CAUSE

Quality, Affordable Health Care for Everyone

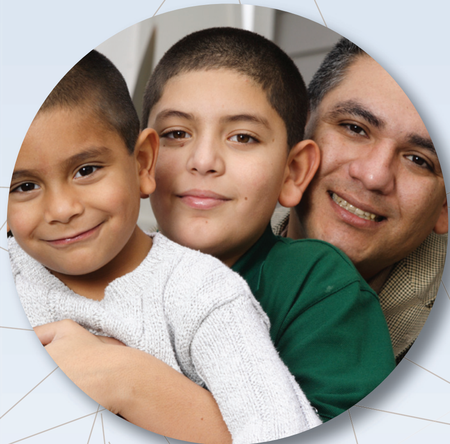
Steven H. Chooljian, M.D.

John Capitman, Ph.D.

Mohammad Rahman, Ph.D.

Kudzai Nyandoro B.S.

Brian Yengoyan B.S.



CENTRAL VALLEY HEALTH POLICY INSTITUTE

California State University, Fresno

INTRODUCTION

The CAUSE approach, a unique solution to the current health care system, was created in response to a conversation between a Central Valley physician and his unsatisfied patient. After their discussion, the physician collaborated with the Central Valley Health Policy Institute, California State University Fresno to help design a practical approach to health care that would work for everyone. Their insight into health inequalities in the Central Valley gives their plan a perspective that works for different places while maintaining patient/doctor relationships and the quality of health care that many in the U.S. already enjoy.

The U.S. health care system is rich in resources. Our hospitals boast sophisticated equipment and most physicians and nurses are well-trained, with remarkable dedication to patient care being the norm. We fund health care more generously than any other nation in the world, yet in the midst of this abundance, there are at least 47 million people uninsured and many more are underinsured, with lapses in coverage. Despite spending more than twice as much on health care than other developed nations, we trail the industrialized world in life expectancy and infant mortality. The lack of health care for everyone affects the health of individuals, families, communities, businesses and our nation as a whole. The Institute of Medicine has identified five basic tenets to guide reform and provide the quality health care system that our nation needs. Health care reform must be:

C: Continuous

A: Affordable

U: Universal

S: Sustainable

E: Effective

CAUSE health care is essential to ensure a healthy, dynamic, productive society.

THE CAUSE APPROACH: A 15–YEAR IMPLEMENTATION

The CAUSE approach is built on the foundation of Medicare. Renamed CAUSE, this new plan expands coverage to the American public over a period of 15 years, ensuring systems are sufficiently in place to provide quality health care for everyone.

CAUSE: YEARS 1–5

In this first phase a new national basic care system for children is established, adults 19–64 will have the option to purchase public primary and preventive care coverage, and the Medicare program for the aged and disabled is updated. Important reforms made to promote healthy behaviors, make private insurance more affordable, increase the use of evidence-based care, and improve the capacity of health systems to deliver needed care.

Children Ages 0–18**:** Beginning in 2010, during the first five years of implementation, children 0–18 will be covered by CAUSE, an approach modeled on Part A and Part B of the current Medicare system. CAUSE will be used as a foundation that will provide all children with basic coverage for health care. There will be income-adjusted premiums. Families can continue with private insurance plans if they offer comparable benefits. There will be an option to purchase additional coverage in the form of private wraparound plans for deductibles and co-pays. There will also be the option to purchase a private supplemental plan for benefits and services not included in the basic CAUSE plan. This will ensure health care for every child, but it will preserve the choice of coverage that the U.S. already enjoys. CAUSE will also maintain the quality of an individualized patient/doctor experience and still not exclude those in the U.S. who truly cannot afford health care for their children.

To encourage the continued purchasing of high-quality, individualized, private plans, incentives will be enacted for private citizens and corporations. Parents who purchase private insurance may deduct the CAUSE costs for qualifying plans. Large firms employing more than 200 employees will receive tax deductions if they offer qualifying plans to employees' children while small firms employing less than 200 employees will receive tax credits if they offer qualifying plans to employees' children. Eligibility for CAUSE will

be determined through tax returns and for those who do not file taxes, annual eligibility determination will be made by state Medicaid programs. A national minimum eligibility for Medicaid will be at 150 percent of Federal Poverty Level (FPL).

