The Time is Now for Real Reform

Nick W. Turkal, MD
CEO, Aurora Health Care
American health care, our elected leaders say, is in need of repealing, replacing or reforming.

I’ve been listening to this ongoing debate for some time and scrutinized the impact of the most recent federal legislation. From my position as CEO of a nationally recognized health system caring each year for more than a million people, and as a family physician, I believe it’s time to weigh in again on this topic. It’s not my intention to sound preachy, but I strongly believe everyone needs to care about this issue. Health care affects every American at some point in our lives. It’s critical that we all take responsibility to make it better. And this means everyone: we as citizens, providers of health care, health insurers, federal, state and local policymakers and literally all stakeholders. From where I sit, on the front lines of caring for people, we are missing the big picture and nibbling at the edges of real reform. Further, we are making the mistake of automatically putting people in various groups according to our preconceived or historical notions of them instead of paying adequate attention to what they really need.

Let’s remember that reform should first and foremost be about the people we serve – our patients and their health. In this paper, I am suggesting several ways we can change the discussion for real health care reform by agreeing on immutable principles, viewing insurance coverage in a new way and strongly urging our elected leaders to work together in a bipartisan manner to improve American health care for the people for whom it is intended: patients in need of care.
We Can Be Better

I recognize that the continued scrutiny over health care is warranted. If you work in health care, in health insurance or any related field or if you or a family member has seen a physician or been in a hospital lately, or if you’ve tried to understand the bill you just received from us, you know we can do better. As a sector. As a country. We in the health care sector need to take responsibility to make things simpler, easier, more transparent, more affordable and understandable. Furthermore, although it might seem obvious that health care reform needs to happen, we need to acknowledge that there is no panacea or silver bullet. We didn’t get here overnight and it will take a comprehensive set of strategies to make a healthier America. As we do this, it’s critical to first take a step back before we can move forward. Let’s answer the fundamental question as to why reform should occur in the first place. As with any complex issue, unless we have a clear understanding of current problems, any solution we propose is likely to further confound the situation. You wouldn’t want your doctor to prescribe something to resolve a symptom while ignoring your underlying health issues, would you?

I believe it’s important to ask how American health care stacks up in the world. Well, we lead the world in several categories. The good news: In overall quality, particularly in our ability to deliver acute services to save and extend lives, we are clearly the best. We have superior technology and near universal access to it. We have enough intensive care unit beds, world class surgeons and superior medical techniques and procedures. The bad news: We as a nation spend more on health care than any other country, nearly a fifth of our gross domestic product, and we don’t have as much to show for it. Our mortality statistics, perinatal mortality and lack of wellness-related outcomes suggest that we are far from the world leader. In these categories, we are almost shamefully behind other developed nations, particularly when it comes to health disparities and life expectancies in certain communities, namely minorities.

On a positive and often glossed over note, health care is an important part of the American economic engine. Health care is often characterized as a cost to society and business, yet as the United States continues to move from a manufacturing economy to an information economy, the growth and innovation in health care has provided stable and sustaining employment for millions of Americans. In many communities today, it’s not the factory or the retailer that’s the major employer; it’s the local health care provider. Construction of health care facilities to meet the demand of the aging Baby Boomer demographic, and provide settings that are more cost-effective and patient-friendly, also provide good jobs and often anchor developments to spur other construction, in hotels, housing units and other associated development.

So, does health care need reform? Certainly. We need to improve quality and access, reduce costs, and move from a model of sick care to well care. But we’ll face some obstacles in reform that should be named at the outset.
Obstacles to Progress We Must Face

As we consider the best path to reform, there are barriers that continue to ‘get in the way’ of an honest discussion.

• We have been unable to come to a basic agreement as to whether health care is a right or a privilege. So we develop solutions to the issues we deem need repairing or reforming without philosophical common ground, and we wonder why we talk past each other. Our choices in this part of the debate quickly become binary. Right vs. privilege. Market forces vs. government involvement. In reality, there should be a mix of these principles. But let’s remember, we’ve developed certain laws that suggest elements of health care are a right, such as the EMTALA law making certain that people with serious conditions are not turned away from emergency rooms. We agree that the primary objective should be how we keep them healthy and out of the emergency room in the first place. Isn’t it time to agree that some basic access to health care is a right in a country like the United States?

• We have argued about whether access and coverage should be equal for all, or not, yet we do not cover all of our citizens with even the most basic insurance. We’re unable to determine whether it’s appropriate to mandate coverage, though as a society we have mandated numerous other things, such as automobile insurance in many states. Can we now have a dialogue about basic coverage options?

