providers and consumers in accessing objective information about drugs and medical devices.
- Pharmacy benefit managers should provide increased transparency concerning drug costs and utilization.
- Health information technology initiatives to improve quality and reduce costs.
- The Federal Health Reserve system and other agencies of the federal government, including the Centers for Medicare and Medicaid Services (CMS), should develop payment methodologies that better align payments and provide incentives for coordinated care.

Tennessee Reform

Individual Coverage Requirement and Enforcement in Tennessee
The Rolling Hills Group's plan would allow Tennessee to begin implementation of universal insurance for those who qualify for existing programs, as well as those who reasonably could afford private insurance. The specific insurance coverage reforms that would be implemented in Tennessee prior to federal reform that would not create additional expenditures for the state are:

- By 2010, all Tennesseans in families with incomes above 400 % of poverty would be required to have at least the basic health plan offered through the insurance pool or have other public services disallowed (licenses, benefits, etc).

- By 2010, children in families with incomes up to 250 % of the federal poverty level should be required to enroll in Tennessee's CoverKids program.

- Enforcement of the insurance coverage requirement should be through an individual's or family's normal interaction with state government, without creating a new bureaucracy.

- In order to implement Tennessee reform within the framework of federal reform recommended by the Rolling Hills Group, beginning in 2010, Tennessee should create a risk pool that would be designed as described under federal reform.

Healthcare Delivery System Reforms to Be Tested in the State and Implemented at Both the State and National Levels

An important part of reform that must work in tandem with universal coverage and insurance reforms is health system reforms. These reforms should increase quality, align provider payments and produce better health outcomes. Tennessee could serve as a laboratory for healthcare financing and delivery system reforms that ultimately could be adopted at the federal level. Specific activities recommended by the Rolling Hills Group include the following:

Outcomes and Quality

- Design and test new methods of provider education that foster adoption of best practices through demonstration projects that can be incorporated into reform as coverage through a risk pool is phased in.
- Leverage national research organizations and Tennessee's medical schools and universities to develop ongoing review of all elements of the healthcare system.

Payment Reform

- Test new models of payment that better align incentives among providers.
- Evaluate new payment systems that include incentives for providers who successfully treat chronic care patients, including a medical home model.
- Require payers to have plans evaluated periodically to ensure payment is supporting the use of primary care and services that assist in disease management.
- Evaluate alternative payment and delivery models that emphasize health and wellness.

Transparency

- Develop and encourage the use of standardized quality measures.
- Provide patients and purchasers information concerning cost and quality of providers and insurers.

End of Life Care

- Evidence-based medical research should enhance information and understanding about end of life care.
- Tennessee should have an ongoing education effort concerning living wills, advanced directives and health proxies.

Tort Reform

- Tort reform should be studied as part of Tennessee reform and at the national level.
- The liability system should be reformed to minimize risk for providers who follow evidence-based guidelines.