CAUSE deductibles and long-term care for beneficiaries ages 0–18 will be paid by individuals through private wraparound plans or by Medicaid. All services will be funded through a financial transaction tax and maintenance of current funding, and increased taxes on tobacco products. Respective national, state and sub-state elected health boards will help create the standards for the CAUSE coverage so that the plans will encompass the needs of the individuals and specific populations within states and sub-state regions. This will help states and sub-state regions to maintain personalized coverage for the unique needs of people in their communities. The newly established health boards will also certify private plans as alternatives to CAUSE coverage. Funding levels for specific health boards will consider both population and health system features, so that regions with health care access and quality challenges have the opportunity to invest in system improvements. The Federal Medical Assistance Program (FMAP) will be changed to provide increased federal funding to large sub-state areas with populations of more than 500,000 people that are poorer than their state averages. This would directly enhance the access to and quality of care. Medicaid payment rates to providers and hospitals will be equal to those of the CAUSE plan.

Adults Ages 19–64: Individuals ages 19–64 will have an option to buy into what is currently Medicare Part B, with an emphasis on outpatient, primary care, and preventive services. It will provide an affordable health care alternative without strangling the private insurance market or interrupting health care coverage that some people prefer. Inpatient services, which are currently a part of Medicare Part A, will remain with private insurers. These plans will be purchased separately from outpatient services and will be coverage for catastrophic care. The quality of care provided currently will not be lowered, but there will still be basic core coverage for primary and preventive services at affordable costs for everyone in this age group. Medicaid will remain as currently designed for persons ages 19 and older.

Primary and preventive services, most outpatient medical services, outpatient mental health/substance abuse services, medications, and equipment and supplies will be included in Part B as determined by individual state and sub-state health boards. The CAUSE deductibles associated with each of the aforementioned services will be determined by the respective health boards to ensure fairness to providers, while maintaining the quality and affordability of services.

Lastly, the ceiling on post-graduate residency training slots for medical students will be lifted to increase the number of board certified physicians able to care for patients. This will guarantee greater numbers of doctors in any given medical facility, increasing the amount of patients able to been seen by a physician and the amount of time and care given to each patient. This will also help provide every individual with a primary care physician, cutting back on chronic disease and high long-term care costs. The quality of care given to both CAUSE holders and private insurance holders would potentially increase.

Adults Ages 65 And Older: Medicare beneficiaries currently consist of individuals ages 65 and older, people with end stage renal disease, and people classified as disabled through the Social Security Administration. Under the CAUSE approach these persons will be provided the current Medicare coverage and cost-sharing structure, but coverage may be modified based on recommendations of the national health board. Under CAUSE, Medicare Part D will be absorbed by what is now Medicare Part B; Medicare Part B will in turn be redesigned to include the vital aspects of Medicare Part D in a more efficient and effective way. CAUSE will eliminate Medicare Part C completely. Services from Medicare parts A and B may be reimbursed on a fee-for-service basis or through qualifying managed care plans. Reimbursement to managed care plans will be on a case-mix adjusted basis that will be based on the medical complexity of patient population, but cannot exceed 95 percent of a new Average Annual Per Capita Cost (AAPCC) covering all of CAUSE.

Insurance Market Reforms

Reforms will be made to the insurance market in three ways. First, the qualifying private plans would not be able to deny children coverage due to health status. Private wraparound plans for adults who buy into the CAUSE plan Part B would not be able to deny coverage due to health status. Lastly, community-based premiums will be charged for children in wraparound plans. This will make more readily available a higher quality of insurance, especially to those most in need of high-quality, private health care plans.

An important part of continuity of care and promotion of health is ensuring that patients stay on their prescribed medications even when they change insurance coverage. CAUSE will, without exception, cover a patient's medical regimen even when the patient changes his or her health care insurance plan or coverage. The choice of medical regimen will be determined by the physician and patient.

Administrative Modifications

The CAUSE approach will be administered through a national health board that serves as a center for medical effectiveness. It will consist of clinicians, researchers, hospital

administrators, business community members, health care managers and economists, nurses, health insurance and managed care organization representatives, consumer groups, patient representatives, public health experts, pharmacists versed on the effectiveness of medications and the costs of drug development, and health policy scholars. Providing a large range of experts will guarantee that all sides of every health issue are looked at carefully and that the best solution or solutions are always made. National health board members will be chosen by the president and confirmed by the Senate for at least 10-year terms so as to exceed the tenure of any single presidential administration and ensure continuity in policy.