• We have relied on employer based insurance to a great degree, and then tried to mimic it in government programs which cover and try to manage the health of decidedly different populations. Perhaps now is the time to acknowledge that populations differ, and design coverage that will truly address their health needs.

• And we have been unable to determine what belongs to the federal government, what belongs to the states and what belongs to our communities. This is a healthy debate, but one that needs to come to a degree of resolution if we are going to improve American health care.

Individuals and groups are afraid of “losing” something important in any type of reform. This is natural and understandable, but here is the current reality: We spend plenty of money on health care in the United States, but hardly anyone is satisfied with the results. Increasingly, families cannot afford health care coverage unless they forgo other basic necessities. There is still concern among families that a health crisis can cause financial calamity. Employers are reaching a breaking point as costs continue to rise. And sadly, millions of Americans have no coverage, meaning that they resort to expensive emergency visits as their last and only option. These current trends are not sustainable. This debate should be around continuous improvement of our system with all relevant stakeholders. Let’s move past the obstacles to get to solutions.
Basic Tenets of Real Reform

I may be an unfailing optimist but I believe that if we can agree on the desired outcomes for reform, are willing to learn from our past mistakes and stimulate rather than frustrate collaboration, we can find workable solutions. We can change our habit of talking past one another by putting a stake in the ground on what we can agree on. I believe that sustainable reform can happen if we keep our patients – the people who come to us for their health needs – at the center of all we do while building reform on three pillars:

- **Coverage and Access** - this means health insurance options for the maximum number of citizens with the ability to find convenient, quality health care.

- **Affordability** - affordable coverage for employers, the federal, state and local governments, families, and individuals. We should underscore that we spend enough in total as a nation on health care, keep its care spend at or below its current rate of our gross domestic product and move ahead. Quality matters -- each time we measure quality and standardize care according to good data, people have better results and costs decrease. We also need to acknowledge the cost equity arguments that the employer community articulates; businesses continue to make up the cost for the underfunding of government programs through a cost shift in premiums to employees.

- **Overall Value** - our needs for health care are as unique as our DNA. Whether you are a healthy newborn or senior facing the end of life, your needs are diverse and change over time. Our health care system should address those needs regardless of your income or age. This care should always be rooted in quality and service which, when combined with affordable cost, translate into a healthier population and greater value for those who buy the coverage and experience the services. We need to incentivize the right things - good outcomes, access, and service at lower cost. The fundamental problem with our system for the past 60 years has been that most incentives are related to doing more, not less. To change this, we need to accelerate incentives for value not just volume of services. Health care is not as different from other industries as some in health care would attest. But we’ve made it very complex because we have the wrong incentives. We should more quickly and effectively incentivize wellness and prevention and transition from our current model of “sick” care to “health” care. Rewarding true collaboration among stakeholders, doctors, insurance companies, medical device manufacturers, pharmaceutical companies and patients is another key tactic to add value. As is the smart use of technology. We are finally getting traction in reducing costs and reducing errors via the use of electronic health records. Let’s continue that journey and continue to improve the products and interoperability of platforms to help patients become empowered with information to better manage their own health.

These may not be new concepts in the study or practice of health care, yet it seems we slight them in our debates. Can we start the discussion fresh and agree that these are foundational and acknowledge they are intertwined?
A Different Way to Think about Coverage and Care

We need to become clearer about how we manage the health of populations. This is a critical strategic imperative in what we do to reform American health care. This means the optimal management of groups of patients in a population according to their risks and needs. In other words, let’s stop trying to manage every group of people the same way. Children are different than seniors. Those with chronic diseases have different needs than healthy people. Perhaps more than anything else, health care reform is truly about managing populations to optimal health and wellness at an appropriate cost.

The issue at hand is that we have created complex silos (insurance groupings and programs) that segment these populations, but not in a way that enhances health. If you are poor with a preexisting health condition, you are eligible for Medicaid. If you are a senior, you are eligible for Medicare, and regardless of your health status, the program looks the same. If you are an employee with chronic conditions, you may have employer sponsored health care. This current silo approach to managing health conditions limits the value of population health management, providing the wrong incentives and lack of clarity in desired outcomes.

Maybe we need to turn this thinking on its head and start anew with how we provide insurance to cover people, in direct association how we care for people for optimal health.