There will be many other important functions of the national health board. One will be to help produce and publicize information that promotes the adoption of clinically based medicine and establishes incentives for best practices. Targeted funding will be provided through the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH) for research which will evaluate new and existing medical treatments and devices on their effectiveness in making our society healthier. Researchers will include health policy experts at academic centers, independent research staffs, and private pharmaceutical or biotechnology companies. A team of research analysts employed by the board will investigate the cost-effectiveness and value of certain medical tests and treatments. The team will also make recommendations regarding what drugs and procedures ought to be covered based on demonstrated effectiveness.

Funding from the board will allow for hospitals and physicians to coordinate appropriate pilot programs, while eliminating co-pays for those procedures or tests that are most effective and increasing co-pays for treatment options found inconsistent with evidence-based medical management. Funding would come from 0.05 percent of projected CAUSE spending from the Medicare Hospital Insurance Trust Fund, 0.05 percent of the projected Medicaid spending from general revenues, and an assessment of 0.05 percent of private insurance premiums. The national health board would also alter reimbursements for physicians by increasing payments for services that result in better health outcomes and have historically been poorly reimbursed, including but not limited to prevention, diagnosis, coordination of care, and following evidenced-based medicine. It will also reduce physician payments for procedures and tests that are not thought to improve health outcomes or quality of life.

There will be at least one elected and appointed health board for each state; states with larger populations could have sub-state regional elected and appointed health boards to keep health care uniquely formed for the specific needs of any given population or special

needs due to region. Board membership selection would be designed to ensure that all stakeholders are represented. This would allow the different health needs and patient populations of each state and sub-state region to communicate needs and policies to the national health board.

State and sub-state boards will monitor CAUSE costs and develop plans for increasing effectiveness and efficiency of CAUSE delivery. The national health board and state health boards will also work with the present Medicare intermediaries in administering the new approach. Public health issues, credentialing and licensure, formularies, malpractice, and safety forums remain under state jurisdiction. State and sub-state boards will also provide a public forum for debate and public input on issues such as ethics, value purchasing, and coverage.

Modifications to Current Medicare Health Care Delivery

Much of the present Medicare and health care delivery framework will remain intact. Some adjustments will be made to areas such as payments. Payments to providers will be a combination of fee-for-service, salary, and capitation to the variety of health delivery systems that we presently have. Fee schedules will be altered to pay more for cognitive services and procedures shown to be of benefit, and less for procedures deemed marginally useful for enhancement of health. Payment for identical services will be uniform regardless of physician specialty. The Federal Medical Assistance Program (FMAP) will be changed to provide supplemental federal funding to large sub-state areas with populations of 500,000 people or more that are poorer than the state averages. This will successfully increase access to health care and enhance the quality of care. Fee-for-service payments for procedures and services should be nationally uniform, with adjustments for differences in cost of living. Additional adjustments based on population health and health care system features will be made into fee-for-service rates. Similar factors will be considered in establishing local area costs as a basis for negotiating organized delivery system rates.

Modifications to Promote Health

The educational system as well as public policy will be utilized to encourage healthy habits in schools and neighborhoods. This will work in prevention, helping attend to habits that contribute to poor health, which in turn will create a generally healthier nation. Ideas like nutrition becoming a part of the elementary and secondary school curriculum, junk food and soda being banned in schools, and having education on lifelong physical activity implemented in schools would help promote prevention from an early age.

To promote health, the reform will encourage utilizing the employer/employee connection in health care. Tax credits will be given to employers to offer programs that enhance health of employees in areas such as exercise, weight loss, and healthy food options. Good health practices such as blood sugar measurement, hemoglobin A1C, blood pressure, cholesterol level, weight, body mass index, and smoking cessation will be rewarded.

If patients meet benchmarks, they could receive rebates or they could be eligible for lower insurance premiums from employers or through CAUSE. The tax code would be amended to allow employees to use flexible spending accounts for specified programs that reward good health practices. The Health Insurance Portability and Accountability Act (HIPPA) would be amended to mandate that all insurance plans are exempt from deductibles as preventive services. This would be recommended and regulated by the national health board with input from the regional boards. To fund such programs, the federal government will increase the federal excise tax on cigarettes to $5.39, with a proportional increase in the taxes on other tobacco products.

To further promote health, primary care and care coordination will be strengthened. Strengthening strategies will include offering financial incentives for medical school graduates to enter primary care specialties and remuneration for cognitive services will be increased relative to procedures. Quality and efficiency-based economic incentives will be offered for physicians who provide patients a medical home as their primary care physician. Additional providers will be trained to accommodate the repeal of the freeze on postgraduate training programs. Training will be modified to encourage primary care; incentives will be provided in the form of pay and a cut in medical school expenses.

Establishment of Systems that Improve the Use of Information

A Health Information Technology (HIT) program will be promoted by CAUSE. This will consist of the federal government levying a 1 percent tax on private insurance premiums and spending 1 percent of CAUSE expenditures for HIT. There could also be matching funds with the states to provide capital assistance to providers as they begin to adopt the HIT program. Federal matching funds with the states will help to develop health information exchange networks. Advancing health information through technology will help health care providers provide the best treatment possible in a more direct and efficient way.

Medical Malpractice Policies

CAUSE would require malpractice law reform nationally in order to reduce the costs of malpractice insurance for providers. Under CAUSE, an individual who files a malpractice claim in state court should have the facts of the case reviewed by a panel chosen in consultation with the state health boards that consists of not less than one qualified medical expert, a physician whose specialty is appropriate to the case, a community representative, and a legal expert. The panel will review the facts of the case to verify that a malpractice claim exists. There would be a presumption of reasonableness if the health care provider demonstrates adherence to the accepted evidence-based and clinical practice guidelines established by the national health board. Using the panel findings, the individual will have the option to engage in non-binding mediation prior to filing an action in court. There would be sanctions against attorneys who file frivolous malpractice claims in court.

CAUSE: YEARS 6–10

In this phase the new national basic care system for children gets more intensive cost control while adults 19–64 will get Part II basic outpatient, primary, and preventive care with the option to purchase Part I coverage at full cost. This will cause private supplement markets to further expand.

The plan will remain the same for children ages 0–18, but covered services may be modified based on recommendations from the national health board.

Individuals ages 19–64 will all become beneficiaries of what is currently Medicare Part B, with the option to purchase private coverage for hospital and catastrophic care. Individuals will pay income-adjusted premiums. There will be a variable deductible based on the value of services in promoting health, and the national health board's research findings will modify coverage for services. Employers and individuals will still have the option to buy into a public plan modeled after the current Medicare Part A (inpatient care).

For individuals 65 and older, CAUSE will remain the same as in year 1–5 of plan implementation.

State and sub-state boards will receive a budget based on the cost information for children ages 0–18, as related to CAUSE, for years 2010–2015. State boards will work within a budget that has been adjusted for population and health care costs. The national health board will negotiate rates and contracts with providers and health care systems. Most plan elements from years 1–5 will remain the same; the administrative modifications to the current Medicare system, the insurance market reforms, and the modifications to promote health remain intact.

CAUSE: YEARS 11–15

In this phase there is further cost control and quality improvement to CAUSE. Persons 60 and older receive CAUSE Part I and Part II with option to purchase supplemental private coverage.

For individuals ages 0–18, the plan will remain the same as in years 6–10. Covered services may be modified based on recommendations from the national health board.

All individuals ages 19–59 will remain beneficiaries of what is currently Medicare Part B. The option to buy into what is currently Medicare Part A will be the same as for those 19–64 in years 6–10 of plan implementation.

Everyone over the age of 60 will become beneficiaries of CAUSE, covered by what are currently Medicare Part A and B. The option to purchase private coverage is still available.

CAUSE: AFTER YEAR 15

All U.S. residents are enrolled in CAUSE Part I and Part II. All U.S. residents continue to have the option to purchase private supplemental plans.

After 15 years the CAUSE approach will be completely implemented. Specific benefits and deductibles associated with covered services will be determined by the national health board.

As in the previous years of CAUSE, private wraparound plans may be purchased to cover deductibles and out-of-pocket costs for services covered by CAUSE and individuals wanting more than the covered services in the basic plan will be able to buy supplemental coverage through private insurance companies. CAUSE private supplemental plans would still not be able to deny coverage to individuals due to health status. Individuals who want more covered services than those available in the basic plan will be able to purchase a secondary policy from private insurers. This would not be governmentally financed or subsidized. Individuals or firms offering supplemental coverage will not receive tax deductions.

The CAUSE approach will financially cover services determined by the national health board to be successful, after receiving input from state and sub-state regional health boards. These would be services that are found to be optimal for the nation's health, based on the principles of evidence-based medicine. Covered services for the basic plan will be determined by the national health board, following recommendations by the NIH, research analysts, and all of the public input of the regional boards.