For example, the recent focus by Congress on high risk pools is promising, but it lacks the fundamental change necessary to deliver real reform. For real reform, let’s seriously consider a future state of health care that underscores the need to provide insurance coverage in a way that directly encourages those of us in the provider community (physicians, hospitals, health systems) to deliver efficient, convenient, safe, high-quality care. The two aspects of American health care – coverage and care - need to be much better coordinated and aligned for real reform to take hold and work.

The following coverage scenario envisions a model to help cover and more effectively manage the health needs of various groups of people based on their health and risk (for insurance purposes, since that’s a key aspect of this debate on reform). While it hasn’t been fully vetted in terms of its economics, it is directionally sound, and it will hopefully provoke a different way of thinking, casting aside sometimes politically charged program monikers in favor of actual ways to cover and care for our citizens. Remember, we are starting with the premise that we spend enough, but are not allocating resources correctly or incentivizing the right outcomes.

• **Healthy Focus Plans:** Commonly known as high risk pools. Let’s eliminate the silos in caring for our country’s sick citizens. Create a national pool, subsidized with state and federal government funds as well as employer and individual contributions, that provides coverage to those with preexisting conditions regardless of income and age. Eligible individuals include those people of all ages with certain chronic diseases, victims of accidents with disabilities, birth disorders, severe mental and behavioral health conditions and certain nursing home patients who are high risk and high care. According to the Kaiser Foundation, the sickest 10% of the population account for nearly two-thirds of health spending.
Currently, people in this group are often not receiving adequate care to maintain maximum health. Allow employers to buy into the pool for employees who meet the eligibility requirements. The needs of the proposed population will be better managed by providers, while employer and individual insurance consumer’s health care costs will decrease. Key to keeping people covered by this plan healthy are so called “wrap around” services that include behavioral health, transportation, financial literacy, social services and other services not necessarily confined to health care but helpful in promoting overall well-being. These services help to equip people to take more responsibility for their own health. Care coordination is also key to reducing costs. Much of the cost savings in this proposal lies in better and more effective management of this population.

- **Medicaid:** Costs and management in Medicaid should change dramatically with a focus on providing coverage to those from birth to age 26 who are not otherwise covered by their parents’ health plans. This would be constructed as a Healthy Children and Young Adult program, with a strong focus on prevention, healthy lifestyle education, and immunizations.

- **Individual and Group Insurance Markets:** Provide greater flexibility on the individual insurance market to offer individuals age 26 to 55 basic minimal plans with the ability to upgrade. Basic plans would include health, wellness, prevention, immunization and catastrophic care, with cost based on income/means. With the correct incentives to employers, this would be a moderately small group and would exclude those people with chronic conditions, including mental health and substance abuse disorders. Insurers should be incentivized to create new plans for individuals, families and groups. Crossing state line sales could encourage more development. With the correct balance in the high risk pools, risk would be moderated and this market would thrive. The need exists, but the products do not currently exist.

- **Medicare:** Medicare should change but less dramatically. By rebranding Medicare as Healthy Seniors and making it available beginning at age 55 for those not covered by employer or individual plans and to all seniors beginning at age 67. From age 55 to 67, there would be a cost to individuals on a sliding scale based on income. It would transition to a Medicare Advantage-like approach, with incentives to providers and insurers to provide excellent access, service and outcomes, including individualized end of life care plans that allow individuals maximum rights and controls, access to the right providers and access to home/hospice care when appropriate and desired. It would exclude certain high-risk individuals with multiple chronic and difficult to manage diseases or conditions. Certain low-risk nursing home patients would be covered in this category.

- **Employer based insurance:** As a key aspect of reform moving forward, employers would be provided incentives to offer insurance coverage, but to do so with a strong focus on prevention and wellness. Insurance risk would be modified by having certain employees with chronic diseases or conditions covered in high risk pools.

A chart depicting these plans is attached as an appendix.

In any case, any plan or program should produce affordability, quality and overall value for the people enrolled, and build on the coverage gains we have already made. Let’s keep the needs of patients front and center and continue this discussion.

Appendix

**Healthy Focus Plans** (formerly high risk pools) – includes patients currently in some other plans (i.e., high risk from Medicaid, SSI, dual eligible)

- Concept = more active management of those with chronic medical + mental health disorders; replaces Medicaid for elderly in nursing homes

**Healthy Children and Young Adult Plans** (formerly Medicaid) – runs only from birth to age 26

**Healthy Senior Plan** (formerly Medicare) – beginning at age 55 for those not covered by other insurance and at 67 for all

**Flexible Individual and Group Plans** – replaces exchange; focuses on basic plan for young adults

**Commercial, Private, Overlay** – Employer based insurance, open market, individual plans, plans for purchase that enhance coverage