These services would include inpatient care, prescription drugs, primary prevention, outpatient care, mental health, vision, hearing services, dental care, emergency care, long-term care separating the medical component from the medical services only to encourage in-home care, physical therapy, occupational therapy, and hospice care. Only the healthcare components of long-term care (and not the so-called "hotel" component) will be covered by CAUSE.

Individuals will be able to rely on private long-term care insurance or Medicaid for these components of long-term care. Not everything in the above services will necessarily be included in the basic plan. It is important that the covered services need to be recognized as medically necessary so as to not undercut basic health care access. In year 15, there will not be cost-sharing for items in which evidence-based medicine has shown cost-saving and benefit to both patient and society so that there is no barrier to obtain the service. There will be cost-sharing for other items not shown to be cost-saving but that are necessary to avoid overutilization of the system.

Medicaid eligibility will be established by states, but minimum eligibility will be at 150 percent of the FPL. Medicaid will pay premiums, deductibles, long-term care hotel component, and additional chronic care benefits as in many current state plans. States will not be able to establish reimbursement rates that are lower than the CAUSE approach. The CAUSE approach will continue to contract with private intermediaries to help process claims and help with diverse managed care and special population plans.

Streamlining the Health Care Delivery System by Removing Duplications in Medical Coverage

In order to streamline the current health care system to avoid duplicated coverage, and ultimately cut costs needed for health care, the current workers' compensation system for medical coverage would be removed. It would become a legal process through which qualified physicians are hired by the state to determine the extent of the claimed disability. This process would be similar to the process used by the Social Security Administration when determining disability.

Multiple benefits would come from this, including saving money by eliminating duplicate services like separate health care providers, lowered premium costs, increased administrative efficiency, and allowing patients to see their own physicians for work-related injuries, thus saving businesses money by lowering or eliminating workers' compensation premiums.

Medical coverage in automobile insurance would also be removed as to avoid duplicated coverage and costs. This would also help to lower premium costs while enhancing efficiency and lessen administrative costs by having patients pay for one delivery system whether injured at home, at work, or in their vehicles.

Cost Savings

There are potential savings to be found in the current health care system, especially in producing and using better information. Using projections offered by the Commonwealth Fund, it is estimated that there will be savings of $88 billion dollars over 10 years by using health information technology. Practicing evidence-based medicine would save $368 billion dollars over the same period. Promoting health and disease prevention could reduce obesity, saving $283 billion dollars. It could reduce tobacco use, saving $191 billion dollars, and positive incentives for health could save $9 billion dollars, all in 10 years. That means there is a projected $939 billion dollar savings to be gained in only the first 10 years of the program by using better information.

Aligning incentives with quality and efficiency by initiating hospital pay-for-performance principles would save a projected $34 billion dollars over 10 years. By simply strengthening primary care and care coordination, we project a savings of $194 billion over 10 years. By eliminating federal tax exemptions for premium contributions when CAUSE is enacted will bring a savings of $200 billion per year. This is a $228 billion dollar savings in 10 years, plus $200 billion each year. By correcting price signals in the health care market, we could save money in another area. Resetting benchmarks for Medicare Advantage would save

$50 billion over 10 years. By negotiating prescription drug prices, we could potentially save $43 billion to $100 billion over 10 years. Lastly, limiting payment updates in high-cost areas could save $158 billion over 10 years. Altogether, the proposed reforms can result in savings of about $2 trillion dollars by improving national health status, reducing administrative costs, aligning incentives, and fixing price signals in the healthcare market.

Associated Costs

Covering children ages 0–18 will be partially offset by eliminating the State Children's Health Insurance Program (SCHIP) and removing much of the Medicaid burden from state budgets. This includes extending Part B coverage to everyone during years 5–10, and removal of health care premiums paid to private insurers for employers and individuals will offset extending CAUSE past year 15.

Sources of Revenue

For the first phase of implementation, 2010–2015, CAUSE will be financed through current Medicare and federal Medicaid expenditures and through imposition of a financial transaction tax of 0.5 percent on sale of stocks, smaller fees on trading of government and corporate bonds, futures contracts, swaps in currency and options, and by increasing taxes on tobacco products. This new tax will raise a projected $120 to $150 billion dollars annually for CAUSE.

Healthcare efficiency improvements and early impacts of preventive measures will cover much of the additional costs during the next two phases of implementation. At full implementation, after 2025, additional sources of revenue will be required. Other sources of revenue will consist of increasing the payroll tax to employers by 3.3 percent, providing $500 to $600 billion dollars annually.

Finally, it may be necessary to include a 2 percent national sales tax so that everyone, regardless of income or citizenship status, contributes to the cost since all U.S. residents and visitors purchase goods and services; this will exempt non-discretionary items such as groceries, utilities and housing. In considering these additional taxes, reduced individual and employer costs for health care and net reductions in the total costs of the health care system in the U.S. must be taken into account.

WHY THE CAUSE MODEL?

Health Care Must Be Continuous

Continuous coverage is necessary for management of a chronic disease. Twenty percent of all Americans have multiple chronic conditions, and almost 80 percent of all health care spending is on patients with chronic conditions. Sixty-six percent of Medicare spending is for patients with five or more chronic conditions. Patients with chronic conditions account for 76 percent of inpatient stays, 72 percent of physician visits, 88 percent of prescriptions and 96 percent of home health care visits; therefore, chronic conditions account for a substantial share of health care costs.

To control costs and prevent unnecessary hospitalization, an insured population needs access to primary care physicians (a medical home) who can focus on preventing disease, identify disease processes early, practice evidence-based medicine to slow disease progression, and coordinate care among ancillary services and specialists. The consequences of lapses in continuous care include increased morbidity and mortality. Uninsured patients, at time of diagnosis of cancer, were 1.6 times more likely to die in five years than those with insurance and have age-specific mortality rates that are 25 percent higher than privately insured adults. In the year 2000, there were 18,000 avoidable deaths among adults ages 25–64 due to lack of health insurance. Lack of routine health care also affects normal development in children.

Health Care Must Be Affordable

The Milliman Medical Index (MMI) estimates that total annual medical costs for a family of four in 2008 was $15,609. Of this, employers will pay $9,442, while employees will spend $3,492 in premiums and $2,675 in out-of-pocket costs. The average household income proportion spent on health care has risen 12 percent and now approaches one-fifth of the average household's spending. Without an employer's contribution, the cost of health care would be one-third of the family's pretax income.

Two-thirds of Americans under age 65 (170 million people) have employment-based insurance, either offered at their jobs or through a spouse or parent. Job-based coverage is affected by health care costs that are rising faster than wages. Since the year 2000, health care premiums for family coverage have grown by 87 percent, compared with cumulative inflation of 18 percent and wage increases of 20 percent, based on the national average. The proportion of employers offering health benefits to employees has fallen from 69 percent to 61 percent, and only seven percent of Americans under age 65 purchase individual or family policies from the private insurance market without employer assistance.

The inability to afford insurance, whether or not employers provide it, is the main reason why people are uninsured. Lack of a financial safety net for families diagnosed with serious medical illnesses is a major reason for bankruptcy. By making health care affordable, the financial health of our families—and therefore our country—gets better.

Health Care Must Be Universal

In 2007, 46 million Americans did not have health insurance. Of these 46 million people, 9.4 million are uninsured children. There are many reasons for the large number of uninsured people. First, medical insurance is tied to employment. Job-based coverage is affected by health care costs rising faster than wages. Second, people often lose their insurance when they become unemployed. Third, when workers retire their spouses may be left without insurance. Fourth, children turning 19 lose insurance under their parents' plan.

The lack of affordability of premiums is the most important reason for the number of uninsured. Medical underwriting practices in states that allow risk rating by age and health status make coverage unaffordable or restrict eligibility. Public programs such as Medicaid and SCHIP have enrollment policies and eligibility that can vary from state to state, and rules can change depending on the economic conditions of the state administering the program. Society pays a steep price when there is insufficient health care for everyone. Costs of increased morbidity and mortality among uninsured Americans are estimated to be $65 to $130 billion per year. In 2003, there was an estimated $35 billion of uncompensated care to the uninsured and the costs have continued to go up since then.

The uninsured affect access to care in the community. For example, rural hospitals with a high uninsured census have fewer intensive care unit (ICU) beds and urban hospitals with a high uninsured census are less likely to have trauma centers. Hospitals with a high uninsured census have overcrowded emergency rooms and exceptionally long wait times, have lower payment rates, and fewer specialty staff.

The uninsured also adversely affect the national economy. Businesses lose profitability every year because of lost productivity from uninsured workers. The HR Policy Association, an association of senior human resource executives, puts the cost of reduced productivity at $87 billion to $126 billion for the year 2004. Employers pay additional costs when health care providers treat the uninsured, amounting on average to $922 per family. American automobile manufacturers claim that $1,400 to $1,500 of the cost of every car or truck can be attributed to health care benefits. Universal health care ending the link between employment and access to health insurance will free employees from career constraints and make our businesses more globally competitive.

Health Care Must Be Sustainable

Health care spending exceeded $2 trillion dollars in 2006; this represents 16 percent of the gross domestic product (GDP). The Centers for Medicare & Medicaid Services (CMS) project that health care spending will be more than $4.1 trillion by 2016, accounting for 19.6 percent of the GDP. Government spending accounted for 46 percent of total health spending in 2006. The federal revenue spent comes from two major entitlement programs, Medicare and Medicaid; federal spending on these two programs was 21 percent of the entire federal budget. Under present growth rates, Medicare and Medicaid spending will rise to eight percent of the GDP by 2030, 14 percent of the GDP by 2050 and 31 percent of the GDP by 2082.

This unbridled growth ensures that there will be a Medicare crisis before there is a social security crisis. Medicare Part A's (coverage for hospital, Extended Care Facility [ECF], and other facility stays), $326 billion trust fund will be wiped out by 2019. Since 2008, Medicare Part A has only enough dedicated tax revenues to cover 94 percent of its spending.

The Medicare Trustees Report for 2008 states that Congress could bring Medicare Part A into balance either by reducing Medicare spending by 51 percent or by increasing payroll taxes from 2.9 percent to 6.4 percent. Medicare Part B (physician costs and outpatient services) faces rapid growth, from $187 billion in 2008 to $325 billion in 2017. This estimate assumes that physicians' fees will be cut 40 percent over the next nine years.

Private insurance companies cannot afford to take care of the oldest or sickest patients because the premiums that they would have to charge would be too high for individuals or families to pay out of pocket. In 2004, health care spending per capita was $14,797 for individual patients over age 65 and $25,691 for individual patients 85 and older. Therefore there has to be public financing for most of the cost of taking care of our elders.

Policymakers cannot shift cost burdens to the states, which are facing rising costs and limited resources. The bulk of the cost must be federally financed because the federal government is in a better position to fund state programs even during economic downturns. It is noteworthy that none of the health care reforms currently under consideration by the government will save Medicare.

Health Care Must Be Effective

The U.S. spends twice per capita what other industrialized countries spend for health care, yet the present system is not always as effective. This is illustrated by the unfortunate fact that the U.S. now ranks last among 19 industrialized nations in the number of deaths that could have been prevented with timely, effective and efficient care The U.S.

system is doing a poor job in chronic disease management with regard to diabetes and hypertension. Achieving the level of control seen in the best health plans would prevent up to 39,000 deaths annually. Only half of adults receive all age-appropriate preventive care. Mental health issues have gone largely ignored by health insurance. One-third of adults with major depression never receive care.

The present U.S. system is not always timely or patient-centered; 46 percent of patients report having same- or next-day appointments when ill, which compares unfavorably to a benchmark of 81 percent in the industrialized countries. U.S. adults are more likely than adults in seven other countries to go to emergency rooms to receive after-hours health care; 21 percent of these U.S. adults went to the emergency room for a condition that could have been treated by their physicians, if they had primary care physicians. In Germany, this rate is at six percent.

Currently, the U.S. health care system lacks primary care physicians. Seventy-three percent of adults report difficulty with access to primary care, compared with 61 percent in 2005. In 2005, 35 percent of non-elderly adults had no access to primary care physicians. To provide primary preventive care for 70 million more adults, to achieve an 80 percent benchmark goal, more primary care physicians are needed. Because of this shortage in primary care physicians, care is not always coordinated. Twenty-two percent of U.S. adults suffering from health issues reported that test results or records were unavailable at the time of their appointments. U.S. patients were five times more likely than patients in the Netherlands to say that doctors unnecessarily repeated tests. Coordination of care at the time of hospital discharge is proven to prevent complications and readmissions to the hospital, cutting down the cost of duplicate visits.

The current system is not efficient due to high administrative costs associated with private insurance. Insurance administrative costs are three times higher in the U.S. than in the most health care efficient countries, which are Finland, Japan, and Austria. Lowering administrative costs to those of the benchmark countries would save the U.S. health care system $100 billion a year. From 2000 to 2006, per capita administrative costs rose 68 percent, from $289 to $485, and health care expenditures increased 47 percent over the same period.

THE CAUSE APPROACH IS THE SOLUTION

After 15 years, the CAUSE approach would result in a health care system that provides continuous care with no coverage lapses. Once people are enrolled into the system they will remain enrolled. Eligibility will be truly continuous because coverage is not employment-based. Once someone is enrolled in the program they would not have to do so again; gaps in coverage would end.

At full implementation the CAUSE approach would result in a health care system that is affordable to individuals and business. The financial burden on employers of both small and large businesses would decrease due to the fact that employers would no longer be required to pay health care premiums for employees. Premiums for workers' compensation and automobile insurance would drop. The various revenue sources, including the financial transaction tax, would spread the financial responsibility of insurance coverage more broadly. Lack of co-pays for evidence-based services and some cost-sharing for less necessary services can remove barriers to necessary care and limit overutilization of the health care system.

At full implementation the CAUSE approach would result in a health care system that provides universal coverage; coverage would have mandatory enrollment for everyone under the age of 65. There would be no eligibility determinations, no re-enrollment procedures and limited enrollment data. Individuals who fail to register initially would be automatically registered when seeking services; this would make enforcement of the individual mandate easier.

The CAUSE approach would result in a health care system that is sustainable for the country; this will happen by having all stakeholders share in its cost and delivery. Sustainability will depend on four factors, which the plan addresses: more health care providers will be required to serve the increased number of insured, cost increases must be contained, there must be effective federal oversight, and everyone must participate. There must be a mandate that everyone is covered and automatically enrolled, but the plan must be phased in.

The CAUSE approach is a public plan modeled after Medicare. Private plans will offer wraparound and supplemental policies to pay for out-of-pocket costs, deductibles and services not covered by CAUSE. Savings will result from:

1. Lower administrative costs from federal financing of CAUSE and by having private insurance fund supplemental health coverage

2. Elimination of the Medicare Advantage Program (Part C)

3. Absorption of Medicare Part D by what is currently Medicare Part B (CAUSE Part II), which will provide drug coverage with negotiated prices

4. Altered fee schedules and reduced economic incentives for physicians to do medically unnecessary procedures and tests

5. An education system that focuses on healthy habits for children and adults;

6. Federal financing that allows for funding mechanisms to better withstand economic downturns, unlike state and local funding

7. Elimination of the employer tax write off for the payment of employee health insurance premiums, once CAUSE is fully implemented and employers are no longer required to pay for health insurance

The culmination of these changes is that more money will go to patient care.

The CAUSE approach would result in a health care system that is effective and efficient. It will decrease unnecessary administrative costs associated with health care. Covered services will be determined by the national health board. This will help national quality standards be defined, monitored and reimbursed uniformly. There will be a national impetus to adopt policies that enhance prevention. The national health board will also ensure cost-effective care and alter reimbursements for physicians. By increasing payments for services that result in better health outcomes and reducing payments for tests and procedures not thought to improve health, incentives will become aligned with quality of care. The national health board will receive information from state and regional boards to allow for variations in local health needs and to promote evidence-based medicine. The plan will cover everyone; the long-term viability of the Medicare system is addressed because services that will be covered are services that prove to be beneficial to patients and because patients using and paying into the system is the same.

CAUSE accomplishes the short- and long-term objective of making our populace healthier and it begins by covering our children. Phasing in health care reforms over 15 years ensures that we have trained enough primary care physicians and other providers to care for the newly insured. This approach will also ultimately relieve employers of the responsibility of providing health insurance to their employees, allowing businesses to better compete with other companies around the world.

This new system also will improve administrative efficiency by eliminating the workers' compensation system's role in providing health care coverage. It ends the need for automobile insurance to have medical coverage. This should lower workers' compensation and automobile insurance premiums for employers and employees. The delivery of care to patients is improved by letting them go to their own physicians for care whether they are injured at work, in their vehicles, or at home. Those patients who wish for coverage services outside of the public plan have the option to buy a secondary policy through private insurance.

The CAUSE approach is unique because it preserves the choice of physician and delivery systems through each stage of implementation—including the last stage—where although the financing is public, the delivery of care still remains private.

1625 E. Shaw Ave., Suite 146
Fresno, CA 93710
www.cvhpi.org